THE 187TH GENERAL COURT OF
THE COMMONWEALTH OF MASSACHUSETTS

Bill S.2270

An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation.

Senate, May 17, 2012 – Text of the Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (being the text of Senate, No. 2260, printed as amended).

Actions for Bill S.2270

Date	Branch	Action
5/23/2012	House	Referred to the House committee on Ways and Means
5/30/2012	House	Committee recommended ought to pass with an amendment striking out all after the enacting clause and inserting in place thereof the text of House document numbered 4127
5/30/2012	House	Bill reported favorably by committee and referred to the committee on House Steering, Policy and Scheduling with the amendment pending
5/30/2012	House	Committee reported that the matter be placed in the Orders of the Day for the next sitting with the amendment pending
5/30/2012	House	Rules suspended
5/30/2012	House	Read second, amended (as recommended by the House committee on Ways and Means) and ordered to a third reading
6/5/2012	House	Read third
6/5/2012	House	Passed to be engrossed - 148 YEAS to 7 NAYS (See YEA and NAY in Supplement, No. 275)
6/14/2012	Senate	Rules suspended
6/14/2012	Senate	Senate NON-concurred in the House amendment
6/14/2012	Senate	Committee of conference (R. Moore-Petruccelli-Tarr) appointed
6/14/2012	House	Rules suspended
6/14/2012	House	House insisted on its actions

6/14/2012	House	Committee of Conference appointed (S. Walsh-Mariano-Barrows)
7/30/2012	Senate	Reported by S2400

Actions for Bill S.2400

Date	Branch	Action
7/30/2012	Senate	Reported from the committee of conference
7/30/2012	Senate	Reported on S2270
7/31/2012	Senate	Rules suspended
7/31/2012	Senate	Committee of conference report accepted -see Roll Call #295 [38 YEAS - 0 NAYS]
7/31/2012	House	Rules suspended
7/31/2012	House	Committee of conference report accepted, in concurrence - 133 YEAS to 20 NAYS (See YEA and NAY in Supplement, No. 357)
7/31/2012	House	Enacted
7/31/2012	Senate	Enacted and laid before the Governor
8/6/2012	Governor	Signed by the Governor, Chapter 224 of the Acts of 2012

Bill H.4155

Text of an amendment recommended by the committee on Ways and Means, as changed by the committee on Bills in the Third Reading and as amended by the House, to the Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2270). June 5, 2012.

Text of an amendment recommended by the committee on Ways and Means, as changed by the committee on Bills in the Third Reading and as amended by the House, to the Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2270). June 5, 2012.

Bill H.4128

The committee on Rules, reports, under the provisions of House Rules 7B and 7C, that the accompanying order relative to special procedures for consideration of the House Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (House, No. 4127) ought to be adopted.

The committee on Rules, reports, under the provisions of House Rules 7B and 7C, that the accompanying order relative to special procedures for consideration of the House Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (House, No. 4127) ought to be adopted.

Sponsors: John J. Binienda

Actions for Bill H.4128

Date	Branch	Action
5/30/2012	House	Reported from the House committee on Rules
5/30/2012	House	Amendment 1 rejected - 35 YEAS to 117 NAYS (See YEA and NAY in Supplement, No. 255)
5/30/2012	House	Adopted

Bill H.4127

An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation

Text of an amendment recommended by the committee on Ways and Means to the Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2270). May 30, 2012.

Sponsors: NONE

Actions for Bill H.4127

Date	Branch	Action
5/30/2012	House	Reported from the House committee on Ways and Means
5/30/2012	House	Recommended new text for S2270
5/30/2012	House	Order adopted, see H4128

5/30/2012	House	Substituted as new text for S2270
6/5/2012	House	Rules suspended
6/5/2012	House	Amendment 1 adopted
6/5/2012	House	Amendment 2 adopted
6/5/2012	House	Amendment 4 adopted
6/5/2012	House	Amendment 88 adopted
6/5/2012	House	Amendment 3 adopted, as changed
6/5/2012	House	Amendment 15 adopted
6/5/2012	House	Amendment 16 adopted
6/5/2012	House	Amendment 82 adopted
6/5/2012	House	Amendment 24 adopted
6/5/2012	House	Amendment 25 adopted
6/5/2012	House	Amendment 192 adopted, as changed
6/5/2012	House	Amendment 13 adopted
6/5/2012	House	Amendment 77 adopted
6/5/2012	House	Amendment 20 adopted, as changed
6/5/2012	House	Amendment 68 adopted
6/5/2012	House	Amendment 134 adopted
6/5/2012	House	Amendment 58 adopted

6/5/2012	House	Amendment 48 adopted
6/5/2012	House	Amendment 49 adopted
6/5/2012	House	Amendment 57 adopted
6/5/2012	House	Amendment 62 adopted
6/5/2012	House	Amendment 38 adopted
6/5/2012	House	Amendment 39 adopted
6/5/2012	House	Amendment 102 adopted
6/5/2012	House	Amendment 73 adopted
6/5/2012	House	Amendment 5 rejected
6/5/2012	House	Amendment 21 rejected - 7 YEAS to 146 NAYS (See YEA and NAY in Supplement, No. 269)
6/5/2012	House	Amendment 114 adopted
6/5/2012	House	Amendment 79 adopted
6/5/2012	House	Amendment 168 pending
6/5/2012	House	Further amendment adopted, precluding vote - 155 YEAS to 0 NAYS (See YEA and NAY in Supplement, No. 270)
6/5/2012	House	Amendment 90 adopted
6/5/2012	House	Amendment 143 adopted
6/5/2012	House	Amendment 149 rejected - 34 YEAS to 120 NAYS (See YEA and NAY in Supplement, No. 271)
6/5/2012	House	Amendment 19 adopted, as changed

6/5/2012	House	Amendment 104 adopted, as changed
6/5/2012	House	Amendment 126 rejected
6/5/2012	House	Amendment 160 adopted
6/5/2012	House	Amendment 161 rejected
6/5/2012	House	Amendment 26 adopted
6/5/2012	House	Amendment 151 adopted
6/5/2012	House	Amendment 155 adopted
6/5/2012	House	Amendment 269 adopted, as changed
6/5/2012	House	Amendment 162 adopted, as changed
6/5/2012	House	Amendment 170 adopted
6/5/2012	House	Amendment 175 rejected
6/5/2012	House	Amendment 179 adopted
6/5/2012	House	Amendment 180 adopted
6/5/2012	House	Amendment 182 adopted
6/5/2012	House	Amendment 189 adopted
6/5/2012	House	Amendment 196 adopted, as changed
6/5/2012	House	Amendment 146 adopted, as changed
6/5/2012	House	Amendment 185 adopted, as changed
6/5/2012	House	Amendment 207 adopted

6/5/2012	House	Amendment 209 rejected
6/5/2012	House	Amendment 210 adopted, as changed
6/5/2012	House	Amendment 208 rejected
6/5/2012	House	Amendment 187 adopted
6/5/2012	House	Amendment 186 rejected
6/5/2012	House	Amendment 213 adopted
6/5/2012	House	Amendment 240 adopted
6/5/2012	House	Amendment 80 adopted, as changed
6/5/2012	House	Amendment 273 adopted
6/5/2012	House	Amendment 191 adopted
6/5/2012	House	Amendment 256 adopted
6/5/2012	House	Amendment 257 adopted
6/5/2012	House	Amendment 226 adopted
6/5/2012	House	Amendment 200 adopted, as changed
6/5/2012	House	Amendment 258 adopted
6/5/2012	House	Amendment 263 adopted
6/5/2012	House	Amendment 271 adopted
6/5/2012	House	Amendment 81 adopted
6/5/2012	House	Amendment 93 adopted, as changed

6/5/2012	House	Amendment 131 adopted, as changed
6/5/2012	House	Amendment 211 adopted, as changed
6/5/2012	House	Amendment 215 adopted, as changed
6/5/2012	House	Amendment 69 adopted, as changed
6/5/2012	House	Amendment 35 adopted, as changed
6/5/2012	House	Amendment 36 adopted
6/5/2012	House	Amendment 37 adopted
6/5/2012	House	Amendment 138 adopted
6/5/2012	House	Amendment 241 adopted
6/5/2012	House	Amendment 28 adopted, as changed
6/5/2012	House	Amendment 41 adopted, as changed
6/5/2012	House	Amendment 270 adopted
6/5/2012	House	Amendment 264 adopted
6/5/2012	House	Amendment 216 laid aside on point of order
6/5/2012	House	Appeal decision of Chair
6/5/2012	House	Decision of the Chair sustained
6/5/2012	House	Amendment 100 adopted
6/5/2012	House	Amendment 221 adopted
6/5/2012	House	Amendment 228 adopted

6/5/2012	House	Amendment 231 adopted
6/5/2012	House	Amendment 232 adopted
6/5/2012	House	Amendment 234 adopted
6/5/2012	House	Amendment 237 adopted
6/5/2012	House	Amendment 253 adopted, as changed
6/5/2012	House	Amendment 202 adopted, as changed
6/5/2012	House	Amendment 233 adopted, as changed
6/5/2012	House	Amendment 167 rejected - 34 YEAS to 119 NAYS (See YEA and NAY in Supplement, No. 272)
6/5/2012	House	Amendment 22 adopted
6/5/2012	House	Amendment 33 adopted, as changed
6/5/2012	House	Amendment 60 adopted, as changed
6/5/2012	House	Amendment 76 rejected
6/5/2012	House	Amendment 125 adopted, as changed
6/5/2012	House	Amendment 137 adopted, as changed
6/5/2012	House	Amendment 157 adopted
6/5/2012	House	Amendment 166 adopted, as changed
6/5/2012	House	Amendment 171 adopted
6/5/2012	House	Amendment 230 adopted

6/5/2012	House	Amendment 238 adopted
6/5/2012	House	Amendment 159 adopted
6/5/2012	House	Amendment 250 adopted
6/5/2012	House	Amendment 252 rejected
6/5/2012	House	Amendment 188 adopted, as changed
6/5/2012	House	Amendment 222 adopted, as changed
6/5/2012	House	Amendment 18 adopted, as changed
6/5/2012	House	Amendment 75 adopted, as changed
6/5/2012	House	Quorum - 151 YEAS to 0 NAYS (See YEA and NAY in Supplement, No. 273)
6/5/2012	House	Rule 1A suspended - 123 YEAS to 30 NAYS (See YEA and NAY in Supplement, No. 274)
6/5/2012	House	Amendment 251 adopted, as changed
6/5/2012	House	Published as amended, see H4155

Amendments in Detail:

Amendment # 1

Mr. Walsh of Lynn moves to amend the bill, H4127, in section 120, in line 1432, by striking out the figure “0.2” and inserting in place thereof the following figure “0.1”.

Amendment # 2

Mr. Basile of Boston offers to amend House bill 4127 in Section 136 (line 3093) by adding after #6.), the following:-

7.) The forms shall allow the incorporation of personalized medicine, diagnostic information, and where relevant, personalized genomic, metabolic, cellular and anatomic data.

Amendment # 3

Representative Chan of Quincy moves to amend House bill 4127, in SECTION 121, in section 57, in line 1980, by inserting after the words “services” the words, “, including patient confidence”;
and in line 2020, by inserting after the word “website.”, the following subsection:-
(d) In designing the website, the division institute shall conduct usability research, including consultation with organizations that represent consumers, and conduct focus groups that represent a cross section of consumers in the commonwealth, including low income consumers and consumers with limited literacy. The website shall comply with the Americans with Disabilities Act, and shall indicate which provider services are physically and programmatically accessible, including access to physical examination equipment, to people with disabilities. The website shall be available in any primary language spoken by more than 5 per cent of the residents of the commonwealth.”

Amendment # 3, as changed

Mr. Chan of Quincy moves to amend House, No. 4127 in section 121, in line by inserting after line 2020 the following subsection:— (d) In designing the website, the division may conduct research regarding ease of use of the website by health care consumers, consult with organizations that represent health care consumers, and conduct focus groups that represent a cross section of health care consumers in the commonwealth, including low income consumers and consumers with limited literacy. The website shall comply with the Americans with Disabilities Act.

Amendment # 4

Mr. Basile moves to amend the bill (House, No. 4127) by inserting the following new section:-
SECTION 1: Section 9 of Chapter 330 of the Statutes of 1994, as amended by Section 3 of Chapter 63 of the Statutes of 1995, is amended by striking out section 6 therein and inserting in place thereof the following:-
Section 6. Upon the approval of the commissioner, the medical professional mutual insurance company, may for any purposes, including, but not limited to the fixing of separate percentages of dividends under section eighty of chapter one hundred and seventy-five, consider the business of each category of health care provider as a separate line of business; provided, however, that the doctor of dental science category of insured shall continue to be treated as a separate line of business by the medical professional mutual insurance company to the extent required by chapter ninety-two of the acts of nineteen hundred and ninety-one, and, as promptly as possible after the effective date of this act, any excess surplus of the association as determined by the commissioner attributable to the doctor of dental science category of business as of the effective date of the conversion shall be paid as a dividend by the mutual company for the benefit of the association's doctor of dental science policyholders entitled thereto in accordance with the methodology established and employed by the association for the payment of dividends to its doctor of dental science policyholders prior to the date of the conversion. Any person in the doctor of dental science category of insureds who was insured by the association at the time of the conversion may elect to continue to be insured by the mutual company by specifically assigning in writing this first dividend to be paid after the effective date of this act back to the mutual company.
Effective January first, two thousand and eleven, all excess surplus as determined by the commissioner, allocable to doctor of dental science policies issued by the company at any time on or prior to December thirty-first, two thousand and ten, shall be paid annually, on or about July first of the following year, as a dividend to those persons, firms and entities entitled thereto, pursuant to the methodology established and employed by the association for the distribution of such dividends prior to the conversion. No portion of such excess surplus as determined by the commissioner shall be used or allocated for any other purpose or purposes and upon the payment of such dividend, there shall be no excess surplus allocable to those doctor of dental science policies issued by the company at any time on or prior to December thirty-first, two thousand and ten. The medical professional mutual insurance company shall annually notify each person, firm or entity entitled to such dividend of the amount of such dividend to which he is entitled. For the purposes of this section, "excess surplus" shall mean any surplus allocable to the association's doctor of dental science category of insureds beyond an amount determined by the commissioner to be reasonably necessary as a margin against adverse development.

Amendment # 5

Mr. Chan of Quincy moves to amend the bill by inserting at the end thereof the following new section:

Section _____There shall be a long-term services and supports advisory committee to advise the general court, the office of Medicaid, and other state agencies on opportunities to improve health care cost and quality through community-based long-term care services. The commission shall consist of the following 16 members and shall be jointly chaired by a member of the house of representatives and a member of the senate: 2 representatives of the house of representatives, 1 of whom shall be chosen by the minority leader; 2 representatives of the senate, 1 of whom shall be chosen by the minority leader; the director of the office of medicaid or a designee; the secretary of elder affairs or a designee; the commissioner of health care finance and policy or a designee; the commissioner of public health or a designee; the secretary of administration and finance or a designee; and 7 appointees of the governor, 2 of whom shall be consumer representatives and 5 of whom shall be representatives of community-based long-term care providers, of which at least 2 are for-profit entities, and all of which represent services approved by the Medicaid State Plan.

The advisory committee shall evaluate the effect of long-term services and supports on reducing health care costs and improving health care quality and shall recommend opportunities to improve or expand existing long-term services and support programs including, but not limited to, implementation of value-based purchasing strategies and the development and deployment of an electronic community care record for community-based long-term care services. The committee shall report the results of its study, together with drafts of legislation, if any, necessary to carry out its recommendations, by filing the same with the clerks of the house of representatives and the senate who shall forward a copy of the study to the house and senate committees on ways and means and the joint committee on health care financing not later than January 15, 2013.

Amendment #6

Ms. Canavan of Brockton moves that the bill be amended in Section 121, by striking out subsection (d) of proposed section 56 of chapter 118G of the General Laws and inserting in place thereof the following subsection:

(d) The division shall coordinate and compile data on quality improvement programs conducted by state agencies and public and private health care organizations. The division shall consider programs designed to (i) improve patient safety in all settings of care; (ii) reduce preventable hospital readmissions; (iii) increase nurse staffing levels; (iv) prevent the occurrence of and improve the treatment and coordination of care for chronic diseases; and (v) reduce variations in care. The division shall make such information available on the division's consumer health information website. The division may recommend legislation or regulatory changes as needed to further implement quality improvement initiatives;

And moves that the bill be further amended in said Section 121, subsection (b) of proposed section 57 of chapter 118G of the General Laws, in line 2010 by striking out the word "and" before the words "(x) descriptions of standard quality measures,";

and in line 2011 by adding after the words "by the division" the following words: " ;and (xi) data concerning the nurse staffing levels at each acute care facility."

Amendment # 7

Messrs. Chan of Quincy and Kafka of Stoughton move to amend the bill in Section 121 in line 2211 by striking the figure “6” and inserting in place thereof the figure “7”;
And by further amending the section in line 2213 by inserting after the words “hospital or hospital association” the following: - “1 representative from a medical device manufacturer,”.

Amendment # 8

Representative Sciortino of Medford moves to amend the bill, in Section 121, in line 1544, by inserting after the words "cultural factors" the following subsection:

"(e) Any alternative payment methodology that contains a provision for shared savings between the provider and the payer shall contain a mechanism to return a percentage of the savings to the plan participants.

Amendment # 9

Rep. Mahoney of Worcester moves to amend House bill 4127 in Section 124 by adding a new subsection: -

Section 17. For the purposes of this section, the following terms shall have the following meanings:

"Telehealth/telehealth technology," includes the delivery of medical services and any diagnostic, treatment or health management assistance utilizing interactive audio, interactive video and/or interactive data transmission relative to the health care of a patient in a home care setting. Telehealth technology services do not include telephone conversations, electronic mail messages or facsimile transmissions.

"Certified home health agency," includes those home health agencies that are approved for participation in the Medicare and Medicaid programs.

"Home care services," services provided to a home health patient by a certified home health agency.

a) For purposes of long-term health care cost savings and enhanced patient care, the division shall encourage the use of telehealth technology provided by a Medicare-certified home health agency or visiting nurse association through the ACO.

b)The Commonwealth shall recognize telehealth provided by home health agencies as a service to clients otherwise reimbursable through Medicaid, provided that the funds authorized herein shall be short term reimbursement made through MassHealth.

c) Rates for telehealth services shall reflect costs on a monthly basis in order to account for daily variation in the intensity and complexity of patients' telehealth service needs; provided that such rates shall further reflect the cost of the daily operation and provision of such services, which costs shall include the following functions undertaken by the participating certified home health agency:

d) The home health patient's shall be responsible for the accuracy, maintenance and instruction on the usage of telehealth technology.

Amendment # 10

Representative O'Day of West Boylston moves to amend the legislation (H.4127) in Section 120, lines 1424-1446, by striking that entire subsection/paragraph and inserting in place thereof the following subsection/paragraph: -
Section 40. (a) Health care systems that operate acute hospitals that have a total of more than $1,000,000,000 in unrestricted net assets as of June 30, 2011, as reported under MGL Chapter 118G, Section 6(A) and in the required hospital financial filings to the Division of Health Care Finance and Policy, shall be assessed a surcharge to be paid to the division for the distressed hospital fund, created under section 2DDDD of chapter 29 to be paid annually starting from July 1, 2013 and through July 1, 2017. The annual surcharge amount for each of these five years shall equal $70,000,000 and be allocated proportionally among the surcharge payers based upon the percentage of the surcharge payer's unrestricted net assets relative to the other surcharge payers' unrestricted net assets. Provided,

however, that this surcharge shall not be assessed on an a health care system which operates an acute care hospital which limits services primarily to children and which qualifies as exempt from the Medicare Prospective Payment system regulations

Amendment # 11

Rep. Mahoney of Worcester moves that the bill be amended in Section 98, in subsection (b) of proposed section 2 of chapter 118G of the General Laws, by striking out the words “1 of whom shall be a practicing nurse licensed to practice in the commonwealth,” and inserting in place thereof the following: “1 of whom shall be a practicing nurse licensed to practice in the commonwealth and a member of the Massachusetts Nurses Association,”

Amendment # 12

Mr. Murphy of Weymouth moves that the bill be amended in Section 20 in subsection 29 (line 247) by adding the following new paragraph:-

“Provided, however that any disclosure of patient level data shall be in compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and with the Fair Information Practices Act, M.G.L. c. 66A, to the extent that the data collected are "personal data" within the meaning of the Fair Information Practices Act, M.G.L. c. 66A. To the extent that the commission is releasing patient level data, the commission shall promulgate regulations that will protect personal health information consistent with HIPAA and the Fair Information Practices Act, M.G.L. c. 66A.”

And that the bill further amended in Section 21 by adding in subsection 32at the end of line 266, the following new language:-

“Provided, however that any disclosure of patient level data shall be in compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and with the Fair Information Practices Act, M.G.L. c. 66A, to the extent that the data collected are "personal data" within the meaning of the Fair Information Practices Act, M.G.L. c. 66A. To the extent that any appropriate public authority is releasing patient level data, that appropriate public authority shall promulgate regulations that will protect personal health information consistent with HIPAA and the Fair Information Practices Act, M.G.L. c. 66A.”

And that the bill further amended in Section 121 by adding in subsection 51(a)(iii) at the end of line 1846, the following new language:-

“Provided, however that any disclosure of patient level data shall be in compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and with the Fair Information Practices Act, M.G.L. c. 66A, to the extent that the data collected are "personal data" within the meaning of the Fair Information Practices Act, M.G.L. c. 66A. The division shall promulgate regulations that will protect personal health information consistent with HIPAA and the Fair Information Practices Act, M.G.L. c. 66A.”

And that the bill further amended in Section 135 by adding in subsection 108M at the end of line 3055, the following new language:-

“Provided, however that any disclosure of patient level data shall be in compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and with the Fair Information Practices Act, M.G.L. c. 66A, to the extent that the data collected are "personal data" within the meaning of the Fair Information Practices Act, M.G.L. c. 66A. The division shall promulgate regulations that will protect personal health information consistent with HIPAA and the Fair Information Practices Act, M.G.L. c. 66A.”

And that the bill further amended in Section 139 by adding in subsection 37 at the end of line 3134, the following new language:-

“Provided, however that any disclosure of patient level data shall be in compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and with the Fair Information Practices Act, M.G.L. c. 66A, to the extent that the data collected are "personal data" within the meaning of the Fair Information Practices Act, M.G.L. c. 66A. The division shall promulgate regulations that will protect personal health information consistent with HIPAA and the Fair Information Practices Act, M.G.L. c. 66A.”

And that the bill further amended in Section 140 by adding in subsection 25 at the end of line 3152, the following new language:-

“Provided, however that any disclosure of patient level data shall be in compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and with the Fair Information Practices Act, M.G.L. c. 66A, to the extent that the data collected are "personal data" within the meaning of the Fair Information Practices Act, M.G.L. c. 66A. The division shall promulgate regulations that will protect personal health information consistent with HIPAA and the Fair Information Practices Act, M.G.L. c. 66A.”

And that the bill further amended in Section 141 by adding in subsection 33 at the end of line 3170, the following new language:-

“Provided, however that any disclosure of patient level data shall be in compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and with the Fair Information Practices Act, M.G.L. c. 66A, to the extent that the data collected are "personal data" within the meaning of the Fair Information Practices Act, M.G.L. c. 66A. The division shall promulgate regulations that will protect personal health information consistent with HIPAA and the Fair Information Practices Act, M.G.L. c. 66A.”

And that the bill further amended in Section 150 by adding in subsection 16 at the end of line 3228, the following new language:-

“Provided, however that any disclosure of patient level data shall be in compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and with the Fair Information Practices Act, M.G.L. c. 66A, to the extent that the data collected are "personal data" within the meaning of the Fair Information Practices Act, M.G.L. c. 66A. The division shall promulgate regulations that will protect personal health information consistent with HIPAA and the Fair Information Practices Act, M.G.L. c. 66A.”

Amendment # 13

Mr. Murphy of Weymouth moves that the bill be amended in Section 96 in line 1203 by striking the word “care” and putting in the place thereof the word “plan”.

Amendment # 14

Mr. Murphy of Weymouth moves that the bill be amended in Section 121 in lines 1910 through 1914 by striking section 55 and inserting in its place the following new section:-

“Section 55. (a) The Division of Insurance shall evaluate measures to address ERISA restrictions and recommend potential incentives for employers who participate in self-funded plans to participate in alterative payment arrangements.”

Amendment # 15

Mr. Mariano of Quincy moves to amend House No. 4127 by inserting after section 143 the following section:

"SECTION 143A. Subsection (b) of section 6 of Chapter 176J of the General laws, as so appearing in the 2010 Official Edition, is hereby amended by adding the following subsection:-
(xi) For purposes of this section, medical loss ratios shall not include fees on commissions included in premiums that are collected solely for the purpose of passing such fees or commissions on to insurance agents or brokers to the extent such fees or commissions are actually paid."

Amendment # 16

Mr. Scibak of South Hadley moves to amend the bill, in SECTION 124 by inserting after subsection (d) in section 10 of proposed Chapter 118J the following new section:-

"(e) The division may evaluate and provide guidance to ACO's regarding the appropriate use and ordering of medically necessary testing enabled though testing protocols and clinical integration of health care providers within and outside of the organization, including, but not limited to the medical director of the clinical laboratory."

Amendment # 17

Mr. Donato of Medford moves that the bill be amended in Section 96 in lines 823 through 839 by striking Section 66 and inserting the following new section:-

Section 66. To the greatest extent possible, the office of Medicaid shall transition providers who are capable of such a transition, away from fee-for-service models of payment, and towards greater use of alternative payment methods including but not limited to shared savings, bundled or episodic payments, or global payments. In developing such a program, the office of Medicaid shall consult with the Medicaid managed care organizations, Senior Care Options plans, PACE plans, and Medicaid Medicare Integrated Plans under contract with the commonwealth to provide services to beneficiaries, and to the greatest extent possible utilize said Medicaid managed care organizations, Senior Care Options plans, PACE plans, and Medicaid Medicare Integrated Plans in implementing the requirements of this section.
In making the transition to alternative payment method, the office of Medicaid, along with the Medicaid managed care organizations, shall achieve the following benchmarks to the maximum extent feasible:
(i) Not later than January 1, 2013, reimbursement for at least 25 per cent of MassHealth enrollees that are not also covered by other health insurance coverage, including Medicare and employer-sponsored or privately purchased insurance shall be based on an alternative payment arrangement for members.
(ii) Not later than January 1, 2014, reimbursement for at least 40 per cent of MassHealth enrollees that are not also covered by other health insurance coverage, including Medicare and employer-sponsored or privately purchased insurance shall be based on an alternative payment arrangement for members.
(iii) Not later than January 1, 2015, reimbursement for at least 50 per cent of MassHealth enrollees that are not also covered by other health insurance coverage, including Medicare and employer-sponsored or privately purchased insurance shall be based on an alternative payment arrangement for members.

Amendment # 18

Mr. Donato of Medford moves to amend the bill (House, No. 4127) in SECTION 84 by inserting after the words "as determined by the board" the following words:--
"to be applicable to the medical specialty"

And further moves to amend the bill in SECTION 84 by inserting after the words “as set forth in 45 CFR 170” the following words:--
“,except for those medical specialties that rely upon other forms of health information technology, including laboratory information systems**.”**

Amendment # 18, changed

Mr. Donato of Medford moves to amend the bill, H. 4127, in section 84, line 706, by inserting at the end the following sentence:- "This section shall not apply to any applicant board certified and practicing as a pathologist.".

Amendment # 19

Representative Lewis of Winchester moves to amend the bill by adding the following section:-
SECTION__. In order to determine, as a basis for legislative and administrative action, the resources and approaches needed to achieve the healthcare and wellness goals of the Commonwealth, a committee, known as the Massachusetts Prevention Council, shall be established. The commission shall consist of the Commissioner of the Department of Public Health, or his designee; the Secretary of the Executive Office of Health and Human Services, or her designee; the Secretary of the Executive Office of Energy and Environmental Affairs, or his designee; the Secretary of Executive Office of Education, or his designee; the Secretary of the Executive Office of Transportation, or his designee; the Secretary of Executive Office of Housing and Economic Development, or his designee; the Secretary of Executive Office of Public Safety, or her designee; the Secretary of Executive Office of Elder Affairs, or her designee; the Commissioner of the Department of Conservation and Recreation, or his designee; the Commissioner of the Department of Environmental Protection, or his designee; the chairs of the Joint Committee on Health Care Financing, or their designees and the chairs of the Joint Committee on Public Health, or their designee. An advisory council to the commission will consist of 1) designees from a representative sample of communities with a population over 125,000, and a representative sample of communities with a population under 125,000; 2) public health advocacy groups; 3) healthcare providers from a representative sample of large hospital systems, small hospitals, and community health centers; 4) other governmental departments. Using the model of the National Prevention Council, the commission shall create Massachusetts Prevention Strategy to work in parallel with federal efforts, as well as to best integrate the ongoing state and local efforts in the Commonwealth. The Massachusetts Prevention Strategy would work to integrate and align policies among federal, state and local governments, as well as promote public and private cooperation and partnerships to achieve a healthier Massachusetts. The commission may hold hearings and invite testimony from experts and the public. The commission shall review and identify best practices learned from similar efforts in other states, and from the federal government, in order to lower health care costs and improve quality of care. Members of the commission shall be named and the commission shall commence its work within 60 days of the effective date of this act. The commission shall report to the general court the results of its investigation and study, and recommendations, if any, together with drafts of legislation necessary to carry its recommendations into effect by filing the same with the Clerks of the Senate and the House of Representatives on or before January 2, 2014. The Clerks of the House and Senate shall make the report available to the public through the Internet.

Amendment # 19, changed

Mr. Lewis of Winchester moves to amend the bill, H 4127, in section 17, in line 223, by inserting at the end thereof the following words:- “There shall be an initial transfer of $20,000,000 out of said fund to the wellness and prevention trust fund as established under section 75 of chapter 10”

Amendment # 20

Representative Denise Andrews of Orange moves to amend the bill, in section 134, by inserting in line 3037 after the first sentence the following sentences:-
The commissioner shall promulgate regulations setting standards for implementation of this clause. Prior to proposing

regulations, the commissioner shall consult with groups representing consumers, patients with chronic disease, people with disabilities, and seniors, experts in behavioral economics, as well as other interested parties. The standards shall protect worker privacy and shall only result in premium rate adjustments for an insured group that offers an approved wellness program.

Amendment # 20, changed

Representative Andrews of Orange moves to amend the bill, H. 4127, in SECTION 134, line 3037 by striking out the word “a” the following words:- “an approved”.

Amendment # 21

Ms. Andrews of Orange moves to amend the bill by inserting at the end thereof the following new section:-
“SECTION XX. (a) Notwithstanding any general or special law to the contrary, there shall be established a health care executive compensation task force. The task force shall consist of the house and senate chairs of the joint committee on labor and workforce development, who shall serve as co-chairs; the speaker of the house of representatives or his designee; the president of the senate or her designee; the house minority leader or his designee, the senate minority leader or his designee, the governor or his designee; the state auditor or her designee; the state treasurer or his designee; the attorney general or her designee; the secretary of labor and workforce development or her designee; and 2 representatives from the general public with expertise in competitive compensation and organizational design to be selected by the co-chairs of said task force.
(b) The task force shall undertake a study of various legislative proposals to amend health care and labor laws, including, but not limited to executive compensation. Said study shall include, but not be limited to, an analysis of: (1) a 20 year comprehensive analysis of total executive compensation, including wages, stock options and benefits, in the absolute and in comparison to the hourly workforce; (2) executive compensation as a percent of health care product, service and delivery costs; and (3) executive compensation trends relative to the consumer price index.
(c) The task force shall complete its study and submit its final report in writing to the joint committee on labor and workforce development, the joint committee on health care financing, the attorney general and the governor on or before July, 1 2013. Said report shall include recommendations for legislation and a fiscal note for implementing such legislation.”

Amendment # 22

Mr. Vallee moves to amend the legislation (H.4127) in Section 98, by striking “9” at 1193 and replacing that language with “10” and moves to further amend the legislation by adding after the words “except in administration and finance,” as appearing at line 1201, the following: “1 of whom shall be an expert representative from a labor organization representing the health care workforce,”

Amendment # 23

Mr. Markey of Dartmouth moves to amend the bill (House, No. 4127) by adding the following new section:-

“SECTION XX. The Commonwealth shall inform MassHealth applicants of the option to enroll in Senior Care Option (SCO) or Program of All-Inclusive Care for the Elderly (PACE) and differential benefits that would be gained by enrolling in a SCO or PACE program at the time of application for MassHealth benefits.

- Any notice or mailings to MassHealth members about MassHealth benefit changes shall include information about the option to enroll in SCO or PACE with specific reference to the member benefits and financial savings gained by enrollment;

- Any notice or mailings to MassHealth members about redeterminations shall include information about the option to enroll in SCO or PACE with specific reference to the member benefits and member financial savings gained by enrollment;
- MassHealth eligibles not enrolled in SCO or PACE shall be informed at least one time per year via a mailing or other means of the option to enroll in SCO or PACE with specific reference to the member benefits and member financial savings gained by enrollment;

Serving Health Information Needs of Elders (SHINE) and other publicly funded Information and Referral counselors shall be oriented to and expected to share information with eligible MassHealth members about the right to enroll in SCO or PACE and the member benefits and member financial savings associated with SCO or PACE membership.".

Amendment # 24

Mr. Cabral of New Bedford moves to amend the bill in Section 123, by striking, in lines 2666-2667, the words "section 1 of chapter 111" and inserting in place thereof the following words:- "section 1 of chapter 118G"

Amendment # 25

Mr. Cabral of New Bedford moves to amend the bill in Section 50, by inserting, in line 1821, after the words "not limited to," the following words:-
"health care services, as defined in section 1 of chapter 118G of the General Laws,"

Amendment # 26

Mr. Cusack of Braintree moves to amend the bill by inserting, after section xx, the following section.
SECTION XX. Chapter 111 of the General Laws is hereby amended by striking out the definition of "clinic" in section 52, and inserting in place thereof the following definition:-
"Clinic", any entity, however organized, whether conducted for profit or not for profit, which is advertised, announced, established, or maintained for the purpose of providing ambulatory medical, surgical, dental, physical rehabilitation, or mental health services. In addition, "clinic" shall include any entity, however organized, whether conducted for profit or not for profit, which is advertised, announced, established, or maintained under a name which includes the word "clinic", "dispensary", or "institute", and which suggests that ambulatory medical, surgical, dental, physical rehabilitation, or mental health services are rendered therein. With respect to any entity which is not advertised, announced, established, or maintained under one of the names in the preceding sentence, "clinic" shall not include a medical office building, a location operated by a corporation organized under chapter 180 for purposes that include the practice of medicine, or one or more practitioners engaged in a solo or group practice, however organized, so long as such practice is wholly owned and controlled by one or more of the practitioners so associated, or a clinic established solely to provide service to employees or students of such corporation or institution; provided, however, that an entity exempt from licensure under this sentence may obtain a license for some, or all, of its locations. For purposes of this section, clinic shall not include a clinic conducted by a hospital licensed under section fifty-one or by the federal government or the commonwealth.

Amendment # 27

Mr. Cusack of Braintree moves to amend the bill by inserting in Section 123 subsection 2B, relative to Health Information Technology, after the words "1 shall be from a long term care facility," the following: "1 shall be from a Medicare-certified home health agency."

Amendment # 28

Representatives Reinstein of Revere, Ferrante of Gloucester, and Lewis of Winchester move to amend the bill (House Bill 4127) by inserting at the end thereof the following new sections:-

Section __. Chapter 111 of the General Laws is hereby amended by inserting after section 51H the following section:-

Section 51I. The department shall promulgate regulations regarding limited services clinics. Such regulations shall promote the availability of limited services clinics as a point of access for health care services within the full scope of practice of a nurse practitioner or other clinician providing services.

Section __. Section 52 of chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting, after the definition of “Institution for unwed mothers” the following 2 definitions:-

“Limited services”, diagnosis, treatment, management, monitoring of acute and chronic disease, wellness and preventative services of a nature that may be provided within the scope of practice of a nurse practitioner or other clinician providing services using available facilities and equipment, including shared toilet facilities for point-of-care testing.

“Limited services clinic”, a clinic that provides limited services and that a limited services clinic may not serve as a patient’s primary care practitioner

Amendment # 28, changed

Ms. Reinstein of Revere moves to amend House Bill 4127 by adding the following section:-
Section X. The department of public health shall amend their regulations regarding limited service clinics to allow such clinics to provide the following services to patients, provided that the limited service clinic only provides those services for which a patient’s primary care provider has given written approval for prior to such care being administered:

1. Monitoring and management of acute and chronic disease
2. Wellness and preventive services

Nothing in this section shall be interpreted to allow a limited service clinic to serve as a patient’s primary care provider.

Amendment # 29

Mr. O’Day of West Boylston moves that the bill (H 4127) be amended in Section 82, proposed section 226 of chapter 111 of the General Laws, by inserting before the definition of “Hospital” the following definition:

“Health Care Workforce”, personnel that have an effect upon the delivery of quality care to patients, including, but not limited to, licensed practical nurses, unlicensed assistive personnel and/or other service, maintenance, clerical, professional and/or technical workers and other healthcare workers.;

And in line 659 of said section, by striking out the word “nurse” and inserting in place thereof the words: “member of the health care workforce”;

And in line 660 of said section by striking out the word “nurse” and inserting in place thereof the word “employee”;

And in said Section 82, subsection (b) of proposed section 226 of chapter 111 of the General Laws, by striking out the word “nurse” and inserting in place thereof the words: “member of the health care workforce”; and striking out the words “an emergency situation” and inserting in place thereof the following words: “a federal or state emergency or a facility wide emergency”;

And moves that the bill be further amended in Section 82,subsection (c) of proposed section 226 of chapter 111 of the General Laws, by striking out the words “an emergency situation” and inserting in place thereof the following words: “a federal or state emergency or a facility wide emergency”;

And moves that the bill be further amended in Section 82,subsection (d) of proposed section 226 of chapter 111 of the General Laws, by striking out the words, “an ‘emergency situation’” and inserting in place thereof the following words: “a ‘facility wide emergency’”.

Amendment #30

Ms. Walz of Boston moves to amend the bill (H. 4127) by adding the following two sections:-
SECTION XX. The department of elementary and secondary education, in consultation with the department of public health, shall conduct a statewide analysis of and submit a report on the provision of health education by school districts and Commonwealth charter schools. In preparing said report, the department of elementary and secondary education shall use the data and information obtained in the Massachusetts School Health Profiles surveys conducted in 2008, 2010, and 2012 as well as data and information it obtains through other means. The report shall include, but not be limited to, the following information for each public school district and Commonwealth charter school:-
(a) a description of health education curricula offered in each grade level and whether these curricula are aligned with the comprehensive health strands and learning standards recommended in the Massachusetts comprehensive health curriculum frameworks;
(b) the number of students receiving such health education by grade level;
(c) health education requirements by grade level; and
(d) the number and percentage of students in each district and charter school who opt-out of any portion of the health education curriculum under the provisions of section 32A of chapter 71.
The department shall report its findings and any recommendations concerning health education to the clerks of the senate and the house of representatives, who shall forward the same to the chairs of the joint committee on education and the chairs of the house and senate committees on ways and means on or before June 30, 2013. The department of elementary and secondary education shall submit an update to the joint committee on education on the status of its efforts to complete this report on or before December 31, 2012.
SECTION XX. The department of elementary and secondary education, in conjunction with the department of public health, shall provide linkages for resources and programs on health education. The department shall biennially update the list and shall post it on the department’s website.

Amendment #31

Ms. Walz of Boston moves to amend the bill (H. 4127) by adding the following section:-
SECTION XXX. There shall be a special task force to study issues related to the accuracy of medical diagnosis in the commonwealth called the Massachusetts diagnostic accuracy task force. The task force shall investigate and report on: (1) the extent to which diagnoses in the commonwealth are accurate and reliable, including the extent to which different diagnoses and inaccurate diagnoses arise from the biological differences between the sexes; (2) the underlying systematic causes of inaccurate diagnoses; (3) an estimation of the financial cost to the state, insurers and employers of inaccurate diagnoses; (4) the negative impact on patients caused by inaccurate diagnoses; and (5) recommendations to reduce or eliminate the impact of inaccurate diagnoses.

The Massachusetts diagnostic accuracy task force shall be comprised of 9 members: 1 of whom shall be the secretary of health and human services, who shall chair the task force; 1 of whom shall be the commissioner of public

health or a designee; 1 of whom shall be the chair of the board of registration in medicine or a designee; 1 of whom shall be the chair of the board of registration in nursing or a designee; and 5 members chosen by the governor, 1 of whom shall be a provider with experience in the area of diagnostic accuracy, 1 of whom shall be a representative of a Massachusetts health plan, 1 of whom shall be an employer with experience in implementing programs to address diagnostic inaccuracy, 1 whom shall represent an organization based in the commonwealth with experience creating and supporting the implementation of programs on diagnostic accuracy and value-based benefit design, and 1 of whom shall be a non-physician health care provider.

Amendment #32

Ms. Walz of Boston moves to amend the bill (H. 4127):-
In Section 124, in line 2820, by striking out (j) and inserting in place thereof (k) and by inserting after the words "palliative care; and" in line 2819 the following:- "(j) The ability to provide reproductive and sexual health services, including comprehensive family planning services either internally within the ACO or by contractual agreement.".

Amendment #33

Ms. Walz of Boston moves to amend the bill (H. 4127):-
In Section 98, in line 1196, by striking out the figure "9" and inserting in place thereof the figure "11"; in line 1197, by striking out the figure "4" and inserting in place thereof the figure "6"; in line 1200, by inserting after the word "care," the following:- "1 of whom shall be an expert in women's health, 1 of whom shall be a purchaser of health insurance selected by the Associated Industries of Massachusetts,".

Amendment #33, changed

Ms. Walz of Boston moves to amend the bill (H. 4127):-
In Section 98, in line 1196, by striking out the figure "9" and inserting in place thereof the figure "11"; in line 1197, by striking out the figure "4" and inserting in place thereof the figure "6"; in line 1200, by inserting after the word "care," the following:- "1 of whom shall be an expert in women's health, 1 of whom shall be a purchaser of health insurance,".

Amendment #34

Mr. Costello of Newburyport moves to amend H.4127 by striking SECTION 67 in its entirety.

Amendment #35

Mr. Costello of Newburyport moves to amend H.4127 in SECTION 67, in line 569, by striking the number "9" and inserting in place thereof the following: "199"

Amendment #35, changed
Mr. Costello of Newburyport moves to amend the bill, H. 4127, in SECTION 67, line 569, by striking out the figure "9" and inserting in place thereof the following figure:- "24";

Further moves to amend in SECTION 104, lines 1336 – 1337, by striking out the words "not more than 9 physicians" and inserting in place thereof the following words:- "24 physicians or fewer";

Further moves to amend in SECTION 111, line 1366, by striking out the words "not more than 9 physicians" and inserting in place thereof the following words:- "24 physicians or fewer";

Further moves to amend in SECTION 121, lines 1641 – 1642, by striking out the words “9 or less” and inserting in place there of the following words:- “24 physicians or less”;

Further moves to amend in SECTION 121, lines 1676, by striking out the words “9 or less” and inserting in place thereof the following words:- “24 physicians or less”;

And further moves to amend in SECTION 121, line 1752, by striking out the words “fewer than 10 physicians” and inserting in place thereof the following words:- “24 physicians of less”.

Amendment #36

Mr. Costello of Newburyport moves to amend H. 4127 by adding the following new section:
“SECTION XXX. To maximize the cost-effective and efficient use of nursing homes licensed under chapter 111, section 71 of the General Laws in the commonwealth’s post-acute health care delivery system, the executive office of health and human services shall seek from the Secretary of the Department of Health and Human Services an exemption or waiver from the Medicare requirement set forth in 42 U.S.C. §1395x(i) that an admission to a skilled nursing facility be preceded by a three-day hospital stay.”

Amendment #37

Mr. Costello of Newburyport moves to amend H.4127 by adding the following new section:
“SECTION XXX. Chapter 111 of the General Laws is hereby amended by inserting after section 70G the following section:-
Section 70H. Notwithstanding any provision in chapter 93A, sections 70E, 72E and 73 and 940 CMR section 4.09, a facility or institution licensed by the department of public health under section 71 may move a resident to different living quarters or to a different room within the facility or institution if, as documented in the resident’s clinical record and as certified by a physician, the resident’s clinical needs have changed such that the resident either (1) requires specialized accommodations, care, services, technologies, staffing not customarily provided in connection with the resident’s living quarters or room, or (2) ceases to require the specialized accommodations, care, services, technologies or staffing customarily provided in connection with the resident’s living quarters or room; provided, however, that nothing in this section shall obviate a resident's notice and hearing rights when movement to different living quarters involves a resident moving from a Medicare-certified unit to a non-Medicare-certified unit or involves a resident moving from a non-Medicare-certified unit to a Medicare-certified unit and, provided, however, that the resident shall have the right to appeal to the facility’s or institution’s medical director a decision to move the resident to a different living quarter or to a different room within the facility or institution.“

Amendment #38

Mr. Costello of Newburyport moves to amend H.4127, in SECTION 136, in lines 3074, 3096, 3105, and 3110 by striking “2013” and inserting in place thereof “2014”.

Amendment #39

Mr. Costello of Newburyport moves to amend H.4127, in Section 120, in line 1456, by adding after “December 31, 2012” the following “; provided further that such one-time assessment funds shall be collected in such manner to allow periodic payments over a three year time period.”

Amendment #40

Mr. Sannicandro of Ashland moves that the bill (House , No. 4127) be amended by inserting the following new section:-

SECTION XX. Chapter 270 of the General Laws is hereby amended by adding the following section:-
Section 6B. Possession of cigarettes or cigarette rolling papers by minors
Whoever, being under eighteen years of age, knowingly purchases, possesses, transports or carries on his person, any tobacco or cigarette rolling papers, shall be required to enroll in a tobacco education and cessation program, provided, however, that this section shall not apply to a person who knowingly possesses, transports or carries on his person, cigarettes or cigarette rolling papers in the course of his employment. Such tobacco education and cessation program imposed by this section shall be approved by the Massachusetts Tobacco Cessation and Prevention Program.
A police officer shall notify the parent or guardian of a person who violates this section of the violation within forty-eight hours of the violation if the contact information of a parent or guardian is reasonably ascertainable by the officer. The notice may be made by any means reasonably calculated to give actual notice, including notice in person, by telephone, or by first-class mail.
A person who violates this section shall forfeit any tobacco and any false identification in his or her possession upon the request of any police officer.
The court shall treat a violation of this section as a civil infraction. A person complained of for such civil infraction shall be adjudicated responsible upon such finding by the court and shall neither be sentenced to a term of incarceration nor be entitled to appointed counsel pursuant to chapter 211D. An adjudication of responsibility under this section shall not be used in the calculation of second and subsequent offenses under any chapter, nor as the basis for the revocation of parole or of a probation surrender.

Amendment #41

Mr. Costello of Newburyport moves to amend H. 4127 in section 145, in line 3186, by deleting the words “only 1 facility” and inserting in place thereof the following: -- “no more than 5 facilities”; and in section 146, in line 3198, by inserting the following new sentence: -- “The provisions of the second and third sentences of this subsection shall not apply to comprehensive cancer centers, as defined in section 1 of chapter 118G of the General Laws.”

Amendment #41, changed

Mr. Costello of Newburyport moves to amend the bill, H. 4127, in SECTION 145, line 3186, by striking out the words “only 1 facility” and inserting in place thereof the following words:- “no more than 5 facilities”.

Amendment #42

Mr. Scaccia of Boston moves to amend H. 4127, in Section 121, in proposed Section 58 of Chapter 118G of the General Laws, in line 2021, by striking out the number "17" and inserting in place thereof the number "18";

And in said Section 121, in proposed Section 58 of Chapter 118G of the General Laws, in line 2032 of said section, by inserting after the word "Recovery," the words ", Massachusetts Nurses Association";

Amendment #43

Mr. Chan of Quincy moves to amend H.4127 in line 1049 by striking out the definition of “medical spend” and inserting in place thereof the following definition:-

“Medical spend”, the annual per capita sum of all health care expenditures in the commonwealth from public and private sources, including: (i) all categories of medical expenses and all non-claims related payments to providers, as included in the health status adjusted total medical expenses reported by the division; (ii) all patient cost-sharing amounts, such as deductibles and copayments; and (iv) the net cost of private health insurance, or as otherwise defined in regulations promulgated by the division.”

And further amends the bill in subsection 47 of section 121 by inserting the following words:-

(h) “Allowed growth”, the percentage as specified in section 46(b)(2) divided by relative price. Allowed growth is equal to the percentage specified in section 46(b)(2) for health care entities for which there is no relative price reported.”

And further amends the bill in section 121 by striking out the words “the modified potential gross state product growth rate” throughout the section and inserting in place thereof the following words: “their allowed”.

Amendment #44

Representative O'Day of West Boylston moves to amend the bill in SECTION 98 Section 2(b) by striking "9" in line 1196 and replacing with "11" and striking "4" in line 1197 and replacing with "6" and adding after the words "and 1 of whom shall be a primary care provider licensed to practice in the commonwealth" in line 1201 the words "and 2 of whom shall be members of labor organizations selected from a list of 3 names submitted by the President of the Massachusetts AFL-CIO."

Amendment #45

Mr. Chan of Quincy moves to amend H.4127 in line 540 by inserting after the words “the facility” the following words: “or its parent company”

And further amends the bill in line 543 by adding after the word “services” the following words: “under commercial contract.”

Amendment #46

Representatives Kane of Holyoke and Finn of West Springfield move to amend the Bill in section 124, line item 2853, by deleting “30,000” replacing it with “15,000”.

Amendment #47

Mr. Kane moves to amend the bill (House, No. 4127) by inserting at the end thereof the following new section:

“Provided further, MassHealth shall establish capitation rates for the senior care options plans and programs of all-inclusive care for the elderly through a rate setting process that is actuarially sound and transparent.”

Amendment #48

Mr. Nangle of Lowell moves that the bill be amended in Section 136 by adding after subsection (d)(6) in line 3092 the following new subsection:

“(e) Nothing in this section shall limit a health plan from requiring prior authorization for services.”

Amendment #49

Mr. Nangle of Lowell moves to amend the bill in Section 124, in line 2914 by striking out the word “may” and inserting in place thereof the word “shall”

Amendment #50

Mr. Nangle of Lowell moves to amend the bill in SECTION 97, in line 1004, by addingafter the word “psychiatric” the words “, physical therapy”.

Amendment #51

Mr. Kulik of Worthington moves to amend the bill, in Section 121, by striking out in lines 2231-2232 the words “and (iv) the Ambulatory Care Experiences Survey” and inserting in place thereof the following words, “(iv) measures of patient confidence or patient engagement; and (v) the Ambulatory Care Experiences Survey”.

Amendment #52

Mr. Kulik moves that the bill be amended in SECTION 85 in line 711 by striking the word “medical”,
And further amends the bill in SECTION 124 in line 2887 by striking the word “medical”,
And further amends the bill in SECTION 179 in line 3645 by striking the word “medical”,
And further amends the bill in SECTION 180 in lines 3661 and 3706 by striking the word “medical”.

Amendment #53

Mr. Torrisi of North Andover moves that House Bill 4127 be amended by striking subsection (i) of Section 66 and inserting the following new subsection:-

(i) The division may grant exemptions from the requirements of this section if a system demonstrates to the satisfaction of the division that at a minimum, the following criteria have been met:
(1) The provider system receives over 50 percent of its revenue from alterative payment arrangements;
(2)The provider system has fully implemented one unifying, interoperable electronic medical record system across all providers and facilities within the system;
(3)The provider system has implemented quality improvement initiatives with demonstrable improvements in quality of care provided;
(4)The provider system has successfully implemented programs to direct care to the appropriate and lowest costing setting within its system; and
(5)The provider system can demonstrate that is has implemented appropriate measures to eliminate unnecessary duplication of health care services within the system.

Amendment # 54

Mr. Basile of Boston moves to amend the bill in Section 121, in line 1568 by adding after the words “social workers” the following: “specialty care providers licensed in the commonwealth to provide rehabilitative and habilitative services, including but not limited to physical therapists, occupational therapists and speech language pathologists, as well as,”

Amendment #55

Mr. Basile of Boston moves to amend the bill in Section 121, in line 2214 by inserting after the words “provider association,” the following: “3 representatives from the following associations of licensed health care professionals providing rehabilitative or habilitative services: The American Physical Therapy Association of Massachusetts, the Massachusetts Association of Occupational therapy, and the Massachusetts Speech Language Hearing Association,”

Amendment #56

Mr. Basil of Boston moves to amend the bill in Section 123, in line 2396 by striking out the figure "19" and inserting in place thereof the figure "22" and in said section 123 by inserting after the word "carriers" the following: "3 shall be representatives from the following associations representing licensed providers of rehabilitative or habilitative services: "the American Physical Therapy Association of Massachusetts, the Massachusetts Association of Occupational Therapy, and the Massachusetts Society of Prosthetic s and Orthotics,"

Amendment #57

Representatives Balser of Newton and Malia of Boston move to amend the bill, H4127, by inserting after Section 167 the following two sections:

SECTION 167A. Subsection (a) of section 12 of chapter 176O of the General Laws is hereby amended by adding at the end of the second paragraph the following:-

"and made easily accessible and up-to-date on a carrier or utilization review organization's website to subscribers, health care providers and the general public. If a carrier or utilization review organization intends either to implement a new preauthorization requirement or restriction or amend an existing requirement or restriction, the carrier or utilization review organization shall ensure that the new or amended requirement or restriction shall not be implemented unless the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction."

SECTION 167B. Section 16 of chapter 176O of the General Laws is hereby amended by striking subsection (b) and inserting in place thereof the following subsection:-

"(b) A carrier shall be required to pay for health care services ordered by a treating physician or primary care provider if: (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary. A carrier may develop guidelines to be used in applying the standard of medical necessity, as defined in this subsection. Any such medical necessity guidelines utilized by a carrier in making coverage determinations shall be: (i) developed with input from practicing physicians and participating providers in the carrier's or utilization review organization's service area; (ii) developed under the standards adopted by national accreditation organizations; (iii) updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier shall consider the individual health care needs of the insured. Any such medical necessity guidelines criteria shall be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website to subscribers, health care providers and the general public. If a carrier or utilization review organization intends either to implement a new medical necessity guideline or amend an existing requirement or restriction, the carrier or utilization review organization shall ensure that the new or amended requirement or restriction shall not be implemented unless the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction."

Amendment #58

Representatives Balser of Newton and Malia of Boston move to amend the bill, H4127, in section 63, in line 2154, by inserting after "proprietary in nature" the following: "and is not in the public interest to disclose. Utilization review criteria, medical necessity criteria and protocols must be made available to the public at no charge regardless of proprietary claims."

Amendment #59

Representatives Balser of Newton and Malia of Boston move to amend the bill, H4127, in section 90, in lines 767 to 770, inclusive, by striking out: “Providers of institutional or community based long term services and supports on a compensated basis shall not function as an independent care coordinator, provided however that the secretary may grant a waiver upon a finding that the public necessity and convenience require such a waiver.”

Amendment #60

Representatives Balser of Newton and Malia of Boston move to amend the bill, H4127, in section 123, in line 2492, by inserting after “centers” the following “and community based behavioral health provider organizations.”; and also in line 2630, by inserting after “participation” the following: “whether the grantee serves a high proportion of public payer clients, whether the grantee is eligible to receive Medicare or Medicaid incentive payments under the federal Health Information Technology for Economic and Clinical Health Act”; and also in line 2645, by inserting after “chapter 111”, the following: “and to community based behavioral health organizations”; and also in line 2667, by inserting after “chapter 111”, the following: “and to community based behavioral health organizations”; and also in line 2695, by inserting after “program”, the following: “and shall give priority to loan applicants who serve a high proportion of public payer clients and to applicants who are not eligible to receive Medicare or Medicaid payments under the federal Health Information Technology for Economic and Clinical Health Act.”

Amendment #60, changed

Ms. Balser of Newton moves to further amend the bill, H4127, in section 123, in line 2492, by inserting after “centers” the following “and community based behavioral health provider organizations.”; and also in line 2630, by inserting after “participation” the following: “whether the grantee serves a high proportion of public payer clients, whether the grantee is eligible to receive Medicare or Medicaid incentive payments under the federal Health Information Technology for Economic and Clinical Health Act”; and also in line 2645, by inserting after “chapter 111”, the following: “and to community based behavioral health organizations”; and also in line 2667, by inserting after “chapter 111”, the following: “and to community based behavioral health organizations”;

Amendment #61

Representatives Balser of Newton and Malia of Boston move to amend the bill, H4127, in section 190, in line 3787, by inserting after “Public Law 110-313,” the following: “without regard to the size of the employer or group.”

Amendment #62

Representatives Balser of Newton and Malia of Boston move to amend the bill, H4127, by adding the following section:

SECTION XX. Chapter 26 of the General Laws is hereby amended by adding after section 8J the following section:-

Section 8K. The commissioner of insurance is hereby authorized to implement applicable provisions of the federal Mental Health Parity and Addiction Equity Act, as codified in Title XVII the Public Health Service Act, 42 USC Sec. 300gg-26, in regards to any carrier licensed under chapters 175, 176A, 176B and 176G.

Amendment #63

Mr. Walsh of Framingham moves to amend the bill by adding at the end thereof the following new section:-

“SECTION ____. There shall be a commission for health delivery of patient centered care and quality of life which shall include interdisciplinary experts in palliative care, psychosocial care, pain management, hospice, primary care and patient/caregiver advocacy. The Commission shall help develop, implement, and evaluate state policy strategies for ensuring integration quality patient-centered and family-focused care services addressing pain, symptom and distress for seriously and chronically ill people from diagnosis onward to relieve suffering and promote quality of life. The Commission shall consist of 8 members: 1 of whom shall be the Secretary of Health and Human Services who shall serve as Chair; 7 of whom shall be appointed by the Governor, 1 of whom shall be a representative of the American Cancer Society, 1 of whom shall be a representative of the Hospice and Palliative Care Federation of Massachusetts, 1 of whom shall be a representative of the Schwartz Center for Compassionate Health Care, 1 of whom shall be a physician representative of the Massachusetts Medical Society specializing in pain management, 1 of whom shall be a representative of the Massachusetts Hospital Association and 1 of whom shall be a representative of the Massachusetts Nurses Association. Said commission shall report its findings to the Joint Committee on Public Health and the Joint Committee on Health Care Financing by July 31, 2013.

Amendment #64

Mr. Donato of Medford moves to amend the bill at the end thereof, by inserting the following new section:-

SECTION __. Chapter 112 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking out section 13 and inserting in place thereof the following new section:-

Section 13. Podiatry as used in this chapter shall mean the diagnosis and treatment of the structures of the human foot and ankle by medical, mechanical, surgical, manipulative and electrical means, including, but not limited to, the treatment of the local manifestation of systemic conditions as they present in the foot and ankle, partial amputation of the foot, and tendon surgery in the foot and ankle, including the Achilles tendon. The practice of podiatry shall not include the administration of a general anesthetic or amputation of the entire foot. Ankle surgery involving bone shall include, but not exceed, portions of the fibula and tibia that directly relate to the ankle, must be performed in a hospital or surgical center and requires credentialing by that facility and shall require either (a) board certification approved by the American Board of Podiatric Surgery (ABPS); or (b) board certification as deemed appropriate by the Massachusetts Board of Registration in Podiatry; or (c) supervision of a Podiatric physician (D.P.M.) who is board certified by the ABPS who has ankle privileges, until competency is established to achieve credentialing by the facility; or (d) supervision of a board certified Allopathic (M.D.) or Osteopathic (D.O.) physician who has ankle privileges, until competency is established to achieve credentialing by the facility.

This section and sections fourteen to twenty-two, inclusive, shall not apply to surgeons of the United States Army, Navy or the United States Public Health Service, nor to physicians registered in the commonwealth. The term physician and surgeon when used in sections twelve B, twelve G, twenty-three N, and eighty B shall include a podiatrist acting within the limitation imposed by this section.

Amendment #65

Mr. Toomey of Cambridge moves to amend the bill by adding the following section:

“Section XX. Section 12 of said chapter 176O, as so appearing, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

(a) Utilization review conducted by a carrier or a utilization review organization shall be conducted under a written plan, under the supervision of a physician and staffed by appropriately trained and qualified personnel and shall include a documented process to: (i) review and evaluate its effectiveness; (ii) ensure the consistent application of utilization review criteria; and (iii) ensure the timeliness of utilization review determinations.

A carrier or utilization review organization shall adopt utilization review criteria and conduct all utilization review activities under said criteria. The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians, consistent with the development of medical

necessity criteria under section 16. Utilization review criteria shall be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website to subscribers, health care providers and the general public. If a carrier or utilization review organization intends either to implement a new preauthorization requirement or restriction or amend an existing requirement or restriction, the carrier or utilization review organization shall ensure that the new or amended requirement or restriction shall not be implemented unless the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction.

Adverse determinations rendered by a program of utilization review or other denials of requests for health services, shall be made by a person licensed in the appropriate specialty related to such health service and, if applicable, by a provider in the same licensure category as the ordering provider.

The disclosure of utilization review criteria required by this section shall not apply to licensed, proprietary criteria purchased by a carrier or utilization review organization. For the purposes of this section, "proprietary criteria" shall be defined as written screening procedures, abstracts, clinical protocols and practice guidelines purchased by a carrier or utilization review entity designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Written screening procedures, abstracts, clinical protocols and practice guidelines that carriers and utilization review organizations must make available upon request as part of a national accreditation shall not be considered proprietary for purposes of this section.".

Amendment #66

Representative Scibak of South Hadley moves to amend the bill by adding at the end thereof the following section:

SECTION ____.(a) There shall be a Pharmaceutical Cost Containment commission established to study methods to reduce the cost of prescription drugs for both public and private payers. The commission shall consist of 18 members: 2 of whom shall be the co-chairs of the joint committee on health care financing, 1 of whom shall be the commissioner of the group insurance commission or a designee, 1 of whom shall be the director of the division of insurance or a designee, 1 of whom shall be the director of the state office of pharmacy services or a designee, 1 of whom shall be the secretary of elder affairs or a designee, 1 of whom shall be the director of the Massachusetts medicaid program or a designee, 2 of whom shall be appointed by the president of the senate, 1 of whom shall be appointed by the minority leader of the senate, 2 of whom shall be appointed by the speaker of the house of representatives, 1 of whom shall be appointed by the minority leader of the house of representatives, 2 of whom shall be appointed by the Governor and shall be knowledgeable in the pharmaceuticals industry, bulk purchasing agreements or health care, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, 1 of whom shall be a representative of the Massachusetts Hospital Association, and 1 of whom shall be a representative of Health Care For All. All necessary appointments shall be made within 60 days of the effective date of this act.

(b) The commission shall examine and report on the following: (i) the ability of the commonwealth to enter into bulk purchasing agreements, including agreements that would require the secretary of elder affairs, the commissioner of GIC, the director of the state office of pharmacy services, the commissioners of the departments of public health, mental health, and mental retardation, and any other state agencies involved in the purchase or distribution of prescription pharmaceuticals, to renegotiate current contracts; (ii) aggregate purchasing methodologies designed to lower prescription pharmaceutical costs for state and non-state providers; (iii) the ability of the commonwealth to operate as a single payer prescription pharmaceutical provider; and, (iv) the feasibility of creating a program to provide all citizens access to prescription pharmaceuticals at prices negotiated by the commonwealth.

(c) The commission shall report the results of its findings as well as any recommendations for legislation, programs, and funding to the clerks of the house of representatives and the senate who shall forward copies of the report to the house and senate committees on ways and means and the joint committee on health care financing no later than 12 months after the effective date of this act.

Amendment #67

Representative Scibak of South Hadley moves to amend the bill, in Section 145, by adding in line 3187 after the word "tier" the following sentences, "Every member shall have access to services in the least expensive cost-sharing tier for every service, provided that the commissioner shall promulgate regulations to enforce this requirement.";
and by inserting in Section 146, line 3202, after the word "locations" the following:- "Prior to implementing smart tiering network plans, the commissioner shall conduct a study on how to best implement smart tiering plans to further these goals. The study shall include consumer focus groups, including non-English speaking and low income residents, to determine how to best inform consumers regarding the selection and use of smart tiering plans.
(k) There shall be a uniform tiering methodology and standards across all carriers in order to allow for a meaningful comparison of cost-sharing between plans. All carriers offering smart tiering plans shall publish the cost and quality criteria for covered services under smart tiering plans.
(l) The consumer guide established by the commissioner pursuant to 211 CMR 152.06(2)(b) shall include information on smart tiering plans.

(m) All promotional materials for smart tiering plans must include a description of quality and cost methods used to establish the tiers, and an explanation of the cost sharing differences in terms understandable to the average consumer. All carriers offering smart tiering plans shall further implement proactive communication mechanisms for consumers, including a consumer hotline with a live person to answer questions regarding cost-sharing, and a dedicated webpage on smart tiering network information that provides access to user-friendly information allowing consumers to compare cost-sharing differences between plans and access a searchable database of tiered services and providers. Health plans shall be required to perform regular member surveys and improve their disclosure contents by reflecting survey results."

Amendment #68

Representative Fennell of Lynn moves to amend H. 4127 by inserting after the word "assistance" in line 1922 the following words:-

"; provided any such interagency agreement with the Department of Revenue shall meet all applicable federal and state privacy and security requirements, including requirements imposed by the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, the American Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45 C.F.R. §§160, 162, 164 and 170 and shall not cause patient payment to Department of Revenue through use of protected health information."

Amendment #69

Representative Brodeur of Melrose moves to amend the bill, in Section 124, by striking out in lines 2896-2897 the following the words, "guidelines for ACOs to create internal appeals plans for denial of care" and inserting in place thereof the words, "ACO appeal procedures for adverse determinations that are consistent with the appeal procedures of sections 12 through 14 of chapter 176O";

and by striking out in lines 2898-2899 the words, "the process for second opinions to occur outside of the ACO" and inserting in place thereof the words, "and a process to provide an independent second opinion outside the ACO at no charge to the patient";

and by inserting in Section 172, line 3495,after the words "internal appeals processes" the following words, "that are consistent with the appeal procedures of sections 12 through 14 of chapter 176O";

and by striking in line 3499 the words "for a patient with a terminal illness" and inserting in place thereof the words, "for a patient with an urgent medical need";

and by striking in lines 3499-3500 the words, “external opinion unless it would be impractical for expedited internal appeals” and inserting in place thereof the words, “independent external opinion at no charge to the patient”;

and by striking in line 3502, the word “a” and inserting in place thereof the words, “an independent”;

and by striking in lines 3503-3504 the sentence, “Provided that any patient who elects to have an independent care coordinator; said care coordinator may act as the patient advocate,” and inserting in place thereof the following sentence, “Provided that any patient may elect any person to act as their patient advocate, including an independent care coordinator”.

Amendment #69, changed

Representative Brodeur of Melrose moves to further amend amendment 69 of House, No. 4127, by striking out the amendment in its entirety and inserting in place thereof the following amendment:
Representative Brodeur of Melrose moves to amend the bill, in Section 124, by striking out in lines 2896-2897 the following the words, “guidelines for ACOs to create internal appeals plans for denial of care” and inserting in place thereof the words, “ACO appeal procedures for adverse determinations that are consistent with the appeal procedures of sections 12 through 14 of chapter 176O”;
and by striking out in lines 2898-2899 the words, “the process for second opinions to occur outside of the ACO” and inserting in place thereof the words, “and a process to provide an independent second opinion outside the ACO;
and by inserting in Section 172, line 3495,after the words “internal appeals processes” the following words, “that are consistent with the appeal procedures of sections 12 through 14 of chapter 176O”;
and by striking in line 3499 the words “for a patient with a terminal illness” and inserting in place thereof the words, “for a patient with an urgent medical need”;
and by striking in lines 3499-3500 the words, “external opinion unless it would be impractical for expedited internal appeals” and inserting in place thereof the words, “independent external opinion”;
and by striking in line 3502, the word “a” and inserting in place thereof the words, “an independent”;
and by striking in lines 3503-3504 the sentence, “Provided that any patient who elects to have an independent care coordinator; said care coordinator may act as the patient advocate,” and inserting in place thereof the following sentence, “Provided that any patient may elect any person, including, but not limited to, a spouse or other family member, an attorney of record or a legal guardian, to act as their patient advocate or independent care coordinator”.

Amendment #70

Rep. Basile of Boston moves to amend the bill (House, No. 4127) in section 136, by inserting after the word “authorization.” in line 3039 the following:- (7) The forms shall include personalized medicine diagnostic information including, where relevant, personalized genomic, metabolic, cellular or anatomic data.”

Amendment #71

Rep. Basile of Boston moves that the bill be amended in Section 121 in line 2240 by striking the words “ACOs or physician organizations”;

And that the bill be further amended by striking the words “ACOs and physician organizations” in line 2258;

And that the bill be further amended by striking the words “ACOs, as defined in section 1, and physician organizations physician organizations as defined in section 53H of chapter 111)” in lines 2271 through 2271;

And that the bill be further amended by striking the words “ACOs and physician organizations” in line 2274;

And that the bill be further amended by striking the words “ACO or physician organization” in line 2278;

And that the bill be further amended by striking the words “ACO and physician organization” in line 2304;

And that the bill be further amended by striking the words “ACO or physician organization” in line 2207;

Amendment #72

Rep. Basile of Boston moves that the bill be amended by striking Section 136 subsection 229 in its entirety (lines 3094 through 3100), and replacing it with the following new section: -

“Section 229. The commissioner shall establish standardized processes and procedures applicable to all health care providers and payers for the determination of a patient’s health benefit plan eligibility at or prior to the time of service by July 1, 2013. As part of such processes and procedures, the commissioner shall (i) require payers to implement automated authorization systems such as decision support software in place of telephone authorizations for specific types of services specified by the commissioner and (ii) require establishment of an electronic data exchange to allow providers to determine eligibility at or prior to the point of care.

Any determination as to eligibility at or prior to the time of treatment is not binding on the plan to the extent that new information on lack of eligibility of the patient for coverage at the time of treatment is provided by the employer to the plan between the time of the prior authorization and the time of claim.”

And moves that the bill be further amended by striking in subsection 230 in Section 136, in its entirety (lines 3101 through 3110), and replacing it with the following new subsection:-

“Section 230. The commissioner shall establish a Task Force to study ways to improve transparency, comprehension and readability in Explanation of Benefits forms, consistent with the approach taken in the Affordable Care Act (ACA) requirements concerning health insurance plan summary of benefits and coverage explanations. The task force shall include representatives from the Massachusetts Medical Society, the Massachusetts Hospital Association, the Massachusetts Association of Health Plans, Blue Cross Blue Shield of Massachusetts, a representative from an employer association and a representative from a health care consumer group. The commissioner shall make recommendations and file a report with the Joint Committee on Financial Services by January 1, 2013.”

Amendment #73

Rep. Basile of Boston moves that the bill be amended in Section 189 by striking the first paragraph, (lines 37751-3774) and inserting the following new paragraph:-

“Following an evaluation by the office of the attorney general, pursuant to section 11M of Chapter 12 of the General Laws, relating to the need of the commonwealth to obtain waivers from certain provisions of federal law including, from the federal office of the inspector general, a waiver of the provisions or expansion of the “safe harbors” provided for under 42 U.S.C. section 1320a-7b; and a waiver of the provisions of 42 U.S.C. section 1395nn(a) to (e), and upon a determination by the attorney general that such waiver or exemption is necessary, the division of health care cost and quality shall, by August 15, 2012, request from the federal office of the inspector general the following:”

Amendment #74

Mr. Costello of Newburyport moves to amend H.4127 by striking section 188 in its entirety and replacing it with the following section:
“SECTION 188. Nothing in this act shall be construed to preclude an individual from obtaining additional medical expense insurance or paying out of pocket for any medical service not covered by the individual’s health plan, provided, however, such insurance may not provide a benefit covering copayments, deductibles, co-insurance or other patient payment responsibility for services that are included in the individual’s health plan.”

Amendment # 75

Representatives Kafka of Stoughton, Chan of Quincy, Linsky of Natick, Galvin of Canton, Ayers of Quincy, Dykema of Holliston, Barrows of Mansfield, and Poirier of North Attleboro move to amend the bill in Section 121, Section 42 by inserting after subsection (d) in line 1521, the following:
"(e) Establish safeguards against underutilization of services, that ensure the use and the continued advancement of medical technologies, treatments, diagnostics or pharmacology products that offer substantial clinical improvements and represent a higher cost than the use of current therapies and protections against and penalties for inappropriate denials of services or treatment and in connection with utilization of any alternative payment method or transition to a global payment system;"

Amendment # 75, changed

Mr. Kafka of Stoughton moves to amend the bill, H 4127, in Section 121 by striking lines 1517 to 1521 and inserting in place thereof the following:-
"(c) issue administrative bulletins and various other forms of official guidance that are necessary to effectuate the purposes of this chapter;
(d) waive any of its requirements to permit and support innovative demonstrations or pilot programs; provided that such waivers may only be renewed if material savings or improvements in the delivery and quality of care can be documented, to the satisfaction of the division; and
(e) establish safeguards against underutilization of innovative technologies and services, although they may represent a higher cost than the use of current therapies."

Amendment #76

Mr. Costello of Newburyport moves to amend H.4127 by inserting after section 143 the following new section:-
"SECTION 143(a). Section 6 of chapter 176J of the General Laws is hereby amended by striking subsection (c), as most recently amended by section 31A of chapter 359 of the acts of 2010, and inserting in place thereof the following subsection:-
(c) Notwithstanding any general or special law to the contrary, the commissioner may require carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or 176G, to file all changes to small group product base rates and to small group rating factors at least 90 days before their proposed effective date. The commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged. The commissioner shall disapprove any change to small group rating factors that is discriminatory or not actuarially sound. The determination of the commissioner shall be supported by sound actuarial assumptions and methods, which shall be provided in writing to the carrier. Rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt regulations to carry out this section."

Amendment #77

Mr. Cusack of Braintree moves to amend the bill, H4127, by adding the following new Section:-
Section X. Notwithstanding any general or special law to the contrary, the state Medicaid office is hereby authorized to establish a pilot program with an external service provider to determine the effectiveness of various fraud management tools to identify potential fraud at claims submission and validation in order to reduce Medicaid fraud prior to payment; provided further, that said pilot program shall evaluate current Medicaid spending programs and utilize said fraud management services to determine the efficacy of current practices. The pilot program shall utilize only vendors currently engaged in systemic waste and fraud detection services. Selected vendor(s) shall not use any data provided to them for any other purpose than waste and fraud detection, shall destroy all data after the completion of their evaluation(s) and may not share the results of the data analysis with any outside entities. The executive office of health and human services shall submit 2 reports to the house and senate committees on ways

and means detailing recoveries and offsets generated by said audits; provided that the first report shall be delivered no later than February 1, 2014 and that the second report shall be delivered no later than December 31, 2015.

Amendment #78

Ms. Spiliotis of Peabody moves to amend the bill in SECTION 14 by adding after word “government.” In line 162, the following:

“The division shall also consult with members of associations representing health care professionals licensed in the commonwealth and providing prevention and wellness services, including but not limited to the American Physical Therapy Association of Massachusetts, the Massachusetts Association of Occupational Therapy, the Massachusetts Society of Orthotics and Prosthetics, the Massachusetts Dietetic Association and the Massachusetts Speech Language Hearing Association.”

Ms. Spiliotis of Peabody further moves to amend the bill in SECTION 101, in line 1316, by adding after the word “Association.” the following:

The division shall also consult with members of associations representing health care professionals licensed in the commonwealth and providing prevention and wellness services, including but not limited to the American Physical Therapy Association of Massachusetts, the Massachusetts Association of Occupational Therapy, the Massachusetts Society of Orthotics and Prosthetics, the Massachusetts Dietetic Association and the Massachusetts Speech Language Hearing Association.”

Amendment #79

Ms. Spiliotis of Peabody moves to amend the bill in SECTION 123, in line 2645, and in line 2666 by inserting after the “providers” each time it appears, the following: “including but not limited to those” and by striking out in line 2645 and in line 2666 the word “as”; and in said SECTION 123, in line 2668 by adding after the word “requirements.” the following: “,provided, further that the executive office shall make said loan funding available to providers of rehabilitative/habilitative services such as physical therapy, occupational therapy and prosthetics and orthotics practitioners.”

Amendment #80

Representatives Sullivan of Fall River and Fallon of Malden move to amend the bill (House No. 4127) by inserting in Section 121, subsection 58 in line 2043 after the word “conditions,” the following “particularly with respect to the effects of cardiovascular disease, diabetes and/or obesity on patients with serious mental illness”

Amendment #80, changed

Mr. Sullivan of Fall River moves to amend the bill, H 4127, in section 58, in line 2042 to 2045, by striking the words:- “ (d) how best to educate all providers to recognize behavioral health conditions and make appropriate decisions regarding referral to behavioral health services; and (e) the unique privacy factors required for the integration of behavioral health information into interoperatable electronic health records.” and inserting in place thereof the following words:- (d) how best to educate all providers to recognize behavioral health conditions and make appropriate decisions regarding referral to behavioral health services; (e) how best to educate all providers about the effects of cardiovascular disease, diabetes, and obesity on patients with serious mental illness; and (f) the unique privacy factors required for the integration of behavioral health information into interoperatable electronic health records.”

Amendment #81

Representatives Sullivan of Fall River, Aguiar of Fall River, Pignatelli of Lenox, and Brady of Brockton move that the bill (House No. 4127) be amended in Section 181, line 3727, by inserting after the word “dentist,” the following words:

“dental hygienist”

Amendment #82

Representatives Sciortino of Medford and Rushing of Boston move to amend the bill in Section 123, in subsection 15 in line 2615 by adding the following at the end of the subsection: “No patient may be refused care for opting out of the health information exchange, or for withholding their HIV related information from the health information exchange.”

Amendment #83

Representatives Fennell of Lynn and DiNatale of Fitchburg move to amend H. 4127 in section 58, in line 2028, by inserting the following:-

“Massachusetts Association for School-Based Health Care.”

Amendment #84

Mr. Costello of Newburyport moves to amend H. 4127, in section 66, in line 543, by inserting after the words “primary care services”, the following:-
“, and (3) such system has been designated as integrated pursuant to regulations which the department, in consultation with the division of insurance, shall adopt. The department shall consider whether a provider system has implemented an interoperable electronic medical record system within the system, implemented quality improvement initiatives with demonstrable results in the quality of care provided, and implemented measures to eliminate unnecessary duplication of services within the system as factors of integration; and provider further, the division of insurance shall conduct a study of the impact of this section on health insurance premium costs. The division shall issue a report on its findings to the senate and house committees on ways and means and the joint committee on health care financing by March 1, 2014.”

Amendment #85

Mr. Scibak of South Hadley moves to amend H 4127 by adding at the end thereof the following new outside section:
Section XXX:
SECTION 1. Notwithstanding any general or special law to the contrary, Section 108 of chapter 175 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following section:-
(a) If a carrier provides coverage for prescription drugs, the carrier shall establish an out-of-pocket limit not to exceed $3,500 per year for prescription drugs subject to coinsurance provided under a health plan to the extent not inconsistent with the federal Affordable Care Act.
A carrier may adjust an out-of-pocket limit, as long as any limit for prescription drugs for coinsurance does not exceed $3,500, to minimize any premium increase that might otherwise result from the requirements of this section.
This section may not be construed to prohibit or limit a carrier's ability to establish specialty tiers for prescription drug coverage, to make determinations of medical necessity or to enforce procedures regarding prior authorization or utilization review in.
For the purposes of this section, the use of the terms "coinsurance" and "out-of-pocket limit" by a carrier must be consistent with the definitions of those terms as prescribed by the Secretary of the United States Department of Health and Human Services pursuant to Section 2715 of the federal Affordable Care Act.
The requirements of this Act apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2013. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
SECTION 2. Notwithstanding any general or special law to the contrary, Section 110 of chapter 175 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following section:-
(a) If a carrier provides coverage for prescription drugs, the carrier shall establish an out-of-pocket limit not to exceed

$3,500 per year for prescription drugs subject to coinsurance provided under a health plan to the extent not inconsistent with the federal Affordable Care Act.
A carrier may adjust an out-of-pocket limit, as long as any limit for prescription drugs for coinsurance does not exceed $3,500, to minimize any premium increase that might otherwise result from the requirements of this section.
This section may not be construed to prohibit or limit a carrier's ability to establish specialty tiers for prescription drug coverage, to make determinations of medical necessity or to enforce procedures regarding prior authorization or utilization review in.
For the purposes of this section, the use of the terms "coinsurance" and "out-of-pocket limit" by a carrier must be consistent with the definitions of those terms as prescribed by the Secretary of the United States Department of Health and Human Services pursuant to Section 2715 of the federal Affordable Care Act.
The requirements of this Act apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2013. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
SECTION 3. Notwithstanding any general or special law to the contrary, Chapter 176A of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following section:-
(a) If a carrier provides coverage for prescription drugs, the carrier shall establish an out-of-pocket limit not to exceed $3,500 per year for prescription drugs subject to coinsurance provided under a health plan to the extent not inconsistent with the federal Affordable Care Act.
A carrier may adjust an out-of-pocket limit, as long as any limit for prescription drugs for coinsurance does not exceed $3,500, to minimize any premium increase that might otherwise result from the requirements of this section.
This section may not be construed to prohibit or limit a carrier's ability to establish specialty tiers for prescription drug coverage, to make determinations of medical necessity or to enforce procedures regarding prior authorization or utilization review in.
For the purposes of this section, the use of the terms "coinsurance" and "out-of-pocket limit" by a carrier must be consistent with the definitions of those terms as prescribed by the Secretary of the United States Department of Health and Human Services pursuant to Section 2715 of the federal Affordable Care Act.
The requirements of this Act apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2013. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
SECTION 4. Notwithstanding any general or special law to the contrary, Chapter 176B of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following section:-
(a) If a carrier provides coverage for prescription drugs, the carrier shall establish an out-of-pocket limit not to exceed $3,500 per year for prescription drugs subject to coinsurance provided under a health plan to the extent not inconsistent with the federal Affordable Care Act.
A carrier may adjust an out-of-pocket limit, as long as any limit for prescription drugs for coinsurance does not exceed $3,500, to minimize any premium increase that might otherwise result from the requirements of this section.
This section may not be construed to prohibit or limit a carrier's ability to establish specialty tiers for prescription drug coverage, to make determinations of medical necessity or to enforce procedures regarding prior authorization or utilization review in.
For the purposes of this section, the use of the terms "coinsurance" and "out-of-pocket limit" by a carrier must be consistent with the definitions of those terms as prescribed by the Secretary of the United States Department of Health and Human Services pursuant to Section 2715 of the federal Affordable Care Act.
The requirements of this Act apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2013. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
SECTION 5. Notwithstanding any general or special law to the contrary, Chapter 176G of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following section:-
(a) If a carrier provides coverage for prescription drugs, the carrier shall establish an out-of-pocket limit not to exceed $3,500 per year for prescription drugs subject to coinsurance provided under a health plan to the extent not inconsistent with the federal Affordable Care Act.
A carrier may adjust an out-of-pocket limit, as long as any limit for prescription drugs for coinsurance does not exceed $3,500, to minimize any premium increase that might otherwise result from the requirements of this section.
This section may not be construed to prohibit or limit a carrier's ability to establish specialty tiers for prescription drug coverage, to make determinations of medical necessity or to enforce procedures regarding prior authorization or

utilization review in.
For the purposes of this section, the use of the terms "coinsurance" and "out-of-pocket limit" by a carrier must be consistent with the definitions of those terms as prescribed by the Secretary of the United States Department of Health and Human Services pursuant to Section 2715 of the federal Affordable Care Act.
The requirements of this Act apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2013. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.
SECTION 6. Notwithstanding any general or special law to the contrary, Chapter 176I of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following section:-
(a) If a carrier provides coverage for prescription drugs, the carrier shall establish an out-of-pocket limit not to exceed $3,500 per year for prescription drugs subject to coinsurance provided under a health plan to the extent not inconsistent with the federal Affordable Care Act.
A carrier may adjust an out-of-pocket limit, as long as any limit for prescription drugs for coinsurance does not exceed $3,500, to minimize any premium increase that might otherwise result from the requirements of this section.
This section may not be construed to prohibit or limit a carrier's ability to establish specialty tiers for prescription drug coverage, to make determinations of medical necessity or to enforce procedures regarding prior authorization or utilization review in.
For the purposes of this section, the use of the terms "coinsurance" and "out-of-pocket limit" by a carrier must be consistent with the definitions of those terms as prescribed by the Secretary of the United States Department of Health and Human Services pursuant to Section 2715 of the federal Affordable Care Act.
The requirements of this Act apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2013. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

Amendment #86

Mr. Cantwell of Marshfield moves that the bill be amended in Section 162, in subsection (a) of proposed section 2A of chapter 176O of the General Laws, by inserting after the words “board of registration in nursing” the following: “, a representative of the Massachusetts Nurses Association”;
And in said section 162, subsection (f) of proposed section 2B of chapter 176O of the General Laws, by inserting after the words “board of registration in nursing” the following: “, a representative of the Massachusetts Nurses Association”.

Amendment #87

Representatives Fennell of Lynn and DiNatale of Fitchburg move to amend H. 4127 by inserting in section 97, in line 1142, the following:-

“School-Based Heath Centers, as defined by United States Code (U.S.C.) 1397”

Amendment #88

Mr. Chan of Quincy moves to amend the bill (H. 4127) by inserting the following new section at the end thereof:

SECTION __. Section 3 of chapter 176D, as appearing in the 2010 official edition, is hereby amended by inserting after every occurrence of words “medical service corporation”, the following words:- “accountable care organization”.

Amendment #89

Mr. Chan of Quincy moves to amend the bill (H. 4127) in Section 12 by inserting at the end thereof the following paragraphs:-

“The Attorney General shall, pursuant to G.L. c. 93A, section 2(c), within 180 days of the enactment of this section, investigate and issue regulations proscribing unfair, deceptive, or anticompetitive conduct within the Commonwealth’s healthcare marketplace. Such regulations shall include, at a minimum, the prohibition of anticompetitive contracting practices between and/or among acute care hospitals and insurers, in which the acute care hospital possesses the market power to impose non-transitory increases in rates charged for health care services.

The following shall be unfair methods of competition and unfair or deceptive acts or practices for providers or provider organizations: (i) entering into any agreement to commit or by any concerted action committing any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of or monopoly in the delivery of health care services, contracting for payment for health care services, or the business of insurance; (ii) seeking to set the price to be paid by any carrier for network contracts at rates that are excessive, unreasonable, discriminatory, predatory, or would otherwise cause the carrier to violate the requirements of its licensure or accreditation; (iii) engaging in any unfair discrimination between individuals who are similarly covered by network contracts; and (iv) making, publishing, disseminating, circulating, or placing before the public, directly or indirectly, any assertion, representation or statement which is untrue, deceptive or misleading.”

Amendment #90

Mr. Winslow of Norfolk moves to amend House Bill 4127 by inserting at the end thereof the following section –

“Section XX. Notwithstanding any general or special law to the contrary, physicians licensed in a state other than Massachusetts shall not be prohibited from providing medical advice, diagnoses, treatments and prescriptions when they communicate with patients through internet-based videoconferences when the physicians are located in the state where they are licensed and the patient is located in Massachusetts at the time of the advice, diagnosis, treatment or prescription. Any such internet-based technology shall include visual and audio notice to patients that the physicians are not licensed in Massachusetts.”

Amendment #91

Representative Lawn of Watertown district moves that the bill be amended in Section 121, in proposed Section 58 of Chapter 118G of the General Laws, line 2021 by striking out the number “17” and inserting in place thereof the number “18”;

And in said Section 121, in proposed Section 58 of Chapter 118G of the General Laws, line 2032 of said section by inserting after the word “Recovery,” the words “, Massachusetts Nurses Association”;

Amendment #92

Mr. Winslow of Norfolk moves to amend House Bill 4127 by inserting at the end thereof the following section –

“SECTION 1. Chapter 175 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after section 111H, the following section:—
Section 111I. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance solely on the basis that it does not include coverage for at least 1 mandated benefit.
(b) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance unless it provides, at a minimum, coverage for:
(1) pregnant women, infants and children as set forth in section 47C;
(2) prenatal care, childbirth and postpartum care as set forth in section 47F;
(3) cytologic screening and mammographic examination as set forth in section 47G;
(3A) diabetes-related services, medications, and supplies as defined in section 47N;
(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.
(c) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance that does not include coverage for at least one mandated benefit unless the carrier continues to offer at least one policy that provides coverage that includes all mandated benefits.
(d) For purposes of this section, “mandated benefit” shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.
(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.
(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a policy of accident and sickness insurance to any employee within 12 months.
SECTION 2. Chapter 176A of the General Laws is hereby amended by inserting after section 1D the following section:
Section 1E. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a contract between a subscriber and the corporation under an individual or group hospital services plan solely on the basis that it does not include coverage for at least one mandated benefit.
(b) The commissioner shall not approve a contract unless it provides, at a minimum, coverage for:
(1) pregnant women, infants and children as set forth in section 8B;
(2) prenatal care, childbirth and postpartum care as set forth in section 8H;
(3) cytologic screening and mammographic examination as set forth in section 8J;
(3A) diabetes-related services, medications, and supplies as defined in section 8P;
(4) early intervention services as set forth in said section 8B; and
(5) mental health services as set forth in section 8A; provided however, that if the contract limits coverage for outpatient physician office visits, the commissioner shall not disapprove the contract on the basis that coverage for outpatient mental health services is not as extensive as required by said section 8A, as long as such coverage is at least as extensive as coverage under the contract for outpatient physician services.
(c) The commissioner shall not approve a contract that does not include coverage for at least one mandated benefit unless the corporation continues to offer at least one contract that provides coverage that includes all mandated benefits.
(d) For purposes of this section, “mandated benefit” shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.
(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.
(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a hospital services plan, to any employee within 12 months.
Chapter 176B of the General Laws is hereby further amended by inserting after section 6B, the following section:—
Section 6C. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a subscription certificate solely on the basis that it does not include coverage for at least one mandated benefit.
(b) The commissioner shall not approve a subscription certificate unless it provides, at a minimum, coverage for:
(1) pregnant women, infants and children as set forth in section 4C;
(2) prenatal care, childbirth and postpartum care as set forth in section 4H;
(3) cytologic screening and mammographic examination;
(3A) diabetes-related services, medications and supplies as defined in section 4S;
(4) early intervention services as set forth in said section 4C; and
(5) mental health services as set forth in section 4A; provided however, that if the subscription certificate limits coverage for outpatient physician office visits, the commissioner shall not disapprove the subscription certificate on the basis that coverage for outpatient mental health services is not as extensive as required by said section 4A, as long as such coverage is at least as extensive as coverage under the subscription certificate for outpatient physician services.
(c) The commissioner shall not approve a subscription certificate that does not include coverage for at least 1 mandated benefit unless the corporation continues to offer at least one subscription certificate that provides coverage that includes all mandated benefits.

(d) For purposes of this section, “mandated benefit” shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.
(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.
(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a subscription certificate, to any employee within 12 months.
SECTION 3. Chapter 176G of the General Laws is hereby amended by inserting after Section 16 the following new section:
Section 16A. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a health maintenance contract solely on the basis that it does not include coverage for at least 1 mandated benefit.
(b) The commissioner shall not approve a health maintenance contract unless it provides coverage for:
(1) pregnant women, infants and children as set forth in section 4;
(2) prenatal care, childbirth and postpartum care as set forth in said section 4 and section 4I;
(3) cytologic screening and mammographic examination as set forth in said section 4;
(3A) diabetes-related services, medications and supplies as defined in section 4H;
(4) early intervention services as set forth in said section 4; and
(5) mental health services as set forth in section 4M; provided however, that if the health maintenance contract limits coverage for outpatient physician office visits pursuant to section 16, the commissioner shall not disapprove the health maintenance contract on the basis that coverage for outpatient mental health services is not as extensive as required by said section 4M as long as such coverage is at least as extensive as coverage under the health maintenance contract for outpatient physician services.
(c) The commissioner shall not approve a health maintenance contract that does not include coverage for at least one mandated benefit unless the health maintenance organization continues to offer at least one health maintenance contract that provides coverage that includes all mandated benefits.
(d) For purposes of this section, “mandated benefit” shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.
(e) The commissioner may promulgate rules and regulations as are necessary to carry out the provisions of this section.
(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a health maintenance contract, to any employee within 12 months.”

Amendment #93

Mr. Finn of West Springfield moves to amend House No.4127 by inserting after section 144 the following 2 sections:-

"SECTION 144A. The last paragraph of subsection (a) of said section 11 of said chapter 176J, as so appearing, is hereby amended by adding the following sentence:- The commissioner may apply waivers to the 12 per cent requirement under this section to carriers who receive 80 per cent or more of their incomes from government programs or which have service areas which do not include either Suffolk or Middlesex Counties and who were first admitted to do business by the division of insurance on or before January 1, 1988, as health maintenance organizations under chapter 176G.

SECTION 144B. Said last paragraph of said subsection (a) of said section 11 of said chapter 176J, as appearing in section 103 of chapter 359 of the acts of 2010, is hereby amended by adding the following sentence:- The commissioner may apply waivers to the 12 per cent requirement under this section to carriers who receive 80 per cent or more of their incomes from government programs or which have service areas which do not include either Suffolk or Middlesex Counties and who were first admitted to do business by the division of insurance on or before January 1, 1988, as health maintenance organizations under chapter 176G."

Amendment #93, changed

Mr. Finn of West Springfield moves to amend the bill, H. 4127 by striking out Section 148 in its entirety and inserting in place thereof the following section:-

Section 148. Said section 11 of chapter 176J of the General Laws, as so appearing, is hereby further amended by inserting the following 2 sentences at the end of subsection (a):- “The division of insurance shall determine the base rate discount on an annual basis. The division of insurance may apply a waiver process from the rate discount under this section to carriers who receive 80 per cent or more of their incomes from government programs or which have service areas which do not include either Suffolk or Middlesex Counties and who were first admitted to do business by the division of insurance on or before January 1, 1988, as health maintenance organizations under chapter 176G.

And further moves to amend by inserting the following section at the end:-

Section XX. Notwithstanding any law or regulation to the contrary, the division of insurance may report specific findings and legislative recommendations including the following: (1) the extent to which tiered products offerings have been adopted and utilized in the marketplace; (2) the extent to which tiered product offerings have reduced health care costs for both patients and employers; (3) the effects that tiered product offerings have on patient education relating to health care costs and quality; (4) the effects that tiered product offerings have on patient utilization of local hospitals and the resulting impact on overall state health care costs; (5) opportunities to incentivize tiered product offerings for both health systems and employers. The report shall be submitted to the Senate and House Committees on Ways and Means and the Joint Committee on Health Care Financing.

Amendment #94

Representatives Brady of Brockton, Creedon of Brockton, Canavan of Brockton and Diehl of Whitman move to amend House 4127 by inserting in Section 124, Chapter 118J subsection (j) after the words “receive these services outside of the ACO,” the following – “including, but not limited to, home health services provided by a certified home health agency or visiting nurse association.”

Amendment #95

Mr. Lyons of Andover moves to amend House Bill 4127 by inserting at the end thereof the following section: -

"SECTION XXXX. (a) Notwithstanding any general or special law to the contrary, the executive office of administration and finance shall prepare a report on detailing the total amount of the Health Safety Net program that is being used to fund benefits on behalf of each of the following categories: 1) Citizens of the Unites States; 2) Qualified Immigrants; 3) Aliens with Special Status; and 4) Persons who have provided no documentation to fit in the other categories.

(b) Said report shall also separately identify all other costs with respect to the Health Safety Net program, including but not limited to: cost to taxpayers; cost shifting to other payers, agencies or insurers; and cost to hospitals, clinics, and other health-care providers.

(c) In calculating the amounts described in subsections (a) and (b), the executive office of administration and finance shall utilize generally accepted accounting principles encompassing all state spending.

(d) Said report shall be filed with to the chair and ranking minority member of the house committee on ways and means, the chair and ranking minority member of the senate committee on ways and means, and the clerks of the House of Representatives and senate no later than October 15, 2012.”.

Amendment #96

Representatives Brady of Brockton, Creedon of Brockton, Canavan of Brockton and Diehl of Whitman move to amend House 4127 by adding at the end thereof the following section:

SECTION XX. Chapter 149 of the General Laws is hereby amended by inserting after section 129D, the following new section:-

Section 129E.

(a) As used in this section, the following words shall have the following meanings:-

“Health care employer”, any individual, partnership, association, corporation or, trust or any person or group of persons employing five or more employees.

“Employee”, an individual employed by a health care facility; including any hospital, clinic, convalescent or nursing home, charitable home for the aged, community health agency, or other provider of health care services licensed, or subject to licensing by, or operated by the department of public health; any state hospital operated by the department; any facility as defined in section three of chapter one hundred and eleven B; any private, county or municipal facility, department or unit which is licensed or subject to licensing by the department of mental health pursuant to section nineteen of chapter nineteen, or by the department of mental retardation pursuant to section fifteen of chapter nineteen B; any facility as defined in section one of chapter one hundred and twenty-three; the Soldiers' Home in Holyoke, the Soldiers' Home in Chelsea; or any facility as set forth in section one of chapter nineteen or section one of chapter nineteen B.

(b) Each health care employer shall annually perform a risk assessment, in cooperation with the employees of the health care employer and any labor organization or organizations representing the employees, all factors, which may put any of the employees at risk of workplace assaults and homicide. The factors shall include, but not be limited to: working in public settings; guarding or maintaining property or possessions; working in high-crime areas; working late night or early morning hours; working alone or in small numbers; uncontrolled public access to the workplace; working in public areas where people are in crisis; working in areas where a patient or resident may exhibit violent behavior; working in areas with known security problems and working with a staffing pattern insufficient to address foreseeable risk factors.

(c) Based on the findings of the risk assessment, the health care employer shall develop and implement a program to minimize the danger of workplace violence to employees, which shall include appropriate employee training and a system for the ongoing reporting and monitoring of incidents and situations involving violence or the risk of violence. Employee training shall include education regarding reports to the appropriate public safety official(s), body(s) or agency(s) and process necessary for the filing of criminal charges, in addition to all employer program policies. The employer program shall be described in a written violence prevention plan. The plan shall be made available to each employee and provided to an employee upon request and shall be provided to any labor organization or organizations representing any of the employees. The plan shall include: a list of the factors, which may endanger and are present with respect to each employee; a description of the methods that the health care employer will use to alleviate hazards associated with each factor, including, but not limited to, employee training and any appropriate changes in job design, staffing, security, equipment or facilities; and a description of the reporting and monitoring system.

(d) Each health care employer shall designate a senior manager responsible for the development and support of an in-house crisis response team for employee-victim(s) of workplace violence. Said team shall implement an assaulted staff action program that includes, but is not limited to, group crisis interventions, individual crisis counseling, staff victims support groups, employee victims family crisis intervention, peer-help and professional referrals.

(e) The Commissioner of Labor shall adopt rules and regulations necessary to implement the purposes of this act. The rules and regulations shall include such guidelines as the commissioner deems appropriate regarding workplace violence prevention programs required pursuant to this act, and related reporting and monitoring systems and employee training.

(f) Any health care employer who violates any rule, regulation or requirement made by the department under authority hereof shall be punished by a fine of not more than two thousand dollars for each offense. The department or its representative or any person aggrieved, any interested party or any officer of any labor union or association, whether incorporated or otherwise, may file a written complaint with the district court in the jurisdiction of which the violation occurs and shall promptly notify the attorney general in writing of such complaint. The attorney general, upon determination that there is a violation of any workplace standard relative to the protection of the occupational health and safety of employees or of any standard of requirement of licensure, may order any work site to be closed by way of the issuance of a cease and desist order enforceable in the appropriate courts of the commonwealth.

(g) No employee shall be penalized by a health care employer in any way as a result of such employees filing of a complaint or otherwise providing notice to the department in regard to the occupational health and safety of such employee or their fellow employees exposed to workplace violence risk factors.

Amendment #97

Mr. Lyons of Andover moves to amend House Bill 4127 by inserting at the end thereof the following section: -
"SECTION XXXX. The General Laws are hereby amended by inserting after chapter 117A the following new chapter:--
Chapter 117B
Residency Requirements for Public Benefits
Section 1. Self declaration of residency shall not be accepted as a valid form of residency verification for people seeking taxpayer-funded individual benefits from the Commonwealth of Massachusetts."

Amendment #98

Representative Sannicandro of Ashland moves to amend H. 4127, in section 121, in line 1592, by adding the following two sentences:- The division shall contract with a private entity to perform an evaluation of the effectiveness of patient-centered medical homes. A report of such evaluation shall be submitted to the chairs of the house and senate committees on ways and means and joint committee on health care financing not later than December 31, 2015.

Amendment #99

Representatives Rushing of Boston and Sciortino of Medford move to amend the bill, H4127, in SECTION 123, in lines 2581 - 2583, by striking in its entirety paragraph (1) and inserting in place thereof the following

"(1) establish a mechanism to allow patients to opt in to the health information exchange and to opt out at any time, including a separate written consent, which may be electronic, permitting the disclosure of information pertaining to health conditions associated with the human immunodeficiency virus. Such written consent shall inform patients of their rights under this section and contain a statement in bold notifying patients of their right to revoke such consent at any time. The Department of Public Health shall establish the form and content of such consent, the use of which shall be deemed to comply with Chapter 111 of the General Laws, Section 70F."

and in lines 2589 - 2590, by striking in its entirety paragraph (3) and inserting in place thereof the following

“(3) provide notice to patients that they may, upon request to a provider, obtain a list of individuals and entities that have accessed their identifiable health information.”

Amendment #100

Mr. Toomey of Cambridge moves to amend the bill in Section 124 in line 2819 by striking the words “and (j) Contract with providers for any other medically necessary, but unavailable within the ACO, services or provide the patient with the ability to receive such services outside of the ACO.” and inserting in place thereof the words
“(j) Contract with providers for any other medically necessary, but unavailable within the ACO, services or provide the patient with the ability to receive such services outside of the ACO; and
(k) Ensure patient access to health care services, including breakthrough technologies and human therapeutic treatments.”

Amendment #101

Mr. Nangle of Lowell moves that the bill be amended in Section 124 in lines 2891 through 2895 by striking Section 12 and inserting the following new section:-

“Section 12. The commissioner shall monitor the functions of licensed ACOs and shall require licensure under M.G.L. Chapter 176G of any ACO or other health care provider that enters into direct-contracting arrangements with individuals, employers or other groups that result in the assumption of all or part of the risk for health care expenses.”

Amendment #102

Mr. Walsh of Lynn moves to amend the bill, H4127, in section 4, line 14 by striking out the figure “65” and inserting in place thereof the following figure:- “63”;

Further moves to amend in section 11, line 52 by striking out the words “health care cost growth” and inserting in place thereof the following words:- “medical spend”;

Further moves to amend in section 12, line 133 by striking out the word “car” and inserting in place thereof the following word:- “care”;

Further moves to amend in section 17, line 178 by striking out the figure “62” and inserting in place thereof the following figure:- “60”;

Further moves to amend in section 17, line 189 by striking out the figure “64” and inserting in place thereof the following figure:- “61”;

Further moves to amend in section 17, line 195 by striking out the figure “62” and inserting in place thereof the following figure:- “60”;

Further moves to amend in section 20, line 233 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 20, line 243 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 21, line 250 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 21, line 262 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 97, line 902 by striking out the word “phyisician” and inserting in place thereof the following word:- “physician”;

Further moves to amend in section 97, line 1096 by inserting before the word “supervises” the following word:- “who”;

Further moves to amend in section 98, line 1201 by striking out the word “provider” and inserting in place thereof the following word:- “physician”;

Further moves to amend in section 101, line 1297 by striking out the figure “59” and inserting in place thereof the following figure:- “57”;

Further moves to amend in section 120, line 1430 by striking out the words “acute hospital’s” and inserting in place thereof the following words:- “acute hospital or ambulatory surgical center’s”;

Further moves to amend in section 120, in line 1431 by inserting after the words “acute hospitals” the following words:- “and ambulatory surgical centers”;

Further moves to amend in section 120, line 1477 by inserting in each instance after the word “hospital” the following words:- “, ambulatory surgical center”;

Further moves to amend in section 120, line 1489 by inserting after the word “hospital” the following word:- “, ambulatory surgical center”;

Further moves to amend in section 120, line 1498 by inserting in each instance after the word “hospital” the following words:- “, ambulatory surgical center”;

Further moves to amend in section 121, line 1541 by striking out the word “shall” and inserting in place thereof the following word:- “may”;

Further moves to amend in section 121, line 1545 by striking out the words “Providers and payers” and inserting in place thereof the following:- “Payers”;

Further moves to amend in section 121, line 1548 by striking out the words “providers or”;

Further moves to amend in section 121, line 1592 by striking out the figure “68” and inserting in place thereof the following figure:- “65”;

Further moves to amend in section 121, line 1624 by inserting after the word “potential” the following word:- “gross”;

Further moves to amend in section 121, line 1636 by inserting after the words “subsection (a)” the following words:- “for each region”;

Further moves to amend in section 121, line 1646 by striking out in the 2nd instance the word “the” and inserting in place thereof the following word:- “a”;

Further moves to amend in section 121, line 1675 by striking out the word “provider” and inserting in place thereof the following words:- “clinic, hospital, ambulatory surgical center”;

Further moves to amend in section 121, line 1790 by inserting after the word “care” the following word:- “services”;

Further moves to amend in section 121, line 1792 by deleting the word “heatlh” and inserting in place thereof the following word:- “health”;

Further moves to amend in section 121, line 1981 by striking out the word “showing” and inserting in place thereof the following word:- “show”;

Further moves to amend in section 121, line 2046 by striking out the word “report”;

Further moves to amend in section 121, line 2054 by inserting before the word “nurse” the following word:- “and”;

Further moves to amend in section 121, line 2068 by striking out the figure “59” and inserting in place thereof the following figure:- “60”;

Further moves to amend in section 121, line 2096 by striking out the figure “58” and inserting in place thereof the following figure:- “59”;

Further moves to amend in section 121, line 2183 by striking out the word “ACOs” and inserting in place thereof the following word:- “ACO”;

Further moves to amend in section 121, line 2211 by striking out the figure “6” and inserting in place thereof the following figure:- “7”;

Further moves to amend in section 124, line 2738 by striking out the figure “65” and inserting in place thereof the following figure:- “63”;

Further moves to amend in section 124, line 2892 by striking out the word “their” and inserting in place thereof the following word:- “its”;

Further moves to amend in section 124, line 2908 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 135, line 3040 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 135, line 3046 by striking out the word “alertinglalerting” and inserting in place thereof the following word:- “alerting”;

Further moves to amend in section 135, line 3051 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 136, line 3062 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 139, line 3119 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 139, line 3126 by striking out the word “alertingalerting” and inserting in place thereof the following word:- “alerting”;

Further moves to amend in section 139, line 3130 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 140, line 3137 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 140, line 3143 by striking out the word “alertingalerting” and inserting in place thereof the following word:- “alerting”;

Further moves to amend in section 140, line 3148 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 141, line 3155 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 141, line 3162 by striking out the word “alertingalerting” and inserting in place thereof the following word:- “alerting”;

Further moves to amend in section 141, line 3166 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 150, line 3214 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 150, line 3220 by striking out the word “alertingalerting” and inserting in place thereof the following word:- “alerting”;

Further moves to amend in section 150, line 3224 by striking out the figure “50” and inserting in place thereof the following figure:- “51”;

Further moves to amend in section 157, line 3268 by striking out the figure “65” and inserting in place thereof the following figure:- “63”;

Further moves to amend in section 161, line 3287 by striking out the figure “65” and inserting in place thereof the following figure:- “63”;

Further moves to amend in section 165, line 3395 by striking out the figure “65” and inserting in place thereof the following figure:- “63”;

And further moves to amend in section 168, line 3407 by striking out the figure “65” and inserting in place thereof the following figure:- “63”.

Amendment #103

Representative Hunt of Sandwich moves to amend House 4127 by adding at the end of SECTION 121, Section 43 (b) the following:

And provided further that 60 days before the Executive Office of Health and Human Services shall seek said federal waiver, the Joint Committees on Health Care Finance, Elder Affairs, Public Health and the House and Senate Committees on Ways and Means shall have a hearing on the potential impacts on the elderly citizens of the Commonwealth from participating in these alternative payment methodologies, integrated care organizations, alternative care organizations, patient centered medical homes, being attributed to primary care physicians and any other facets of the newly designed health care system.

Amendment #104

Representatives Golden of Lowell and Walsh of Boston move to amend the bill in SECTION 98 Section 2(e) by removing the words “or any other employees” in line 1230.

Amendment #104, changed

Mr.Golden of Lowell moves to amend House, No. 4127 in section 98, in lines 1229 through 1231,by striking out the fifth sentence of subsection (e) of section 2, and inserting in place thereof the following 2 sentences:—
Sections 9A, 45, 46, and 46C of chapter 30, chapter 31 and chapter 150E shall not apply to the executive director of the division. Sections 45, 46 and 46C of chapter 30 shall not apply to any employee of the division.

Amendment #105

Mr. Golden of Lowell moves to amend the bill by striking out section 66 in its entirety.

Amendment #106

Representative Hunt of Sandwich moves to amend H 4127 by adding after the word year in line 1660 the following: And provided further that for the purpose of analyzing the cost growth of individual health care entities within the regions, the costs associated with implementing the health information technology and e-health medical records provisions of this act shall not be considered and provided further that the costs associated with capital investments greater than $1,000,000 that are deemed necessary by the provider to enhance the quality of health care in the region shall not be considered and provided further that any assessments required to pay for the provisions of this act shall not be considered.

Amendment #107

Representatives Diehl of Whitman and Webster of Pembroke moves to amend House Bill 4127 by inserting, in line 2433, after the words “and manage the affairs of the institute.”, the following: “The director of the institute shall not have been employed previously by any medical device manufacturer.”.

Amendment #108

Representatives Diehl of Whitman and Webster of Pembroke moves to amend House Bill 4127 by striking section 54.

Amendment #109

Mr. Honan of Boston moves that the bill be amended in Section in SECTION 121, by striking lines 1630-1634 and inserting in place thereof the following: (2) The division shall calculate the modified potential gross state product growth rate by taking the rate as defined by the secretary under paragraph (1) and making the following adjustments: (A) Calendar Year 2012-2016: plus 1% (B) Calendar Years 2017-2027: No modification “(C) Calendar Years 2028 and beyond plus 1%; and in line 1661, by striking the number “2016” and inserting in place thereof the number “2017”; and in line 1666, by striking the number “2016” and inserting in place thereof the number “2017”; and in line 1680, by inserting after the word “division.” the following: “For those health care entities that are payers, the division shall also determine if the payer’s net cost of private health insurance is materially in excess of the modified potential gross state product growth rate.”

Amendment #110

Mr. Honan of Boston moves that the bill be amended in SECTION 97,by striking the definition of “Medical spend”, in lines 1049-1051 and inserting place thereof the following new definition: “Medical spend,” the annual per capita sum of all health care expenditures in the commonwealth from public and private sources, and shall include : (i) allowed claims for all categories of medical spending including but not limited to pharmaceuticals, long term care costs and medical devices, (ii) all patient cost-sharing amounts such as deductibles and copayments (iii) all non-claims related payments to health care providers, adjusted by health status, and (iv) the net cost of private health insurance.

Amendment #111

Rep. Dwyer of Woburn moves to amend the bill in section 123, in line 2713, by inserting after the word “angiography” the following:- “and nuclear medicine, including”; and by striking in line 2714 the words:- “cardiac imaging, ultrasound diagnostic imaging,”.

Amendment #112

Mr. Kane of Holyoke moves to amend the bill (H.4127) by striking lines 1426-1448 in their entirety; and in line 1467, by striking the words “an acute hospital, an ambulatory surgical center, or”; and by striking lines 1470-1473 in their entirety; and in lines 1476-1477 by striking the words “an acute hospital or” and inserting in place thereof the word “a”; and in line 1477, by striking the words “if an acute hospital or” and inserting in place thereof the word “a”; and in line 1484, by striking the words “acute hospital or”; and in line 1485, by striking the words “acute hospital or”; and in line 1489, by striking the words “an acute hospital or” and inserting in place thereof the word “a”; and in line 1492, by striking the words “acute hospital or”; and in line 1496, by striking the words “an acute hospital or” and inserting in place thereof the word “a”; and in line 1498, by striking the words “acute hospital or”; and in lines 1498-1499, by striking the words “an acute hospital or” and inserting in place thereof the word “a”; and by striking lines 1505-1506 in their entirety; and by striking lines 1881-1909 in their entirety.

Amendment #113

Representative Mark of Peru moves to amend House bill 4127 in Section 56, in line 1944, by striking out the words, “2 weeks” and inserting in place thereof “4 weeks”; and in line 1945, by inserting after the figure “$1,000” the words, “for payers and $200 for providers”.

Amendment #114

Representatives Mark of Peru and Brodeur of Melrose move to amend House bill 4127 in Section 45, in subsection (3), in line 1562, by striking out the words, “scientifically based health care”, and inserting in place thereof the words,

“evidence based healthcare based on the most recently published peer reviewed literature, professional consensus, or best practices,”.

Amendment #115

Representatives Mark of Peru and Brodeur of Melrose move to amend House bill 4127 in Section 45, in subsection (2), in line 1559, by inserting after the words, “not limited to,” the words, “Chiropractic Physician,”.

Amendment #116

Ms. Spiliotis of Peabody moves to amend H.4127 in SECTION 121, in line 2248, by inserting after the words “This amount shall be equal to” the following: “50 per cent of”; and in line 2255, by inserting after the number “29” the following: “. Estimated and actual expenses of the Massachusetts E-Health Institute and the health information technology council, as defined in chapter 118I, shall not be included in the net amount.”

Amendment #117

Representatives Galvin of Canton and Kafka of Stoughton move to amend H.4127 in SECTION 120, section 40(a) in line 1148, by adding at the end thereof the following: “Provided further that an ambulatory surgery center with less than $50,000,000 in total net assets or more than the average state wide percentage of Distressed Hospital Funds revenue that are used for ambulatory surgery centers reimbursement shall be exempt from this section.”

Amendment #118

Mr. Linsky of Natick moves to amend House Bill 4127 in Section 98, in lines 1195-1209 by striking out the figure “9” and inserting in place thereof the figure “10”, and striking out the words “2 members appointed by the governor” and inserting in place thereof “3 members appointed by the governor” and inserting after the words “primary care provider licensed to practice in the commonwealth” the words “ 1 of whom shall be an expert in women’s health”. And be further amended in Section 121 in, lines 2205-2217, by striking out the figure “6” and inserting in place thereof the figure “7”, and inserting after the words “1 representative from a health care consumer group” the words “ 1 representative who is an expert in women’s health”.

Amendment #119

Representatives Nangle of Lowell, DiNatale of Fitchburg, Fennell of Lynn, Golden of Lowell, Murphy of Lowell, and Reinstein of Revere move to amend the bill in section 97 by inserting after the word, “surgical’, in line 967, the word, “chiropractic care”.

Amendment #120

Mr. Finn of West Springfield and Mr. Kane of Holyoke moves to amend the bill (H.4127) in Section 121, in line 2248, by inserting after the words “This amount shall be equal to” the following: “50 per cent of”; and in line 2255, by inserting after the number “29” the following: “. Estimated and actual expenses of the Massachusetts E-Health Institute and the health information technology council, as defined in chapter 118I, shall not be included in the net amount.”

Amendment #121

Mr. Finn of West Springfield and Mr. Kane of Holyoke moves that the bill be amended in Section in SECTION 121, by striking lines 1630-1634 and inserting in place thereof the following: (2) The division shall calculate the modified

potential gross state product growth rate by taking the rate as defined by the secretary under paragraph (1) and making the following adjustments: (A) Calendar Year 2012-2016: plus 1% (B) Calendar Years 2017-2027: No modification “(C) Calendar Years 2028 and beyond plus 1%; and in line 1661, by striking the number “2016” and inserting in place thereof the number “2017”; and in line 1666, by striking the number “2016” and inserting in place thereof the number “2017”; and in line 1680, by inserting after the word “division.” the following: “For those health care entities that are payers, the division shall also determine if the payer’s net cost of private health insurance is materially in excess of the modified potential gross state product growth rate.”

Amendment #122

Mr. Finn of West Springfield and Mr. Kane of Holyoke moves to amend the bill (H.4127) in section 98, by striking subsection (b) in lines 1195-1209 and inserting in place thereof the following new subsection:
(b) There shall be a board, with duties and powers established by this chapter, which shall govern the division. The board shall consist of 12 members: the secretary of administration and finance, ex officio; the secretary of health and human services, ex officio; the commissioner of the division of insurance, ex officio; 9 members appointed by the governor, provided that each organization named herein shall provide the governor with three names from which to select an appointee, and the governor shall select a nominee from the list of names provided; including 1 independent expert in payment methodologies, 1 representative of the Massachusetts Association of Health Plans, 1 representative of the Blue Cross Blue Shield of Massachusetts,1 representative of the Massachusetts Hospital Association, 1 representative of the Massachusetts Medical Society, 1 representative of a fully insured employer, 1 representative of a self insured employer, 1 consumer representative, and 1 labor union representative. The chairperson shall be selected by majority vote, provided however, for the first 30 days the governor shall designate an interim chairperson. The chairperson shall serve for a term of one year and is not permitted to serve consecutive terms. The board shall annually elect 1 of its members to serve as vice-chairperson. All board appointments shall serve a term of 3 years, but a person appointed to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall be eligible for reappointment. Each member of the board serving ex officio may appoint a designee under section 6A of chapter 30.
and in lines 1255 by striking the following “(e) The chairperson shall appoint an executive director.” and inserting in place thereof the following:”(e) The chairperson shall nominate an executive director. Such nomination shall be subject to confirmation by the board.”

Amendment #123

Mr. Finn of West Springfield and Mr. Kane of Holyoke moves to amend the bill (H.4127) by inserting the following new section:- Section XX. Notwithstanding any general or special law to the contrary, there shall be established and set up on the books of the commonwealth as a separate fund to be known as the Medicaid and Health Care Reform FMAP Trust Fund. The fund shall consist of any funds that may be appropriated or transferred for deposit into the trust fund, interest earned on such revenues, and other sources. The comptroller shall deposit an amount to the fund determined by secretary of administration and finance that is equivalent to the additional funding provided by the federal government pursuant to the increased federal Medicaid assistance percentage pursuant to the Patient Protection and Affordable Care Act of 2010 and Section 1201 of the Health Care and Education Reconciliation Act of 2010. The fund shall be used for the following purposes: (1) to support the financing of health insurance coverage for low-income Massachusetts residents, including state health insurance programs and insurance offered through the commonwealth’s health insurance exchange and (2) to improve Medicaid reimbursement to health care providers. The secretary of administration and finance shall administer the fund. No later than January 31 of each year, the secretary, in consultation with the executive office of health and human services, the commonwealth health insurance connector authority, healthcare providers participating in the Medicaid program, and consumer representatives, shall submit a report to the house and senate ways and means committees and the joint committee on health care financing that includes the current funding available in the fund, the funding estimated to be deposited through the end of the current and subsequent fiscal year, estimated expenditures from the fund, and recommendations for transferring such funds to other state accounts and funds in a manner consistent with the purpose of the fund.

Amendment #124

Mr. Finn of West Springfield and Mr. Kane of Holyoke moves that the bill be amended in SECTION 97,by striking the definition of “Medical spend”, in lines 1049-1051 and inserting place thereof the following new definition: “Medical spend,” the annual per capita sum of all health care expenditures in the commonwealth from public and private sources, and shall include : (i) allowed claims for all categories of medical spending including but not limited to pharmaceuticals, long term care costs and medical devices, (ii) all patient cost-sharing amounts such as deductibles and copayments (iii) all non-claims related payments to health care providers, adjusted by health status, and (iv) the net cost of private health insurance.

Amendment #125

Representative Fox of Boston moves to amend the bill, in section 121, by striking out in line 1561 the word “; and” and inserting in place thereof the following: “.”; and by inserting, in line 1565, the following paragraphs: “(4) Emphasize, enhance, and encourage the use of primary care, including prevention, wellness and care coordination. “(5) Encourage patient-centered care, including active participation by the patient and family or legal guardian in decision making and care plan development. “(6) Provide patients with a consistent, ongoing contact with a provider or team of providers to ensure continuous and appropriate care for the patient’s condition. “(7) Emphasize a multi-disciplinary team-based approach to care. “(8) Ensure care coordination across settings, including referral and transition management, with case manager follow up. “(9) Ensure that patient-centered medical homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including group visits, chronic disease self-management programs and an assessment of health risks and chronic conditions. “(10) Promote the integration of mental health and behavioral health services with primary care services including, but not limited to, the establishment of a behavioral health medical home; recovery coaching and peer support, and services provided by peer support workers, certified peer specialists and licensed alcohol and drug counselors. “(11) Improve access to health care services and quality of care for vulnerable populations including, but not limited to, children, the elderly, low-income individuals, individuals with disabilities, individuals with chronic illnesses and racial and ethnic minorities, including demonstrating an ability to provide culturally and linguistically appropriate care, patient education and outreach provided by community health workers.”; and by inserting in Section 124, in line 2814, after the word “management” the following words: “, including group visits and chronic disease self-management programs,”; and by inserting in line 2817, after the word “agreement” the following: “, including but not limited to, recovery coaching and peer support, and services provided by peer support workers, certified peer specialists and licensed alcohol and drug counselors”; and by striking out, in lines 2818 to 2819, subparagraph (i), in inserting in place thereof the following subparagraph:- (i) promote patient-centeredness by, including, but not limited to, establishing mechanisms to conduct patient outreach and education on the necessity and benefits of care coordination, including group visits and chronic disease self-management programs; demonstrating an ability to engage patients in shared decision making taking into account patient preferences; demonstrating an ability to effectively involve patients in care transitions to improve the continuity and quality of care across settings, with case manager follow up; demonstrating an ability to engage and activate patients at home, through methods such as home visits or telemedicine, to improve self-management; and establishing mechanisms to evaluate patient satisfaction with the access and quality of their care; and by adding in line 2820 after the letter “(j)” the following words: “the ability to improve access to health care services and quality of care for vulnerable populations including, but not limited to, children, the elderly, low-income individuals, individuals with disabilities, individuals with chronic illnesses and racial and ethnic minorities, including demonstrating an ability to provide culturally and linguistically appropriate care, patient education and outreach provided by community health workers.

Amendment #125, changed

Representative Fox of Boston moves to amend the bill, in section 121, by striking out in line 1557 by striking out the punctuation mark “.” and inserting place thereof the following punctuation mark:- “;”;

Further moves to amend in section 121, line 1561 by striking out the following word:- “and”

And further moves to amend in section 121, line 1565, by striking out the punctuation mark “.” and insert following words:-

“;

(4) Ensure that patient-centered medical homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including group visits, chronic disease self-management programs and an assessment of health risks and chronic conditions.;

(5) Promote the integration of mental health and behavioral health services with primary care services including, but not limited to, the establishment of a behavioral health medical home; recovery coaching and peer support, and services provided by peer support workers, certified peer specialists and licensed alcohol and drug counselors; and

(6) Improve access to health care services and quality of care for vulnerable populations including, but not limited to, children, the elderly, low-income individuals, individuals with disabilities, individuals with chronic illnesses and racial and ethnic minorities, including demonstrating an ability to provide culturally and linguistically appropriate care, patient education and outreach provided by community health workers.”.

Amendment #126

Mr. Pignatelli of Lenox moves to amend the bill in section 98, by striking subsection (b) in lines 1195-1209 and inserting in place thereof the following new subsection: (b) There shall be a board, with duties and powers established by this chapter, which shall govern the division. The board shall consist of 12 members: the secretary of administration and finance, ex officio; the secretary of health and human services, ex officio; the commissioner of the division of insurance, ex officio; 9 members appointed by the governor, provided that each organization named herein shall provide the governor with three names from which to select an appointee, and the governor shall select a nominee from the list of names provided; including 1 independent expert in payment methodologies, 1 representative of the Massachusetts Association of Health Plans, 1 representative of the Blue Cross Blue Shield of Massachusetts,1 representative of the Massachusetts Hospital Association, 1 representative of the Massachusetts Medical Society, 1 representative of a fully insured employer, 1 representative of a self insured employer, 1 consumer representative, and 1 labor union representative. The chairperson shall be selected by majority vote, provided however, for the first 30 days the governor shall designate an interim chairperson. The chairperson shall serve for a term of one year and is not permitted to serve consecutive terms. The board shall annually elect 1 of its members to serve as vice-chairperson. All board appointments shall serve a term of 3 years, but a person appointed to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall be eligible for reappointment. Each member of the board serving ex officio may appoint a designee under section 6A of chapter 30. and in lines 1255 by striking the following “(e) The chairperson shall appoint an executive director.” and inserting in place thereof the following:”(e) The chairperson shall nominate an executive director. Such nomination shall be subject to confirmation by the board.”

Amendment #127

Representative Walsh of Boston moves to amend the bill in subsection 6 of Section 124 by adding at the end thereof a new item “k”: K. In communities within the service area of the ACO that have more than 150,000 residents, the ability to contract with municipal public health departments for the provision of preventive, population, or wellness services to enrolled individuals in a manner that will improve the delivery of preventive health services at reduced costs.

Amendment #128

Representative Walsh of Boston moves to amend the bill in section xx by inserting the following at the end thereof:- SECTION 1. Section 22 of Chapter 32A of the General Laws is hereby amended by striking out the last paragraph,

inserted by section 1 of chapter 80 of the acts of 2000, and inserting in place thereof the following paragraph:— For the purposes of this section, “licensed mental health professional” shall mean a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, or a licensed alcohol and drug counselor I. SECTION 2. Section 47B of Chapter 175 of the General Laws is hereby amended by striking out the next to last paragraph, inserted by section 2 of chapter 80 of the acts of 2000, and inserting in place thereof the following paragraph:— For the purposes of this section, “licensed mental health professional” shall mean a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, or a licensed alcohol and drug counselor I. SECTION 3. Section 8A of Chapter 176A of the General Laws is hereby amended by striking out the next to last paragraph, inserted by section 4 of chapter 80 of the acts of 2000, and inserting in place thereof the following paragraph:— For the purposes of this section, “licensed mental health professional” shall mean a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, or a licensed alcohol and drug counselor I. SECTION 4. Section 4A of Chapter 176B of the General Laws is hereby amended by striking out the next to the last paragraph, inserted by section 6 of chapter 80 of the acts of 2000, and inserting in place thereof the following paragraph:— For the purposes of this section, “licensed mental health professional” shall mean a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, or a licensed alcohol and drug counselor I. SECTION 5. Section 4M of Chapter 176G of the General Laws is hereby amended by striking out the next to last paragraph, inserted by section 10 of chapter 80 to the acts of 2000, and inserting in place thereof the following paragraph:— For the purposes of this section, “licensed mental health professional” shall mean a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, or a licensed alcohol and drug counselor I.

Amendment #129

Representative Walsh of Boston moves to amend the bill in section XX by inserting the following section: “SECTION___ There is hereby established and set up on the books of the commonwealth a separate fund to be known as the Community Health Center Infrastructure Capacity Building Trust Fund, which shall be administered by the division of health care cost and quality. Expenditures from the Community Health Center Infrastructure Capacity Building Trust Fund shall be dedicated to efforts to improve and enhance the ability of community health centers to serve populations in need more efficiently and effectively, including, but not limited to, the ability to provide community-based care, clinical support and care coordination services, improve health information technology, or other efforts to create effective coordination of care. The division, in consultation with the Massachusetts League of Community Health Centers, shall develop a competitive grant process for awards to be distributed to distressed community health centers out of said fund. The grant process shall consider the following factors, including but not be limited to (1) payer mix, (2) financial health, (3) geographic need, and (4) population need.” “Section___The Secretary of the Executive Office of Health and Human Services shall transfer $30,000,000 received under the current Medicaid Waiver, granted under section 1115 of Title XI of the Social Security Act, intended for innovation and infrastructure capacity building to the Community Health Center Infrastructure Capacity Building Trust Fund, established under section _____.”

Amendment #130

Representative Walsh of Boston moves to amend the bill in Section 121 by adding the following language after "pilot programs" at line 2072: ",including incentive grant programs to support cooperative efforts between representatives of employees and management that are focused on controlling costs and improving the quality of care through workforce engagement,”

Amendment #131

Representative Walsh of Boston moves to amend the bill in section xx by inserting the following at the end thereof:- “Section XX. Sections 37 and 39 shall take effect on January 1, 2013.”

Amendment #131, changed

Mr. Walsh of Boston moves to amend the bill, H. 4127, by inserting at the end of the bill the following 2 sections:-

SECTION XX. Notwithstanding any provision of any general law or special law or regulation to the contrary, health care providers that receive written notice from the department of public health, prior to December 31, 2012, that they do not need a determination of need review for a project shall be exempt from needing to file a determination of need review at a later date if there project exceeds the newly established thresholds under Sections 37, 39 or 53 of this bill.

SECTION XX. Notwithstanding the provisions of any general or special law or regulation to the contrary, the provisions of Section 25E ½ of Chapter 111 of the General Laws, as proposed to be added by Section 55, shall not apply to the review of an application for a determination of need that is filed with the department of public health under any applicable provision of Chapter 111 of the General Laws on or before December 31, 2013.

Amendment #132

Mr. Finn moves to amend the bill (H.4127) by striking lines 1426-1448 in their entirety; and in line 1467, by striking the words “an acute hospital, an ambulatory surgical center, or”; and by striking lines 1470-1473 in their entirety; and in lines 1476-1477 by striking the words “an acute hospital or” and inserting in place thereof the word “a”; and in line 1477, by striking the words “if an acute hospital or” and inserting in place thereof the word “a”; and in line 1484, by striking the words “acute hospital or”; and in line 1485, by striking the words “acute hospital or”; and in line 1489, by striking the words “an acute hospital or” and inserting in place thereof the word “a”; and in line 1492, by striking the words “acute hospital or”; and in line 1496, by striking the words “an acute hospital or” and inserting in place thereof the word “a”; and in line 1498, by striking the words “acute hospital or”; and in lines 1498-1499, by striking the words “an acute hospital or” and inserting in place thereof the word “a”; and by striking lines 1505-1506 in their entirety; and by striking lines 1881-1909 in their entirety.

Amendment #133

Mr. Walsh of Boston moves to amend the bill in line item4000-0300 by adding the following language:- “ provided further that the executive office shall pay an overall reimbursement rate for all primary and ancillary services received on the same day by a MassHealth or a Commonwealth Care patient at a federally qualified health center in the Southern Section of the City of Boston operating under the license of a disproportionate share teaching hospital in Suffolk County by having an above or add-on incentive rate that is case based and encompasses multiple encounters in a single day.”

Amendment #134

Mr. Cusack of Braintree moves that the bill be amended in Section 121, subsection 65 in line 2211 by striking the number “6” and replacing it with the number “7” and further moves that the bill be amended in the same section by striking lines 2233 through 2235 in their entirety.

Amendment #135

Mr. Walsh of Boston moves that the bill be amended in line item 4000-0300 by adding the following language:- “provided further that the executive office shall make a supplemental payment to the fiscal year 2012 PAPE rate paid to federal qualified health centers in the Southern Section of the City of Boston operating under the license of a disproportionate share teaching hospital in Suffolk County to pay an overall reimbursement rate not less than the Medicaid rate paid to independent federally qualified health centers.”

Amendment #136

Representatives Bradley of Hingham, Reinstein of Revere, and Galvin of Canton move to amend H.4127 in section 121 by inserting after the word, “physician assistants” in line 1560, the word, “, chiropractors” and further in section 121 by inserting after the word, “hospitals,” in line 1568, the word, “chiropractors,” and further in section 124 by inserting after the word, “physician assistant,” in line 2801, the word, “chiropractor,”.

Amendment #137

Representative Golden of Lowell moves to amend the bill in SECTION 55 Section 25E1/2(b) by striking "3" in line 459 and replacing with "5" and adding after the words "and at least 1 shall have experience in health care market planning and service line analysis" in line 461 the words "and 2 of whom shall be members of labor organizations selected from a list of 3 names submitted by the President of the Massachusetts AFL-CIO."

Amendment #137, changed

Representative Golden of Lowell moves to amend the bill in SECTION 55 Section 25E1/2(b) by striking "3" in line 459 and replacing with "5" and adding after the words "and at least 1 shall have experience in health care market planning and service line analysis" in line 461 the words "and one of whom shall be members of labor organizations selected from a list of 3 names submitted by the President of the Massachusetts AFL-CIO."

Amendment #138

Representative Khan of Newton moves to amend H.4127 by deleting SECTION 90 in its entirety and inserting in place thereof the following:- SECTION 90. Chapter 118E of the General Laws is hereby amended by inserting after section 9E the following section:- Section 9F. (a) As used in this section, the following words shall have the following meanings:- “Dual eligible”, or “dually eligible person”, any person age 21 or older and under age 65 who is enrolled in both Medicare and MassHealth. “Integrated care organization” or “ICO”, a comprehensive network of medical, health care and long term services and supports providers that integrates all components of care, either directly or through subcontracts and has been contracted with by the Executive Office of Health and Human Services and designated an ICO to provide services to dually eligible individuals pursuant to this section. (b) Members of the MassHealth dual eligible pilot program on ICOs or any successor program integrating care for dual eligible persons shall be provided an independent community care coordinator by the ICO or successor organization, who shall be a participant in the member’s care team. The community care coordinator shall assist in the development of a long term support and services care plan. The community care coordinator shall: (1) participate in initial and ongoing assessments of the health and functional status of the member, including determining appropriateness for long term care support and services, either in the form of institutional or community-based care plans and related service packages necessary to improve or maintain enrollee health and functional status; (2) arrange and, with the agreement of the member and the care team, coordinate the provision of appropriate institutional and community long term supports and services, including assistance with the activities of daily living and instrumental activities of daily living, housing, home-delivered meals, transportation, and under specific conditions or circumstances established by the ICO or successor organization, authorize a range and amount of community-based services; and (3) monitor the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate

by the member and the care team; and track member satisfaction and the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate by the member and the care team. (c) The ICO or successor organization shall not have a direct or indirect financial ownership interest in an entity that serves as an independent care coordinator. Providers of institutional or community based long term services and supports on a compensated basis shall not function as an independent care coordinator, provided however that the secretary may grant a waiver of this restriction upon a finding that public necessity and convenience require such a waiver. For the purposes of this section, an organization compensated to provide only evaluation, assessment, coordination, skills training, peer supports and fiscal intermediary services shall not be considered a provider of long term services and supports.

Amendment #139

Mr. Sannicandro of Ashland moves to amend the bill in SECTION 101, in line 1301, after the words “employer-sponsored health benefit plans in the commonwealth” the following words- “including, but not limited to, access to: preventive and primary care services; emergency services; hospitalization services; ambulatory patient services; mental health and behavioral health services; access to specialty care units, including, but are not limited to, burn, coronary care, cancer care, neonatal care, post-obstetric and post operative recovery care, pulmonary care, renal dialysis and surgical, including trauma and intensive care units; pediatric services; diagnostic imaging and screening services; maternity and newborn care services; radiation therapy and treatment services; skilled nursing facilities; family planning services; obstetrics and gynecology services; home health services; treatment and prevention services for alcohol and other drug abuse; breakthrough technologies and treatments; and allied health services including, but not limited to, advance practice nurses, optometric care, direct access to chiropractic services, occupational therapists, dental care, physical therapy and midwifery services;”

Amendment #140

Representatives Linsky of Natick, Puppulo of Springfield, Cariddi of North Adams, Kane of Holyoke, and Golden of Lowell move that the bill (H.4127) be amended by inserting at the end thereof the following new section: SECTION XX. Chapter 111 of the General Laws is hereby amended by adding the following section:- Section 225. (a) For purposes of this section, the following terms shall have the following meanings: “Health care practitioner”, any person licensed or registered under section 2, 16, 74 or 74A of chapter 112 , including any intern, resident, fellow or medical officer who conducts or assists with the performance of surgery. “Operating room circulator”, a licensed registered nurse who is educated, trained and experienced in perioperative nursing and who is immediately available to physically intervene in providing care to the surgical patient. “Surgical facility”, any organization, partnership, association, corporation, trust, the commonwealth, or any subdivision thereof, or any person or group of persons that provides surgical health care services, whether inpatient or outpatient and whether overnight or ambulatory including, but not limited to, any hospital, clinic or private office of a health care practitioner, whether conducted for charity or for profit and whether or not subject to section 25C. “Surgical technologist”, any person who provides surgical technology services but is not a health care practitioner. “Surgical technology”, surgical patient care including, but not limited to, 1 or more of the following: (i) collaboration with an operating room circulator prior to a surgical procedure to carry out the plan of care by preparing the operating room, gathering and preparing sterile supplies, instruments and equipment, preparing and maintaining the sterile field using sterile and aseptic technique and ensuring that surgical equipment is functioning properly and safely; (ii) intraoperative anticipation and response to the needs of a surgeon and other team members by monitoring the sterile field and providing the required instruments or supplies; (iii) performance of tasks at the sterile field, as directed in an operating room setting, including: (1) passing supplies, equipment or instruments; (2) sponging or suctioning an operative site; (3) preparing and cutting suture material; (4) transferring and irrigating with fluids; (5) transferring, but not administering, drugs within the sterile field; (6) handling specimens; (7) holding retractors; and (8) assisting in counting sponges, needles, supplies and instruments with an operating room circulator. (b) A surgical facility shall not employ or otherwise retain the services of any person to perform surgical technology tasks or functions unless such person: (1) has successfully completed an accredited educational program for surgical technologists and holds and maintains a certified surgical technologist credential administered by a nationally recognized surgical technologist certifying body accredited by the National Commission for Certifying Agencies and recognized by the American College of Surgeons and the Association of Surgical

Technologists; (2) has successfully completed an accredited school of surgical technology but has not, as of the date of hire, obtained the certified surgical technologist certification required in clause (1), provided that such certification shall be obtained within 12 months of the graduation date; (3) was employed as a surgical technologist in a surgical facility on July 1, 2012; (4) has successfully completed a training program for surgical technology in the Army, Navy, Air Force, Marine Corps or Coast Guard of the United States or in the United States Public Health Service which has been deemed appropriate by the commissioner; or (5) is performing surgical technology tasks or functions in the service of the federal government, but only to the extent the person is performing duties related to that service. (c) A person employed or otherwise retained to practice surgical technology in a healthcare facility may assist in the performance of operating room circulator duties under the direct l supervision, limited to clinical guidance of the operating room circulator if: (1) the operating room circulator is present in the operating room for the duration of the procedure; (2) any such assistance has been assigned to such person by the operating room circulator; and (3) such assistance is consistent with the education, training and experience of the person providing such assistance. (d) Nothing in this section shall prohibit a registered nurse, licensed or registered health care provider or other health care practitioner from performing surgical technology tasks or functions if such person is acting within the scope of such person's license. (e) The commissioner of the department of public health shall adopt regulations necessary to carry out the purposes of this act. Such regulations shall be adopted not later than 90 days after the effective date of this act. (f) Subsections (a), (b), (c) and (d) shall take effect 180 days after the effective date of this act.

Amendment #141

Representatives Webster of Pembroke and Diehl of Whitman move to amend House Bill 4127 by adding the following section:- "SECTION XX. Section 36 of chapter 118G of the General Laws is hereby repealed."

Amendment #142

Representatives Jones of North Reading, Peterson of Grafton, Hill of Ipswich, Poirier of North Attleboro, and deMacedo of Plymouth move to amend House Bill 4127 by adding, at the end thereof, the following sections:- "SECTION XX. Chapter 270 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after section five, the following section:— Section 5A. As used in this section and section 6 the following words shall, unless the context clearly requires otherwise, have the following meanings: "Tobacco Products", cigarettes, bidis, cigars, chewing tobacco, pipe tobacco, snuff, or tobacco in any of its forms. "Retailer", any establishment that sells tobacco products to individuals for personal consumption. "Person", individual, employer, employee, retail store manager or owner, or the owner or operator of any establishment engaged in the sale of tobacco products. "Proof of age", a motor vehicle license issued pursuant to section eight of chapter 90, a liquor purchase identification card issued pursuant to section 34B of chapter 138, a valid passport issued by the United States government, or by the government, recognized by the United States government, of a foreign country, or a valid United States issued military identification card. "Local Permit", any permit that a retailer is required to obtain by local ordinance, by-law or board of health regulation in order to sell or distribute tobacco products. "Smoking", inhaling, exhaling, burning or carrying any lighted cigar, cigarette, or other tobacco product in any form. SECTION XX. Said chapter 270 is hereby further amended by striking out section 6, as so appearing, and inserting in place thereof the following section:— Section 6. (a) No person under 18 years of age shall smoke, possess, or use any tobacco products in the commonwealth. (b) No person shall sell tobacco products or permit tobacco products to be sold to any person under 18 years of age nor shall any person give a person under 18 years of age a tobacco product. (c) Every retailer shall verify by means of proof of age that no person purchasing tobacco products is under 18 years of age. No person under 18 years of age shall misrepresent his or her age by presenting false proof of age to purchase tobacco products. No such verification is required for any person over 26 years of age. (d) Nothing in this section shall prohibit persons under 18 years of age from participating in compliance checks conducted in order to enforce and monitor compliance with this section or any other law governing the sale of tobacco products to minors or persons under 18 years of age. (e) Any retailer who violates any provision of this section shall be fined $100 for the first offense, $200 for the second offense, and $300 for the third or subsequent offense. Any retailer who violates this act 4 or more times within a 3 year period, calculated from the date of the first offense, shall be subject to a fine of $300 for each offense and shall have his local permit suspended for 7 consecutive calendar days. The board of health shall provide notice of the intent to suspend a tobacco permit, which notice shall contain the reasons for the

permit suspension and establish a date and time for a hearing. The date of the hearing shall be no earlier than 7 days after the date of said notice. The permittee shall have an opportunity to be heard at such hearing and shall be notified of the Board's decision and reasons in writing. (f) Any person who is under 18 years of age who violates any provision of this act may be required to perform 20 hours of community service and enroll in a tobacco education program; provided, however, that this section shall not apply to a person who is under 18 years of age who possesses, transports, or carries on his person tobacco products in the course of his employment.
SECTION XX. Said chapter 270 is hereby further amended by inserting after section 7, the following section:— Section 7A. (a) Police officers, school officials and their agents shall have the authority to confiscate any tobacco products from any person under 18 years of age and may return the confiscated tobacco products to said person's parent or legal guardian upon written request within 30 days. If the tobacco product is not claimed within 30 days, the police officers, school officials and their agents shall destroy the tobacco product. (b) In addition to the penalties provided in section 6 of chapter 270 upon petition of a board of health to the commissioner of revenue that a retailer has been cited in violation of said section 6, 4 or more times within a 3 year period, calculated from the date of the first offense, the commissioner of revenue shall, after providing the retailer with notice and opportunity to be heard, suspend for 30 days the retailer's license, issued in accordance with section 67 of chapter 62C. The commissioner shall provide notice of the intent to suspend said license, which notice shall contain the reasons for the suspension and establish a date and time for a hearing. The date of the hearing shall be no earlier than 7 days after the date of said notice. The licensee shall have an opportunity to be heard at such hearing and shall be notified of the commissioner's decision and reasons in writing. Any person aggrieved by the commissioner's suspension of said license may within 60 days of the date of notice of such suspension appeal to the appellate tax board, whose decision shall be final. (c) Police officers, school officials and their agents shall have the authority to confiscate any tobacco products from any person who is under 18 years of age; the commonwealth of Massachusetts or its agents, including but not limited to the department of public health, the attorney general, and the state police; any city or town or its agent, any board of health or its agent, and any city or town police department, any school official or its agent may enforce all other provisions of this act. If the enforcing authority is a board of health or its authorized agent, any violation of this section may be disposed of by the non-criminal method of disposition procedures contained in section 21D of chapter 40 without an enabling ordinance or bylaw. If the enforcing authority is any city or town or its agent, any board of health or its agent, or any city or town police department, fines that are assessed pursuant to section 6 of chapter 270 may be payable to the city or town in which the violation of this section occurs. Any city or town may, by ordinance or bylaw, establish a fund for the disposition of any revenues received from fines levied in accordance with the provisions of section 6 of chapter 270, in which case, the municipal health department or board of health shall expend said funds for the purpose of enforcing this act or any local law that regulates the sale of tobacco products.".

Amendment #143

Representatives Jones of North Reading, Peterson of Grafton, Hill of Ipswich, Poirier of North Attleboro, and deMacedo of Plymouth move to amend House Bill 4127 by adding the following new section:— "SECTION X. The secretary of administration and finance in conjunction with the secretary of health and human services shall evaluate the feasibility of contracting for recycling durable medical equipment purchased and issued by the commonwealth through any and all of its medical assistance programs. Said evaluation shall include, but not be limited to, a request for qualifications or proposals for entities capable of developing, implementing and operating a system of recycling whereby an inventory of such equipment is developed and managed so as to maximize the quality of service delivery to equipment recipients and to minimize costs and losses attributable to waste, fraud or abuse. The secretary of administration and finance shall report to the joint committee on health care financing, the house committee on ways and means and the senate committee on ways and means the findings of said evaluation, together with cost estimates for the operation of a recycling program, estimates of the savings it would generate, and legislative recommendations not later than October 31, 2012.".

Amendment #144

Representatives Jones of North Reading, Peterson of Grafton, Hill of Ipswich, Poirier of North Attleboro, deMacedo of Plymouth, and Hunt of Sandwich move to amend House Bill 4127 by inserting in SECTION 130, in line 2948, after the word “individual” the following words:— “, who is a resident of the commonwealth,”.

Amendment #145

Representatives Jones of North Reading, Peterson of Grafton, Hill of Ipswich, Poirier of North Attleboro, and deMacedo of Plymouth move to amend House Bill 4127 adding the following section:— “SECTION XX. Subsection (b) of section 38C of chapter 3 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting at the end thereof the following: Notwithstanding the foregoing or any general or special law or regulation to the contrary, no mandated health benefit bill shall be reported favorably by any joint committee of the general court or the house or senate committees on ways and means, unless and until the rate of increase in the Consumer Price Index (CPI) for medical care services as reported by the United States Bureau of Labor Statistics remains at 0 or below 0 for 2 consecutive years. The Institute of Health Care Finance and Policy shall file an annual report with the house and senate committees on ways and means, the joint committee on insurance and the joint committee on health care no later than the last day of January for the previous year certifying the rate of increase in the CPI for medical care services.”.

Amendment #146

Representatives Jones of North Reading, Peterson of Grafton, Hill of Ipswich, Poirier of North Attleboro, deMacedo of Plymouth, and O’Connell of Taunton move to amend House Bill 4127 adding the following new section:— “SECTION XX. Section 4 of chapter 32A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting, after the first paragraph, the following:- Among the policies purchased by the commission, at least one shall include a health savings account in its design.”

Amendment #146, changed

Ms. O’Connell of Taunton moves to amend House, No. 4127 by adding the following new section:—

SECTION XX. The division of health care cost and quality, established in chapter 118G of the General Laws, shall investigate and review methods of, and make recommendations relative to, increasing the use and adoption of health savings accounts and similar tax-favored health plans and developing and implementing incentives to increase the utilization of health savings accounts and similar tax favored health plans. The Division shall examine the feasibility of such accounts and plans for public payers and commercial insurers and the feasibility of a pilot program. The division shall submit a report of its findings and recommendations to the house and senate committees on ways and means and the joint committee on health care financing no later than April 1, 2013.

Amendment #147

Representatives Jones of North Reading, Peterson of Grafton, Hill of Ipswich, Poirier of North Attleboro, and deMacedo of Plymouth move to amend House Bill 4127 by inserting, in line 1379, after the word “employees”, the following:- “and the mean salary and benefits of job categories including administrators, doctors, technicians, and nurses,”.

Amendment #148

Representatives Jones of North Reading, Peterson of Grafton, Hill of Ipswich, Poirier of North Attleboro, and deMacedo of Plymouth move to amend House Bill 4127 adding the following new section:— “SECTION X. The

Massachusetts Health Connector shall establish a special small business commission composed solely of small business owners and their employees to: (a) identify those mandates that unduly increase the cost of small business insurance; (b) make recommendations to the legislature on mandates that need to be rescinded or revised; and, (c) submit a report to the general court on any proposed mandated health benefit bill; provided however, that no new mandated health benefit mandate shall be approved until 90 days after the clerks of the house and senate are in receipt of such report.”.

Amendment #149

Representatives Jones of North Reading, Peterson of Grafton, Hill of Ipswich, Poirier of North Attleboro, deMacedo of Plymouth, and O’Connell of Taunton move to amend House Bill 4127 by adding the following section:— “SECTION X. Notwithstanding any general or special law to the contrary, it shall be the policy of the general court to impose a moratorium on all new mandated health benefit legislation until December 31, 2015.”.

Amendment #150

Representatives Jones of North Reading, Peterson of Grafton, Hill of Ipswich, Poirier of North Attleboro, and deMacedo of Plymouth move to amend House Bill 4127 by adding, at the end thereof, the following:-
“SECTION XX. The office of Medicaid shall, within 6 months of the passage of this act, take any and all necessary actions to ensure that social security numbers are required on all medical benefits request forms to the extent permitted by federal law and that social security numbers are provided by all applicants who possess them. If for any reason the office of Medicaid determines that it is or will be unable to accomplish the foregoing within 6 months of the passage of this act, the office shall submit a detailed report of the reasons for such inability to the clerks of the house of representatives and the senate within 6 months following the passage of this act.
SECTION XX. The division of health care cost and quality shall, within 6 months of the passage of this act, ensure (i) that the identity, age, residence and eligibility of all applicants are verified before payments, other than emergency bad debt payments, are made by the Health Safety Net Trust Fund; and (ii) that the health safety net is the payor of last resort by performing third party liability investigations on health safety net claims and by implementing other such programs as needed. If for any reason the division determines that it is or will be unable to accomplish the foregoing within 6 months of the passage of this act, the division shall submit a detailed report of the reasons for such inability to the clerks of the house of representatives and the senate within 6 months following the passage of this act.”.

Amendment #151

Representatives Jones of North Reading, Peterson of Grafton, Hill of Ipswich, Poirier of North Attleboro, and deMacedo of Plymouth move to amend House Bill 4127 adding the following new section:— “SECTION XX. Notwithstanding any general or special law, rule or regulation to the contrary, no additional benefit, procedure or service shall be required for minimum creditable coverage, so- called, without prior legislative authorization therefore.”.

Amendment #152

Representatives Jones of North Reading, Peterson of Grafton, Hill of Ipswich, Poirier of North Attleboro, and deMacedo of Plymouth move to amend House Bill 4127 by striking SECTION 66.

Amendment #153

Representatives Jones of North Reading, Peterson of Grafton, Hill of Ipswich, Poirier of North Attleboro, and deMacedo of Plymouth move to amend House Bill 4127 by adding the following sections:—
“SECTION XX. Section 1 of chapter 94C of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 248, the words "sections 66 and 66B" and inserting in place thereof the following

words:- either sections 66 and 66B or sections 66 and 66C.
SECTION XX. Section 7 of said chapter 94C, as so appearing, is hereby amended by striking out, in line 202, the words "sections 66 and 66B" and inserting in place thereof the following words:- either sections 66 and 66B or sections 66 and 66C.
SECTION XX. Section 9 of said chapter 94C, as so appearing, is hereby amended by striking out, in line 2, the words "sections 66 and 66B" and inserting in place thereof the following words:- either sections 66 and 66B or sections 66 and 66C.
SECTION XX. Said section 9 of said chapter 94C, as so appearing, is hereby further amended by inserting after the word "podiatrist", in line 64, the following word:- , optometrist.
SECTION XX. Section 66 of chapter 112 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after the word "utilization", in line 7, the following words:- and prescription.
SECTION XX. Said section 66 of said chapter 112, as so appearing, is hereby further amended by striking out, in line 12, the words " and 66B" and inserting in place thereof the following words:- , 66B and 66C.
SECTION XX. The first paragraph of section 66A of said chapter 112, as so appearing, is hereby amended by adding the following sentence:- A registered optometrist may utilize epinephrine, adrenaline or other agents used in the percutaneous treatment of anaphylaxis.
SECTION XX. Section 66B of said chapter 112, as so appearing, is hereby amended by inserting after the words "injection" in line 13, the third time it appears, the following words:- , except for the utilization of epinephrine, adrenaline or other agents used in the percutaneous treatment of anaphylaxis.
SECTION XX. Said chapter 112 is hereby further amended by inserting after section 66B the following section:- Section 66C. (a) A registered optometrist, qualified by examination for practice under section 68, duly certified in accordance with section 68C and duly registered to issue written prescriptions in accordance with subsection (h) of section 7 of chapter 94C may, for the purpose of diagnosing, preventing, correcting, managing or treating ocular diseases, including glaucoma and ocular abnormalities of the human eye and adjacent tissue, utilize and prescribe topical and oral therapeutic pharmaceutical agents, described in 21 U.S.C. Section 812 or chapter 94C, which are used in the practice of optometry as defined in section 66, including those placed in schedules III, IV, V and VI by the commissioner pursuant to section 2 of said chapter 94C, and including the utilization of epinephrine, adrenalin or other agents used in the percutaneous treatment of anaphylaxis. Nothing in this section shall be construed to permit optometric utilization or prescription of: (i) therapeutic pharmaceutical agents for the treatment of systemic diseases; (ii) invasive surgical procedures; or (iii) pharmaceutical agents administered by subdermal injection, intramuscular injection, intravenous injection, subcutaneous injection or retrobulbar injection, except as authorized herein for the percutaneous treatment of anaphylaxis. The use of pharmaceutical agents placed in schedule III under section 2 of said chapter 94C shall be limited to narcotic analgesics and shall not include the use of hallucinogenic substances or anabolic steroids. Oral steroid treatment required beyond 14 days shall be continued only in consultation with the patient’s physician. (b) If during the course of examining or treating a patient with the aid of a diagnostic or therapeutic pharmaceutical agent, an optometrist, exercising professional judgment and that degree of expertise, care and knowledge ordinarily possessed and exercised by optometrists under like circumstances, determines the existence of signs of previously unevaluated disease which requires treatment not included in the scope of optometric practice as set forth in section 66, the optometrist shall refer the patient to a licensed physician or other qualified health care practitioner. Optometrists may utilize and prescribe nonlegend agents. (c) Nothing in this section shall prevent a qualified optometrist from serving as an approved investigator in a clinical trial evaluating pharmaceutical agents for use in the practice of optometry as defined in section 66; provided, however, that such pharmaceutical agent is, or would be anticipated to be, utilized or prescribed by optometrists in accordance with subsections (a) or (b). (d) If a patient exam shows newly diagnosed congenital glaucoma or if, during the course of examining, managing or treating a patient with glaucoma, surgical treatment is indicated, an optometrist shall refer that patient to a qualified physician for treatment. (e) Optometrists licensed under this chapter and the board of registration in optometry shall participate in appropriate state or federal reports or data collection efforts relative to patient safety and medical error reduction including, but not limited to, any such efforts coordinated by the Betsy Lehman center for patient safety and medical error reduction established in section 16E of chapter 6A.
SECTION XX. Said chapter 112 is hereby further amended by inserting after section 68B the following section:- Section 68C (a) The board of registration in optometry shall administer an examination designed to measure the qualifications necessary to safely utilize and prescribe therapeutic pharmaceutical agents defined in subsection (a) of section 66C. Such examination shall be held in conjunction with examinations provided in sections 68, 68A and 68B and shall include any portion of the examination administered by the National Board of Examiners in Optometry or

other appropriate examinations covering the subject matter of therapeutic pharmaceutical agents. Nothing shall prohibit the board from administering 1 examination to measure the qualifications necessary under sections 68, 68A, 68B and 68C. (b) Examination for the utilization and prescription of therapeutic pharmaceutical agents placed under schedules III, IV, V and VI by the commissioner pursuant to section 2 of chapter 94C and defined in subsection (a) of section 66C shall, upon application, be open to an optometrist registered under section 68, 68A or 68B and to any person who meets the qualifications for examination under said sections 68, 68A and 68B. Each such applicant registered as an optometrist under said section 68, 68A or 68B shall possess a current Massachusetts controlled substance registration for the use of topical pharmaceutical agents described in section 66B and placed under schedule VI by the commissioner pursuant to said section 2 of said chapter 94C and shall furnish to the board of registration in optometry evidence of the satisfactory completion of 40 hours of didactic education and 20 hours of supervised clinical education relating to the utilization and prescription of therapeutic pharmaceutical agents. Such education shall be provided by the Massachusetts Society of Optometrists or a duly accredited medical school or college of optometry and shall otherwise meet the guidelines and requirements of the board of registration in optometry. The board of registration in optometry shall provide to the department of public health and each successful applicant a certificate of qualification in the utilization and prescription of all therapeutic pharmaceutical agents as defined in said subsection (a) of said section 66C. (c) An optometrist licensed in another jurisdiction after January 1, 2009 and seeking to become licensed as an optometrist in the commonwealth may submit evidence to the board of registration in optometry of practice equivalent to that required in section 68, 68A or 68B and the board, at its discretion, may accept such evidence in order to satisfy any of the requirements of this section. An optometrist licensed in another jurisdiction to utilize and prescribe therapeutic pharmaceutical agents substantially equivalent to those placed under schedules III, IV, V and VI by the commissioner under section 2 of chapter 94C and defined in subsection (a) of section 66C may submit evidence to the board of registration in optometry of equivalent didactic and supervised clinical education in order to satisfy all of the requirements of this section. (d) In order to satisfy all of the requirements of this section, a licensed optometrist who has completed a Council on Optometric Education-approved, post-graduate residency program after July 31, 1997 may submit an affidavit to the board of registration in optometry from their residency supervisor or the director of residencies at the affiliated college of optometry attesting that an equivalent level of instruction and supervision was completed. (e) As a requirement of license renewal, an optometrist licensed under this section shall submit to the board of registration in optometry evidence attesting to the completion of 3 hours of continuing education specific to glaucoma.

SECTION XX. Section 66C of chapter 112, as so appearing, shall apply to registered optometrists qualified by examination for practice under section 68 of said chapter 112 after January 1, 2009.

SECTION XX. Under subsection (a) of section 68C of chapter 112 of the General Laws, as so appearing, the board shall only qualify a person for the practice of optometry in accordance with sections 68, 68A, 68B and 68C of chapter 112 of the General Laws; provided, however, that any applicant who presents satisfactory evidence of graduation subsequent to January 1, 2009, from a school or college of optometry approved by the board shall be deemed to have satisfied all of the requirements of sections 68, 68A, 68B and 68C of said chapter 112.

SECTION XX. Within 90 days after the effective date of this act, the department of public health and the board of registration in optometry shall promulgate rules and regulations necessary for the implementation of the amendments to sections 7 and 9 of chapter 94C of the General Laws and sections 66, 66A, 66B, 66C and 68C of chapter 112 of the General Laws as provided in this act.”.

Amendment #154

Representatives Jones of North Reading, Peterson of Grafton, Hill of Ipswich, Poirier of North Attleboro, deMacedo of Plymouth, and Hunt of Sandwich move to amend House Bill 4127 by inserting, in line 2996, after the words “employer’s discretion”, the following:— “(11) For the purpose of the fair share contribution compliance test, an employer may count employees that have qualifying health insurance coverage from a spouse, a parent, a veteran’s plan, Medicare, Medicaid, or a plan or plans due to a disability or retirement towards their qualifying take-up rate as a “contributing employer”, as defined by the Institute of Health Care Finance and Policy. The employer is still required to offer group medical insurance and must keep and maintain proof of their employee’s insurance status.”.

Amendment #155

Representatives Jones of North Reading, Peterson of Grafton, Hill of Ipswich, Poirier of North Attleboro, and deMacedo of Plymouth move to amend House Bill 4127 by adding, at the end thereof, the following section:- "SECTION XX. The office of Medicaid and the department of unemployment assistance shall, in consultation with the executive office of health and human services, develop and implement a means by which the office of Medicaid may access information as to the status of or termination of unemployment benefits and the associated insurance coverage by the medical security plan, as administered by the executive office of labor and workforce development, for the purposes of determination of eligibility for those individuals applying for benefits through health care insurance programs administered by the executive office of health and human services. The office and the department shall implement this system not later than 3 months following the passage of this act; provided, however, that if legislative action is required prior to implementation, recommendations for such action shall be filed with the house and senate clerks and the joint committee on health care financing not later than 2 months following the passage of this act.".

Amendment #156

Representative Lawn moves to amend H.4127 by striking out Section 178.

Amendment #157

Representative Lawn and others move to amend H.4127, in section 180, in lines 3713 to 3716 inclusive, by striking out the following:
"Section 60M. In any action for malpractice, negligence, error, omission, mistake or the unauthorized rendering of professional services against a provider of health licensed pursuant to section 2 of chapter 112, including actions pursuant to section 60B, an expert witness shall have been engaged in the practice of medicine at the time of the alleged wrongdoing."

Amendment #158

Representatives Benson of Lunenburg, DiNatale of Fitchburg, Atkins of Concord, Finn of West Springfield, Garballey of Arlington, and Provost of Somerville move to amend the bill in section 97, in line 1004, by inserting after the word "rehabilitative" the words "nurse-midwifery"

Amendment #159

Representative Lawn and others move to amend H.4127, in section 180, in lines 3717 to 3721 inclusive, by striking out the following: "Section 60N. In any action for malpractice, negligence, error, omission, mistake or the unauthorized rendering of professional services against a provider of health licensed pursuant to section 2 of chapter 112, including actions pursuant to section 60B of this chapter, an expert witness shall be board certified in the same specialty as the defendant physician as licensed pursuant to section 2 of chapter 112."

Amendment #160

Mr. Pignatelli of Lenox moves to amend the bill in SECTION 121 in line 2097 after the words "for medical" by inserting the following: "or nursing"

Amendment #161

Mr. Pignatelli of Lenox moves to amend the bill (H. 4127) in section 97, line 1092, by inserting after the word "commonwealth", the following:- ", or a doctor of podiatric medicine licensed to practice in the commonwealth."

Amendment #162

Representatives Benson of Lunenburg, DiNatale of Fitchburg, Farley-Bouvier of Pittsfield, Diehl of Whitman, Walz of Boston, Garballey of Arlington, Atkins of Concord, Lewis of Winchester, O'Connell of Taunton, Hogan of Stow, and Forry of Dorchester move to amend the bill by adding the following sections: SECTION X. Section 47G of chapter 175 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following sentence:-- Annual cytologic screenings performed at the same time as an annual physical exam may be separately billed by the health care provider and shall be paid by the insurer. SECTION X. Subdivision L of section 110 of said chapter 175, as so appearing, is hereby amended by adding the following sentence:-- Annual cytologic screenings performed at the same time as an annual physical exam may be separately billed by the health care provider and shall be paid by the insurer. SECTION X. Section 8J of chapter 176A, as so appearing, is hereby amended by adding the following sentence:-- Annual cytologic screenings performed at the same time as an annual physical exam may be separately billed by the health care provider and shall be paid by the insurer.

Amendment #162, changed

Ms. Benson of Lunenburg moves to amend House Bill 4127 by adding the following sections:-
SECTION X. Section 47G of chapter 175 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following sentence:-- Annual cytologic screenings performed at the same time as an annual physical exam may not be separately billed by the health care provider and shall be paid by the insurer.
SECTION X. Subdivision L of section 110 of said chapter 175, as so appearing, is hereby amended by adding the following sentence:-- Annual cytologic screenings performed at the same time as an annual physical exam may not be separately billed by the health care provider and shall be paid by the insurer.
SECTION X. Section 8J of chapter 176A, as so appearing, is hereby amended by adding the following sentence:-- Annual cytologic screenings performed at the same time as an annual physical exam may not be separately billed by the health care provider and shall be paid by the insurer.

Amendment #163

Representatives Benson of Lunenburg, DiNatale of Fitchburg, Forry of Dorchester, and Hecht of Watertown move to amend the bill by inserting in Section 124, line 2791, after the words "integrating physical and behavioral services," the following:-"including care provided in home and community-based settings by home health agencies or visiting nurse associations."

Amendment #164

Ms. Khan of Newton moves to amend the bill H.4127 by inserting the following new sections:-
SECTION XX. Section 80B of Chapter 112 of the General Laws, as appearing in the 2008 Official Edition is hereby amended by inserting in the last paragraph after the words "licensed practical nurse" the following: "(8) the administration of or assistance with the administration of medications in the home by a home health aide as defined under G.L. c. 111, § 72F, provided that such an aide has completed agency training regulations to be drafted according to regulations promulgated by the Board of Registration in Nursing and the Department of Public Health and that the administration or assistance with administration is performed under the supervision of a registered nurse. The delegation permitted under this subparagraph eight shall be limited to medications which are oral, ophthalmic, otic, topical, internasal, transdermal, suppository, prefilled, or products which are administered by inhalation. Administration of medications by intramuscular, subcutaneous, intradermal, intraosseous, intravenous shall not be permitted. Agencies shall provide training and establish documentation protocols according to the nurse delegation model and regulations to be drafted by the Board of Registration in Nursing and the Department of Public Health. These regulations shall specify that the registered nurse delegator and the home health aide are accountable for their own actions in the delegation process and that no registered nurse shall be required to delegate if the registered nurse determines it is inappropriate to do so. These regulations shall specify that delegation of administration of medication does not alter the responsibility of the home health agency or hospice to teach and the patient/family to

participate in learning, self administration of medications, whenever appropriate. A nurse licensed under this chapter who delegates a specific nursing activity or task in compliance with the rules adopted in these regulations shall not be subject to disciplinary action by the board of nursing for the performance of a person to whom the nursing activity or task is delegated.
SECTION XX. Section 9 of Chapter 94 C of the General Laws in hereby amended by inserting in the first paragraph after the words “veterinarian when registered pursuant to the provisions of Chapter 7” the following: “a home health aide pursuant to the provisions of G.L Chapter 112 S 80B (8).”

Amendment #165

Representatives Benson of Lunenburg, Wolf of Cambridge, DiNatale of Fitchburg, Provost of Somerville, Garballey of Arlington, and Finn of West Springfield move to amend the bill in section 121, in line 1560; and in line 2004, by inserting after the words “nurse practitioners” the words “nurse-midwives”; and in line 2098, by inserting after the words “internal medicine”, the words “nurse midwifery”.

Amendment #166

Mr. Mahoney of Worcester moves to amend the bill by inserting in Section 121, subsection 45(g) after the words “as defined by the department of public health,” the following: - “a Medicare-certified home health agency.”

Amendment #166, changed

Mr. Mahoney of Worcester moves to amend the bill, H 4127, in section 121, in line 1595, by inserting after the words “public health,” the following words:- “Medicare-certified home health agency for those patients that receive home-health services,”

Amendment #167

Mr. Winslow of Norfolk moves to amend House Bill 4127 by inserting at the end thereof the following section – “SECTION XX. Chapter 175 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after section 111H, the following section:— Section 111I. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance solely on the basis that it does not include coverage for at least 1 mandated benefit. (b) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance unless it provides, at a minimum, coverage for: (1) pregnant women, infants and children as set forth in section 47C; (2) prenatal care, childbirth and postpartum care as set forth in section 47F; (3) cytologic screening and mammographic examination as set forth in section 47G; (3A) diabetes-related services, medications, and supplies as defined in section 47N; (4) early intervention services as set forth in said section 47C; and (5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services. (c) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance that does not include coverage for at least one mandated benefit unless the carrier continues to offer at least one policy that provides coverage that includes all mandated benefits. (d) For purposes of this section, “mandated benefit” shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care. (e) The commissioner may promulgate rules and regulations as are necessary to carry out this section. (f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a policy of accident and sickness insurance to any employee within 12 months.
SECTION XX. Chapter 176A of the General Laws is hereby amended by inserting after section 1D the following section: Section 1E. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a

contract between a subscriber and the corporation under an individual or group hospital services plan solely on the basis that it does not include coverage for at least one mandated benefit. (b) The commissioner shall not approve a contract unless it provides, at a minimum, coverage for: (1) pregnant women, infants and children as set forth in section 8B; (2) prenatal care, childbirth and postpartum care as set forth in section 8H; (3) cytologic screening and mammographic examination as set forth in section 8J; (3A) diabetes-related services, medications, and supplies as defined in section 8P; (4) early intervention services as set forth in said section 8B; and (5) mental health services as set forth in section 8A; provided however, that if the contract limits coverage for outpatient physician office visits, the commissioner shall not disapprove the contract on the basis that coverage for outpatient mental health services is not as extensive as required by said section 8A, as long as such coverage is at least as extensive as coverage under the contract for outpatient physician services. (c) The commissioner shall not approve a contract that does not include coverage for at least one mandated benefit unless the corporation continues to offer at least one contract that provides coverage that includes all mandated benefits. (d) For purposes of this section, “mandated benefit” shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care. (e) The commissioner may promulgate rules and regulations as are necessary to carry out this section. (f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a hospital services plan, to any employee within 12 months. Chapter 176B of the General Laws is hereby further amended by inserting after section 6B, the following section:— Section 6C. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a subscription certificate solely on the basis that it does not include coverage for at least one mandated benefit. (b) The commissioner shall not approve a subscription certificate unless it provides, at a minimum, coverage for: (1) pregnant women, infants and children as set forth in section 4C; (2) prenatal care, childbirth and postpartum care as set forth in section 4H; (3) cytologic screening and mammographic examination; (3A) diabetes-related services, medications and supplies as defined in section 4S; (4) early intervention services as set forth in said section 4C; and (5) mental health services as set forth in section 4A; provided however, that if the subscription certificate limits coverage for outpatient physician office visits, the commissioner shall not disapprove the subscription certificate on the basis that coverage for outpatient mental health services is not as extensive as required by said section 4A, as long as such coverage is at least as extensive as coverage under the subscription certificate for outpatient physician services. (c) The commissioner shall not approve a subscription certificate that does not include coverage for at least 1 mandated benefit unless the corporation continues to offer at least one subscription certificate that provides coverage that includes all mandated benefits. (d) For purposes of this section, “mandated benefit” shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care. (e) The commissioner may promulgate rules and regulations as are necessary to carry out this section. (f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a subscription certificate, to any employee within 12 months.

SECTION XX. Chapter 176G of the General Laws is hereby amended by inserting after Section 16 the following new section: Section 16A. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a health maintenance contract solely on the basis that it does not include coverage for at least 1 mandated benefit. (b) The commissioner shall not approve a health maintenance contract unless it provides coverage for: (1) pregnant women, infants and children as set forth in section 4; (2) prenatal care, childbirth and postpartum care as set forth in said section 4 and section 4I; (3) cytologic screening and mammographic examination as set forth in said section 4; (3A) diabetes-related services, medications and supplies as defined in section 4H; (4) early intervention services as set forth in said section 4; and (5) mental health services as set forth in section 4M; provided however, that if the health maintenance contract limits coverage for outpatient physician office visits pursuant to section 16, the commissioner shall not disapprove the health maintenance contract on the basis that coverage for outpatient mental health services is not as extensive as required by said section 4M as long as such coverage is at least as extensive as coverage under the health maintenance contract for outpatient physician services. (c) The commissioner shall not approve a health maintenance contract that does not include coverage for at least one mandated benefit unless the health maintenance organization continues to offer at least one health maintenance contract that provides coverage that includes all mandated benefits. (d) For purposes of this section, “mandated benefit” shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care. (e) The commissioner may promulgate rules and regulations as are necessary to carry out the provisions of this section. (f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this

section shall be available to an employer who has provided a health maintenance contract, to any employee within 12 months."

Amendment #168

Representatives Forry of Boston, Jones of North Reading, Peterson of Grafton, Kafka of Stoughton, Keenan of Salem, Peake of Provincetown, Toomey of Cambridge, Hogan of Stow, Atkins of Concord, Benson of Lunenburg, McMurtry of Dedham, DiNatale of Fitchburg, Calter of Kingston, Fox of Boston, Coppinger of Boston, Dykema of Holliston, O'Connell of Taunton, D'Emilia of Bridgewater, Levy of Marlborough and Hunt of Sandwich move to amend the bill (House, No. 4127) by inserting after section 130 the following section:- "SECTION 130A. Said subsection (c) of said section 188 of said chapter 149, as so amended, is hereby further amended by adding the following clause:- (11) In calculating the fair share assessment, employees who have qualifying health insurance coverage from a spouse, parent, veteran's plan, Medicare, Medicaid or a plan or plans due to a disability or retirement shall not be included in the numerator or denominator for purposes of determining whether an employer is a contributing employer, as defined in 114.5 CMR 16.02."; and By inserting after section 201 the following new section:- "SECTION 201A. Section 130A shall take effect on February 1, 2013.".

Amendment #168 - further amendment

Ms. Forry of Boston moves to amend H.4127 by adding after the definition of "employee" in lines 2948-2950 the following definition:-

"Seasonal employee," A seasonal employee as defined in Chapter 151A, Section 1.;

Further moves to amend the bill, in SECTION 130, by inserting after the word "section" in line 2949, the words:- "Seasonal employees and";

Further moves to amend the bill by striking the definition of "Seasonal Employee" in Section 1 of Chapter 151A and replacing it with the following:-
"Seasonal Employee shall mean any employee who:

1. Is employed by any employer, whether the employer is a seasonal employer as defined in Chapter 151A, Section 1 or any other employer, in seasonal employment during a regularly recurring period or period of up to sixteen consecutive weeks in a calendar year for all such seasonal periods, as determined by the director of unemployment assistance in consultation with the employer, and
1. Has been hired for a specific temporary seasonal period as determined by the director of unemployment assistance in consultation with the employer; and

1. Has been notified in writing at the time hired, or immediately following the seasonal determination by the department, whichever is later:

1. That the individual is performing services in seasonal employment for a specified season; and

1. That the individual's employment is limited to the beginning and ending dates of the employer's seasonal period as determined by the department in consultation with the employer.";

Further moves to amend the bill, H. 4127, in SECTION 130, line 2952, by striking out the figure "11" and inserting in place thereof the following figure:- "21";

Further moves to amend the bill, H. 4127, by inserting after SECTION 130 the following section:-

SECTION 130A. Said subsection (c) of said section 188 of said chapter 149, as so amended, is hereby further amended by adding the following clause:-

"(11) In calculating the fair share assessment, employees who have qualifying health insurance coverage from a spouse, parent, veteran's plan, or a plan due to disability or retirement shall not be included in the numerator or denominator for purposes of determining whether an employer is a contributing employer, as defined by the authority. The employer shall keep and maintain proof of their employee's insurance status, in a reasonable manner as defined by the authority.";

And further moves to amend by inserting after SECTION 201 the following section:-

"SECTION 201A. Section 130A shall take effect on February 1, 2013."

Amendment #169

Representatives Khan of Newton, Keenan of Salem, and Toomey of Cambridge move that the bill be amended in SECTION 162 by striking it in its entirety and further move to amend Chapter 176O, as so appearing, in subsection (b) of Section 2 by striking (3) in its entirety and inserting in its place the following: - "(3) take into consideration any projected compliance costs for such variation. In order to reduce health care costs and improve access to health care services, the bureau shall establish by regulation no later than January 1, 2014, as a condition of accreditation that carriers use uniform forms, standards and methodologies for credentialing of providers, including any health care provider type licensed under chapter 112 that provide identical services. The division shall, before adopting regulation under this section, review the procedures adopted in states with uniform credentialing requirements of health care providers and consult with the division of health care cost and quality, the department of public health, the group insurance commission, the Centers for Medicare and Medicaid Services and each carrier. Accreditation by the bureau shall be valid for a period of 24 months."

Amendment #170

Representative Parisella of Beverly moves to amend the bill by adding the following section: Section X. (a) The Director of Medicaid (Director) shall utilize the federal Public Assistance Reporting Information System (PARIS) to identify veterans and their dependents or survivors who are enrolled in the MassHealth program and assist them in obtaining federal veteran health care benefits. (b) The Director shall exchange information with PARIS and identify veterans and their dependents or survivors who are receiving MassHealth benefits. (c) The Director shall refer identified veterans who are receiving high-cost services, including long-term care, to their local veteran service officers (VSOs) to obtain information regarding, and assistance in obtaining, Department of Veterans' Affairs benefits. (d) In implementing this section, the Director of Medicaid shall do all of the following: (1) Enter into an agreement with the Department of Veterans' Services (DVS) to perform VSO outreach services. The DVS agreement shall contain performance standards that will allow the Director to measure the effectiveness of the program established by this

section. (2) Enter into any agreements that are required by the federal government to utilize the PARIS system. (3) Perform any information technology activities that are necessary to utilize the PARIS system.

Amendment #171

Mr. Linsky of Natick moves to amend the bill (H. 4127) in Section 97 by inserting, in line 1006, after the words “community health center” the following words:- “home health and hospice care provider,”.

Amendment #172

Representative Hunt of Sandwich moves to amend House Bill 4127 by adding, at the end thereof, the following section:
“SECTION XX. Section 6 of chapter 62 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking subsection (f), in its entirety, and inserting, in place thereof, the following: (f) There is hereby established a credit for businesses offering health insurance to their employees. For the purposes of this section, the term "businesses" shall include professions, sole proprietorships, trades, businesses, or partnerships. Any business which (a) has 1 or more full-time equivalent employees unrelated to its owners or partners but no more than 50 of such employees calculated on an average annual basis, (b) makes qualifying health insurance premium expenditures for a health insurance plan covering its employees in each year beginning on December 31, 2012 and ending on December 31, 2014, including any year in which a credit is taken pursuant to this section, shall be allowed a credit against its income tax due under this chapter in 2 consecutive tax years. The amount of such credit in the first tax year in which it is taken shall be 20 per cent of the entire amount of the qualifying health insurance premium expenditure made by such business in such tax year. The amount of such credit in the second tax year in which it is taken shall be 10 per cent of the entire amount of such qualifying health insurance premium expenditure made by such business in such tax year. To qualify for such credits, the health insurance premium expenditure of such business must equal at least 50 per cent of the total cost of the premiums for such health insurance plan and such health insurance plan must be available at least to all of the full-time employees of such business. For the purposes of this section, "unrelated" shall mean not having the familial relationship of spouse, mother, father, or child. Credits pursuant to this subsection shall be available only in tax years beginning on December 31, 2012 and ending on December 31, 2014. This subsection shall expire on December 31, 2014.”.

Amendment #173

Representatives Hunt of Sandwich, Jones of North Reading, Peterson of Grafton, Hill of Ipswich, Poirier of North Attleboro, and deMacedo of Plymouth move to amend House Bill 4127 by striking, in line 2952, the figure “11” and inserting in place thereof the following: - “51”.

Amendment #174

Representatives Creedon of Brockton, Canavan of Brockton, Brady of Brockton, DiNatali of Fitchburg, McMurtry of Dedham, Atsalis of Barnstable, and Sullivan of Fall River move to amend House, No. 4127 by inserting the following SECTIONS:-- “SECTION 1. Subsection (a) of section 188 of chapter 149, as appearing in the 2010 Official Edition, is hereby amended by adding the following definition:- “Exempted employer”, an employer whose employees are dependents under a group health plan, as defined in 26 U.S.C. 5000(b)(1). SECTION 2. Said section 188 of said chapter 149 is hereby further amended by striking out the first sentence, as appearing in section 135 of chapter 3 of the acts of 2011, and inserting in place thereof the following sentence:- For the purpose of more equitably distributing the costs of health care provided to uninsured residents of the commonwealth, each employer that (i) employs 11 or more full-time equivalent employees in the commonwealth and (ii) is not a contributing employer nor an exempted employer shall pay a per-employee contribution at a time and in a manner prescribed by the director of unemployment assistance, in this section called the fair share employer contribution. SECTION 3. Said section 188 of said chapter 149, as appearing in the 2010 Official Edition, is hereby further amended by adding the following subsection:- (f) Each exempted employer shall provide the department with evidence that its employees are

dependents under a group health plan, as defined by 26 U.S.C. 5000(b)(1), at a time and in a manner prescribed by the director of unemployment assistance."

Amendment #175

Representative Peake of Provincetown moves to amend the bill by adding the following section:
SECTION XX. Section 1. Chapter 112 of the General Laws is hereby amended by inserting after section 160 the following section:- Section 160A. The needles used in acupuncture shall be sterile, one-use, disposable, solid filiform instruments which shall include but not be limited to: dermal needles, plum blossom needles, press needles, prismatic needles, and disposal lancets. The use of staples in the practice of acupuncture shall be prohibited. Section 2. Chapter 175 of the General Laws is hereby amended by inserting after section 47AA the following section:- Section 47BB. (a) All individual or group accident and health insurance policies and health service contracts delivered, issued or renewed by an insurer or nonprofit health service corporation which provide benefits to individual subscribers and members within the commonwealth or to all group members having a principal place of employment within the commonwealth shall provide benefits for the acupuncture diagnostic techniques in subsection (b), the acupuncture services in subsection (c), and the adjunctive therapies in subsection (d); provided those techniques, services and adjunctive therapies are provided by an acupuncturist licensed under sections 148 to 162, inclusive, of chapter 112 or a licensed physician practicing acupuncture under section 162 of chapter 112. (b) Acupuncture diagnostic techniques shall include, but not be limited to, the use of observation, listening, smelling, inquiring, palpation, pulses, tongue, physiognomy, 5 element correspondences, ryodoraku, German electro-acupuncture, and thermography. (c) Acupuncture services shall include, but not be limited to: (i) auricular, hand, nose, face, foot and/or scalp acupuncture therapy; (ii) stimulation to points (including but not limited to acupuncture points, trigger points and motor points), acupuncture channels, and areas on the body by use of any of the following: needles, moxibustion, cupping, thermal methods, magnets, scraping techniques, ion cord linking acupuncture devices with wires, hot and cold packs, electromagnetic wave therapy and lasers; manual stimulation, including stimulation by an instrument or mechanical device that does not pierce the skin, massage, acupressure, reflexology, shiatsu and tui na; and electrical stimulation including electro-acupuncture, percutaneous and transcutaneous electrical nerve stimulation. (d) Adjunctive therapies shall include, but not be limited to: (i) oriental nutritional counseling, and the recommendation of nonprescription substances that meet the federal Food and Drug Administration labeling requirements as dietary supplements to promote health; (ii) instruction and training of meditation, breathing techniques and therapeutic movement exercises, including, but not limited to, tai chi, Qi Gong, Sotai; and (iii) lifestyle, behavioral, supportive, educational and stress counseling. (e) If an insurer or nonprofit health service corporation denies benefits relative to acupuncture diagnostic techniques, acupuncture services or adjunctive therapies, the denial must be by, under the direction of, or subject to the review of an acupuncturist licensed under said sections 148 to 162, inclusive, of said chapter 112, or a licensed physician practicing acupuncture under section 162 of chapter 112. Section 3. Said chapter 175 is hereby amended by inserting after the section 205 the following section:- Section 205A. (a) The commissioner shall not approve a policy under section 205 that does not provide benefits for the acupuncture diagnostic techniques in subsection (b), the acupuncture services in subsection (c), and the adjunctive therapies in subsection (d); provided those techniques, services and adjunctive therapies are provided by an acupuncturist licensed under sections 148 to 162, inclusive, of chapter 112, or a licensed physician practicing acupuncture under section 162 of chapter 112. (b) Acupuncture diagnostic techniques shall include, but not be limited to, the use of observation, listening, smelling, inquiring, palpation, pulses, tongue, physiognomy, 5 element correspondences, ryodoraku, German electro-acupuncture, and thermography. (c) Acupuncture services shall include, but not be limited to: (i) auricular, hand, nose, face, foot and/or scalp acupuncture therapy; (ii) stimulation to acupuncture points and channels by use of any of the following: needles, moxibustion, cupping, thermal methods, magnets, scraping techniques, ion cord linking acupuncture devices with wires, hot and cold packs, electromagnetic wave therapy and lasers; manual stimulation, including stimulation by an instrument or mechanical device that does not pierce the skin, massage, acupressure, reflexology, shiatsu and tui na; and electrical stimulation including electro-acupuncture, percutaneous and transcutaneous electrical nerve stimulation. (d) Adjunctive therapies shall include, but not be limited to: (i) oriental nutritional counseling, and the recommendation of nonprescription substances that meet the federal Food and Drug Administration labeling requirements as dietary supplements to promote health; (ii) instruction and training of meditation, breathing techniques and therapeutic movement exercises, including, but not limited to, tai chi, Qi Gong, Sotai; and (iii) lifestyle, behavioral, supportive, educational and stress counseling. (e) If benefits relative to acupuncture diagnostic

techniques, acupuncture services or adjunctive therapies are denied under a policy under said section 205, the denial must be by, under the direction of, or subject to the review of an acupuncturist licensed under said sections 148 to 162, inclusive, of said chapter 112, or a licensed physician practicing acupuncture under section 162 of chapter 112. Section 4. Chapter 176A of the General Laws is hereby amended by inserting after section 8DD the following section:- Section 8EE. (a) Any contract between a subscriber and the corporation under an individual or group hospital service plan delivered, issued or renewed in the commonwealth shall provide as benefits to all individual subscribers and members within the commonwealth and to all group members having a principal place of employment within the commonwealth for the acupuncture diagnostic techniques in subsection (b), the acupuncture services in subsection (c), and the adjunctive therapies in subsection (d); provided those techniques, services and adjunctive therapies are provided by an acupuncturist licensed under sections 148 to 162, inclusive, of chapter 112, or a licensed physician practicing acupuncture under section 162 of chapter 112. (b) Acupuncture diagnostic techniques shall include, but not be limited to, the use of observation, listening, smelling, inquiring, palpation, pulses, tongue, physiognomy, 5 element correspondences, ryodoraku, German electro-acupuncture, and thermography. (c) Acupuncture services shall include, but not be limited to: (i) auricular, hand, nose, face, foot and/or scalp acupuncture therapy; (ii) stimulation to acupuncture points and channels by use of any of the following: needles, moxibustion, cupping, thermal methods, magnets, scraping techniques, ion cord linking acupuncture devices with wires, hot and cold packs, electromagnetic wave therapy and lasers; manual stimulation, including stimulation by an instrument or mechanical device that does not pierce the skin, massage, acupressure, reflexology, shiatsu and tui na; and electrical stimulation including electro-acupuncture, percutaneous and transcutaneous electrical nerve stimulation. (d) Adjunctive therapies shall include, but not be limited to: (i) oriental nutritional counseling, and the recommendation of nonprescription substances that meet the federal Food and Drug Administration labeling requirements as dietary supplements to promote health; (ii) instruction and training of meditation, breathing techniques and therapeutic movement exercises, including, but not limited to, tai chi, Qi Gong, Sotai; and (iii) lifestyle, behavioral, supportive, educational and stress counseling. (e) If a non-profit hospital service corporation denies benefits relative to acupuncture diagnostic techniques, acupuncture services or adjunctive therapies, the denial must be by, under the direction of, or subject to the review of an acupuncturist licensed under said sections 148 to 162, inclusive, of said chapter 112, or a licensed physician practicing acupuncture under section 162 of chapter 112. Section 5. Chapter 176B of the General Laws is hereby amended by inserting after section 4DD the following section:- Section 4EE. (a) Any subscription certificate under an individual or group medical service agreement delivered, issued or renewed in the commonwealth shall provide a benefits to all individual subscribers and members within the commonwealth and to all group members having a principal place of employment within the commonwealth for the acupuncture diagnostic techniques in subsection (b), the acupuncture services in subsection (c), and the adjunctive therapies in subsection (d); provided those techniques, services and adjunctive therapies are provided by an acupuncturist licensed under sections 148 to 162, inclusive, of chapter 112, or a licensed physician practicing acupuncture under section 162 of chapter 112. (b) Acupuncture diagnostic techniques shall include, but not be limited to, the use of observation, listening, smelling, inquiring, palpation, pulses, tongue, physiognomy, 5 element correspondences, ryodoraku, German electro-acupuncture, and thermography. (c) Acupuncture services shall include, but not be limited to: (i) auricular, hand, nose, face, foot and/or scalp acupuncture therapy; (ii) stimulation to acupuncture points and channels by use of any of the following: needles, moxibustion, cupping, thermal methods, magnets, scraping techniques, ion cord linking acupuncture devices with wires, hot and cold packs, electromagnetic wave therapy and lasers; manual stimulation, including stimulation by an instrument or mechanical device that does not pierce the skin, massage, acupressure, reflexology, shiatsu and tui na; and electrical stimulation including electro-acupuncture, percutaneous and transcutaneous electrical nerve stimulation. (d) Adjunctive therapies shall include, but not be limited to: (i) oriental nutritional counseling, and the recommendation of nonprescription substances that meet the federal Food and Drug Administration labeling requirements as dietary supplements to promote health; (ii) instruction and training of meditation, breathing techniques and therapeutic movement exercises, including, but not limited to, tai chi, Qi Gong, Sotai; and (iii) lifestyle, behavioral, supportive, educational and stress counseling. (e) If a medical service corporation denies benefits relative to acupuncture diagnostic techniques, acupuncture services or adjunctive therapies, the denial must be by, under the direction of, or subject to the review of an acupuncturist licensed under said sections 148 to 162, inclusive, of said chapter 112, or a licensed physician practicing acupuncture under section 162 of chapter 112. Section 6. Chapter 176G of the General Laws is hereby amended by inserting after section 4V the following section:- Section 4W. (a) Any group health maintenance contract shall provide coverage for the acupuncture diagnostic techniques in subsection (b), the acupuncture services in subsection (c), and the adjunctive therapies in subsection (d); provided those techniques, services and adjunctive therapies are provided by an

acupuncturist licensed under sections 148 to 162, inclusive, of chapter 112, or a licensed physician practicing acupuncture under section 162 of chapter 112. (b) Acupuncture diagnostic techniques shall include, but not be limited to, the use of observation, listening, smelling, inquiring, palpation, pulses, tongue, physiognomy, 5 element correspondences, ryodoraku, German electro-acupuncture, and thermography. (c) Acupuncture services shall include, but not be limited to: (i) auricular, hand, nose, face, foot and/or scalp acupuncture therapy; (ii) stimulation to acupuncture points and channels by use of any of the following: needles, moxibustion, cupping, thermal methods, magnets, scraping techniques, ion cord linking acupuncture devices with wires, hot and cold packs, electromagnetic wave therapy and lasers; manual stimulation, including stimulation by an instrument or mechanical device that does not pierce the skin, massage, acupressure, reflexology, shiatsu and tui na; and electrical stimulation including electro-acupuncture, percutaneous and transcutaneous electrical nerve stimulation. (d) Adjunctive therapies shall include, but not be limited to: (i) oriental nutritional counseling, and the recommendation of nonprescription substances that meet the federal Food and Drug Administration labeling requirements as dietary supplements to promote health; (ii) instruction and training of meditation, breathing techniques and therapeutic movement exercises, including, but not limited to, tai chi, Qi Gong, Sotai; and (iii) lifestyle, behavioral, supportive, educational and stress counseling. (e) If a health maintenance organization denies benefits relative to acupuncture diagnostic techniques, acupuncture services or adjunctive therapies, the denial must be by, under the direction of, or subject to the review of an acupuncturist licensed under said sections 148 to 162, inclusive, of said chapter 112, or a licensed physician practicing acupuncture under section 162 of chapter 112.

Amendment #176

Representatives Peake of Provincetown and Atsalis of Barnstable move to amend the bill by adding the following section:
SECTION XX. Notwithstanding the provisions of any general or special law or regulation to the contrary, the provisions of Section 25E ½ of Chapter 111 of the General Laws, as proposed to be added by SECTION 55, shall not apply to the review of an application for a determination of need that is filed with the department of public health under any applicable provision of Chapter 111 of the General Laws on or before the later of (a) December 31, 2013, or (b) the date on which said department submits for the first time a state health plan in accordance with Section 25E ½ of Chapter 111 of the General Laws, as proposed to be amended by SECTION 55.

Amendment #177

Representatives Peake of Provincetown, Atsalis of Barnstable, Cariddi of North Adams, Farley-Bouvier of Pittsfield and Pignatelli of Lenox move to amend the bill in Section 97 by striking out lines 1159 to 1165 in their entirety and replacing them with the following: “Sole community provider”, any acute hospital which qualifies as a sole community provider under Medicare regulations or under regulations promulgated by the executive office, which regulations shall consider factors including, but not limited to, 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; provided, that such hospitals shall include those which are located more than 20 miles driving distance from other such hospitals in the commonwealth and which provide services for at least 60 per cent of their primary service area.

Amendment #178

Representatives Peake of Provincetown and Atsalis of Barnstable move to amend the bill in Section 46, line 1660, by adding after the word “year” the following: And provided further that for the purpose of analyzing the cost growth of individual health care entities within the regions, the costs associated with implementing the health information technology and ehealth medical records provisions of this act shall not be considered and provided further that the costs associated with capital investments greater than $1,000,000 that are deemed necessary by the provider to enhance the quality of health care in the region shall not be considered and provided further that any assessments required to pay for the provisions of this act shall not be considered.

Amendment #179

Ms. Malia of Boston moves to amend the bill (House, No. 4127) in section 123, in line 2714, by striking out the following words:- “ultrasound diagnostic imaging"

Amendment #180

Mr. Conroy of Wayland moves to amend the bill in SECTION 124, in lines 2891 to 2895, inclusive, by striking Section 12 in its entirety and inserting in place thereof the following: “Section 12: The commissioner of insurance shall make a determination if an ACO has adequate reserves to meet their risk arrangements. The commissioner of insurance shall have the authority to promulgate regulations to ensure the viability of an ACO for all risks including, but not limited to, global payment or shared savings risk, and to establish financial oversight provisions and requirements for ACOs. Upon the satisfaction of the commissioner of insurance, the division of insurance shall submit a certificate of approval to the division.”

Amendment #181

Mr. Conroy of Wayland moves to amend the bill in SECTION 188, in line 3770, by inserting, after “plan” the following sentence: “This section does not apply to any health coverage that supplements Medicare, including coverage subject to chapter 176K of the General Laws, as appearing in the 2010 Official Edition.”

Amendment #182

Ms. Provost of Somerville moves to amend the bill, H.4127, by inserting, after Section 65, the following new section:- Section XX. Chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after section 51H the following section:– Section 51I. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:- “Adverse event”, injury to a patient resulting from a medical intervention, and not to the underlying condition of the patient. “Checklist of care”, pre-determined steps to be followed by a team of healthcare providers before, during and after a given procedure to decrease the possibility of adverse effects and other patient harm by articulating standards of care. “Facility,” a hospital; institution maintaining an Intensive Care Unit; institution providing surgical services, or clinic providing ambulatory surgery. (b) The department shall encourage the development and implementation of checklists of care that prevent adverse events and reduce healthcare-associated infection rates. The department shall develop model checklists of care, which may be implemented by facilities; provided however, that facilities may develop and implement checklists independently. (c) Facilities shall report data and information relative to their use or non-use of checklists to the department and the Betsy Lehman center for patient safety and medical error reduction. The department may consider facilities that use similar programs to be in compliance. Reports shall be made in the manner and form established by the department. The department shall publicly report on individual hospitals’ compliance rates.” ”

Amendment #183

Representatives Provost of Somerville and Sciortino of Medford move to amend the bill, H.4127, in Section 121, by inserting in line 2182 after the words, “patient choice”, the following words, “of services and of in-network and out-of-network providers”; and by deleting in Section 124, line 2819, after the words “palliative care;” the word “and”; and by inserting in line 2820, after the letter “(j)”, the following subsection:- “Establishment of mechanisms to protect patient choice of providers, including the requirement that patient choice of in-network or out-of-ACO providers may not be limited if such providers accept the comparable in-ACO rate for service and agree to comply with reasonable in-ACO administrative requirements; and (k)”.

Amendment #184

Ms. Provost of Somerville move to amend the bill, H.4127, by inserting at the end thereof the following new section:- SECTION XX. Chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended, by inserting at the end thereof, the following new section: Section 226. (a) As used in this section the following terms shall, unless the context clearly requires otherwise, have the following meanings: “Appropriate”, consistent with applicable legal, health and ethical professional standards, the patient’s clinical and other circumstances and the patient’s reasonably known wishes and beliefs. “Attending health care practitioner”, a physician or nurse practitioner who has primary responsibility for the care and treatment of the patient. Where more than 1 physician or nurse practitioner share that responsibility, each of them has a responsibility under this section, unless they agree to assign that responsibility to 1 of them. “Palliative care”, a health care treatment plan, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient’s quality of life, which could include hospice care. “Terminal illness or condition”, an illness or condition which can reasonably be expect to cause death within 6 months, whether or not treatment is provided. (b) The commissioner shall adopt regulations requiring each licensed hospital, skilled nursing facility, health center or assisted living facility to distribute to patients in its care written information regarding the availability of palliative care and end-of-life options. (c) If a patient is diagnosed with a terminal illness or condition, the patient’s attending health care practitioner shall offer to provide the patient with information and counseling regarding palliative care appropriate to the patient, including, but not limited to: (i) the range of options appropriate to the patient; (ii) the prognosis, risks and benefits of the various options; and (iii) the patient’s legal rights to comprehensive pain and symptom management. The information and counseling may be provided orally or in writing. Where the patient lacks capacity to reasonably understand and make informed choices, the attending health care practitioner shall provide information and counseling under this section to a person with authority to make health care decisions for the patient. The attending health care practitioner may arrange for information and counseling under this section to be provided by another professionally qualified individual. Where the attending health care practitioner is not willing to provide the patient with information and counseling under this section, the attending health care practitioner shall arrange for another physician or nurse practitioner to do so, or shall refer or transfer the patient to another physician or nurse practitioner willing to do so. (d) The department shall consult with the Hospice and Palliative Care Federation of Massachusetts, in developing educational documents, rules and regulations related to this section.

Amendment #185

Representatives Khan of Newton and Scibak of South Hadley move to amend the bill H.4127 by inserting after Section 228 Subsection (d) the following: “(e) This section will not apply if a payer or any entity acting for a payer under contract uses a prior authorization methodology that utilizes an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system.”

Amendment #185, changed

Representatives Khan of Newton and Scibak of South Hadley moves to amend amendment 185 by striking the text and inserting in place thereof the following text:

“Nothing in this section will prohibit a payer or any entity acting for a payer under contract from using a prior authorization methodology that utilizes an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system in lieu of a paper form, developed pursuant to subsection (c)”

Amendment #186

Ms. O'Connell of Taunton moves to amend House Bill 4127 by inserting at the end thereof the following section:- "SECTION XX. Section 60I of chapter 231 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking the second paragraph, and inserting in place thereof the following: An attorney shall not contract for or collect a contingent fee for representing any person seeking damages in connection with an action for malpractice, negligence, error, omission, mistake, or the unauthorized rendering of professional services against a provider of health care in excess of the following limits: (1) Thirty-five per cent of the first two hundred thousand dollars recovered; (2) Thirty-three and one-third per cent of the next two hundred thousand dollars recovered; (3) Thirty per cent of the next one hundred thousand dollars recovered; (4) Twenty-five per cent of any amount by which the recovery exceeds five hundred thousand dollars.".

Amendment #187

Ms. O'Connell of Taunton moves to amend the bill (House, No. 4127), in section 178, by striking out, in line 3642, the figure:- "3" and inserting in place thereof the following figure:- "2".

Amendment #188

Representatives Walsh of Boston, Scaccia of Boston, Wolf of Cambridge, Malia of Boston, Khan of Newton, and McMurtry of Dedham move to amend the bill, H. 4127, in SECTION 54 by inserting after item (3), in line 442, the following:— " (4) are likely to serve unique patient populations requiring specialized resources, and (5) are likely to serve a significant number of regional, national or international patients." And further moves to amend the bill in SECTION 121, in subsection (b) of the newly created Section 42 of Chapter 118G of the General Laws by inserting at the end thereof, in line 1516, the following:— "In doing so the Division shall establish protections and incentives for selection and service of high-cost patients by providers with special expertise in serving patients with complex conditions." And further moves to amend the bill in SECTION 121, in the newly created Section 43 of said Chapter 118G by striking subsection (d), in lines 1541 through 1544, and inserting in place thereof the following: "(d) Any alternative payment methodology shall include a risk adjustment based on health status. The division shall create standards for the calculation of risk adjustments and update those standards on an annual basis. The division shall assure that a risk adjustment methodology used for pediatric patients accounts for the differential diagnoses and care needs of children. In establishing risk adjustment standards, the division may take into account functional status, socioeconomic, or cultural factors. The division shall require yearly updating of risk profiles to reflect changes in the population served by the provider." And further moves to amend the bill in SECTION 121, in subsection (a)(3) of the newly created Section 45 of Chapter 118G of the General Laws by inserting after the word "organizations" in line 1554 the following:— "The Division shall modify existing models or standards as necessary and reasonable to apply to practices serving as pediatric patient-centered medical homes." And further moves to amend the bill in SECTION 121, in subsection (b) of the newly created Section 54 of Chapter 118G of the General Laws by inserting at the end thereof, in line 1890, the following:— "The division shall not compare providers that primarily serve children with providers that primarily serve adults." And further moves to amend the bill in SECTION 121 in the newly created section 65 of Chapter 118G of the General Laws by inserting after the word "specialty in line 2225, the following:— "and shall ensure that the standard quality measure set as it applies to pediatric providers shall rely on pediatric specific quality measures" And further moves to amend the bill in SECTION 124, in the definition of "Accountable Care Organization" in Section 1 of the newly created Chapter 118J of the General Laws by inserting at the end thereof, in line 2725, the following:— "Unless otherwise specified, an Accountable Care Organization or ACO shall include a pediatric ACO." And by inserting after the definition of "Payer" in lines 2724 through 2746, the following: "Pediatric ACO", an ACO that primarily serves individuals under the age of 18 or individuals with chronic or congenital conditions originating in childhood. And further moves to amend the bill in SECTION 124 in Section 6 of the newly created Chapter 118J of the General Laws by inserting at the end of subsection (e), in line 2812, the following:— ", provided that quality measures for pediatric ACOs may differ from those primarily serving adults." And by inserting after subsection (j), in lines 2820 and 2821, the following: — "(k) If the ACO serves children, the ability to provide or contract for pediatric specialty care, including mental health care, by persons with recognized expertise in specialty

pediatrics to ACO members requiring such services." And further moves to amend the bill in SECTION 124, in Section 8 of said Chapter 118J by inserting after the phrase "covered lives," in line 2853, the following:— "A pediatric ACO shall have a minimum of 5,000 covered lives. Minor children may be enrolled in different ACOs than their parents." And further moves to amend the bill in SECTION 124, in subsection (a) of Section 10 of said Chapter 118J by inserting at the end thereof, in line 2874, the following:— "The division shall modify the standard measure set and set minimum standards for pediatric ACOs as necessary to meet the purposes of this section."

Amendment #188, changed

Representatives Walsh of Boston, Scaccia of Boston, Wolf of Cambridge, Malia of Boston, Khan of Newton, and McMurtry of Dedham move to amend the bill, H. 4127, in SECTION 121, in the newly created section 43 of said chapter 118G by striking subsection (d), in lines 1541 through 1544, and inserting in place thereof the following:— (d) Any alternative payment methodology shall include a risk adjustment based on health status. The division shall create standards for the calculation of risk adjustments and update those standards on an annual basis; provided that such calculations as affect pediatric patients shall take into account the diagnoses and care needs of children. In establishing risk adjustment standards, the division may take into account functional status, socioeconomic or cultural factors.

Amendment #189

Representatives Walsh of Boston, Collins of Boston, and Diehl of Whitman move to amend the bill in section 58 in line 2021 by striking the number "17" and replacing it with the number "18" and by inserting the following after "recovery" in line 2032:- "Recovery Homes Collaborative."

Amendment #190

Mr. Collins of Boston moves to amend the bill (House, No. 4127) by striking SECTION 66.

Amendment #191

Mr. Walsh of Lynn moves to amend House Bill 4127 in Section 188, by striking out "provided, however, that supplemental insurance may not cover co-payments, deductibles, co-insurance, or other patient payment responsibilities for services that are included in the individuals health plan"

Amendment #192

Mr. Collins of Boston moves to amend the bill (House, No. 4127) by striking lines 540 through 543 and inserting in place thereof the following:-
"If a system has entered into alternative payment methodology contracts, as defined in section 1 of chapter 118G of the General Laws, or into contracts that involve partial risk or pay for performance provisions, and more than 50 percent of the total patients of such system who are enrolled in products offered by health maintenance organizations, as defined in section 1 of chapter 176G of the General Laws, and who are assigned to primary care providers within such system are covered under such contracts, then the provisions of this section 51I, other than of this subsection (i), shall not apply such system or to the facilities within such system."

Amendment #192, changed

Mr. Collins of Boston moves to amend House, No. 4127 in section 66 by striking lines 540 through 543 and inserting in place thereof the following:—

(i) If a system or one or more of its facilities (1) has entered into one or more alternative payment methodology contracts, as defined in section 1 of chapter 118G, and (2) receives payment through an alternative payment methodology for at least 50 per cent of the total number of patients of such system who are assigned to primary care providers within such system, the provisions of this section shall not apply to such system or to any facility within such system.
Mr. Collins of Boston moves to further amend House, No. 4127, by adding the following new section:—
SECTION XX. Section 66 shall take effect on January 1, 2014.

Amendment #193

Mr. Speliotis of Danvers moves to amend the bill (H. 4127) in Section 124 by striking, in line 2914, after the word "division" the word "may" and inserting in place thereof the following word:- "shall" ; and further in Section 124 by striking, in line 2915, after the word "division" the word "may" and inserting in place thereof the following word:- "shall"

Amendment #194

Mr. Collins of Boston moves to amend the bill (House, No. 4127), by striking lines 2857 through 2860. Mr. Collins of Boston moves to further amend the bill (House, No. 4127), in line 2861, by striking "(c)" and inserting in place thereof the following:- "(b)"

Amendment #195

Representatives Straus of Mattapoisett, Cabral of New Bedford, Sullivan of Fall River, Markey of Dartmouth move to amend the bill by adding a new section: New Section 202. (a) There shall be established a Health Care Cost Savings Commission, which shall evaluate the cost savings and effectiveness of tiered products offered by both health plans and health systems in slowing the growth in health care costs. The commission shall consist of 11 members: 1 of whom shall be the secretary of health and human services or his/her appointee; 1 of whom shall be a member of the Massachusetts Association of Health Plans; 1 of whom shall be a member of the Massachusetts Hospital Association; 1 of whom shall be a representative of a disproportionate share hospital chosen by the Governor; 1 of whom shall be a member of the Massachusetts Council of Community Hospitals; 1 of whom shall be an expert in health policy chosen by the Governor; 1 of whom shall be from the Massachusetts Association of Community Health Centers; 1 of whom shall be from the Massachusetts Medical Society; 1 of whom shall be the executive director of the Massachusetts Group Insurance Commission or his/her designee; 1 of whom shall be the Speaker of the House of Representatives or his/her designee; and 1 of whom shall be the Senate President or his/her designee. (b) The commission shall review tiered product offerings, including an analysis of all relevant utilization and cost data so as to determine the effectiveness and cost savings associated with tiered products offered by health plans and health systems. The commission's review shall include specific findings and legislative recommendations including the following: (1) the extent to which tiered products offerings have been adopted and utilized in the marketplace; (2) the extent to which tiered product offerings have reduced health care costs for both patients and employers; (3) the effects that tiered product offerings have on patient education relating to health care costs and quality; (4) the effects that tiered product offerings have on patient utilization of local hospitals and the resulting impact on overall state health care costs; (5) opportunities to incentivize tiered product offerings for both health systems and employers. (c) In conducting its examination, the commission shall obtain and use actual health plan and health system data from the all-payer claims database. (d) The commission shall report the results of its review and its recommendations together with drafts of legislation necessary to carry out such recommendations by December 31, 2012. The report shall be provided to the chairs of the house and senate committees on ways and means, the house and senate chairs of the joint committee on health care financing, and the secretary of health and human services, and shall be posted on the appropriate state website.

Amendment #196

Mr. Collins of Boston moves to amend the bill (House, No. 4127), in line 1744, by striking “or require the health care entity to renegotiate contracts that, in the division's opinion, are contributing to exceeding the modified potential gross state product growth rate, provided, however, that the division shall not participate in such negotiations.” and inserting in place thereof the following:- “.”

Amendment #196, changed

Mr. Collins of Boston amends H. 4127 by striking lines 1742-1746 and inserting in place thereof the following: Should the health care entity fail to successfully complete the performance improvement plan, the division may require the parties to resubmit a new plan consistent with this section. If the Division determines that the health care entity has not implemented the performance improvement plan to their satisfaction then they shall submit a recommendation for proposed legislation to the joint committee on health care financing if the division determines that further legislative authority is needed to achieve the health care quality and spending sustainability objectives of this act.

Amendment #197

Representatives Creedon of Brockton, Canavan of Brockton, Brady of Brockton, DiNatale of Fitchburg, McMurtry of Dedham, Atkins of Concord, Dwyer of Woburn, and Sullivan of Fall River move to amend House, No. 4128 by inserting the following SECTIONS:-- “SECTION 1. Subsection (a) of section 188 of chapter 149, as appearing in the 2010 Official Edition, is hereby amended by adding the following definition:- “Exempted employer”, an employer whose employees are dependents under a group health plan, as defined in 26 U.S.C. 5000(b)(1). SECTION 2. Said section 188 of said chapter 149 is hereby further amended by striking out the first sentence, as appearing in section 135 of chapter 3 of the acts of 2011, and inserting in place thereof the following sentence:- For the purpose of more equitably distributing the costs of health care provided to uninsured residents of the commonwealth, each employer that (i) employs 11 or more full-time equivalent employees in the commonwealth and (ii) is not a contributing employer nor an exempted employer shall pay a per-employee contribution at a time and in a manner prescribed by the director of unemployment assistance, in this section called the fair share employer contribution. SECTION 3. Said section 188 of said chapter 149, as appearing in the 2010 Official Edition, is hereby further amended by adding the following subsection:- (f) Each exempted employer shall provide the department with evidence that its employees are dependents under a group health plan, as defined by 26 U.S.C. 5000(b)(1), at a time and in a manner prescribed by the director of unemployment assistance.”

Amendment #198

Mr. Collins of Boston moves to amend the bill (House, No. 4127) by striking sections 37, 38, 39, 44, 45, 46, 47, 48, 49, 51, 52, 53, 54, 56, 63, and 64. Mr. Collins of Boston moves to further amend the bill (House, No. 4127) by inserting at the end thereof the following new section:- “SECTION ___. The provisions of Section 25C of Chapter 111 of the General Laws, as proposed to be added by SECTION 54, and of Section 25E1/2 (d) of Chapter 111 of the General Laws, as proposed to be added by SECTION 55, shall not apply to the review of an application for a determination of need that is filed with the department of public health under any applicable provision of Chapter 111 of the General Laws on or before the date on which said department submits for the first time a health resource plan in accordance with Section 25E1/2 of Chapter 111 of the General Laws, as proposed to be amended by SECTION 55.”

Amendment #199

Representatives Turner of Dennis, Forry of Boston, Provost of Somerville, Hunt of Sandwich, Ferguson of Holden, and Levy of Marlborough moves to amend H.4127 by adding after the definition of “employee” in lines 2948-2950 the following definition:- “Seasonal employee,” A seasonal employee as defined in Chapter 151A, Section 1 And further

amend the bill, in SECTION 130, by inserting after the word “section” in line 2949, the words:- “Seasonal employees and” And further amend the bill by striking the definition of “Seasonal Employee” in Section 1 of Chapter 151A and replacing it with the following:- “Seasonal Employee shall mean any employee who: (1) Is employed by any employer, whether the employer is a seasonal employer as defined in Chapter 151A, Section 1 or any other employer, in seasonal employment during a regularly recurring period or period of up to sixteen consecutive weeks in a calendar year for all such seasonal periods, as determined by the director of unemployment assistance in consultation with the employer, and (2) Has been hired for a specific temporary seasonal period as determined by the director of unemployment assistance in consultation with the employer; and (3) Has been notified in writing at the time hired, or immediately following the seasonal determination by the department, whichever is later: (A) That the individual is performing services in seasonal employment for a specified season; and (B) That the individual’s employment is limited to the beginning and ending dates of the employer’s seasonal period as determined by the department in consultation with the employer.”

Amendment #200

Mr. Collins of Boston moves to amend the bill (House, No. 4127) by inserting after line 2475, the following:- “(c) In carrying out the purposes of this section the executive office shall, to the maximum extent practicable, adopt policies that are consistent with those relating to similar subject matters adopted by the Office of the National Coordinator for Health Information Technology of the federal Department of Health and Human Services.”

Amendment #200, changed

Mr. Collins of Boston moves to amend House, No. 4127 in section 123 by inserting after line 2475 the following subsection:—
(c) In carrying out the purposes of this section, the executive office shall, to the maximum extent practicable, adopt policies that are consistent with those relating to similar subject matters adopted by the Office of the National Coordinator for Health Information Technology of the federal Department of Health and Human Services; provided, however, that nothing herein shall be construed to limit the executive office’s ability to advance interoperability and other health information technology beyond the standards adopted by the ONC, including without limitation any applicable meaningful use standards.

Amendment #201

Mr. Collins of Boston moves to amend the bill (House, No. 4127) by striking lines 1751 through 1763 and inserting in place thereof the following:- “Section 49. (a) The division may conduct a market impact review under the following circumstances: (i) a corporate affiliation between a provider organization and a carrier; (ii) mergers or acquisitions of hospitals or hospital systems; or (iii) acquisition of insolvent provider organizations; provided, however, that contracting units of fewer than 10 physicians, and organizations already subject to review pursuant to 15 USC § 18A, shall not be subject to such review. The division shall initiate a market impact review by sending such provider a notice of a market impact review which shall detail the particular factors that it seeks to examine through the review. The division shall establish, by regulation, rules for conducting market impact reviews.” Mr. Collins of Boston moves to further amend the bill (House, No. 4127), in line 1778, by striking the words “; and (11) any other factors that the division determines to be in the public interest”

Amendment #202

Mr. Winslow of Norfolk moves to amend House Bill 4127 by inserting at the end thereof the following sections – “Section XX. Notwithstanding any general or special law to the contrary, the board shall issue a telemedicine license to allow medical advice, diagnoses, treatments and prescriptions by physicians who hold a full and unrestricted medical license in a state other than Massachusetts. The board shall establish requirements for such licensure. Section XX. A telemedicine license shall not be issued for a period that exceeds two years. A physician may seek

renewal of a telemedicine license upon application and compliance with other requirements established by the board."

Amendment #202, changed

Mr. Winslow of Norfolk moves to further amend the following: –
"SECTION XX. Notwithstanding any general or special law to the contrary, section 2 of chapter 112 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by adding, at the end thereof, the following sections: –
Notwithstanding any other provisions of this chapter, the board may issue a telemedicine license to allow medical advice, diagnoses, treatments and prescriptions by physicians who hold a full and unrestricted medical license in a state other than Massachusetts. The board shall establish requirements for such licensure.
A telemedicine license shall not be issued for a period that exceeds two years. A physician may seek renewal of a telemedicine license upon application and compliance with other requirements established by the board."

Amendment #203

Mr. Collins of Boston moves to amend the bill (House, No. 4127), in line 336, by striking the word "licensed" and inserting in place thereof the following:- "registered" Mr. Collins of Boston moves to further amend the bill (House, No. 4127), in line 866, by striking the word "licensed" and inserting in place thereof the following:- "registered" Mr. Collins of Boston moves to further amend the bill (House, No. 4127), in line 2723, by striking the words "may be licensed" and inserting in place thereof the following:- "shall be registered" Mr. Collins of Boston moves to further amend the bill (House, No. 4127), by striking lines 2750 through 2920 and inserting in place thereof the following:- Section 2. (a) The division shall develop and administer a registration program for ACOs. (b) The division shall promulgate regulations to ensure the uniform reporting of the information collected under this section. Such uniform reporting shall include the following: (1) payment structure; (2) functional capabilities; (3) organizational structure; (4) use of interoperable health information technology; (5) quality measurement; (6) adequacy of reserves; (7) internal consumer protection processes; and (8) ability to provide patients with relevant prices. (c) The division shall use such information for the purposes of monitoring and analyzing the development and performance of ACOs over the period of the next 5 years with regard to cost, quality, and access. The division shall report its findings to the Joint Committee on Health Care Finance and shall make any recommendations necessary to advance the objectives of providing coordinated care and reducing costs.

Amendment #204

Representatives Ross of Attleboro and O'Connell of Taunton move to amend House Bill 4127 in SECTION 121, by striking out proposed section 54, contained in lines 1881 through 1909.

Amendment #205

Representatives Ross of Attleboro and O'Connell of Taunton move to amend House Bill 4127 by striking SECTION 120, in its entirety.

Amendment #206

Mr. Collins of Boston moves to amend the bill (House, No. 4127) by striking lines 1545 through 1549.

Amendment #207

Representative Dykema of Holliston moves that the bill be amended in Section 123, in subsection (b) of proposed section 2 of chapter 118I of the General Laws, in line 2396 by deleting the number "19" and inserting in place thereof

the number "20"; And in said Section 123, in subsection (b) of proposed section 2 of chapter118I of the General Laws, in line 2401 by inserting following the words"commissioner of public health or designee;" the following words: "1 of whom shall be a registered nurse;"

Amendment #208

Representative Dykema of Holliston moves to amend House No., 4127 by inserting the following new section:- Section XX. Notwithstanding any general or special law to the contrary, there shall be established and set up on the books of the commonwealth as a separate fund to be known as the Medicaid and Health Care Reform FMAP Trust Fund. The fund shall consist of any funds that may be appropriated or transferred for deposit into the trust fund, interest earned on such revenues, and other sources. The comptroller shall deposit an amount to the fund determined by secretary of administration and finance that is equivalent to the additional funding provided by the federal government pursuant to the increased federal Medicaid assistance percentage pursuant to the Patient Protection and Affordable Care Act of 2010 and Section 1201 of the Health Care and Education Reconciliation Act of 2010. The fund shall be used for the following purposes: (1) to support the financing of health insurance coverage for low-income Massachusetts residents, including state health insurance programs and insurance offered through the commonwealth's health insurance exchange and (2) to improve Medicaid reimbursement to health care providers. The secretary of administration and finance shall administer the fund. No later than January 31 of each year, the secretary, in consultation with the executive office of health and human services, the commonwealth health insurance connector authority, healthcare providers participating in the Medicaid program, and consumer representatives, shall submit a report to the house and senate ways and means committees and the joint committee on health care financing that includes the current funding available in the fund, the funding estimated to be deposited through the end of the current and subsequent fiscal year, estimated expenditures from the fund, and recommendations for transferring such funds to other state accounts and funds in a manner consistent with the purpose of the fund.

Amendment #209

Representative Dykema of Holliston moves to amend House No., 4127 in SECTION 121, by striking out subsection 65 in lines 2205 and 2235 inclusive and inserting in place the following section:-- "Section 65. The division shall develop the uniform reporting of a standard set of health care quality measures for each health care provider facility, medical group, or provider group in the commonwealth hereinafter referred to as the "Standard Quality Measure Set." The division shall convene a statewide advisory committee which shall recommend to the division a Standard Quality Measure Set. The statewide advisory committee shall consist of the executive director of the division or designee, who shall serve as the chair; the executive director of the group insurance commission or designee, the Medicaid director or designee; and 6 representatives of organizations to be appointed by the governor including at least 1 representative from an acute care hospital or hospital association, 1 representative from a provider group or medical association or provider association, 1 representative from a medical group, 1 representative from a private health plan, 1 representative from the Massachusetts Association of Health Plans, 1 representative from an employer association, 1 representative from a patient safety group, and 1 representative from a health care consumer group. In developing its recommendation of the Standard Quality Measure Set, the advisory committee shall, after consulting with state and national organizations that monitor and develop quality and safety measures, select from existing quality measures and shall not select quality measures that are still in development or develop its own quality measures. The committee shall annually recommend to the division any updates to the Standard Quality Measure Set by November 1. The committee may solicit for consideration and recommend other nationally recognized quality measures, including, but not limited to, recommendations from medical, safety or provider specialty groups as to appropriate quality measures for that group's specialty. At a minimum, the Standard Quality Measure Set shall consist of the following quality measures: (i) the Centers for Medicare and Medicaid Services hospital process measures, acute myocardial infarction, congestive heart failure, pneumonia and surgical infection prevention; (ii) the Hospital Consumer Assessment of Healthcare Providers and Systems survey; (iii) the Healthcare Effectiveness Data and Information Set reported as individual measures and as a weighted aggregate of the individual measures by medical or provider group; (iv) the Ambulatory Care Experiences Survey; and (v) Centers for Disease Control and Prevention of the United States Department of Health and Human Services Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. The division shall require all payers to limit their

collection and utilization of health care quality measures from providers to the standard quality measure set, as developed by the division under this section."

Amendment #210

Representative Dykema of Holliston moves to amend House No., 4127 in SECTION 11, by striking out subsection d, lines 58 to 68 inclusive and inserting in place there of:-- "(d) The commissioner shall annually award not less than 75 per cent of the Prevention and Wellness Trust Fund through a competitive grant process to municipalities, community-based organizations, health care providers, regional-planning agencies, and health plans that apply for the implementation, evaluation and dissemination of evidence-based community preventive health activities. To be eligible to receive a grant under this subsection, a recipient shall be: (i) a municipality or group of municipalities working in collaboration; (ii) a community-based organization working in collaboration with 1 or more municipalities; (iii) a community-based organization working in collaboration with a health care provider including but not limited to primary care physician offices or a health plan; (iv) a health care provider or a health plan working in collaboration with 1 or more municipalities and a community-based organization; or (v) a regional planning agency. Expenditures from the fund for such purposes shall supplement and not replace existing local, state, private or federal public health-related funding." And to amend the bill by striking out SECTION 14, lines 147to 162 inclusive, and inserting in place there of:-- "SECTION 14. Section 7A of chapter 26 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting at the end, the following paragraph:— The division shall create a model wellness guide for payers, employers and consumers. The guide shall provide the following information: 1) the importance of healthy lifestyles, disease prevention, and the benefits of care management and health promotion; 2) financial and other incentives for participating in wellness programs; 3) an explanation of the use of technology to provide wellness information and services; 4) the benefits of participating in tobacco cessation programs, weight loss programs, and complying with disease management; 5) a description of the discounts available to employees under the Affordable Care Act; 6) and 7) the ability of payers to reduce premiums by offering incentives to patients with chronic diseases or at high-risk of hospitalization to better comply with prescribed drugs and follow up care. In developing the model guide, the division shall consult with the department of public health and health care stakeholders, including, but not limited to, employers, including representatives of employers with 50 employees or more and representatives of employers with less than 50 employees, providers, both for profit and not for profit, health plans and public payers, researchers, community organizations, consumers, and government."

Amendment #210, changed

Ms. Dykema of Holliston moves to amend the bill, H. 4127, in SECTION 14, line 162 by inserting after the word "consumers" the following word:- ", community organizations".

Amendment #211

Representative Dykema of Holliston moves to amend House No., 4127 in SECTION 121, in line 2057, by striking out the words "patients, including patient access" and inserting in place thereof the following words:- "patients including patients with disabilities whose disabilities may include but are not limited to intellectual and developmental disabilities, including patient access"

Amendment #211, changed
Ms. Dykema of Holliston moved to amend the bill in section 121, in line 2057, by inserting after the word "patients" the words ", including patients with disabilities whose disabilities may include but are not limited to intellectual and developmental disabilities".

Amendment #212

Representative Barrows of Mansfield moves to amend House Bill 4127 by adding the following section:- "SECTION XX. Section 6 of chapter 176J of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by

adding, at the end thereof, the following subsection:- (g) Notwithstanding any general or special law to the contrary, the commissioner shall prohibit carriers that offer health benefit plans to small businesses and eligible individuals from limiting insurance policies to exclude plans that reimburse more than 50 per cent of the plan deductible.”.

Amendment #213

Mr. Conroy of Wayland moves to amend the bill, H4127, in section 67, in lines 558-567, by striking paragraphs (4), (5), and (6) of subsection (b) of section 53H and inserting in place thereof the following paragraphs:- (4) to establish, in consultation with the boards of professional licensure, a standardized electronic system for the public reporting of provider license information; and (5) to perform such other functions and duties as may be required to carry out this section.

Amendment #214

Mr. Nangle of Lowell moves to amend the bill (H. 4127) in section 97, line 1092, by inserting after the word “commonwealth”, the following:- “, or a doctor of podiatric medicine licensed to practice in the commonwealth.”

Amendment #215

Representatives Wolf of Cambridge, Finn of West Springfield, Hecht of Watertown, Puppolo of Springfield, Provost of Somerville, Sannicandro of Ashland, Smith of Everett, Toomey of Cambridge, Torrisi of North Andover, Walz of Boston move to amend the bill in section 96, in line 806, by inserting after the word “payment” the following: “; provided further, that said bonus to qualifying hospitals and providers shall apply to all health care services provided to medical assistance recipients including outpatient, inpatient and behavioral health services, including, but not limited to, those under primary care clinician/mental health and substance abuse plan or through a health maintenance organization under contract; and provided further that qualifying hospitals and providers that qualify for said bonus shall also be eligible for a restoration of fiscal year 2012 Medicaid rate cuts resulting from methodology changes to outpatient rates and inpatient rates, including, but not limited to, the add-on payment for the acute hospitals who serve a high relative proportion of Medicaid patient care and the outpatient payment amount per episode rate methodology and rates no less than in effect in fiscal year 2011 and from prior year cuts to graduate medical education adjustments, including, but not limited to, the training for primary care and mental health care”; And in said section in line 816, by inserting after the word “shall” the following: “, in consultation with safety net providers including high Medicaid and low-income public payer hospitals, (1) support the state’s efforts to improve health, care delivery and cost-effectiveness; (2) include incentives for high quality, coordinated care, including wellness services, primary care services and behavioral health services; (3) include a risk adjustment element based on health status; (4) to the extent possible, include a risk adjustment element that takes into account functional status, socioeconomic status or cultural factors; (5) preserve the use of intergovernmental transfer financing mechanisms by the governmental acute public hospital consistent with the Medical Assistance Trust Fund provisions in effect as of fiscal year 2012; (6) recognize the unique circumstances and reimbursement requirements of high Medicaid disproportionate share hospitals and other safety net providers with concentrated care in government programs; and (7) to the extent aligned with the Medicaid population and reimbursement requirements,”; And in said section in line 828, by striking out the following: “2013” and inserting in place thereof the following: “2014”; And in said section in line 832, by striking out the following: “2014” and inserting in place thereof the following: “2015”; And in said section in line 836, by striking out the following: “2015” and inserting in place thereof the following: “2016”; And in section 192 of the bill, in line 3814, by striking out the following: “, office of Medicaid, and the commonwealth connector authority”.

Amendment #215, changed

Ms. Wolf of Cambridge moves to amend House, No. 4127 in section 96 in line 806 by inserting after the word “payment” the following:—
; provided further, that said bonus to qualifying hospitals and providers shall apply to all health care services provided

to medical assistance recipients including outpatient, inpatient and behavioral health services, including, but not limited to, those under primary care clinician and mental health and substance abuse plans or through a health maintenance organization under contract

Mr. Walsh of Lynn moves to further amend House, No. 4127 in section 96 in line 822 by inserting after the word "section." the following:—

The office of Medicaid shall also consult with safety net providers including high Medicaid and low-income public payer hospitals to ensure that said alternative payment methodologies (1) support the state's efforts to improve health, care delivery and cost-effectiveness; (2) include incentives for high quality, coordinated care, including wellness services, primary care services and behavioral health services; (3) include a risk adjustment element based on health status; (4) to the extent possible, include a risk adjustment element that takes into account functional status, socioeconomic status or cultural factors; (5) preserve the use of intergovernmental transfer financing mechanisms by governmental acute public hospitals consistent with the Medical Assistance Trust Fund provisions in effect as of fiscal year 2012; and (6) recognize the unique circumstances and reimbursement requirements of high Medicaid disproportionate share hospitals and other safety net providers with concentrated care in government programs.

Amendment #216

Representatives Hecht of Watertown, Lewis of Winchester, Khan of Newton, Kaufman of Lexington, Honan of Boston, Kulik of Worthington, Sanchez of Boston, Scibak of South Hadley, Balser of Newton, Malia of Boston, Provost of Somerville, Smizik of Brookline, Walz of Boston, Brodeur of Melrose, Cantwell of Marshfield, Sciortino of Medford, Lawn of Watertown, Andrews of Orange, Pignatelli of Lenox, Farley-Bouvier of Pittsfield, Garballey of Arlington, Fallon of Malden, Hogan of Stow, Ehrlich of Marblehead, Sannicandro of Ashland, Fresolo of Worcester, Dykema of Holliston, Atkins of Concord, Walsh of Framingham, Coppinger of Boston, Turner of Dennis, O'Day of West Boylston, Benson of Lunenburg, Mark of Hancock, Cariddi of North Adams, Swan of Springfield, Wolf of Cambridge, Fox of Boston, Mahoney of Worcester, Smith of Everett, Forry of Boston, Dwyer of Woburn, Sullivan of Fall River, Toomey of Cambridge, Aguiar of Fall River, Walsh of Boston, Peake of Provincetown, Basile of Boston, Linsky of Natick, McMurtry of Dedham, Michlewitz of Boston, and Kocot of Northampton move to amend the bill by adding the following sections:

"SECTION A. The second paragraph of section 1 of chapter 64C of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out the words 'snuff, snuff flour and any other tobacco or tobacco product prepared in such manner as to be suitable for chewing, including, but not limited to cavendish, plug, twist and fine-cut tobaccos' and inserting in place thereof the following words:– 'any product containing, made, or derived from tobacco that is intended for human consumption, whether chewed, absorbed, dissolved, inhaled, snorted, sniffed, or ingested by any other means other than smoking, or any component, part, or accessory of a tobacco product, including, but not limited to, snuff; snuff flour; cavendish; plug and twist tobacco; fine-cut and other chewing tobacco; shorts; refuse scraps, clippings, cuttings and sweepings of tobacco, and other kinds and forms of tobacco; but does not include cigars, cigarettes, or smoking tobacco as defined in chapter 64C. "Smokeless tobacco" excludes any tobacco product that has been approved by the United States Food and Drug Administration for sale as a tobacco cessation product, as a tobacco dependence product, or for other medical purposes, and is being marketed and sold solely for such an approved purpose'.

SECTION B. The definition of "smoking tobacco" in subsection (a) of section 7B of chapter 64C of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking the words 'roll-your-own tobacco and pipe tobacco and other kinds and forms of tobacco suitable for smoking' and inserting in place thereof the following words:– 'roll-your-own tobacco and pipe tobacco and other kinds and forms of tobacco, or substance that contains tobacco, suitable for smoking, and "smoking tobacco" shall additionally include tobacco leaf, tobacco sheet, or any substance containing tobacco which is suitable for rolling or wrapping tobacco or any other substance for smoking'.

SECTION C. Said section 7B of said chapter 64C of the General Laws is hereby further amended by adding the following subsection:– (m) In addition to the excise imposed by subsection (b), an excise shall be imposed on all cigars weighing more than 3 pounds per 1,000 units and not more than 12 pounds per 1,000 units held in the commonwealth at the rate of 80 per cent of the wholesale price of such product. In addition to the excise imposed by paragraph (b), an excise shall be imposed on all smoking tobacco held in the commonwealth at the rate of 90 per cent of the wholesale price of such product.

SECTION D. The final sentence of subsection (a) of section 7C of chapter 64C of the General Laws is hereby amended by striking out the words ‘twenty-five per cent’ and inserting in place thereof the following words:– ‘45 per cent’.
SECTION E. Section 7C of chapter 64C of the General Laws is hereby further amended by adding the following subsection:- (d) Any change, henceforth, to the state excise tax rate for cigarettes shall cause a commensurate adjustment in the state excise tax for all other tobacco products under chapter 64C. For purposes of this subsection (d), the term “commensurate adjustment” shall be determined by dividing the change in the state cigarette excise tax by the total cigarette excise tax prior to that change, and the resulting percentage change shall be applied to calculate the commensurate adjustment to the state excise taxes for cigars, smokeless tobacco and smoking tobacco. There shall be no negative commensurate adjustments, and the said rate for each tobacco product each shall be adjusted independently of the other such product categories under chapter 64C. The change in cigarette excise tax and commensurate adjustments shall have the same effective date.
SECTION F. Notwithstanding any general or special law to the contrary, all additional revenue resulting from the enactment of sections A, B, C, D and E of this Act, as estimated by the commissioner of revenue, shall be deposited in the Prevention and Wellness Trust Fund, as established in section 11 of the bill (as printed).”

Amendment #217

Mr. Sanchez of Boston and Mr. Rushing of Boston move to amend the bill (H.4127) by inserting the following new sections:
SECTION XX. The second paragraph of section 16 of chapter 6A of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking out the words “and, (7) the health facilities appeals board ” and inserting after in place thereof the following words :- (7) the health facilities appeal board; and (8) the office of health equity.
SECTION XX. Section 16O of said chapter 6A, as so appearing, is hereby amended by inserting after the word, “recommendations,” in line 3, the following words :- to the director of the office of health equity.
SECTION XX. Said section 16O of said chapter 6A, as so appearing, is hereby further amended by striking out, in line 15, the figure “37” and inserting in place thereof the following figure :- 38.
SECTION XX. Said section 16O of said chapter 6A, as so appearing, is hereby further amended by inserting after the word “ officio ”, in line 19, the following words :- ; the director of the office of health equity, or the director’s designee.
SECTION XX. Said chapter 6A is hereby amended by inserting after section 16S the following section: — Section 16T. There shall be an office of health equity within the executive office of health and human services. The office shall be in the charge of a director, who shall report directly to the secretary of health and human services. The health disparities council, described in section 16O, shall serve as an advisory board to the office of health equity.
SECTION XX. The General Laws are hereby amended by inserting after chapter 111N the following chapter:– CHAPTER 111O . OFFICE OF HEALTH EQUITY. Section 1. As used in this chapter the following words shall, unless the context clearly requires otherwise, have the following meanings: – “Disparities” or “Racial and ethnic health and health care disparities”, differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific racial and ethnic groups. “Office”, the office of health equity, as established by section 16T of chapter 6A. Section 2. The office, subject to appropriation, shall coordinate all activities of the commonwealth to eliminate racial and ethnic health and health care disparities. The office shall set goals for the reduction of disparities and prepare an annual plan for the commonwealth to eliminate disparities. Section 3. The office, subject to appropriation, shall collaborate with other state agencies of the commonwealth on disparities reduction initiatives to address the social factors that influence health inequality. These state agencies shall include, but shall not be limited to, the executive office of health and human services, the executive office of housing and economic development, the executive office of public safety and security, the executive office of energy and environmental affairs, the Massachusetts Department of Transportation, the executive office of labor and workforce development and the executive office of education. The office shall facilitate communication and partnership between these agencies to develop greater understanding of the intersections between agency activities and health outcomes. The office shall facilitate development of interagency initiatives to address the social and economic determinants of health and key health disparities issues including, but not limited to, healthcare access and quality; housing availability and quality; transportation availability, location and cost; community policing and safe spaces; air, water, land usage and quality; employment and workforce development; and education access and quality. Section 4. The

office, subject to appropriation, shall evaluate the effectiveness of programs and interventions to eliminate health disparities, identifying best practices and model programs for the state. Section 5. The secretary of health and human services shall annually, on the day assigned for submission of the budget to the general court under section 7H of chapter 29, designate major initiatives of the commonwealth affecting the health and health care of residents of the commonwealth. These initiatives may include any activity of the commonwealth including, but not limited to, activities of the executive office of health and human services, the executive office of housing and economic development, the executive office of public safety and security, the executive office of energy and environmental affairs, the Massachusetts Department of Transportation, the executive office of labor and workforce development and the executive office of education. For each major initiative, the office shall prepare a disparities impact statement evaluating the likely positive or negative impact of each initiative on eliminating or reducing racial and ethnic health disparities. The statements shall, to the extent possible, include quantifiable impacts and evaluation benchmarks. The statements shall be posted on the official internet site of the executive office of health and human services and submitted to the clerks of the house of representatives and senate, members of the health disparities council, appropriate legislative committees and the house and senate committees on ways and means. Section 6. The office, subject to appropriation, shall prepare an annual health disparities report card. The report card shall evaluate the progress of the commonwealth toward eliminating racial and ethnic health disparities, using, where possible, quantifiable measures and comparative benchmarks. The report card shall report on progress on a regional basis, based on regions designated by the office. The office shall hold public hearings in several regions of the state to get public information on the topics of the report card. The report card shall be delivered to the governor, speaker of the house of representatives and president of the senate and the members of the health disparities council, established under section 16O of chapter 6A, before July 1 of each year and shall be posted on the official internet site of the office or executive office of health and human services. SECTION 8. Section 16K of Chapter 6A of the General Laws, as so appearing, is hereby amended by striking out, in subsection (h), as amended by section 3 of chapter 288 of the acts of 2010, the third sentence and inserting in place thereof the following sentence:- The council shall also establish goals that are intended to reduce health care disparities in racial, ethnic and disabled communities and in doing so shall seek to incorporate the recommendations of the health disparities council and the office of health equity.

Amendment #218

Mr. Sanchez of Boston and Mr. Rushing of Boston move to amend the bill (H.4127) by inserting the following new section:- SECTION XX. Chapter 111N of the General Laws is hereby amended by adding the following section:– Section 7. (a) The office shall, subject to appropriation, administer a community-based agency disparities reduction grant program. The grants shall support efforts by community-based agencies to eliminate racial and ethnic health disparities among predominantly underserved populations, including efforts addressing social factors integral to such disparities. Grants shall be awarded following a competitive application process. In awarding grants, the office shall give priority to programs replicable by other community-based agencies. Grants shall be provided to a broad range of agencies that support diverse communities throughout the state. No community-based agency may receive more than one grant concurrently. All grants shall include an evaluation component. (b) The program shall provide grants to community-based agencies and non-profit community organizations to address key disparities issues including but not limited to: the social and economic barriers that impact health outcomes, the development of a diverse healthcare workforce across wide range of healthcare professions, increasing the access, utilization and quality of healthcare services, and supporting community health workers to facilitate the use of health and human services (c) For the purposes of this section, a “community-based agency” shall include agencies that provide direct services, education, or support to underserved populations, including community health centers and hospitals, social service organizations, community nonprofit organizations, educational institutions, faith based organizations and other non-governmental agencies and other organizations as defined by the office.

Amendment #219

Mr. Sanchez of Boston, Mr. Rushing of Boston, and Mr. Smizik of Brookline move to amend the bill (House, No. 4127), in section 121, by inserting in line 1544, after the word “factors.”, the following paragraph: “(e) Any alternative payment methodology shall include the use of payment incentives that improve quality and care coordination, including, but not limited to, incentives to reduce avoidable hospitalizations, avoidable readmissions, adverse events

and unnecessary emergency room visits; incentives to reduce racial, ethnic and linguistic health disparities in the patient population; and in all cases ensuring that alternative payment methodologies do not create any incentive to deny or limit medically necessary care, especially for patients with high risk factors or multiple health conditions."

Amendment #220

Mr. Sanchez of Boston, Mr. Rushing of Boston and Mr. Smizik of Brookline move to amend the bill (House, No. 4127) in section 121, in proposed subsection (a) of proposed section 51 of chapter 118G of the General Laws, by striking clause (iii) and inserting in place thereof the following clause: (iii) Establish procedures for payers to disclose patient-level data including, but not limited to, health care service utilization; medical expenses; demographics, including, if available, patient race, ethnicity and preferred language; and where services are being provided, to all providers in their network, provided that data shall be limited to patients treated by that provider, so as to aid providers in managing the care of their own patient panel; and by inserting in line 2235 after the words "Ambulatory Care Experiences Survey.", the following sentence:-- "The Committee shall determine the measures in the Standard Quality Measure Set for which it is appropriate for payers to stratify collected data by patient race, ethnicity and preferred language in order to identify disparities in care."

Amendment #221

Mr. Sanchez of Boston moves to amend the bill (House, No. 4127), in section 121, by inserting in line 2235 after the words "Ambulatory Care Experiences Survey.", the following sentences:-- " The Standard Quality Measure Set shall include outcome measures. The Committee shall review additional appropriate outcome measures as they are developed."

Amendment #222

Mr. Finn of West Springfield moves to amend the bill (House, No 4127) in section 121 by striking out proposed subsections (a) and (d) of section 49 of chapter 118 of the General Laws and inserting in place thereof the following 4 subsections:- Section 49. (a) Every provider shall be subject to market impact review by the division, provided, however, that contracting units of fewer than 10 physicians shall not be subject to such review. The division shall establish, by regulation, rules for conducting market impact reviews. Such rules shall define primary service areas and dispersed service areas based on the geographic capacity of major service categories. The division shall conduct a market impact review for a provider when the division determines that market impact review is in the public interest. The division shall conduct a market impact review for any provider whose market concentration in primary or dispersed service areas exceeds the antitrust safety zone as set forth in Federal Trade Commission and Department of Justice Antitrust Division in the final policy statement of antitrust enforcement policy regarding ACOs participating in the Medicare shared savings program, 42 CFR 425. The division shall initiate a market impact review by sending such provider a notice of a market impact review which shall detail the particular factors that it seeks to examine through the review. (b) A market impact review may examine factors including, but not limited to: (1) the provider's size and market share by major service category within its primary service areas and dispersed service areas; (2) provider price, including its relative prices filed with the division of insurance pursuant to chapter 176S; (3) provider quality, including patient experience; (4) the availability and accessibility of services similar to those provided, or proposed to be provided, through the organization within its primary service areas and dispersed service areas; (5) the provider's impact on competing options for the delivery of health care services within its primary service areas and dispersed service areas; including if not applicable , the impact on existing service providers of a provider organization's expansion, affiliation, merger or acquisition, to enter a primary or dispersed service area in which it did not previously operate; (6) the methods used by the organization to attract patient volume and to recruit or acquire health care professionals or facilities; (7) the role of the provider in serving at-risk, underserved and government payer patient populations within its primary service areas and dispersed service areas; (8) the role of the provider in providing low margin or negative margin services within its primary service areas and dispersed service areas; (9) the financial solvency of the provider; (10) consumer concerns, including but not limited to complaints or other allegations that the provider has engaged in any unfair method of competition or any unfair or deceptive act or practice; and (11)

any other factors that the division determines to be in the public interest. (c) The department of public health shall submit information to the division regarding any proposed projects, mergers or acquisitions that will result in a substantial capital expenditure or substantial change in services under determination of need with respect to a provider. (d) If, after completing a market impact review, the division determines that a substantial capital expenditure or substantial change in services has resulted or would result in any unfair method of competition, any unfair or deceptive act or practice, as defined in chapter 93A, or determines that a proposed project, merger or acquisition will result in a material change under determination of need that would result in any unfair method of competition, or any unfair or deceptive act or practice, the division shall refer its findings, together with any supporting documents, data or information to the attorney general for further review and action. The division shall require the provider organization to submit, within 60 days, to the division and the attorney general, a written response to the division's findings.

Amendment #222, changed

Mr. Finn of West Springfield moves to amend the bill (House, No 4127) in section 121, line 1764, by striking out proposed subsections (b) of section 49 of chapter 118 of the General Laws and inserting in place thereof the following subsection:-

(b) A market impact review may examine factors including, but not limited to: (1) the provider's size and market share by major service category within its primary service areas and dispersed service areas; (2) provider price, including its relative prices filed with the division of insurance pursuant to chapter 176S; (3) the provider's impact on competing options for the delivery of health care services within its primary service areas and dispersed service areas; including if not applicable , the impact on existing service providers of a provider organization's expansion, affiliation, merger or acquisition, to enter a primary or dispersed service area in which it did not previously operate; (4) the methods used by the organization to attract patient volume and to recruit or acquire health care professionals or facilities; (5) the role of the provider in serving at-risk, underserved and government payer patient populations within its primary service areas and dispersed service areas; (6) the financial solvency of the provider; and (7) consumer concerns, including but not limited to complaints or other allegations that the provider has engaged in any unfair method of competition or any unfair or deceptive act or practice.

Amendment #223

Mr. Sanchez of Boston moves to amend the bill (H.4127) by inserting the following new sections: SECTION XX. Section 18 of chapter 15A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by adding to the end of the first paragraph, in line 12, the following words:- , including the commonwealth care health insurance program under chapter 176Q. SECTION XX. Section 1 of chapter 111M of the General Laws, as so appearing, is hereby amended by striking out the words "and (l)", in line 21, and inserting in place thereof the following words:- (l) the commonwealth care health insurance program under chapter 176Q for such health care enrollees who are enrolled in a post-secondary program and qualify for a student health insurance program, under section 18 of chapter 15A, if such students were enrolled in the commonwealth care health insurance program on or before the first day of such full-time, post-secondary program; and (m). SECTION XX. Section 3 of chapter 118H of the General Laws, as so appearing, is hereby amended by inserting after subsection (b) the following subsection:- (c) An individual eligible to participate in the program under subsection (a) on or before the first day of a full-time, post-secondary program shall be allowed to continue on the program even when qualifying for a student health insurance program, required by section 18 of chapter 15A, if they so choose.

Amendment #224

Representatives Hogan of Stow, Smizik of Brookline, McMurtry of Dedham, and Levy of Marlborough move to amend the bill by adding the following section: "SECTION X: Section 28 of Chapter 118E of the General Laws is hereby amended by inserting at the end thereof the following sections: In accordance with P.L. 109-171 amending Section 1917(c)(2)(D) of the Social Security Act, the division shall establish criteria and procedures for determining whether undue hardship exists as a result of the imposition of a period of ineligibility, which shall include written notice to said

individual that an undue hardship waiver shall be granted and an opportunity to appeal. An individual shall have no fewer than 30 days after the date of the final decision including court appeals to impose a period of ineligibility to request an undue hardship waiver. There shall be a rebuttable presumption that an institutionalized individual is eligible for an undue hardship waiver if the individual provides documentation that all of the following criteria are met: 1) the individual has insufficient available resources (excluding the community spouse resource allowance) to provide medical care, food, shelter, clothing and other necessities of life such that the individual would be at risk of serious deprivation or harm; 2) the individual has made reasonable attempts to retrieve the transferred resources or receives adequate compensation. Reasonable attempts shall not include the filing of frivolous lawsuits; 3) there is no available lest costly alternative to institutional care that would meet the individual's care needs; and 4) the period of ineligibility will not be a mere inconvenience to the applicant but rather will create a situation that would subject the applicant to risk of serious deprivation. A nursing facility does not have to express an intent to discharge the individual for nonpayment in order for a hardship waiver to be granted. The division shall promulgate regulations incorporating these criteria for consideration of an undue hardship waiver request."

Amendment #225

Mr. Sanchez of Boston moves to amend the bill by inserting the following 2 sections:- "SECTION 202. Chapter 175 of the General Laws is hereby amended by inserting after section 47AA, the following section: Section 47BB. For the purposes of this section, "telemedicine" as it pertains to the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. "Telemedicine" shall not include the use of audio-only telephone, facsimile machine or e-mail. An insurer may limit coverage of telemedicine services to those health care providers in a telemedicine network approved by the insurer. A contract that provides coverage for services under this section may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation. Coverage for health care services under this section shall be consistent with coverage for health care services provided through in-person consultation." SECTION 203. The requirements of section 47BB of chapter 175 of the General Laws shall apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed on or after January 1, 2013. For purposes of that section, all contracts shall be deemed to be renewed not later than the next yearly anniversary of the contract date."

Amendment #226

Mr. Conroy of Wayland moves to amend the bill in SECTION 121 by inserting, in line 1625, after "2012" the following sentence: "The statewide medical spend benchmark shall not be used by any party in any other setting, including but not limited to any proceeding arising out of the review by the division of insurance of any carrier's insured rates, which are and shall be subject to disapproval if excessive, discriminatory, or unreasonable in relation to the benefits provided."

Amendment #227

Mr. Sanchez of Boston moves to amend the bill (House, No. 4127) by inserting the following new section: SECTION XX. Chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after section 224 the following section:-
Section 225. (1) The department shall implement a provider vaccine brand choice program as part of the commonwealth's universal immunization program pursuant to section 24I of chapter 111; the the vaccines for children program operated by the department under the authority of 42 U.S.C. §1396s; and in any other existing or future immunization program for children or adults administered through the state using local, state or federal funds. The vaccine brand choice program shall allow all healthcare providers participating in the state's immunization programs to select any vaccine licensed by the federal Food and Drug Administration, including any combination vaccine and dosage form, that is (A) recommended by the National Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, and (B) made available to the Department of Public Health by the National

Centers for Disease Control and Prevention. (2) This section shall not apply in the event of a disaster or public health emergency, terrorist attack, hostile military or paramilitary action, or extraordinary law enforcement emergency. The Department of Public Health shall implement all or part of the provider choice system as soon as it is determined to be feasible, provided, however, that the department shall complete full implementation of the system not later than July 1, 2013.

Amendment #228

Mr. Sanchez of Boston moves to amend the bill (House, No. 4127) in section 66, by striking out, in line 521, the words “new section” and inserting in place thereof the following words:- “2 new sections”; and by further amending section 66 by adding at the end thereof the following:- Section 51J. As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:- “Adverse Event”, injury to a patient resulting from a medical intervention, and not to the underlying condition of the patient. “Checklist of Care”, pre-determined steps to be followed by a team of healthcare providers before, during, and after a given procedure to decrease the possibility of patient harm by standardizing care. “Facility,” a hospital, institution maintaining an Intensive Care Unit, institution providing surgical services, or clinic providing ambulatory surgery. The department shall encourage the development and implementation of checklists of care that prevent adverse events and reduce healthcare-associated infection rates. The department shall develop model checklists of care, which may be implemented by facilities; provided however, facilities may develop and implement checklists independently. Facilities shall report data and information relative to their use or non-use of checklists to the department and the Betsy Lehman Center for Patient Safety and Medical Error Reduction. Reports shall be made in the manner and form established by the department.

Amendment #229

Mr. Sanchez of Boston moves to amend the bill by (House, No. 4127) by inserting the following 2 new sections:- SECTION XX. Subsection (a) of section 51H of chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after the definition of “Healthcare-associated infection” the following definition:- “Multi-drug resistant organism”, microorganisms, predominantly bacteria, that have developed resistance to antimicrobial drugs. SECTION XX. Section 51H of chapter 111, as so appearing, is hereby amended by adding at the end thereof the following subsection:– (e) The department shall encourage the development and implementation of screening and precautionary procedures that reduce infection rates for multidrug-resistant organisms (MDRO), including but not limited to Methicillin-Resistant Staphylococcus Aureus (MRSA), vancomycin-resistant enterococci (VRE), and certain gram-negative bacilli (GNB). The department shall develop model MDRO screening and precautionary procedures for high-risk patients, as defined by the department, which may be implemented by facilities; provided however, that facilities may develop and implement MDRO screening and precautionary procedures independently. The department definition of high-risk patients may include the following: (i) the patient has documented medical conditions making them more susceptible to infection and is scheduled for an inpatient surgery. (ii) the patient has been documented as having been previously discharged from a general acute hospital within the past 30 days prior to the current hospital admission. (iii) the patient is being admitted to either an intensive care unit or a burn unit at the healthcare facility. (iv) the patient receives inpatient dialysis treatment. (v) the patient is being transferred from a nursing facility. Facilities shall report on their use or non-use of MDRO screening and precautionary procedures to the department and the Betsy Lehman Center for Patient Safety and Medical Error Reduction. Reports shall be made in the manner and form established by the department.

Amendment #230

Mr. Sanchez of Boston moves to amend the bill (House, No. 4127) by adding the following section:- SECTION XX. Section 5 of Chapter 112 of the General Laws is hereby amended by striking out paragraphs 6 through 8, inclusive, and inserting in place thereof the following four paragraphs: - The board shall collect the following information reported to it to create individual profiles on licensees and former licensees, in a format created by the board that shall be available for dissemination to the public: (a) a description of any criminal convictions for felonies and serious

misdemeanors as determined by the board. For the purposes of this subsection, a person shall be deemed to be convicted of a crime if he pleaded guilty or if he was found or adjudged guilty by a court of competent jurisdiction; (b) a description of any charges for felonies and serious misdemeanors as determined by the board to which a physician pleads nolo contendere or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction; (c) a description of any final board disciplinary actions; (d) a description of any final disciplinary actions by licensing boards in other states; (e) a description of revocation or involuntary restriction of privileges by a hospital, clinic or nursing home under the provisions of chapter 111, or of any employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth, for reasons related to competence or character that have been taken by the governing body or any other official of the hospital, clinic or nursing home or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth after procedural due process has been afforded, or the resignation from or nonrenewal of medical staff membership or the restriction of privileges at a hospital, clinic or nursing home or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth taken in lieu of or in settlement of a pending disciplinary case related to competence or character in that hospital, clinic or nursing home or of any employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth ; (f) all medical malpractice court judgments and all medical malpractice arbitration awards in which a payment is awarded to a complaining party and all settlements of medical malpractice claims in which a payment is made to a complaining party. Dispositions of paid claims shall be reported in a minimum of three graduated categories indicating the level of significance of the award or settlement. Information concerning paid medical malpractice claims shall be put in context by comparing an individual licensee's medical malpractice judgment awards and settlements to the experience of other physicians within the same specialty. Information concerning all settlements shall be accompanied by the following statement: "Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred." Nothing herein shall be construed to limit or prevent the board from providing further explanatory information regarding the significance of categories in which settlements are reported. Pending malpractice claims shall not be disclosed by the board to the public. Nothing herein shall be construed to prevent the board from investigating and disciplining a licensee on the basis of medical malpractice claims that are pending. (g) names of medical schools and dates of graduation; (h) graduate medical education; (i) specialty board certification; (j) number of years in practice; (k) names of the hospitals where the licensee has privileges; (l) appointments to medical school faculties and indication as to whether a licensee has a responsibility for graduate medical education within the most recent ten years; (m) information regarding publications in peer-reviewed medical literature within the most recent ten years; (n) information regarding professional or community service activities and awards; (o) the location of the licensee's primary practice setting; (p) the identification of any translating services that may be available at the licensee's primary practice location; (q) an indication of whether the licensee participates in the medicaid program. The board shall provide individual licensees with a copy of their profiles prior to release to the public. A licensee shall be provided a reasonable time to correct factual inaccuracies that appear in such profile A physician may elect to have his profile omit certain information provided pursuant to clauses (l) to (n), inclusive, concerning academic appointments and teaching responsibilities, publication in peer-reviewed journals and professional and community service awards. In collecting information for such profiles and in disseminating the same, the board shall inform physicians that they may choose not to provide such information required pursuant to said clause (l) to (n), inclusive. For physicians who are no longer licensed by the board, the board shall continue to make available the profiles of such physicians, except for those who are known by the board to be deceased. The board shall maintain the information contained in the profiles of physicians no longer licensed by the board as of the date the physician was last licensed, and include on the profile a notice that the information is current only to that date.

Amendment #231

Mr. Sanchez of Boston moves to amend the bill (House, No. 4127), in Section 17, by inserting in line 177 after the word "medical" the following words:- "physician assistant"; and further, in section 121, in proposed subsection (a) of

proposed section 60 of chapter 118G of the General Laws by inserting, in line 2097, after the words “are graduates of medical”, the following words:- “physician assistant”.

Amendment #232

Mr. Sanchez of Boston moves to amend the bill (House, No. 4127) by inserting the following new sections:-
SECTION XX. Section 2 of chapter 32A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after paragraph (h) the following paragraph:- (h 1/2) “Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 22 of said chapter 32A, as so appearing, is hereby amended by striking out, in line 36, the word “physician” and inserting in place thereof the following word:- provider.
SECTION XX. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Net value of policies” the following definition:- “Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 47B of said chapter 175, as so appearing, is hereby amended by striking out, in line 46, the word “physician” and inserting in place thereof the following word:- provider.
SECTION XX. Section 8A of chapter 176A of the General Laws, as so appearing, is hereby amended by striking out, in line 41, the word “physician” and inserting in place thereof the following word:- provider.
SECTION XX. Subsection (c) of said section 8A of chapter 176A, as so appearing, is hereby amended by adding the following paragraph:- For the purposes of this subsection, the term “primary care provider” shall mean a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 1 of chapter 176B of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Participating optometrist” the following definition:- “Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 4A of said chapter 176B, as so appearing, is hereby amended by striking out, in line 43, the word “physician” and inserting in place thereof the following word:- provider.
SECTION XX. Section 1 of chapter 176G of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Person” the following definition:- “Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 4M of said chapter 176G, as so appearing, is hereby amended by striking out, in line 40, the word “physician” and inserting in place thereof the following word:- provider.

Amendment #233

Mr. Sanchez of Boston moves to amend the bill (House, No. 4127) by adding the following new sections:-
SECTION XX. Section 8 of chapter 118E of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after paragraph (e). the following paragraph:- (e1/2). “Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 17A of said chapter 118E, as so appearing, is hereby amended by striking out, in lines 60 and 62, the word “physician” and inserting in place thereof the following word in each instance:- provider.
SECTION XX. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby amended by inserting after

the definition of “Net value of policies” the following definition:- “Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 47U of said chapter 175, as so appearing, is hereby amended by striking out, in lines 62 and 64, the word “physician” and inserting in place thereof the following word in each instance:- provider.
SECTION XX. Paragraph (a) of section 8U of chapter 176A, as so appearing, is hereby amended by inserting after the definition of “Insured” the following definition:- “Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 8U of said chapter 176A, as so appearing, is hereby amended by striking out, in lines 64 and 66, the word “physician” and inserting in place thereof the following word in each instance:- provider.
SECTION XX. Section 1 of chapter 176B of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Participating optometrist” the following definition:- “Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 4U of said chapter 176B, as so appearing, is hereby amended by striking out, in lines 64 and 66, the word “physician” and inserting in place thereof the following word in each instance:- provider.
SECTION XX. Section 1 of chapter 176G of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Person” the following definition:- “Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 5 of said chapter 176G, as so appearing, is hereby amended by striking out, in lines 59 and 61, the word “physician” and inserting in place thereof the following word in each instance:- provider.
SECTION XX. Section 20 of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 19 and 22, the words “care physician” and inserting in place thereof the following words in each instance:- care provider.

Amendment #233, changed

Rep. Sanchez of Boston moves to amend the bill (House, No. 4127) by adding the following new sections:-
SECTION XX. Section 8 of chapter 118E of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after paragraph (e). the following paragraph:-
(e1/2). “Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 17A of said chapter 118E, as so appearing, is hereby amended by striking out, in lines 60 and 62, the word “physician” and inserting in place thereof the following word in each instance:- provider.
SECTION XX. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Net value of policies” the following definition:-
“Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 47U of said chapter 175, as so appearing, is hereby amended by striking out, in lines 62 and 64, the word “physician” and inserting in place thereof the following word in each instance:- provider.
SECTION XX. Paragraph (a) of section 8U of chapter 176A, as so appearing, is hereby amended by inserting after the definition of “Insured” the following definition:-
“Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 8U of said chapter 176A, as so appearing, is hereby amended by striking out, in lines 64 and

66, the word “physician” and inserting in place thereof the following word in each instance:- provider.
SECTION XX. Section 1 of chapter 176B of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Participating optometrist” the following definition:-
“Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 4U of said chapter 176B, as so appearing, is hereby amended by striking out, in lines 64 and 66, the word “physician” and inserting in place thereof the following word in each instance:- provider.
SECTION XX. Section 1 of chapter 176G of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Person” the following definition:-
“Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 5 of said chapter 176G, as so appearing, is hereby amended by striking out, in lines 59 and 61, the word “physician” and inserting in place thereof the following word in each instance:- provider.
SECTION XX. Section 1 of Chapter 176O, as so appearing, he hereby amended by inserting after the definition of “Person” the following definition:-
“Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 20 of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 19 and 22, the words “care physician” and inserting in place thereof the following words in each instance:- “care provider”

Amendment #234

Mr. Sanchez of Boston moves to amend the bill (House, No. 4127) by inserting the following new sections:-
SECTION XX. Section 1 of chapter 111 of the General Laws, as appearing in the 2010 official edition, is hereby amended by inserting after the definition of “Nuclear reactor” the following definition:- “Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.
SECTION XX. Section 67F of said chapter 111, as so appearing, is hereby amended by striking out, in lines 15 and 19, the word “physician” and inserting in place thereof the following word in each instance:- provider.

Amendment #235

Mr. Sanchez of Boston moves to amend the bill (House, No. 4127), in section 169, in proposed section 15 of Chapter 176O, by striking out subsection (d) and inserting in place thereof the following subsection:- (d) A carrier shall provide coverage for health services for up to 30 days from the effective date of coverage to a new insured by a provider who is not a participating provider in the carrier's network if: (1) the insured's employer only offers the insured a choice of carriers in which said provider is not a participating provider, and (2) said provider is providing the insured with an ongoing course of treatment or is the insured's primary care provider. With respect to an insured in her second or third trimester of pregnancy, this provision shall apply to services rendered through the first postpartum visit. With respect to an insured with a terminal illness, this provision shall apply to services rendered until death.

Amendment #236

Mr. Sanchez of Boston moves to amend the bill (House, No. 4127) by inserting, in line 2577, after the words “extension center,” the following sentence:- “And provided further that the Massachusetts Health Information Technology Fund shall make available to the Boston Visiting Nurses Association, in fiscal year 2013, $1,000,000 for the purpose of enhancing their electronic health records system and provided further that the Boston Visiting Nurse Association shall provide $2,000,000 in matching funds for said purpose over the life of the project.”

Amendment #237

Mr. Sanchez of Boston moves to amend the bill (House, No. 4127) by adding the following new section:- SECTION XX. Section 7 of chapter 176O of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 48, the word “physician” and inserting in place thereof the following word:- provider.

Amendment #238

Mr. Sanchez of Boston moves to amend the bill (H. 4127) in Section 12 by striking out, in lines 136 to 138, subsection (b) in its entirety and inserting in place thereof the following words:- “(b) The attorney general shall, in consultation with the division of health care cost and quality, take appropriate action within existing statutory authority to: (i) prevent excess consolidation or collusion of provider organizations and to remedy these or other related anti-competitive dynamics in the health care market; (ii) prevent unreasonable increases in health care rates, charges, medical expenses or prices; and (iii) prevent or mitigate adverse effects on patient access and quality in the health care market.”

Amendment #239

Representatives Hogan of Stow and Benson of Lunenburg move to amend the bill in Section 124, after line 2920, by inserting the following section: “Section X: Provided further that, in order to be eligible to apply for Medicare certification and to bill MassHealth for home health services, any new applicant seeking to provide home health services must submit to a Certificate of Need (CON) review established by the Massachusetts Department of Public Health and assessed by an independent board appointed by the Governor, General Court, the Secretary of Health and Human Services, and the Home Care Alliance of Massachusetts. To obtain a CON, an application must be filed with said independent board in which the applicant demonstrates the need for or prove the cost efficiency of a new agency. The applicant must present to the department and board both evidence of unmet need and how the proposed agency would fit into the comprehensive health care delivery system of the service area. This application requirement shall not apply to Medicare-certified home health agencies providing care as of July 1, 2012.”

Amendment #240

Mr. Conroy of Wayland moves to amend the bill in SECTION 121 by striking, in line 2185, the words “commissioner of insurance” and inserting in place thereof the word “division.”

Amendment #241

Ms. Khan of Newton moves to amend the bill H. 4127, in section 123, by inserting in line 2711 at the end of the paragraph and following the period, the following: “In addition, the division shall advance the dissemination of innovative technologies, including, but not limited to, those technologies that would allow diagnostic imaging exams to be seamlessly processed and transferred electronically through means that may include, but shall not be limited to, cloud-based technologies.”

Amendment #242

Representative Garballey of Arlington moves to amend the bill in SECTION 156 by adding after the words "Blue Cross Blue Shield of Massachusetts" the words "and the Massachusetts AFL-CIO."

Amendment #243

Mr. Garballey of Arlington moves to amend the bill by adding the following section: -
"SECTION XX. Section 23 of chapter 32A of the General Laws, as appearing in the 2000 Official Edition, is hereby amended by adding the following paragraph:- The commission shall provide to any minor 21 years of age or younger who is the child of an active or retired employee of the commonwealth and who is insured under the group insurance commission coverage for the full cost of one (1) hearing aid per hearing-impaired ear up to two thousand dollars ($2,000) for each hearing aid, as defined in section 196 of chapter 112, every 36 months upon a written statement from such minor's treating physician that the hearing aids are medically necessary. Coverage under this section shall include all related services prescribed by a licensed audiologist or hearing instrument specialist, as defined in that section, including the initial hearing aid evaluation, fitting and adjustments, and supplies, including ear molds. The insured may choose a higher priced hearing aid and may pay the difference in cost above the two thousand dollar ($2,000) limit as provided in this section without any financial or contractual penalty to the insured or to the provider of the hearing aid. The benefits in this section shall not be subject to any greater deductible, coinsurance, copayments or out-of-pocket limits than any other benefits provided by the insurer. Nothing in this section shall prohibit the commission from offering greater coverage for hearing aids than that required by this section. This section shall also require coverage for such hearing aids under any non-group policy.
SECTION 2. Section 47U of chapter 175 of the General Laws, as so appearing, is hereby amended by adding the following paragraph:- Any policy of accident and sickness insurance as described in section 108 which provides hospital expense and surgical expense insurance and which is delivered, issued or subsequently renewed by agreement between the insurer and policyholder in the commonwealth; any blanket or general policy of insurance described in subdivision (A), (C) or (D) of section 110 which provides hospital expense and surgical expense insurance and which is delivered, issued or subsequently renewed by agreement between the insurer and the policyholder, within or without the commonwealth; or any employees' health and welfare fund which provides hospital expense and surgical expense benefits and which is delivered, issued or renewed to any person or group of persons in the commonwealth, shall provide coverage for any minor child 21 years of age or younger, who is insured under the policy or fund, for the full cost of one (1) hearing aid per hearing impaired ear up to two thousand dollars ($2,000) for each hearing aid, as defined under section 196 of chapter 112, every 36 months upon a written statement from such minor's treating physician that the hearing aids are medically necessary. Coverage under this section shall include all related services prescribed by a licensed audiologist or hearing instrument specialist, as defined in that section, including the initial hearing aid evaluation, fitting and adjustments, and supplies, including ear molds. The insured may choose a higher priced hearing aid and may pay the difference in cost above the two thousand dollar ($2,000) limit as provided in this section without any financial or contractual penalty to the insured or to the provider of the hearing aid. The benefits in this section shall not be subject to any greater deductible, coinsurance, copayments or out-of-pocket limits than any other benefits provided by the insurer. Nothing in this section shall prohibit an insurer from offering greater coverage for hearing aids than that required by this section. This section shall also require coverage for such hearing aids under any non-group policy.
SECTION 3. Section 8U of chapter 176A of the General Laws, as so appearing, is hereby amended by adding the following paragraph:- Any contracts, except contracts providing supplemental coverage to Medicare or other governmental programs, between a subscriber and the corporation under an individual or group hospital service plan which is delivered, issued or renewed in the commonwealth shall provide as benefits to all individual subscribers or members within the commonwealth and to all group members having a principal place of employment within the commonwealth, coverage for their minor children 21 years of age or younger, who are insured under such contracts or plans, for the full cost of one (1) hearing aid per hearing impaired ear up to two thousand dollars ($2,000) for each hearing aid, as defined under section 196 of chapter 112, every 36 months upon a written statement from such minor's treating physician that the hearing aids are medically necessary. Coverage under this section shall include all related services prescribed by a licensed audiologist or hearing instrument specialist, as defined in that section, including the initial hearing aid evaluation, fitting and adjustments, and supplies, including ear molds. The insured may choose a higher priced hearing aid and may pay the difference in cost above the two thousand dollar ($2,000) limit as provided in this section without any financial or contractual penalty to the insured or to the provider of the hearing aid. The benefits in this section shall not be subject to any greater deductible, coinsurance, copayments or out-of-pocket limits than any other benefits provided by the insurer. Nothing in this section shall prohibit a corporation from offering greater coverage for hearing aids than that required by this section. This section shall also require

coverage for such hearing aids under any non-group policy.
SECTION 4. Section 4U of chapter 176B of the General Laws, as so appearing, is hereby amended by adding the following paragraph:- Any subscription certificate under an individual or group medical service agreement, except certificates which provide supplemental coverage to Medicare or other governmental programs, that shall be delivered, issued or renewed within the commonwealth shall provide as benefits to all individual subscribers or members within the commonwealth and to all group members having a principal place of employment in the commonwealth, coverage for their minor children 21 years of age or younger, who are insured under such certificates or agreements, for the full cost of one (1) hearing aid per hearing impaired ear up to two thousand dollars ($2,000) for each hearing aid, as defined under section 196 of chapter 112, every 36 months upon a written statement from such minor's treating physician that the hearing aids are medically necessary. Coverage under this section shall include all related services prescribed by a licensed audiologist or hearing instrument specialist, as defined in that section, including the initial hearing aid evaluation, fitting and adjustments, and supplies, including ear molds. The insured may choose a higher priced hearing aid and may pay the difference in cost above the two thousand dollar ($2,000) limit as provided in this section without any financial or contractual penalty to the insured or to the provider of the hearing aid. The benefits in this section shall not be subject to any greater deductible, coinsurance, copayments or out-of-pocket limits than any other benefits provided by the insurer. Nothing in this section shall prohibit an insurer from offering greater coverage for hearing aids than that required by this section. This section shall also require coverage for such hearing aids under any non-group policy.
SECTION 5. The first section 4N of chapter 176G of the General Laws, as so appearing, is hereby amended by adding the following paragraph:- An individual or group health maintenance contract, except contracts providing supplemental coverage to Medicare or other governmental programs, shall provide coverage and benefits forminors 21 years of age or younger, who are insured under such contracts, for expenses incurred for the full cost of one (1) hearing aid per hearing impaired ear up to two thousand dollars ($2,000) for each hearing aid, as defined under section 196 of chapter 112, every 36 months upon a written statement from such minor's treating physician that the hearing aids are medically necessary. Coverage under this section shall include all related services prescribed by a licensed audiologist or hearing instrument specialist, as defined in that section, including the initial hearing aid evaluation, fitting and adjustments, and supplies, including ear molds. The insured may choose a higher priced hearing aid and may pay the difference in cost above the two thousand dollar ($2,000) limit as provided in this section without any financial or contractual penalty to the insured or to the provider of the hearing aid. The benefits in this section shall not be subject to any greater deductible, coinsurance, copayments or out-of-pocket limits than any other benefits provided by the insurer. Nothing in this section shall prohibit an insurer from offering greater coverage for hearing aids than that required by this section. This section shall also require coverage for such hearing aids under any non-group policy."

Amendment #244

Representative Garballey of Arlington moves to amend the bill in SECTION 162 Section 2A(a) by adding after the words "and a representative of the department of public health" in line 3298 the words "and a representative of a labor organization selected from a list of 3 names submitted by the President the Massachusetts AFL-CIO."

Amendment #245

Representative Garballey of Arlington moves to amend the bill in SECTION 162 Section 2B(f) by adding after the words "and a representative of the department of public health" in line 3376 the words "and a representative of a labor organization selected from a list of three names submitted by the President the Massachusetts AFL-CIO."

Amendment #246

Representative Garballey of Arlington moves to amend the bill in SECTION 121 Section 65 by striking "6" in line 2211 and replacing with "7" and adding after the words "and 1 representative from a health care consumer group" the words "and 1 of whom shall be a member of a labor organization selected from a list of 3 names submitted by the President of the Massachusetts AFL-CIO."

Amendment #247

Mr. Garballey of Arlington moves to amend the bill in Section 123, line 2396, by striking the number “19” and replacing it with the following number:- “20”; and further, in Section 29, line 2406, by inserting after the words “small physician group practice;” the following:- “1 shall be a non-physician health care provider from an independent practice;”

Amendment #248

Mr. Garballey of Arlington moves to amend the bill by adding the following section: - “SECTION XX. Chapter 175 of the General Laws is hereby amended by inserting after section 47Z the following section:- Section 47AA. Any individual policy of accident and sickness insurance issued pursuant to section 108 and any group blanket policy of accident and sickness insurance issued pursuant to section 110 shall provide coverage and reimbursement for prescription amino acid-based elemental formulas, regardless of delivery method, for the diagnosis and treatment of (i) eosinophilic gastrointestinal disorders and (ii) short bowel syndrome when the prescribing physician has issued a written order stating that the amino acid-based elemental formula is medically necessary.”

Amendment #249

MR. ATSALIS of WEST HYANNISPORT moves to amend the bill (House 4127) by adding the following section: "SECTION XX. “Notwithstanding the provisions of any general or special law or regulation to the contrary, the provisions of Section 25E ½ of Chapter 111 of the General Laws, as proposed to be added by SECTION 55, shall not apply to the review of an application for a determination of need that is filed with the department of public health under any applicable provision of Chapter 111 of the General Laws on or before the later of (a) December 31, 2013, or (b) the date on which said department submits for the first time a state health plan in accordance with Section 25E ½ of Chapter 111 of the General Laws, as proposed to be amended by SECTION 55."

Amendment #250

MR. ATSALIS of WEST HYANNISPORT moves to amend House Bill 4127 by removing the definition of “Sole community provider” that starts at line 1158 and replacing it with the following paragraph: “Sole community provider”, any acute hospital which qualifies as a sole community provider under Medicare regulations or under regulations promulgated by the executive office, which regulations shall consider factors including, but not limited to, 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; provided, that such hospitals shall include those which are located more than 20 miles driving distance from other such hospitals in the commonwealth and which provide services for at least 60 per cent of their primary service area.

Amendment #251

Mr. Walsh of Lynn moves to amend the bill, H 4127, in section 97, line 1051 by inserting after the word “year” the following words:- “as further defined by the division in regulation” Further moves to amend in section 120, line 1447 by striking the word “and” and inserting in place thereof the following word:- “or” Further moves to amend in section 121, line 1619, by inserting after the word “statewide” the following words:- “per capita”; Further moves to amend in section 121, line 1620, by inserting after the word “statewide” the following words:- “per capita”; Further moves to amend in section 121, line 1623, by inserting after the word “statewide” the following words:- “per capita”; Further moves to amend in section 121, line 1627, by inserting before the word “potential” the following word:- “projected”; Further moves to amend in section 121, line 1629, by inserting before the word “potential” the following word:- “projected”; Further moves to amend in section 121, line 1635, by inserting after the word “regional” the following words:- “per capita”; Further moves to amend in section 121, line 1638, by inserting at the end the following sentence:- “The total of the regional per capita medical spend benchmark, in all years, shall equal the statewide per

capita medical spend benchmark calculated pursuant to section (b).” Further moves to amend in section 121, line 1646, by inserting after the word “regional” the following words:- “per capita”; Further moves to amend in section 121, line 1649, by inserting after the word “regional” the following words:- “per capita”; Further moves to amend in section 121, line 1664, by inserting after the word “regional” the following words:- “per capita”; Further moves to amend in section 121, line 1818 by inserting after the words “division shall” the following words:- “annually report on or” Further moves to amend in section 121, line 1820 by inserting after the word “The” the following words:- “report or” Further moves to amend in section 121, line 1923 by striking out the words “, subject to chapter 30B,” Further moves to amend in section 121, line 1938 by striking the word “council” and inserting in place thereof the following word:- “division” Further moves to amend in section 121, line 1942 by striking the word “council” and inserting in place thereof the following word:- “division” Further moves to amend in section 121, line 1943 by striking the word “council” and inserting in place thereof the following word:- “division” Further moves to amend in section 121, line 2185, by striking out the words “commissioner of insurance” and inserting place thereof the following word:- “division”; Further moves to amend in section 123, lines 2437-2438 by striking the words “the MassHealth electronic health records incentive program; and” and inserting in place thereof the following words:-“fulfill its current and any future contract obligations with the Office of Medicaid to administer specific operational components of the MassHealth electronic health records incentive program; and” Further moves to amend in section 123, line 2575 by striking the word “contact” and inserting in place thereof the following word:- “contract” Further moves to amend in section 130, line 2944 by striking out the words “division of health care cost and quality” and inserting in place thereof the following:- “authority”; And further moves to amend the bill by inserting at the end the following section:- SECTION XX. Notwithstanding any general or special law or rule or regulation to the contrary, all orders, rules and regulations duly made and all approvals duly granted by the transferor agency, the division of health care finance and policy, in relation to section 18 of chapter 15A, sections 6C and 18B of chapter 118G and section 188 of chapter 149 of the General Laws, which are in force immediately before the effective date of this act, shall continue in force and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in accordance with law, by the transferee agency, the commonwealth health insurance connector.

Amendment #251, changed

Mr. Walsh of Lynn moves to amend the bill, H 4127, in section 97, line 1051 by inserting after the word “year” the following words:- “as further defined by the division in regulation” Further moves to amend in section 120, line 1447 by striking the word “and” and inserting in place thereof the following word:- “or” Further moves to amend in section 121, line 1619, by inserting after the word “statewide” the following words:- “per capita”; Further moves to amend in section 121, line 1620, by inserting after the word “statewide” the following words:- “per capita”; Further moves to amend in section 121, line 1623, by inserting after the word “statewide” the following words:- “per capita”; Further moves to amend in section 121, line 1627, by inserting before the word “potential” the following word:- “projected”; Further moves to amend in section 121, line 1629, by inserting before the word “potential” the following word:- “projected”; Further moves to amend in section 121, line 1635, by inserting after the word “regional” the following words:- “per capita”; Further moves to amend in section 121, line 1646, by inserting after the word “regional” the following words:- “per capita”; Further moves to amend in section 121, line 1649, by inserting after the word “regional” the following words:- “per capita”; Further moves to amend in section 121, line 1664, by inserting after the word “regional” the following words:- “per capita”; Further moves to amend in section 121, line 1818 by inserting after the words “division shall” the following words:- “annually report on or” Further moves to amend in section 121, line 1820 by inserting after the word “The” the following words:- “report or” Further moves to amend in section 121, line 1923 by striking out the words “, subject to chapter 30B,” Further moves to amend in section 121, line 1938 by striking the word “council” and inserting in place thereof the following word:- “division” Further moves to amend in section 121, line 1942 by striking the word “council” and inserting in place thereof the following word:- “division” Further moves to amend in section 121, line 1943 by striking the word “council” and inserting in place thereof the following word:- “division” Further moves to amend in section 121, line 2185, by striking out the words “commissioner of insurance” and inserting place thereof the following word:- “division”; Further moves to amend in section 123, lines 2437-2438 by striking the words “the MassHealth electronic health records incentive program; and” and inserting in place thereof the following words:-“fulfill its current and any future contract obligations with the Office of Medicaid to administer specific operational components of the MassHealth electronic health records incentive program; and” Further moves to amend in section 123, line 2575 by striking the word “contact” and inserting in place thereof the following word:- “contract” Further moves to amend in section 130, line 2944 by striking out the words “division of health care cost and quality” and inserting in place thereof the following:- “authority”; And further moves to amend the bill by inserting at

the end the following section:- SECTION XX. Notwithstanding any general or special law or rule or regulation to the contrary, all orders, rules and regulations duly made and all approvals duly granted by the transferor agency, the division of health care finance and policy, in relation to section 18 of chapter 15A, sections 6C and 18B of chapter 118G and section 188 of chapter 149 of the General Laws, which are in force immediately before the effective date of this act, shall continue in force and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in accordance with law, by the transferee agency, the commonwealth health insurance connector.

Amendment #252

Representative Vieira of East Falmouth moves to amend the bill (H4127) by striking section 49.

Amendment #253

Mr. Hecht of Watertown moves to amend the bill in section 121, line 1952 by inserting after the word “payer.” the following: “Access to data shall also include disclosing to consumers, on a timely basis and in an easily readable and understandable format, all data collected on health care services they have personally received”.

Amendment #253, changed

Mr. Hecht of Watertown moves to amend the bill in section 121, line 1952 by inserting after the word “payer.” the following: “Access to data shall also include disclosing to health care consumers, on a timely basis and in an easily readable and understandable format, data on health care services they have personally received”.

Amendment #254

Representatives Atsalis of West Hyannisport and DiNatale of Fitchburg move that the bill (House No. 4127) be amended by striking out SECTION 99 and inserting in place thereof the following: - SECTION 99. Section 2A of chapter 118G of the General Laws, as so appearing, is hereby amended by striking out the first and second sentence and inserting in place thereof the following: - The secretary, in consultation with the division, shall establish rates of payment for health care services. The secretary shall have the sole responsibility for establishing rates to be paid to providers for health care services by governmental units, including the division of industrial accidents; provided that in connection with the establishment of rates of payment for health care services adjudged compensable under chapter 152, as provided in section 13 of chapter 152, the secretary shall also consult with the commissioner of insurance and said commissioner shall certify that any proposed increase in such provider rates shall not adversely affect employers’ workers’ compensation insurance rates and premiums.

Amendment #255

Representatives Atsalis of West Hyannisport and DiNatale of Fitchburg move that the Bill (House No. 4127) be amended by striking out SECTION 132 and inserting in place thereof the following: -
SECTION 132. Subsection (1) of section 13 of chapter 152 is hereby amended by striking out the first sentence therein and inserting in place thereof the following: - The rate of payment by insurers for health care services adjudged compensable under this chapter shall be established by the division of health care cost and quality under the provisions of chapter one hundred and eighteen G; provided, however, that the division shall consult with the commissioner of insurance in the establishment of such provider rates and said commissioner shall certify that any proposed increase in such provider rates shall not adversely affect employers’ workers’ compensation insurance rates and premiums. A different rate for services may be agreed upon by the insurer, the employer and the health care service provider; provided that any collusion between or among providers to obtain higher rates of payment from any insurer than those established under chapter one hundred and eighteen G shall be deemed to be a violation of chapter 93A.

Amendment #256

Representative O'Connell of Taunton moves to amend House Bill 4127 by adding the following section:- "SECTION XX. Chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by adding, after section 72Z, the following section:- Section 72Z½. As used in this section, the following word shall have the following meaning: "Psychotropic medication", a chemical substance that acts primarily upon the central nervous system where it alters brain function, resulting in temporary changes in perception, mood, consciousness and behavior. Every resident in a nursing home, rest home, or other long term care facility that is prescribed psychotropic medications, shall have the facility in which they reside, as well as the prescribing physician, first obtain informed consent from the resident, and the resident's health care proxy, or a court appointed Rogers guardian. The facility shall keep on record a copy of the written consent form between the resident and the prescribing physician when prescribing psychotropic medications.".

Amendment #257

Mr. Lawn of Watertown moves that the bill be amended by a new section, Section XX: Section 18 of chapter 15A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 14 and 36, the words "division of health care finance and policy" and inserting in place thereof, in each instance, the following words:- commonwealth health insurance connector.

Amendment #258

Mr. Dempsey of Haverhill moves to amend H. 4127 by striking, in line 233, after the words "chapter 118G", the words:- not later than January 1, 2014.
And further amended by striking, in line 250, after the words "chapter 118G", the words:- not later than January 1, 2014.
And further amended by striking, in line 639, the words "Effective July 1, 2013, upon" and replacing them with the following word:- Upon
And further amended by striking, in lines 674 and 675, the following words:- The department of public health on or before February 1, 2013 shall promulgate regulations or guidelines to implement the findings of this section.
And further amended by striking, in line 676, the words "Beginning April 15, 2013, hospitals" and replacing them with the following word:- Following
And further amended by striking subsection (f) of section 226 of chapter 111 of the General Laws, as inserted by section 83 of this act, in lines 679-684.
And further amended by striking, in line 800, the words "As of July 1, 2013, rates" and replacing them with the following word:- Rates
And further amended by striking section 68 of chapter 118E of the General Laws, as inserted by section 97 of this act, in lines 844-846.
And further amend the bill by adding the following sections:
SECTION XX. The department of public health, on or before February 1, 2013, shall promulgate regulations or guidelines to implement the findings of hearings conducted under section 226 of chapter 111 of the General Laws as to what constitutes an "emergency situation", warranting mandatory overtime of nurses.
SECTION XX. The department of public health, on or before January 1, 2014, shall promulgate regulations to establish a system to levy an administrative fine on any facility that violates this section or any regulation issued under this section. The fine shall be not less than $100 and not greater than $1,000 for each violation and fines collected shall be dedicated to the department of public health's statewide sexual assault nurse examiner program. Said regulations shall also establish an independent appeals process for penalized entities.
SECTION XX. MassHealth shall implement, no later than July 1, 2013, the Express Lane re-enrollment program for streamlined eligibility procedures to renew eligibility for parents with children who are enrolled in the SNAP program.
SECTION XX. Section 27 of chapter 32A of the General Laws, as inserted by section 20 of this act, shall take effect on January 1, 2014.
SECTION XX. Section 30 of chapter 32B of the General Laws, as inserted by section 21 of this act, shall take effect

on January 1, 2014.
SECTION XX. Section 225 of chapter 111 of the General Laws, as inserted by section 83 of this act, shall take effect on July 1, 2013.
SECTION XX. Subsection (e) of section 226 of chapter 111 of the General Laws, as inserted by section 83 of this act, shall take effect on April 15, 2013.
SECTION XX. Section 64 of chapter 111 of the General Laws, as inserted by section 83 of this act, shall take effect on July 1, 2013.

Amendment #259

Ms. Story of Amherst moves to amend the bill (House No. 4127) in section 121, in line 2231, by striking out the word "and"; and moves to further amend the bill, in line 2232, after the word "Survey", by inserting the following words:- "; and (v) the American Medical Association Physician Consortium for Performance Improvement's Maternity Care Quality Set."

Amendment #260

Ms. Story of Amherst moves to amend the bill (House No. 4127) in section 121, in line 2231, by striking out the word "and"; and moves to further amend the bill, in line 2232, after the word "Survey" by inserting the following words:- "; and (v) the National Quality Forum's Child Health Quality Measures."

Amendment #261

Representatives Story of Amherst and Garballey of Arlington move to amend the bill (House No. 4127) in section 42, in line 1518, after the word "chapter" by inserting the following:- ", including, but not limited to: (1) Protect quality, access and patient choice of primary care provider and accountable care organization for the residents of the commonwealth. (2) Establish standards for alternative payment methodologies to be utilized in contracts between payers and ACOs and other providers. Such standards shall include, but not be limited to the requirement that payment levels to providers under alternative payment methodologies shall be dependent, in part, on the achievement of quality performance and shall include risk adjustment for health status. All payers shall develop and employ alternative payment methodologies consistent with the requirements of this chapter. All contracts between payers and ACOs that contain a provision for shared savings between the provider and the payer may contain a mechanism to return a percentage of the savings to the ACO participants. (3) Establish safeguards against underutilization of services and protections against and penalties for inappropriate denials of services or treatment in connection with utilization of any alternative payment method or transition to a global payment system. (4) Establish safeguards against and penalties for inappropriate selection of low cost patients and avoidance of high cost patients by any provider accepting a risk based contract, including but not limited to requiring that ACOs accept as ACO patients all individuals regardless of payer source or clinical profile. (5) Establish parameters to measure and ensure access by disabled and other individuals with chronic or complex medical conditions to appropriate specialty care. (6) Evaluate and provide guidance through regulations relative to consumer protections and any deficiencies of patient choice of provider that may arise in the transition from a fee-for-service system. The division shall monitor the movement of patients from and between ACOs, and shall establish parameters for out-of-ACO arrangements, as well as for patient provider choice and other consumer protections; (7) Establish by regulation requirements for ACOs to address consumer grievances"

Amendment #262

Ms. Story of Amherst moves to amend the bill (House No. 4127) in section 11, in line 54, after the words "increase healthy behaviors" by inserting the following words:- ", including the management of chronic diseases"

Amendment #263

Ms. Story moves to amend the bill (House No. 4127), in section 11, in line 66 by striking the word “or”; and moves to further amend the bill, in line 68, after the words “health-related funding” by inserting the following words:- “; or (v) a community-based organization or group of community-based organizations working in collaboration”

Amendment #264

Ms. Story moves to amend the bill (House No. 4127), in section 17, in line 180 after the words “rural primary care sites” by inserting the following words:- “ or family planning sites ”

Amendment #265

Ms. Story moves to amend the bill (House No. 4127), in section 96, in line 825 after the words “care services.” by inserting the following sentence:- “Family planning organizations may be reimbursed directly to insure necessary timely care.”

Amendment #266

Representatives Forry and Walsh of Boston move to amend the bill (House, No. 4127) by inserting, in line 800, after the word “hospitals” the following:- “, community health centers”; by striking out, in line 801, the words “an additional 2 per cent” and inserting in place thereof the following words:- “a rate equal to the Boston area medical CPI but not less than 4 per cent”; by inserting, in line 804, after the word “hospitals” the following:- “, health centers”; by striking out, in line 806, the words “the 2 per cent” and inserting in place thereof the following words:- “a rate equal to the Boston area medical CPI but not less than the 4 per cent”; and by striking out, in line 808, the words “the 2 per cent” and inserting in place thereof the following words:- “a rate equal to the Boston area medical CPI but not less than 4 per cent”.

Amendment #267

Representatives Khan of Newton, Lewis of Winchester and Sciortino of Medford move to amend the bill by adding the following sections:
"Section 6 of Chapter 64H of the Massachusetts General Laws, as appearing in the 2008 official Edition, is hereby amended in paragraph (h) by deleting the following: “soft drinks” and further amended inserting after the second sentence the following new sentence; "Food products" does not include soft drinks. "Soft drink" means any non-alcoholic beverage sold for human consumption including, but not limited to, the following: soda water, ginger ale, all drinks commonly referred to as cola, lime, lemon, lemon-lime and other flavored drinks whether naturally or artificially flavored, including any fruit or vegetable drink containing fifty percent (50%) or less natural fruit juice, natural vegetable juice, and all other drinks and beverages commonly referred to as soft drinks but not including coffee or tea unless the coffee or tea is bottled as a liquid for sale. All sales tax revenues collected from the sale of soft drinks under this chapter shall be deposited in the Prevention and Wellness Trust Fund, established in section 2G of chapter 111.”

Amendment #268

MS. ANDREWS of ORANGE moves that the bill (House No. 4127) be amended by striking out SECTION 17 and inserting in place thereof the following: -
SECTION 17. Chapter 29 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after section 2EEEE the following 2 sections:—
Section 2FFFF. (a)There is hereby established and set up on the books of the commonwealth a separate fund to be known as the Health Care Workforce Trust Fund, hereinafter called the fund. The fund shall be administered by the

health care workforce center which may contract with any appropriate entity to administer the fund or any portion therein. The purposes of the fund shall include:
(i) 50 per cent of the monies in the Fund shall be transferred for the purposes of making awards to primary care professionals and 50 percent of the monies in the Fund shall be transferred for the purposes of making awards to primary care physicians for repayment assistance for medical or nursing school loans pursuant to section 62 of chapter 118G; provided, however that in administering the loan forgiveness grant program; that at least 90 per cent of funds provided to primary care physicians herein shall be granted to applicants performing terms of service in rural primary care sites that meet the criteria of a medically underserved area as determined by the health care workforce center;
(ii) providing employment training opportunities, job placement, career ladder and educational services for currently employed or unemployed health workers who are seeking new positions or responsibilities within the health care industry with a focus on aligning training and education with industry needs, provided that the fund shall support the distribution of grants to selected health systems, non-profit organizations, labor unions, labor-industry partnerships and others;
(iii) funding residency positions in primary care pursuant to section 64 of chapter 118G;
and
(iv) funding rural health rotation programs, rural health clerkships, and rural health preceptorships at medical and nursing schools to expose students to practicing in rural and small town communities.
(b) There shall be credited to the fund all monies payable pursuant to (i) funds that are paid to the health care workforce loan repayment program, established under section 62 of chapter 118G, as a result of a breach of contract and private funds contributed from other sources; and (ii) any revenue from appropriations or other monies authorized by the general court and specifically designated to be credited to the fund, and any gifts, grants, private contributions, investment income earned on the fund's assets and all other sources. Money remaining in the fund at the end of a fiscal year shall not revert to the General Fund.
(c) The fund shall supplement and not replace existing publically-financed health care workforce development programs.
(d) The health care workforce center shall promulgate regulations pursuant to the distribution of monies from the fund to programs listed under subsection (a) and applicant eligibility criteria for said funds.
(e) The health care workforce center shall annually, not later than December 31, report to the secretary of administration and finance, the house and senate committees on ways and means, and the joint committee on health care financing regarding the revenues and distribution of monies from the fund in the prior fiscal year.
Section 2GGGG. There is hereby established and set up on the books of the commonwealth a separate fund to be known as the Distressed Hospital Trust Fund, which shall be administered by the division of health care cost and quality. Expenditures from the Distressed Hospital Trust Fund shall be dedicated to efforts to improve and enhance the ability of community hospitals to serve populations in need more efficiently and effectively, including, but not limited to, the ability to provide community-based care, clinical support and care coordination services, improve health information technology, or other efforts to create effective coordination of care.
The division, in consultation with the Massachusetts Hospital Association, shall develop a competitive grant process for awards to be distributed to distressed hospitals out of said fund. The grant process consideration shall include, but not be limited to, the following factors: (1) payer mix, (2) financial health and its financial needs in the context of being viable in the long term, (3) geographic need, and (4) population need. In assessing financial health, the division shall take into account day’s cash on hand, net working capital, earnings before depreciation and amortization, and access to working capital.

Amendment #269

Representative Moran of Boston moves to amend the bill by adding the following section: "SECTION XXX. Notwithstanding any law or rule the contrary, for fiscal year 2013, in establishing Medicaid reimbursement rates for inpatient services provided by chronic disease rehabilitation hospitals located in the commonwealth that serve solely children and adolescents, the department of health and human services shall apply a multiplier of 1.5 times the hospital’s inpatient per diem rate in fiscal year 2012. For fiscal year 2014 and beyond, such rates of reimbursement shall not be lower than the rates in effect for the prior fiscal year”.

Amendment #269, changed

Mr. Moran of Boston moves to amend House Bill 4127 by adding the following three sections:-

"SECTION X. Notwithstanding any law or rule the contrary, for fiscal year 2013, in establishing Medicaid reimbursement rates for inpatient services provided by chronic disease rehabilitation hospitals located in the commonwealth that serve solely children and adolescents, the department of health and human services shall apply a multiplier of 1.5 times the hospital's inpatient per diem rate in fiscal year 2012. For fiscal year 2014 and beyond, such rates of reimbursement shall not be lower than the rates in effect for the prior fiscal year.

SECTION XX. SECTION X is hereby repealed.

SECTION XXX. SECTION XX shall take effect on June 30, 2015.

Amendment #270

Mr. Collins of Boston moves to amend the bill (House, No. 4127) in section 124, in item 2910, by inserting the following after the phrase "All accountable care organizations":- " and any government entity that contracted with a health plan or insurer utilizing ACOs was a party to the appeals process",

Amendment #271

Mr. Garballey of Arlington moves that the bill be amended by adding the following section: - "SECTION XX. Section 18 of chapter 15A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 14 and 36, the words "division of health care finance and policy" and inserting in place thereof, in each instance, the following words:- commonwealth health insurance connector."

Amendment #272

Mr. DiNatale of Fitchburg moves to amend the bill by inserting the following two sections:
SECTION XX. Chapter 288 of the Acts of 2010 is hereby amended by striking out section 66 and inserting in place thereof the following section:
SECTION 66. For small group base rate factors applied under section 3 of chapter 176J of the General Laws between October 1, 2010 and July 1, 2015, a carrier shall limit the effect of the application of any single or combination of rate adjustment factors identified in paragraphs (2) to (6), inclusive, of subsection (a) of said chapter 3 of said chapter 176J that are used in the calculation of an individual's or small group's premium so that the final annual premium charged to an individual or small group does not increase by more than an amount established annually by the commissioner by regulation.
SECTION XX. Section 70 of chapter 288 of the acts of 2010 is hereby amended by striking out the figure "2012" and inserting in place thereof the following figure:- 2015.

Amendment #273

Ms. O'Connell of Taunton moves to amend House Bill 4127 by inserting at the end thereof the following section:- "SECTION XX: Notwithstanding any general or special law to the contrary, the executive office of health and human services shall conduct a study commission to investigate the implementation of a pilot program to increase the adoption of health savings accounts and consumer-driven health plans in the marketplace, including state employees and persons receiving subsidized health care. The study commission shall be chaired by EOHHS and shall include: 1 person appointed by the Governor; 1 appointee of the Senate President; 1 appointee of the Senate Minority Leader; 1 appointee of the Speak of the House; 1 appointee of the House Minority Leader; 1 representative from the GIC; 1 representative from the banking industry; 1 representative from Mass Health Underwriters Association; 1 representative from the Association of Health Plans; 1 representative from AIM. The commission shall file a report with recommendations for implementation with the House Clerk by April 1, 2013." The scope of the commission shall include, without limitation, identifying: the barriers to full implementation of health savings accounts, consumer-driver

health plans, and high-deductible health plans; providing greater consumer choice; incentives to increase utilization of health savings accounts, consumer-driver health plans, and high-deductible health plans."

Amendment #274

Ms. Khan of Newton moves to amend the bill H. 4127 by adding the following section: SECTION 181 of House No. 4127 is hereby amended by inserting after the number "111", in line 3732, the following words: - , a psychiatric facility licensed under Chapter 19,. Here is the redline: At line 3732: "Facility", a hospital, clinic or nursing home licensed pursuant to chapter 111, a psychiatric facility licensed under Chapter 19, or a home health agency. The term shall also include any corporation, professional corporation, partnership, limited liability company, limited liability partnership, authority, or other entity comprised of such facilities.

Amendment #275

Mr. Walsh of Boston moves that the bill be amended, in Section 121, by striking out the text in lines 1619 to 1673, inclusive, and inserting in place thereof the following text:- Section 46. (a) The division shall calculate a statewide medical spend benchmark by July 1. The benchmark shall be calculated by multiplying (1) the statewide medical spend benchmark of the prior year; and (2) the modified potential gross state product growth rate, as determined in subsection (b). For the initial statewide medical spend benchmark in 2012, the division shall calculate the medical spend for 2011 and multiply that number by the modified potential state product growth rate for calendar year 2012. (b) (1) As part of the governor's annual budget submission, the secretary for administration and finance shall publish the potential gross state product growth rate for the following calendar year beginning on January 1. Notwithstanding this subsection, for calendar years 2012 and 2013 the potential gross state product growth rate shall be 3.6%. (2) The division shall calculate the modified potential gross state product growth rate by taking the rate as defined by the secretary under paragraph (1) and making the following adjustments: (A) Calendar Years 2012 – 2015: No modification (B) Calendar Years 2016 – 2026: minus 0.5% (C) Calendar Years 2027 and beyond: plus 1% (c) The division shall calculate a regional medical spend benchmark in a fashion similar to subsection (a). The division shall divide the commonwealth into 3 geographic regions. The division may adjust the regions once every 5 years to account for any changes in medical operations that significantly impact the regions. Section 47. (a) As used in this section, the following word shall have the following meaning: "Health care entity", a clinic, hospital, ambulatory surgical center, physician organization, accountable care organization, or payer; provided however that physician contracting units of 9 or less shall be excluded from this definition. (b) Within 180 days of the end of each calendar year, the division shall conduct a review of the medical spend in each of the 3 geographic regions established under section 46, provided however, that the division shall have 300 days for its initial review. (c) If the division determines that the regional medical spend benchmark, as established under section 46, was met in a geographic region, then the division shall take no action on any health care entity within that region. (d) If the division determines that a region exceeded its regional spend benchmark for the year, the division shall determine if the excess growth was caused in whole or in part by circumstances beyond the control of health care entities within such region. When reviewing the circumstances beyond the control of health care entities, the division may review items such as 1) age and other health status adjusted factors, 2) other cost inputs such as pharmaceutical expenses and medical device expenses, and 3) the region's ability to meet the benchmark in previous years. The division shall take no action if it determines that the excess growth was beyond the control of such health care entities. (e) If the division determines, under the analysis established under subsection (d), that excessive growth was not beyond the control of such health care entities, then the division shall analyze the cost growth of individual health care entities located within such region Based on the results of such analysis, beginning in calendar year 2016, the division may take actions as established under section 48. taking into consideration factors such as: (1) the costs, price and utilization trends of the health care entity over time, and any demonstrated improvement to reduce spending; (2) any ongoing strategies or investments that the health care entity is implementing to improve future long-term efficiency and reduce cost growth; (3) whether the factors that led to increased costs for the health care entity can reasonably be considered to be unanticipated and outside of the control of the entity; (4) the overall financial condition of the health care entity; (5) the proportionate impact of the health care entity's costs on the growth in medical spend within its region; (6) the need to invest in an promote utilization of services that have been historically under-resourced and underutilized; and (7) any other factors the division considers relevant. (f) The division shall provide notice to all health care entities within any geographic

region that exceeds the regional medical spend benchmark for a given year that said benchmark has been exceeded. Such notice shall state that the division may analyze the cost growth of individual health care entities located within such region and, beginning in calendar year 2016, may require certain actions, as established in section 48, and, at any time following the effective date of this act of this act, if such analysis indicates that an individual health care entity unduly contributed to excessive growth as a result of excessive consolidation, or collusion, the division shall refer such entity to the attorney general to take appropriate action. (g) The division may submit a recommendation for proposed legislation to the joint committee on health care financing if the division determines that modified potential gross state product growth rate or actions under section 48 should be modified, or believes that further legislative authority is needed to achieve the health care quality and spending sustainability objectives of this act.

Bill H.1849

An Act improving the quality of health care and controlling costs by reforming health systems and payments

An Act improving the quality of health care and controlling costs by reforming health systems and payments

Sponsors: Deval Patrick

Actions for Bill H.1849

Date	Branch	Action
2/22/2011	House	Referred to committee on Health Care Financing
2/24/2011	Senate	Senate concurred
4/7/2011	Joint	Hearing scheduled for 05/16/2011 from 10:00 AM-05:00 PM in Gardner Auditorium
5/17/2011	Joint	Hearing scheduled for 05/23/2011 from 11:00 AM-05:00 PM in UMass Medical School
5/31/2011	Joint	Hearing scheduled for 06/06/2011 from 11:00 AM-04:00 PM in Salem State University
6/27/2011	Joint	Hearing scheduled for 07/08/2011 from 11:00 AM-04:00 PM in Riverview School
4/26/2012	Senate	Discharged to the Senate committee on Ways and Means
5/7/2012	House	House concurred
5/9/2012	Senate	Accompanied a new draft, see S2260

Bill S.2260

An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation

Senate, May 9, 2012 – New draft of House, No. 1849 reported from the Senate committee on the Ways and Means.

Sponsors: Senate Committee on Ways and Means

Actions for Bill S.2260

Date	Branch	Action
5/9/2012	Senate	Reported from the committee on Senate Ways and Means
5/9/2012	Senate	New draft of H1849
5/9/2012	Senate	Read
5/9/2012	Senate	Order relative to subject matter adopted
5/9/2012	Senate	Placed in the Orders of the Day for Tuesday, May 15, 2012
5/15/2012	Senate	Read second
5/15/2012	Senate	Amendment #1 (Flanagan) rejected
5/15/2012	Senate	Amendment #4 (Clark) adopted
5/15/2012	Senate	Amendment #7 (Donnelly) adopted
5/15/2012	Senate	Amendment #16 (Michael Moore) adopted
5/15/2012	Senate	Amendment #18 (McGee) adopted
5/15/2012	Senate	Amendment #22 (Rosenberg) adopted
5/15/2012	Senate	Amendment #25 (Michael Moore) adopted
5/15/2012	Senate	Amendment #39 (Candaras) rejected

5/15/2012	Senate	Amendment #41 (Fargo) rejected
5/15/2012	Senate	Amendment #43 (Montigny) adopted
5/15/2012	Senate	Amendment #35 (Petruccelli) adopted
5/15/2012	Senate	Amendment #50 (Creem) rejected
5/15/2012	Senate	Amendment #52 (Chandler) rejected
5/15/2012	Senate	Amendment #49 (Rush) adopted
5/15/2012	Senate	Amendment #60 (Rodrigues) rejected
5/15/2012	Senate	Amendment #65 (Berry) rejected
5/15/2012	Senate	Amendment #66 (Fargo) rejected
5/15/2012	Senate	Amendment #74 (Timilty) rejected
5/15/2012	Senate	Amendment #75 (Timilty) rejected
5/15/2012	Senate	Amendment #77 (Timilty) rejected
5/15/2012	Senate	Amendment #84 (Rush) adopted
5/15/2012	Senate	Amendment #86 (Fargo) rejected
5/15/2012	Senate	Amendment #88 (Berry) adopted
5/15/2012	Senate	Amendment #89 (Berry) rejected
5/15/2012	Senate	Amendment #90 (Richard Moore) adopted - Roll Call #177 [YEAS 37 - NAYS 0]
5/15/2012	Senate	Amendment #92 (Fargo) rejected

5/15/2012	Senate	Amendment #93 (Fargo) rejected
5/15/2012	Senate	Amendment #94 (Fargo) rejected
5/15/2012	Senate	Amendment #96 (Fargo) rejected
5/15/2012	Senate	Amendment #101 (Rosenberg) adopted
5/15/2012	Senate	Amendment #107 (Creem) adopted
5/15/2012	Senate	Amendment #112 (Fargo) rejected
5/15/2012	Senate	Amendment #118 (Berry) rejected
5/15/2012	Senate	Amendment #119 (Kennedy) adopted
5/15/2012	Senate	Amendment #121 (Richard Moore) adopted
5/15/2012	Senate	Amendment #125 (Eldridge) rejected - Roll Call #178 [YEAS 15 - NAYS 22]
5/15/2012	Senate	Amendment #128 (Welch) adopted
5/15/2012	Senate	Amendment #131 (Welch) adopted
5/15/2012	Senate	Amendment #136 (Jehlen) rejected
5/15/2012	Senate	Amendment #137 (Jehlen) adopted
5/15/2012	Senate	Amendment #156 (Jehlen) rejected
5/15/2012	Senate	Amendment #159 (Michael Moore) rejected
5/15/2012	Senate	Amendment #161 (Michael Moore) rejected
5/15/2012	Senate	Amendment #163 (Tarr) rejected - Roll Call #179 [YEAS 6 - NAYS 30]
5/15/2012	Senate	Amendment #164 (Tarr) rejected - Roll Call #180 [YEAS 5 - NAYS 30]

5/15/2012	Senate	Amendment #165 (Spilka) rejected - Roll Call #181 [YEAS 35 - NAYS 0]
5/15/2012	Senate	Amendment #169 (Donnelly) rejected
5/15/2012	Senate	Amendment #172 (Tarr) rejected
5/15/2012	Senate	Amendment #174 (Tarr) rejected
5/15/2012	Senate	Amendment #176 (Tarr) rejected
5/15/2012	Senate	Amendment #179 (Kennedy) rejected
5/15/2012	Senate	Amendment #181 (Tarr) adopted
5/15/2012	Senate	Amendment #182 (Tarr) rejected
5/15/2012	Senate	Amendment #187 (Berry) rejected
5/15/2012	Senate	Amendment #188 (Tarr) rejected - Roll Call #182 [YEAS 5 - NAYS 30]
5/15/2012	Senate	Amendment #190 (Kennedy) rejected
5/15/2012	Senate	Amendment #191 (Tarr) rejected - Roll Call #183 [YEAS 7 - NAYS 28]
5/15/2012	Senate	Amendment #192 (Knapik) rejected
5/15/2012	Senate	Amendment #193 (Tarr) rejected
5/15/2012	Senate	Amendment #194 (Richard Moore) adopted
5/15/2012	Senate	Amendment #197 (Tarr) rejected
5/15/2012	Senate	Amendment #198 (Tarr) rejected
5/15/2012	Senate	Amendment #199 (Kennedy) rejected
5/15/2012	Senate	Amendment #200 (Tarr) rejected

5/15/2012	Senate	Amendment #201 (Tarr) rejected
5/15/2012	Senate	Amendment #208 (Tarr) rejected
5/15/2012	Senate	Amendment #209 (Tarr) rejected
5/15/2012	Senate	Amendment #210 (Fargo) rejected
5/15/2012	Senate	Amendment #216 (Keenan) adopted
5/15/2012	Senate	Amendment #221 (Tarr) rejected
5/15/2012	Senate	Amendment #223 (Keenan) adopted
5/15/2012	Senate	Amendment #224 (Keenan) adopted
5/15/2012	Senate	Amendment #214 (Keenan) adopted
5/15/2012	Senate	Amendment #225 (Keenan) adopted
5/15/2012	Senate	Amendment #226 (Keenan) adopted
5/15/2012	Senate	Amendment #229 (Chang-Diaz) adopted
5/15/2012	Senate	Amendment #236 (Keenan) adopted
5/15/2012	Senate	Amendment #238 (Spilka) adopted
5/15/2012	Senate	Amendment #240 (Keenan) rejected
5/15/2012	Senate	Amendment #243 (Keenan) adopted
5/15/2012	Senate	Amendment #245 (Tarr) rejected
5/15/2012	Senate	Amendment #252 (Tarr) rejected
5/15/2012	Senate	Amendment #258 (Tarr) adopted

5/17/2012	Senate	Amendment #258 (Tarr) adopted
5/17/2012	Senate	Amendment #2 (Flanagan) rejected
5/17/2012	Senate	Amendment #3 (Flanagan) rejected
5/17/2012	Senate	Amendment #5 (McGee) adopted
5/17/2012	Senate	Amendment #6 (Donnelly) adopted
5/17/2012	Senate	Amendment #17 (Michael Moore) rejected
5/17/2012	Senate	Amendment #19 (McGee) adopted
5/17/2012	Senate	Amendment #26 (Rodrigues) rejected
5/17/2012	Senate	Amendment #27 (Rodrigues) rejected
5/17/2012	Senate	Amendment #34 (Finegold) adopted
5/17/2012	Senate	Amendment #54 (Hart) rejected - Roll Call #184 [YEAS 35 - NAYS 0]
5/17/2012	Senate	Amendment #68 (Creem) adopted
5/17/2012	Senate	Amendment #76 (Timilty) adopted
5/17/2012	Senate	Amendment #103 (Wolf) adopted
5/17/2012	Senate	Amendment #138 (Chandler) adopted
5/17/2012	Senate	Amendment #151 (Rodrigues) adopted
5/17/2012	Senate	Amendment #155 (Spilka) adopted
5/17/2012	Senate	Amendment #158 (Petruccelli) adopted
5/17/2012	Senate	Amendment #160 (Spilka) rejected

5/17/2012	Senate	Amendment #162 (Spilka) rejected
5/17/2012	Senate	Amendment #166 (Tarr) rejected - Roll Call #185 [YEAS 5 - NAYS 30]
5/17/2012	Senate	Amendment #167 (Spilka) rejected
5/17/2012	Senate	Amendment #173 (Petruccelli) adopted
5/17/2012	Senate	Amendment #177 (Petruccelli) adopted
5/17/2012	Senate	Amendment #218 (Creem) rejected
5/17/2012	Senate	Amendment #230 (Kennedy) rejected
5/17/2012	Senate	Amendment #249 (Tarr) rejected
5/17/2012	Senate	Amendment #254 (Tarr) rejected
5/17/2012	Senate	Amendment #255 (Tarr) rejected - Roll Call #186 [YEAS 5 - NAYS 31]
5/17/2012	Senate	Amendment #262 (Creem) rejected
5/17/2012	Senate	Amendment #184 (Berry) adopted
5/17/2012	Senate	Amendment #206 (Tarr) rejected - Roll Call #187 [YEAS 4 - NAYS 32]
5/17/2012	Senate	Amendment #186 (Berry) adopted
5/17/2012	Senate	Amendment #263 (Tarr) rejected - Roll Call #188 [YEAS 5 - NAYS 32]
5/17/2012	Senate	Amendment #170 (Tarr) adopted
5/17/2012	Senate	Amendment #95 (Joyce) adopted
5/17/2012	Senate	Amendment #23 (Rodrigues) adopted
5/17/2012	Senate	Amendment #30 (Chandler) adopted

5/17/2012	Senate	Amendment #36 (Petruccelli) adopted
5/17/2012	Senate	Amendment #38 (Candaras) adopted
5/17/2012	Senate	Amendment #81 (Montigny) adopted
5/17/2012	Senate	Amendment #117 (Creem) adopted
5/17/2012	Senate	Amendment #139 (DiDomenico) adopted
5/17/2012	Senate	Amendment #150 (Downing) adopted
5/17/2012	Senate	Amendment #189 (Chang-Diaz) adopted
5/17/2012	Senate	Amendment #203 (Finegold) adopted
5/17/2012	Senate	Amendment #213 (Richard Moore) adopted
5/17/2012	Senate	Amendment #215 (Keenan) adopted
5/17/2012	Senate	Amendment #219 (Keenan) adopted
5/17/2012	Senate	Amendment #227 (Keenan) adopted
5/17/2012	Senate	Amendment #233 (Richard Moore) adopted
5/17/2012	Senate	Amendment #28 (Chandler) adopted
5/17/2012	Senate	Amendment #87 (Hart) adopted
5/17/2012	Senate	Amendment #10 (Brownsberger) adopted
5/17/2012	Senate	Amendment #53 (Hart) adopted
5/17/2012	Senate	Amendment #80 (Montigny) adopted
5/17/2012	Senate	Amendment #147 (Welch) adopted

5/17/2012	Senate	Amendment #8 (Donnelly) rejected
5/17/2012	Senate	Amendment #37 (Richard Moore) adopted
5/17/2012	Senate	Amendment #42 (Fargo) rejected
5/17/2012	Senate	Amendment #44 (Fargo) rejected
5/17/2012	Senate	Amendment #45 (Montigny) rejected
5/17/2012	Senate	Amendment #46 (Montigny) rejected
5/17/2012	Senate	Amendment #51 (Candaras) rejected
5/17/2012	Senate	Amendment #55 (Creem) rejected
5/17/2012	Senate	Amendment #57 (Hart) rejected
5/17/2012	Senate	Amendment #58 (Fargo) rejected
5/17/2012	Senate	Amendment #59 (Berry) rejected
5/17/2012	Senate	Amendment #61 (Hart) adopted
5/17/2012	Senate	Amendment #62 (Berry) rejected
5/17/2012	Senate	Amendment #67 (Fargo) rejected
5/17/2012	Senate	Amendment #69 (Fargo) rejected
5/17/2012	Senate	Amendment #72 (Fargo) rejected
5/17/2012	Senate	Amendment #73 (Brownsberger) rejected
5/17/2012	Senate	Amendment #78 (Timilty) rejected
5/17/2012	Senate	Amendment #79 (Timilty) rejected

5/17/2012	Senate	Amendment #82 (Fargo) rejected
5/17/2012	Senate	Amendment #83 (Brownsberger) rejected
5/17/2012	Senate	Amendment #85 (Fargo) rejected
5/17/2012	Senate	Amendment #98 (Fargo) rejected
5/17/2012	Senate	Amendment #100 (Fargo) rejected
5/17/2012	Senate	Amendment #102 (Fargo) rejected
5/17/2012	Senate	Amendment #104 (Fargo) rejected
5/17/2012	Senate	Amendment #106 (Fargo) rejected
5/17/2012	Senate	Amendment #108 (Fargo) rejected
5/17/2012	Senate	Amendment #132 (Jehlen) rejected
5/17/2012	Senate	Amendment #132 (Jehlen) rejected
5/17/2012	Senate	Amendment #133 (Jehlen) rejected
5/17/2012	Senate	Amendment #143 (Pacheco) rejected
5/17/2012	Senate	Amendment #168 (Jehlen) rejected
5/17/2012	Senate	Amendment #171 (Jehlen) rejected
5/17/2012	Senate	Amendment #202 (Tarr) rejected
5/17/2012	Senate	Amendment #204 (Tarr) adopted
5/17/2012	Senate	Amendment #205 (Kennedy) rejected
5/17/2012	Senate	Amendment #207 (Tarr) rejected

5/17/2012	Senate	Amendment #212 (Knapik) rejected
5/17/2012	Senate	Amendment #217 (McGee) rejected
5/17/2012	Senate	Amendment #228 (Keenan) rejected
5/17/2012	Senate	Amendment #231 (Spilka) rejected
5/17/2012	Senate	Amendment #232 (Spilka) rejected
5/17/2012	Senate	Amendment #234 (Keenan) rejected
5/17/2012	Senate	Amendment #235 (Keenan) rejected
5/17/2012	Senate	Amendment #237 (Keenan) rejected
5/17/2012	Senate	Amendment #241 (Keenan) rejected
5/17/2012	Senate	Amendment #244 (Keenan) rejected
5/17/2012	Senate	Amendment #246 (Keenan) rejected
5/17/2012	Senate	Amendment #247 (Keenan) rejected
5/17/2012	Senate	Amendment #248 (Spilka) rejected
5/17/2012	Senate	Amendment #250 (Keenan) rejected
5/17/2012	Senate	Amendment #256 (Spilka) rejected
5/17/2012	Senate	Amendment #257 (Knapik) rejected
5/17/2012	Senate	Amendment #259 (Keenan) rejected
5/17/2012	Senate	Amendment #260 (Keenan) rejected
5/17/2012	Senate	Amendment #13 (Michael Moore) adopted

5/17/2012	Senate	Amendment #175 (Tarr) rejected
5/17/2012	Senate	Amendment #178 (Tarr) rejected
5/17/2012	Senate	Amendment #185 (Tarr) adopted
5/17/2012	Senate	Amendment #91 (Wolf) adopted
5/17/2012	Senate	Amendment #183 (Hart) adopted
5/17/2012	Senate	Amendment #109 (Hart) adopted
5/17/2012	Senate	Amendment #211 (Tarr) rejected
5/17/2012	Senate	Amendment #130 (DiDomenico) adopted
5/17/2012	Senate	Amendment #265 (DiDomenico) adopted
5/17/2012	Senate	Pending Senate Ways and Means amendment adopted, as amended
5/17/2012	Senate	Substituted as a new draft for H1849
5/17/2012	Senate	Ordered to a third reading
5/17/2012	Senate	Read third
5/17/2012	Senate	Passed to be engrossed - Roll Call #190 [YEAS 35 - NAYS 2]
5/17/2012	Senate	Reprinted as amended, see S2270

Amendments in Detail:

[Text of proposed amendments to the Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2260)]

Last updated: Friday, May 18, 2012 5:01 PM

Rejected

Clerk #1

Consumer Health Information Website

Ms. Flanagan and Mr. DiDomenico moves to amend the bill (Senate, No. 2260) in Section 20, line 835, by adding at the end thereof the following language: "(v) data concerning the nurse staffing levels at each facility."

Clerk #2

CHILDREN'S MENTAL HEALTH CLINICIANS

Ms. Flanagan, Ms. Spilka and Messrs. Keenan, DiDomenico and Joyce moved that the bill (Senate, No. 2260) be amended by inserting, after Section _____, the following new Sections:-

"SECTION 1. Section 22 of chapter 32A of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after the word "setting", in line 85, the following words: - "and, for persons under the age of 19, shall include collateral services"

SECTION 2. Subsection (i) of said section 22 of said chapter 32A, as so appearing, is hereby amended by striking out the last paragraph.

SECTION 3. Said section 22 of said chapter 32A, as so appearing, is hereby amended by adding the following subsection:—

Under this section, the following words shall have the following meanings unless the context requires otherwise:-

“Collateral services”, face-to-face or telephonic consultation, of at least 15 minutes in duration, by a licensed mental health professional with parties determined by the licensed mental health professional to be necessary to make a diagnosis, and develop and implement a treatment plan.

“Licensed mental health professional”, a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist or a licensed marriage and family therapist.

SECTION 4. Chapter 118E of the General Laws, as so appearing, is amended by inserting after section 10F the following section:—

Section 10G. (a) The division shall provide coverage for collateral services performed by a licensed mental health professional for persons under 19 years of age. Nothing contained in this section shall be construed to abrogate any obligation to provide coverage for mental health services pursuant to any law or regulation of the commonwealth or the United States or under the terms or provisions of any policy, contract, or certificate.

(b) Under this section, the following words shall have the following meanings unless the context requires otherwise:-

“Collateral services”, face-to-face or telephonic consultation, of at least 15 minutes in duration, by a licensed mental health professional with parties determined by the licensed mental health professional to be necessary to make a diagnosis, and develop and implement a treatment plan.

“Licensed mental health professional”, a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist or a licensed marriage and family therapist.

SECTION 5. Section 47B of chapter 175 of the General Laws, as so appearing , is hereby amended by inserting after the word “setting”, in lines 98 and 99, the following words:- “and, for persons under the age of 19, shall include collateral services.“

SECTION 6. Subsection (i) of said chapter 47B of said chapter 175, as so appearing, is hereby amended by striking out the second and third paragraphs.

SECTION 7. Said section 47B of said chapter 175, as so appearing, is hereby further amended by adding the following 2 subsections:—

(j) Under this section, the following words shall have the following meanings unless the context requires otherwise:-

“Collateral services”, face-to-face or telephonic consultation, for at least 15 minutes of duration, by a licensed mental health professional with parties determined by the licensed mental health professional to be necessary to make a diagnosis, and develop and implement a treatment plan.

“Licensed mental health professional”, a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist or a licensed marriage and family therapist.

(k) For the purposes of this section, psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered in a manner identical to all other medical services.

SECTION 8. Section 8A of chapter 176A of the General Laws, as so appearing, is hereby amended by inserting after the word “setting”, in lines 92 and 93, the following words: - “and, for persons under the age of 19, shall include collateral services.“

SECTION 9. Subsection (i) of said section 8A of said chapter 176A, as so appearing, is hereby amended by striking out the second and third paragraphs.

SECTION 10. Said section 8A of said chapter 176A, as so appearing, is hereby further amended by adding the following 2 subsections:—

(j) Under this section, the following words shall have the following meaning unless the context requires otherwise:-

“Collateral services”, face-to-face or telephonic consultation, of at least 15 minutes of duration, by a licensed mental health professional with parties determined by the licensed mental health professional to be necessary to make a diagnosis, and develop and implement a treatment plan.

“Licensed mental health professional”, a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist or a licensed marriage and family therapist.

(k) For the purposes of this section, psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered in a manner identical to all other medical services.

SECTION 11. Section 4A of chapter 176B of the General Laws, as so appearing, is hereby amended by inserting after the word “setting”, in lines 95 and 96, the following words:- “and, for persons under the age of 19, shall include collateral services.“

SECTION 12. Subsection (i) of said section 4A of said chapter 176B, as so appearing, is hereby amended by striking out the second and third paragraphs.

SECTION 13. Said section 4A of said chapter 176B, as so appearing, is hereby further amended by adding the following 2 subsections:—

(j) Under this section, the following words shall have the following meanings unless the context requires otherwise:-

“Collateral services”, face-to-face or telephonic consultation, of at least 15 minutes of duration, by a licensed mental health professional with parties determined by the licensed mental health professional to be necessary to make a diagnosis, and develop and implement a treatment plan.

“Licensed mental health professional”, a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist or a licensed marriage and family therapist.

(k) For the purposes of this section, psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered in a manner identical to all other medical services.

SECTION 14. Section 4M of chapter 176G of the General Laws, as so appearing, is hereby amended by inserting after the word “setting”, in lines 89 and 90, the following words:- “and, for persons under the age of 19, shall include collateral services.“

SECTION 15. Subsection (i) of said section 4M of said chapter 176G, as so appearing, is hereby amended by striking out the second and third paragraphs.

SECTION 16. Said section 4M of said chapter 176G of the General Laws, as so appearing, is hereby further amended by adding the following 2 subsections:—

(j) Under this section, the following words shall have the following meanings unless the context requires otherwise:-

"Collateral services", face-to-face or telephonic consultation, of at least 15 minutes of duration, by a licensed mental health professional with parties determined by the licensed mental health professional to be necessary to make a diagnosis, and develop and implement a treatment plan.

"Licensed mental health professional", a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist or a licensed marriage and family therapist.

(k) For the purposes of this section, psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered in a manner identical to all other medical services."

Clerk #3

YOUTH TOBACCO POSSESSION

Ms. Flanagan, Mr. Knapik and Ms. Chandler moved that the bill (Senate, No. 2260) be amended by inserting the following new section:-

SECTION XX. Chapter 270 of the General Laws is hereby amended by adding the following section:-

Section 6B. Possession of cigarettes or cigarette rolling papers by minors

Whoever, being under eighteen years of age, knowingly purchases, possesses, transports or carries on his person, any tobacco or cigarette rolling papers, shall be punished by a fine of not more than twenty-five dollars for the first offense, not more than fifty dollars for a second offense, and not more than one hundred dollars for a third or subsequent offense; provided, however, that this section shall not apply to a person who knowingly possesses, transports or carries on his person, cigarettes or cigarette rolling papers in the course of his employment. The fines imposed by this

section shall be directed to the Massachusetts Tobacco Cessation and Prevention Program.

A police officer shall notify the parent or guardian of a person who violates this section of the violation within forty-eight hours of the violation if the contact information of a parent or guardian is reasonably ascertainable by the officer. The notice may be made by any means reasonably calculated to give actual notice, including notice in person, by telephone, or by first-class mail. A person who violates this section shall forfeit any tobacco and any false identification in his or her possession upon the request of any police officer.

ADOPTED

REDRAFT Clerk #4

Representation on e-health commission

Ms. Clark and Messrs. Rosenberg and Joyce move to amend the bill (Senate, No. 2260) by striking out section 191 and inserting in place thereof the following section:-

SECTION 191. (a) There shall be an e-Health commission which shall evaluate the effectiveness of expenditures authorized under section 6D of chapter 40J of the General Laws. The commission shall consist of 17 members: 1 of whom shall be the secretary of administration and finance or a designee, who shall serve as chair; 1 of whom shall be the secretary of health and human services or a designee; 1 of whom shall be the executive director of the institute of health care finance and policy or a designee; 1 of whom shall be the secretary of housing and economic development or a designee; 13 of whom shall be appointed by the governor, 1 of whom shall be an expert in health information technology, 1 of whom shall be an expert in state and federal health privacy laws, 1 of whom shall be an expert in health policy, 1 of whom shall be an expert in health information technology relative to privacy and security, 1 of whom shall be from an academic medical center, 1 of whom shall be from a community hospital, 1 of whom shall be from a community health center, 1 of whom shall be from

a long term care facility, 1 of whom shall be from a physician group practice, 1 of whom shall be a front-line registered nurse, 1 of whom shall be from a Medicare-certified home health agency, and 2 of whom shall represent health insurance carriers.

(b) The commission shall review the Massachusetts e-Health Institute, including an analysis of all relevant data so as to determine the effectiveness and return on investment of funding under said section 6D of said chapter 40J. The commission's review shall include specific findings and legislative recommendations including the following:-

(1) to what extent the program increased the adoption of interoperable electronic health records, including to what extent the program increased the adoption of interoperable electronic health records for providers;

(2) to what extent the program reduced health care costs or the growth in health care cost trends on a provider-based net cost and health plan based premium basis, including an analysis of what entities benefitted from, or were disadvantaged by, any cost reductions and the specific impact of the funding mechanism as established in subsection (a) of section 70 of chapter 118E;

(3) to what extent the program increased the number of health care providers in achieving and maintaining compliance with the standards for meaningful use, beyond stage 1, established by the United States Department of Health and Human Services ;

(4) to what extent the program should be discontinued, amended or expanded, and if so, a timetable for implementation of the recommendations; and

(5) to what extent additional public funding is needed for the e-Health Institute Fund, as established in section 6E of chapter 40J of the General Laws.

(c) To conduct these studies, the commission shall contract with an outside organization with expertise in the analysis of the health care financing. In conducting its examination, the outside organization shall, to the extent possible, obtain and use actual health plan data from the all-payer claims database as administered by the institute of health care finance and policy; but such data shall be confidential and shall not be a public record for any purpose.

(d) The commission shall report the results of its review and its recommendations, if any, together with drafts of legislation necessary to carry out such recommendations by March 31, 2017. The report shall be provided to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and shall be posted on the department's website.

Clerk #5

Expert Witness Testimony

Messrs. McGee and Joyce moves that the bill (Senate, No. 2260) be amended in section 166, by striking out lines 4556 through 4563.

REDRAFT Clerk #6

Commission on Prevention and Wellness

Mr. Donnelly moves to amend the bill, Senate No. 2260, in Section 192, by striking out the number "19" and inserting in place thereof the following number:- "20"

Mr. Donnelly moves to further amend the bill, in line 4957, by inserting after the words" workers;" the following:- "and 1 of whom shall be a person representing frontline registered nurses"

ADOPTED

Clerk #7

Commonwealth Health Care Quality and Finance Authority

Senator Donnelly moves to amend the bill, Senate No. 2260, in section 2(f) of Section 162, by striking, in line 3960, the words "or any other employees."

Clerk #8

Healthcare Workforce Representation on the Special Commission to Review Public Payer Rates

Messrs. Donnelly, DiDomenico and Montigny moves that the bill be amended, Senate No. 2260, Section 189, by striking out, in line 4825, the figure "11", and inserting in place thereof the following figure:- 12.

Mr. Donnelly moves to further amend the bill, in Section 189, by adding, in line 4833, after the words "Massachusetts Association for Behavioral Healthcare;" the following words:- 1 of whom shall be appointed by the Massachusetts division of 1199SEIU-HealthCare Workers East;"

REDRAFT Clerk #9

Strengthen Patient-Centered Care in Beacon ACOs

Ms. Chang-Díaz moves to amend the bill (Senate, No. 2260), in Section 162, by inserting in line 4258, after the word "measures", the words:- ", including measures of quality of life and physical and programmatic access to health care services for people with disabilities and measures of patient confidence and patient engagement"; and

by inserting in line 4272, after the word "care", the words:- "and care coordination"; and

by inserting, in line 4276, after the word "minorities", the words:- ", including demonstrating an ability to provide culturally and linguistically appropriate care, and including patient education and outreach provided by community health workers"; and

by inserting, in line 4279, after the word "home", the words:- ", recovery coaching and peer support, and services provided by peer support workers, certified peer specialists and licensed alcohol and drug counselors"; and

by inserting, in line 4282, after the word “coordination”, the words:- “, including group visits and chronic disease self-management programs”;

REDRAFT Clerk #10

Consumer Protections in Appeals Processes for Provider Organizations

Mr. Brownsberger moves to the amend the bill, in section 150, in the first paragraph of proposed section 23 of chapter 176O of the General Laws by adding the following sentence: “The decision on the appeal shall be in writing and shall notify the patient of the right to file a further external appeal.”; and

in said section 150, in said proposed section 23 of chapter 176O of the General Laws, by striking out the second paragraph and inserting in place thereof the following paragraph:-

“The department of public health shall establish by regulation an external review process for the review of grievances submitted by or on behalf of patients of provider organizations registered under section 10 of chapter 12C utilizing alternative payment methodologies. The process shall specify the maximum amount of time for the completion of a determination and review after a grievance is submitted and shall include the right to have benefits continued pending appeal. The department shall establish expedited review procedures applicable to emergency and urgent care situations.”.

Clerk #11

WITHDRAWN

Clerk #12

WITHDRAWN

Clerk #13 REDRAFT

Qualifying Health Insurance Coverage

Mr. Michael O. Moore moves to amend the bill (Senate, No. 2260) by inserting, after section 114 the following section:-

"SECTION 114A. Said subsection (c) of said section 188 of said chapter 149, as so amended, is hereby further amended by adding the following clause:-
(11) In calculating the fair share assessment, employees who have qualifying health insurance coverage from a spouse, parent, veteran's plan, Medicare, Medicaid or a plan or plans due to a disability or retirement shall not be included in the numerator or denominator for purposes of determining whether an employer is a contributing employer, as defined in 114.5 CMR 16.02."; and

By inserting after section 202 the following new section:-

"SECTION 202A. Section 114A shall take effect on February 1, 2013.".

Clerk #14

Chronic Disease Management

Messrs. Michael O. Moore and Joyce moves to amend the bill (Senate, No. 2260), in section 48, by striking out, in line 1381 the word "or"; and in said section 48, by inserting after the words "prevention programming", in line 1382, the following clause:- "; or (vi) promote daily management of chronic diseases to achieve healthy outcomes".

Clerk #15

Behavioral Health Task Force

Messrs. Michael O. Moore and Joyce moves to amend the bill (Senate, No. 2260), in section 182, by inserting after the word "outcomes;", in line 4740, the following words:- ", particularly with respect the effects of cardiovascular disease, diabetes and/or obesity on patients with serious mental illness."

ADOPTED

Clerk #16

Disclosure of Utilization Review Criteria

Mr. Michael O. Moore moves to amend the bill (Senate, No. 2260) in section 144, in proposed subsection (a) of section 12 of chapter 176O, by adding the following sentence:-

"The disclosure of utilization review criteria required by this section shall not apply to licensed, proprietary criteria purchased by a carrier or utilization review organization.".

Clerk #17

Medical Loss Ratios

Messrs. Michael O. Moore and Knapik moves to amend the bill (Senate, No. 2260) by inserting, after section ___, the following section:-

"SECTION ___. Subsection (b) of section 6 of Chapter 176J of the General laws is hereby amended by adding the following subsection:-

(xi) For purposes of this section, medical loss ratios shall not include fees on commissions included in premiums that are collected solely for the purpose of passing such fees or commissions on to insurance agents or brokers to the extent such fees or commissions are actually paid."

ADOPTED

Clerk #18

Labor Organizations 1

Mr. McGee moves that the bill (Senate, No. 2260) be amended in section 14, line 293, by inserting “and labor organizations” after the words “and public and private payers”.

REDRAFT Clerk #19

Labor Organizations 2

Mr. McGee moved to amend the bill in section 50, line 1519, by striking out the words “and consumer representatives” and inserting in place thereof the following words:- “, consumer representatives and labor organizations”.

Clerk #20

WITHDRAWN

Clerk #21

WITHDRAWN

ADOPTED
Clerk #22

Education and Training for Nurses

Messrs. Rosenberg, Downing and McGee moves to amend the bill (Senate, No. 2260) in section 178, by striking out, in line 4698, the words “health care providers” and inserting in place thereof the following word:-“physicians”; andin said section 178, by inserting, in line 467, after the word “management.” the following:-
“Notwithstanding any general or special law to the contrary, the board of registration in nursing, established under section 13 of chapter 13 of the General Laws, shall promulgate regulations relative to the education and training of advanced practice nurses authorized to practice consistent with section 80B of chapter 112, in the early

disclosure of adverse events, including but not limited to, continuing education requirements. Nothing in this section shall affect the total hours of continuing education required by the board"

2nd REDRAFT Clerk #23

Transparency in Billing

Mr. Rodrigues moves to amend the bill (Senate, No. 2260), in section 14, by inserting after the word "networks;", in line 735, the following words:- "(iv) the impact of any assessments including, but not limited to, the health system benefit surcharge collected under section 68 of chapter 118E, on health insurance premiums;".

Clerk #24

Medication Aides in Nursing Homes

Mr. Finegold moves to amend the bill (Senate, No. 2260) by inserting, after section 67, the following section:-

"SECTION 67A. Said chapter 111 of the General Laws, as so appearing, is hereby amended by inserting, after section 72AA, the following section:-

Section 72BB. (a) As used in this section the following words shall have the following meanings:-

"Long term care facility", a convalescent home, nursing home, rest home or charitable home for the aged licensed under the provisions of section seventy-one.

"Certified medication aide," any employee of a long term care facility who has completed a department-certified medication administration training program and is therefore qualified to dispense oral medication which is not included in the schedules of controlled substances established under the federal Comprehensive Drug Abuse

Prevention and Control Act of 1970, 21 U.S.C. Sec. 801 et seq., to patients in such long term care facility.

(b) The department shall establish rules and regulations to establish a medication administration training and certification program for medication aides. The regulations shall include: (1) provisions for continuing education requirements for certified medication aides; (2) requirements for re-certification of certified medication aides on a biennial basis; (3) fees for the issuance of certification to certified medication aides; and (4) standards for qualification of applicants for certification, including the applicant's criminal history, work record, and prohibitions against behavior which may be potentially harmful to patients.

(c) Any person administering a long term care facility may hire a certified medication aide for the purpose of dispensing oral medication which is not included in the schedules of controlled substances established under the federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. Sec. 801 et seq., to patients in such long term care facility.

(d) The department may promulgate rules and regulations to carry out the provisions of this section."

ADOPTED

Clerk #25

Graduate Medical Education

Mr. Michael O. Moore moves to amend the bill (Senate, No. 2260) by inserting, after section ___, the following section:-

SECTION XX. There shall be a special commission to examine the economic, social and educational value of graduate medical education in the commonwealth and to recommend a fair and sustainable model for the future funding of graduate medical

education in the commonwealth.

The commission shall consist of 13 members: 1 of whom shall be the secretary of health and human services or a designee, who shall serve as chair; 1 of whom shall be the secretary of administration and finance or a designee; 1 of whom shall be the secretary of labor and workforce development or a designee; 1 of whom shall be the commissioner of public health or a designee; 1 of whom shall be a representative of the Massachusetts Hospital Association; 1 of whom shall be a representative of the Massachusetts Medical Society; 1 of whom shall be a representative of the Massachusetts League of Community Health Centers; 4 of whom shall represent each of the commonwealth's 4 medical schools; 1 of whom shall be a representative of the Conference of Boston Teaching Hospitals; and 1 of whom shall be a resident in training at a Massachusetts hospital, appointed by the secretary of health and human services.

The commission shall investigate and report on the following issues:

1. The role of residents and medical faculty in the provision of health care in the commonwealth and throughout the United States.
2. The relationship of graduate medical education to the state's physician workforce and emerging models of delivery of care.
3. The current availability and adequacy of all sources of revenue to support graduate medical education and potential additional or alternate sources of funding for graduate medical education. Such review shall include the availability of federal graduate medical education funding to different types of institutes where training takes place.
4. Approaches taken by other states to fund graduate medical education through Medicaid programs, including, but not limited to: (a) establishment of medical education trust funds, and(b) efforts to link payments to state policy goals, including:

i. Increasing the number of high demand specialties or fellowships;
ii. Enhancing retention of physicians in Massachusetts practice;
iii. Promoting practice in medically underserved areas of the state and reducing disparities in health care;
iv. Increasing the primary care workforce;
v. Increasing the behavioral health care workforce; and
vi. Increasing racial and ethnic diversity within the physician workforce.

The commission shall file a report of its findings and recommendations, together with drafts of legislation, if any, necessary to carry out its recommendations by filing the same with the clerks of the house and senate who shall forward a copy of the report to the house and senate committees on ways and means and the joint committee on health care financing not later than April 1, 2013.

Clerk #26

Small Business Wellness Incentive Program

Messrs. Rodrigues, DiDomenico Knapik and Joyce moves to amend the bill (S. 2260) by striking it out section 160 in its entirety and inserting in place thereof the following section:-

SECTION 160. Chapter 176Q of the General Laws is hereby amended by striking out section 7A and inserting in place thereof the following section:-

Section 7A. (a) There shall be a small group wellness incentive pilot program to expand the prevalence of employee wellness initiatives by small businesses. The program shall be administered by the board of the connector, in consultation with the department of public health. The program shall provide subsidies and technical assistance for eligible small groups to implement evidence-based employee health and wellness programs to improve employee health, decrease employer health costs and increase productivity.

(b) An eligible small group shall be qualified to participate in the program if:

1. the eligible small group purchases group coverage from a carrier certified by the connector to participate in the program;
2. the eligible small group enrolls in an evidence-based, employee wellness program offered by that certified carrier;
3. the eligible small group meets certain minimum criteria, as determined by the connector board; and
4. the eligible small group meets certain minimum employee participation requirements in the qualified wellness program, as determined by the connector board, in collaboration with the department of public health.

(c) For eligible small groups participating in the program, the connector shall provide an annual subsidy not to exceed 15 per cent of eligible employer health care costs as calculated by the connector board. If the director determines that funds are insufficient to meet the projected costs of enrolling new eligible employers, the director shall impose a cap on enrollment in the program.

(d) The connector shall report annually to the joint committee on community development and small business, the joint committee on health care financing and the house and senate committees on ways and means on the enrollment in the small business wellness incentive program and evaluate the impact of the program on expanding wellness initiatives for small groups.

(e) The connector shall promulgate regulations to implement this section.

Clerk #27

Entities Able to Purchase through Health Connector

Messrs. Rodrigues and Knapik moves to amend the bill (S. 2260) by striking out Section 159 in its entirety.

REDRAFT Clerk #28

Nursing Facilities

Ms. Chandler moves to amend the bill, (Senate, No. 2260) by inserting after SECTION___, the following section:-

SECTION__: Chapter 111 of the General Laws is hereby amended by inserting after section 70G of said chapter 111, the following section:-

Section 70H. Notwithstanding any provision in chapter 93A, sections 70E, 72E and 73 of chapter 111 of the General Laws, and 940 Code of Massachusetts Regulations section 4.09, a facility or institution licensed by the department of public health pursuant to General Laws chapter 111 , section 71 may move a resident to different living quarters or to a different room within the facility or institution if, as documented in the resident's clinical record and as certified by a physician, the resident's clinical needs have changed such that the resident either (1) requires specialized accommodations, care, services, technologies, staffing not customarily provided in connection with the resident's living

quarters or room, or (2) ceases to require the specialized accommodations, care, services, technologies or staffing customarily provided in connection with the resident's living quarters or room; provided, however, that nothing in this section shall obviate a resident's notice and hearing rights when movement to different living quarters involves a resident moving from a Medicare-certified unit to a non-Medicare-certified unit or involves a resident moving from a non-Medicare-certified unit to a Medicare-certified unit and, provided, however, that the resident shall have the right to appeal to the facility's or institution's medical director a decision to move the resident to a different living quarter or to a different room within the facility or institution.

Clerk #29

MEDICALLY NECESSARY TESTING

Ms. Chandler moves to amend the bill, (Senate, No. 2260) in SECTION 162 in line 4265 by inserting after the words "diagnostic imaging and screening services" in section 8(c)(3) of proposed Chapter 176S of the General Laws the following words:--"; clinical laboratory and pathology services" and in SECTION 162 by inserting the following new subsection of section 8(c) of proposed Chapter 176S of the General Laws:- (15) to ensure that patients receive the medically necessary testing required for optimal diagnosis and treatment through (a) a decision making process, guidelines or protocol mechanism by which an accountable care organization makes medical determinations on the appropriate ordering and use of clinical laboratory services, and (b) clinical integration of the medical director of the laboratory, accredited or certified under the federal Clinical Laboratory Improvements Act of 1988 (CLIA), providing these services to the organization.

REDRAFT Clerk #30

Prevention and Wellness Trust

Ms. Chandler and Ms. Chang-Diaz move to amend the bill (Senate, No.2260), in section 192, by striking out subsection (b) and inserting in place thereof the following subsection:-

"(b) The commission shall review the program authorized under said section 2G of said chapter 111 and shall issue a report. The report shall include an analysis of all relevant data to determine the effectiveness and return on investment of the program including, but not limited to, an analysis of: (i) the extent to which the program impacted the prevalence of preventable health conditions; (ii) the extent to which the program reduced health care costs or the growth in health care cost trends; (iii) whether health care costs were reduced, and who benefitted from the reduction; (iv) the extent to which workplace-based wellness or health management programs were expanded, and whether those programs improved employee health, productivity and recidivism; (v) if employee health and productivity was improved or employee recidivism was reduced, the estimated statewide financial benefit to employers; (vi) recommendations for whether the program should be discontinued, amended or expanded, as well as a timetable for implementation of the recommendations; and (vii) recommendations for whether the funding mechanism for the Prevention and Wellness Trust Fund, as established under section 68 of chapter 118E of the General Laws, should be extended beyond 2017, or whether an alternative funding mechanism should be established.".

Clerk #31

WITHDRAWN

Clerk #32

WITHDRAWN

Clerk #33

WITHDRAWN

2nd REDRAFT Clerk #34

Primary Care Residency Grant Program

Messrs. Finegold, Hart, Petruccelli, Keenan, Ms. Chandler, Ms.Chang-Diaz and Ms. Donoghue move to amend the bill (Senate, No. 2660) by striking out section 23 and inserting in place thereof the following section:-

"SECTION 23. Chapter 29 of the General Laws is hereby amended by inserting after section 2EEEE the following section:-

Section 2FFFF. There shall be established upon the books of the commonwealth a separate fund to be known as the Health Care Workforce Transformation Fund to be expended, without further appropriation, by the secretary of labor and workforce development. The fund shall consist of any funds that may be appropriated or transferred for deposit into the trust fund, public and private sources such as gifts, grants and donations to further health care workforce development and interest earned on such revenues, and other sources.

The secretary of labor and workforce development as trustee, shall administer the fund. The secretary, in consultation with the Health Care Workforce Advisory Board established in subsection (c), shall make expenditures from this account consistent with the subsections (e) and (f); provided, that not more than 10 per cent of the amounts held in the fund in any 1 year shall be used by the secretary for the combined cost of program administration, technical assistance to grantees and program evaluation.

(b) Revenues deposited in the fund that are unexpended at the end of the fiscal year shall not revert to the General Fund and shall be available for expenditure in the following fiscal year.

(c) There shall be Health Care Workforce Advisory Board constituted to make recommendations to the secretary concerning the administration and allocation of the fund, establish evaluation criteria and perform any other functions specifically granted to it by law.

The board shall consist of the following members: the secretary of labor and workforce development, who shall serve as chair; the executive director of the institute of health care finance and policy or a designee; the commissioner of public health or a designee, and no more than 13 members who shall be appointed by the secretary of labor and workforce development and who shall reflect a broad distribution of diverse perspectives on the health care system and health care workforce needs, including health care professionals, labor organizations, educational institutions, consumer representatives, providers and payers.

The secretary shall, under the advice and guidance of the Health Care Workforce Advisory Board, annually report on its strategy for administration and allocation of the fund, including relevant evaluation criteria, and short-term and long-term programmatic and policy recommendations to improve workforce performance.

(d) All expenditures from the Health Care Workforce Transformation Fund shall have 1 or more of the following purposes:-

(i) support the development and implementation of employer and work programs to enhance worker skills, income, productivity and retention rates;

(ii) address critical workforce shortages;

(iii) address workforce needs identified in the health resource plan developed under section 25A of chapter 111;

(iv) improve employment in the health care industry for the unemployed or low-income individuals and low-wage workers;

(v) provide training or educational services for currently employed or unemployed health care workers who are seeking new positions or responsibilities within the health care industry;

(vi) provide training or educational services for existing health care workers in emerging fields of care delivery models;

(vii) provide loan repayment and incentive programs for health care workers;

(viii) provide career ladder programs for health care workers; or

(ix) any other purpose the secretary, in consultation with the Health

Care Workforce Advisory Board, determines.

(e) The secretary shall establish a competitive grant process funded by the Health Care Workforce Transformation Fund to eligible applicants to provide education and training to health care workers. Eligible applicants shall include: employers and employer associations; local workforce investment boards; labor organizations; joint labor-management partnerships; community-based organizations; institutions of higher education; vocational education institutions; one-stop career centers; local workforce development entities; and any partnership or collaboration between eligible applicants. Expenditures from the fund for such purposes shall complement and not replace existing local, state, private, or federal funding for training and educational programs.

(f) A grant proposal submitted under subsection (e) shall include, but not be limited to:

(i) a plan that defines specific goals for health care workforce training and educational improvements over a multi-year period in specific areas;

(ii) the evidence-based programs the applicant shall use to meet the goals;

(iii) a budget necessary to implement the plan, including a detailed description of any funding or in-kind contributions the applicant or applicants will be providing in support of the proposal;

(iv) any other private funding or private sector participation the applicant anticipates in support of the proposal; and

(v) the anticipated number of individuals who would receive a benefit due to the implementation of the plan.

Priority may be given to proposals that target areas of critical labor needs for the health care industry or that are projected to be critical labor needs of the health care industry in the near future. Priority may also be given to proposals that target geographic areas with specific health care workforce needs or that target geographic areas with unemployment levels higher than the state average. If no proposals were offered in areas of particular need, the secretary may provide technical assistance and

planning grant funding directly to eligible applicants in order to develop grant proposals.

The secretary shall, in consultation with the Health Care Workforce Advisory Board, develop guidelines for an annual review of the progress being made by each grantee. Each grantee shall participate in any evaluation or accountability process implemented by or authorized by the secretary.

(g) The secretary shall annually expend not less than 20 per cent of available funds in the Health Care Workforce Transformation Fund to expand training and loan forgiveness programs for primary care providers in the commonwealth. The training and loan forgiveness programs for primary care providers shall include, but not be limited to:

(i) The secretary shall establish a competitive primary care residency grant process funded by the Health Care Workforce Transformation Fund to eligible applicants for the purpose of financing the training of primary care providers at teaching community health centers. Eligible applicants shall include teaching community health centers accredited through affiliations with a commonwealth funded medical school or licensed as part of a teaching hospital with a residency program in primary care or family medicine and teaching health centers that are the independently accredited sponsoring organization for the residency program and whose residents are employed by the health center.

To receive funding, an applicant shall (a) include a review of recent graduates of the teaching community health center's residency program, including information regarding what type of practice said graduates are involved in 2 years following graduation from the residency program; and (b) achieve a threshold of at least 50 per cent for the percentage of graduates practicing primary care within 2 years after graduation. Graduates practicing (a) more than 50 per cent inpatient care or (b) more than 50 per cent specialty care, as listed in the American Medical Association Masterfile, shall not qualify as graduates practicing primary care.

Awardees of the primary care residency grant program shall maintain their teaching accreditation as either an independent teaching community health center or as a

teaching community health center accredited through affiliation with a commonwealth funded medical school or licensed as part of a teaching hospital.

(ii) A primary care workforce development and loan forgiveness grant program at community health centers, for the purpose of enhancing recruitment and retention of primary care physicians and other clinicians at community health centers throughout the commonwealth. The grant program shall be administered by the department of public health; provided, that the department may contract with an organization to administer the grant program. Funds for the grant program shall be matched by other public or private funds.

(iii) The health care provider workforce loan repayment program, established in section 25N of chapter 111, as administered by the department of public health.

(h) The comptroller shall annually transfer not less than 10 per cent of available funds in the Health Care Workforce Transformation Fund to the Massachusetts Nursing and Allied Health Workforce Development Trust Fund established in section 33 of chapter 305 of the acts of 2008 to develop and support strategies that increase the number of public higher education faculty members and students who participate in programs that support careers in fields related to nursing and allied health.

(i) The secretary shall, annually on or before January 31, report on expenditures from the Health Care Workforce Transformation Fund. The report shall include, but shall not be limited to: (i) the revenue credited to the fund; (ii) the amount of fund expenditures attributable to the administrative costs of the secretary of labor and workforce development; (iii) an itemized list of the funds expended through the competitive grant process and a description of the grantee activities; and (iv) the results of the evaluation of the effectiveness of the activities funded through grants. The report shall be provided to the chairs of the house and senate committees on ways and means, the joint committee on public health, the joint committee on health care financing and the joint committee on labor and workforce development and shall be posted on the department of public health’s website.

(j) The secretary of labor and workforce development may promulgate appropriate regulations to carry out this section.”.

ADOPTED

REDRAFT Clerk #35

Use of Prior Authorization

Mr. Petruccelli moves to amend the bill (Senate, No. 2260) in section 150 by adding the following subsection:-

(f) Nothing in this section shall limit a health plan from requiring prior authorization for services.

Clerk #36

Actuarial Soundness of Rates

Mr. Petruccelli moves to amend the bill (Senate, No. 2260) by inserting after section 124, the following new language:-

SECTION 125. Section 6 of chapter 176J of the General Laws is hereby amended by striking subsection (c), as most recently amended by section 31A of chapter 359 of the acts of 2010, and inserting in place thereof the following subsection:-

(c) Notwithstanding any general or special law to the contrary, the commissioner may require carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or 176G, to file all changes to small group product base rates and to small group rating factors at least 90 days before their proposed effective date. The commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged. The commissioner shall disapprove any change to small group rating factors that is discriminatory or not actuarially sound. The determination of the commissioner shall be supported by sound actuarial assumptions and methods, which shall be provided in writing to the carrier. Rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-

sixth of section 7 of chapter 4. The commissioner shall adopt regulations to carry out this section.

Clerk #37

Provider Refunds

Messrs. Richard T. Moore and Joyce moves to amend the bill (Senate, No. 2260) by inserting at the end thereof the following new section:-

SECTION__. Notwithstanding any general or special law to the contrary, a participating provider, as defined in chapter 176O of the General Laws, may contract with a carrier, as defined in chapter 176J of the General Laws, to provide one-time supplemental funding for the purposes of issuing refunds for all health benefit plans issued to its current eligible individuals and small groups under said chapter 176J. The refund may take the form of either a refund on the premium for the applicable 12-month period or any other form determined by the parties by contract. The division of insurance may require the filing of such contracts after execution for the purposes of ensuring distribution as provided in the contracts. The division shall issue a public report by December 31, 2013 detailing the participating providers who have entered into such contracts in calendar year 2012 and 2013, the amount of one-time supplemental funding by participating provider, and the estimated aggregate refunds to be provided to eligible individuals and small groups. The commissioner may issue further regulations as necessary to implement this section.

REDRAFT Clerk #38

Expanded Authority for the Office of the Attorney General

Ms. Candaras moves to amend the bill (Senate, No. 2260) by striking out section 13 and inserting in place thereof the following section:-

"SECTION 13. Chapter 12 of the General Laws is hereby amended by inserting after section 11M the following section:-

Section 11N. (a) The attorney general shall monitor trends in the health care market including, but not limited to, trends in provider organization size and composition, consolidation in the provider market, payer contracting trends and patient access and quality issues in the health care market. The attorney general may obtain the following information from a private health care payer, public health care payer, provider or provider organization, as those terms are defined in section 1 of chapter 12C: (i) any information that is required to be submitted under sections 9, 10 and 11 of chapter 12C, (ii) filings, applications and supporting documentation related to any material change subject to a cost, market impact and solvency review under section 10 of chapter 12C and (iii) filings, applications and supporting documentation related to a determination of need application filed under section 25C of chapter 111. Under section 15 of chapter 12C and section 6 of chapter 176S, and subject to the limitations stated in those sections, the attorney general may require that any provider, provider organization, private health care payer or public health care payer produce documents, answer interrogatories and provide testimony under oath related to health care costs and cost trends , the factors that contribute to cost growth within the commonwealth's health care system and the relationship between provider costs and payer premium rates.

(b) The attorney general shall, in consultation with the institute of health care finance and policy, take appropriate action within existing statutory authority to: (i)prevent excess consolidation or collusion of provider organizations and to remedy these or other related anti-competitive dynamics in the health care market; (ii) prevent unreasonable increases in health care rates, charges, medical expenses or prices; and (iii) prevent or mitigate adverse effects on patient access and quality in the health care market.

(c) The attorney general may intervene or otherwise participate in efforts by the commonwealth to obtain exemptions or waivers from certain federal laws regarding provider market conduct, including, from the federal Office of the Inspector General, a

waiver of, or expansion of, the "safe harbors" provided for under 42 U.S.C. section 1320a-7b and obtaining from the federal Office of the Inspector General a waiver of, or exemption from, 42 U.S.C. section 1395nn subsections (a) to (e).

(d) The attorney general may act under existing authority including, but not limited to, subsection (b) of section 15 of chapter 12C and section 6 of chapter 176S to carry out this section."; and

by inserting after the words "chapter 12C," in line 1638, the following words:- "shall take into account any comments from the attorney general"; and

by inserting after the word "application" in line 1651, the following words:- "at its discretion or at the request of the attorney general. The attorney general may intervene in any hearing under this section.".

Rejected

Clerk #39

Non-Acute Determination of Need

Ms. Candaras moves that the bill be amended by inserting after section X, the following new language:-

SECTION XXX: Section 25B of Chapter 111 of the General Laws, is hereby further amended by striking out, in lines 23, 28, 29, and 44, of the 2008 official edition the words "acute care."

Clerk #40

Oversight of the Health Care Market to Ensure Fair Competition

Ms. Candaras moves that the bill be amended by inserting after section X, the following new language:-

Chapter 12 of the General Laws is hereby amended by inserting at the end thereof the following section:

Section 33. (a) The Attorney General shall, pursuant to G.L. c. 93A, section 2(c), within 180 days of the enactment of this section, investigate and issue regulations proscribing unfair, deceptive, or anticompetitive conduct within the Commonwealth's healthcare marketplace. Such regulations shall include, at a minimum, the prohibition of anticompetitive contracting practices between and/or among acute care hospitals and insurers, in which the acute care hospital possesses the market power to impose non-transitory increases in rates charged for health care services.

(b) The following shall be unfair methods of competition and unfair or deceptive acts or practices for providers or provider organizations: (i) entering into any agreement to commit or by any concerted action committing any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of or monopoly in the delivery of health care services, contracting for payment for health care services, or the business of insurance; (ii) seeking to set the price to be paid by any carrier for network contracts at rates that are excessive, unreasonable, discriminatory, predatory, or would otherwise cause the carrier to violate the requirements of its licensure or accreditation; (iii) engaging in any unfair discrimination between individuals who are similarly covered by network contracts; and (iv) making, publishing, disseminating, circulating, or placing before the public, directly or indirectly, any assertion, representation or statement which is untrue, deceptive or misleading.

Rejected

Clerk #41

Regulation of Pharmacy Audits

Ms. Fargo and Ms. Donoghue moves to amend Senate No. 2260 by adding the following section:-

SECTION XXX

The General Laws are hereby amended by inserting after chapter 175K the following chapter:-

Chapter 175L

Regulation of Pharmacy Audits

Section 1. Definitions.

For purposes of this chapter the following terms shall have the following meanings:

"Pharmacy Benefits Manager", any person or entity that administers the prescription drug, prescription device, pharmacist services or prescription drug and device and pharmacist services portion of a health benefit plan on behalf of plan sponsors such as self-insured employers, insurance companies, and labor unions. A health benefit plan that does not contract with a pharmacy benefit manager shall be considered a pharmacy benefit manager for the purposes of this chapter unless specifically exempted. The provisions of this chapter shall not apply to a public health care payer as defined in section 1 of chapter 118G.

"Commissioner", the commissioner of insurance or his designee.

Section 2. Certification of Pharmacy Benefits Managers

(a) Except as provided in subsection (d) of this section, no person shall act as a pharmacy benefits manager without first obtaining a certificate of registration from the commissioner.

(b) Any person seeking a certificate of registration shall apply to the commissioner, in writing, on a form provided by the commissioner. The application form shall state (1) the name, address, official position and professional qualifications of each individual responsible for the conduct of the affairs of the pharmacy benefits manager, including

all members of the board of directors, board of trustees, executive committee, other governing board or committee, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association and any other person who exercises control or influence over the affairs of the pharmacy benefits manager, and (2) the name and address of the applicant's agent for service of process in the Commonwealth.

(c) Each application for a certificate of registration shall be accompanied by a nonrefundable fee set by the Commissioner of no less than five hundred dollars.

(d) A health benefit plan that does not contract with a pharmacy benefit manager shall not be required to obtain a certificate of registration. Such health benefit plan shall notify the commissioner annually, in writing that it is affiliated with or operating a business as a pharmacy benefits manager.

(e) Any person acting as a pharmacy benefits manager on January 1, 2011, and required to obtain a certificate of registration under subsection (a) of this section, shall obtain a certificate of registration from the commissioner not later than April 1, 2011.

Section 3. Audit Scope and Procedures.

(a) Notwithstanding any general or special law to the contrary, an audit of the records of a pharmacy conducted by a pharmacy benefit manager shall conform to the standards set forth by the January 2012 report: Model Audit Guidelines for Pharmacy Claims by the Academy of Managed Care Pharmacy.

Section 4. The provisions of this chapter shall not apply to any audit or investigation that involves potential fraud, willful misrepresentation, or abuse, including, but not limited to, investigative audits or any other statutory or regulatory provision that authorizes investigations relating to insurance fraud.

Section 5. The commissioner may promulgate regulations to enforce the provisions of this chapter.

Clerk #42

Office of Health Equity and Community Based Grants Programs to Eliminate Racial and Ethnic Health Disparities

Ms. Fargo and Ms. Chang-Diaz moves to amend S. 2260 by inserting the following new sections:-

"SECTION XX. Said chapter 6A is hereby amended by inserting after section 16S the following section: –

Section 16T. There shall be an office of health equity within the executive office of health and human services. The office shall be in the charge of a director, who shall report directly to the secretary of health and human services. The health disparities council, described in section 16O, shall serve as an advisory board to the office of health equity.

SECTION XXX. The General Laws are hereby amended by inserting after chapter 111N the following chapter:–

CHAPTER 111O. OFFICE OF HEALTH EQUITY.

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

"Disparities" or "Racial and ethnic health and health care disparities", differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific racial and ethnic groups.

"Office", the office of health equity, as established by section 16T of chapter 6A.

Section 2. The office, subject to appropriation, shall coordinate all activities of the commonwealth to eliminate racial and ethnic health and health care disparities. The office shall set goals for the reduction of disparities and prepare an annual plan for the commonwealth to eliminate disparities.

Section 3. The office, subject to appropriation, shall collaborate with other state agencies of the commonwealth on disparities reduction initiatives to address the social factors that influence health inequality. These state agencies shall include, but shall not be limited to, the executive office of health and human services, the executive office of housing and economic development, the executive office of public safety and security, the executive office of energy and environmental affairs, the Massachusetts Department of Transportation, the executive office of labor and workforce development and the executive office of education.

The office shall facilitate communication and partnership between these agencies to develop greater understanding of the intersections between agency activities and health outcomes. The office shall facilitate development of interagency initiatives to address the social and economic determinants of health and key health disparities issues including, but not limited to, healthcare access and quality; housing availability and quality; transportation availability, location and cost; community policing and safe spaces; air, water, land usage and quality; employment and workforce development; and education access and quality.

Section 4. The office, subject to appropriation, shall evaluate the effectiveness of programs and interventions to eliminate health disparities, identifying best practices and model programs for the state.

Section 5. (a) The office shall, subject to appropriation, administer a community-based agency disparities reduction grant program. The grants shall support efforts by community-based agencies to eliminate racial and ethnic health disparities among predominantly underserved populations, including efforts addressing social factors integral to such disparities. Grants shall be awarded following a competitive application

process. In awarding grants, the office shall give priority to programs replicable by other community-based agencies. Grants shall be provided to a broad range of agencies that support diverse communities throughout the state. No community-based agency may receive more than one grant concurrently. All grants shall include an evaluation component.

(b) The program shall provide grants to community-based agencies and non-profit community organizations to address key disparities issues including but not limited to: the social and economic barriers that impact health outcomes, the development of a diverse healthcare workforce across wide range of healthcare professions, increasing the access, utilization and quality of healthcare services, and supporting community health workers to facilitate the use of health and human services

(c) For the purposes of this section, a "community-based agency" shall include agencies that provide direct services, education, or support to underserved populations, including community health centers and hospitals, social service organizations, community nonprofit organizations, educational institutions, faith based organizations and other non-governmental agencies and other organizations as defined by the office.

Section 6. The secretary of health and human services shall annually, on the day assigned for submission of the budget to the general court under section 7H of chapter 29, designate major initiatives of the commonwealth affecting the health and health care of residents of the commonwealth. These initiatives may include any activity of the commonwealth including, but not limited to, activities of the executive office of health and human services, the executive office of housing and economic development, the executive office of public safety and security, the executive office of energy and environmental affairs, the Massachusetts Department of Transportation, the executive office of labor and workforce development and the executive office of education.

For each major initiative, the office shall prepare a disparities impact statement evaluating the likely positive or negative impact of each initiative on eliminating or reducing racial and ethnic health disparities. The statements shall, to the extent

possible, include quantifiable impacts and evaluation benchmarks. The statements shall be posted on the official internet site of the executive office of health and human services and submitted to the clerks of the house of representatives and senate, members of the health disparities council, appropriate legislative committees and the house and senate committees on ways and means.

Section 7. The office, subject to appropriation, shall prepare an annual health disparities report card. The report card shall evaluate the progress of the commonwealth toward eliminating racial and ethnic health disparities, using, where possible, quantifiable measures and comparative benchmarks. The report card shall report on progress on a regional basis, based on regions designated by the office. The office shall hold public hearings in several regions of the state to get public information on the topics of the report card. The report card shall be delivered to the governor, speaker of the house of representatives and president of the senate and the members of the health disparities council, established under section 16O of chapter 6A, before July 1 of each year and shall be posted on the official internet site of the office or executive office of health and human services.

Section 8. Section 16K of Chapter 6A of the General Laws, as so appearing, is hereby amended by striking out, in subsection (h), as amended by section 3 of chapter 288 of the acts of 2010, the third sentence and inserting in place thereof the following sentence:- The council shall also establish goals that are intended to reduce health care disparities in racial, ethnic and disabled communities and in doing so shall seek to incorporate the recommendations of the health disparities council and the office of health equity.

Section 9. The second paragraph of Section 16 of Chapter 6A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out the words, “and, (7) the health facilities appeals board;” and inserting in place thereof the following words :-

“(7) the health facilities appeal board; and (8) the office of health equity.”

Section 10. Section 16O of said chapter 6A, as so appearing, is hereby amended by inserting after the word, "recommendations," in line 3, the following words: - "to the direct of the office of health equity."

Section 11. Said section 16O of said chapter 6A, as so appearing, is hereby further amended by striking out, in line 15, the "37" and inserting in place thereof the following figure : - "38."

Section 12. Said section 16O of said chapter 6A, as so appearing, is hereby further amended by inserting after word "offio", in line 19, the following words : - "the direct of the office of health equity, or the director's designee."

ADOPTED

REDRAFT Clerk #43

Insurance Coverage of Telemedicine Services

Mr. Montigny moves to amend the bill, (Senate, No. 2260) by inserting after section 122 the following section:-

"SECTION 122A. Chapter 175 of the General Laws is hereby amended by inserting after section 47AA, the following section:

Section 47BB

For the purposes of this section, "telemedicine" as it pertains to the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. "Telemedicine" shall not include the use of audio-only telephone, facsimile machine or e-mail.

An insurer may limit coverage of telemedicine services to those health care providers in a telemedicine network approved by the insurer.

A contract that provides coverage for services under this section may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

Coverage for health care services under this section shall be consistent with coverage for health care services provided through in-person consultation."; and

by inserting after section 202 the following section:-

"SECTION 202A. The requirements of section 47BB of chapter 175 of the General Laws shall apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed on or after January 1, 2013. For purposes of that section, all contracts shall be deemed to be renewed not later than the next yearly anniversary of the contract date."

Clerk #44

Composition of the Board of the Commonwealth Health Care Quality and Finance Authority

Ms. Fargo and Ms. Chang-Diaz moves to amend S. 2260 in Section 4 of CHAPTER 176S, line 3921 by striking out the number "11" and inserting in place thereof the following number "12";

And further amend the bill in Section 2(b) of CHAPTER 176S, line 3924, by inserting after the word "model" the following words: - "and 1 other member whom shall be an expert in racial and ethnic health disparity,"

Clerk #45

ACO Good Outcomes Incentives

Mr. Montigny moves to amend the bill, in section 162, by striking out, in line 4300, the words, "avoidable hospitalizations, adverse events and unnecessary emergency room visits" and inserting in place thereof the words, "avoidable hospitalizations, avoidable readmissions, adverse events and unnecessary emergency room visits through the use of payment incentives".

Clerk #46

ACO Governance Members Conflicts of Interest

Mr. Montigny moves to amend the bill, S. 2260, in section 162, by inserting after line 4249, after the words "subsequent Medicare regulations.", the following paragraph:

"Members of the governance body shall not have any financial conflicts of interest. The governance body shall have a transparent governing process. The authority shall develop standards to implement the provisions of this paragraph."

Clerk #47

WITHDRAWN

Clerk #48

WITHDRAWN

ADOPTED

REDRAFT Clerk #49

Distressed Community Hospital Fund

Mr. Rush moves to amend the bill (Senate, No. 2260) by inserting after section 173 the following section:-

"SECTION 173. (a)There is hereby established and set upon the books of the commonwealth a separate fund to be known as the Distressed Community Hospital Trust Fund, which shall be administered by the institute of health care finance and policy established under chapter 12C of the General Laws. Expenditures from the Distressed Community Hospital Trust Fund shall be dedicated to efforts to improve and enhance the ability of qualified community hospitals to serve populations in need more effectively.

(b)The Distressed Community Hospital Trust Fund shall consist of any funds that may be appropriated or transferred for deposit into the trust fund and any funds provided from other sources.

(c)The institute shall develop a competitive grant process for awards to be distributed from said fund to qualified community hospitals. The grant process shall consider, among other factors: payer mix, uncompensated care, financial health, geographic need and population need. In assessing financial health, the institute shall take into account days cash on hand, net working capital and earnings before income tax, depreciation and amortization.

(d)A qualified community hospital shall not include a hospital that is a teaching hospital, a hospital that is receiving delivery system transformation initiative funds or a hospital whose relative prices are above the statewide median relative price.

(e)The competitive grant process shall include, at a minimum, a comprehensive uses of funds proposal and a sustainability plan. As a condition of an award, the institute may require a qualified community hospital to agree to take steps to increase its sustainability, including reconfiguration of services, changes in staffing, wages or benefits, changes in governance or a transfer of ownership.".

Rejected

Redraft Clerk #50

Disparities in Health Care Coverage

Ms. Creem moves to amend the bill (Senate, No.2260) by inserting at the end of the bill the following new section:-

Section XXX. The Institute of Health Care Finance and Policy, in conjunction with the Division of Insurance, is hereby directed and authorized to conduct a comprehensive study to investigate disparities in the provision of health care coverage to individuals and/or their spouses when there is a change in marital status. Said study shall include, but not be limited to, the identification and review of disparities in both insured and self-insured plans, as well as recommendations for alleviating disparities. The Institute shall file a report of its study, including recommendations and drafts of any legislation, if necessary, with the clerks of the Senate and House of Representatives within one year of the effective date of this act.

Clerk #51

Healthcare Payment Reform Trust Fund

Ms. Candaras and Messrs. Welch and Knapik moves to amend the bill in section 162, line 4341, by adding the following, after the word "delivery":

and (3) to support safety-net provider participation in new payment and healthcare service delivery models.

and in section 162, line 4345, by adding the following, after the word "authority":

Provided that, in providing assistance from the Fund the Authority shall give preference to entities that include hospitals that receive greater than 63% of their gross patient service revenue from governmental payers.

Rejected

Clerk #52

Massachusetts Prevention Council

Ms. Chandler and Messrs. Montigny and Joyce move to amend the bill, (Senate, No. 2260) by inserting after SECTION___, the following section:-

SECTION__. In order to determine, as a basis for legislative and administrative action, the resources and approaches needed to achieve the healthcare and wellness goals of the Commonwealth, a committee, known as the Massachusetts Prevention Council, shall be established. The commission shall consist of the Commissioner of the Department of Public Health, or his designee; the Secretary of the Executive Office of Health and Human Services, or her designee; the Secretary of the Executive Office of Energy and Environmental Affairs, or his designee; the Secretary of Executive Office of Education, or his designee; the Secretary of the Executive Office of Transportation, or his designee; the Secretary of Executive Office of Housing and Economic Development, or his designee; the Secretary of Executive Office of Public Safety, or her designee; the Secretary of Executive Office of Elder Affairs, or her designee; the Commissioner of the Department of Conservation and Recreation, or his designee; the Commissioner of the Department of Environmental Protection, or his designee; the chairs of the Joint Committee on Health Care Financing, or their designees and the chairs of the Joint Committee on Public Health, or their designee. An advisory council to the commission will consist of 1) designees from a representative sample of communities with a population over 125,000, and a representative sample of communities with a population under 125,000; 2) public health advocacy groups; 3) healthcare providers from a representative sample of large hospital systems, small hospitals, and community health centers; 4) other governmental departments. Using the model of the National Prevention Council, the commission shall create Massachusetts Prevention Strategy to work in parallel with federal efforts, as well as to best integrate the ongoing state and local efforts in the Commonwealth. The Massachusetts Prevention Strategy would work to integrate and align policies among federal, state and local governments, as well as promote public and private cooperation and partnerships to achieve a healthier Massachusetts. The commission may hold hearings and invite testimony from experts

and the public. The commission shall review and identify best practices learned from similar efforts in other states, and from the federal government, in order to lower health care costs and improve quality of care. Members of the commission shall be named and the commission shall commence its work within 60 days of the effective date of this act. The commission shall report to the general court the results of its investigation and study, and recommendations, if any, together with drafts of legislation necessary to carry its recommendations into effect by filing the same with the Clerks of the Senate and the House of Representatives on or before January 2, 2014. The Clerks of the House and Senate shall make the report available to the public through the Internet.

2nd REDRAFT Clerk #53

Transparency of Discounts Among Providers

Mr. Hart moves to amend the bill (Senate, No. 2260), in section 14, in subsection (a) of proposed section 9 of chapter 12C of the General Laws, by adding the following sentence:- "The institute shall also promulgate regulations to require providers to report the existence of any agreements through which 1 provider agrees to furnish another provider with a discount, rebate or any other type of refund or remuneration in exchange for, or in any way related to, the provision of heath care services.".

REDRAFT Clerk #54

Prohibiting Random Transfers of Patients Into Different Payment Structures

Mr. Hart moves to amend the bill (Senate Bill, No. 2260) in section 150 by inserting at the end thereof the following:-

Section 25. The division shall promulgate regulations under which a carrier may move members into and out of different payment methodologies, including without limitation different product types, without mutual agreement from the participating provider.

Redraft Clerk #55

Student Medical Expenses Study

Ms. Creem moves to amend the bill (Senate, No.2260) by inserting at the end of the bill the following new section:-

Section XXX. The Department of Elementary and Secondary Education, in consultation with the Institute of Health Care Finance and Policy and the Office of the State Auditor, shall conduct a comprehensive study to investigate the cost to municipalities of providing medically necessary treatments for disease, illness, injury or bodily dysfunction which are required by a student's individual education program, individualized family service plan, individualized service plan or the federal Individuals with Disabilities Act. The study shall include, but not be limited to, possible barriers of transitioning medically necessary costs from municipalities to insurance companies, as well as the potential savings to municipalities. The Department shall file a report of its findings, including recommendations and drafts of any legislation, if necessary, with the clerks of the Senate and House of Representatives within one year of the effective date of this act.

Clerk #56

WITHDRAWN

Clerk #57

Commonwealth Health Care Quality and Finance Authority

Messrs. Hart, Rush, M. Moore, Rodrigues moves to amend the bill (Senate, No. 2260) in Section 162 by striking said section in its entirety and inserting in place thereof the following section:-

“SECTION 162. The General Laws are hereby amended by inserting, after chapter 176R the following 2 chapters:

CHAPTER 176S

COMMONWEALTH HEALTH CARE QUALITY AND FINANCE AUTHORITY

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

“Actual economic growth benchmark,” the actual annual percentage change in the per capita state’s gross state product, excluding the impact of business cycles, as established under section 7H½ of chapter 29.

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

“Alternative payment contract”, any contract between a provider or provider organization and a public health care payer or a private health care payer which utilizes alternative payment methodologies.

“Alternative payment methodologies”, methods of payment that are not directly fee-for-service reimbursement for services; provided, that “alternative payment methodologies” may include, but not be limited to, global payments, shared savings arrangements, bundled payments and episodic payments.

“Authority”, the commonwealth health care quality and finance authority.

“Beacon ACO”, a certification given by the board of the authority to indicate that a provider organization meets certain standards regarding quality, cost containment and patient protection.

“Board”, the board of the commonwealth health care quality and finance authority, established by section 2.

“Business entity”, a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

“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; a health maintenance organization organized under chapter 176G; and an organization entering into a preferred provider arrangement under chapter 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of 1 or more subsidiaries or affiliated corporations of the employer; provided that, unless otherwise noted, the term “carrier” shall not include any entity to the extent it offers a policy, certificate or contract that provides coverage solely for dental care services or visions care services.

“Facility,” a licensed institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers and rehabilitation and other therapeutic health settings.

“Fee-for-service“, a form of contract under which a provider or provider organization is paid for discrete and separate units of service and each provider is separately reimbursed for each discrete service rendered to a patient; provided, however, that up to 10 per cent of total reimbursement under such contracts may depend on the achievement of certain targets of performance or conduct.

“Institute”, the institute of health care finance and policy established in chapter 12C.

“Health benefit plan”, any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; a group medical service plan issued by a non-profit medical service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; a coverage for young adults health insurance plan under section 10 of chapter 176J; provided that “health benefit plan” shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued under chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner of insurance by regulation may set, insurance arising out of a workers compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. section 55 if offered as a separate insurance policy, or any policy subject to chapter 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans; provided, further that “health benefit plan” shall not include a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A which shall be governed by said chapter 15A; provided, further that the authority may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

“Health care cost growth benchmark,” the projected annual percentage change, year over year, in total health care expenditures in the commonwealth, as established in section 5.

“Health care entity”, a provider, provider organization, or providers certified, or otherwise registered under chapter 111, carrier, or other entity that the authority identifies as a material contributor to health care expenses in the commonwealth.

“Health care professional,” a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with law.

“Health care services,” services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

“Health status adjusted total medical expenses”, the total cost and spending for private payer and governmental payer including but not limited to Medicaid, Medicare, and self pay, so called, for the Massachusetts patient population incurred for all categories of medical expenses including without limitation, premiums, allowed claims paid to providers, non-claims related payments to providers, including, but not limited to special payments, supplemental payments, pharmaceutical costs, medical device costs, long term care costs, labor costs, carrier administrative costs, all adjusted by age and health status, and expressed on a per member per month basis, as calculated under section 9 and the regulations promulgated by the institute.

“Major service category,” a set of service categories to be established by regulation, which may include: (i) acute hospital inpatient services, by major diagnostic category, including but not limited to technology, administrative expenses and labor; (ii) outpatient and ambulatory services, by categories as defined by the Centers for Medicare and Medicaid, or as established by regulation, not to exceed 15, including a residual category for “all other” outpatient and ambulatory services that do not fall within a defined category; (iii) behavioral and mental health services by categories as defined by the Centers for Medicare and Medicaid, or as established by regulation; (iv)

professional services, by categories as defined by the Centers for Medicare and Medicaid, or as established by regulation; (v) sub-acute services, by major service line or clinical offering, as defined by regulation; (vi) outpatient drugs; (vii) durable medical equipment, long term care costs, home care and hospice care.

"Medicaid program", the medical assistance program administered by the division of medical assistance under chapter 118E and in accordance with Title XIX of the Federal Social Security Act or any successor statute.

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

"Performance improvement plan," a plan submitted to the authority by a carrier, a provider or a provider organization under section 7, which shall be kept confidential by the board and shall not be considered a public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66.

"Projected economic growth benchmark," the long-term average projected percentage chance in the per capita state's gross state product, excluding the impact of business cycles, as established under section 7H½ of chapter 29.

"Provider," a health care professional or a facility.

"Provider organization," any corporation, partnership, business trust, association or organized group of persons whether incorporated or not that consists of or represents 1 or more providers in contracting with carriers for the payments the provider or providers receive for the provision of heath care services; provided, that "provider organization" shall include, but not be limited to, physician organizations, physician-hospital organizations, independent practice associations, accountable care organizations, provider networks and any other organization that contracts with carriers for payment for health care services.

“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.

“Total health care expenditures,” the annual per capita sum of all health care expenditures in the commonwealth, including spending for private payer and governmental payer including but not limited to Medicaid, Medicare, and self pay, so called, for the Massachusetts patient population incurred for all categories of medical expenses including without limitation, premiums, allowed claims paid to providers, non-claims related payments to providers, including, but not limited to special payments, supplemental payments, pharmaceutical costs, medical device costs, long term care costs, labor costs, carrier administrative costs.”

Section 2. (a) There shall be a body politic and corporate and a public instrumentality to be known as the commonwealth health care quality and finance authority, which shall be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the commonwealth except as specifically provided in any general or special law. The exercise by the authority of the powers conferred by this chapter shall be considered to be the performance of an essential public function. The purpose of the authority shall be to set health care cost containment goals for the commonwealth and to foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care.

(b) There shall be a board, with duties and powers established by this chapter, that shall govern the authority. The authority’s board shall consist of 11 members: the secretary of administration and finance, ex officio; the secretary of health and human services, ex officio; the secretary of housing and economic development, ex officio; 1 other member appointed by the governor whom shall be an expert in health care delivery and payment models; 3 members appointed by the attorney general, 1 of

whom shall be a health economist, 1 of whom shall represent the interests of businesses and 1 of whom shall have experience in the administration of a health care provider organization; 3 members appointed by the state auditor, 1 of whom shall be an expert in behavioral health services and behavioral health reimbursement systems, 1 of whom shall be a representative of a health consumer organization and 1 of whom shall be a representative of organized labor. The governor, attorney general and the auditor shall, by majority vote, jointly appoint 1 member who is an expert in health care finance and policy in the commonwealth, to act as the chair. All members shall serve a term of 3 years, but a member appointed to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall be eligible for reappointment. The board shall annually elect 1 of its members to serve as the vice-chairperson. Each member of the board serving ex officio may appoint a designee under section 6A of chapter 30.

(c) A member of the board shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, have a financial stake in or otherwise be a representative of a health care entity while serving on the board.

(d) Six members of the board shall constitute a quorum and the affirmative vote of 6 members of the board shall be necessary and sufficient for any action taken by the board. No vacancy in the membership of the board shall impair the right of a quorum to exercise all the rights and duties of the connector. Members shall serve without pay but shall be reimbursed for actual expenses necessarily incurred in the performance of their duties. The chairperson of the board shall report to the governor and to the general court not less frequently than annually.

(e) Any action of the authority may take effect immediately and need not be published or posted unless otherwise provided by law. Meetings of the board shall be subject to section 11A of chapter 30A; but, said section 11A shall not apply to any meeting of members of the board serving ex officio in the exercise of their duties as officers of the commonwealth if no matters relating to the official business of the authority are

discussed and decided at the meeting. The authority shall be subject to all other provisions of said chapter 30A and records pertaining to the administration of the authority shall be subject to section 42 of chapter 30 and section 10 of chapter 66. All moneys of the authority shall be considered to be public funds for purposes of chapter 12A. The operations of the authority shall be subject to chapter 268A and chapter 268B.

(f) The chairperson shall hire an executive director to supervise the administrative affairs and general management and operations of the authority and also serve as secretary of the authority, ex officio. The executive director shall receive a salary commensurate with the duties of the office. The executive director may appoint other officers and employees of the authority necessary to the functioning of the authority. Sections 9A, 45, 46 and 46C of chapter 30, chapter 31 and chapter 150E shall not apply to the executive director or any other employees of the authority. The executive director shall, with the approval of the board:

(i) plan, direct, coordinate and execute administrative functions in conformity with the policies and directives of the board;

(ii) employ professional and clerical staff as necessary;

(iii) report to the board on all operations under the executive director’s control and supervision;

(iv) prepare an annual budget and manage the administrative expenses of the authority; and

(v) undertake any other activities necessary to implement the powers and duties under this chapter.

Section 3. The board of the authority shall set health care cost containment goals for the commonwealth and foster the innovation of health care delivery and payment models that lower health care cost growth while improving the quality of patient care.

The board shall have all powers necessary or convenient to carry out and effectuate its purposes including, but not limited to, the power to:

(a) to develop a plan of operation for the authority, which shall include, but not be limited to:

(1) establishing procedures for operations of the authority;

(2) establishing procedures for communications with the executive director;

(3) establishing procedures for setting an annual health care cost growth benchmark;

(4) holding annual hearings concerning the growth in total health care expenditures relative to the health care cost benchmark, including an examination of health care provider, provider organization and payer costs, prices and health status adjusted total medical expense trends;

(5) providing an annual report on recommendations for strategies to meet future annual health care cost growth benchmarks and to promote an efficient health delivery system;

(6) establishing procedures that, in the event the annual health care cost growth benchmark is exceeded, require certain health care entities to file a performance improvement plan and the procedures for approving said plan;

(7) establishing procedures for monitoring compliance and implementation by a health care entity of a performance improvement plan, including standards to ascertain whether a health care entity has failed to implement a performance improvement plan in good faith;

(8) establishing procedures and developing criteria for the certification of certain provider organizations as Beacon ACOs, based on standards related to cost containment, quality improvement and patient protections;

(9) establishing procedures to decertify certain provider organizations as Beacon ACOs;

(10) developing best practices and standards for alternative payment methodologies to be adopted by the office of Medicaid, the group insurance commission and other state-funded health insurance programs;

(11) fostering health care innovation by identifying, developing, supporting and evaluating health care delivery and payment reform models and best practices, in consultation with health care entities, that reduce health care cost growth while improving the quality of patient care; and

(12) administering the Healthcare Payment Reform Fund, established under section 100 of chapter 194 of the acts of 2011, to support the activities of the authority;

(b) to adopt by-laws for the regulation of its affairs and the conduct of its business;

(c) to adopt an official seal and alter the same;

(d) to maintain an office at such place or places in the commonwealth as it may designate;

(e) to sue and be sued in its own name, plead and be impleaded;

(f) to establish lines of credit, and establish 1 or more cash and investment accounts to receive payments for services rendered, appropriations from the commonwealth and for all other business activity granted by this chapter except to the extent otherwise limited by any applicable provision of the Employee Retirement Income Security Act of 1974;

(g) to approve the use of its trademarks, brand names, seals, logos and similar instruments by participating carriers, employers or organizations; and

(h) to enter into interdepartmental agreements with the institute of health care finance and policy, the executive office of health and human services, the division of insurance and any other state agencies the board considers necessary.

Section 4. There shall be an advisory board to the authority. The advisory board shall advise on the overall operation and policy of the authority. The advisory board shall consist of 7 ex-officio members, including the state auditor, the inspector general, the attorney general, the commissioner of insurance, the executive director of the institute of health care finance and policy, the commissioner of public health and the executive director of the group insurance commission, or their designees; and 11 additional members to be appointed by the governor, 1 of whom shall be a representative of a health care quality improvement organization recognized by the federal Centers for Medicare and Medicaid Services, 1 of whom shall be a representative of the Institute for Healthcare Improvement recommended by the organization's board of directors, 1 of whom shall be a representative of the Massachusetts chapter of the National Association of Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts Association of Health Underwriters, Inc., 1 of whom shall be a representative of the Massachusetts Medicaid Policy Institute, Inc., 1 of whom shall be a expert in health care policy from a foundation or academic institution, 1 of whom shall be a representative of a non-governmental purchaser of health insurance, 1 of whom shall be an organization representing the interests of small businesses with fewer than 50 employees, 1 of whom shall be an organization representing the interests of large businesses with 50 or more employees, 1 of whom shall be a physician licensed to practice in the commonwealth and 1 of whom shall be a non-physician health care professional licensed to practice in the commonwealth.

Section 5. (a) Not later than April 15 of every year, the board shall establish a health care cost growth benchmark for the average growth in total health care expenditures in the commonwealth for the next calendar year. The authority shall establish procedures to prominently publish the annual health care cost growth benchmark on the authority’s website.

(b) For calendar years 2012-2015, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29, plus 0.5%.

(c) For calendar years 2016-2022, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29.

(c) For calendar years 2027 and thereafter, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29, plus 1%.

Section 6. (a) Not later than October 1 of every year, the board shall hold public hearings based on the report submitted by the institute under section 15 of chapter 12C comparing the growth in total health care expenditures to the health care cost growth benchmark for the previous calendar year. The hearings shall examine health care provider, provider organization and private and public health care payer costs, prices, and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system. The attorney general may intervene in such hearings.

(b) Public notice of any hearing shall be provided at least 60 days in advance.

(c) The authority shall identify as witnesses for the public hearing a representative sample of providers, provider organizations and, payers, and others including: (i) at least 3 academic medical centers, including the 2 acute hospitals with the highest level of net patient service revenue; (ii) at least 3 disproportionate share hospitals, including the 2 hospitals whose largest per cent of gross patient service revenue is attributable to Title XVIII and XIX of the federal Social Security Act or other governmental payers; (iii) community hospitals from at least 3 separate regions of the state; (iv) freestanding ambulatory surgical centers from at least 3 separate regions of the state; (v) community health centers from at least 3 separate regions of the state; (vi) the 5 private health care payers with the highest enrollments in the state; (vii) any managed care organization that provides health benefits under Title XIX or under the commonwealth care health insurance program; (viii) the group insurance commission; (ix) at least 3 municipalities that have adopted chapter 32B; (x) at least 3 provider

organizations, at least 1 of which shall be a physician organization and at least 1 of which has been certified as a Beacon ACO; (xii) persons with knowledge regarding the cost of post-acute care, pharmaceuticals, biologics, medical supplies, medical devices, and the wages and benefits paid to health care workers, and (xiii) any witness identified by the attorney general or the institute of health care finance and policy.

(d) Witnesses shall provide testimony under oath and subject to examination and cross examination by the board, the executive director of the institute and the attorney general at the public hearing in a manner and form to be determined by the board, including without limitation: (i) in the case of providers and provider organizations, testimony concerning payment systems, care delivery models, payer mix, cost structures, administrative and labor costs, capital and technology cost, adequacy of public payer reimbursement levels, reserve levels, utilization trends, relative price, quality improvement and care-coordination strategies, investments in health information technology, the relation of private payer reimbursement levels to public payer reimbursements for similar services, efforts to improve the efficiency of the delivery system and efforts to reduce the inappropriate or duplicative use of technology; and (ii) in the case of private and public payers, testimony concerning factors underlying premium cost and rate increases, the relation of reserves to premium costs, the payer's efforts to develop benefit design, network design and payment policies that enhance product affordability and encourage efficient use of health resources and technology including utilization of alternative payment methodologies, efforts by the payer to increase consumer access to health care information, efforts by the payer to reduce price variance between providers, efforts by the payer to promote the standardization of administrative practices and any other matters as determined by the board.

(e) In the event that the institute's annual report under section 15 of chapter 12C finds that the percentage change in total health care expenditures exceeded the health care cost benchmark in the previous calendar year, the authority may identify additional witnesses for the public hearing. Witnesses shall provide testimony subject to

examination and cross examination by the board, the executive director of the institute and attorney general at the public hearing in a manner and form to be determined by the board, including without limitation: (i) testimony concerning unanticipated events that may have impacted the total health care cost expenditures, including, but not limited to, a public health crisis such as an outbreak of a disease, a public safety event or a natural disaster; (ii) testimony concerning trends in patient acuity, complexity or utilization of services; (iii) testimony concerning trends in input cost structures, including, but not limited to, the introduction of new pharmaceuticals, medical devices and other health technologies or changes in price of such items; (iv) testimony concerning the cost of providing certain specialty services, including but not limited to, the provision of health care to children, the provision of cancer-related health care and the provision of medical education; (v) testimony related to unanticipated administrative costs for carriers, including, but not limited to, costs related to information technology, administrative simplification efforts, labor costs and transparency efforts; (vi) testimony related to costs due the implementation of state or federal legislation or government regulation; and (vii) any other factors that may have led to excessive health care cost growth.

(f) The authority shall compile an annual report concerning spending trends and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system. The report shall be based on the authority's analysis of information provided at the hearings by providers, provider organizations and insurers, data collected by the institutes under sections 9, 10 and11 of chapter 12C, and any other information the authority considers necessary to fulfill its duties under this section, as further defined in regulations promulgated by the authority. The report shall address, among other things, cost drivers within health care facilities including but not limited to the cost of labor, capital, pharmaceuticals, and supplies, cost drivers within carriers including but not limited to administrative expenses, the cost of outpatient drugs, post acute care, and other costs that materially impact private sector premiums and public, government healthcare expenditures. The report shall be submitted to the chairs of the house and senate committees on ways and means, the

chairs of the joint committee on health care financing and shall be published and available to the public not later than December 31 of each year. The report shall include any legislative language necessary to implement the recommendations.

Section 7. (a) If the percentage change in total health care expenditures exceeded the health care cost benchmark in the previous calendar year, then the authority shall provide public notice to all health care entities: (1) whose increase in health status adjusted total medical expense is materially in excess of the applicable economic growth rate factor as set in accordance with section 5 of this chapter and (2) whose health status adjusted total medical expense is at a minimum one standard deviation above the statewide median. Such notice shall state that the health care entity has been identified as having an excessive increase in health status adjusted total medical expense. The authority shall post a list of all entities receiving such an notice on its web site.

(b) For calendar year 2015, in the event that the institute's annual report under section 15 of chapter 12C finds that average percentage change in cumulative total health care expenditures from 2012 to 2014 exceeded the average health care cost benchmark from 2012 to 2014, and in order to support the state's efforts to meet future health care cost growth benchmarks, as established in section 5, the authority shall establish procedures to assist health care entities to improve efficiency and reduce cost growth through the requirement of certain health care entities to file and implement a performance improvement plan.

Beginning in calendar year 2016, in the event that the institute's annual report under said section 15 of said chapter 12C finds that percentage change in total health care expenditures exceeded the health care cost benchmark in the previous calendar year, and in order to support the state's efforts to meet future health care cost growth benchmarks, as established in said section 5, the authority shall establish procedures to assist health care entities to improve efficiency and reduce the cost growth through the

requirement of certain health care entities to file and implement a performance improvement plan.

(c) In addition to the confidential notice provided under subsection (a), the authority shall provide confidential notice to each such health care entity that it will be required to file a performance improvement plan. Within 45 days of receiving this notice from the authority, the health care entity shall either:

(1) file a confidential performance improvement plan with the authority; or

(2) file a confidential application with the authority to waive or extend the requirement to file a performance improvement plan. The health care entity may file any documentation or supporting evidence with the authority to support the health care entity's application to waive or extend the requirement to file a performance improvement plan. The authority shall require the health care entity to submit any other relevant information it deems necessary in considering the waiver or extension application.

All information submitted shall remain confidential and exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 and chapter 66.

(d) The authority may waive or delay the requirement for a health care entity to file a performance improvement plan in response to a waiver or extension request filed under paragraph (2) of subsection (c) based on a consideration of the following factors, in light of all information received from the health care entity:

(1) the costs, price and utilization trends of the health care entity over time, and any demonstrated improvement to reduce health status adjusted total medical expenses;

(2) any ongoing strategies or investments that the health care entity is implementing to improve future long-term efficiency and reduce cost growth, including certification as a Beacon ACO;

(3) whether the factors that led to increased costs for the health care entity can reasonably be considered to be outside of the control of the entity or unanticipated;
(4) the overall financial condition of the health care entity;
(5) the proportionate impact of the health care entity's costs on the growth of total health care medical expenses statewide;
(6) a significant deviation between the projected economic growth benchmark and the actual economic growth benchmark, as established under section 7H½ of chapter 29; and
(7) any other factors the authority considers relevant, including any information or testimony collected by the authority under the subsection (e) of section 6. The authority shall maintain records documenting all waivers and extensions granted by the authority and shall grant waivers and extensions on an equitable basis, such that similarly situated health care entities are treated on the same terms.

If the authority declines to waive or extend the requirement for the health care entity to file a performance improvement plan, the authority shall provide confidential notice to the health care entity that its application for a waiver or extension was denied and the health care entity shall file a performance improvement plan within 45 days.

(e) A health care entity shall file a performance improvement plan: (i) within 45 days of receipt of a notice under subsection (c); (ii) if the health care entity has requested a waiver or extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or (iii) if the health care entity is granted an extension, on the date given on such extension. The performance improvement plan shall be generated by the health care entity and shall identify the causes of the entity's cost growth and shall include, but not be limited to, specific strategies, adjustments and action steps the entity proposes to implement to improve cost performance, as measured by health status adjusted total medical expenses. The proposed performance improvement plan

shall include specific identified and measurable expected outcomes and a timetable for implementation. The timetable for a performance improvement plan shall not exceed 18 months.

(f) The authority shall approve any performance improvement plan that it determines is reasonably likely to address the underlying cause of the entity's cost growth and has a reasonable expectation for successful implementation.

(g) If the board determines that the performance improvement plan is unacceptable or incomplete, the authority may provide consultation on the criteria that have not been met and may allow an additional time period, up to 30 calendar days, for resubmission; provided however, that all aspects of the performance improvement plan shall be proposed by the health care entity and the authority shall not require specific elements for approval. In filing a performance improvement plan, a health care entity may document cost saving or efficiency initiatives that cannot be implemented within an 18 month period due to regulatory requirements, collective bargaining agreements, the need for capital investments or other factors.

(h) Upon approval of the proposed performance improvement plan, the authority shall notify the health care entity to begin immediate implementation of the performance improvement plan. Public notice shall be provided by the authority on its website identifying that the health care entity is implementing a performance improvement plan; provided however, that the performance improvement plan itself shall remain confidential. All health care entities implementing an approved performance improvement plan shall be subject to additional confidential reporting requirements, as determined by the authority. The authority shall provide assistance to the health care entity in the successful implementation of the performance improvement plan. If a performance improvement plan requires regulatory or other governmental approvals for implementation, the authority shall provide favorable recommendations to the relevant regulatory authority in support of such plan.

(i) All health care entities shall, in good faith, work to implement the performance improvement plan. At any point during the implementation of the performance improvement plan the health care entity may file amendments to the performance improvement plan, subject to approval of the authority.

(j) At the conclusion of the timetable established in the performance improvement plan, the health care entity shall report to the authority regarding the outcome of the performance improvement plan. If the performance improvement plan was found to be unsuccessful, the authority shall either: (i) extend the implementation timetable of the existing performance improvement plan; (ii) approve amendments to the performance improvement plan as proposed by the health care entity; (iii) require the health care entity to submit a new performance improvement plan under subsection (e); or (iv) waive or delay the requirement to file any additional performance improvement plans.

(k) Upon the successful completion of the performance improvement plan, or a decision by the board to waive or delay the requirement to file a new performance improvement plan, the identity of the health care entity shall be removed from the authority's website.

(l) If the authority determines that a health care entity has: (i) willfully neglected to file a performance improvement plan with the authority within 45 days as required under subsection (e); (ii) failed to file an acceptable performance improvement plan in good faith with the authority; (iii) failed to implement the performance improvement plan in good faith; or (iv) knowingly failed to provide information required by this section to the authority or that knowingly falsifies the same, the authority may assess a civil penalty to the health care entity of not more than $500,000. The authority shall seek to promote compliance with this section and shall only impose a civil penalty as a last resort.

(m) The authority may submit a recommendation of proposed legislation to the joint committee on health care financing if the authority believes that further legislative

authority is needed to assist health care entities to implement successful performance improvement plans or to ensure compliance under this section.

(n) The authority shall promulgate regulations as necessary to implement this section; provided however, that notice of any proposed regulations shall be filed with the joint committee on state administration and the joint committee on health care financing at least 180 days before adoption.

Section 8. (a) The authority, in consultation with the advisory board, shall develop standards and a common application form for certain provider organizations to be voluntarily certified as Beacon ACOs. The purpose of the Beacon ACO certification process shall be to encourage the adoption of certain best practices by provider organizations in the commonwealth related to cost containment, quality improvement and patient protection. Provider organizations seeking this certification shall apply directly to the authority and shall submit all necessary documentation as required by the authority. The Beacon ACO certification shall be assigned to all provider organizations that meet the standards developed by the board.

(b) In developing standards for Beacon ACO certification, the authority shall include a review of the best practices employed by health care entities in the commonwealth, and at a minimum, all applicable requirements developed by the Centers for Medicare & Medicaid Services under the Pioneer ACO model, including, but not limited to, requirements that all Beacon ACOs shall: (i) commit to entering alternative payment methodology contracts with other purchasers such that the majority of the Beacon ACO’s total revenues will be derived from such arrangements; (ii) be a legal entity with its own tax identification number, recognized and authorized under the laws of the commonwealth; (iii) include patient and consumer representation on its governance; and (iv) commit to ensuring at least 50 per cent of the Beacon ACO’s primary care providers are meaningfully using certified EHR technology as defined in the HITECH Act and subsequent Medicare regulations.

(c) The board shall develop additional standards necessary to be certified as a Beacon ACO, related to quality improvement, cost containment and patient protections. In developing additional standards, the board shall consider, at a minimum, the following requirements for Beacon ACOs:

(1) to reduce the growth of health status adjusted total medical expenses over time, consistent with the state's efforts to meet the health care cost benchmark established under section 5;

(2) to improve the quality of health services provided, as measured by the statewide quality measure set and other appropriate measures;

(3) to ensure patient access to health care services across the care continuum, including, but not limited to, access to: preventive and primary care services; emergency services; hospitalization services; ambulatory patient services; mental health and behavioral health services; access to specialty care units, including, but are not limited to, burn, coronary care, cancer care, neonatal care, post-obstetric and post operative recovery care, pulmonary care, renal dialysis and surgical, including trauma and intensive care units; pediatric services; diagnostic imaging and screening services; maternity and newborn care services; radiation therapy and treatment services; skilled nursing facilities; family planning services; home health services; treatment and prevention services for alcohol and other drug abuse; breakthrough technologies and treatments; and allied health services including, but not limited to, advance practice nurses, optometric care, direct access to chiropractic services, occupational therapists, dental care, physical therapy and midwifery services;

(4) to improve access to certain primary care services, including but not limited to, by having a demonstrated primary care capacity and a minimum number of practices engaged in becoming patient centered medical homes;

(5) to improve access to health care services and quality of care for vulnerable

populations including, but not limited to, children, the elderly, low-income individuals, individuals with disabilities, individuals with chronic illnesses and racial and ethnic minorities.

(6) to promote the integration of mental health and behavioral health services with primary care services including, but not limited to, the establishment of a behavioral health medical home;

(7) to promote patient-centeredness by, including, but not limited to, establishing mechanisms to conduct patient outreach and education on the necessity and benefits of care coordination; demonstrating an ability to engage patients in shared decision making taking into account patient preferences; demonstrating an ability to effectively involve patients in care transitions to improve the continuity and quality of care across settings, with case manager follow up; demonstrating an ability to engage and activate patients at home, through methods such as home visits or telemedicine, to improve self-management; and establishing mechanisms to evaluate patient satisfaction with the access and quality of their care;

(8) to adopt certain health information technology and data analysis functions, including, but not limited to, population-based management tools and functions; the ability to aggregate and analyze clinical data; the ability to electronically exchange patient summary records across providers who are members of the Beacon ACO and other providers in the community to ensure continuity of care; the ability to provide access to multi-payer claims data and performance reports and the ability to share performance feedback on a timely basis with participating providers; and the ability to enable the beneficiary access to electronic health information;

(9) to demonstrate excellence in the area of quality improvement and care coordination, as evidenced by the success of previous or existing care coordination, pay

for performance, patient centered medical home, quality improvement or health outcomes improvement initiatives, including, but not limited to, a demonstrated commitment to reducing avoidable hospitalizations, adverse events and unnecessary emergency room visits;

(10) to promote community-based wellness programs and community health workers, consistent with efforts funded by the department of public health through the Prevention and Wellness Trust Fund established in section 2G of chapter 111;

(11) to promote worker training programs and skills training opportunities for employees of the provider organization, consistent with efforts funded by the secretary of labor and workforce development through the Health Care Workforce Transformation Trust Fund;

(12) to adopt certain governance structure standards;

(13) to adopt certain financial capacity standards, including certification under subsection (e) of section 10 of chapter 12C, to protect Beacon ACOs from assuming excess risk;

(14) to demonstrate the administrative, clinical, and financial capability to meet the primary and secondary care needs of a defined population of patients, consisting of no less than 50,000 covered lives; and

(15) any other requirements the board considers necessary.

(d) The authority shall update the standards for certification as a Beacon ACO at least every 2 years, or at such other times as the authority determines necessary. In developing the standards, the authority shall seek to allow for provider organizations of different compositions, including, but not limited to, physician group entities and independent physician organizations, to successfully apply for certification.

(e) Provider organizations that wish to maintain certification shall renew their certification as a Beacon ACO every two years. Failure to meet the requirements represented in the certification may result in decertification, as determined by the board.

Section 9. (a) The authority, in consultation with the advisory board, shall develop best practices and standards for alternative payment methodologies for use by the group insurance commission, the office of Medicaid and any other state funded insurance program. Any alternative payment methodology shall: (1) support the state's efforts to meet the health care cost benchmark established in section 5; (2) include incentives for higher quality care; (3) include a risk adjustment element based on health status; and (4) to the extent possible, include a risk adjustment element that takes into account functional status, socioeconomic status or cultural factors. The authority shall also consider methodologies to account for the following costs: (i) medical education; (ii) stand-by services and emergency services, including, but not limited to, trauma units and burn units; (iii) services provided by disproportionate share hospitals or other providers serving underserved populations; (iv) services provided to children; (v) care coordination and community based services provided by allied health professionals; (vi) the greater integration of behavioral and mental health; and (viii) the use and the continued advancement of new medical technologies, treatments, diagnostics or pharmacology products that offer substantial clinical improvements and represent a higher cost than the use of current therapies.

Any best practices and standards developed under this section shall be shared with all private health plans for their voluntary adoption.

Section 10. (a) The authority, in consultation with the advisory board, shall administer the Healthcare Payment Reform Fund, established under section 100 of chapter 194 of the acts of 2011. The fund shall be used for the following purposes: (1) to support the activities of the authority; and (2) to foster innovation in payment and health care service delivery.

(b) The authority shall establish a competitive process for health care entities to develop, implement, or evaluate promising models in payment and health care service delivery. Assistance from the authority may take the form of incentives, grants, technical assistance, evaluation assistance or partnerships, as determined by the authority.

(c) Prior to making a request for proposals under subsection (b), the authority shall solicit ideas for payment changes and health care delivery service reforms directly from providers, provider organizations, carriers, research institutions, health professionals, public institutions of higher education, community-based organizations and private-public partnerships, or any combination thereof. The authority shall review payment and service delivery models so submitted and shall seek input from other relevant stakeholders in evaluating their potential.

(d) All approved activities funded through the Healthcare Payment Reform Fund shall support the commonwealth's efforts to meet the health care cost growth benchmark established under section 5, and shall include measurable outcomes in both cost reduction and quality improvement.

(e) To the maximum extent feasible, the authority shall seek to coordinate expenditures from the Healthcare Payment Reform Fund with other public expenditures from the Prevention and Wellness Trust Fund, the e-Health Institute Trust Fund, the Health Care Workforce Transformation Trust Fund, the executive office of health and human services and any funding available through the Medicare program and the CMS Innovation Center, established under the federal Patient Protection and Affordable Care Act.

(f) Activities funded through the Healthcare Payment Reform Fund which demonstrates measurable success in improving care or reducing costs shall be shared with other providers, provider organizations and payers as model programs which may be voluntarily adopted by such other health care entities. The authority may also incorporate any successful models and practices into its standards for the Beacon ACO

certification under section 8 and for alternative payment methodologies established for state-funded programs under section 9.

(g) The authority shall, annually on or before January 31, report on expenditures from the Healthcare Payment Reform Fund. The report shall include, but not be limited to: (i) the revenue credited to the fund; (ii) the amount of fund expenditures attributable to the administrative costs of the authority; (iii) an itemized list of the funds expended through the competitive process and a description of the grantee activities; and (iv) the results of the evaluation of the effectiveness of the activities funded through grants. The report shall be provided to the chairs of the house and senate committees on ways and means and the joint committee on health care financing and shall be posted on the authority's website.

Section 11. (a) All expenses incurred in carrying out this chapter shall be payable solely from funds provided under the authority of this chapter and no liability or obligations shall be incurred by the authority under this chapter beyond the extent to which monies shall have been provided under this chapter.

(b) The authority shall be liable on all claims made as a result of the activities, whether ministerial or discretionary, of any member, officer or employee of the authority acting as such, except for willful dishonesty or intentional violation of the law, in the same manner and to the same extent as a private person under like circumstances; provided, however, that the authority shall not be liable to levy or execution on any real or personal property to satisfy judgment, for interest prior to judgment, for punitive damages or for any amount in excess of $100,000.

(c) No person shall be liable to the commonwealth, to the authority or to any other person as a result of the person's activities, whether ministerial or discretionary, as a member, officer or employee of the authority except for willful dishonesty or intentional violation of the law; provided, however, that such person shall provide reasonable cooperation to the authority in the defense of any claim. Failure of such person to

provide reasonable cooperation shall cause such person to be jointly liable with the authority, to the extent that such failure prejudiced the defense of the action.

(d) The authority may indemnify or reimburse any person, or a person's personal representative, for losses or expenses, including legal fees and costs, arising from any claim, action, proceeding, award, compromise, settlement or judgment resulting from such person's activities, whether ministerial or discretionary, as a member, officer or employee of the authority; provided, that the defense of settlement thereof shall have been made by counsel approved by the authority. The authority may procure insurance for itself and for its members, officers and employees against liabilities, losses and expenses which may be incurred by virtue of this section or otherwise.

(e) No civil action under this chapter shall be brought more than 3 years after the date upon which the cause thereof accrued.

(f) Upon dissolution, liquidation or other termination of the authority, all rights and properties of the authority shall pass to and be vested in the commonwealth, subject to the rights of lien holders and other creditors. In addition, any net earnings of the authority, beyond that necessary for retirement of any indebtedness or to implement the public purpose or purposes or program of the commonwealth, shall not inure to the benefit of any person other than the commonwealth.

Section 12. The authority shall keep an accurate account of all its activities and of all its receipts and expenditures and shall annually make a report thereof as of the end of its fiscal year to its board, to the governor, to the general court and to the state auditor, such reports to be in a form prescribed by the board, with the written approval of the auditor. The board or the auditor may investigate the affairs of the authority, may severally examine the properties and records of the authority and may prescribe methods of accounting and the rendering of periodical reports in relation to projects undertaken by the authority. The authority shall be subject to biennial audit by the state auditor.

Section 13. The authority may adopt regulations to implement this chapter."

Clerk #58

Public Health Nurse on the Prevention and Wellness Board

Ms. Fargo moves to amend S. 2260 in Section 48, line 1457 by striking out the number "15" and inserting in place thereof the following number "16";

And further amend the bill in Section 48, line 1470 after the words "community health care workers" by adding the following "and 1 of whose shall be a public health nurse"

Clerk #59

Direct Access to Physical Therapy Services

Messrs. Berry and Joyce moves to amend the bill (S2260) in Section 162, subsection 8, in line 4269, by inserting after the words "direct access to chiropractic services" the following: " as well as to physical therapy," and in line 4270 by striking out the words : "physical therapy"

Rejected

REDRAFT Clerk # 60

DSH Medicaid Rate Adjustments

Mr. Rodrigues moves to amend the bill (S. 2260) in section 97, line 2535, by inserting after the words "financial requirements" the following:-"and disproportionate share hospital's, as defined in section 1, of Chapter 118 G, shall receive payments that include adjustments in each disproportionate share hospital's rates, which rates shall not be less than 90% of such hospital's reasonable financial requirements."

REDRAFT Clerk #61

Total Medical Expenses

Mr. Hart moves to amend the bill (Senate, No. 2260) in section 14, in section 1 of proposed chapter 12C of the General Laws, by inserting, after the definition of "Medicare program" the following definition:-

'"Net cost of private health insurance," the difference between health premiums earned and benefits incurred, which shall consist of: (i) all categories of administrative expenditures, as included in medical loss ratio regulations promulgated by the division of insurance; (ii) net additions to reserves; (iii) rate credits and dividends; and (iv) profits or losses, or as otherwise defined by regulations promulgate by the institute."' ; and

in said section 14, in said section 1 of proposed chapter 12C of the General Laws, by striking out the definition of "Total health care expenditures" and inserting in place thereof the following definition:-

'"Total health care expenditures", the annual per capita sum of all health care expenditures in the commonwealth from public and private sources, including: (i) all categories of medical expenses and all non-claims related payments to providers, as included in the health status adjusted total medical expenses reported by the institute under subsection (d) of section 9; (ii) all patient cost-sharing amounts, such as, deductibles and copayments; and (iv) the net cost of private health insurance, or as otherwise defined in regulations promulgated by the institute."; and

in section 162, in proposed section 1 of chapter 176S of the General Laws, by inserting after the definition of "Medicare program" the following definition:-

'"Net cost of private health insurance," the difference between health premiums earned and benefits incurred, which shall consist of: (i) all categories of administrative expenditures, as included in medical loss ratio regulations promulgated by the division of insurance; (ii) net additions to reserves; (iii) rate credits and dividends; and (iv)

profits or losses, or as otherwise defined by regulations promulgated by the institute under chapter 12C."' ; and

in said section 162, in said proposed section 1 of said chapter 176S, by striking out the definition of "Total health care expenditures" and inserting in place thereof the following definition:-

'"Total health care expenditures", the annual per capita sum of all health care expenditures in the commonwealth from public and private sources, including: (i) all categories of medical expenses and all non-claims related payments to providers, as included in the health status adjusted total medical expenses reported by the institute under subsection (d) of section 9 of chapter 12C; (ii) all patient cost-sharing amounts, such as, deductibles and copayments; and (iv) the net cost of private health insurance, or as otherwise defined by the institute in regulations promulgated under said chapter 12C.".

Clerk #62

Membership of Health Care Finance & Policy Institute and Prevention Wellness Advisory Board

Mr. Berry moves to amend the bill (S2260) in Section 14, subsection 3, in line 293, by adding the following:- The council shall include at least five (5) member health care professionals in preventive health care and wellness initiatives. Those members shall be nominated to the executive director by their associations and shall be at a minimum be representative of the following organizations: the American Physical Therapy Association of Massachusetts, the Massachusetts Association of Occupational Therapy, the Massachusetts Society of Orthotics and Prosthetics, the Massachusetts Dietetic Association and the Massachusetts Speech Language Hearing Association.

Mr. Berry further moves to amend the bill (S2260) in Section 48, in line 1457 by striking out the figure "15" and inserting in place thereof the figure "20" and by adding

after the words "community health workers", in line 1470, the following: "; and five (5) health care professionals in health care and wellness initiatives. Such representatives shall be representative from the following organizations: American Physical Therapy Association of Massachusetts, the Massachusetts Association of Occupational Therapy, the Massachusetts Society of Orthotics and Prosthetics, the Massachusetts Dietetic Association and the Massachusetts Speech Language Hearing Association."

Clerk #63

DSH Representative Public Payer Reimbursement Commission

Mr. Rodrigues moves to amend the bill (S. 2260) in section 189, line 4829, by inserting after the word "Association" the following:- "1 of whom shall represent a disproportionate share hospital"

Clerk #64

Promoting Rate Equity

Mr. Rodrigues moves to amend the bill (S. 2260) in section 14, line 759, by inserting after the word "promote" the following:- "rate equity, and"

Rejected

Clerk #65

Health Care Safety Net Parity

Mr. Berry moves to amend the bill (S2260) by adding at the end the following:-

Section XXX.

Section 34 of Chapter 118G of the General Laws is hereby amended by striking it in its entirety and replacing it with the following:-

Section 34. As used in sections 34 to 39, inclusive, the following words shall, unless the context clearly requires otherwise, have the following meanings:

“Acute hospital'', the teaching hospital of the University of Massachusetts medical school and any hospital licensed under section 51 of chapter 111 and which contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of public health.

“Allowable reimbursement'', payment to acute hospitals and community health centers for health services provided to uninsured or underinsured patients of the commonwealth under section 39 and any further regulations promulgated by the health safety net office.

“Ambulatory surgical center'', a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and meets the requirements of the federal Health Care Financing Administration for participation in the Medicare program.

“Ambulatory surgical center services”, notwithstanding any provision of general or special law or regulation to the contrary, shall be defined as services described for purposes of the Medicare program under 42 U.S.C. 1395k(a)(2)(F)(I). These services include both facility services and surgical and other related medical procedures.

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

“Community health center'', a health center operating in conformance with the requirements of Section 330 of United States Public Law 95-626, including all

community health centers which file cost reports as requested by the division of health care finance and policy.

“Critical access services'', those health services which are generally provided only by acute hospitals, as further defined in regulations promulgated by the division.

“Director'', the director of the health safety net office.

“DRG'', a patient classification scheme known as diagnosis related grouping, which provides a means of relating the type of patients a hospital treats, such as its case mix, to the cost incurred by the hospital.

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

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

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

“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.

“Fund'', the Health Safety Net Trust Fund established under section 36.

“Fund fiscal year'', the 12-month period starting in October and ending in September.

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

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

“Laboratory”, shall be defined for these purposes as a laboratory that is licensed by the department of public health and pursuant to M.G.L. c. 111D section 1(1) that is not operated by a community health center.

“Office'', the health safety net office established under section 35.

“Payments subject to surcharge”, notwithstanding any provision of general or special law or regulation to the contrary, shall be defined as all amounts paid, directly or indirectly, by surcharge payors to acute hospitals for health care services, to ambulatory surgical centers for ambulatory surgical center services, to specialty health care providers for specialty health care services, and to laboratories as defined in this section; and provided, however, that payments subject to surcharge shall not include:

(i) payments, settlements and property or casualty insurance policies; (ii) payments made on behalf of Medicaid recipients, Medicare beneficiaries or persons enrolled in policies issued under chapter 176K or similar policies issued on a group basis; and provided further, that payments subject to surcharge may exclude amounts established by 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.

“Pediatric hospital'', an acute care hospital which limits services primarily to children and which qualifies as exempt from the Medicare Prospective Payment system regulations.

“Pediatric specialty unit'', a pediatric unit of an acute care hospital in which the ratio of licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeded 0.20. In calculating that ratio, licensed pediatric beds shall include the total of all pediatric service beds, and the total of all licensed hospital beds shall include the total of all licensed acute care hospital beds, consistent with Medicare's acute care hospital reimbursement methodology as put forth in the Provider Reimbursement Manual Part 1, Section 2405.3G.

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

“Reimbursable health services'', health services provided to uninsured and underinsured patients who are determined to be financially unable to pay for their care, in whole or part, under applicable regulations of the office; provided that the health services are emergency, urgent and critical access services provided by acute hospitals or services provided by community health centers; and provided further, that such services shall not be eligible for reimbursement by any other public or private third-party payer.

“Resident'', a person living in the commonwealth, as defined by the office by regulation; provided, however, that such regulation shall not define as a resident a person who moved into the commonwealth for the so le 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.

“Specialty health care provider”, shall be defined as any entity including a physician practice providing outpatient services typically provided in a hospital setting, including but not limited to: (1) an entity providing anesthesia, conscious sedation and/or diagnostic injection services (including endoscopy services and excluding dental facilities); (ii) an entity employing major medical, diagnostic and/or therapeutic equipment, including but not limited to equipment defined as new technology or as providing an innovative service, pursuant to chapter 111, section 25B and excluding x-ray equipment; and (iii) which is not a hospital, ambulatory surgical center or community health center. The department shall promulgate regulations with respect to the classification of specialty health care providers.

“Surcharge payor”, notwithstanding any provision of general or special law or regulation to the contrary, shall be defined as an individual or entity that pays for or arranges for the purchase of health care services provided by acute hospitals, ambulatory surgical center services provided by ambulatory surgical centers, specialty health care services provided by specialty health care providers, and laboratory services provided by laboratories, as defined in this section; provided, however, that the term surcharge payor shall not include Title XVIII and Title XIX programs and their beneficiaries or recipients, other governmental programs of public assistance and their beneficiaries or recipients and the workers compensation program established by chapter 152

“Underinsured patient'', a patient whose health insurance plan or self-insurance health plan does not pay, in whole or in part, for health services that are eligible for reimbursement from the health safety net trust fund, provided that such patient meets income eligibility standards set by the office.

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

SECTION 2. Section 35 of Chapter 118G of the General Laws is hereby amended by inserting after the phrase acute hospitals the following :- , ambulatory surgical centers, specialty health care providers, laboratories,.

SECTION 3. Section 36 of Chapter 118G of the General Laws is hereby amended by inserting after the phrase all amounts paid by acute hospitals the following :- , ambulatory surgical centers, specialty health care providers, laboratories,.

SECTION 4. Section 37 of Chapter 118G of the General Laws is hereby amended by adding the following subsection prior to subsection (a):-

(a) Ambulatory surgical centers, specialty health care providers, and laboratories, notwithstanding any provision of general or special law or regulation to the contrary, shall be liable to the health safety net trust fund in the same manner as acute care hospitals. The division of health care finance and policy, in consultation with the office of Medicaid, shall establish through implementing regulations the mechanism by which the liability of said providers is to be assessed, paid, monitored, and enforced.

SECTION 5. The General Laws are hereby amended, after each appearance of the term acute hospital, by inserting the following phrase:- and ambulatory surgical center, specialty health care provider, and laboratory.

SECTION 6. The General Laws are hereby amended, after each appearance of the term ambulatory surgical center, by inserting the following phrase:- , specialty health care provider, and laboratory.

SECTION 7: (A) Section 25B of chapter 111 of the general laws, as appearing in the 2006 official edition, is hereby amended, in line 22, by inserting, after the words as

defined in section fifty-two the following:- specialty health care providers as defined in this section.

(B) said section 25B of said chapter 111, as so appearing, is hereby further amended, within the definition of expenditure minimum with respect to substantial capital expenditures after the clause other than ambulatory surgery the following:- or other than expenditures with respect to a specialty health care provider.

(C) Said section 25B of said chapter 111, as so appearing, is hereby further amended by adding, at the end thereof, the following:

“Specialty health care provider”, any entity including a physician practice providing outpatient services typically provided in a hospital setting, including but not limited to: (1) an entity providing anesthesia, conscious sedation and/or diagnostic injection services (including endoscopy services and excluding dental facilities); (ii) an entity employing major medical, diagnostic and/or therapeutic equipment, including but not limited to equipment defined as new technology or as providing an innovative service, pursuant to chapter 111 , section 25B and excluding x-ray equipment; and (iii) which is not a hospital, ambulatory surgical center or community health center. The department shall promulgate regulations with respect to the classification of specialty health care providers.

(D) Said chapter 111 of the general laws, is hereby amended by inserting after section 53G, as added by section 11 of chapter 305 of the acts of 2008, the following new section: -

Section 53H. Notwithstanding any general or special law or regulation to the contrary, any specialty health care provider shall be a clinic for the purpose of licensure under section 51 and no original license shall be issued pursuant to said section 51 to establish any such specialty health care provider clinic unless there is a determination by the department that there is a need for such a facility. The department shall

promulgate regulations to implement this section, including with respect to the classification and grandfathering of existing specialty health care providers.

Rejected

Clerk #66

Prevention of Unlawful Discrimination

Ms. Fargo and Mr. DiDomenico moves to amend Senate No. 2260 in Section 25A, in line 1490, by inserting, after the word "pain.", the following words:- "The Department of Public Health shall establish by regulation procedures and rules relating to the unlawful practice for a health care resource to discriminate again a patient or an applicant because of race, color, religious creed, national origin, sex, sexual orientation, disability, genetic information, or ancestry of any individual, or to discriminate against such individual in the terms, conditions or privileges of health care payment coverage."

Clerk #67

Racial and Ethnic Health Disparity Expert on the Health Information Technology Council

Ms. Fargo and Ms. Chang-Diaz moves to amend S. 2260 in Section 6D(b) of SECTION 29, line 1078 by striking out the number "15" and inserting in place thereof the following number "16";

And further amend the bill in Section 6D (b), line 1082 by striking out the number "11" and inserting in place thereof the following number "12";

And further amend the bill in Section 6D (b), line 1088, by inserting after the word "practice," the following words: - "1 of whom shall be an expert in racial and ethnic health disparity,"

Redraft Clerk #68

Barriers to changing insurance plans study

Ms. Creem moves to amend the bill (Senate, No.2260) by inserting at the end of the bill the following new section:-

Section XXX. The Institute of Health Care Finance and Policy shall conduct a comprehensive study to investigate barriers to individuals seeking to change health insurance plans, either upon a qualifying status change or during an open-enrollment period. Said study shall include, but not be limited to, the identification and review of such barriers, such as the impact of a change in insurance plans on consumers who have used some or all of their yearly plan deductibles, as well as recommendations for alleviating any barriers. The Institute shall file a report of its study, including recommendations and drafts of any legislation, if necessary, with the clerks of the Senate and House of Representatives within one year of the effective date of this act.

Clerk #69

Massachusetts Diagnostic Accuracy Task Force

Ms. Fargo and Ms. Chang-Diaz moves to amend S. 2260 in SECTION 184, line 4759 by inserting after the word "payers" the following words: - "and racial and ethnic health disparity experts."

Clerk #70

Behavioral Health Treatment Task Force

Ms. Fargo moves to amend S. 2260 in SECTION 182, by striking in line 4733 and 4734 the following words "in behavioral health treatment, service delivery, integration of behavioral health with primary care and behavioral health reimbursement systems." And inserting in place thereof the following words: - "a health service provider with cultural insight program experience, a provider with expertise in the mental health needs of hard to reach populations, an academic responsible for teaching mental health

cultural competence, a health plan expert responsible for determining adequate access to appropriately skilled network providers, a public health practitioner with experience developing culturally appropriate services for dually diagnosed patients (substance abuse and mental health), at least two consumer advocates and users of behavioral health services with at least one of whom shall be a representative of a population experiencing health disparities and a mental health group with experience in contracting with health plans to provide culturally competent behavioral health services."

Clerk #71

WITHDRAWN

Clerk #72

Composition of the Advisory Board to the Commonwealth Health Care Quality and Finance Authority

Ms. Fargo and Ms. Chang-Diaz moves to amend S. 2260 in Section 4 of CHAPTER 176S, line 4023 by striking out the number "7" and inserting in place thereof the following number "8";

And further amend the bill in Section 4 of CHAPTER 176S, line 4027 by striking out the number "11" and inserting in place thereof the following number "12";

And further amend the bill in Section 4 of CHAPTER 176S, line 4039, by inserting after the word "commonwealth" the following words: - "1 of whom shall be an expert in racial and ethnic health disparity,"

Clerk #73

Relative to Comprehensive Cancer Centers

Mr. Brownsberger moves to amend the bill (Senate, No. 2260), by striking, in Section 14, in line 786, the word "No," and by inserting in its place the following:- "Except for a comprehensive cancer center, as defined in Section 8 of Chapter 118E, no";

and, by inserting, in Section 162, in line 4263, after the words "cancer care," the words "the services of a comprehensive cancer center, as defined in section 8 of Chapter 118E,";

and, by deleting, in Section 162, in line 4332, the word "and" and by inserting after the word "therapies" in Section 162, in line 4335, the following:- ";and (ix) costs associated with the services of a comprehensive cancer center, as defined in section 8 of Chapter 118E".

Clerk #74

WITHDRAWN

Rejected

Clerk #75

Medicaid Fraud Prevention Pilot Program

Messrs. Timilty and Knapik moves to amend the bill (S. 2260) by adding the following new Section:-

Section X. Notwithstanding any general or special law to the contrary, the state Medicaid office is hereby authorized to establish a pilot program with an external service provider to determine the effectiveness of various fraud management tools to identify potential fraud at claims submission and validation in order to reduce Medicaid fraud prior to payment; provided further, that said pilot program shall evaluate current Medicaid spending programs and utilize said fraud management services to determine the efficacy of current practices. The pilot program shall utilize only vendors currently engaged in systemic waste and fraud detection

services. Selected vendor(s) shall not use any data provided to them for any other purpose than waste and fraud detection, shall destroy all data after the completion of their evaluation(s) and may not share the results of the data analysis with any outside entities. The executive office of health and human services shall submit 2 reports to the house and senate committees on ways and means detailing recoveries and offsets generated by said audits;

provided that the first report shall be delivered no later than February 1, 2014 and that the second report shall be delivered no later than December 31, 2015.

REDRAFT CLERK 76

Council Membership

Messrs. Timilty, Downing, and Keenan move to amend the bill (Senate, No. 2260) in Section 29, in subsection (b) of proposed section 6D of chapter 40J of the General Laws, by striking out the third paragraph and inserting in place thereof the following paragraph:-

"The council shall consist of 18 members: 1 of whom shall be the secretary of administration and finance, who shall serve as chair; 1 of whom shall be the secretary of health and human services; 1 of whom shall be the executive director of the institute of health care finance and policy or a designee; 1 of whom shall be the secretary of housing and economic development or a designee; 14 of whom shall be appointed by the governor, at least 1 of whom shall be an expert in health information technology, 1 of whom shall be an expert in state and federal health privacy laws, 1 of whom shall be an expert in health policy, 1 of whom shall be an expert in health information technology relative to privacy and security, 1 of whom shall be from an academic medical center, 1 of whom shall be from a community hospital, 1 of whom shall be from a community health center, 1 of whom shall be from a long term care facility, 1 of whom shall be from a physician group practice, 1 of whom shall be a non-physician health care provider, 1 of whom shall be a registered nurse, 1 of whom shall be a

member from a behavioral health, substance abuse disorder or mental health services organization and 2 of whom shall represent the health insurance carriers. The council may consult with such parties, public or private, as it deems desirable in exercising its duties under this section, including persons with expertise and experience in the development and dissemination of interoperable electronic health records systems and the implementation of interoperable electronic health record systems by small physician groups or ambulatory care providers as well as persons representing organizations within the commonwealth interested in and affected by the development of networks and interoperable electronic health records systems, including, but not limited to, persons representing local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, community-based behavioral providers, substance use disorder and mental health care providers, the medical and nursing professions, physicians, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with expertise in health information technology and other stakeholders as identified by the secretary of health and human services. Appointive members of the council shall serve for terms of 2 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation.”.

Rejected

Clerk #77

Cost and Quality Criteria

Mr. Timilty moves to amend the bill (S. 2260) in Section 14, in line 475, by inserting after the word “appropriate” the following:-

“(xi) all accountable care organizations registered with the institute shall publish cost and quality criteria used by the ACO, to determine inclusion of any registered provider in the preferred tier of any benefit design offered to the public. The ACO shall certify that they applied their quality and efficiency equally to all licensed providers. Providers excluded from the preferred tier of a health plan offered by an ACO shall have a right of

appeal. A provider who requests an appeal shall have 60 days to review the ACO's cost and quality criteria. Disputes unresolved by the parties shall be filed with the Institute. The provisions of (xi) shall apply to all health benefit products offered by ACOs, ACOs sponsored by licensed insurers, HMOs, PPOs, enrolling both private and publically sponsored members".

Clerk #78

Alternative Payment Methodologies Definition

Messrs. Timilty Ross move to amend the bill (S. 2260) in Section 14, in line 77, by inserting after the words "episodic payments" the following:-

"and other payment methods appropriate for providers in smaller service areas with populations less than 250,000 where the majority of residents are served by PCPs that have been designated as Level 3 Patient Centered Medical Homes by the National Committee for Quality Assurance'";

and in Section 162, in line 3810, by inserting after the words "episodic payments" the following:-

"and other payment methods appropriate for providers in smaller service areas with populations less than 250,000 where the majority of residents are served by PCPs that have been designated as Level 3 Patient Centered Medical Homes by the National Committee for Quality Assurance".

Clerk #79

Prioritized Providers

Messrs. Timilty Ross move to amend the bill (S. 2260) in Section 180, in line 4716, by inserting after the words "chapter 176S," the following:- "and providers in smaller service areas with populations less than 250,000 where the majority of residents are

served by PCPs that have been designated as Level 3 Patient Centered Medical Homes by the National Committee for Quality Assurance".

Clerk #80

Bulk Purchasing

Messrs. Montigny and Eldridge and Ms. Chang-Diaz and Mr. Joyce move to amend the bill, S. 2260, by inserting at the end thereof the following new sections:-

SECTION_____. Section 271 of Chapter 127 of the acts of 1999 is hereby amended by inserting in the first paragraph after the words "the secretary of the executive office of elder affairs" the following words:- ", the executive director of the Commonwealth Health Insurance Connector Authority".

SECTION_____. Section 271 of Chapter 127 of the acts of 1999 is hereby amended by striking out in the first paragraph the following words;-

"(i) participants in the Senior Pharmacy program, so-called, pursuant to section 16B of chapter 118E of the General Laws"

and inserting in place thereof the following words:

"(i) enrollees in Commonwealth Care pursuant to chapter 176Q of the General Laws".

SECTION _____. Section 62 of Chapter 177 of the Acts of 2001 is hereby amended in the first paragraph by inserting after the words "the Commissioner of the group insurance commission" the following words: - ",the executive director of the Commonwealth Health Insurance Connector Authority".

SECTION _____. The provisions of Section 271 of Chapter 127 of the acts of 1999, as amended, and Section 62 of Chapter 177 of the Acts of 2001, as amended, shall be fully implemented by January 1, 2013.

REDRAFT Clerk #81

Protection for Vulnerable Patients

Mr. Rush moves to amend the bill (Senate, No. 2260) in section 14, in subsection (a) of proposed section 11 of chapter 12C of the General Laws by adding the following sentence:- The institute shall adopt regulations to require private and public health care payers which utilize alternative payment methodologies to report on the extent to which such alternative payment methodologies conform with the best practices developed by the authority under section 9 of chapter 176S including, but not limited to, whether such methodologies include the risk adjustment elements set out in said section 9 of said chapter 176S."

Clerk #82

Inclusion of Racial and Ethnic Health Disparity Experts on Beacon ACO's Governance

Ms. Fargo and Ms. Chang-Diaz moves to amend Senate No. 2260 in Section 8(b), in line 4246 and 4247, by striking the following words, "include patient and consumer representation on its governance" and inserting in place thereof the following words :- "include patient and consumer representation and racial and ethnic health disparity experts on its governance;".

Clerk #83

Relative to regional planning agencies

Mr. Brownsberger moves to amend the bill (Senate, No. 2260) in Section 2G(d), in line 1384, after the word "municipalities", by inserting the following words:- "regional planning agency," and in line 1388, after the word "organization", by inserting the following words:- "or regional planning agency".

ADOPTED

Clerk #84

DPH Processing

Mr. Rush moves to amend the bill (S.2260) in Section 52 by striking, in line 1670, the figure "8" and inserting in place thereof the figure "4".

Clerk #85

Calculation of Return on Investment for Compensating Non-Clinician Services and Community Activities

Ms. Fargo moves to amend Senate No. 2260 in Section 8(c), in line 4303 by inserting after "111" the following words: - "and calculate the return on investment made in compensating non-clinician services and community activities, particularly those efforts with an emphasis on the social determinants of health, that integrate community public health interventions and which have been proven to improve health and well-being over the long term;"

Rejected

Clerk #86

Family Friendly Employers

Ms. Fargo moves to amend Senate No. 2260, by adding a new section:-

"SECTION XX: Chapter 149 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after section 105D, the following section:-

Section 105E. (a) For purposes of this section, the following words shall have the following meanings:-

"Employee", an employee as defined in section 1 of chapter 151B.

“Employer”, an employer as defined in section 1 of chapter 151B.

“Labor organization”, a labor organization as defined in section 1 of chapter 151B.

(b) No employer or labor organization shall prohibit an employee from expressing breast milk during any meal period or other break period required by law to be provided by the employer or required by a collective bargaining agreement. Employers and labor organizations shall also provide reasonable unpaid break time each day to an employee who needs to express breast milk for her child. If possible, the break time for breastfeeding shall run concurrently with any break time already provided to the employee. The employer or labor organization shall make reasonable efforts to provide a room or other location in close proximity to the work area, other than a toilet stall, where the employee can express her breast milk in privacy. An employer or labor organization is not required to provide break time for breastfeeding by an employee under this section if to do so would unduly disrupt the operations of the employer or labor organization.

(c) It shall be an unlawful discriminatory practice for any employer or labor organization, because an employee expresses milk at the workplace, to refuse to hire or employ or to bar or to discharge from employment such employee or to discriminate against such employee in compensation or in terms, conditions or privileges of employment, unless based upon a bona fide occupational qualification.

(d) Violation of this section shall be subject to the second paragraph of section 150 and to section 180. An employer or labor organization shall be not liable for a violation of this section if reasonable efforts have been made to comply with its provisions. Nothing in this section shall prohibit employers or labor organizations from establishing internal rules and guidelines for employees who may wish to breastfeed or express breast milk in the workplace.

Section 2. (a) The executive office of health and human services shall maintain and make available for public inspection a list of businesses in the commonwealth and

covered by this act that it designates as accommodating the needs of lactating women in the workplace. A business seeking such designation may submit its lactation policies to the executive office of health and human services.

(b) The executive office of health and human services shall develop a unique identifying mark or name to distinguish those designated businesses that accommodating the needs of lactating women in the workplace and a business may use such mark or name in its promotional materials, if the business develops and implements a written policy supporting the practice of workplace lactation which includes the following elements:

(1) work schedule flexibility, including scheduling breaks and work patterns to provide time for expression of milk;

(2) the provision of accessible locations allowing privacy other than a bathroom stall;

(3) access to an electrical outlet; and

(4) access near to a clean, safe water source and a sink for washing hands and any needed breast-pumping equipment; and

(5) access to hygienic storage in the workplace for the mother's breast milk.

REDRAFT

CLERK #87

DSH Hospitals Transparency

Mr. Hart moves to amend the bill (Senate, No. 2260), in section 14, in proposed section 15 of chapter 12C of the General Laws, by striking out, in lines 735 and 736, the following words:-

"(iv) price variance between providers and any efforts undertaken by payers to reduce such variance;"; and

in said section 14, in subsection (a) of said proposed section 15 of said chapter 12C, by inserting after the first paragraph the following paragraph:-

"As part of its annual report, the institute shall report on price variation between health care providers, by payer and provider type. The institute's report shall include: (i) baseline information about price variation between health care providers by payer including, but not limited to, identifying providers or provider organizations that are paid more than 10 per cent above or more than 10 per cent below the weighted average relative price and identifying payers which have entered into alternative payment contracts that vary by more than 10 per cent; (ii) the annual change in price variation, by payer, among the payer's participating providers; (iii) factors that contribute to price variation in the commonwealth's health care system; (iv) the impact of price variations on disproportionate share hospitals and other safety net providers; and (v) the impact of health reform efforts on price variation including, but not limited to, the impact of increased price transparency, increased prevalence of alternative payment contracts and provider organizations with integrated care networks."; and

in section 162, in proposed chapter 176S of the General Laws, by striking out proposed section 6 and inserting in place thereof the following section:-

"Section 6. (a) Not later than October 1 of every year, the board shall hold public hearings based on the report submitted by the institute under section 15 of chapter 12C comparing the growth in total health care expenditures to the health care cost growth benchmark for the previous calendar year. The hearings shall examine health care provider, provider organization and private and public health care payer costs, prices, and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system. The attorney general may intervene in such hearings.

(b) Public notice of any hearing shall be provided at least 60 days in advance.

(c) The authority shall identify as witnesses for the public hearing a representative sample of providers, provider organizations, payers and others, including: (i) at least 3 academic medical centers, including the 2 acute hospitals with the highest level of net patient service revenue; (ii) at least 3 disproportionate share hospitals, including the 2 hospitals whose largest per cent of gross patient service

revenue is attributable to Title XVIII and XIX of the federal Social Security Act or other governmental payers; (iii) community hospitals from at least 3 separate regions of the state; (iv) freestanding ambulatory surgical centers from at least 3 separate regions of the state; (v) community health centers from at least 3 separate regions of the state; (vi) the 5 private health care payers with the highest enrollments in the state; (vii) any managed care organization that provides health benefits under Title XIX or under the commonwealth care health insurance program; (viii) the group insurance commission; (ix) at least 3 municipalities that have adopted chapter 32B; (x) at least 3 provider organizations, at least 1 of which shall be a physician organization and at least 1 of which has been certified as a Beacon ACO; and (xii) any witness identified by the attorney general or the institute of health care finance and policy.

(d) Witnesses shall provide testimony under oath and subject to examination and cross examination by the board, the executive director of the institute and the attorney general at the public hearing in a manner and form to be determined by the board, including without limitation: (i) in the case of providers and provider organizations, testimony concerning payment systems, care delivery models, payer mix, cost structures, administrative and labor costs, capital and technology cost, adequacy of public payer reimbursement levels, reserve levels, utilization trends, relative price, quality improvement and care-coordination strategies, investments in health information technology, the relation of private payer reimbursement levels to public payer reimbursements for similar services, efforts to improve the efficiency of the delivery system and efforts to reduce the inappropriate or duplicative use of technology; and (ii) in the case of private and public payers, testimony concerning factors underlying premium cost and rate increases, the relation of reserves to premium costs, the payer’s efforts to develop benefit design, network design and payment policies that enhance product affordability and encourage efficient use of health resources and technology including utilization of alternative payment methodologies, efforts by the payer to increase consumer access to health care information, efforts by the payer to promote the standardization of administrative practices and any other matters as determined by the board. The board shall solicit

testimony from any payer which has been identified by the institute's annual report under section 15 of chapter 12C as (i) paying providers more than 10 per cent above or more than 10 percent below the weighted average relative price or (ii) entering into alternative payment contracts that vary by more than 10 per cent. Any payer identified by the institute's report shall explain the extent of price variation between the payer's participating providers and describe any efforts to reduce such price variation.

(e) In the event that the institute's annual report under section 15 of chapter 12C finds that the percentage change in total health care expenditures exceeded the health care cost benchmark in the previous calendar year, the authority may identify additional witnesses for the public hearing. Witnesses shall provide testimony subject to examination and cross examination by the board, the executive director of the institute and attorney general at the public hearing in a manner and form to be determined by the board, including without limitation: (i) testimony concerning unanticipated events that may have impacted the total health care cost expenditures, including, but not limited to, a public health crisis such as an outbreak of a disease, a public safety event or a natural disaster; (ii) testimony concerning trends in patient acuity, complexity or utilization of services; (iii) testimony concerning trends in input cost structures, including, but not limited to, the introduction of new pharmaceuticals, medical devices and other health technologies; (iv) testimony concerning the cost of providing certain specialty services, including but not limited to, the provision of health care to children, the provision of cancer-related health care and the provision of medical education; (v) testimony related to unanticipated administrative costs for carriers, including, but not limited to, costs related to information technology, administrative simplification efforts, labor costs and transparency efforts; (vi) testimony related to costs due the implementation of state or federal legislation or government regulation; and (vii) any other factors that may have led to excessive health care cost growth.

(f) The authority shall compile an annual report concerning spending trends and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system. The report shall be based on the authority's

analysis of information provided at the hearings by providers, provider organizations and insurers, data collected by the institutes under sections 9, 10 and 11 of chapter 12C, and any other information the authority considers necessary to fulfill its duties under this section, as further defined in regulations promulgated by the authority. The report shall be submitted to the chairs of the house and senate committees on ways and means, the chairs of the joint committee on health care financing and shall be published and available to the public not later than December 31 of each year. The report shall include any legislative language necessary to implement the recommendations.".

ADOPTED

Clerk #88

Health Safety Net Office

Mr. Berry moves to amend the bill (S2260) in Section 104 by deleting "and" in line 2815, inserting a comma in its place, and by adding, following "Community Health Centers" the following:- "and the Conference of Boston Teaching Hospitals"

Rejected

Clerk #89

Health Care Quality and Finance Authority Board

Mr. Berry moves to amend the bill (S2260) in Section 162 as follows:

by deleting, in line 3925, the words "health economist" and inserting in their place the following:- "representative of an academic medical center"

by deleting, in line 3927, the word "auditor" and inserting in its place the following:- "treasurer"

by deleting, in line 3930, the word “auditor” and inserting in its place the following:- “treasurer”

by deleting, in line 3931, the words “an expert in health care finance and policy” and inserting in their place the following:- “a health economist”

ADOPTED
Roll Call #177 [37-0]
Clerk #90

Physician Profiles

Messrs. Richard T. Moore and Joyce moves to amend the bill (Senate, No. 2260) by inserting at the end thereof the following new section:-

SECTION __. Section 5 of Chapter 112 of the General Laws is hereby amended by striking out paragraphs 6 through 8, inclusive, and inserting in place thereof the following four paragraphs: -

The board shall collect the following information reported to it to create individual profiles on licensees and former licensees, in a format created by the board that shall be available for dissemination to the public:

(a) a description of any criminal convictions for felonies and serious misdemeanors as determined by the board. For the purposes of this subsection, a person shall be deemed to be convicted of a crime if he pleaded guilty or if he was found or adjudged guilty by a court of competent jurisdiction;

(b) a description of any charges for felonies and serious misdemeanors as determined by the board to which a physician pleads nolo contendere or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction;

(c) a description of any final board disciplinary actions, and a copy of any original board disciplinary orders;

(d) a description of any final disciplinary actions by licensing boards in other states;

(e) a description of revocation or involuntary restriction of privileges by a hospital, clinic or nursing home under the provisions of chapter 111, or of any employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth, for reasons related to competence or character that have been taken by the hospital, clinic or nursing home or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth governing body or any other official of the hospital, clinic or nursing home or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth after procedural due process has been afforded, or the resignation from or nonrenewal of medical staff membership or the restriction of privileges at a hospital, clinic or nursing home or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth taken in lieu of or in settlement of a pending disciplinary case related to competence or character in that hospital, clinic or nursing home or of any employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth ;

(f) all medical malpractice court judgments and all medical malpractice arbitration awards in which a payment is awarded to a complaining party and all settlements of medical malpractice claims in which a payment is made to a complaining party. Dispositions of paid claims shall be reported in a minimum of three graduated categories indicating the level of significance of the award or settlement. Information concerning paid medical malpractice claims shall be put in context by comparing an individual licensee’s medical malpractice judgment awards and settlements to the

experience of other physicians within the same specialty. Information concerning all settlements shall be accompanied by the following statement: "Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred." Nothing herein shall be construed to limit or prevent the board from providing further explanatory information regarding the significance of categories in which settlements are reported.

Pending malpractice claims shall not be disclosed by the board to the public. Nothing herein shall be construed to prevent the board from investigating and disciplining a licensee on the basis of medical malpractice claims that are pending.

(g) names of medical schools and dates of graduation;

(h) graduate medical education;

(i) specialty board certification;

(j) number of years in practice;

(k) names of the hospitals where the licensee has privileges;

(l) appointments to medical school faculties and indication as to whether a licensee has a responsibility for graduate medical education within the most recent ten years;

(m) information regarding publications in peer-reviewed medical literature within the most recent ten years;

(n) information regarding professional or community service activities and awards;

(o) the location of the licensee's primary practice setting;

(p) the identification of any translating services that may be available at the licensee's primary practice location;

(q) an indication of whether the licensee participates in the medicaid program.

The board shall provide individual licensees with a copy of their profiles prior to release to the public. A licensee shall be provided a reasonable time to correct factual inaccuracies that appear in such profile.

A physician may elect to have his profile omit certain information provided pursuant to clauses (l) to (n), inclusive, concerning academic appointments and teaching responsibilities, publication in peer-reviewed journals and professional and community service awards. In collecting information for such profiles and in disseminating the same, the board shall inform physicians that they may choose not to provide such information required pursuant to said clause (l) to (n), inclusive.

For physicians who are no longer licensed by the board, the board shall continue to make available the profiles of such physicians, except for those who are known by the board to be deceased. The board shall maintain the information contained in the profiles of physicians no longer licensed by the board as of the date the physician was last licensed, and include on the profile a notice that the information is current only to that date.

2nd REDRAFT CLERK #91

Joint Labor Management Quality Care Initiative

Mr. Wolf and Ms. Candaras move to amend the bill (Senate Bill, No. 2260) in section 162 in proposed chapter 176S of the General Laws by striking out section 10 and inserting in place thereof the following section:-

"Section 10. (a) The authority, in consultation with the advisory board, shall administer the Healthcare Payment Reform Fund, established under section 100 of chapter 194 of

the acts of 2011. The fund shall be used for the following purposes: (1) to support the activities of the authority; and (2) to foster innovation in payment and health care service delivery.

(b) The authority shall establish a competitive process for health care entities to develop, implement, or evaluate promising models in payment and health care service delivery. Assistance from the authority may take the form of incentives, grants, technical assistance, evaluation assistance or partnerships, as determined by the authority.

(c) Prior to making a request for proposals under subsection (b), the authority shall solicit ideas for payment changes and health care delivery service reforms directly from providers, provider organizations, carriers, research institutions, health professionals, public institutions of higher education, community-based organizations and private-public partnerships, or any combination thereof. The authority shall review payment and service delivery models so submitted and shall seek input from other relevant stakeholders in evaluating their potential.

(d) The authority shall consider proposals that achieve the following goals: (i) to support safety-net provider and disproportionate share hospital participation in new payment and health care service delivery models; (ii) to support the successful implementation of performance improvement plans by health care entities under section 7; (iii) to support cooperative effort between representatives of employees and management that are focused on controlling costs and improving the quality of care through workforce engagement; (iv) to support the evaluation of mobile health and connected health technologies to improve health outcomes among under-served patients with chronic diseases; and (v) to develop the capacity to safely and effectively treat chronic, common and complex diseases in rural and underserved areas and to monitor outcomes of those treatments.

(e)All approved activities funded through the Healthcare Payment Reform Fund shall support the commonwealth’s efforts to meet the health care cost growth benchmark established under section 5, and shall include measurable outcomes in both cost reduction and quality improvement.

(f) To the maximum extent feasible, the authority shall seek to coordinate expenditures from the Healthcare Payment Reform Fund with other public expenditures from the Prevention and Wellness Trust Fund, the e-Health Institute Trust Fund, the Health Care Workforce Transformation Trust Fund, the Distressed Community Hospital Fund, the executive office of health and human services, any funding available through the Medicare program and the CMS Innovation Center, established under the federal Patient Protection and Affordable Care Act and any funding expended under the Delivery System Transformation Initiative Master Plan and hospital-specific plans approved in the MassHealth section 1115 demonstration waiver.

(g) Activities funded through the Healthcare Payment Reform Fund which demonstrates measurable success in improving care or reducing costs shall be shared with other providers, provider organizations and payers as model programs which may be voluntarily adopted by such other health care entities. The authority may also incorporate any successful models and practices into its standards for the Beacon ACO certification under section 8 and for alternative payment methodologies established for state-funded programs under section 9.

(h) The authority shall, annually on or before January 31, report on expenditures from the Healthcare Payment Reform Fund. The report shall include, but not be limited to: (i) the revenue credited to the fund; (ii) the amount of fund expenditures attributable to the administrative costs of the authority; (iii) an itemized list of the funds expended through the competitive process and a description of the grantee activities; and (iv) the results of the evaluation of the effectiveness of the activities funded through grants. The report shall be provided to the chairs of the house and senate committees on ways and means and the joint committee on health care financing and shall be posted on the authority's website.".

Rejected

Clerk #92

Restricting the sale of tobacco products where health professionals are employed

Ms. Fargo moves to amend Senate No. 2260, amend by adding a new section:-

"SECTION XX: Chapter 112 of the Massachusetts General Laws is hereby amended at the end thereof by inserting after section 61 the following new section: -

"Section 61A (a) Definitions.

"Health care institution" as used in this section shall mean any individual, partnership, association, corporation or trust or any person or group of persons that provides health care services and employs health care providers licensed or subject to licensing by the Massachusetts Department of Health under this chapter. This definition includes but is not limited to hospitals, clinics, health centers, pharmacies, and doctors' and dentists' offices.

"Retail establishment" as used in this section shall mean any store that sells goods or articles of personal services to the public.

"Tobacco products" as used in this section shall mean any substance containing tobacco leaf, including but not limited to cigarettes, cigars, pipe tobacco, snuff, chewing tobacco and dipping tobacco.

(b) Prohibition of Tobacco Sales

(1) No health care institution located in Massachusetts shall sell or cause to be sold tobacco products.

(2) No retail establishment that operates or has a health care institution within it, shall sell or cause to be sold tobacco products, except that this prohibition shall not apply to buildings or sites where tobacco sales are conducted at a site with separate street entrances which are more than 75 feet from the site where health services are offered, and, where no interior hallways or other passageways provide access to both the health care facility and the site of tobacco sales.

(3) The Board of Registration in Medicine and each board of registration within the Division of Health Professions Licensure, including but not limited to the Board of Registration in Nursing, the Board of Registration in Podiatry, the Board of Registration in Pharmacy, the Board of Registration in Optometry, and the Board of Registration of Chiropractors, shall promulgate regulations within 90 days of the effective date of this legislation which prohibit their licensees from working in their professional capacity in any retail establishment where tobacco products are sold or in workspaces leased within or from such retail establishment."

Rejected

Clerk #93

Health Benefits of Breastfeeding

Ms. Fargo moves to amend Senate No. 2260, by adding a new section:-

"SECTION XX: Chapter 111 of the General Laws is hereby amended by inserting after section 224, the following section:-

Section 225. The department shall provide educational information to the public on the health benefits of breastfeeding. All such information shall be compatible with the nutritional requirements to be provided by the department under section 1 of chapter 111I. The department shall post such information on its public internet site and may make the information available in written format, to local boards of health and to any state department, division or agency that administers a maternal or child health service or program, for public dissemination."

Rejected

Clerk #94

Data Collection Tool

Ms. Fargo moves to amend Senate No. 2260 in Section 9, in line 370, by inserting, after the word "costs.", the following words:- "The data collection tool shall be the Behavioral Factor Surveillance System (hereinafter referred to as BRFSS), an annual telephone survey that collects data on emerging public health issues, health conditions, risk factors and behaviors, including racial discrepancies in health and health care, trends in chronic diseases and health risk factors, where the results are used for health care policy planning, as a guide for developing preventive health interventions, and as an assessment of health status."

REDRAFT Clerk #95

Integrated Care Organizations

Messrs. Joyce, Tarr, Eldridge, Knapik, Rodrigues, Wolf, Donnelly, DiDomenico, Montigny and Ms. Jehlen and Ms. Chang-Diaz move to amend the bill by adding at the end therof the following section:

SECTION _____. Chapter 118E of the General Laws is hereby amended by inserting after section 9E the following section:-

Section 9F. (a) As used in this section, the following words shall have the following meanings:-

"Dual eligible", or "dually eligible person", any person age 21 or older and under age 65 who is enrolled in both Medicare and MassHealth.

"Integrated care organization" or "ICO", a comprehensive network of medical, health care and long term services and supports providers that integrates all components of care, either directly or through subcontracts and has been contracted with by the Executive Office of Health and Human Services and designated an ICO to provide services to dually eligible individuals pursuant to this section.

(b) Members of the MassHealth dual eligible pilot program on ICOs or any successor program integrating care for dual eligible persons shall be provided an independent community care coordinator by the ICO or successor organization, who shall be a participant in the member's care team. The community care coordinator shall assist in the development of a long term support and services care plan. The community care coordinator shall:

(1) participate in initial and ongoing assessments of the health and functional status of the member, including determining appropriateness for long term care support and services, either in the form of institutional or community-based care plans and related service packages necessary to improve or maintain enrollee health and functional status;

(2) arrange and, with the agreement of the member and the care team, coordinate the provision of appropriate institutional and community long term supports and services, including assistance with the activities of daily living and instrumental activities of daily living, housing, home-delivered meals, transportation, and under specific conditions or circumstances established by the ICO or successor organization, authorize a range and amount of community-based services; and

(3) monitor the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate by the member and the care team; and track member satisfaction and the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate by the member and the care team.

(c) The ICO or successor organization shall not have a direct or indirect financial ownership interest in an entity that serves as an independent care coordinator. Providers of institutional or community based long term services and supports on a

compensated basis shall not function as an independent care coordinator, provided however that the secretary may grant a waiver of this restriction upon a finding that public necessity and convenience require such a waiver. An individual who becomes dually eligible after the age of 60 shall receive independent care coordination services pursuant to section 4B of chapter 19 A. For the purposes of this section, an organization compensated to provide only evaluation, assessment, coordination and fiscal intermediary services shall not be considered a provider of long term services and supports.

Rejected

Clerk #96

The Office of Health Equity Benchmarks on improving Health Disparities

Ms. Fargo and Ms. Chang-Diaz moves to amend Senate No. 2260 in Section 2G (h) in SECTION 48, in line 1443, by inserting, after the word "status", the following words: - "The Office of Health Equity, in conjunction with accountable care organizations, other health care entities and other stakeholders (Department of Public Health/Prevention and Wellness Advisory Board), shall set benchmarks to measure the continued improvement in health disparities reduction among racial, ethnic and linguistic populations;"

Clerk #97

Fair Competition in Health Care

Messrs. Rodrigues and McGee and Ms. Jehlen moves to amend the bill (S. 2260) in section 13, line 57, by inserting after subsection (d) the following two subsections:-

"(e) The attorney general shall, pursuant to G.L. c. 93A, section 2(c), within 180 days of the enactment of this section, investigate and issue regulations proscribing unfair, deceptive, or anticompetitive conduct with the Commonwealth's healthcare

marketplace. The following shall be unfair methods of competition and unfair or deceptive acts or practices. (i) entering into any agreement to commit or by any concerted action committing any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of or monopoly in the delivery of health care services, contracting for payment for health care services, or the business of insurance; (ii) seeking to set the price to be paid by any carrier for network contracts at rates that are excessive, unreasonable, discriminatory, predatory, or would otherwise cause the carrier to violate the requirements of its licensure or accreditation; (iii) engaging in any unfair discrimination between individuals who are similarly covered by network contracts; (iv) making, publishing, disseminating, circulating, or placing before the public, directly or indirectly, any assertion, representation or statement which is untrue, deceptive or misleading; and (v) restricting the ability of any health care provider, licensed under chapter 112 and practicing his profession in accordance with applicable state law or regulation, to provide general or specialty medical or other health services, within that health care provider's respective scope of practice. Any person or legal entity taking action to restrict the lawful practice of a licensed health care provider's profession through contract or in employment, including but not limited to adverse internal policies; by-laws; membership; term or condition of employment or contract; guideline; protocol; or referral; shall be considered to have violated this section.

(f) Nothing in this section shall be construed to exclude any private right of action by a health care provider licensed under chapter 112.

Clerk #98

Beacon Accountable Care Organizations Certifications

Ms. Fargo moves to amend Senate No. 2260 in Section 8, in line 4249, by inserting, after the word "regulations", the following words:- "and (v) ensure that payment methods to accountable care organizations and other health care entities shall reward reduction of racial, ethnic, and linguistic health disparities in their patient population

and health professionals shall not insure monetary or other penalties for serving patients with high risk factors."

Clerk #99

Competitive Bidding

Mr. Rodrigues moves to amend the bill (S. 2260) by striking out sections 180 and 181 in their entirety and inserting in place thereof the following new sections:-

"SECTION 180. Notwithstanding any general or special law to the contrary, the Commonwealth Health Care Quality and Finance Authority shall collaborate with Medicaid, the group insurance commission, the commonwealth health insurance connector authority and all other state funded insurance programs to competitively bid with such provider organizations which have been certified by the board of the health care quality and finance authority as Beacon ACOs, under section 8 of chapter 176S, to contract directly with Medicaid, the group insurance commission, the commonwealth health insurance connector authority and all other state funded insurance programs for the delivery of publicly funded health services of such beneficiaries.

SECTION 181. Any provider organization that entered a network contract prior to the effective date of chapter 12C of the General Laws, which organization receives, or represents providers who collectively receive, at least $1,000,000 in annual net patient service revenue from carriers or third-party administrators or which has entered full-risk contracts or which is corporately affiliated with a carrier, shall register under section 10 of said chapter 12C not later than December 1, 2012. Any other provider organization that entered a network contract prior to the effective date of said chapter 12C and is required under said section 10 of said chapter 12C to register shall register not later than December 1, 2013.

Notwithstanding any other provision of said chapter 12C, and as a condition of licensure under chapter 111 of the General Laws, any provider that is part of or represented by a

provider organization that entered a network contract and fails to register under said section 10 of said chapter 12C shall continue to deliver care under such network contract for the duration of such contract, or a period of 5 years, whichever is longer, at the contract terms and payment levels in effect upon the date the provider organization should have registered under said section 10 of said chapter 12C."

Clerk #100

Beacon Accountable Care Organizations Standards

Ms. Fargo moves to amend Senate No. 2260 in Section 8(c), in line 4251, by inserting, after the word "protections.", the following words:- "It shall be unlawful for accountable care organizations or other health care entities to ration care for patients with multiple or serious risk factors under the health care payment systems' payment methodologies."

ADOPTED

Clerk #101

Pharmaceutical Cost Containment Commission

Messrs. Rosenberg and Eldridge and Ms. Jehlen and Messrs. Wolf and Joyce move to amend the bill (Senate, No. 2260) by inserting after section 192 the following new section:-

SECTION 192A. (a) There shall be a Pharmaceutical Cost Containment commission established to study methods to reduce the cost of prescription drugs for both public and private payers. The commission shall consist of 16 members: 2 of whom shall be the co-chairs of the joint committee on health care financing, 1 of whom shall be the commissioner of the group insurance commission or a designee, 1 of whom shall be the director of the division of insurance or a designee, 1 of whom shall be the director of the state office of pharmacy services or a designee, 1 of whom shall be the secretary of

elder affairs or a designee, 1 of whom shall be the director of the Massachusetts medicaid program or a designee, 2 of whom shall be appointed by the president of the senate, 1 of whom shall be appointed by the minority leader of the senate, 2 of whom shall be appointed by the speaker of the house of representatives, 1 of whom shall be appointed by the minority leader of the house of representatives, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, 1 of whom shall be a representative of the Massachusetts Hospital Association, and 1 of whom shall be a representative of Health Care For All. All necessary appointments shall be made within 60 days of the effective date of this act.

(b) The commission shall examine and report on the following: (i) the ability of the commonwealth to enter into bulk purchasing agreements, including agreements that would require the secretary of elder affairs, the commissioner of GIC, the director of the state office of pharmacy services, the commissioners of the departments of public health, mental health, and mental retardation, and any other state agencies involved in the purchase or distribution of prescription pharmaceuticals, to renegotiate current contracts; (ii) aggregate purchasing methodologies designed to lower prescription pharmaceutical costs for state and non-state providers; (iii) the ability of the commonwealth to operate as a single payer prescription pharmaceutical provider; and, (iv) the feasibility of creating a program to provide all citizens access to prescription pharmaceuticals at prices negotiated by the commonwealth.

(c) The commission shall report the results of its findings as well as any recommendations for legislation, programs, and funding to the clerks of the house of representatives and the senate who shall forward copies of the report to the house and senate committees on ways and means and the joint committee on health care financing no later than 12 months after the effective date of this act.

Clerk #102

Culturally and Linguistically Appropriate Services

Ms. Fargo moves to amend Senate No. 2260 in Section 9, in line 4330, by inserting, after the word "premiums;", the following words: - "Culturally and Linguistically Appropriate Services (hereafter referred to as CLAS) , be recognized as standards issued by the United States Department of Health Human Services, and be adopted by the Commonwealth to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner;"

REDRAFT Clerk #103

Determination of Need

Mr. Wolf moves to amend the bill (Senate, No. 2260) by inserting after section 198 the following section:-

"SECTION 198C. Subsection (c) of section 25A of chapter 111 of the General Laws and clause (2) of subsection (g) of section 25C of said chapter 111 shall not apply to the review of an application for a determination of need that is filed with the department of public health under said chapter 111 until (i) October 1, 2013 or (ii) the date on which the department of public health submits for the first time a health resource plan under said section 25A of said chapter 111, whichever occurs first.".

Clerk #104

Allied Health Professionals

Ms. Fargo moves to amend Senate No. 2260 in Section 9, in line 4331, by inserting, after the word "professionals", the following words: - "who are to be defined as health professionals whose services are utilized in care models for the purpose of helping a patient achieve whole health, including but not limited to community health workers, legal advocates, medical interpreters, clinical prevention specialists, human services workers, social workers, and licensed alcohol and drug counselors."

Clerk #105

Health Care Quality and Finance Authority Advisory Board

Mr. Berry moves to amend the bill (S2260) in Section 162 as follows:

by deleting, in line 4024, the word "auditor" and inserting in its place the following:- "treasurer"

by deleting, in line 4027, "11" and inserting in its place the following:- "12"

by deleting in lines 4036 to 4038, the words "1 of whom shall be an organization representing the interests of small businesses with fewer than 50 employees, 1 of whom shall be an organization representing the interests of large businesses with 50 or more employees," and inserting in their place the following:- "1 of whom shall be a representative of an organization representing the interests of small businesses with fewer than 50 employees, 1 of whom shall be a representative of an organization representing the interests of large businesses with 50 or more employees, 1 of whom shall be a representative of an organization representing the interests of academic medical centers,

Clerk #106

Socioeconomic Status and Cultural factors

Ms. Fargo moves to amend Senate No. 2260 in Section 9, in line 4327, by inserting, after the word "factors", the following words: - "here defined as characteristics of an individual or population that may create disincentives for accountable care organizations or other health care providers because of the real or perceived likelihood that said characteristics correlate to a higher monetary cost in providing health care to the individual or population."

ADOPTED

Clerk #107

Image Exchange Technology

Ms. Creem and Messrs. Downing, Eldridge and Rosenberg, Ms. Spilka and Messrs. Finegold and DiDomenico move to amend the bill (Senate No. 2260), in section 29, by inserting after the words "decision support" in line 1125, the following words:- "and image exchange"

Clerk #108

Underserved Populations

Ms. Fargo moves to amend Senate No. 2260 in Section 9, in line 4330, by inserting, after the word "populations", the following words: - "that are defined as populations including but not limited to the following groups, which suffer adverse health outcomes based on race, ethnicity, disability, housing type, income level, primary language, or educational attainment."

2nd REDRAFT Clerk #109

Special Commission on Price Variation

Messrs. Finegold and Knapik and Ms. Spilka and Ms. Donoghue moves to amend the bill (Senate, No. 2660) by striking out section 190 and inserting in place thereof the following section:-

"SECTION 190. There shall be a special commission to review variation in prices among providers. The commission shall consist of 22 members: 1 of whom shall be the executive director of the institute of health care finance and policy or a designee, who shall serve as chair; 1 of whom shall be the secretary of administration and finance or a designee; 1 of whom shall be the executive director of the group insurance commission

or a designee; 1 of whom shall be the secretary of health and human services or a designee; 1 of whom shall be the attorney general or a designee; 8 of whom shall be appointed by the governor, 1 of whom shall be a health economist, 1 of whom shall have expertise in the area of health care payment methodology, 1 of whom shall represent non-physician health care providers, 1 of whom shall represent an academic medical center or teaching hospital, 1 of whom shall represent a high Medicaid and low-income public payer disproportionate share hospital, 1 of whom shall represent a hospital with 200 beds or less, 1 of whom shall be a nurse practitioner; 1 of whom shall represent frontline nurses, and 1 of whom shall represent pharmaceutical manufacturers; 1 of whom shall be appointed by the senate president and shall be a health economist or have expertise in the area of health care payment methodology; 1 of whom shall be appointed by the speaker of the house of representatives and shall be a health economist or have expertise in the area of health care payment methodology; 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc.; 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc.; 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc.; 1 of whom shall be a representative of the Massachusetts Medical Society; 1 of whom shall be a representative of the Massachusetts Medical Device Industry Council; and 1 of whom shall be a representative of the Conference of Boston Teaching Hospitals.

The commission shall conduct a rigorous analysis to identify the acceptable and unacceptable factors contributing to price variation in physician, hospitals, diagnostic testing and ancillary services. The analysis shall include, but not be limited to, an examination of the following factors: quality, medical education, stand-by service capacity, emergency service capacity, special services provided by disproportionate share hospitals and other providers serving underserved or unique populations, market share of individual providers and affiliated providers, provider size, advertising, location, research, costs, care coordination, community-based services provided by allied health professionals and use of and continued advancement of medical

technology and pharmacology. The analysis shall also include a comparison of price variation between providers in the commonwealth and providers in other states.

After identifying such factors, the commission shall recommend steps to reduce provider price variation and shall recommend the maximum reasonable adjustment to a commercial insurer's median rate for individual or groupings of services for each acceptable factor.

To conduct its review and analysis, the commission may contract with an outside organization with expertise in the analysis of health care financing and provider payment methodologies. The institute of health care finance and policy shall provide the commission and any contracted outside organization, to the extent possible, relevant data necessary for the evaluation; provided, however, that such data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

The commission shall file the results of its study, together with drafts of legislation, if any, necessary to carry out its recommendations, by filing the same with the clerks of the house of representatives and the senate who shall forward a copy of the study to the house and senate committees on ways and means and the joint committee on health care financing not later than January 1, 2014.".

Clerk #110

WITHDRAWN

Rejected

Clerk #111

Health Care Entities under the Commonwealth Health Care Quality and Finance Authority

Ms. Fargo moves to amend Senate No. 2260 in Section 1, of CHAPTER 176S in line 3867, by striking "a provider, provider organization or carrier" and inserting in place thereof the following words: - "All entities, other than accountable care organizations, that provide reimbursements to health care providers in exchange for the health care providers providing medical care and services to patient."

Rejected

Clerk #112

Health Care Professional under the Commonwealth Health Care Quality and Finance Authority

Ms. Fargo moves to amend Senate No. 2260 in Section 25A, in line 1490, by inserting, after the word "law", the following words:- "and health professionals whose services are utilized in care models for the purpose of helping a patient achieve whole health, including but not limited to community health workers, legal advocates, medical interpreters, clinical prevention specialists, human services workers, social workers and licensed alcohol and drug counselors."

Clerk #113

Special Commission on Public Payer Reimbursement Rates Membership

Mr. Finegold moves to amend the bill (Senate, No. 2260) in section 189 by inserting after the word "Association", in line 4829, the following:- "; 1 of whom shall represent a high Medicaid and low income public payer disproportionate share hospital".

Clerk #114

WITHDRAWN

Clerk #115

Special Commission on Public Payer Reimbursement Rates

Mr. Finegold and Ms. Donoghue moves to amend the bill (Senate, No. 2260) in section 189 by inserting after the word "methodologies", in line 4840, the following:- "; the current health status adjusted total medical expenses for MassHealth enrollees for each health care provider, community and statewide; actuarially sound rates for MassHealth enrollees, and how alternative payment methods of payment for MassHealth will address and reduce the variation between actuarially sound rates for the MassHealth population and current MassHealth total medical expense;"

Clerk #116

WITHDRAWN

REDRAFT Clerk #117

Diagnostic Accuracy Task Force members

Ms. Creem and Ms. Spilka move to amend the bill (Senate, No. 2260) by striking out section 184 and inserting in place thereof the following section:-

"SECTION 184. There shall be a special task force to study issues related to the accuracy of medical diagnosis in the commonwealth, called the Massachusetts Diagnostic Accuracy Task Force. The task force shall investigate and report on: (a) the extent to which diagnoses in the commonwealth are accurate and reliable, including the extent to which different diagnoses and inaccurate diagnoses arise from the biological differences between the sexes; (b) the underlying systematic causes of inaccurate diagnosis; (c) estimation of the financial cost to the state, insurers and employers of inaccurate diagnoses; (d) the negative impact on patients caused by inaccurate diagnoses; and (e) recommendations to reduce or eliminate the impact of inaccurate diagnoses.

The Massachusetts Diagnostic Accuracy Task Force shall be comprised of 9 members: 1 of whom shall be the secretary of health and human services, who shall chair the task force; 1 of whom shall be the commissioner of public health, or a designee; 1 of whom shall be the chair of the board of registration in medicine, or a designee; 1 of whom shall be the chair of the board of registration in nursing, or a designee; and 5 members chosen by the governor: 1 of whom shall be a provider with experience in the area of diagnostic accuracy,1 of whom shall be a representative of a Massachusetts health plan, 1 of whom shall be an employer with experience in implementing programs to address diagnostic inaccuracy, 1 whom shall represent an organization based in the commonwealth with experience creating and supporting the implementation of programs on diagnostic accuracy and value-based benefit design, and 1 of whom shall be a non-physician health care provider."

Rejected

Clerk #118

"Meaningful Use" Requirements Effective Date

Mr. Berry moves to amend the bill (S2260) in Section 200, line 5074, by deleting the date "2015" and inserting in its place the following:- "2017".

ADOPTED

Clerk #119

Medicare "3-Day Rule" Exemption Waiver

Mr. Kennedy moves to amend the bill (S. 2260) by adding at the end of thereof the following new section:

Section___: "the executive office of health and human services shall seek from the Secretary of the Department of Health and Human Services an exemption or waiver from the Medicare requirement set forth in 42 U.S.C. §1395x(i) that an admission to a skilled nursing facility be preceded by a three-day hospital stay".

Clerk #120

Impact of Price Transparency

Mr. Rodrigues moves to amend the bill (S. 2260) in section 14, lines 735-736, by striking out (iv) in its entirety and inserting in place thereof the following:-

"(iv) price variance between providers and the impact of price transparency as measured by the reduction in the weighted average relative prices by provider type and efforts undertaken to reduce such variance;"

ADOPTED

Clerk #121

Palliative Care Awareness

Messrs. Richard T. Moore, DiDomenico and Joyce moves to amend the bill (Senate, No. 2260) by inserting at the end thereof the following new section:-

SECTION __. Chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended, by inserting at the end thereof, the following new section:

Section 226. (a) As used in this section the following terms shall, unless the context clearly requires otherwise, have the following meanings:

"Appropriate", consistent with applicable legal, health and professional standards, the patient's clinical and other circumstances and the patient's reasonably known wishes and beliefs.

"Attending health care practitioner", a physician or nurse practitioner who has primary responsibility for the care and treatment of the patient. Where more than 1 physician or nurse practitioner share that responsibility, each of them has a responsibility under this section, unless they agree to assign that responsibility to 1 of them.

"Palliative care", a health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including hospice care.

"Terminal illness or condition", an illness or condition which can reasonably be expect to cause death within 6 months, whether or not treatment is provided.

(b) The commissioner shall adopt regulations requiring each licensed hospital, skilled nursing facility, health center or assisted living facility to distribute to appropriate patients in its care information regarding the availability of palliative care and end-of-life options.

(c) If a patient is diagnosed with a terminal illness or condition, the patient's attending health care practitioner shall offer to provide the patient with information and counseling regarding palliative care and end-of-life options appropriate to the patient, including, but not limited to: (i) the range of options appropriate to the patient; (ii) the prognosis, risks and benefits of the various options; and (iii) the patient's legal rights to comprehensive pain and symptom management at the end of life. The information and counseling may be provided orally or in writing. Where the patient lacks capacity to reasonably understand and make informed choices relating to palliative care, the attending health care practitioner shall provide information and counseling under this section to a person with authority to make health care decisions for the patient. The attending health care practitioner may arrange for information and counseling under this section to be provided by another professionally qualified individual.

Where the attending health care practitioner is not willing to provide the patient with information and counseling under this section, the attending health care practitioner shall arrange for another physician or nurse practitioner to do so, or shall refer or transfer the patient to another physician or nurse practitioner willing to do so.

(d) The department shall consult with the Hospice and Palliative Care Federation of Massachusetts, in developing educational documents, rules and regulations related to this section.

Clerk #122

WITHDRAWN

Clerk #123

WITHDRAWN

Clerk #124

WITHDRAWN

Rejected
Roll Call #178 [15-22]
REDRAFT CLERK #125

Single Payer Health Care

Messrs. Eldridge, Rosenberg, Downing, Wolf, Brownsberger, Ms. Fargo, Ms. Chang-Díaz, and Ms. Jehlen move to amend the bill (Senate, No. 2260), in SECTION 14 by adding the following definition:-

"Single payer health care," a system that guarantees continuous, high-quality, publicly-financed health coverage for all state residents in a manner regardless of income, assets, health status, or availability of other health coverage. A single payer health care system shall, therefore, be guided by the following principles:

- Health care coverage must be universal;
- Health care coverage must be continuous;
- Health care coverage must be affordable;

- Health care costs must be affordable and sustainable for the Commonwealth as a whole; and
- Health care coverage must support patient-centered care, protecting the relationship between patients and their health care practitioners.

And further amends the bill in SECTION 14 by adding the following new section at the end thereof:-

Section 23. The institute shall monitor, review, and evaluate reports related to single payer health care; provided, however, that the institute shall also monitor the performance of single payer health care systems in other states and countries.

The institute shall establish a single payer benchmark which shall be the cost in total health care expenditures of providing continuous, high-quality, publicly-financed health coverage for all Massachusetts residents in a manner regardless of income, assets, health status, or availability of other health coverage.

The institute shall submit annual written reports on all findings, evaluations, and recommendations from its monitoring obligations related to the single payer health care benchmark to the governor, president of the senate, the speaker of the house of representatives, to the joint committee on health care financing, and the house and senate committees on ways and means. This report shall include a plan of action, timeline, funding recommendations (subject to legislative approval), and specific legislative and regulatory measures needed to achieve a single payer health care system in Massachusetts. The institute shall post the report on its public website.

If at the outset of state fiscal year 2015, the institute determines that the single payer health care benchmark has outperformed the "health care cost growth benchmark", as defined in chapter 176S section 5 of the general laws, the Executive Office of Health and Human Services shall, no later than June 30, 2016, submit a "Single Payer health care Implementation Plan" to the legislature after holding public hearings and meetings, which shall be consistent with the principles of "single payer health care" as defined in this chapter and the annual reports of the institute.

FURTHER Clerk #125.1

WITHDRAWN

Clerk #126

WITHDRAWN

Clerk #127

WITHDRAWN

ADOPTED

CLERK #128

Health Resource Plan Public Hearings

Mr. Welch moves to amend the bill (Senate No. 2260), in line 1522, by inserting after the word "state" the following words:- "with not less than 2 within the following counties: Berkshire, Franklin, Hampden, and Hampshire".

Clerk #129

End of Life Care Services

Messrs. DiDomenico and Joyce and Ms. Chang-Díaz moves to amend the bill (Senate, No. 2260) in Section 162, line 4270, by inserting after "midwifery services" the following:- "and end of life care services including hospice and palliative care;"

Clerk #130

Health Care Quality and Finance Advisory Council

Mr. DiDomenico moves to amend the bill (Senate, No. 2260) in Section 162, line 4027, by striking the figure "11" and inserting in place thereof the figure:- "13"; and in line 4040, by inserting after the word "commonwealth" the following:- "and 2 of whom shall be selected from a list of 3 names provided by the President of the Massachusetts AFL-CIO."

ADOPTED

Clerk #131

Information for Utilization Review

Mr. Welch moves to amend the bill (Senate No. 2260) in section 145 by adding at the end thereof the following sentence:-

"Nothing in this provision shall restrict the ability of a carrier or utilization review organization to deny a claim for an admission, procedure or service if the admission, procedure or service was not medically necessary, based on information provided at the time of claim. Nothing in this provision shall restrict the ability of a carrier or utilization review organization to deny a claim for an admission, procedure or service if other terms and conditions of coverage are not met at the time of service or time of claim."

Clerk #132

Commission to Review Public Payer Reimbursement

Ms. Jehlen and Messrs. DiDomenico, Knapik and Welch move to amend the bill Senate no. 2260, in section 189, line 4825, by striking out the number "11" and replacing it with the number "12"; in line 4833, by adding the following, after the word "Healthcare;"the following:- "1 of whom shall be a representative of a high Medicaid and low-income public payer disproportionate share hospital;" and in line 4840, by adding the following, after the word "methodologies" the following:- "including their impact on high Medicaid and low-income public payer disproportionate share hospitals and other safety net providers with concentrated patient care in low-income public

payers; the impacts and policy options for addressing Medicaid and low-income public payer reimbursement deficiencies in establishing the baseline for alternative payment models for said public payers set forth in section 186 of this act and section 1 of chapter 12C."

REDRAFT Clerk #133

Long term support services

Ms. Jehlen moves to amend the bill Senate No. 2260, in section 189, line 4825, by striking out the number "11" and replacing it with the number "12"

and in line 4826, by adding the following, after the word "chair;": "1 of whom shall be the Secretary of Elder Affairs or a designee;"

and in line 4823 by inserting after the word "health care services":
"including long term support services"

and in line 4824 by inserting after the word "health care providers": "and long term support services"

Clerk #134

Protecting Patient Choice

Ms. Creem and Ms. Chang-Diaz moves to amend the bill (Senate, No. 2260), in Section 150, by inserting the following new section:-

"Section xx. (a) A provider organization registered under section 10 of chapter 12C which utilizes alternative payment methodologies, as defined in section 1 of said chapter, shall establish mechanisms to protect continuity of care and patient choice of providers, including access to medically necessary out-of-network care.", in Section 162, in line 4286, by striking the word "and"; and in line 4287, after the word "care;",

by inserting the following words:- “and establishing mechanisms to protect patient provider choice, including parameters for out-of-ACO arrangements;”

Clerk #135

WITHDRAWN

Rejected

Clerk #136

Price Variation Commission NP membership

Ms. Jehlen and Mr. McGee moves to amend the bill Senate no. 2260 in section 190, in line 4856, by striking the word, “14” and inserting the following:, “15”; and in section 190, in line 4870 by inserting after the words “Association, Inc.:” the following: “1 of whom shall be a representative of the Massachusetts Coalition of Nurse Practitioners;”

ADOPTED

Clerk #137

Check list public reporting

Ms Jehlen moves to amend the Senate bill no. 2260, Section 60, in lines 1852 to 1854, by striking out the sentence “Individual reports shall be kept confidential by the department and the Betsy Lehman Center, but aggregated compliance rates shall be posted publicly.” and inserting in place thereof the following sentence: “The department shall publicly report on individual hospitals’ compliance rates.”

Clerk #138

Physicians Assistants and Dental Hygienists

Ms. Chandler, Messrs. Eldridge and Brownsberger, Ms. Creem and Messrs. Knapik, Welch, McGee and Joyce move to amend the bill, (Senate, No. 2260) in line 4579 by

inserting after the word “nurse practitioner,” the following words: “Physician assistant” and in line 4578 by inserting after the word “dentist” the following words: “dental hygienist”

REDRAFT Clerk #139

Alternative Payment Models for Medicaid and Other State Funded Insurance Programs

Mr. DiDomenico, Ms. Jehlen, Mr. Hart and Ms. Fargo and Mr. Knapik move to amend the bill (Senate, No. 2260), in section 162, by striking out section 9 and inserting in place thereof the following section:-

“Section 9. The authority, in consultation with the advisory board, shall develop best practices and standards for alternative payment methodologies for use by the group insurance commission, the office of Medicaid and any other state funded insurance program. Any alternative payment methodology shall: (1) support the state’s efforts to meet the health care cost benchmark established in section 5; (2) include incentives for high quality, coordinated care, including wellness services, primary care services and behavioral health services; (3) include a risk adjustment element based on health status; (4) to the extent possible, include a risk adjustment element that takes into account functional status, socioeconomic status or cultural factors; (5) preserve the use of intergovernmental transfer financing mechanisms by the governmental acute public hospital consistent with the Medical Assistance Trust Fund provisions in effect as of fiscal year 2012; and (6) recognize the unique circumstances of high Medicaid disproportionate share hospitals and other safety net providers with concentrated care in government programsThe authority shall also consider methodologies to account for the following costs: (i) medical education; (ii) stand-by services and emergency services, including, but not limited to, trauma units and burn units; ; (iii) services provided by disproportionate share hospitals or other providers serving underserved populations, including but not limited to, groups which suffer adverse health outcomes based on race, sex, ethnicity, disability, housing type, income level, primary language

or educational attainment; (iv) services provided to children; (v) research; (vi) care coordination and community based services provided by allied health professionals, including, but not limited to, community health workers, legal advocates, medical interpreters, clinical prevention specialists, human services workers, social workers and licensed alcohol and drug counselors; (vii) the greater integration of behavioral and mental health; (viii) the use and the continued advancement of new medical technologies, treatments, diagnostics or pharmacology products that offer substantial clinical improvements and represent a higher cost than the use of current therapies; (ix) culturally and linguistically appropriate services; (x) interpreter services; (xi) dedicated care management responsibilities and administrative responsibilities in alternative payment methodologies; and (xii) costs associated with the services of a comprehensive cancer center, as defined in section 8 of chapter 118E

Any best practices and standards developed under this section shall be shared with all private health plans for their voluntary adoption.”; and
in section 186, by adding the following sentence:-“Any alternative payment methodology shall be consistent with the best practices and standards developed by the health care quality and finance authority under subsection (a) of section 9 of said chapter 176S.”.

Clerk #140

WITHDRAWN

Clerk #141

WITHDRAWN

Clerk #142

WITHDRAWN

Clerk #143

Provider Organization Reporting

Mr. Pacheco moves to amend the bill (Senate, No. 2260) in section 14, by inserting after the word "appropriate," in line 475, the following words:- ", including but not limited to plans to monitor any impacts on reductions in annual costs as it relates to patient quality of care and access to services".

REDRAFT Clerk #144

Access to State-Subsidized Health Insurance

Mr. Downing moves to amend the bill (Senate, No. 2260) by inserting, after section 9 of the new chapter 176S, the following new section:-

SECTION 9A; The authority shall annually certify that the office of Medicaid, the group insurance commission, the commonwealth health insurance connector authority and any other state funded health insurance program offers health insurance coverage of a range of providers that is adequate to serve the needs of subscribers in all geographic regions of the Commonwealth. The commissioner of insurance shall promulgate regulations for the administration and enforcement of this section.

Clerk #145

Commonwealth Care eligibility

Messrs. Downing, DiDomenico and Joyce moves to amend the bill (Senate, No. 2260) by inserting the following new section:-

SECTION 206. Chapter 118H of the General Laws is hereby amended by striking out Section 3(b), and inserting in place thereof the following section:-

Section 3(b)

(1) The board may waive clause (4) of subsection (a) if:

i. The individual's employer complies with section 110 of chapter 175, section 81/2 of chapter 176A, section 3B of chapter 176B or section 6A of chapter 176G.

ii. The individual is self-employed as defined in Section 1 of Chapter 12C, and the increase in that individual's private insurance premium exceeds the average premium increase for private insurers in the state, as determined by the division of insurance, by more than 10 percent.

(2) The employer's health insurance premium contribution for the applying individual, which shall be the cash equivalent of the premium contribution that would otherwise be made by an employer on behalf of the applying individual for the plan and rate basis type for which the individual would be eligible or, in cases where the individual is eligible to participate in more than 1 plan, the cash equivalent of the premium contribution for the most popular plan and rate basis type for which the individual is eligible, shall be paid to the connector. The connector shall use the employer's health insurance premium contribution payment for the individual to first offset the commonwealth's premium assistance payment for the individual with any residual amount offsetting the individual.

Clerk #146

Installing a Registered Nurse on the Health Information Technology Council

Mr. Downing moves to amend the bill (Senate, No.2260) in Section 29, by striking, in line 1078 the number "15" and inserting in place thereof the number "16" and further, by inserting, in line 1089 after the word "carriers" the following words:- "1 of whom shall be a registered nurse;"

2nd REDRAFT Clerk #147

Cost Containment and Safety Net Services

Mr. Welch moves to amend the bill (Senate, No. 2260) in section 14 by striking out proposed subsections (g) and (h) of section 10 of chapter 12C of the General Laws and inserting in place thereof the following 2 subsections:-

"(g) Every provider organization shall, before making any change to its operations or governance structure affecting the provider organization's registration, submit notice to the institute and the attorney general of such change. The institute may promulgate regulations prescribing the contents of any notices required to be filed under this section. The institute may promulgate regulations further defining material change and not material change.

If the change is not material, the notice shall be filed not fewer than 15 days before the date of the change. A change that is not material may proceed on the date identified in the notice once the notice has been accepted by the institute. Changes that are not material, for purposes of this section, shall include, at a minimum, changes in board membership except when such changes are related to a corporate affiliation, changes involving employment decisions by the provider organization, changes that are subject to review by a state agency through any other administrative process and changes that are necessary to comply with state or federal law. The institute may promulgate regulations defining additional categories of changes that it shall consider not material.

If the change is material, the notice shall be filed not fewer than 60 days before the date of the proposed change. Within 30 days of receipt of a notice filed under the institute's regulations, the institute shall conduct a preliminary review to determine whether the change is likely to result in a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, established in section 5 of chapter 176S, on the competitive market or on a provider organization's solvency. The institute shall notify the attorney general that it is conducting a preliminary review. Material changes that are likely to result in a significant impact shall include, but not be limited to: a corporate affiliation between a provider organization and a carrier; mergers or acquisitions of hospitals or hospital systems; acquisition of insolvent

provider organizations; and mergers or acquisitions of provider organizations which will result in a provider organization having a near-majority of market share in a given service or region. The institute shall specify, through regulations, other categories of material changes likely to result in significant impact. The institute may require supplementary submissions from the provider organization to provide data necessary to carry out this preliminary review. A provider organization's supplementary submissions shall be confidential and shall not be considered a public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66 until the issuance of the institute's report on its findings as a result of the preliminary review.

If the institute finds that the material change is unlikely to have a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, established in section 5 of chapter 176S, on the competitive market or on the provider organization's solvency, then the institute shall notify the provider organization of the outcome of its preliminary review and the material change may proceed on the date identified in the notice. If the institute finds that the material change is likely to have a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, on the competitive market or on the provider organization's solvency, the institute shall conduct a cost, market impact and solvency review under subsection (h).

(h) The institute shall establish by regulation rules for conducting cost, market impact and solvency reviews where there has been a material change to a provider organization's registration which the institute determines is likely to have a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, on the competitive market or on the provider organization's solvency under subsection (g).

Within 60 days of receipt of a notice of a material change filed under subsection (g), the institute shall initiate a cost, market impact and solvency review by sending the provider organization a notice of a cost, market impact and solvency review which shall explain the particular factors that the institute seeks to examine through the

review. The institute shall notify the attorney general and the division of insurance whenever it initiates a cost, market impact and solvency review and shall issue a public notice soliciting comments to inform its review. The attorney general may intervene in the cost, market impact and solvency review and may require documents and testimony under oath from the provider organization, other providers or provider organizations, private health care payers and public health care payers to inform the review. The provider organization shall submit to the institute and the attorney general, within 21 days of the institute's notice, a written response to the notice, including, but not limited to, any information or documents sought by the institute or the attorney general which are described in the institute's notice. A provider organization's written response and information provided to the attorney general under this section shall be confidential and shall not be considered a public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66 only until such time as the executive director determines the response is complete.

A cost, market impact and solvency review may examine factors including, but not limited to: (i) the provider organization's size and market share within its primary service areas by major service category, and within its dispersed service areas; (ii) provider price, including its relative prices filed with the institute; (iii) provider quality, including patient experience; (iv) provider cost and cost trends in comparison to total health care expenditures statewide; (v) the availability and accessibility of services similar to those provided, or proposed to be provided, through the provider organization within its primary service areas and dispersed service areas; (vi) the provider organization's impact on competing options for the delivery of health care services within its primary service areas and dispersed service areas including, if applicable, the impact on existing service providers of a provider organization's expansion, affiliation, merger or acquisition, to enter a primary or dispersed service area in which it did not previously operate; (vii) the methods used by the provider organization to attract patient volume and to recruit or acquire health care professionals or facilities; (viii) the role of the provider organization in serving at-risk, underserved and government payer patient populations, including those with

behavioral, substance use disorder and mental health conditions, within its primary service areas and dispersed service areas; (ix) the role of the provider organization in providing low margin or negative margin services within its primary service areas and dispersed service areas; (x) the financial solvency of the provider organization; (xi) consumer concerns, including but not limited to, complaints or other allegations that the provider organization has engaged in any unfair method of competition or any unfair or deceptive act or practice; and (xii) any other factors that the institute determines to be in the public interest.

The institute shall make factual findings and issue a final report on the cost, market impact and solvency review within 60 days of initiating the cost, market impact and solvency review. The institute shall forward a copy of the final report to the attorney general and the division of insurance.

If the institute finds in its report that the provider organization proposed material change will have an adverse cost, market or solvency impact, the institute shall require the provider organization to submit, within 60 days, to the institute and the attorney general, a written response to the institute's report. Nothing in this section shall prohibit a proposed material change; provided, however, that any proposed material change that the institute determined will have an adverse cost, market or solvency impact shall not be completed until at least 30 days after the provider organization has submitted its written response.".

Clerk #148

Student Health Insurance

Mr. Downing moves to amend the bill (Senate, No. 2260) by inserting the following sections:-

"SECTION 199. Section 18 of chapter 15A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by adding to the end of the first paragraph, in

line 12, the following words:- , including the commonwealth care health insurance program under chapter 176Q.

SECTION 200. Section 1 of chapter 111M of the General Laws, as so appearing, is hereby amended by striking out the words "and (l)", in line 21, and inserting in place thereof the following words:- (l) the commonwealth care health insurance program under chapter 176Q for such health care enrollees who are enrolled in a post-secondary program and qualify for a student health insurance program, under section 18 of chapter 15A, if such students were enrolled in the commonwealth care health insurance program on or before the first day of such full-time, post-secondary program; and (m).

SECTION 201. Section 3 of chapter 118H of the General Laws, as so appearing, is hereby amended by inserting after subsection (b) the following subsection:-

(c) An individual eligible to participate in the program under subsection (a) on or before the first day of a full-time, post-secondary program shall be allowed to continue on the program even when qualifying for a student health insurance program, required by section 18 of chapter 15A, if they so choose.

Clerk #149

WITHDRAWN

2nd REDRAFT Clerk #150

<u>Employer Wellness Program Funding</u>

Messrs. Downing, M. Moore, Keenan, Ms. Spilka and Ms. Fargo move to amend the bill (Senate, No. 2260) by striking out section 48 and inserting in place thereof the following section:-

"SECTION 48. Said chapter 111 is hereby further amended by inserting after section 2F the following 2 sections:–

Section 2G. (a) There shall be established and set upon the books of the commonwealth a separate fund to be known as the Prevention and Wellness Trust Fund to be expended, without further appropriation, by the department of public health. The fund shall consist of health system benefit surcharge revenues collected by the commonwealth under section 68 of chapter 118E, public and private sources such as gifts, grants and donations to further community-based prevention activities, interest earned on such revenues and any funds provided from other sources.

The commissioner of public health, as trustee, shall administer the fund. The commissioner, in consultation with the Prevention and Wellness Advisory Board established under section 2H, shall make expenditures from the fund consistent with subsections (d) and (e); provided, that not more than 15 per cent of the amounts held in the fund in any 1 year shall be used by the department for the combined cost of program administration, technical assistance to grantees or program evaluation.

(b) Revenues deposited in the fund that are unexpended at the end of the fiscal year shall not revert to the General Fund and shall be available for expenditure in the following fiscal year.

(c) All expenditures from the Prevention and Wellness Trust Fund shall support the state's efforts to meet the health care cost growth benchmark established in section 5 of chapter 176S and any activities funded by the Healthcare Payment Reform Fund, and 1 or more of the following purposes: (i) reduce rates of the most prevalent and preventable health conditions, including substance abuse ; (ii) increase healthy behaviors, including the management of chronic diseases; (iii) increase the adoption of workplace-based wellness or health management programs that result in positive returns on investment for employees and employers; (iv) address health disparities; or (v) develop a stronger evidence-base of effective prevention programming.

(d) The commissioner shall annually award not less than 75 per cent of the Prevention and Wellness Trust Fund through a competitive grant process to municipalities, community-based organizations, health care providers, regional-planning agencies, and

health plans that apply for the implementation, evaluation and dissemination of evidence-based community preventive health activities. To be eligible to receive a grant under this subsection, a recipient shall be: (i) a municipality or group of municipalities working in collaboration; (ii) a community-based organization working in collaboration with 1 or more municipalities; (iii) a health care provider or a health plan working in collaboration with 1 or more municipalities and a community-based organization; or (iv) a regional planning agency. Expenditures from the fund for such purposes shall supplement and not replace existing local, state, private or federal public health-related funding.

(e) A grant proposal submitted under subsection (d) shall include, but not be limited to: (i) a plan that defines specific goals for the reduction in preventable health conditions and health care costs over a multi-year period; (ii) the evidence-based programs the applicant shall use to meet the goals; (iii) a budget necessary to implement the plan, including a detailed description of any funding or in-kind contributions the applicant or applicants will be providing in support of the proposal; (iv) any other private funding or private sector participation the applicant anticipates in support of the proposal; (v) a commitment to include women, racial and ethnic minorities and low income individuals; and (vi) the anticipated number of individuals that would be affected by implementation of the plan.

Priority may be given to proposals in a geographic region of the state with a higher than average prevalence of preventable health conditions, as determined by the commissioner of public health, in consultation with the Prevention and Wellness Advisory Board. If no proposals were offered in areas of the state with particular need, the department shall ask for a specific request for proposal for that specific region. If the commissioner determines that no suitable proposals have been received, such that the specific needs remain unmet, the department may work directly with municipalities or community-based organizations to develop grant proposals.

The department of public health shall, in consultation with the Prevention and Wellness Advisory Board, develop guidelines for an annual review of the progress being made by each grantee. Each grantee shall participate in any evaluation or accountability process implemented or authorized by the department.

(f) The commissioner of public health may annually expend not more than 10 per cent of the Prevention and Wellness Trust Fund to support the increased adoption of workplace-based wellness or health management programming. The department of public health shall expend such funds for activities including, but not limited to: (i) developing and distributing informational tool-kits for employers, including a model wellness guide developed by the department; (ii) providing technical assistance to employers implementing wellness programs; (iii) hosting informational forums for employers; (iv) promoting awareness of wellness tax credits provided through the state and federal government, including the wellness subsidy provided by the commonwealth health connector authority; (v) public information campaigns that quantify the importance of healthy lifestyles, disease prevention, care management and health promotion programs; and (vi) providing stipends or grants to employers for the implementation and administration of workplace wellness programs in an amount up to 50 per cent of the costs associated with implementing the plan, subject to a cap as established by the commissioner based on available funds.

The department of public health shall develop guidelines to annually review progress toward increasing the adoption of workplace-based wellness or health management programming.

(g) The department of public health shall, annually on or before January 31, report on expenditures from the Prevention and Wellness Trust Fund. The report shall include, but not be limited to: (i) the revenue credited to the fund; (ii) the amount of fund expenditures attributable to the administrative costs of the department of public health; (iii) an itemized list of the funds expended through the competitive grant process and a description of the grantee activities; (iv) the results of the evaluation of the

effectiveness of the activities funded through grants; and (v) an itemized list of expenditures used to support workplace-based wellness or health management programs. The report shall be provided to the chairs of the house and senate committees on ways and means and the joint committee on public health and shall be posted on the department of public health's website.

(h) The department of public health shall, under the advice and guidance of the Prevention and Wellness Advisory Board, annually report on its strategy for administration and allocation of the fund, including relevant evaluation criteria. The report shall set forth the rationale for such strategy, including, but not limited to: (i) a list of the most prevalent preventable health conditions in the commonwealth, including health disparities experienced by populations based on race, ethnicity, gender, disability status, sexual orientation or socio-economic status; (ii) a list of the most costly preventable health conditions in the commonwealth; (iii) a list of evidence-based or promising community-based programs related to the conditions identified in clauses (i) and (ii); and (iv) a list of evidence-based workplace wellness programs or health management programs related to the conditions in clauses (i) and (ii). The report shall recommend specific areas of focus for allocation of funds. If appropriate, the report shall reference goals and best practices established by the National Prevention and Public Health Promotion Council and the Centers for Disease Control and Prevention, including, but not limited to the national prevention strategy, the healthy people report and the community prevention guide.

(i) The department of public health may promulgate regulations to carry out this section.

Section 2H. There shall be a Prevention and Wellness Advisory Board to make recommendations to the commissioner concerning the administration and allocation of the Prevention and Wellness Trust Fund established in section 2G, establish evaluation criteria and perform any other functions specifically granted to it by law.

The board shall consist 17 members: 1 of whom shall be the commissioner of public health or a designee, who shall serve as chair; 1 of whom shall be the executive director of the institute of health care finance and policy established in chapter 12C or a designee; 1 of whom shall be the secretary of health and human services or a designee; 14 of whom shall be appointed by the governor, 1 of whom shall be a person with expertise in the field of public health economics; 1 of whom shall be a person with expertise in public health research; 1 of whom shall be a person with expertise in the field of health equity; 1 of whom shall be a person from a local board of health for a city or town with a population greater than 50,000; 1 of whom shall be a person of a board of health for a city or town with a population less than 50,000; 2 of whom shall be representatives of health insurance carriers; 1 of whom shall be a person from a consumer health organization; 1 of whom shall be a person from a hospital association; 1 of whom shall be a person from a statewide public health organization; 1 of whom shall be a representative of the interest of businesses; 1 of whom shall administer an employee assistance program; 1 of whom shall be a public health nurse or a school nurse; and 1 of whom shall be a person from an association representing community health workers.

Redraft Clerk #151

Ensure An Accessible Consumer Health Information Web Site

Mr. Rodrigues moves to amend the bill (Senate, No. 2260) in section 14, by striking out the words “and satisfaction”, in line 847, and inserting in place thereof the following words:- “, satisfaction and confidence”; and

in said section 14, in the fourth paragraph of proposed section 20 of chapter 12C of the General Laws by adding the following 2 sentences:- “In establishing and maintaining the website, the institute shall rely on industry standards for usability, including standards which are relevant for low-income consumers and consumers with limited literacy. The website shall comply with the Americans with Disabilities Act, and shall

indicate which provider services are physically and programmatically accessible, including access to physical examination equipment for people with disabilities.”.

Clerk #152

WITHDRAWN

Clerk #153

WITHDRAWN

Clerk #154

Health Care Quality and Finance Authority – Advisory Board

Ms. Spilka moves to amend the bill (Senate Bill 2260) in section 4 of chapter 176S, as inserted by SECTION 162, by striking out the figure “11” , in line 4027, and inserting in place thereof the following figure “12”; and in section 4 by inserting after the words “additional members to be appointed by the governor,”, in line 4027, the following: “1 of whom shall be a member of the Massachusetts Biotechnology Council,”.

REDRAFT Clerk #155

Medical Device and Medical Technology Industry

Ms. Spilka moves to amend the bill (Senate Bill 2260) in section 3 of chapter 12C, as inserted by SECTION 14, by inserting after the words “consumer representatives,”, in line 293, the following:- “medical device manufacturers, representatives of the biotechnology industry, pharmaceutical manufacturers,”;

Rejected

Clerk #156

Dual Eligible’s under 65

Ms. Jehlen and Mr. Eldridge moves to amend the bill Senate no. 2260 by adding the following section:-

SECTION XX. Chapter 118E of the General Laws is hereby amended by inserting after section 9E the following section:–

Section 9F. (a) As used in this section, the following words shall have the following meanings:

"Certified peer specialist," a current or former user of mental-health services who is fully integrated as a mental health professional into the medical home and other care settings after meeting appropriate training, education and recovery-oriented requirements.

"Community-based organization" ("CBO"), an entity with a governing board membership comprised of 51% or more of people with disabilities or elders.

"Dual eligible", or "dually eligible person", any person age 21 or older and under age 65 who is enrolled in both Medicare and MassHealth or CommonHealth; provided that the executive office may include within the definition of dual eligible any person enrolled in MassHealth or CommonHealth who also receives benefits under Title II of the Social Security Act on the basis of disability and will be eligible for Medicare within 24 months, provided that the executive office may limit eligibility to those who will be eligible for Medicare within a prescribed number of months that is less than 24.

"Integrated care organization" or "ICO", a comprehensive network of medical, health care and long term services and supports providers that integrates all components of care, either directly or through subcontracts and has been contracted with by the Executive Office of Health and Human Services and designated an ICO to provide services to dually eligible individuals pursuant to this section.

“Medically necessary”, a service reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions or daily activity functioning in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, result in illnesses, impairment, or infirmity, or inhibit integration into the community; or that is reasonably calculated to promote habilitation, wellness, recovery, or integration into the community.

(b) The executive office of health and human services may, subject to appropriation and the availability of federal financial participation and pursuant to a memorandum of understanding or contract with the federal Centers for Medicare and Medicaid Services (CMS), establish a program of medical and functional long-term services and supports, known as the MassHealth integrated care organization initiative, for Massachusetts residents who are dually eligible. The executive office shall contract with integrated care organizations (ICOs) to provide a comprehensive network of medical, health care and long term services and supports (LTSS) that coordinates and integrates all components of care, either directly or through subcontracts.

(c) The integrated care organization shall be required to maintain contractual agreements with nonprofit entities capable of providing long term support services coordination for the enrollee, and which shall have the capacity to oversee the evaluation, assessment and plan of care functions to assure that services and supports are delivered to meet the enrollee's needs and achieve intended outcomes. A majority of the governing board of eligible entities shall consist of individuals with disabilities or the elderly. No integrated care organization or provider of institutional long term care shall have a direct or indirect financial ownership interest in an entity which serves as a long term support services coordinator. Providers of community based long term services and supports on a compensated basis shall not function as a long term support services coordinator, provided however that the secretary may waive this restriction when she finds that the provision of certain limited services does not create a conflict of interest and upon a finding that public necessity and convenience require such a

waiver. An organization compensated to provide only evaluation, assessment, care management, skills training, peer mentoring, and fiscal intermediary services shall not be considered a provider of long term services and supports for purposes of the restriction in this section.

(d) ICOs shall provide participants in the program with all medically necessary services, including, but not limited to:

(1) all services covered by Medicare parts A, B and D;

(2) all Medicaid services provided under MassHealth standard coverage;

(3) For individuals not already enrolled in a waiver program at the time of enrollment into an ICO, Medicaid services provided under waiver programs as of January 1, 2012, and any additional service provided under waivers implemented or expanded after January 1, 2012;

(4) long term services and supports, that help people with disabilities meet their daily needs for assistance with activities of daily living and instrumental activities of daily living, promote recovery, and improve the quality of their lives. Such services shall include eating, bathing, toileting and dressing, chore and cleaning, laundry and shopping, peer services, certified peer specialists and other recovery oriented behavioral health services, durable medical equipment, assistive technology, and transportation. Long term services and supports shall be provided in the most integrated and least restrictive setting possible. A member determined to be clinically eligible for long-term services and support shall be given a choice of care setting, which shall include at a minimum community-based services, including housing and supportive services on a twenty-four hour per day basis, or nursing facility services as an alternative. The executive office shall establish protections for current levels of LTSS expenditures and future levels of LTSS expenditures with the intent of protecting the

right of dual eligibles to live in the least restrictive setting possible in accordance with *Olmstead*;

(5) interpretation services, including interpreting services for the deaf and hard of hearing, in hospital and rehabilitative settings as well as other settings that are part of the beneficiary's treatment plan, including, but not limited to, wellness and other preventive care services and programs;

(6) additional services, including services necessary for the treatment, recovery from, or prevention of mental illness or substance abuse, as designated by the executive office and CMS;

(7) services provided by certified peer specialists and peer support workers, which include Personal Care Attendants in mental health, peer bridgers in inpatient settings, members of crisis teams and well-being coaches, in order to assist members to attain or maintain the sufficient level of functioning needed to achieve community inclusion and participation, independence, productivity, and recovery;

(8) counseling regarding all state and federal employment incentive programs and regarding vocational rehabilitation and assistance services; and

(9) additional services determined by the member's care team to be medically necessary.

The member may direct the withdrawal or reinstatement of any member of the care team and any time.

(e) (1) The executive office shall establish a Health Equity Alliance, referred to hereinafter as the "Alliance." The Alliance shall be established by January 2013. It shall be an independent consumer oversight entity that provides quality assurance, conducts performance monitoring, and advises the executive office regarding ongoing operations. The Alliance shall facilitate and coordinate education, outreach and enrollment into the

program through a pilot peer navigator program in coordination with the executive office.

(2) The composition and structure of the Alliance shall be determined by the executive office in collaboration with disability rights organizations, including Disability Advocates Advancing our Health Care Rights (DAAHR). The entity should be representative of the broader disability community and include representatives of consumer and disability rights and senior advocacy organizations as a majority of its membership.

(3) The responsibilities of the Alliance shall include, but not be limited to: review of compliance and transition plans to ensure ICOs meet requirements of the Americans with Disabilities Act (ADA) and culturally and linguistically appropriate services (CLAS) standards; monitoring quality and performance data, including network adequacy and consumer satisfaction; review of eligibility and enrollment coverage policies; and review of medical necessity criteria and protocols.

(4) The Alliance shall collect information from ICO consumer advisory councils, as defined in subsection (f), to facilitate such monitoring and compliance.

(5) The Alliance shall have the authority to review, in collaboration with a designated community-based organization, compliance and transition plans for full compliance with the ADA, and shall report noncompliance with the ADA to appropriate authorities.

(6) The Alliance shall provide an advisory role to the executive office on the development, implementation and evaluation of the program in all areas, including but not limited to: risk adjustment; quality and outcomes measures; monitoring of network adequacy and consumer satisfaction; the number and types of grievances and appeals; enrollment and disenrollment; and ADA compliance monitoring. The executive office shall seek guidance from the Alliance prior to any change in contracts, regulations, polices or procedures affecting the provision of care in an ICO.

(7) The executive office shall provide the Alliance with the staff and technical assistance as is necessary to enable the Alliance to make effective recommendations, and such accommodations as necessary to enable participations by individuals with

diverse disabilities and to those not proficient in English.

(8) The executive office, in consultation with the Alliance, shall contract with an independent agency to provide ombudsman services to assist ICO members with concerns or questions regarding the demonstration, and assist members with the grievance and appeals processes. Ombudsman services shall include but not be limited to: providing information, investigation, negotiation, mediation, advice, assistance or representation to any member of the program filing a complaint, grievance or appeal. The Alliance and the executive office shall jointly develop a detailed protocol for the performance of the ombudsman function by an independent agency.

(9) The executive office shall promulgate regulations, in consultation with the Alliance, establishing the right of all members of an ICO to advance notice in writing of any adverse action denying, reducing, modifying or terminating a requested service and the right to a due process hearing to appeal any such adverse action, including the right to appeal a care plan. Each ICO shall develop an internal grievance and appeal process, including procedures for expedited decisions. The decision of an ICO shall be in writing and shall notify the member of the right to an external appeal and due process hearing before the board of hearings of the office of Medicaid. Such additional protections shall include, but not be limited to, the rights to: file an appeal within 60 days of an adverse action, establish good cause for a late appeal, maintain continued benefits pending appeal, and obtain a second independent opinion of medical necessity at no cost to the member.

(10) An ICO shall provide members access to out-of-network providers, other than primary care physicians, through single case agreements if the provider will accept the ICO rate for the comparable service offered and the ICO determines that the provider meets applicable professional standards and has no disqualifying quality of care issues.

(11) The executive office shall promulgate regulations, in consultation with the Alliance, protecting beneficiaries from being involuntary disenrolled from an ICO, except in the case of disruptive behavior that substantially impairs the ICO’s ability to arrange for or provide services to the individual or other plan members. An individual cannot be

considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment. The ICO shall attempt to resolve the problems presented by the individual, providing the member with a choice of alternate providers both in and out of the ICO network and providing reasonable accommodations, as determined by the executive office.

(f) The executive office shall, in consultation with the Alliance, promulgate regulations requiring every ICO to establish an advisory council or other meaningful direct mechanism for dually-eligible consumers to advise the ICO. The advisory council or other mechanism shall include members enrolled in the ICO, and may also include family members, legal guardians, or unpaid caregivers of members enrolled in the ICO and representatives of consumer advocacy organizations. The advisory council shall meet at least quarterly throughout the year and shall annually elect participating consumers, family members, and advocates who shall have a seat on the ICO's governing board. The ICO's consumer advisory council or other mechanism shall advise the ICO on all policies and practices of the ICO affecting the members' experience of care, shall have access to such information regarding the ICO's policies and practices as may be necessary for said purpose, and may make recommendations for changes in policy or practice to be presented to the ICO's governing body. The Health Equity Alliance, as defined in subsection (e), shall work with the ICO consumer advisory councils or other mechanism to promote quality of care across ICOs. ICOs shall assure that participation in consumer advisory councils is accessible to individuals with diverse disabilities and to those not proficient in English.

(g) (1) The executive office shall require every ICO and its network of providers to comply with the Americans with Disabilities Act, 42 U.S.C. 12101 *et seq.* ("ADA") in the rendering of all care and services at the time of contract, or to provide a transition plan for full compliance with the ADA within six months of the contract date.

(2) ADA compliance must include the following: physical access to buildings, services and equipment and flexibility in scheduling and processes; effective communication, including interpreter services, and the active participation of patients

and their families in the process of making medical decisions; staff training on accessibility and accommodation, which covers all aspects of care and includes people with disabilities as active participants in the design and delivery of the training, including target audiences as those who provide hands-on care; and programmatic access that ensures equal access to and equal benefit from all services.

(3) The executive office shall develop requirements for compliance plans, timetables for compliance, enforcement, and penalties for failure to comply with the requirements under this subsection, including removal of certification as an ICO. ICOs shall contract with CBOs for technical assistance and determination of ICO compliance with the ADA. Following contract approval, the CBO shall monitor implementation of transition plans and continued ADA compliance for each ICO. The CBO shall report on continued ADA compliance to the Alliance created under subsection (p). Such CBOs shall have full access to records and facilities to perform their duties, subject to agreements to protect the confidentiality of individual patients. The executive office shall develop regulations to implement this subsection.

(4) ADA compliance shall be determined by a review of quality metrics, which include architectural barriers, medical equipment, policies and procedures, training, communications and patient engagement. Financial penalties shall be assessed for each year that an ICO is not in compliance with the ADA, with increases for each year of noncompliance.

(h) The executive office shall by regulation require every ICO to demonstrate its capacity to reduce disparities in care and provide culturally competent services that are appropriate to the complex needs of a diverse population in language, ethnicity, disability, including compliance with all CLAS (culturally and linguistically appropriate services) standards promulgated by the department of public health. Every ICO shall demonstrate progress in reducing disparities in care based on sex, race, ethnicity, socioeconomic status, sexual orientation, gender identity/expression, primary language, disability or disability status.

Clerk #157

Protecting Health Care Reform

Messrs. Rodrigues, Welch and DiDomenico move to amend the bill (S.2260) by inserting the following new section:-

Section ___. Notwithstanding any general or special law to the contrary, there shall be established and set up on the books of the commonwealth as a separate fund to be known as the Medicaid and Health Care Reform FMAP Trust Fund. The fund shall consist of any funds that may be appropriated or transferred for deposit into the trust fund, interest earned on such revenues, and other sources. The comptroller shall deposit an amount to the fund determined by secretary of administration and finance that is equivalent to the additional funding provided by the federal government pursuant to the increased federal Medicaid assistance percentage pursuant to the Patient Protection and Affordable Care Act of 2010 and Section 1201 of the Health Care and Education Reconciliation Act of 2010. The fund shall be used for the following purposes: (1) to support the financing of health insurance coverage for low-income Massachusetts residents, including state health insurance programs and insurance offered through the commonwealth's health insurance exchange and (2) to improve Medicaid reimbursement to health care providers. The secretary of administration and finance shall administer the fund. No later than January 31 of each year, the secretary, in consultation with the executive office of health and human services, the commonwealth health insurance connector authority, healthcare providers participating in the Medicaid program, and consumer representatives, shall submit a report to the house and senate ways and means committees and the joint committee on health care financing that includes the current funding available in the fund, the funding estimated to be deposited through the end of the current and subsequent fiscal year, estimated expenditures from the fund, and recommendations for transferring such funds to other state accounts and funds in a manner consistent with the purpose of the fund.

and further amends the bill in section 189, in line 4850, by inserting before the words "The commission" the following:- "The commission shall make recommendations for

improving Medicaid reimbursement rates over time to more closely align the reimbursement of health care providers with the cost of providing care to Medicaid patients."

2nd REDRAFT Clerk #158

Chiropractic Care

Mr. Petruccelli, Ms. Donoghue, Messrs. Michael O. Moore, Berry and Tarr move to amend the bill (Senate, No. 2260) in section 14, by inserting after the word ", surgical", in line 138, the word "chiropractic,"; and further, in section 90, by inserting after the word ", surgical", in line 2122 , the word "chiropractic,".

Rejected

Clerk #159

Joint Appointments for Clinicians

Mr. Michael O. Moore moves to amend the bill (Senate, No. 2260) by inserting, after section ___, the following section:-

"SECTION ___. Notwithstanding any law or rule the contrary, the department of higher education shall investigate the possibility of dedicating funds for joint appointments for clinicians with clinical agencies and universities. As part of the arrangement, clinicians pursuing doctoral education would receive tuition and fee reimbursement from a Massachusetts public higher education institution for maintaining a clinical position and teaching at the entry level of the academic program while pursuing their doctoral degree or after receiving their doctoral degree."

Clerk #160

Recognizing the Importance of Public Vision Awareness

Ms. Spilka moves to amend the bill (Senate, No. 2260) by inserting at the end thereof the following new sections:-

SECTION XX. Subsection (a) of section 3 of chapter 17, as appearing in the 2010 Official Edition, is hereby amended by striking out the figure "14", in line 4, and inserting in place thereof the following figure:- "15".

SECTION XX. Subsection (c) of section 3 of chapter 17, as appearing in the 2010 Official Edition, is hereby amended by striking out the word "Four", in line 17, and inserting in place thereof the following new word:- "Five".

SECTION XX. Said subsection (c) of section 3 of chapter 17, as so appearing, is hereby amended by inserting after the words, "1 of whom shall have expertise in home or community-based care management,", in lines 20 and 21, the following:- "1 of whom shall appointed from among a list of three nominated by the Massachusetts Society of Optometrists;".

Rejected

Clerk #161

Provider Task Force

Mr. Michael O. Moore moves to amend the bill (Senate, No. 2260) by inserting, after section __, the following section:-

"Section __. Notwithstanding any general or special law to the contrary, there shall be a special task force to evaluate, but not limited to, changes in health care resulting in new and changing roles for providers and support personnel and to develop models for the delivery of care that consider existing needs as well as emerging roles such as expanded home care, e-medical records support, technology advances. The Task Force would be comprised of three members appointed by the Governor, one of whom will be appointed by the Governor chairman, three members of the House of Representatives appointed by the Speaker, three members of the Senate appointed by the Senate President, one member selected by each of the following: Commissioner of Higher Education, Massachusetts Hospital Association, Nursing Home Association, Association

for Massachusetts Health Centers, Massachusetts Medical Society, Massachusetts Nurses Association."

Clerk #162

Breast Cancer Recovery Study

Ms. Spilka moves to amend the bill (Senate Bill 2260) by inserting at the end thereof the following new section:-

SECTION XX. Notwithstanding any general or special law to the contrary, the health care quality and finance authority shall conduct a study on the feasibility and potential healthcare cost and quality impacts of implementing reforms related to cancer recovery. Such study shall examine the quality of care received in diagnosing breast cancer and in recovering from procedures including, but not limited to, mastectomy, lumpectomy, and lymph node dissection for treatment of breast cancer, as well as the short- and long-term costs associated with re-hospitalization of patients recovering from such procedures.

The study shall analyze the healthcare cost and quality impacts of potential reforms including, but not limited to:

(i) requiring carriers to provide coverage for a minimum hospital stay for such period as determined by the attending physician in consultation with the patient to be medically appropriate for patients undergoing a lymph node dissection, lumpectomy or a mastectomy for the treatment of breast cancer;

(ii) requiring every policy which provides hospital, medical, major medical, or similar comprehensive-type coverage to provide coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation of a course of treatment for cancer;

(iii) requiring every policy which provides hospital, medical, major medical, or similar comprehensive-type coverage to provide the following coverage for breast reconstruction surgery after a mastectomy: (1) all stages of reconstruction of the breast on which the mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications of mastectomy, including lymphedemas;

(iv) requiring every policy which provides hospital, medical, major medical, or similar comprehensive-type coverage to provide coverage which includes benefits for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema;

(v) prohibiting carriers and their providers from taking any action intended to reduce or limit coverage for cancer recovery treatments.

The study shall also examine the extent to which recovering patients are negatively impacted by carrier policies that limit coverage for minimum hospital stays and secondary medical opinions, including, but not limited to, the incidence of re-injury or re-hospitalization resulting from such policies and the healthcare costs associated with such re-injury and re-hospitalization. The institute shall submit the study to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and the clerks of the house and senate by January 1, 2013.

Rejected

Roll Call #179 [6-30]

Redraft Clerk #163

Mandate Moratorium

Mr. Tarr moves to amend the bill (Senate, No. 2260) by adding the following section:-

"SECTION___. Notwithstanding any general or special law to the contrary, a moratorium on any new mandated health benefit shall exist until December 31, 2013.".

Rejected

Roll Call #180 [5-30]

Clerk #164

Prescription Drug Mandate

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section 85 the following section:-

"SECTION __. Section 1 of chapter 111M of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 46, at the end of the definition of the term "Creditable coverage" the following:- Minimum creditable coverage, as defined by the board under the authority granted herein, shall not require, in the case of individuals subject to chapter 58 of the acts of 2006, coverage for prescription drugs.".

ADOPTED

Roll Call #181 [35-0]

Clerk #165

Noncompliance with Uniform Coding Provisions

Ms. Spilka and Mr. Richard T. Moore and Chang-Diaz move to amend the bill (Senate Bill 2260) by inserting, after SECTION 136, the following new section:-

SECTION 136A. Said chapter 176O, as so appearing, is hereby amended by inserting after section 5B the following section:-

Section 5C. If the commissioner determines that a carrier is neglecting to comply with the coding standards and guidelines under this chapter in the form and within the time required then the commissioner shall notify the carrier of such neglect. If the carrier does not come into compliance within a period determined by the commissioner then the carrier shall be fined $5000 for each day during which such neglect continues.

Redraft Clerk #166

Preventing Consumer Price Increases

Mr. Tarr moves to amend the bill (Senate, No. 2260) in Section 14 by striking proposed Section 8 of chapter 12C and inserting in place thereof the following section:-

"Section 8. The institute shall file a report 6 months after the effective date of this act with the clerks of the house and the senate and the house and senate committees on ways and means detailing any additional funding requirements to achieve the goals set forth in this bill.".

Clerk #167

Coverage for Court Ordered Medically Necessary Treatment

Ms. Spilka and Ms. Flanagan move to amend the bill (Senate, No. 2260) by inserting at the end thereof the following new section:-

SECTION XX. Notwithstanding any general or special law to the contrary, where an insured child is directed by a court to participate in mental or behavioral health treatment or services which are eligible for coverage by an insurance plan under section 22 of chapter 32A, section 10F of chapter 118E, section 47B of chapter 175, section 8A of chapter 176A, or section 4A of chapter Ch.176B Sec.4A, payment for such treatment or services shall not be denied if the treatment or services otherwise meet the criteria for health plan coverage.

REDRAFT Clerk #168

Residential care facilities

Ms. Jehlen and Mr. Hedlund move to amend the bill Senate no. 2260, in section 189, line 4825, by striking out the number "11" and replacing it with the number "12"

and in line 4826, by adding the following, after the word "chair;": "1 of whom shall be the Secretary of Elder Affairs or a designee;"

and in line 4823 by inserting after the word “health care services”:
“including residential care facilities”

and in line 4824 by inserting after the word “health care providers”: “and residential care facilities”

Rejected

Clerk #169

Accountable Care Organizations

Mr. Kennedy moves to amend the bill (S. 2260) in Section 10 by striking out, in line 475, the words, “(x) such other information as the institute considers appropriate” and inserting in place thereof the following words:- “(x) such other information as the institute considers appropriate; and (xi) all accountable care organizations, registered with the institute shall publish cost and quality criteria used by the accountable care organizations, to determine inclusion of any registered provider in the preferred tier of any benefit design offered to the public. The accountable care organizations shall certify that they applied their quality and efficiency equally to all licensed providers. Providers excluded from the preferred tier of a health plan offered by an accountable care organizations shall have a right of appeal. A provider who requests an appeal shall have sixty days to review the accountable care organizations’ cost and quality criteria. Disputes unresolved the the parties shall be filed with the Institute.

The provisions of (xi) of subsection (c) of section (10) shall apply to all health benefit products offered by accountable care organizations, accountable care organizations sponsored by licensed insurers, health maintenance organization, preferred provider organization, enrolling both private and publically sponsored members.”.

Clerk #170

COMMONWEALTH CARE CONTINUITY OF COVERAGE

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section __ the following new section:-

"SECTION ___. Notwithstanding any special or general law to the contrary, the office of Medicaid shall not terminate the coverage of any commonwealth care recipient in the event that requested documentation has been provided by the recipient, and its receipt has been acknowledged, including the eligibility review form, until the office determines the eligibility for benefits based on the submitted information. The director shall promulgate regulations to ensure the proper implementation of this provision."

Clerk #171

Shared Savings

Ms. Jehlen moves to the amend the bill, Senate no. 2260, in Section 162, by striking out in line 4310 the word, "and" and inserting after the number "(14)" the following words, "to adopt requirements that all contracts between payers and ACOs that contain a provision for shared savings between the provider and the payer shall contain a mechanism to return a percentage of the savings to the ACO participants; and (15)".

ADOPTED

Clerk #172

TRANSITION TO EOHHS STATE COVERAGE

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section __ the following new section:-

"SECTION __. The office of Medicaid and the department of unemployment assistance shall, in consultation with the executive office of health and human services, develop and implement a means by which the office of Medicaid may access information as to the status of or termination of unemployment benefits and the associated insurance coverage by the medical security plan, as administered by the executive office of labor and workforce development, for the purposes of determination of eligibility for those individuals applying for benefits through health care insurance programs administered by the executive office of health and human services. The office and the department shall implement this system not later than three months following the passage of this

act; provided, however, that if legislative action is required prior to implementation, recommendations for such action shall be filed with the house and senate clerks and the joint committee on health care financing not later than two months following the passage of this act.

REDRAFT Clerk #173

Primary Care Provider and Chiropractic Care

Mr. Petruccelli, Ms. Donoghue, Messrs. M. Moore and Berry move to amend the bill (Senate, No. 2260) in section 162, by inserting after the words "specialist care", in line 4451, the following words":- and chiropractic care.

ADOPTED

REDRAFT Clerk #174

Protecting Rescuers

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section 88 the following section:-

"SECTION __. Section 12B of chapter 112, is hereby amended by striking the section in its entirety and replacing it with the following:

Section 12B. No physician duly registered under the provisions of section two, two A, nine, nine A or nine B, no physician assistant duly registered under the provisions of section nine I or his employing or supervising physician, no nurse duly registered or licensed under the provisions of section seventy-four, seventy-four A or seventy-six, no pharmacist duly registered under the provisions of section twenty-four, no pharmacy technician duly registered under the provisions of section twenty-four C, no dentist duly registered under the provisions of section forty-five, or forty-five A, no psychologist duly licensed under the provisions of sections one hundred and eighteen through one hundred and twenty-nine, no social worker duly licensed under the provisions of sections one hundred and thirty through one hundred and thirty-seven, no marriage

and family therapist or mental health counselor duly licensed under the provisions of sections 165 through 171, and no radiologic technologist duly licensed under the provisions of section 5L of chapter 111, or resident in another state, in the District of Columbia or in a province of Canada, and duly registered or licensed therein, who, in good faith, as a volunteer and without fee, renders emergency care or treatment, other than in the ordinary course of his practice, shall be liable in a suit for damages as a result of his acts or omissions, nor shall he be liable to a hospital for its expenses if, under such emergency conditions, he orders a person hospitalized or causes his admission."

Clerk #175

Protecting small businesses

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section 112 the following section:-

"SECTION ___. Subsection (b) of said section 188 of said chapter 149, as amended by section 134 of chapter 3 of the acts of 2011, is hereby further amended by striking out, in line 19, the number "11" and inserting in place thereof the following number:- 50".

Rejected

Clerk #176

Sensible Malpractice Measures

Mr. Tarr moves to amend the bill (Senate, No. 2260) in section 166 by inserting after proposed section 60N of chapter 231 of the General Laws, the following sections:-

"Section 60O. In every action for malpractice, negligence, error, omission, mistake or the unauthorized rendering of professional services against a provider of health care the court may, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals

or exceeds $50,000 in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages, and court shall require a defendant who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the defendant.

(a)(1) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Such payments shall only be subject to modification in the event of the death of the judgment creditor.

(2) In the event that the court finds that the defendant has exhibited a continuing pattern of failing to make the payments as specified in paragraph (1), the court shall find the defendant in contempt of court and, in addition to the required periodic payments, shall order the defendant to pay the plaintiff all damages caused by the failure to make such periodic payments, including court costs and attorney’s fees.

(b)Money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the plaintiff, but shall be paid to persons to whom the plaintiff owed a duty of support, as provided by law, immediately prior to his death, or to whom the plaintiff assigned, transferred, or bequeathed his right to receive payment. In such cases the court which rendered the original judgment, may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subdivision.

(c) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the defendant to make future payments shall cease and any security given, pursuant to this section shall revert to the defendant.

Section 60P. In any action for malpractice, error, omission, mistake or the unauthorized rendering of professional services against a provider of health care, the liability of each defendant for damages shall be several only and shall not be joint. Each defendant shall be liable only for the amount of damages allocated to that defendant in direct proportion to that defendant's percentage of fault, and a separate judgment shall be rendered against that defendant for that amount.".

Clerk #177

The Massachusetts Chiropractic Society

Mr. Petruccelli, Ms. Donoghue, Messrs. M. Moore, Berry and Joyce move to amend the bill (Senate, No. 2260) in section 54, by striking out the number "16", in line 1763, and inserting in place thereof the number "17"; and further, by inserting after the words "Massachusetts Hospital Association, Inc.;" in line 1774, the words "the Massachusetts Chiropractic Society, Inc.;".

Clerk #178

Spousal Coverage

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section 115 the following new section:-

"SECTION ___. Subsection (c) of section 188 of said chapter 149 is hereby amended by inserting at the end thereof the following paragraph:-

(11) For the purpose of the fair share contribution compliance test, an employer may count employees that have qualifying health insurance coverage from a spouse, a parent, a veteran's plan, Medicare, Medicaid, or a plan or plans due to a disability or retirement towards their qualifying take-up rate as a "contributing employer", as defined by the Institute of Health Care Finance and Policy. The employer is still required to offer group medical insurance and must keep and maintain proof of their employee's insurance status.".

Rejected

Clerk #179

Language to Achieve a Healthy, Competitive Marketplace

Mr. Kennedy moves to amend the bill (S. 2260) in Section 13 by striking out, in line 57, the words "(d) The attorney general may act under subsection (b) of section 15 of chapter 12C to carry out this section" and inserting in place thereof the following words:- "(d) The attorney general may act under subsection (b) of section 15 of chapter 12C to carry out this section; and

(e) Notwithstanding any general or special law or rule or regulation to the contrary, no health care facility as defined in Section 187 of chapter 149, no carrier as defined in Section 1 of chapter 176R, nor any person or legal entity, that employs or contracts with a health care provider licensed under chapter 112, shall restrict the ability of said health care provider to provide general or specialty medical or other health services, within that health care provider's respective scope of practice. Any person or legal entity taking action to restrict the lawful practice of a licensed health care provider's profession through contract or in employment, including but not limited to adverse internal policies; by-laws; membership; term or condition of employment or contract; guideline; protocol; or referral; inconsistent with a licensed health care provider practicing his profession in accordance with applicable state health care provider licensure law or regulation, shall be considered to have engaged in an unfair and deceptive practice and shall be in violation of chapter 93A.

(f) Nothing in the section shall be construed to exclude any private right of action by a health care provider licensed under chapter 112.".

Clerk #180

WITHDRAWN

ADOPTED

Redraft Clerk #181

DURABLE MEDICAL EQUIPMENT

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section 198 the following new section:-

"SECTION 198A. The secretary of administration and finance and the secretary of health and human services shall evaluate the feasibility of contracting for recycling durable medical equipment purchased and issued by the commonwealth through any and all of its medical assistance programs.

Said evaluation shall include but not be limited to a request for qualifications or proposals for entities capable of developing, implementing and operating a system of recycling whereby an inventory of such equipment is developed and managed so as to maximize the quality of service delivery to equipment recipients and to minimize costs and losses attributable to waste, fraud or abuse.

The secretary of administration and finance shall report to the joint committee on health care financing, the house committee on ways and means and the senate committee on ways and means the findings of said evaluation, together with cost estimates for the operation of a recycling program, estimates of the savings it would generate, and legislative recommendations, not later than October 31, 2012.".

Rejected

Clerk #182

MEDICAID UTILIZATION

Mr. Tarr moved that the bill (Senate, No. 2260) be amended by inserting after section __ the following new sections:-

"SECTION __. The division of health care finance and policy shall, within eight months of the passage of this act, develop regulations to ensure the following: i) that Medicare-like claims editing is fully and effectively implemented and used to determine

reimbursements from the Health Safety Net Trust Fund; and ii) that claims editing is effectively used to reduce the occurrence of payments for medically unnecessary services, medically unlikely events, and duplicate services.

SECTION __. The office of Medicaid shall, within eight months of the passage of this act, develop regulations to ensure that incentives or regulations are implemented to increase competition among MassHealth managed care organizations, reduce the size of some provider networks offered by managed care organizations, and/or to reduce cost of managed care organizations."

ADOPTED

Clerk #183

PA Inclusion in Health Care Workforce Center

Messrs. Berry, Welch, Brownsberger and McGee move to amend the bill (S2260) in line 1763 by striking out the figures "16" and inserting in place thereof the figures "17" and inserting in line 1773 after the words "the Massachusetts Nurses Association;" the following: "the Massachusetts Association of Physician Assistants;" and further by striking out Section 25L and inserting in place thereof the following:-

Section 25L. There shall be in the department a health care provider workforce center to improve access to health and behavioral health care services. The center, in consultation with the healthcare provider workforce advisory council established by section 25M and the secretary of labor and workforce development, shall: (i) coordinate the department's health care workforce activities with other state agencies and public and private entities involved in health care workforce training, recruitment and retention, including with the activities of the Health Care Workforce Transformation Fund; (ii) monitor trends in access to primary care providers, nurse practitioners and physician assistants practicing as primary care providers, behavioral health providers, and other physician and nursing providers, through activities including: (1) review of existing data and collection of new data as needed to assess the capacity of the health care and behavioral health care workforce to serve patients, including patient access

and regional disparities in access to physicians, physician assistants or nurses and behavioral health professionals and to examine physician, physician assistant and nursing and behavioral health professionals' satisfaction; (2) review existing laws, regulations, policies, contracting or reimbursement practices and other factors that influence recruitment and retention of physicians, physician assistants and nurses and behavioral health professionals; (3) making projections on the ability of the workforce to meet the needs of patients over time; (4) identifying strategies currently being employed to address workforce needs, shortages, recruitment and retention; (5) studying the capacity of public and private medical, nursing and behavioral health professional schools in the commonwealth to expand the supply of primary care physicians, nurse practitioners and physician assistants practicing as primary care providers, and licensed behavioral health professionals; (iii) establish criteria to identify underserved areas in the commonwealth for administering the loan repayment program established under section 25N and for determining statewide target areas for health care provider placement based on the level of access; and (iv) address health care workforce shortages by: (1) coordinating state and federal loan repayment and incentive programs for health care providers; (2) providing assistance and support to communities, physician groups, community health centers, community based behavioral health organizations and community hospitals in developing cost-effective and comprehensive recruitment initiatives; (3) maximizing all sources of public and private funds for recruitment initiatives; (4) designing pilot programs and make regulatory and legislative proposals to address workforce needs, shortages, recruitment and retention; and (5) making short-term and long-term programmatic and policy recommendations to improve workforce performance, address identified workforce shortages and recruit and retain physicians, physician assistants, nurses and behavioral health professionals.

Clerk #184

PA Practice Modernization

Messrs. Berry, Welch, Brownsberger, and Knapik move to amend the bill (S2260) by inserting after Section 205 the following:-

Section XXX:

Section 9E of chapter 112 of the General Laws, as so appearing, is hereby amended by striking out, in lines 5 and 6, the words "A registered physician shall supervise no more than 4 physician assistants at any one time."

Section 9E of chapter 112 is hereby amended by striking out, in lines 15 through 17, the words "Any prescription of medication made by a physician assistant must include the name of the supervising physician.".

Section 9C of chapter 112 of the General Laws, as so appearing, is hereby amended by striking the definition of "physician assistant" and inserting in place thereof the following definition:-

"Physician assistant," a person who is duly registered and licensed by the board.

Clerk #185

Fair Share for Massachusetts Residents

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section 112 the following section:-

"SECTION ___. Said subsection (a) of said section 188 of said chapter 149, as so appearing, is hereby further amended by inserting in the definition of "Employee", after the word "individual" the following words:- ,who is a resident of the commonwealth,".

Clerk #186

Filing Requirements

Mr. Berry moves to amend the bill (S2260) in subsection 17(a) of Section 14 by striking the first paragraph and inserting in place thereof the following paragraph:-

"Section 17. (a) No provider organization may negotiate network contracts with any carrier or third-party administrator except for provider organizations which are registered under this chapter and regulations promulgated under this chapter; provided, however, that nothing in this chapter shall require a provider organization which receives, or which represents providers who collectively receive, less than $500,000 in annual net patient service revenue from carriers or third-party administrators and which has fewer than 5 affiliated physicians to be registered if such provider organization does not accept risk".

Rejected

Clerk #187

Accountable Care Organization Risk

Mr. Berry moves to amend the bill (S2260) in Section 14 by striking out Section 10(e) of the new Chapter 12C of the general laws and inserting in place thereof the following:-

(e) The institute shall, in collaboration with the division of insurance, establish by regulation a certification process for any provider organization which enters into alternative payment contracts. Such certification process shall be designed to determine whether a provider organization has adequate reserves and other measures of financial solvency to meet its risk arrangements. The standards for such certification may vary based on the provider organization size, the type of alternative payment methodology employed, the amount and type of risk assumed and such other criteria as the commissioner of insurance considers appropriate to ensure that provider organizations do not assume excess risk; provided, that said institution in collaboration with the division of insurance shall establish a level of certification that is sufficient to authorize a Beacon ACO to establish business arrangements for self insured employee health insurance coverage, products or other arrangements including but not limited to global payments arrangements with such self-insured employers. The institute, in

collaboration with the division of insurance, shall establish a schedule to renew such certification. The institute and the commissioner of insurance shall create and administer the program under which one or more Beacon ACOs shall directly contract with self-insured employers, so-called, on a global payment basis for the delivery of accountable care to persons employed or covered by such employers. The institute shall establish such other criteria for such program after holding a public hearing and seeking the input of employers and Beacon ACOs. An agreement between a self-insured employer, so-called, and a Beacon ACO certified under section 8 of Chapter 176S, under which the accountable care organization is paid in whole or in part, on a global payment or risk-based basis, or other alternative payment methodology, shall not be deemed to be a contract of insurance; and a Beacon ACO participating in the program shall not be deemed an insurer or a health maintenance organization under chapter 175 or chapter 176, respectively, of the General Laws.

Rejected

Roll Call #182 [5-30]

Clerk #188

Flexible Benefit Options

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section 175 the following sections:-

"SECTION___. Section 1 of chapter 175, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 15, after the word "commonwealth", the following definition:-

"Flexible health benefit policy" means a health insurance policy that in whole or in part, does not offer state mandated health benefits.; and

by inserting in line 30, after the word "inclusive", the following definition:

“Policy of Accident and Sickness Insurance,” any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of this chapter.; and

by inserting, in line 38, after the word “context”, the following definition:

“State mandated health benefits" means coverage required or required to be offered in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;

2. places limitations or restrictions on deductibles, coinsurance, copayments, or

any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an

insured is entitled to receive care.

SECTION___. Section 108 of said chapter 175, as so appearing, is hereby amended by inserting after subsection 12 the following subsection:-

13. A carrier authorized to transact individual policies of accident or sickness insurance under this section may offer a flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the carrier shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

SECTION___. Section 110 of said chapter 175, as so appearing, is hereby amended by inserting after subsection (P) the following:-

(Q) A carrier authorized to transact group policies of accident or sickness insurance under this section may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the carrier shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group policyholder the option of purchasing at least on health insurance policy that provides all state mandated benefits. The carrier shall provide each subscriber under a group policy upon enrollment with written notice stating that this a flexible health benefit policy and describing the state mandated health benefits that are not included in the policy.

SECTION___. Said chapter 175, as so appearing, is hereby amended by inserting after section 111H the following:-

Section 111I. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance solely on the basis that it does not include coverage for at least 1 mandated benefit.

(b) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A) diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance that does not include coverage for at least one mandated benefit unless the carrier continues to offer at least one policy that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a policy of accident and sickness insurance to any employee within 12 months.

SECTION___. Chapter 176A, as appearing in the 2010 Official Edition, is hereby amended by adding after section 1D the following sections:-

Section 1E. Definitions

The following words, as used in this chapter, unless the text otherwise requires or a different meaning is specifically required, shall mean-

“Flexible health benefit policy,” a health insurance policy that in whole or in part, does not offer state mandated health benefits.

"State mandated health benefits," coverage required or required to be offered

in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;

2. places limitations or restrictions on deductibles, coinsurance, copayments, or

any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an

insured is entitled to receive care.

“Policy of Accident and Sickness Insurance,” any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of chapter 175 of the general laws.

Section 1F. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a contract between a subscriber and the corporation under an individual or group hospital services plan solely on the basis that it does not include coverage for at least one mandated benefit.

(b) The commissioner shall not approve a contract unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A) diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a contract that does not include coverage for at least one mandated benefit unless the corporation continues to offer at least one contract that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a hospital services plan, to any employee within 12 months.”; and

by inserting after section 123 the following section:-

“SECTION___. Section 8 of chapter 176A, as so appearing, is hereby amended by inserting after subsection (g) the following:—

(h) A non-profit hospital service corporation authorized to transact individual policies of accident or sickness insurance under this section may offer a one flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the non-profit hospital service corporation shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

(i) A non-profit hospital service corporation authorized to transact group policies of accident or sickness insurance under this section may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the non-profit hospital service corporation shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group policyholder the option of purchasing at least on health insurance policy that provides all state mandated benefits. The non-profit hospital service corporation shall provide each subscriber under a group policy upon enrollment with written notice stating that this a flexible health benefit policy and describing the state mandated health benefits that are not included in the policy.”; and

by inserting after section 124 the following sections:-

“SECTION___. Section 1 of Chapter 176B, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 11, after the word “support”, the following new definition:—

“Flexible health benefit policy” means a health insurance policy that in whole or in part, does not offer state mandated health benefits.

; and, further, in line 56, after the word “corporation”, the following definition:

“Policy of Accident and Sickness Insurance,” any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of chapter 175 of the general laws.

; and, further, in line 62, after the word “twelve”, the following definition:

"State mandated health benefits" means coverage required or required to be offered in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;

2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

SECTION___. Section 4 of chapter 176B, as so appearing, is hereby amended by inserting the following paragraphs at the end thereof:—

A medical service corporation authorized to transact individual policies of accident or sickness insurance under this chapter may offer a one flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the medical service corporation shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

A medical service corporation authorized to transact group policies of accident or sickness insurance under this section may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the medical service corporation shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and

provide to the prospective group policyholder the option of purchasing at least on health insurance policy that provides all state mandated benefits.

The medical service corporation shall provide each subscriber under a group policy upon enrollment with written notice stating that this a flexible health benefit policy and describing the state mandated health benefits that are not included in the policy.

SECTION___. Said chapter 176B, as so appearing, is hereby amended by inserting after section 6B the following section:-

Section 6C. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a subscription certificate solely on the basis that it does not include coverage for at least one mandated benefit.

(b) The commissioner shall not approve a subscription certificate unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A) diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health

services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a subscription certificate that does not include coverage for at least 1 mandated benefit unless the corporation continues to offer at least one subscription certificate that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a subscription certificate, to any employee within 12 months.

SECTION___. Section 1 of chapter 176G, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 42, after the word “entitled” the following new definition:—

“Flexible health benefit policy” means a health insurance policy that in whole or in part, does not offer state mandated health benefits.

; and, further, in line 102, after the words “chapter 175”, the following definitions:

“Policy of Accident and Sickness Insurance,” any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of chapter 175 of the general laws.

"State mandated health benefits" means coverage required or required to be offered in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;

2. places limitations or restrictions on deductibles, coinsurance, copayments, or

any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an

insured is entitled to receive care.

SECTION___. Section 4 of chapter 176G, as appearing in the 2010 Official Edition, is hereby amended by adding the following paragraph at the end thereof:—

A health maintenance organization authorized to transact individual policies of accident or sickness insurance under this chapter may offer a one flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the health maintenance organization shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

SECTION___. Chapter 176G, as appearing in the 2010 Official Edition is hereby amended by inserting after section 4V the following section:-

Section 4W. A health maintenance organization authorized to transact group policies of accident or sickness insurance under this chapter may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the health maintenance organization shall provide to the prospective group policyholder

written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group policyholder the option of purchasing at least on health insurance policy that provides all state mandated benefits. The health maintenance organization shall provide each subscriber under a group policy upon enrollment with written notice stating that this a flexible health benefit policy and describing the state mandated health benefits that are not included in the policy.

SECTION___. Chapter 176G of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after Section 16B the following section:-

Section 16C. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a health maintenance contract solely on the basis that it does not include coverage for at least 1 mandated benefit.

(b) The commissioner shall not approve a health maintenance contract unless it provides coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A) diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a health maintenance contract that does not include coverage for at least one mandated benefit unless the health maintenance organization continues to offer at least one health maintenance contract that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out the provisions of this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a health maintenance contract, to any employee within 12 months.”; and

by inserting after section 128 the following sections:-

“SECTION___. Section 1 of chapter 176M, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 101, after the word “claims” the following new definition:—

“Flexible health benefit policy” means a health insurance that, in whole or in part, does not offer state mandated health benefits.

; and, further, in line 255, after the word “basis”, the following definition:

"State mandated health benefits" means coverage required to be offered any general or special law that:

1. includes coverage for specific health care services or benefits;

2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

SECTION___. Section 2 of chapter 176M, as appearing in the 2010 Official Edition, is hereby further amended by striking out the first sentence of subsection (d) and inserting in place thereof the following:-

A carrier that participates in the nongroup health insurance market shall make available to eligible individuals a standard guaranteed health plan established pursuant to paragraph (c) and may additionally make available to eligible individuals no more than two alternative guaranteed issue health plans, one of which may be a flexible health benefit policy, with benefits and cost sharing requirements, including deductibles, that differ from the standard guaranteed issue health plan.

Clerk #189

Continue Funding the Prevention and Wellness Trust

Ms. Chang-Díaz and Mr. DiDomenico moves to amend the bill (Senate, No. 2260) by striking out section 202 and section 205.

Rejected

Clerk #190

Increase Number of Members in Provider Group

Mr. Kennedy moves to amend the bill (S. 2260) by inserting in place thereof the following:-

Section 1. By deleting in line 216, the number "1" and the inserting in place thereof the following: "10".

Section 2. By inserting after the word "organization" in line 220 the following" "of ten or more providers".

Section 3. By inserting after the word "provider" in line 315 by the following: "organization";

Section 4. By deleting the word "providers" in line 362 and inserting in place there of the following: "provider organizations and licensed facilities".

Section 5. By inserting after the word "organization" in line 780 the following: ",as defined in Section One of Chapter 12C" .

Section 6. By deleting lines 868 through 892 commencing with "(2)".

Section 7, By deleting the word "provider" in line 1948 and inserting in place thereof the following: "accountable care".

Section 8. By deleting the number "1" in line 3420 and inserting in place there of the following: "10".

Section 9. By insertion after the word "organization" in line 3424 the following: "of ten or more providers".

Rejected

Roll Call #183 [7-28]

Clerk #191

INSPECTOR GENERAL AUDIT OF MEDICAID

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section __ the following new section:-

"SECTION __. In hospital fiscal year 2013, the office of the inspector general may expend funds from the the HealthCare Payment Reform Fund as appearing in section 100 of chapter 194 of the Acts of 2011, for the costs associated with conducting an

audit of the Commonwealth's Medicaid program. The inspector general may examine the practices utilized in all hospitals including, but not limited to, the care of the insured receiving health care services reimbursed pursuant to the Commonwealth's Medicaid system. The inspector general shall submit a report to the house and senate committees on ways and means containing the findings of any audits so conducted and any other completed analyses not later than 6 months after funds are deposited into the HealthCare Payment Reform Fund. For the purposes of such audits, health care services shall be defined pursuant to said chapter 118G and any regulations adopted there under."

Rejected

Clerk #192

DEFINING THE EFFECTIVE DATE OF THIS ACT

Mr. Knapik moves to amend the bill (Senate, No. 2260) by inserting the following new section:-

SECTION XX. This act shall be effective not less than 30 days after the Supreme Court of the United States renders a decision in the matter of Thomas More Law Center, Jann DeMars, John Ceci, Steven Hyder, and Salina Hyder v. Barack Hussein Obama, in his official capacity as President of the United States, et al.

Rejected

Clerk #193

Reporting Municipal Costs

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section 2 the following section:-

"SECTION__. Paragraph (1) of Subsection (d) of said section 38C of said chapter 3, as so appearing, is hereby further amended by striking paragraph (1) and inserting in place thereof the following:-

(1) the financial impact of mandating the benefit, including the extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years, the extent to which the proposed coverage might

increase the appropriate or inappropriate use of the treatment or service over the next 5 years, the extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service, the extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next 5 years, the effects of mandating the benefit on the cost of health care, particularly the premium, administrative expenses and indirect costs of municipalities, large employers, small employers, employees and nongroup purchasers, the potential benefits and savings to municipalities, large employers, small employers, employees and nongroup purchasers, the effect of the proposed mandate on cost shifting between private and public payors of health care coverage, the cost to health care consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed treatment and the effect on the overall cost of the health care delivery system in the commonwealth;".

ADOPTED

Clerk #194

Limited Services Clinics

Messrs. Richard T. Moore, DiDomenico and Joyce moves to amend the bill (Senate, No. 2260) by inserting at the end thereof the following new sections:-

SECTION __. Chapter 111 of the General Laws is hereby amended by inserting after section 51H the following section:-

Section 51I. The department shall promulgate regulations regarding limited services clinics. Such regulations shall promote the availability of limited services clinics as a point of access for health care services within the full scope of practice of a nurse practitioner or other clinician providing services.

SECTION __. Section 52 of chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting, after the definition of "Institution for unwed mothers" the following 2 definitions:-

"Limited services", diagnosis, treatment, management, monitoring of acute and chronic disease, wellness and preventative services of a nature that may be provided within the

scope of practice of a nurse practitioner or other clinician providing services using available facilities and equipment, including shared toilet facilities for point-of-care testing.

"Limited services clinic", a clinic that provides limited services.

Clerk #195

WITHDRAWN

Clerk #196

Greater Transparency, Accountability and Administrative Review of Provider Price Variation

Messrs. Finegold, Knapik and Welch and Ms. Donoghue move to amend the bill (Senate, No. 2260) by inserting, after section 136, the following section:-

"SECTION 136A. Said chapter 176O of the General Laws is hereby amended by inserting, after section 5B, the following section:-

"Section 5C. (a) A contract or agreement between a carrier and a health care provider, including a hospital or physician group practice, effective January 1, 2013, shall adhere to the following: a contract for payment between a carrier and a disproportionate share hospital, as defined in section 1 of chapter 118G, and its affiliated physician group practices, shall not contain rates that are less than the carrier's statewide average rate, as defined by the previous year of October 1 to September 30 plus an annual adjustment for the projected change of the New England Consumer Price Index for Medical Care Services, published by the United States Department of Labor, Bureau of Labor Statistics.

(b) Each carrier shall be required to file an annual report to the division of insurance which discloses what actions the carrier has taken to remedy the relative rate disparity identified in the attorney general's findings in "Examination of Health Care Cost Trends

and Cost Drivers" filed on June 22, 2011, which concluded that said disproportionate share hospitals are paid considerably less than other acute hospital providers."

Rejected

Clerk #197

HEALTH SAVINGS ACCOUNTS

Mr. Tarr and Mr. Joyce moves to amend the bill (Senate, No. 2260) by inserting after section ___ the following new section:-

"SECTION __. Section 4 of Chapter 32A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting, after the first paragraph, the following:- Among the policies purchased by the commission, at least one shall include a health savings account in its design.".

Clerk #198

EFFECTIVE DATE

Mr. Tarr moves to amend the bill (Senate, No. 2260) by striking sections 2000 through 205, inclusive;

And moves to amend the bill further by inserting at the end thereof the following new section:-"SECTION ___. No provision of this act shall take effect before January 1, 2014."

Rejected

Clerk #199

Teaching Hospital

Mr. Kennedy moves to amend the bill (S. 2260) by striking out Section 190 and inserting in place thereof the following words:-

"SECTION 190. There shall be a special commission to review variation in prices among providers. The commission shall consist of 14 members: 1 of whom shall be the executive director of the institute of health care finance and policy or a designee, who shall serve as chair; 1 of whom shall be the secretary of administration and finance or a designee; 1 of whom shall be the executive director of the group insurance commission or a designee; 1 of whom shall be the secretary of health and human services or a designee; 1 of whom shall be the attorney general or a designee; 4 of whom shall be appointed by the governor, 1 of whom shall be a health economist, 1 of whom shall have expertise in the area of health care payment methodology, 1 of whom shall represent non-physician health care providers and 1 of whom shall represent an academic medical center or teaching hospital; 1 of whom shall represent a high Medicaid and low income public payer disproportionate share hospital. 1 of whom shall be appointed by the senate president and shall be a health economist or have expertise in the area of health care payment methodology; 1 of whom shall be appointed by the speaker of the house of representatives and shall be a health economist or have expertise in the area of health care payment methodology; 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc.; 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc.; 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc.; and 1 of whom shall be a representative of the Massachusetts Medical Society.".

Rejected

Clerk #200

IMPACT OF MANDATES ON SMALL BUSINESSES

Mr. Tarr and Mr. Joyce moves to amend the bill (Senate, No. 2260) by inserting after section __ the following new sections:-

"SECTION __. The Massachusetts Health Connector shall establish a special small business commission composed solely of small business owners and their employees to (a) identify those mandates that unduly increase the cost of small business insurance

(b) make recommendations to the legislature on mandates that need to be rescinded or revised and (c) submit a report to the general court on any proposed mandated health benefit bill; provided however that no new mandated health benefit mandate is approved until 90 days after the clerks of the house and senate are in receipt of such report.

Rejected

Clerk #201

Operations Affecting Mandated Benefits

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting at the beginning thereof the following section:-

"SECTION__. Section 38C of chapter 3 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking subsection (a) and inserting in place thereof the following:-

(a) For the purposes of this section, a mandated health benefit proposal is one that mandates health insurance coverage for specific health services, specific diseases or certain providers of health care services or that affects the operations of health insurers in the administration of health insurance coverage as part of a policy or policies of group life and accidental death and dismemberment insurance covering persons in the service of the commonwealth, and group general or blanket insurance providing hospital, surgical, medical, dental, and other health insurance benefits covering persons in the service of the commonwealth, and their dependents organized under chapter 32A , individual or group health insurance policies offered by an insurer licensed or otherwise authorized to transact accident or health insurance organized under chapter 175, a nonprofit hospital service corporation organized under chapter 176A, a nonprofit medical service corporation organized under chapter 176B, a health maintenance organization organized under chapter 176G, or an organization entering into a preferred provider arrangement under chapter 176I, any health plan issued,

renewed, or delivered within or without the commonwealth to a natural person who is a resident of the commonwealth, including a certificate issued to an eligible natural person which evidences coverage under a policy or contract issued to a trust or association for said natural person and his dependent, including said person's spouse organized under chapter 176M.".

Clerk #202

Beacon ACO protections

Mr. Tarr moves to amend the bill (Senate, No. 2260) in Section 162 in proposed chapter 176S of the General Laws by inserting after the word "protections", in line 3996, the following words:- "provided, however, that no certificate is rejected because of geography or volume".

Clerk #203

Special Commission to Examine Required Co-pays for MassHealth Services

Mr. Finegold Mr. Joyce moves to amend the bill (Senate, No. 2260) by inserting, after section 190, the following section:-

"SECTION 190A. There shall be a special commission to examine: (1) the feasibility of implementing required co-pays for MassHealth services, the proceeds of which shall be deposited into a trust fund to restore MassHealth Adult Dental Benefits; and (2) methods to encourage health care providers to accept patients covered by MassHealth on a limited basis. The commission shall consist of 8 members: 1 of whom shall be the secretary of health and human services or a designee, who shall serve as chair; 1 of whom shall be the director of the office of Medicaid; 1 of whom shall be the executive director of the institute of health care finance and policy; 1 of whom shall be appointed by the Massachusetts Medical Society; 1 of whom shall be appointed by the Massachusetts Senior Care Association; 1 of whom shall be appointed by the

Massachusetts League of Community Health Centers; 1 of whom shall be the executive director of Health Care For All, Inc.; and 2 of whom shall be appointed by the governor, 1 of whom shall represent managed care organizations contracting with MassHealth.

The commission shall file the results of its study, together with drafts of legislation, if any, necessary to carry out its recommendations, by filing the same with the clerks of the house of representatives and the senate who shall forward a copy of the study to the house and senate committees on ways and means and the joint committee on health care financing not later than October 1, 2013."

Clerk #204

MEDICAID VERIFICATION FOR COVERAGE

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting, after section __, the following new section:-

"Section __. The office of Medicaid shall, within six months of the passage of this act, take any and all necessary actions to ensure that social security numbers are required on all medical benefits request forms and that social security numbers are provided by all applicants who possess them.

If for any reason the office determines that it is or will be unable to accomplish the foregoing within six months of the passage of this Act, it shall submit a detailed report of the reasons for such inability to the clerks of the house of representatives and the senate within three months following the passage of this act."

Section __. The division of health care finance and policy shall, within six months of the passage of this act, ensure ii) that the identity, age, residence and eligibility of all applicants are verified before payments are made by the Health Safety Net Trust Fund; and iii) that no payment is made for any expense which is otherwise covered by third

party liability, private insurance, or other governmental coverage, including Medicare and MassHealth.

If for any reason the division determines that it is or will be unable to accomplish the foregoing within six months of the passage of this Act, it shall submit a detailed report of the reasons for such inability to the clerks of the house of representatives and the senate within three months following the passage of this act."

Clerk #205

Medicaid Hospitals

Mr. Kennedy moves to amend the bill (S. 2260) by striking out Section 189 and inserting in place thereof the following words:-

SECTION 189. There shall be a special commission to review public payer

reimbursement rates and payment systems for health care services and the impact of such rates and payment systems on health care providers and on health insurance premiums in the commonwealth. The commission shall consist of 12 members: 1 of whom shall be the secretary of health and human services or a designee, who shall serve as chair; 1 of whom shall be the director of the office of Medicaid; 1 of whom shall be the executive director of the institute of health care finance and policy; 1 of whom shall be appointed by the Massachusetts Hospital Association; 1 of whom shall represent a high Medicaid and low income public payer disproportionate share hospital 1 of whom shall be appointed by the Massachusetts Medical Society; 1 of whom shall be appointed by the Massachusetts Senior Care Association; 1 of whom shall be appointed by the Home Care Alliance of Massachusetts; 1 of whom shall be appointed by the Massachusetts League of Community Health Centers; 1 of whom shall be appointed by the Massachusetts Association for Behavioral Healthcare; and 2 of whom shall be appointed by the governor, 1 of whom shall be represent managed care organizations contracting with MassHealth and 1 of whom shall be an expert in medical payment

methodologies from a foundation or academic institution. The commission shall examine whether public payer rates and rate methodologies provide fair compensation for health care services and promote high-quality, safe, effective, timely, efficient, culturally competent and patient-centered care. The commission's analysis shall include, but not be limited to, an examination of MassHealth rates and rate methodologies; current and projected federal financing, including Medicare rates; cost-shifting and the interplay between public payer reimbursement rates and health insurance premiums; and the degree to which public payer rates reflect the actual cost of care. To conduct its review and analysis, the commission may contract with an outside organization with expertise in the analysis of health care financing. The institute of health care finance and policy and the office of Medicaid shall provide the outside organization, to the extent possible, with any relevant data necessary for the evaluation; provided, however, that such data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws. The commission shall file the results of its study, together with drafts of legislation, if any, necessary to carry out its recommendations, by filing the same with the clerks of the house of representatives and the senate who shall forward a copy of the study to the house and senate committees on ways and means and the joint committee on health care financing not later than April 1, 2013.

REDRAFT Clerk #206

MANAGED CARE FOR MEDICAID

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section __ the following new sections:-

"SECTION __. The Secretary of Health and Human Services shall develop a plan to ensure that, to maximum feasible extent, the care being provided to those receiving full health insurance benefits be provided through managed care programs. Said plan shall be implemented not later than one year following the passage of this act, provided that

the provisions of the plan shall be reported to the clerks of the senate and the house of representatives not later than 60 days prior to its effective date."

REDRAFT Clerk #207

RATES OF PAYMENT

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting, after Section__, the following new Section:-

"SECTION__. Notwithstanding any general or special law to the contrary, any provider of health care subject to a contract of insurance with a carrier, as definite in section 1 of chapter 12C of the general laws, which receives a rate of payment for a particular service or procedure that is less than the rate paid to one or more other providers for consumers in the same geographic region may request and receive in writing from said insurer the explanation and justification therefore, together with any actions which the provider may take to address this discrepancy."

Rejected

Clerk #208

CONSUMER DIRECTED HEALTH CARE

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section ___ the following new section:-

"SECTION __. The institute shall develop a plan for the authorization, implementation and regulation of so-called "consumer-directed health care" in the commonwealth for the purpose of empowering consumers with the knowledge, ability and incentives to make choices in the purchase of health care which facilitate sound health outcomes and the cost-effective delivery of services.

For the purposes of this section, consumer-directed health care shall include, by not be limited to, the utilization of health savings accounts, insurance coverage with deductibles of dollar amounts greater than the state average for such amounts, and expanded access to information detailing the actual cost of services being provided to the consumer.

Said plan, together with any legislative and regulatory actions necessary to its implementation and maintenance, shall be filed with the clerks of the House and Senate no later than one year following the passage of this act."

Rejected

Clerk #209

MEDICAID CLAIMS EDITING

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section __ the following new section:-

"SECTION __. The institute shall, within 120 days following the passage of this act, design and develop measures to penalize those receiving state subsidized health care benefits for personal actions which contribute to the increased cost of health care, which are avoidable, such as the failure to appear for schedules appointments with providers without proper justification therefore.

Said institute shall also design and develop methodologies to incent and reward personal decisions and behaviors that are proven to improve health, such as smoking cessation, weight loss, and dietary planning.

Such measures and methodologies shall be reported, together with any legislative and regulatory actions necessary to their implementation, to the clerks of the house and senate not later than nine months following the passage of this act.

Rejected

Clerk #210

Evaluation of Health Care Payment System

Ms. Fargo moves to amend Senate No. 2260 in SECTION189, in line 4843, by inserting, after the word "care" following words: -

"The analysis shall also include a determination of the health care payment system's payment methodologies' impact on: (1) vulnerable populations, including but not limited to the homeless, the disabled, women, the elderly and children; (2) racial, ethnic and socioeconomic health disparities; and (3) applicants to and patients of accountable care organizations and other health care entities, and difference to acceptance, care and treatment based on race, color, religious creed, national origin, sex, sexual orientation, disability, genetic information or ancestry. Data collected as part of the commission's evaluation of the health care payment system shall include state BRFSS data and shall comply with standard data standards, including but not limited to nationally comparable collection of data on disability and minorities. Data collected shall meet both state and federal CLAS standards."

REDRAFT Clerk #211

Preventing Consumer Costs

Mr. Tarr moves to amend the bill (Senate, No. 2260) by adding the following section:-

Section__. Notwithstanding any special or general law to the contrary, any fee imposed pursuant to this act shall not be incorporated or reflect in any charge or cost imposed directly or indirectly on those with health care insurance coverage in the commonwealth.

Clerk #212

AFFILIATION AGREEMENTS

Mr. Knapik moves to amend the bill (Senate, No. 2260) in Section 190, in line 4878, by inserting after the word "coordination," the following:- ", the impact of affiliation agreements on acute-care hospitals licensed for 200 beds or less,"

Clerk #213

Beacon ACOs

Mr. Richard T. Moore and Mr. Joyce moves to amend the bill (Senate, No. 2260) in Section 162 by striking section 8 in its entirety and inserting in place thereof the following:-

Section 8. (a) The authority, in consultation with the advisory board, shall develop standards and a common application form for certain provider organizations to be voluntarily certified as Beacon ACOs. The purpose of the Beacon ACO certification process shall be to encourage the adoption of certain best practices by provider organizations in the commonwealth related to cost containment, quality improvement and patient protection. Provider organizations seeking this certification shall apply directly to the authority and shall submit all necessary documentation as required by the authority. The Beacon ACO certification shall be assigned to all provider organizations that meet the standards developed by the board.

(b) In developing standards for Beacon ACO certification, the authority shall review the best practices employed by health care entities in the commonwealth and the standards included in models developed by the Centers for Medicare & Medicaid Services, including the Pioneer ACO, the Medicare Shared Savings Model, and any safety net accountable care organization models, and shall include, at a minimum, a requirement that all Beacon ACOs shall: (i) commit to entering alternative payment methodology

contracts with other purchasers; (ii) be a legal entity with its own tax identification number, recognized and authorized under the laws of the commonwealth; (iii) include patient and consumer representation on its governance; and (iv) commit to ensuring at least 50 per cent of the Beacon ACO's primary care providers are meaningfully using certified EHR technology as defined in the HITECH Act and subsequent Medicare regulations.

(c) The board shall develop additional standards necessary to be certified as a Beacon ACO, related to quality improvement, cost containment and patient protections. In developing additional standards, the board shall consider, at a minimum, the following requirements for Beacon ACOs:

(1) to reduce the growth of health status adjusted total medical expenses over time, consistent with the state's efforts to meet the health care cost benchmark established under section 5;

(2) to improve the quality of health services provided, as measured by the statewide quality measure set and other appropriate measures;

(3) to ensure patient access to health care services across the care continuum, including, but not limited to, access to: preventive and primary care services; emergency services; hospitalization services; ambulatory patient services; mental health and behavioral health services; access to specialty care units, including, but are not limited to, burn, coronary care, cancer care, neonatal care, post-obstetric and post operative recovery care, pulmonary care, renal dialysis and surgical, including trauma and intensive care units; pediatric services; diagnostic imaging and screening services; maternity and newborn care services; radiation therapy and treatment services; skilled nursing facilities; family planning services; home health services; treatment and prevention services for alcohol and other drug abuse; breakthrough technologies and treatments; hospice services; and allied health services including, but not limited to, advance practice nurses, optometric care, direct access to chiropractic services, occupational therapists, dental care, physical therapy and midwifery services;

(4) to improve access to certain primary care services, including but not limited to, by having a demonstrated primary care capacity and a minimum number of practices engaged in becoming patient centered medical homes;

(5) to improve access to health care services and quality of care for vulnerable populations including, but not limited to, children, the elderly, low-income individuals, individuals with disabilities, individuals with chronic illnesses and racial and ethnic minorities.

(6) to promote the integration of mental health and behavioral health services with primary care services including, but not limited to, the establishment of a behavioral health medical home;

(7) to promote patient-centeredness by, including, but not limited to, establishing mechanisms to conduct patient outreach and education on the necessity and benefits of care coordination; demonstrating an ability to engage patients in shared decision making taking into account patient preferences; demonstrating an ability to effectively involve patients in care transitions to improve the continuity and quality of care across settings, with case manager follow up; demonstrating an ability to engage and activate patients at home, through methods such as home visits or telemedicine, to improve self-management; and establishing mechanisms to evaluate patient satisfaction with the access and quality of their care;

(8) to adopt certain health information technology and data analysis functions, including, but not limited to, population-based management tools and functions; the ability to aggregate and analyze clinical data; the ability to electronically exchange patient summary records across providers who are members of the Beacon ACO and other providers in the community to ensure continuity of care; the ability to provide access to multi-payer claims data and performance reports and the ability to share performance feedback on a timely basis with participating providers; and the ability to enable the beneficiary access to electronic health information;

(9) to demonstrate excellence in the area of quality improvement and care coordination, as evidenced by the success of previous or existing care coordination, pay for performance, patient centered medical home, quality improvement or health outcomes improvement initiatives, including, but not limited to, a demonstrated commitment to reducing avoidable hospitalizations, adverse events and unnecessary emergency room visits;

(10) to promote community-based wellness programs and community health workers, consistent with efforts funded by the department of public health through the Prevention and Wellness Trust Fund established in section 2G of chapter 111;

(11) to promote worker training programs and skills training opportunities for employees of the provider organization, consistent with efforts funded by the secretary of labor and workforce development through the Health Care Workforce Transformation Trust Fund;

(12) to adopt certain governance structure standards;

(13) to adopt certain financial capacity standards, including certification under subsection (e) of section 10 of chapter 12C, to protect Beacon ACOs from assuming excess risk; and

(14) any other requirements the board considers necessary.

(d) The authority shall update the standards for certification as a Beacon ACO at least every 2 years, or at such other times as the authority determines necessary. In developing the standards, the authority shall seek to allow for provider organizations of different compositions, including, but not limited to, hospital and physician organizations, physician group entities and independent physician organizations, to successfully apply for certification. The authority may waive certain Beacon ACO standards for provider organizations composed of safety net providers, including high

Medicaid disproportionate share hospitals and their affiliated providers, if it determines that such standards represent an insurmountable barrier to successful certification.

(e) Provider organizations shall annually renew their certification as a Beacon ACO. Failure to meet the requirements represented in the certification may result in decertification, as determined by the board.

ADOPTED

Clerk #214

Addressing psychiatric workforce issues

Mr. Keenan moves that the bill (Senate, No. 2260), be amended in section 54, in line 1763 by striking the number "16" and inserting in place thereof the following number: - "17"; and in said section by adding in line 1769 after the words "Behavioral Healthcare" the following words:- "the Massachusetts Psychiatric Society,".

Clerk #215

Further defining behavioral health

Mr. Keenan and Mr. Joyce moves to amend the bill (Senate, No. 2260), by striking out section 131 and inserting in place thereof the following section: -

"SECTION 131. Section 1 of chapter 176O of the General Laws, as so appearing, is hereby amended by inserting after the definition of "Adverse determination" the following definition:-

"Allowed amount," the contractually agreed upon amount paid by a carrier to a health care provider for health care services provided to an insured."

and by striking the definition of "Behavioral health manager" and inserting in place thereof the following definition:

"Behavioral health manager", a company, organized under the law of the commonwealth or organized under the laws of another state and qualified to do business in the commonwealth, that has entered into a contractual arrangement with a carrier to provide or arrange for the provision of behavioral, substance use disorder and mental health services to voluntarily enrolled member of the carrier."

and by striking the definition of "Emergency medical condition" and inserting in place thereof the following definition:

"Emergency medical condition", a medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

and by striking the definition of "Health care services" and inserting in place thereof the following definition:

"Health care services", services for the diagnosis, prevention, treatment, cure or relief of a physical, behavioral, substance use disorder or mental health condition, illness, injury or disease.

ADOPTED

Clerk #216

Access for at-risk populations

Mr. Keenan and Mr. Joyce moves to amend the bill (Senate, No. 2260), in section 10, by adding in line 568 after the words "patient populations" the following words:- ", including those with behavioral, substance use disorder and mental health conditions,".

Clerk #217

Postpartum Depression

Mr. McGee moves to amend the bill (Senate No. 2260) in section 162, line 4265, by adding after the words "maternity and newborn care services" the following:- "and mental health outcomes"

Clerk #218

Clarifying the Statutes of Limitation and Repose

Ms. Creem moves to amend the bill (Senate, No. 2260), by striking section 170.

Clerk #219

Behavioral Health & Substance Abuse Task Force

Mr. Keenan and Mr. Joyce moves to amend the bill (Senate, No. 2260), in section 182, by striking out said section and inserting in place thereof the following section:-

Section 182. There shall be a task force consisting of 15 members with expertise in behavioral health, substance use disorder and mental health treatment, service delivery, the integration of behavioral health, substance use disorder and mental health care with primary care, and such reimbursement systems. Members shall include one representative from each of the following organizations representing mental health professionals and clinical, hospital and consumer advocacy groups: Massachusetts Psychiatric Society, Massachusetts Psychological Association, National Association of Social Workers- Massachusetts Chapter, Massachusetts Mental Health Counselors

Association, Massachusetts Nurses Association, Massachusetts Association for Registered Nurses, Massachusetts Organization for Addiction Recovery, Massachusetts Recovery Home Collaborative, Massachusetts Association of Behavioral Health Systems, Association for Behavioral Healthcare, Mental Health Legal Advisors Committee, National Alliance for the Mentally Ill, Children's Mental Health Campaign, Home Care Alliance of Massachusetts and one member chosen by the governor who shall serve as chairperson . The task force shall report to the authority its findings and recommendations relative to (a) the most effective and appropriate approach to including behavioral health services in the array of services provided by ACOs, including transition planning for providers and maintaining continuity of care; (b) how current prevailing reimbursement methods and covered behavioral health benefits may need to be modified to achieve more cost effective, integrated and high quality behavioral health outcomes including attention to interoperative electronic health records; (c) the extent to which and how payment for behavioral health services should be included under alternative payment methodologies established or regulated under this act including how mental health parity and patient choice of providers and services could be achieved and the design and use of medical necessity criteria and protocols; (d) how best to educate all providers to recognize behavioral health conditions and make appropriate decisions regarding referral to behavioral health services; and (e) the unique privacy factors required for the integration of behavioral health information into interoperative electronic health records. The first meeting shall be convened by the authority within 60 days after passage of this act. The task force shall submit its report, findings, recommendations along with proposed legislation and regulatory changes to the Clerk of the House and the Senate, the Committee on Mental Health and Substance Abuse, The Committee on Health Care Financing and to the authority no later than.July 1, 2013.

Clerk #220

Medical Malpractice Reform

Ms. Creem moves to amend the bill (Senate, No. 2260), by striking sections 165 and 166 and inserting in place thereof the following 2 sections:-

SECTION 165. Section 60K of chapter 231 of the General Laws, as so appearing, is hereby amended by striking out, in line 14, the words “4 per cent” and inserting in place thereof the following:- 2 per cent

SECTION 166. Said chapter 231 is hereby amended by inserting after section 60K, the following 3 sections:-

Section 60L. (a) Except as provided in this section, a person shall not commence an action against a provider of health care as defined in the seventh paragraph of section 60B unless the person has given the health care provider written notice under this section of not less than 182 days before the action is commenced.

(b) The notice of intent to file a claim required under subsection (a) shall be mailed to the last known professional business address or residential address of the health care provider who is the subject of the claim.

(c) The 182 day notice period in subsection (a) shall be shortened to 90 days if:

(1) the claimant has previously filed the 182 day notice required against another health care provider involved in the claim; or

(2) the claimant has filed a complaint and commenced an action alleging medical malpractice against 1 or more of the health care providers involved in the claim.

(d) The 182 day notice of intent required in subsection (a) shall not be required if the claimant did not identify and could not reasonably have identified a health care provider to which notice shall be sent as a potential party to the action before filing the complaint;

(e) The notice given to a health care provider under this section shall contain, but need not be limited to, a statement including:

(1) the factual basis for the claim;

(2) the applicable standard of care alleged by the claimant;

(3) the manner in which it is claimed that the applicable standard of care was breached by the health care provider;

(4) the alleged action that should have been taken to achieve compliance with the alleged standard of care;

(5) the manner in which it is alleged the breach of the standard of care was the proximate cause of the injury claimed in the notice; and

(6) the names of all health care providers that the claimant is notifying under this section in relation to a claim.

(f) Not later than 56 days after giving notice under this section, the claimant shall allow the health care provider receiving the notice access to all of the medical records related to the claim that are in the claimant's control and shall furnish release for any medical records related to the claim that are not in the claimant's control, but of which the claimant has knowledge. This subsection shall not restrict a patient's right of access to the patient's medical records under any other law or regulation.

(g) Within 150 days after receipt of notice under this section, the health care provider or authorized representative against whom the claim is made shall furnish to the claimant or the claimant's authorized representative a written response that contains a statement including the following:

(1) the factual basis for the defense, if any, to the claim;

(2) the standard of care that the health care provider claims to be applicable to the action;

(3) the manner in which it is claimed by the health care provider that there was or was not compliance with the applicable standard of care; and

(4) the manner in which the health care provider contends that the alleged negligence of the health care provider was or was not a proximate cause of the claimant's alleged injury or alleged damage.

(h) If the claimant does not receive the written response required under subsection (g) within the required 150 day time period, the claimant may commence an action alleging medical malpractice upon the expiration of the 150 day time period. If a provider fails to respond within 150 days and that fact is made known to the court in the plaintiffs' complaint or by any other means then interest on any judgment against that provider shall accrue and be calculated from the date that the notice was filed rather than the date that the suit is filed. At any time before the expiration of the 150 day period, the claimant and the provider may agree to an extension of the 150 day period.

(i) If at any time during the applicable notice period under this section a health care provider receiving notice under this section informs the claimant in writing that the health care provider does not intend to settle the claim within the applicable notice period, the claimant may commence an action alleging medical malpractice against the health care provider, so long as the claim is not barred by the statute of limitations or repose.

(j) A lawsuit against a health care provider filed within 6 months of the statute of limitations expiring as to any claimant, or within 1 year of the statute of repose expiring as to any claimant, shall be exempt from compliance with this section.

(k) Nothing in this section shall prohibit the filing of suit at any time in order to seek court orders to preserve and permit inspection of tangible evidence.

Section 60M. In any action for malpractice, negligence, error, omission, mistake or the unauthorized rendering of professional services against a provider licensed under section 2 of chapter 112, including actions under section 60B, an expert witness shall have been engaged in the practice of medicine at the time of the alleged wrongdoing.

Section 60N. In any action for malpractice, negligence, error, omission, mistake or the unauthorized rendering of professional services against a provider licensed under section 2 of chapter 112, including actions under section 60B, an expert witness shall be board certified in the same specialty as the defendant provider as licensed under section 2 of chapter 112.

Rejected

Clerk #221

CREDITABLE COVERAGE

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section __ the following new section:-

SECTION __. Notwithstanding any general or special law, rule or regulation to the contrary, no additional benefit, procedure or service shall be required for minimum creditable coverage, so- called, without prior legislative authorization therefore.

Clerk #222

Definition of behavioral health

Messrs. Keenan, Donnelly, Ms. Jehlan, Mr. Rush and Mr. Joyce moves to amend the bill (Senate, No. 2260), in section 14, by adding in line 138 after the word "medical," the following words:- "behavioral health, substance use disorder, mental health,"; and

in said section 14 by adding in line 153 after the word "medical," the following words:- "behavioral health, substance use disorder, mental health,"; and

in said section 14 by adding in line 184 after the word “behavioral” the following words:- “substance use disorder,”; and

in said section 14 by adding in line 602 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 14 by adding in line 631 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 14 by adding in line 666 after the word “behavioral” the following words:- “, substance use disorder and mental”; and

in said section 14 by adding in line 671 after the word “behavioral” the following words:- “, substance use disorder and mental”; and

in said section 14 by adding in line 631 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in section 29 by adding in line 1212 after the word “integrate” the following words:- “behavioral, substance use disorder and” ; and striking in said line 1212 the following words:- “and substance abuse”.; and

in section 50 by adding in line 1511 after the word “integrate” the following words:- “, behavioral, substance use disorder and ” ; and striking in said line 1511 the following words:- “and substance abuse”; and

in section 53 by adding in line 1708 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 53 by adding in line 1714 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 53 by adding in line 1716 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 53 by adding in line 1718 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 53 by adding in line 1719 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 53 by adding in line 1721 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 53 by adding in line 1724 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 53 by adding in line 1726 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 53 by adding in line 1732 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 53 by adding in line 1738 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 53 by adding in line 1748 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 53 by adding in line 1749 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 53 by adding in line 1750 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in section 54 by adding in line 1762 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 54 by adding in line 1767 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 54 by adding in line 1783 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 54 by adding in line 1804 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in section 89 by adding in line 2053 after the word “physical” the following words:- “, behavioral, substance use disorder” ; and

in section 90 by adding in line 2092 after the word “physical” the following words:- “, behavioral, related to substance use disorder” ; and

in said section 90 by adding in line 2122 after the word “medical” the following words:- “, behavioral, substance use disorder and mental,” ; and

in said section 90 by adding in line 2140 after the word “medical” the following words:- “, behavioral, substance use disorder and mental” ; and

in section 104 by adding in line 2674 after the word “physical” the following words:- “, behavioral, related to substance use disorder” ; and

in said section 104 by adding in line 2691 after the word “necessary” the following words:- “, medical, behavioral, substance use disorder and mental health” ; and

in said section 104 by adding in line 2728 after the words “Reimbursable health services” the following words:- “, behavioral, related to substance use disorder, mental health and other” ; and

in section 162 by adding in line 3871 after the word “a” the following words:- “ physical, behavioral, substance use disorder or mental” ; and

in said section 162 by adding in line 3881 after the word “behavioral” the following words:- “substance use disorder ” ; and

in said section 162 by adding in line 3928 after the word “behavioral” the following words:- “substance use disorder and mental” ; and after the second word “behavioral” the following words:- “substance use disorder and mental”; and

in said section 162 by adding in line 4261 after the words “mental health” the following words:- “ ,substance use disorder” ; and

in said section 162 by adding in line 4277 after the words “mental health” the following words:- “ , substance use disorder” ; and

in said section 162 by adding in line 4278 after the word “behavioral” the following words:- “, substance use disorder and mental” ; and

in said section 162 by adding in line 4332 after the word “behavioral” the following words:- “ , substance use disorder” ; and

in section 182 by adding in line 4733 after the words “in behavioral” the following words:- “ , substance use disorder and mental”; and by adding after the words “of behavioral” the following words:-“, substance use disorder and mental”; and

in said section 182 by adding in line 4734 after the word “behavioral” the following words:- “ , substance use disorder and mental”; and

in said section 182 by adding in line 4737 after the word “behavioral” the following words:- “ , substance use disorder and mental”; and

in said section 182 by adding in line 4738 after the word “behavioral” the following words:- “ , substance use disorder and mental”; and

in said section 182 by adding in line 4740 after the word “behavioral” the following words:- “ , substance use disorder and mental”; and by adding in said line after the word “for behavioral” the following words:- “substance use disorder and mental”; and

in section 187 by adding in line 4796 after the word “behavioral” the following words:- “ , substance use disorder ”; and

ADOPTED

Clerk #223

e-Health Institute

Mr. Keenan and Mr. Joyce moves that the bill (Senate, No. 2260), be amended in section 29, in line 1145, by adding after the word “centers” the following words:- “and community-based behavioral, substance use disorder and mental health care providers”,

and by adding in line 1191 of said section after the word “facilities” the following words:- “and community-based behavioral, substance use disorder and mental health care providers”,

and in line 1215 of said section by adding after (7) the following new section”- (8) whether the provider serves a high proportion of public payer clients”, and in line 1216 by deleting the number “(8)” and adding in its place the number “(9)”.

ADOPTED

Clerk #224

Behavioral health workforce training

Mr. Keenan and Mr. Joyce moves to amend the bill (Senate, No. 2260), in section 54, in line 1789, by adding after the word "for" the following words:- ", undergraduate, graduate and", and in line 1781 by adding after the word "schools" the following words:- "or accredited colleges, universities or graduate schools", and in line 1791 after the words "obstetrics/gynecology" the following words:-"behavioral health,"

ADOPTED

Clerk #225

Definition of facility

Mr. Keenan moves to amend the bill (Senate, No. 2260), in section 168, in line 4573, by adding after the number "111" the following words:- "a psychiatric facility licensed under chapter 19,".

ADOPTED

Clerk #226

Emergency Notifications

Mr. Keenan and Mr. Joyce moves to amend the bill (Senate, No. 2260), in section 52 by striking out subsection (i) in its entirety and inserting in its place thereof the following:-

"(i) Except in the case of an emergency situation determined by the department as requiring immediate action to prevent further damage to the public health or to a health care facility, the department shall not act upon an application for such determination unless: (1) the application has been on file with the department for at least 30 days; (2) the institute of health care finance and policy, the state and appropriate regional comprehensive health planning agencies and, in the case of long-term care facilities only, the department of elder affairs, or in the case of any facility providing inpatient services for the mentally ill or developmentally disabled, the departments of mental health or developmental services, respectively, have been provided copies of such

application and supporting documents and given reasonable opportunity to comment on such application; and (3) a public hearing has been held on such application when requested by the applicant, the state or appropriate regional comprehensive health planning agency or any 10 taxpayers of the commonwealth. If, in any filing period, an individual application is filed which would implicitly decide any other application filed during such period, the department shall not act only upon an individual.";

and further by striking out subsection (m) in its entirety and inserting in its place thereof the following:-

"(m) The department shall notify the secretary of elder affairs forthwith of the pendency of any proceeding, of any public hearing and of any action to be taken under this section on any application submitted by or on behalf of any long-term care facility. In instances involving applications submitted on behalf of any facility providing inpatient services for the mentally ill or developmentally disabled, the department shall notify the appropriate commissioner."

Clerk #227

Ensuring health care parity

Mr. Keenan and Mr. Joyce moves to amend the bill (Senate, No. 2260), in section 176, by adding in line 4665 after the words "section 511 of Public Law 110-343," the following words:- "and section 4M of chapter 176G of the Massachusetts General Laws, as appearing in the 2010 edition, without regard to the size of the employer or group."; and

in said section by adding in line 4672 after the word "Act" the following words:- "and section 4M of chapter 176G of the Massachusetts General Laws, as appearing in the 2010 edition,"; and

in said section 176 by adding in line 4674 after the word "Act" the following words:- "and section 4M of chapter 176G of the Massachusetts General Laws, as appearing in the 2010 edition,"; and

in section 177 by adding in line 4680 after the words "section 511 of Public Law 110-343," and section 4M of chapter 176G of the Massachusetts General Laws, as appearing in the 2010 edition."; and

in said section 177 by adding in line 4689 after the word "Act" the following words: "and section 4M of chapter 176G of the Massachusetts General Laws, as appearing in the 2010 edition,"; and

in said section 177 by adding in line 4691 after the word "Act" the following words: "and section 4M of chapter 176G of the Massachusetts General Laws, as appearing in the 2010 edition,"

Clerk #228

Further defining medically necessary services

Messrs. Keenan and Joyce and Ms. Chang-Diaz moves to amend the bill (Senate, No. 2260), in section 90, by adding in line 2170 after the word "shall" the following words:- "include behavioral, substance use disorder and mental health inpatient and outpatient services; and provided further, shall"; and

in section 154, by adding in line 3632 after the word "shall" the following words:- "include behavioral, substance use disorder and mental health inpatient and outpatient services; and provided further, shall"

ADOPTED

Clerk #229

Cost Growth Benchmark

Ms. Chang-Díaz moves to amend the bill (Senate, No. 2260) in Section 162, in proposed Chapter 176S, by striking out Section 5 and inserting in place thereof the following section:-

"Section 5. (a) Not later than April 15 of every year, the board shall establish a health care cost growth benchmark for the average growth in total health care expenditures in the commonwealth for the next calendar year. The authority shall establish procedures to prominently publish the annual health care cost growth benchmark on the authority's website.

(b) For calendar years 2012-2015, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29, plus 0.5%.

(c) For calendar years 2016 and thereafter, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29."

Clerk #230

Apology Reports

Mr. Kennedy moves to amend the bill (S. 2260) by adding at the end of thereof the following new section:

Section____: Chapter 112 Section 5 of the Massachusetts General Laws as appearing in the 2008 Official edition is hereby amended by the insertion after the word "years." in line 78 of the following:

Provided, however, that payments made as part of a disclosure, apology and early offer program and made on behalf of a system, (a participating hospital, clinic, health or liability insurer or similar entity) shall not be construed to be reportable against a physician identified during the root cause analysis conducted as part of a disclosure,

apology and early offer program, absent a determination of substandard care rendered on the part of said physician.

Clerk #231

Obstetrics and Gynecology

Ms. Spilka and Ms. Candaras moves to amend the bill (Senate Bill 2260) in section 8 of chapter 176S, as inserted by SECTION 162, by inserting after the words, "preventive and primary care services", in line 4260, the following words:- "including, but not limited to, obstetrics and gynecology;".

Clerk #232

Data Stratification

Ms. Spilka and Ms. Chang-Diaz moves to amend the bill (Senate Bill 2260) in section 8 of chapter 176S, as inserted by SECTION 162, by inserting after the words, "population-based management tools and functions;", in line 4289, the following words:- "data stratification by sex and sex-race groups;".

Clerk #233

Beacon ACOs – Continuity of Care

Mr. Richard T. Moore and Mr. Joyce moves to amend the bill (Senate, No. 2260) by striking section 180 and inserting in place thereof the following:-

SECTION 180. Notwithstanding any general or special law to the contrary, to the extent that the office of Medicaid, the group insurance commission, the commonwealth health insurance connector authority and any other state funded insurance program determine that accountable care organizations offer opportunities for cost-effective and high quality care, such state funded insurance programs shall prioritize provider

organizations which have been certified by the board of the health care quality and finance authority as Beacon ACOs, under section 8 of chapter 176S, for the delivery of publicly funded health services, provided that such Beacon ACOs, to the extent possible, assure the continuity of patient care.

Clerk #234

Health information technology council membership

Mr. Keenan and Mr. Joyce moves that the bill (Senate, No. 2260) be amended in section 29, in line 1078, by striking the number "15" and inserting in place thereof the following number:- "16", and line 1082 by striking the number "11" and inserting in place thereof the following number:- "12", and in said section by adding in line 1089 after the word "carriers" the following words:- "1 of whom shall be from a behavioral health, substance use disorder or mental health services organization",

and in line 1097 after the word "purchasers" the following words:- "community-based behavioral, substance use disorder and mental health care providers".

Clerk #235

Health Information Technology Council

Mr. Keenan and Mr. Joyce moves to amend the bill (Senate, No. 2260), in section 29, by striking out the second paragraph of subsection (b) in its entirety and inserting in its place the following:-

"The council shall consist of 16 members: 1 of whom shall be the secretary of administration and finance, who shall serve as chair; 1 of whom shall be the secretary of health and human services; 1 of whom shall be the executive director of the institute of health care finance and policy or a designee; 1 of whom shall be the secretary of housing and economic development or a designee; 12 of whom shall be appointed by the governor, of whom at least 1 shall be an expert in health information technology, 1

of whom shall be an expert in state and federal health privacy laws, 1 of whom shall be an expert in the health policy, 1 of whom shall be an expert in health information technology relative to privacy and security, 1 of whom shall be from an academic medical center, 1 of whom shall be from a community hospital, 1 of whom shall be from a community health center, 1 of whom shall be from a long term care facility, 1 of whom shall be from a physician group practice, 1 of whom shall be from a behavioral, substance abuse disorder, and mental health organization, and 2 of whom shall represent the health insurance carriers. The council may consult with such parties, public or private, as it deems desirable in exercising its duties under this section, including persons with expertise and experience in the development and dissemination of interoperable electronic health records systems, and the implementation of interoperable electronic health record systems by small physician groups or ambulatory care providers, as well as persons representing organizations within the commonwealth interested in and affected by the development of networks and interoperable electronic health records systems, including, but not limited to, persons representing local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, physicians, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with expertise in health information technology and other stakeholders as identified by the secretary of health and human services. Appointive members of the council shall serve for terms of 2 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation.

ADOPTED

Clerk #236

Home health and mental health distinction

Mr. Keenan moves to amend the bill (Senate, No. 2260), in section 50, by striking in line 1495 after the word “health” the word “and”; and adding following words:- “; behavioral health and”;

Clerk #237

Institute advisory council

Mr. Keenan moves to amend the bill (Senate, No. 2260), in section 14, by striking section 3 in its entirety and inserting in its place thereof the following:-

Section 3. There shall be an institute of health care finance and policy council. The council shall consist of 7 members and advise on the overall operation and policy of the institute. The governor shall appoint three members, the attorney general shall appoint two members, and the auditor shall appoint two members. Members shall reflect a broad distribution of diverse perspectives on the health care system, including health care professionals, educational institutions, consumer representatives, providers, provider organizations and public and private payers. The council shall not be compensated for their services and shall serve at the pleasure of the appointing authority.

ADOPTED

Clerk #238

Women’s Health Resources

Ms. Spilka moves to amend the bill (Senate Bill 2260), in Section 25A(a)(1) of chapter 111, as inserted by SECTION 50, by inserting after the words “family planning services;”, in line 1497, the following words:- “obstetrics and gynecology services;”.

Clerk #239

WITHDRAWN

Rejected

Clerk #240

Maintaining hospital essential services

Mr. Keenan and Ms. Jehlen, and Mr. Joyce moves that the bill (Senate, No. 2260), be amended in section 18, in line 793, by adding after the word “expenditure” the following words:- “and substantial”,

and in section 52, in line 1568, by adding after the word “construction” the following words:- “or alteration”, and in line 1562 by adding after the word “substantially” the following words:- “increase, reduce or otherwise”, and in line 1587 in said section by adding after the word “increase” the following words:- “or decrease”, and in line 1588 in said section by adding after the word “increase” the following words:- “or decrease”,

and in line 1643 of said section by adding after the word “increase” the following words:- “or decrease”, and in line 1644 by adding after the word “increase” the following words:- “or decrease”

and by striking out section 58 in its entirety and replacing in place thereof the following section:-

Section 58. Chapter 111 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking Section 51G(4) and inserting in place thereof the following section:—

(4) Any hospital shall inform the department 180 days prior to the closing of the hospital or the discontinuance of any essential health service provided therein. The department shall by regulation define “essential health service” for the purposes of this section. The department shall, in the event that a hospital proposes to discontinue an essential health service or services, determine whether any such discontinued services

are necessary for preserving access and health status in the hospital's service area, require hospitals to submit a plan for assuring access to such necessary services following the hospital's closure of the service, and assure continuing access to such services in the event that the department determines that their closure will significantly reduce access to necessary services. The department shall conduct a public hearing prior to a determination on the closure of said essential services or of the hospital. No original license shall be granted to establish or maintain an acute-care hospital, as defined by section 25B, unless the applicant submits a plan, to be approved by the department, for the provision of community benefits, including the identification and provision of essential health services. In approving the plan, the department may take into account the applicant's existing commitment to primary and preventive health care services and community contributions as well as the primary and preventive health care services and community contributions of the predecessor hospital. In approving the plan, the department shall consider the financial health and capacity of the hospital and/or of the network which owns said hospital, and shall deny or delay said plan if the hospital's and/or network's net profit at the time of such application exceeds 5 percent. The department may waive this requirement, in whole or in part, at the request of the applicant which has provided or at the time the application is filed, is providing, substantial primary and preventive health care services and community contributions in its service area.

Clerk #241

Medically Necessary Services

Messrs. Keenan and Donnelly and Ms. Jehlen moves to amend the bill (Senate, No. 2260), by striking Section 147 in its entirety and inserting in its place thereof the following:-

"SECTION 147. Section 16 of said chapter 176O, as so appearing, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) A carrier shall be required to pay for health care services ordered by a treating physician or a primary care provider if: (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary; provided, however, that in making an adverse determination for mental health or substance abuse treatment, the carrier or its designated utilization review organization shall defer to the judgment of the treating clinician unless there is a preponderance of evidence that the requested admission, continued stay or other health care service does not meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness. A carrier may develop guidelines to be used in applying the standard of medical necessity, as defined in this subsection. Any such medical necessity guidelines utilized by a carrier in making coverage determinations shall be: (i) developed with input from practicing physicians and participating providers in the carrier's or utilization review organization's service area; (ii) developed under the standards adopted by national accreditation organizations; (iii) updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier shall consider the individual health care needs of the insured. Any such medical necessity guidelines criteria shall be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website to subscribers, health care providers and the general public. If a carrier or utilization review organization intends either to implement a new medical necessity guideline or amend an existing requirement or restriction, the carrier or utilization review organization shall ensure that the new or amended requirement or restriction shall not be implemented unless the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction."

Clerk #242

WITHDRAWN

ADOPTED

Clerk #243

Prescription Drug Database

Mr. Keenan and Mr. Joyce moves to amend the bill (Senate, No. 2260), in section 188 by inserting after the words "National Council for Prescription Drug Programs" as they appear in line 4817 the following:- ", as well as any steps that should be taken to integrate information available through the Commonwealth's prescription monitoring program."

Clerk #244

Prevention and Wellness Advisory Board

Mr. Keenan moves to amend the bill (Senate, No. 2260), in section 48, by striking out section 2H in its entirety and inserting in its place thereof the following:-

"Section 2H. There shall be a Prevention and Wellness Advisory Board to make recommendations to the commissioner concerning the administration and allocation of the Prevention and Wellness Trust Fund established in section 2G, establish evaluation criteria and perform any other functions specifically granted to it by law.

The board shall consist 16 members: 1 of whom shall be the commissioner of public health or a designee, who shall serve as chair; 1 of whom shall be the executive director of the institute of health care finance and policy established in chapter 12C or a designee; 1 of whom shall be the secretary of health and human services or a designee; 13 of whom shall be appointed by the governor, 1 of whom shall be a person with expertise in the field of public health economics; 1 of whom shall be a person with expertise in public health research; 1 of whom shall be a person with expertise in the field of health equity; 1 of whom shall be a person from a local board of health for a city or town with a population greater than 50,000; 1 of whom shall be a person of a

board of health for a city or town with a population less than 50,000; 2 of whom shall be representatives of health insurance carriers; 1 of whom shall be a person from a consumer health organization; 1 of whom shall be a person from a hospital association; 1 of whom shall be a person from a statewide public health organization; 1 of whom shall be a representative of the interest of businesses; 1 of whom shall be an administer of an employee assistance program; and 1 of whom shall be a person from an association representing community health workers."

Clerk #245

COST EFFECTIVE COVERAGE

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section __ the following new section:-

"SECTION __. The Commonwealth Connector shall develop a plan for insurance coverage which, to the greatest extent possible, minimizes mandated benefits and provides for the coverage of essential health services, provided that the contents of said plan, together with any regulatory or legislative actions necessary to its implementation, shall be filed with the clerks of the senate and house of representatives not later than six months following the passage of this act.

Clerk #246

Public payer reimbursement rates special commission

Mr. Keenan moves to amend the bill (Senate, No. 2260), in section 189, by striking the words "11 members" and inserting the following in place thereof:- "12 members",

and by striking, in line 4833, after the word "the" the following:- "Massachusetts",

and by adding after the words " Massachusetts Medical Society" the following " 1 appointed by the Massachusetts Association of Behavioral Health Systems".

Clerk #247

Substance Abuse Prevention Funds

Mr. Keenan moves to amend the bill (Senate, No. 2260), in section 48 by striking out subsections (c) and (d) in their entirety and inserting in their place the following two subsections:-

"(c) All expenditures from the Prevention and Wellness Trust Fund shall support the state's efforts to meet the health care cost growth benchmark established in section 5 of chapter 176S and any activities funded by the Healthcare Payment Reform Fund, and 1 or more of the following purposes: (i) reduce rates of the most prevalent and preventable health conditions, including substance abuse; (ii) increase healthy behaviors; (iii) increase the adoption of workplace-based wellness or health management programs that result in positive returns on investment for employees and employers; (iv) address health disparities; or (v) develop a stronger evidence-base of effective prevention programming.

(d) The commissioner shall annually award not less than 75 per cent of the Prevention and Wellness Trust Fund through a competitive grant process to municipalities, community-based organizations, health care providers, and health plans that apply for the implementation, evaluation and dissemination of evidence-based substance abuse awareness and prevention programs and community preventive health activities. To be eligible to receive a grant under this subsection, a recipient shall be: (i) a municipality or group of municipalities working in collaboration; (ii) a community-based organization working in collaboration with 1 or more municipalities; or (iii) a health care provider or a health plan working in collaboration with 1 or more municipalities and a community-based organization. Expenditures from the fund for such purposes shall supplement and not replace existing local, state, private or federal public health-related funding.

Clerk #248

Massachusetts Diagnostic Accuracy Task Force

Ms. Spilka moves to amend the bill (Senate Bill 2260) in SECTION 184 by inserting after the word "diagnoses;", in line 4751, the following:- "the sex differences in disease arising from the biological differences between the sexes and the resulting differences in diagnosis for the same disease in different sexes"

REDRAFT Clerk #249

Revenues for Healthcare

Mr. Tarr moves to amend the bill (Senate, No. 2260) in Section 14 by striking proposed section 8 of chapter 12C of the General Laws and inserting in place thereof the following section:-

"Section 8. The institute shall be funded by the HealthCare Payment Reform Fund as appearing in section 100 of chapter 194 of the Acts of 2011. Any further funds necessary to the operations of the institute shall be subject to appropriation."

Clerk #250

Workforce Advisory Board Budget

Mr. Keenan moves to amend the bill (Senate, No. 2260), in section 23, by striking the number "15" as it appears in line 959, and inserting in its place the following:- "10"

Clerk #251

WITHDRAWN

Rejected

2nd Redraft Clerk #252

HEALTH CARE COST GROWTH BENCHMARKS

Mr. Tarr moves to amend the bill (Senate, No. 2260), in Section 162, by striking lines 4041 through 4051, inclusive, and inserting in place thereof the following language:-

"Section 5. (a) Not later than April 15 of every odd-numbered year, the board shall establish a health care cost growth benchmark for the average growth in total health care expenditures in the commonwealth for the next two calendar years. The authority shall establish procedures to prominently publish the biennial health care cost growth benchmark on the authority's website.

Prior to setting a health care cost growth benchmark, the board shall convene one or more public hearings for the purposes of soliciting input to facilitate the development of a consensus benchmark figure. At the conclusion of these hearings, the board shall submit its recommendation for a health care cost growth benchmark in writing to the clerks of the house and the senate for final legislative approval, along with supporting documentation on how the board arrived at its figure. If the house and the senate fail to act on the board's recommendation within 60 days of its receipt by the clerks of the house and the senate, the board's recommended benchmark figure shall be deemed approved and in full force and effect for the next two calendar years.

To the maximum extent possible, the health care cost growth benchmark should reflect the following goals:

(b) For calendar years 2012-2015, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29.

(c) For calendar years 2016-2026, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29, plus 1%.

(c) For calendar years 2027 and thereafter, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29."

Clerk #253

Payment disparities

Ms. Creem moves to amend the bill (Senate, No.2260) in Section 162, by inserting the following new section:-

"Section xx. The Authority will conduct at least one hearing yearly on payment disparities among providers, and the Institute is charged with preparing yearly reports to examine payment disparities on behalf of the authority, and to require and approve plans intended to reduce the payment disparities. These plans might be required of payers as well as from providers. In addition, the Authority may require payment modifications if disparities are not reduced by a percentage to be determined by the Institute."

REDRAFT Clerk #254

CONTRACTING PROVISIONS

Mr. Tarr moves to amend the bill (Senate, No. 2260) by striking Sections 158 and 159, inclusive, and inserting in place thereof the following Section:-

"SECTION__. Section 3 of chapter 176Q, as so appearing, is hereby further amended by adding the following subsection:-

(u) to publish a comprehensive directory of providers of health insurance available in the Commonwealth, which shall be posted prominently on the board's website and made readily available to the public."

Clerk #255

Health System Benefit

Mr. Tarr moves to amend the bill (Senate, No. 2260) by striking, in lines 1362-1363, the words "health system benefit surcharge revenues collected by the commonwealth under section 68 of chapter 118E", and inserting in place thereof the following words:-

"10% of the proceeds in the HealthCare Payment Reform Fund as appearing in section 100 of chapter 194 of the Acts of 2011"; and

by striking in section 104 proposed section 70 of chapter 118E of the general laws and inserting in place thereof the following section:-

"70(a).10% of the proceeds in the HealthCare Payment Reform Fund shall be evenly divided, 5% shall be deposited in the Prevention and Wellness Trust Fund, established in section 2G of chapter 111, 5% shall be deposited in the e-Health Institute Fund, established in section 6E of chapter 40J."

Clerk #256

Prevention and Wellness Trust Fund Grant Guidelines

Ms. Spilka and Ms. Chang-Diaz moves to amend the bill (Senate Bill 2260) in section 2G(e) of chapter 111, as inserted by SECTION 48, by inserting after the word "plan", in line 1400, the following:-

"and (vi) a commitment to include women, racial and ethnic minorities and low income individuals; and (vii) a plan to stratify data by sex, sex-race groups, and by socio-economic status and to include stratified data in all final reports"

Clerk #257

Price Variation Commission Membership

Mr. Knapik and Ms. Jehlen moves to amend the bill (Senate, No. 2260) in Section 190, by striking out, in line 4856, the figure "14" and inserting in place thereof the following figure:- "15";

In said section 190, in line 4864, inserting after the word "teaching hospital" the following:- ", 1 of whom shall represent an acute-care hospital licensed with a capacity less than 200 beds;"

ADOPTED

Clerk #258

STATE LONG-TERM HEATLH CARE MASTER PLAN

Mr. Tarr moves to amend the bill (Senate, No. 2260) by inserting after section __ the following new section:-

"SECTION ___. The secretary of elder affairs, the commissioner of the department of housing and community development, and the commissioner of public health shall, in conjunction with other agencies of the commonwealth as necessary, develop a state-wide plan for the development and maintenance of assisted living facilities, so-called, long-term care facilities, home health agencies and rest homes. Said plan shall include and assessment of existing and projected need for such facilities across all income levels, available capacity of existing facilities for tenants at all income levels, and projected development of additional capacity in the next twenty-five years. Said plan shall also assess any and all means being utilized for payment by individuals for residence in assisted living facilities and the projected availability of such means in the future for individuals at all income levels from public and private sources, including but not limited to, Medicare, Medicaid and private insurers.

Said plan, based on said assessments, shall included strategies to meet the needs identified in such assessments and to facilitate the availability of assisted living facilities for individuals of all income levels throughout the commonwealth, including the development and maintenance of capital infrastructure, program services, and public and private sources of financing assisted living residence for the citizens of the commonwealth. Said plan prescribed herein, together with any recommendations for

legislation necessary to the plan, shall be filed with the clerks of the senate and house of representatives not later than two years following the passage of this act.”

Clerk #259

Greater Transparency, Accountability and Administrative Review of Provider Price Variation

Mr. Kennedy and Mr. Joyce moves to amend the bill (S. 2260) by inserting after Line 4477 the following section:-

“Chapter 176U:

SECTION 1: Chapter 176O is hereby amended by inserting after section 5 the following section:-

Section 5A. (a) A contract or agreement between a carrier and a health care provider, including a hospital or physician group practice, effective January 1,

2013, shall adhere to the following:

(1) A carrier with contracts for payment between the carrier and a Disproportionate share hospital, as defined in section 1 of Chapter 118 G, and its Affiliated physician group practices, shall not contain rates that are less than the carrier’s statewide average rate, as defined by the previous year of October 1 to September 30 plus an annual adjustment for the projected change of the Consumer Price Index for Medical Care Services for the New England region.

(2) Each carrier shall be required to report and explain to the Division of Insurance what actions they have taken to remedy the relative rate disparity identified in the Attorney General's July 31, 2011 Findings From Examinations of Health Care Cost Trends and Cost Drivers which concluded that said disproportionate share hospitals are paid considerably less than other Acute hospital providers.”.

Clerk #260

Defining medical necessity

Mr. Keenan moves to amend the bill (Senate, No. 2260), by adding the following new section;

Section XX. Section 1 of chapter 176O of the General Laws, as so appearing, is hereby amended by striking the definition of "Medical necessity" or "medically necessary" and inserting in place thereof the following:

"Medical necessity" or "medically necessary", behavioral, substance use disorder, mental health and other health care services that are recommended by the treating physician or licensed practitioner that reflect the most appropriate supply or level of service, considering potential benefits and harms to the patient, and known to be effective in improving behavioral, substance use disorder, mental health and other health care conditions, illnesses or injuries.

Clerk #261

Establishing the MA Payment Advisory Commission to Reduce Payment Variation

Mr. Finegold and Ms. Donoghue moves to amend the bill (Senate, No. 2260) be amended by inserting, after section 87, the following two sections:-

SECTION 87A. The General Laws are hereby amended by inserting after Chapter 111N the following chapter:-

CHAPTER 111O

MASSACHUSETTS PAYMENT ADVISORY COMMISSION

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

“Alternative Payment Methods”, models of payment for health care services, as agreed to by a carrier and a health care provider that incorporate various degrees of risk sharing and reimburse the health care provider for the provision and coordination of care for a range of covered services and may include prospective payments, blended capitated payments, shared savings, or other payment methods that promote improved coordination of care, higher quality, a reduction in inappropriate utilization, and lower costs.

“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; a health maintenance organization organized under chapter 176G; and an organization entering into a preferred provider arrangement under chapter 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. Unless otherwise noted, the term “carrier” shall not include any entity to the extent it offers a policy, certificate or contract that provides coverage solely for dental care services or visions care services.

“Fee-for-Service Model of Payment”, a model of payment for health care services whereby payers pay health care providers a negotiated fee for each covered service produced by the health care provider.

“Health Care Provider”, physicians licensed under the provisions of chapter one hundred and twelve, physician group practices, or a hospital licensed under the provisions of chapter one hundred and eleven and its agents and employees, or a public hospital and its agents and employees. This shall include any licensed health care provider, its parent corporation, and its parent’s subsidiaries.

"Relative prices", the contractually negotiated amounts paid to providers by each private and public carrier for health care services, including non-claims related payments and expressed in the aggregate relative to the payer's network-wide average amount paid to providers, as calculated under section 6 of chapter 118G and regulations promulgated by the commissioner.

Section 2. (a) There shall be a body politic and corporate and a public instrumentality to be known as the Massachusetts Payment Advisory Commission, which shall be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the commonwealth except as specifically provided in any general or special law. The purpose of the commission is to examine requests submitted by health care providers for reimbursement rates from carriers to determine whether such requests are justified and address unwarranted price variations in rates of reimbursements under various payment arrangements, including but not limited to alternative payment methods or fee-for-service model of payment.

(b) The commission shall consist of the secretary of administration and finance, who will serve as chair, a health economist appointed by the governor, and an expert in the area of payment methodology with previous experience on the Medicare Payment Advisory Commission appointed by the attorney general. Members of the commission shall be appointed for terms of 3 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation.

Section 3. (a) Where a carrier and a health care provider are unable to reach an agreement on a rate of reimbursement for health care services, the health care provider may submit a request to the commission to review its requested rate of reimbursement from a carrier. In submitting said request, the health care provider shall provide information to support its requested rate of reimbursement including its current level of reimbursement from the carrier, any proposed increase and its projected cost trends. A health care provider may also submit information listed by

physician group, hospital inpatient and hospital outpatient on the cost and cost trends for such services, the quality of care it provides in relation to other providers, stand-by service capacity, emergency service capacity, and services provided to underserved or unique populations. The health care provider shall send a copy of the request for review and any materials it submitted to the commission in support of its request to the carrier.

(b) If a health care provider requests a reimbursement rate from a carrier that is in excess of the carrier's median relative price by provider type, the carrier may submit a request to the commission to review the requested rate of reimbursement. In submitting a request, the carrier shall provide the commission with information that compares the relative prices paid to its network providers, by provider-type, including physician groups and hospitals along with other relevant information to demonstrate that the provider's requested rate of increase is unreasonable. The carrier shall send a copy of the request for review and any materials it submitted to the commission in support of its request to the health care provider.

(c) The commission shall determine a process that will apply to fee-for-service model of payment and a separate process for alternative payment methods.

(d) No later than 30 days after a request has been submitted, the commission may request additional information from either party as part of the request for review to complete or supplement the request, including the factors used in determining the rate of reimbursement. Such information shall be submitted within 30 days following the commission's request and the filing shall be deemed complete.

(e) Any information related to the request submitted by the health care provider or carrier shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4 only until such time as the commission determines the filing is complete.

(f) The existing contract and rate of reimbursement between the health care provider and the carrier shall remain in effect until the commission's has issued a final determination.

(g) Within 60 days of receipt of a complete filing or supplementary filing, the commission will determine whether the request is justified. In determining whether the requested rate of reimbursement is justified, the commission shall make its decision based on the health care provider's demonstrated quality, utilizing information developed by the statewide quality advisory committee or other national recognized quality standards, information submitted to the division of health care finance and policy or attorney general as required by section 6 ½ of chapter 118G, and the overall impact on carrier member premiums. Other factors that the commission may take into account shall be limited to teaching intensity ratios, hospital case mix index, relative payor mix, the health care provider's geographic location, the health care provider's market share compared to other health care providers in the geographic location, or other value-based factors that the commission can demonstrate, by actuarial analysis, are appropriate factors for consideration in examining the requested rate of reimbursement. Prior to issuing a final determination, the commission may also conduct an informational public hearing, to gather additional information relevant to the review.

(h) If the commission determines that the request by the health care provider is justified, then the carrier shall accept the requested rate of reimbursement. If the panel determines the request by the health care provider is not justified, then the rate of reimbursement shall be the lower of (i) the carrier's median reimbursement rate paid to providers in its network or (ii) the rate of reimbursement they received for services from the carrier in their preceding contract.

(i) Within 10 days of the commission's determination, the health care provider or carrier may submit a request for hearing. The commission must schedule a hearing within 10 days of receipt and shall issue a written decision within 30 days after the conclusion of the hearing.

(j) The commissioner shall promulgate regulations to enforce this section.

SECTION 87B. Chapter 112 of the General Laws is hereby amended by inserting, after section 2C, the following section:-

Section 2D. Every health care provider, which provides covered services to a person must provide such services to any such person as a condition of their licensure, and must accept payment by a carrier consistent with the provisions of section 3 of chapter 111O, and may not balance bill such person for any amount in excess of the amount paid by the carrier pursuant to this section, other than applicable co-payments, co-insurance and deductibles. Any health care provider that participates in a carrier's network or any health benefit plan shall not refuse to participate in the carrier's network due to the carrier's compliance with this section.";

and by inserting, after section 124, the following section:-

"SECTION 124A. Section 6 of chapter 176J, as so appearing, is hereby amended by striking subsection (c) in its entirety and inserting in place thereof the following subsection:-

(c) Notwithstanding any general or special law to the contrary, the commissioner may require carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or 176G, to file all changes to small group product base rates and to small group rating factors at least 90 days before their proposed effective date. The commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged. In reviewing the proposed changes to the base rates, the commissioner shall take into consideration the carrier's compliance with section 3 of chapter 111O. The commissioner shall disapprove any change to small group rating factors that is discriminatory or not actuarially sound. Rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in

clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt regulations to carry out this section."

Redraft Clerk #262

Price Transparency

Ms. Creem and Mr. Joyce moves to amend the bill (Senate, No. 2260), by inserting in Section 14, at line 850, the following :-

Section xx. "The Institute shall promulgate regulations requiring actual costs and prices of health care services submitted to the consumers health information website to be readily understandable by consumers. The Institute shall determine the frequency by which providers should submit such information in order to ensure the continued accuracy of information."

REDRAFT Clerk #263

REDUCING HEALTH CARE COSTS

Mr. Tarr moves to amend the bill (Senate, No. 2260) by striking all after the enacting clause and inserting in place thereof the following new text:-

"SECTION 1. Purpose: In order to promote quality of life of the citizens of the commonwealth, it shall be the policy of state government to foster health care which provides cost-effective treatment in a timely manner, in appropriate settings, maximizing choice and competition, and incenting and rewarding lifestyle and dietary choice which promote good health.

SECTION 2. Section 38C of chapter 3 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 25, 29, 32, 35, 37, 39, 40, 44 and 45, 47, 48, 54, 86, 89 and 93, the word "division" and inserting in place thereof, in each instance, the following word:- institute.

SECTION 3. Subsection (d) of said section 38C of said chapter 3, as so appearing, is hereby amended by striking out, in line 43, the words ", the health care quality and cost council,".

SECTION 4. Section 105 of chapter 6 of the General Laws , as amended by section 9 of chapter 3 of the acts of 2011, is hereby further amended by striking out the words "commissioner of health care finance and policy" and inserting in place thereof the following words:- executive director of the institute of health care finance and policy.

SECTION 5. Section 16 of chapter 6A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 52, the words "pursuant to section 2A of chapter 118G" and inserting in place thereof the following words:- under section 13C of chapter 118E.

SECTION 6. Sections 16J to 16L, inclusive, of said chapter 6A of the General Laws are hereby repealed.

SECTION 7. Section 16M of said chapter 6A, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 3 and 4, the words "commissioner of health care financing" and inserting in place thereof the following words:- executive director of the institute of health care finance.

SECTION 8. Section 16M of said chapter 6A, as so appearing, is hereby further amended by striking out, in lines 23, 32, 39 and 43 the word "division" and inserting in place thereof, in each instance, the following word:- institute.

SECTION 9. Said section 16M of said chapter 6A, as so appearing, is hereby further amended by striking out, in line 24, the word "118G" and inserting in place thereof the following word:- 12C.

SECTION 10. Section 16N of said chapter 6A, as so appearing, is hereby amended by striking out, in lines 5 and 6, the words "commissioner of health care finance and

policy” and inserting in place thereof the following words:- executive director of the institute of health care finance and policy.

SECTION 11. Subsection (a) of section 16O of said chapter 6A, as so appearing, is hereby amended by striking out the fifth sentence.

SECTION 12. The third sentence of subsection (c) of section 4R of chapter 7 of the General Laws, as inserted by section 15 of chapter 68 of the acts of 2011, is hereby amended by striking out the word “division” and inserting in place thereof the following word:- institute.

SECTION 13. Section 22N of said chapter 7, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 10 and 37, the word “118G” and inserting in place thereof, in each instance, the following word:- 118E.

SECTION 14. Chapter 12 of the General Laws is hereby amended by inserting after section 11M the following section:-

Section 11N. (a) The attorney general shall monitor trends in the health care market including, but not limited to, trends in provider organization size and composition, consolidation in the provider market, payer contracting trends and patient access and quality issues in the health care market.

(b) The attorney general shall, in consultation with the institute of health care finance and policy, take appropriate action within existing statutory authority to prevent excess consolidation or collusion of provider organizations and to remedy these or other related anti-competitive dynamics in the health care market.

(c) The attorney general shall provide assistance as needed to support efforts by the commonwealth to obtain exemptions or waivers from certain federal laws, to the extent the attorney general determines such exemptions or waivers are necessary, including, from the federal Office of the Inspector General, a waiver of, or expansion of,

the “safe harbors” provided for under 42 U.S.C. section 1320a-7b and obtaining from the federal Office of the Inspector General a waiver of, or exemption from, 42 U.S.C. section 1395nn subsections (a) to (e).

(d) The attorney general may act under subsection (b) of section 15 of chapter 12C to carry out this section.

SECTION 15. The General Laws are hereby further amended by inserting after chapter 12B the following chapter:-

Chapter 12C

Institute of Health Care Finance and Policy

Section 1. 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.

“Actual economic growth benchmark,” the actual annual percentage change in the per capita state’s gross state product, excluding the impact of business cycles, as established under section 7H½ of chapter 29.

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

“Alternative payment contract”, any contract between a provider or provider organization and a public health care payer or a private health care payer which utilizes alternative payment methodologies.

“Alternative payment methodologies”, methods of payment that are not fee-for-service reimbursements; provided that, “alternative payment methodologies” may include, but not be limited to, global payments, shared savings arrangements, bundled payments and episodic payments.

“Ambulatory surgical center”, any distinct entity that operates exclusively to provide surgical services to patients not requiring hospitalization and meets the requirements of the federal Health Care Financing Administration for participation in the Medicare program.

“Ambulatory surgical center services”, services described for purposes of the Medicare program under 42 USC § 1395k(a)(2)(F)(I); provided, that “ambulatory surgical center services” shall include facility services only and shall not include surgical procedures.

“Beacon ACO”, a certification given by the board of the authority to indicate that a provider organization meets certain standards regarding quality, cost containment and patient protection.

“Business entity”, a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

“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; a health maintenance organization organized under chapter 176G; and an organization entering into a preferred provider arrangement under chapter 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of 1 or more subsidiaries or affiliated corporations of the employer; provided that, unless otherwise noted, the term “carrier” shall not include any entity to the extent it offers a policy, certificate or contract that provides coverage solely for dental care services or visions care services.

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

“Charge”, the uniform price for specific services within a revenue center of a hospital.

“Child”, a person who is under 18 years of age.

“Clinical affiliation,” any relationship between a provider organization and another entity for the purpose of increasing the level of collaboration in the provision of health care services, including but not limited to sharing of physician resources in hospital or other ambulatory settings, co-branding, expedited transfers to advanced care settings, provision of inpatient consultation coverage or call coverage, enhanced electronic access and communication, co-located services, provision of capital for service site development, joint training programs, video technology to increase access to expert resources and sharing of hospitalists or intensivists.

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

“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 208, 209 or 209C.

“Dispersed service area,” a geographic area of the commonwealth in which a provider organization delivers health care services; provided, however, that the institute may by regulation establish standards to determine dispersed service areas based on the number of zip codes, towns, counties or primary service areas, which standards may vary based upon the population density of various regions of the commonwealth.

“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; provided, that “employee” shall not include a person who is self-employed.

“Employer”, an employer as defined in section 1 of chapter 151A.

“Executive director”, the executive director of the institute of health care finance and policy.

“Facility”, a licensed institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

"Fee-for-service", a form of contract under which a provider or provider organization is paid for discrete and separate units of service and each provider is separately reimbursed for each discrete service rendered to a patient; provided, however, that up to 10 per cent of total reimbursement under such contracts may depend on the achievement of certain targets of performance or conduct.

“Fiscal year”, the 12 month period during which a hospital keeps its accounts and which ends in the calendar year by which it is identified.

“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 under chapter 111B 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 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 patient service revenue", the total dollar amount of a hospital's charges for services rendered in a fiscal year.

"Health benefit plan", any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; a group medical service plan issued by a non-profit medical service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; a coverage for young adults health insurance plan under section 10 of chapter 176J; provided that "health benefit plan" shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued under chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner of

insurance by regulation may set, insurance arising out of a workers compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. section 55 if offered as a separate insurance policy, or any policy subject to chapter 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans; provided, further that "health benefit plan" shall not include a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A which shall be governed by said chapter 15A; provided, further that the authority may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

"Health care cost growth benchmark," the projected annual percentage change in total health care expenditures in the commonwealth, as established in section 5.

"Health care entity", a provider, provider organization or carrier.

"Health care professional," a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with law.

"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 insurance company", a company as defined in section 1 of chapter 175 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 1 of chapter 176G.

“Health status adjusted total medical expenses”, the total cost of care for the patient population associated with a provider group based on allowed claims for all categories of medical expenses and all non-claims related payments to providers, adjusted by health status, and expressed on a per member per month basis, as calculated under this chapter and the regulations promulgated by the institute.

“Hospital”, any hospital licensed under section 51 of chapter 111, the teaching hospital of the University of Massachusetts Medical School and any psychiatric facility licensed under section 19 of chapter 19.

“Hospital service corporation”, a corporation established to operate a nonprofit hospital service plan as provided in chapter 176A.

“Institute”, the institute of health care finance and policy.

“Major service category,” a set of service categories to be established by regulation, which may include: (i) acute hospital inpatient services, by major diagnostic category; (ii) outpatient and ambulatory services, by categories as defined by the Centers for Medicare and Medicaid, or as established by regulation, not to exceed 15, including a residual category for “all other” outpatient and ambulatory services that do not fall within a defined category; (iii) behavioral and mental health services by categories as defined by the Centers for Medicare and Medicaid, or as established by regulation; (iv)

professional services, by categories as defined by the Centers for Medicare and Medicaid, or as established by regulation; and (v) sub-acute services, by major service line or clinical offering, as defined by regulation.

“Medicaid program”, the medical assistance program administered by the division of medical assistance under chapter 118E 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.

“Medical service corporation”, a corporation established to operate a nonprofit medical service plan as provided in chapter 176B.

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

“Network contract,” a contract entered between a provider or provider organization and a carrier or third-party administrator concerning payment for the provision of heath care services.

“Non-acute hospital”, any hospital which is not an acute hospital.

“Patient”, any natural person receiving health care services.

“Performance improvement plan,” a plan submitted to the authority by a carrier, a provider or a provider organization under section 7, which shall be kept confidential by the board and shall not be considered a public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66.

“Projected economic growth benchmark,” the long-term average projected percentage chance in the per capita state’s gross state product, excluding the impact of business cycles, as established under section 7H½ of chapter 29.

"Primary service area," a geographic area of the commonwealth in which consumers are likely to travel to obtain health services, provided however that the institute may by regulation establish standards to determine primary service areas by major service category, which standards may vary based upon the population density of various regions of the commonwealth.

“Private health care payer”, a carrier authorized to transact accident and health insurance under chapter 175, a nonprofit hospital service corporation licensed under chapter 176A, a nonprofit medical service corporation licensed under chapter 176B, a dental service corporation organized under chapter 176E, an optometric service corporation organized under chapter 176F, a self-insured plan, to the extent allowable under federal law governing health care provided by employers to employees, or a health maintenance organization licensed under chapter 176G.

“Provider”, any person, corporation partnership, governmental unit, state institution or any other entity qualified under the laws of the commonwealth to perform or provide health care services.

“Provider organization,” any corporation, partnership, business trust, association or organized group of persons whether incorporated or not that consists of or represents 1 or more providers in contracting with carriers for the payments the provider or providers receive for the provision of heath care services; provided, that “provider organization” shall include, but not be limited to, physician organizations, physician-hospital organizations, independent practice associations, provider networks, accountable care organizations and any other organization that contracts with carriers for payment for health care services.

“Public health care payer”, the Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid or the commonwealth health insurance connector to pay for or arrange the purchase of health care services on behalf of individuals enrolled in health coverage programs under Titles XIX or XXI, or under the commonwealth care health insurance program, including prepaid health plans subject to the provisions of section 28 of chapter 47 of the acts of 1997; the group insurance commission established under chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

“Purchaser”, a natural person responsible for payment for health care services rendered by a hospital.

“Registered provider organization,” a provider organization that has been registered in accordance with this chapter and regulations promulgated under this chapter.

“Relative prices”, the contractually negotiated amounts paid to providers by each private and public carrier for health care services, including non-claims related payments and expressed in the aggregate relative to the payer’s network-wide average amount paid to providers, as calculated under section 9 and regulations promulgated by the institute.

“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 institute 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; and provided, further that 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.

“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 term “surcharge payor” shall include a managed care organization; and provided further, that “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 under 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.

"Total health care expenditures," the annual per capita sum of all health care expenditures in the commonwealth, including public and private sources.

Section 2. There is hereby established an institute of health care finance and policy. There shall be in the institute an executive director, who shall be the administrative head of the institute and who shall be appointed by a majority vote of the attorney general, the state auditor and the governor for a term of 5 years. The person so appointed shall be selected without regard to political affiliation and solely on the basis of expertise in health care policy, expertise in health care finance and such other educational requirements and experience that the attorney general, state auditor and governor determine are necessary.

In the case of a vacancy in the position of executive director a successor shall be appointed in the same manner as the original appointment for the unexpired term. No person shall be appointed for more than 2 consecutive 5-year terms.

The person so appointed may be removed from office, for cause, by a majority vote of the attorney general, the state auditor and the governor. Such cause may include substantial neglect of duty, gross misconduct or conviction of a crime. The reasons for removal of the executive director shall be stated in writing and shall include the basis for such removal. The writing shall be sent to the clerk of the senate, the clerk of the house of representative and to the governor at the time of the removal and shall be a public document. Chapter 268A shall to the executive director.

Section 3. There shall be an institute of health care finance and policy council. The council shall advise on the overall operation and policy of the institute. The council shall be chosen by the executive director and shall reflect a broad distribution of diverse perspectives on the health care system, including health care professionals, educational

institutions, consumer representatives, providers, provider organizations and public and private payers. Chapter 268A shall apply to all council members of the institute.

Section 4. The executive director may appoint and remove, subject to appropriation, such agents and subordinate officers as the executive director may consider necessary and may establish such subdivisions within the institute as the executive director considers appropriate to fulfill the following duties: (i) to collect, analyze and disseminate health care data to assist in the formulation of health care policy and in the provision and purchase of health care services including, but not limited to, collecting, storing and maintaining data in a payer and provider claims database; (ii) to provide an analysis of health care spending trends as compared to the health care cost growth benchmark established by the institute of health care finance and policy under section 5 of chapter 176S; (iii) to develop and administer a registration system for provider organizations and collect, analyze and disseminate information regarding provider organizations to increase the transparency and improve the functioning of the health care system; (iv) to provide information to, and work with, the general court and other state agencies including, but not limited to, the executive office of health and human services, the department of public health, the department of mental health, the institute of health care finance and policy, the office of Medicaid and the division of insurance to collect and disseminate data concerning the cost, price and functioning of the health care system in the commonwealth and the health status of individuals; (v) to participate in and provide data and data analysis for annual hearings conducted by the institute of health care finance and policy concerning health care provider and payer costs, prices and cost trends; (vi) report to consumers comparative health care cost and quality information through the consumer health information website established under section 20; and (viii) to set health care cost containment goals for the commonwealth and to foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care. The institute shall make available actual costs and prices of health care services, as supplied by each provider, to the general public in a conspicuous manner on the institute’s official

website. Chapter 268A shall apply to all agents, subordinate officers, and employees of the institute.

Section 5. The position of executive director shall be classified under section 45 of chapter 30 and the salary shall be determined under section 46C of said chapter 30.

Section 6. The institute shall adopt and amend rules and regulations, in accordance with chapter 30A, for the administration of its duties and powers and to effectuate this chapter. Such regulations shall be adopted, after notice and hearing, only upon consultation with representatives of providers, provider organizations, private health care payers and public health care payers.

Section 7. In addition to the powers conferred on state agencies, the institute shall have the following powers:—

(a) to make, amend and repeal rules and regulations for the management of its affairs;

(b) to make contracts and execute all instruments necessary or convenient for the carrying on of its business;

(c) 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; and

(d) to enter into agreements 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.

Section 8. The institute shall file a report 6 months after the effective date of this act with the clerks of the house and the senate and the house and senate committees on ways and means detailing any additional funding requirements to achieve the goals set forth in this bill.

Section 8B. Not later than April 15 of every odd-numbered year, the institute shall establish a health care cost growth benchmark for the average growth in total health care expenditures in the commonwealth for the next two calendar years. The institute shall establish procedures to prominently publish the biennial health care cost growth benchmark on the institute's website.

Prior to setting a health care cost growth benchmark, the institute shall convene one or more public hearings for the purposes of soliciting input to facilitate the development of a consensus benchmark figure. At the conclusion of these hearings, the institute shall submit its recommendation for a health care cost growth benchmark in writing to the clerks of the house and the senate for final legislative approval, along with supporting documentation on how the institute arrived at its figure. If the house and the senate fail to act on the institute's recommendation within 60 days of its receipt by the clerks of the house and the senate, the institute's recommended benchmark figure shall be deemed approved and in full force and effect for the next two calendar years.

To the maximum extent possible, the health care cost growth benchmark should reflect the goal of not exceeding the economic growth benchmark established under section 7H½ of chapter 29.

Section 8C. The institute shall have all powers necessary or convenient to carry out and effectuate its purposes including, but not limited to, the power to:

(a) to develop a plan of operation for the institute, which shall include, but not be limited to:

(1) establishing procedures for setting an annual health care cost growth benchmark;

(2) holding annual hearings concerning the growth in total health care expenditures relative to the health care cost benchmark, including an examination of health care provider, provider organization and payer costs, prices and health status adjusted total medical expense trends;

(3) providing an annual report on recommendations for strategies to meet future annual health care cost growth benchmarks and to promote an efficient health delivery system;

(4) establishing procedures that, in the event the annual health care cost growth benchmark is exceeded, require certain health care entities to file a performance improvement plan and the procedures for approving said plan;

(5) establishing procedures for monitoring compliance and implementation by a health care entity of a performance improvement plan, including standards to ascertain whether a health care entity has failed to implement a performance improvement plan in good faith;

(6) establishing procedures and developing criteria for the certification of certain provider organizations as Beacon ACOs, based on standards related to cost containment, quality improvement and patient protections;

(7) establishing procedures to decertify certain provider organizations as Beacon ACOs;

(8) developing best practices and standards for alternative payment methodologies to be adopted by the office of Medicaid, the group insurance commission and other state-funded health insurance programs;

(9) fostering health care innovation by identifying, developing, supporting and evaluating health care delivery and payment reform models and best practices, in consultation with health care entities, that reduce health care cost growth while improving the quality of patient care; and

(10) administering the Healthcare Payment Reform Fund, established under section 100 of chapter 194 of the acts of 2011, to support the activities of the institute

Section 8D. Not later than October 1 of every year, the institute shall hold public hearings comparing the growth in total health care expenditures to the health care cost growth benchmark for the previous calendar year. The hearings shall examine health care provider, provider organization and private and public health care payer costs, prices, and cost trends, with particular attention to factors that contribute

to cost growth within the commonwealth's health care system. The attorney general may intervene in such hearings.

(b) Public notice of any hearing shall be provided at least 60 days in advance.

(c) The institute shall identify as witnesses for the public hearing a representative sample of providers, provider organizations and payers, including: (i) at least 3 academic medical centers, including the 2 acute hospitals with the highest level of net patient service revenue; (ii) at least 3 disproportionate share hospitals, including the 2 hospitals whose largest per cent of gross patient service revenue is attributable to Title XVIII and XIX of the federal Social Security Act or other governmental payers; (iii) community hospitals from at least 3 separate regions of the state; (iv) freestanding ambulatory surgical centers from at least 3 separate regions of the state; (v) community health centers from at least 3 separate regions of the state; (vi) the 5 private health care payers with the highest enrollments in the state; (vii) any managed care organization that provides health benefits under Title XIX or under the commonwealth care health insurance program; (viii) the group insurance commission; (ix) at least 3 municipalities that have adopted chapter 32B; (x) at least 3 provider organizations, at least 1 of which shall be a physician organization and at least 1 of which has been certified as a Beacon ACO; and (xii) any witness identified by the attorney general or the institute of health care finance and policy.

(d) Witnesses shall provide testimony under oath and subject to examination and cross examination by the board, the executive director of the institute and the attorney general at the public hearing in a manner and form to be determined by the board, including without limitation: (i) in the case of providers and provider organizations, testimony concerning payment systems, care delivery models, payer mix, cost structures, administrative and labor costs, capital and technology cost, adequacy of public payer reimbursement levels, reserve levels, utilization trends, relative price, quality improvement and care-coordination strategies, investments in health information technology, the relation of private payer reimbursement levels to

public payer reimbursements for similar services, efforts to improve the efficiency of the delivery system and efforts to reduce the inappropriate or duplicative use of technology; and (ii) in the case of private and public payers, testimony concerning factors underlying premium cost and rate increases, the relation of reserves to premium costs, the payer's efforts to develop benefit design, network design and payment policies that enhance product affordability and encourage efficient use of health resources and technology including utilization of alternative payment methodologies, efforts by the payer to increase consumer access to health care information, efforts by the payer to reduce price variance between providers, efforts by the payer to promote the standardization of administrative practices and any other matters as determined by the board.

(e) In the event that the institute's annual report finds that the percentage change in total health care expenditures exceeded the health care cost benchmark in the previous calendar year, the institute may identify additional witnesses for the public hearing. Witnesses shall provide testimony subject to examination and cross examination by the board, the executive director of the institute and attorney general at the public hearing in a manner and form to be determined by the board, including without limitation: (i) testimony concerning unanticipated events that may have impacted the total health care cost expenditures, including, but not limited to, a public health crisis such as an outbreak of a disease, a public safety event or a natural disaster; (ii) testimony concerning trends in patient acuity, complexity or utilization of services; (iii) testimony concerning trends in input cost structures, including, but not limited to, the introduction of new pharmaceuticals, medical devices and other health technologies; (iv) testimony concerning the cost of providing certain specialty services, including but not limited to, the provision of health care to children, the provision of cancer-related health care and the provision of medical education; (v) testimony related to unanticipated administrative costs for carriers, including, but not limited to, costs related to information technology, administrative simplification efforts, labor costs and transparency efforts; (vi) testimony related to costs due the implementation of

state or federal legislation or government regulation; and (vii) any other factors that may have led to excessive health care cost growth.

(f) The institute shall compile an annual report concerning spending trends and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system. The report shall be based on the institute's analysis of information provided at the hearings by providers, provider organizations and insurers, data collected by the institutes under sections 9, 10 and11 of chapter 12C, and any other information the institute considers necessary to fulfill its duties under this section, as further defined in regulations promulgated by the institute. The report shall be submitted to the chairs of the house and senate committees on ways and means, the chairs of the joint committee on health care financing and shall be published and available to the public not later than December 31 of each year. The report shall include any legislative language necessary to implement the recommendations.

Section 9. (a) The institute shall provide confidential notice to health care entities whose increase in health status adjusted total medical expense is considered excessive and who threaten the ability of the state to meet the health care cost growth benchmark as identified by the institute under section 16 of chapter 12C. Such notice shall state that the health care entity has been identified as having an excessive increase in health status adjusted total medical expense.

(b) For calendar year 2015, in the event that the institute's annual report under section 15 finds that average percentage change in cumulative total health care expenditures from 2012 to 2014 exceeded the average health care cost benchmark from 2012 to 2014, and in order to support the state's efforts to meet future health care cost growth benchmarks, as established in section 5, the institute shall establish procedures to assist health care entities to improve efficiency and reduce cost growth through the requirement of certain health care entities to file and implement a performance improvement plan.

Beginning in calendar year 2016, in the event that the institute's annual report under said section 15 of said chapter 12C finds that percentage change in total health care expenditures exceeded the health care cost benchmark in the previous calendar year, and in order to support the state's efforts to meet future health care cost growth benchmarks, as established in said section 5, the institute shall establish procedures to assist health care entities to improve efficiency and reduce the cost growth through the requirement of certain health care entities to file and implement a performance improvement plan.

(c) In addition to the confidential notice provided under subsection (a), the institute may provide confidential notice to the health care entity that it will be required to file a performance improvement plan. Within 45 days of receiving this notice from the institute, the health care entity shall either:

(1) file a confidential performance improvement plan with the institute; or

(2) file a confidential application with the institute to waive or extend the requirement to file a performance improvement plan. The health care entity may file any documentation or supporting evidence with the institute to support the health care entity's application to waive or extend the requirement to file a performance improvement plan. The institute shall require the health care entity to submit any other relevant information it deems necessary in considering the waiver or extension application.

All information submitted shall remain confidential and exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 and chapter 66.

(d) The institute may waive or delay the requirement for a health care entity to file a performance improvement plan in response to a waiver or extension request filed under paragraph (2) of subsection (c) based on a consideration of the following factors, in light of all information received from the health care entity:

(1) the costs, price and utilization trends of the health care entity over time, and any demonstrated improvement to reduce health status adjusted total medical expenses;

(2) any ongoing strategies or investments that the health care entity is implementing to improve future long-term efficiency and reduce cost growth;

(3) whether the factors that led to increased costs for the health care entity can reasonably be considered to be outside of the control of the entity and unanticipated;

(4) the overall financial condition of the health care entity;

(5) the proportionate impact of the health care entity's costs on the growth of total health care medical expenses statewide;

(6) a significant deviation between the projected economic growth benchmark and the actual economic growth benchmark, as established under section 7H½ of chapter 29; and

(7) any other factors the institute considers relevant, including any information or testimony collected by the institute under the subsection (e) of section 6.

If the institute declines to waive or extend the requirement for the health care entity to file a performance improvement plan, the institute shall provide confidential notice to the health care entity that its application for a waiver or extension was denied and the health care entity shall file a performance improvement plan within 45 days.

(e) A health care entity shall file a performance improvement plan: (i) within 45 days of receipt of a notice under subsection (c); (ii) if the health care entity has requested a waiver or extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or (iii) if the health care entity is granted an extension, on the date given on such extension. The performance improvement plan shall be generated by the health care entity and shall identify the causes of the entity's cost growth and shall include, but not be limited to, specific strategies, adjustments and action steps the entity proposes to implement to improve cost performance, as

measured by health status adjusted total medical expenses. The proposed performance improvement plan shall include specific identified and measurable expected outcomes and a timetable for implementation. The timetable for a performance improvement plan shall not exceed 18 months.

(f) The institute shall approve any performance improvement plan that it determines is reasonably likely to address the underlying cause of the entity's cost growth and has a reasonable expectation for successful implementation.

(g) If the board determines that the performance improvement plan is unacceptable or incomplete, the institute may provide consultation on the criteria that have not been met and may allow an additional time period, up to 30 calendar days, for resubmission; provided however, that all aspects of the performance improvement plan shall be proposed by the health care entity and the institute shall not require specific elements for approval.

(h) Upon approval of the proposed performance improvement plan, the institute shall notify the health care entity to begin immediate implementation of the performance improvement plan. Public notice shall be provided by the institute on its website identifying that the health care entity is implementing a performance improvement plan; provided however, that the performance improvement plan itself shall remain confidential. All health care entities implementing an approved performance improvement plan shall be subject to additional confidential reporting requirements and compliance monitoring, as determined by the institute. The institute shall provide assistance to the health care entity in the successful implementation of the performance improvement plan.

(i) All health care entities shall, in good faith, work to implement the performance improvement plan. At any point during the implementation of the performance improvement plan the health care entity may file amendments to the performance improvement plan, subject to approval of the institute.

(j) At the conclusion of the timetable established in the performance improvement plan, the health care entity shall report to the institute regarding the outcome of the performance improvement plan. If the performance improvement plan was found to be unsuccessful, the institute shall either: (i) extend the implementation timetable of the existing performance improvement plan; (ii) approve amendments to the performance improvement plan as proposed by the health care entity; (iii) require the health care entity to submit a new performance improvement plan under subsection (e); or (iv) waive or delay the requirement to file any additional performance improvement plans.

(k) Upon the successful completion of the performance improvement plan, or a decision by the board to waive or delay the requirement to file a new performance improvement plan, the identity of the health care entity shall be removed from the institute's website.

(l) If the institute determines that a health care entity has: (i) willfully neglected to file a performance improvement plan with the institute within 45 days as required under subsection (e); (ii) failed to file an acceptable performance improvement plan in good faith with the institute; (iii) failed to implement the performance improvement plan in good faith; or (iv) knowingly failed to provide information required by this section to the institute or that knowingly falsifies the same, the institute may assess a civil penalty to the health care entity of not more than $500,000. The institute shall seek to promote compliance with this section and shall only impose a civil penalty as a last resort.

(m) The institute may submit a recommendation of proposed legislation to the joint committee on health care financing if the institute believes that further legislative institute is needed to assist health care entities to implement successful performance improvement plans or to ensure compliance under this section.

(n) The institute shall promulgate regulations as necessary to implement this section; provided however, that notice of any proposed regulations shall be filed with

the joint committee on state administration and the joint committee on health care financing at least 180 days before adoption.

Section 10. (a) The institute shall develop standards and a common application form for certain provider organizations to be voluntarily certified as Beacon ACOs. The purpose of the Beacon ACO certification process shall be to encourage the adoption of certain best practices by provider organizations in the commonwealth related to cost containment, quality improvement and patient protection. Provider organizations seeking this certification shall apply directly to the institute and shall submit all necessary documentation as required by the institute. The Beacon ACO certification shall be assigned to all provider organizations that meet the standards developed by the board.

(b) In developing standards for Beacon ACO certification, the institute shall include a review of the best practices employed by health care entities in the commonwealth, and at a minimum, all applicable requirements developed by the Centers for Medicare & Medicaid Services under the Pioneer ACO model, including, but not limited to, requirements that all Beacon ACOs shall: (i) commit to entering alternative payment methodology contracts with other purchasers such that the majority of the Beacon ACO's total revenues will be derived from such arrangements; (ii) be a legal entity with its own tax identification number, recognized and authorized under the laws of the commonwealth; (iii) include patient and consumer representation on its governance; and (iv) commit to ensuring at least 50 per cent of the Beacon ACO's primary care providers are meaningfully using certified EHR technology as defined in the HITECH Act and subsequent Medicare regulations.

(c) The institute shall develop additional standards necessary to be certified as a Beacon ACO, related to quality improvement, cost containment and patient protections. In developing additional standards, the institute shall consider, at a minimum, the following requirements for Beacon ACOs:

(1) to reduce the growth of health status adjusted total medical expenses over time, consistent with the state's efforts to meet the health care cost benchmark established under section 5;

(2) to improve the quality of health services provided, as measured by the statewide quality measure set and other appropriate measures;

(3) to ensure patient access to health care services across the care continuum, including, but not limited to, access to: preventive and primary care services; emergency services; hospitalization services; ambulatory patient services; mental health and behavioral health services; access to specialty care units, including, but are not limited to, burn, coronary care, cancer care, neonatal care, post-obstetric and post operative recovery care, pulmonary care, renal dialysis and surgical, including trauma and intensive care units; pediatric services; diagnostic imaging and screening services; maternity and newborn care services; radiation therapy and treatment services; skilled nursing facilities; family planning services; home health services; treatment and prevention services for alcohol and other drug abuse; breakthrough technologies and treatments; and allied health services including, but not limited to, advance practice nurses, optometric care, direct access to chiropractic services, occupational therapists, dental care, physical therapy and midwifery services;

(4) to improve access to certain primary care services, including but not limited to, by having a demonstrated primary care capacity and a minimum number of practices engaged in becoming patient centered medical homes;

(5) to improve access to health care services and quality of care for vulnerable populations including, but not limited to, children, the elderly, low-income individuals, individuals with disabilities, individuals with chronic illnesses and racial and ethnic minorities.

(6) to promote the integration of mental health and behavioral health services with primary care services including, but not limited to, the establishment of a behavioral health medical home;

(7) to promote patient-centeredness by, including, but not limited to, establishing mechanisms to conduct patient outreach and education on the necessity

and benefits of care coordination; demonstrating an ability to engage patients in shared decision making taking into account patient preferences; demonstrating an ability to effectively involve patients in care transitions to improve the continuity and quality of care across settings, with case manager follow up; demonstrating an ability to engage and activate patients at home, through methods such as home visits or telemedicine, to improve self-management; and establishing mechanisms to evaluate patient satisfaction with the access and quality of their care;

(8) to adopt certain health information technology and data analysis functions, including, but not limited to, population-based management tools and functions; the ability to aggregate and analyze clinical data; the ability to electronically exchange patient summary records across providers who are members of the Beacon ACO and other providers in the community to ensure continuity of care; the ability to provide access to multi-payer claims data and performance reports and the ability to share performance feedback on a timely basis with participating providers; and the ability to enable the beneficiary access to electronic health information;

(9) to demonstrate excellence in the area of quality improvement and care coordination, as evidenced by the success of previous or existing care coordination, pay for performance, patient centered medical home, quality improvement or health outcomes improvement initiatives, including, but not limited to, a demonstrated commitment to reducing avoidable hospitalizations, adverse events and unnecessary emergency room visits;

(10) to promote community-based wellness programs and community health workers, consistent with efforts funded by the department of public health through the Prevention and Wellness Trust Fund established in section 2G of chapter 111;

(11) to adopt certain governance structure standards;

(12) to adopt certain financial capacity standards, including certification to protect Beacon ACOs from assuming excess risk; and

(13) any other requirements the institute considers necessary.

(d) The institute shall update the standards for certification as a Beacon ACO at least every 2 years, or at such other times as the institute determines necessary. In developing the standards, the institute shall seek to allow for provider organizations of different compositions, including, but not limited to, physician group entities and independent physician organizations, to successfully apply for certification.

(e) Provider organizations shall annually renew their certification as a Beacon ACO. Failure to meet the requirements represented in the certification may result in decertification, as determined by the board.

Section 11. (a) The institute shall develop best practices and standards for alternative payment methodologies for use by the group insurance commission, the office of Medicaid and any other state funded insurance program. Any alternative payment methodology shall: (1) support the state's efforts to meet the health care cost benchmark established in section 5; (2) include incentives for higher quality care; (3) include a risk adjustment element based on health status; and (4) to the extent possible, include a risk adjustment element that takes into account functional status, socioeconomic status or cultural factors. The institute shall also consider methodologies to account for the following costs: (i) medical education; (ii) stand-by services and emergency services, including, but not limited to, trauma units and burn units; (iii) services provided by disproportionate share hospitals or other providers serving underserved populations; (iv) services provided to children; (v) research; (vi) care coordination and community based services provided by allied health professionals; (vii) the greater integration of behavioral and mental health; and (viii) the use and the continued advancement of new medical technologies, treatments, diagnostics or pharmacology products that offer substantial clinical improvements and represent a higher cost than the use of current therapies.

Any best practices and standards developed under this section shall be shared with all private health plans for their voluntary adoption.

Section 12. (a) The institute shall promulgate regulations to require providers to report such data as necessary to identify, on a patient-centered and provider-specific basis, statewide and regional trends in the cost, price, availability and utilization of medical, surgical, diagnostic and ancillary services provided by acute hospitals, nursing homes, chronic care and rehabilitation hospitals, other specialty hospitals, clinics, including mental health clinics and such ambulatory care providers as the institute may specify. Such regulations shall ensure uniform reporting of revenues, charges, prices, costs and utilization of health care services delivered by institutional and non-institutional providers and, relative to acute care hospitals, uniform reporting of hospital inpatient and outpatient costs, including direct and indirect costs.

(b) With respect to any acute or non-acute hospital, the institute shall, by regulation, designate information necessary to effectuate this chapter including, but not be limited to, the filing of a charge book, the filing of cost data and audited financial statements and the submission of merged billing and discharge data. The institute shall, by regulation, designate standard systems for determining, reporting and auditing volume, case-mix, proportion of low-income patients and any other information necessary to effectuate this chapter and to prepare reports comparing acute and non-acute care hospitals by cost, utilization and outcome. Such regulations may require such hospitals to file required information and data by electronic means; provided, however, that the institute shall allow reasonable waivers from such requirement. The institute shall, at least annually, publish a report analyzing such comparative information to assist third-party payers and other purchasers of health services in making informed decisions. Such report shall include comparative price and service information relative to outpatient mental health services.

(c) The institute shall also collect and analyze such data as it considers necessary in order to better protect the public's interest in monitoring the financial conditions of acute hospitals. Such information shall be analyzed on an industry-wide and hospital-specific basis and shall include, but not be limited to: (i) gross and net patient service revenues; (ii) sources of hospital revenue, including revenue excluded

from consideration in the establishment of hospital rates and charges under section 13G of chapter 118E; (iii) private sector charges; (iv) trends in inpatient and outpatient case mix, payer mix, hospital volume and length of stay; and (v) other relevant measures of financial health or distress.

The institute shall publish annual reports and establish a continuing program of investigation and study of financial trends in the acute hospital industry, including an analysis of systemic instabilities or inefficiencies that contribute to financial distress in the acute hospital industry. Such reports shall include an identification and examination of hospitals that the institute considers to be in financial distress, including any hospitals at risk of closing or discontinuing essential health services, as defined by the department of public health under section 51G of chapter 111, as a result of financial distress.

The institute may modify uniform reporting requirements established under subsections (a) and (b) and may require hospitals to report required information quarterly to effectuate this subsection.

(d) The institute shall publicly report and place on its website information on health status adjusted total medical expenses including a breakdown of such health status adjusted total medical expenses by major service category and by payment methodology, relative prices and hospital inpatient and outpatient costs, including direct and indirect costs under this chapter on an annual basis; provided, however, that at least 10 days prior to the public posting or reporting of provider specific information the affected provider shall be provided the information for review. The institute shall request from the federal Centers for Medicare and Medicaid Services the health status adjusted total medical expenses of provider groups that serve Medicare patients.

(e) When collecting information or compiling reports intended to compare individual health care providers, the institute shall require that:

(1) providers which are representative of the target group for profiling shall be meaningfully involved in the development of all aspects of the profile methodology, including collection methods, formatting and methods and means for release and dissemination;

(2) the entire methodology for collecting and analyzing the data shall be disclosed to all relevant provider organizations and to all providers under review;

(3) data collection and analytical methodologies shall be used that meet accepted standards of validity and reliability;

(4) the limitations of the data sources and analytic methodologies used to develop provider profiles shall be clearly identified and acknowledged, including, but not limited to, the appropriate and inappropriate uses of the data;

(5) to the greatest extent possible, provider profiling initiatives shall use standard-based norms derived from widely accepted, provider-developed practice guidelines;

(6) provider profiles and other information that have been compiled regarding provider performance shall be shared with providers under review prior to dissemination; provided, however, that opportunity for corrections and additions of helpful explanatory comments shall be provided prior to publication; and, provided, further, that such profiles shall only include data which reflect care under the control of the provider for whom such profile is prepared;

(7) comparisons among provider profiles shall adjust for patient case-mix and other relevant risk factors and control for provider peer groups, when appropriate;

(8) effective safeguards to protect against the unauthorized use or disclosure of provider profiles shall be developed and implemented;

(9) effective safeguards to protect against the dissemination of inconsistent, incomplete, invalid, inaccurate or subjective profile data shall be developed and implemented; and

(10) the quality and accuracy of provider profiles, data sources and methodologies shall be evaluated regularly.

Section 13. (a) The institute shall develop and administer a registration program for provider organizations and shall collect and analyze such data as it considers necessary in order to better protect the public's interest in monitoring the financial conditions, organizational structure, market power and business practices of provider organizations. The institute shall promulgate such regulations as may be necessary to ensure the uniform reporting of data collected under this section. Such uniform reporting shall, at a minimum, enable the institute to identify and analyze: (i) the organizational structure of each provider organization, including parent entities, clinical affiliates and corporate affiliates as applicable; (ii) the financial condition and solvency of each provider organization and ability to manage any alternative payment contracts that it has entered into; and (iii) market share by provider organization by primary service areas, dispersed service areas and the categories of services provided.

(b) The institute shall establish by regulation at least 5 levels of registration requirements and standards for provider organizations which vary based on factors including degree of provider integration, operational size, annual net patient service revenue, related business activities including insurance and the extent to which the provider organization accepts alternative payment methodologies. One level of registration requirements and standards shall be applicable to provider organizations certified as Beacon ACOs by the institute of health care finance and policy. One level of standards and registration requirements shall be designed for provider organizations that do not accept risk payments. For each level, the institute shall establish minimum registration and public reporting requirements on consumer protections and quality benchmarks.

(c)The institute shall require, at a minimum, that all provider organizations provide: (i) organizational charts showing the ownership, governance and operational structure of the provider organization, including any clinical affiliations and community advisory boards; (ii) the number of affiliated health care professional full-time equivalents by license type, specialty, name and address of principal practice location and whether the professional is employed by the organization; (iii) the name and

address of licensed facilities by license number, license type and capacity in each major service category; (iv) a comprehensive financial statement, including information on parent entities and corporate affiliates as applicable, and including details regarding annual costs, annual receipts, realized capital gains and losses, accumulated surplus and accumulated reserves; (v) Information on stop-loss insurance and any non-fee-for-service payment arrangements; (vi) information on clinical quality, care coordination and patient referral practices; (vii) information regarding expenditures and funding sources for payroll, teaching, research, advertising, taxes or payments-in-lieu-of-taxes and other non-clinical functions; (viii) information regarding charitable care and community benefit programs; (ix) for any provider organization which enters alternative payment contracts, a certification under subsection (e); and (x) such other information as the institute considers appropriate.

(d) Each registered provider organization shall annually file with the institute a comprehensive financial statement showing the organization's financial condition for the prior year, including information on parent entities and corporate affiliates as applicable and such other information as the institute may require by regulation, such as organizational or clinical information. Annual reporting shall be in a form provided by the institute and shall include, at a minimum, sufficient information to demonstrate the solvency of the provider organization and its ability to manage any alternative payment contracts into which it has entered. Any provider organization which enters or renews alternative payment contracts shall provide, with the provider organization's annual report, a certification under subsection (e). The institute may require in writing, at any time, such additional information as is reasonable and necessary to determine the financial condition of a registered provider organization.

(e) The institute shall, in collaboration with the division of insurance, establish by regulation a certification process for any provider organization which enters into alternative payment contracts. Such certification process shall be designed to determine whether a provider organization has adequate reserves and other measures of financial solvency to meet its risk arrangements. The standards for such certification

may vary based on the provider organization size, the type of alternative payment methodology employed, the amount and type of risk assumed and such other criteria as the commissioner of insurance considers appropriate to ensure that provider organizations do not assume excess risk. The institute, in collaboration with the division of insurance, shall establish a schedule to renew such certification; provided, that such certification be renewed at least annually.

(f) In developing standards, registration and reporting requirements, the institute shall consider other rules and regulations applicable to such organizations, shall consult with the division of insurance regarding standards concerning risk-bearing by providers and provider organizations.

(g) Every provider organization shall, before making any change to its operations or governance structure affecting the provider organization's registration, submit notice to the institute of such change. The institute may promulgate regulations prescribing the contents of any notices required to be filed under this section. The institute may promulgate regulations further defining material change and not material change.

If the change is not material, the notice shall be filed not fewer than 15 days before the date of the change. A change that is not material may proceed on the date identified in the notice once the notice has been accepted by the institute. Changes that are not material, for purposes of this section, shall include, at a minimum, changes in board membership except when such changes are related to a corporate affiliation, changes involving employment decisions by the provider organization, changes that are subject to review by a state agency through any other administrative process and changes that are necessary to comply with state or federal law. The institute may promulgate regulations defining additional categories of changes that it shall consider not material.

If the change is material, the notice shall be filed not fewer than 60 days before the date of the change. Within 30 days of receipt of a notice filed under the institute's regulations, the institute shall conduct a preliminary review to determine whether the

change is likely to result in a significant impact on the commonwealth's ability to meet the health care cost growth benchmark on the competitive market or on a provider organization's solvency. Material changes that are likely to result in a significant impact shall include, but not be limited to: a corporate affiliation between a provider organization and a carrier; mergers or acquisitions of hospitals or hospital systems; acquisition of insolvent provider organizations; and mergers or acquisitions of provider organizations which will result in a provider organization having a near-majority of market share in a given service or region. The institute shall specify, through regulations, other categories of material changes likely to result in significant impact. The institute may require supplementary submissions from the provider organization to provide data necessary to carry out this preliminary review. A provider organization's supplementary submissions shall be confidential and shall not be considered a public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66 until the issuance of the institute's report on its findings as a result of the preliminary review.

If the institute finds that the material change is unlikely to have a significant impact on the commonwealth's ability to meet the health care cost growth benchmark on the competitive market or on the provider organization's solvency, then the institute shall notify the provider organization of the outcome of its preliminary review and the material change may proceed on the date identified in the notice. If the institute finds that the material change is likely to have a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, on the competitive market or on the provider organization's solvency, the institute shall conduct a cost, market impact and solvency review under subsection (h).

(h) The institute shall establish by regulation rules for conducting cost, market impact and solvency reviews where there has been a material change to a provider organization's registration which the institute determines is likely to have a significant impact on the commonwealth's ability to meet the health care cost growth benchmark,

on the competitive market or on the provider organization's solvency under subsection (g).

The institute shall initiate a cost, market impact and solvency review by sending the provider organization a notice of a cost, market impact and solvency review which shall explain the particular factors that the institute seeks to examine through the review. The institute shall notify the attorney general and the division of insurance whenever it initiates a cost, market impact and solvency review and shall issue a public notice soliciting comments to inform its review. The provider organization shall submit to the institute and the attorney general, within 21 days of the institute's notice, a written response to the notice, including, but not limited to, any information or documents sought by the institute's notice. A provider organization's written response shall be confidential and shall not be considered a public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66 only until such time as the executive director determines the response is complete.

A cost, market impact and solvency review may examine factors including, but not limited to: (i) the provider organization's size and market share within its primary service areas by major service category, and within its dispersed service areas; (ii) provider price, including its relative prices filed with the institute; (iii) provider quality, including patient experience; (iv) provider cost and cost trends in comparison to total health care expenditures statewide; (v) the availability and accessibility of services similar to those provided, or proposed to be provided, through the provider organization within its primary service areas and dispersed service areas; (vi) the provider organization's impact on competing options for the delivery of health care services within its primary service areas and dispersed service areas; (vii) the methods used by the provider organization to attract patient volume and to recruit or acquire health care professionals or facilities; (viii) the role of the provider organization in serving at-risk, underserved and government payer patient populations within its primary service areas and dispersed service areas; (ix) the role of the provider organization in providing low margin or negative margin services within its primary

service areas and dispersed service areas; (x) the financial solvency of the provider organization; (xi) consumer concerns, including but not limited to, complaints or other allegations that the provider organization has engaged in any unfair method of competition or any unfair or deceptive act or practice; and (xii) any other factors that the institute determines to be in the public interest.

The institute shall issue a final report on the cost, market impact and solvency review within 60 days of receipt of a notice of material change filed under subsection (g) and which the institute determined was likely to result in significant impact on the commonwealth's ability to meet the health care cost growth benchmark on the competitive market or on the provider organization's solvency. The institute shall forward a copy of the final report to the attorney general and the division of insurance.

(i) Nothing in this section shall limit the application of other laws or regulations that may be applicable to a provider organization, including laws and regulations governing insurance.

Section 14.(a) The institute may promulgate regulations necessary to ensure the uniform reporting of information from private and public health care payers, including third-party administrators, that enables the institute to analyze: (i) changes over time in health insurance premium levels; (ii) changes in the benefit and cost-sharing design of plans offered by these payers; (iii) changes in measures of plan cost and utilization; provided that this analysis shall facilitate comparison among plans and between public and private payers; and (iv) changes in type of payment methods implemented by payers and the number of members covered by alternative payment methodologies; provided, that this analysis shall facilitate comparison among plans and plan types, including the self-insured. The institute shall adopt regulations to require private and public health care payers to submit claims data, member data and provider data to develop and maintain a database of health care claims data under this chapter.

(b) The institute shall require the submission of data and other information from each private health care payer offering small or large group health plans including,

but not limited to: (i) average annual individual and family plan premiums for each payer's most popular plans for a representative range of group sizes, as further determined in regulations and average annual individual and family plan premiums for the lowest cost plan in each group size that meets the minimum standards and guidelines established by the division of insurance under section 8H of chapter 26; (ii) information concerning the actuarial assumptions that underlie the premiums for each plan; (iii) summaries of the plan and network designs for each plan, including whether behavioral health or other specific services are carved-out from any plans; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan, using a uniform methodology and collected under section 21 of chapter 176O; (v) information concerning the payer's current level of reserves and surpluses; (vi) information on provider payment methods and levels; (vii) health status adjusted total medical expenses by registered provider organization, provider group and local practice group and zip code calculated according to the method established under section 51 of chapter 288 of the acts of 2010; (viii) relative prices paid to every hospital, registered provider organization, physician group, ambulatory surgical center, freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by type of provider, with hospital inpatient and outpatient prices listed separately and product type, including health maintenance organization and preferred provider organization products and determined using the method established under section 52 of chapter 288 of the acts of 2010; (ix) hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology; (x) the annual rate of growth, stated as a percentage, of the weighted average relative price by provider type and product type for the payer’s participating health care providers, whether that rate exceeds the rate of growth of the applicable producer price index as reported by the United States Bureau of Labor Statistics and identified by the commissioner of insurance and whether that rate exceeds the rate of growth in projected economic growth benchmark established under section 7H½ of chapter 29; and (xi) a comparison of relative prices for the payer’s participating health care providers by provider type which shows the

weighted average relative price, the extent of variation in price, stated as a percentage and identifies providers who are paid more than 10 per cent, 15 per cent and 20 per cent above and more than 10 per cent, 15 per cent and 20 per cent below the weighted average relative price.

(c) The institute shall require the submission of data and other information from public health care payers including, but not limited to: (i) average premium rates for health insurance plans offered by public payers and information concerning the actuarial assumptions that underlie these premiums; (ii) average annual per-member per-month payments for enrollees in MassHealth primary care clinician and fee for service programs; (iii) summaries of plan and network designs for each plan or program, including whether behavioral health or other specific services are carved-out from any plans; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan or program; (v) where appropriate, information concerning the payer's current level of reserves and surpluses; (vi) information on provider payment methods and levels, including information concerning payment levels to each hospital for the 25 most common medical procedures provided to enrollees in these programs, in a form that allows payment comparisons between Medicaid programs and managed care organizations under contract to the office of Medicaid; (vii) health status adjusted total medical expenses by registered provider organization, provider group and local practice group and zip code calculated according to the method established under section 51 of chapter 288 of the acts of 2010;; and (viii) relative prices paid to every hospital, registered provider organization, physician group, ambulatory surgical center, freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by type of provider, with hospital inpatient and outpatient prices listed separately, and product type and determined using the method established under section 52 of chapter 288 of the acts of 2010; (ix) hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology; (x) the annual rate of growth, stated as a percentage, of the weighted average relative price by provider type and product type for the payer’s participating health care providers,

whether that rate exceeds the rate of growth of the applicable producer price index as reported by the United States Bureau of Labor Statistics and identified by the commissioner of insurance and whether that rate exceeds the rate of growth in projected economic growth benchmark established under section 7H½ of chapter 29; and (xi) a comparison of relative prices for the payer's participating health care providers by provider type which shows the weighted average relative price, the extent of variation in price, stated as a percentage and identifies providers who are paid more than 10 per cent, 15 per cent and 20 per cent above and more than 10 per cent, 15 per cent and 20 per cent below the weighted average relative price.

(d) The institute shall require the submission of data and other information from public and private health care payers which utilize alternative payment contracts, including, but not limited to: (i) the negotiated monthly budget for each alternative payment contract in the current contract year; (ii) any applicable measures of provider performance in such alternative payment contracts; and (iii) the average negotiated monthly budget weighted by member months for each zip code.

For purposes of this subsection, payers shall report the negotiated monthly budget assuming a neutral health status score of 1.0 using an industry accepted health status adjustment tool and shall separately report the budget allowances for: all medical and behavioral health care at both in and out-of-network providers; pharmacy coverage allowance; administrative expenses such as data analytics, health information technology, clinical program development and other program management fees; the purchase of reinsurance or stop-loss; risk reserves; and quality bonus monies, unit cost adjustments or other special allowances. If out-of-network care, behavioral health, stop-loss insurance or any other clinical services are carved out of any global budget, bundled payments or other alternative payment methodologies such that there is no allowance included in the budget for those services, payers shall report actual claims costs of these items on a per member per month basis for the year immediately prior to the current contract year.

(e) Except as specifically provided otherwise by the institute or under this chapter, insurer data collected by the institute under this section shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66.

Section 15. The institute shall ensure the timely reporting of information required under sections 12, 13 and 14. The institute shall notify payers, providers and provider organizations of any applicable reporting deadlines. The institute shall notify, in writing, a private health care payer, provider or provider organization, which has failed to meet a reporting deadline and that failure to respond within 2 weeks of the receipt of the notice may result in penalties. The institute may assess a penalty against a payer, provider or provider organization that fails, without just cause, to provide the requested information within 2 weeks following receipt of the written notice required under this paragraph, of up to $1,000 per week for each week of delay after the 2 week period following the payer's, provider’s or provider organization’s receipt of the written notice; provided, however, that the maximum annual penalty against a private payer under this section shall be $50,000. Amounts collected under this section shall be deposited in the Healthcare Payment Reform Fund.

Section 16. (a) The institute shall be the sole repository for health care data collected under sections 12, 13 and 14. The institute shall collect, store and maintain such data in a payer and provider claims database. The institute shall acquire, retain and oversee all information technology, infrastructure, hardware, components, servers and employees necessary to carry out this section. All other agencies, authorities, councils, boards and commissions of the commonwealth seeking health care data that is collected under this section shall, whenever feasible, utilize such data prior to requesting data directly from health care providers and payers. In order to ensure patient data confidentiality, the institute shall not contract or transfer the operation of the database or its functions to a third-party entity, nonprofit organization or governmental entity; provided, however, that the institute may enter into interagency services agreements for transfer and use of the data.

The institute shall, to the extent feasible, make data in the payer and provider claims database available to payers and providers in real-time; provided, that all such data-sharing complies with applicable state and federal privacy laws. The institute may charge a fee for real-time access to such data.

(b) The institute shall permit providers, provider organizations, public and private health care payers, government agencies and researchers to access de-identified, aggregated data collected by the institute for the purposes of lowering total medical expenses, coordinating care, benchmarking, quality analysis and other research, administrative or planning purposes, provided, that such data shall not include information that would allow the identification of the health information of an individual patient or the disclosure of rates of payment in individual provider agreements. The institute shall charge user fees sufficient to defray the institute's cost of providing such access to non-governmental entities.

Section 17. The institute shall, before adopting reporting regulations under this chapter, consult with other agencies of the commonwealth and the federal government, affected providers, provider organizations and affected payers, as applicable, to ensure that the reporting requirements imposed under the regulations are not duplicative or excessive. If reporting requirements imposed by the institute result in additional costs for the reporting providers, these costs may be included in any rates promulgated by the executive office of health and human services or a governmental unit designated by the executive office for these providers. The institute may specify categories of information which may be furnished under an assurance of confidentiality to the provider; provided that such assurance shall only be furnished if the information is not to be used for setting rates.

Section 18. (a) The institute shall publish an annual report based on the information submitted under sections 12, 13 and 14 concerning health care provider, provider organization and private and public health care payer costs and cost trends. The institute shall detail: (i) baseline information about cost, price, quality, utilization and

market power in the commonwealth's health care system; (ii) factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates; (iii) the impact of health care reform efforts on health care costs including, but not limited to, the development of limited and tiered networks, increased price transparency, increased utilization of electronic medical records and other health technology and increased prevalence of alternative payment contracts and provider organizations with integrated care networks; (iv) price variance between providers and any efforts undertaken by payers to reduce such variance; (v) trends in utilization of unnecessary or duplicative services, with particular emphasis on imaging and other high-cost services (vi) the prevalence and trends in adoption of alternative payment methodologies and impact of alternative payment methodologies on overall health care spending, insurance premiums and provider rates; and (vii) the development and status of provider organizations in the commonwealth including, but not limited to, the formation of provider organizations with integrated care networks, acquisitions, mergers, consolidations and any evidence of excess consolidation or anti-competitive behavior by provider organizations.

The institute shall publish the report and may contract with an outside organization with expertise in issues related to the topics of the hearings to produce this report.

(b) The attorney general may review and analyze any information submitted to the institute under said sections 12, 13 and 14. The attorney general may require that any provider, provider organization or payer produce documents, answer interrogatories and provide testimony under oath related to health care costs and cost trends or documents that the attorney general considers necessary to evaluate factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates. The attorney general shall keep confidential all nonpublic information and documents obtained under this section and shall not disclose such information or documents to any person without the consent of the provider or payer that produced the information or documents, except in a public hearing under, a rate hearing before the division of insurance or in a case

brought by the attorney general, if the attorney general believes that such disclosure will promote the health care cost containment goals of the commonwealth and that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. Such confidential information and documents shall not be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

Section 19. The institute shall perform ongoing analysis of data it receives under sections 12, 13 and 14 to identify any payers, providers or provider organizations whose increase in health status adjusted total medical expense is considered excessive and who threaten the ability of the state to meet the health care cost growth benchmark.

Section 20. (a) No provider organization may negotiate network contracts with any carrier or third-party administrator except for provider organizations which are registered under this chapter and regulations promulgated under this chapter; provided, however, that nothing in this chapter shall require a provider organization which receives, or which represents providers who collectively receive, less than $1,000,000 in annual net patient service revenue from carriers or third-party administrators and which has fewer than 10 affiliated physicians to be registered if such provider organization does not accept risk contracts. No specialty hospital may be registered to negotiate network contracts with any carrier or third-party administrator as part of a provider organization that includes health care facilities that are not on the specialty hospital's license or health care professionals that are not employed by the specialty hospital.

(b) Nothing in this chapter shall require a carrier to negotiate a network contract with a registered provider organization or with a registered provider organization for all providers that are part of, or represented by, a registered provider organization.

Section 21. The institute shall review and comment upon all capital expenditure projects requiring a determination of need under section 25C of chapter 111, including, but not limited to, the availability and accessibility of services similar to those provided, or proposed to be provided, through the provider organization within its primary service areas and dispersed service areas; the provider organization's impact on competing options for the delivery of health care services within its primary service areas and dispersed service areas; 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 institute 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 institute shall appear and comment on any application for a determination of need where a public hearing is required under said section 25C of said chapter 111. To carry out this paragraph, the institute shall appoint a senior professional employee to act as a liaison with said department.

Section 22. The institute shall establish a continuing program of investigation and study of the uninsured and underinsured in the commonwealth, including the health insurance needs of the residents of the geographically isolated or rural areas of the commonwealth. Said continuing investigation and study shall examine the overall impact of programs developed by the institute and the division of medical assistance on the uninsured, the underinsured and the role of employers in assisting their employees in affording health insurance.

Section 23. The institute shall maintain a consumer health information website. The website shall contain information comparing the quality, price and cost of health care services and may also contain general health care information as the institute considers appropriate. The website shall be designed to assist consumers in making informed decisions regarding their medical care and informed choices among health care providers. Information shall be presented in a format that is understandable to the

average consumer. The institute shall take appropriate action to publicize the availability of its website.

The institute shall annually develop and adopt a reporting plan specifying the quality, price and cost measures to be included on the consumer health information website and the security measures used to maintain confidentiality and preserve the integrity of the data. In developing the reporting plan, the institute, to the extent possible, shall collaborate with other organizations or state or federal agencies that develop, collect and publicly report health care quality, price and cost measures and the institute shall give priority to those measures that are already available in the public domain. As part of the reporting plan, the institute shall determine for each service the comparative information to be included on the consumer health information website, including whether to: (i) list services separately or as part of a group of related services; or (ii) combine the price and cost information for each facility and its affiliated clinicians and physician practices or to list facility and professional price and costs separately.

The institute shall, after due consideration and public hearing, adopt the reporting plan and adopt or reject any revisions. If the institute rejects the reporting plan or any revisions, the institute shall state its reasons for the rejection. The reporting plan and any revisions adopted by the institute shall be promulgated by the institute. The institute shall submit the reporting plan and any periodic revisions to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and the clerks of the house and senate.

The website shall provide updated information on a regular basis, at least annually, and additional comparative quality, price and cost information shall be published as determined by the institute. To the extent possible, the website shall include: (i) comparative quality information by facility, clinician or physician group practice for each service or category of service for which comparative price and cost information is provided; (ii) general information related to each service or category of service for which comparative information is provided; (iii) comparative quality information by

facility, clinician or physician practice that is not service-specific, including information related to patient safety and satisfaction; and (iv) data concerning healthcare-acquired infections and serious reportable events reported under section 51H of chapter 111.

Section 24. The institute shall coordinate with the public health council and the boards of registration for health care providers to develop a uniform and interoperable electronic system of public reporting for providers as a condition of licensure. The uniform provider licensure reporting system shall include information designed for health resource planning and for analysis of market share by provider organization by primary service areas and dispersed service areas, including, but not limited to, reporting for each licensed provider its principal business locations; the categories of services provided; the provider organization with which the provider is affiliated for contracting purposes, or by which the provider is employed, if any; whether and to what extent the provider is practicing on license; and such other factors as the institute deems appropriate. The institute may centralize the uniform provider licensure reporting system or create a central portal for public access to the uniform provider licensure information.

Section 25. Any provider of health care services that receives reimbursement or payment for treatment of injured workers under chapter 152 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 executive director, or the executive director's designated representative and the attorney general or a designee, to examine such books and accounts as may reasonably be required for the institute to perform its duties; (2) file with the executive director from time to time or on request, such data, statistics, schedules or other information as the institute 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 the provider's charges to the public for

health care services, supplies and accommodations; and (3) accept reimbursement or payment at the rates established by the secretary of health and human services or a governmental unit designated by the executive office, subject to a right of appeal under section 13E of chapter 118E, 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.

Any provider of health care services that knowingly fails to file with the institute data, statistics, schedules or other information required under this section or by any regulation promulgated by the institute or knowingly falsifies the same shall be punished by a fine of not less than $100 nor more than $500.

If, upon application by the institute or its designated representative, the superior court upon summary hearing determines that a provider of health care services has, without justifiable cause, refused to permit any examination or to furnish information, as required in this section, it shall issue an order directing all governmental units to withhold payment for general health supplies, care and rehabilitative services and accommodations to such provider of services until further order of the court.

In addition, the appropriate licensing authority may suspend or revoke, after an adjudicatory proceeding under chapter 30A, the license of any provider of health care services that knowingly fails to file with the institute data, statistics, schedules or other information required by this section or by any regulation of the institute or that knowingly falsifies the same.

Section 26. The institute shall develop a plan for the authorization, implementation and regulation of so-called “consumer-directed health care” in the commonwealth for the purpose of empowering consumers with the knowledge, ability and incentives to make choices in the purchase of health care which facilitate sound health outcomes and the cost-effective delivery of services.

For the purposes of this section, consumer-directed health care shall include, but not be limited to, the utilization of health savings accounts, insurance coverage with deductibles of dollar amounts greater than the state average for such amounts, and expanded access to information detailing the actual cost of services being provided to the consumer.

Said plan, together with any legislative and regulatory actions necessary to its implementation and maintenance, shall be filed with the clerks of the House and Senate no later than one year following the passage of this act.

Section 27. The institute shall establish, within 90 days of the passage of this act, a Long Term Care Cost Containment and Reduction Strategy Task Force to develop strategies for the containment and reduction of the costs of long term care in the commonwealth and methodologies for assisting consumers with the payment of costs for such care. Said task force shall include, but not be limited to, representatives of those who operate nursing homes, rest homes and other relevant institutions; providers of home care and telemetric care; hospitals and other acute care facilities; those with expertise in pharmacy, nursing, labor, finance, and technology; and consumers of long term care in the commonwealth. Said task force shall conduct its operations for a period of five years following the passage of this act, and shall produce annually on or before December 31 a report identifying and detailing any strategies and methodologies so developed, together with any legislative recommendations to implement them, which report shall be filed with the clerks of the house and senate.

SECTION 16. Section 18 of chapter 15A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 14 and 36, the words "division of health care finance and policy" and inserting in place thereof, in each instance, the following words:- commonwealth health insurance connector.

SECTION 17. Section 8H of chapter 26 of the General Laws, as so appearing, is hereby amended by striking out, in lines 60, 64, 71 and 73 and 74 the word "division" and inserting in place thereof, in each instance, the following word:- institute.

SECTION 18. Said section 8H of said chapter 26, as so appearing, is hereby further amended by striking out, in lines 56, 77 and 78, each time they appear, the words "uncompensated care pool under section 18 of chapter 118G" and inserting in place thereof, in each instance, the following words:- health safety net under chapter 118E .

SECTION 19. Chapter 29 of the General Laws is hereby amended by inserting after section 7H the following section:-

Section 7H ½. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Actual economic growth benchmark," the actual annual percentage change in the per capita state's gross state product, as established by the secretary of administration and finance in subsection (c).

"Projected economic growth benchmark," the long-term average projected percentage change in the per capita state's gross state product, excluding business cycles.

(b) On or before January 15, the secretary of administration and finance shall meet with the house and senate committees on ways and means and shall jointly develop a projected economic growth benchmark for the ensuing calendar year which shall be agreed to by the secretary and said committees. In developing a projected economic growth benchmark the secretary and said committees, or subcommittees of said committees, may hold joint hearings on the economy of the commonwealth; provided, however, that in the first year of the term of office of a governor who has not served in the preceding year, said parties shall agree to the projected economic growth benchmark not later than January 31 of said year. The secretary and the committees may agree to incorporate this hearing into any consensus tax revenue forecast hearing held under section 5B. The projected economic growth benchmark shall be included with the consensus tax revenue forecast joint resolution under said section 5B and placed before the members of the general court for their consideration. Such joint resolution, if passed by both branches of the general court, shall establish the projected

economic growth benchmark to be used by the institute to establish the health care cost growth benchmark.

(c) Not later than September 15 of each year, the secretary shall report the actual economic growth benchmark for the previous calendar year, based on the best information available at the time. The information shall be provided to the institute of health care finance and policy.

SECTION 20. Section 2OOO of chapter 29 of the General Laws, as so appearing, is hereby amended by striking out, in line 6, the words "18B of chapter 118G" and inserting in place thereof the following words:- 18 of chapter 176Q.

SECTION 21. Said section 2OOO of said chapter 29, as so appearing, is hereby further amended by striking out, in line 16, the words "established by section 18 of chapter 118G".

SECTION 22. Section 2PPP of said chapter 29, as so appearing, is hereby amended by striking out, in lines 16 and 17, the words "section 35 of chapter 118G" and inserting in place thereof the following words:- section 65 of chapter 118E.

SECTION 23. Section 2RRR of said chapter 29 of the General Laws, as so appearing, is hereby amended by striking out, in lines 5 to 10, inclusive, the words "(a) any receipts from the assessment collected under section 27 of chapter 118G, including transfers by the department of developmental services of amounts sufficient to pay the assessment for public facilities, (b) any federal financial participation received by the commonwealth as a result of expenditures funded by such assessments, and (c) any interest thereon" and inserting in place thereof the following words:- (a) any federal financial participation received by the commonwealth as a result of expenditures funded by such assessments, and (b) any interest thereon.

SECTION 24. Section 1 of chapter 29D of the General Laws, as so appearing, is hereby amended by striking out, in line 13, the words “25 and 26 of chapter 118G” and inserting in place thereof the following words:- 63 of chapter 118E.

SECTION 25. Section 3 of said chapter 29D, as so appearing, is hereby amended by striking out, in line 18, the words “25 and 26 of chapter 118G” and inserting in place thereof the following words:- 63 of chapter 118E.

SECTION 26. Said section 3 of said chapter 29D, as so appearing, is hereby amended by striking out, in line 22, the words “25 and 26 of said chapter 118G” and inserting in place thereof the following words:- 63 of said chapter 118E.

SECTION 27. Section 8B of chapter 62C of the General Laws, as so appearing, is hereby amended by striking out, in line 28, the word “division”, the second time it appears, and inserting in place thereof the following word:- institute.

SECTION 28. Clause (22) of subsection (b) of section 21 of said chapter 62C, as so appearing, is hereby amended by striking out, in lines 141 and 142, the words “division of health care finance and policy” and inserting in place thereof the following words:- executive office of health and human services.

SECTION 29. Said clause (22) of said subsection (b) of said section 21 of said chapter 62C, as so appearing, is hereby further amended by striking out, in line 143, the word “118G” and inserting in place thereof the following word:- 118E.

SECTION 30. Clause (23) of said subsection (b) of said section 21 of said chapter 62C, as so appearing, is hereby amended by striking out, in line 145, the words “division of health care finance and policy” and inserting in place thereof the following words:- executive office of health and human services.

SECTION 31. Said clause (23) of said subsection (b) of said section 21 of said chapter 62C, as so appearing, is hereby further amended by striking out, in lines 48 and 49, the

words “section 39 of chapter 118G” and inserting in place thereof the following words:- section 69 of chapter 118E.

SECTION 32. Section 1 of chapter 62D of the General Laws, as amended by section 13 of chapter 142 of the acts of 2011, is hereby amended by striking out, in lines 8 to 10, the words “the division of health care finance and policy in the exercise of its duty to administer the uncompensated care pool pursuant to chapter 118G” and inserting in place thereof the following words:- the executive office of health and human services in the exercise of its duty to administer the Health Safety Net Trust Fund under chapter 118E.

SECTION 33. Said section 1 of said chapter 62D, as so amended, is hereby further amended by striking out the words “division of health care finance and policy on behalf of the uncompensated care pool by a person or a guarantor of a person who received free care services paid for in whole or in part by the uncompensated care pool or on whose behalf the uncompensated care pool paid for emergency bad debt, pursuant to subsection (m) of section 18 of chapter 118G” and inserting in place thereof the following words:- executive office of health and human services on behalf of the Health Safety Net Trust Fund by a person or a guarantor of a person who received free care services paid for in whole or in part by the Health Safety Net Trust Fund or on whose behalf said fund paid for emergency bad debt.

SECTION 34. Said section 1 of said chapter 62D, as so amended, is hereby further amended by striking out, in line 55, the words “section 39 of chapter 118G” and inserting in place thereof the following words:- section 69 of chapter 118E.

SECTION 35. Section 8 of said chapter 62D, as appearing in the 2010 Official Edition, is hereby amended by striking out the second paragraph.

SECTION 36. Section 10 of said chapter 62D, as so appearing, is hereby amended by striking out, in lines 8 and 9, the words “the division of medical assistance, the corporation, the office of the state comptroller, and the division of health care finance

and policy” and inserting in place thereof the following words:- the office of medicaid, the corporation, the office of the state comptroller and the executive office of health and human services.

SECTION 37. Section 13 of said chapter 62D, as amended by section 14 of chapter 142 of the acts of 2011, is hereby further amended by striking out the words “section 39 of chapter 118G” and inserting in place thereof the following words:- section 69 of chapter 118E.

SECTION 38. Section 3 of chapter 62E of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 7 and 8, the words “division of health care finance and policy” and inserting in place thereof the following words:- executive office of health and human services.

SECTION 39. Section 12 of said chapter 62E, as so appearing, is hereby amended by striking out, in lines 19 and 20, the words “division of health care finance and policy” and inserting in place thereof the following words:- executive office of health and human services.

SECTION 40. Said section 12 of said chapter 62E, as so appearing, is hereby amended by striking out, in lines 21 to 22, the words “sections 34 to 39, inclusive, of chapter 118G and sections 6B, 6C and 18B of chapter 118G” and inserting in place thereof the following words:- sections 64 to 69, inclusive, of chapter 118E and sections 17 and 18 of chapter 176Q.

SECTION 41. Section 17A of chapter 66 of the General Laws, as so appearing, is hereby amended by striking out, in line 11, the word “118G” and inserting in place thereof the following word:- 118E.

SECTION 42. Section 3 of chapter 71B of the General Laws, as so appearing, is hereby amended by striking out, in line 177, the words “2A of chapter 118G” and inserting in place thereof the following words:- 13C of chapter 118E.

SECTION 43. Section 1 of chapter 111 of the General Laws, as so appearing, is hereby amended by striking out the definition of "Board of health" and inserting in place thereof the following 2 definitions:-

"Allowed amount", the contractually agreed upon amount paid by a carrier to a health care provider for health care services provided to an insured.

"Board of health", shall include the board or officer having like powers and duties in towns where there is no board of health.

SECTION 43A. Said chapter 111 is hereby further amended by inserting after section 2F the following 2 sections:–

Section 2G. (a) There shall be established and set upon the books of the commonwealth a separate fund to be known as the Prevention and Wellness Trust Fund to be expended, without further appropriation, by the department of public health. The fund shall consist of revenues deposited from the general fund, public and private sources such as gifts, grants and donations to further community-based prevention activities, interest earned on such revenues and any funds provided from other sources.

The commissioner of public health, as trustee, shall administer the fund. The commissioner, in consultation with the Prevention and Wellness Advisory Board established under section 2H, shall make expenditures from the fund consistent with subsections (d) and (e); provided, that not more than 10 per cent of the amounts held in the fund in any 1 year shall be used by the department for the combined cost of program administration, technical assistance to grantees or program evaluation.

(b) Revenues deposited in the fund that are unexpended at the end of the fiscal year shall not revert to the General Fund and shall be available for expenditure in the following fiscal year.

(c) All expenditures from the Prevention and Wellness Trust Fund shall support the state's efforts to meet the health care cost growth benchmark established in section 5 of chapter 176S and any activities funded by the Healthcare Payment Reform Fund, and 1 or more of the following purposes: (i) reduce rates of the most prevalent and preventable health conditions; (ii) increase healthy behaviors; (iii) increase the adoption of workplace-based wellness or health management programs that result in positive returns on investment for employees and employers; (iv) address health disparities; or (v) develop a stronger evidence-base of effective prevention programming.

(d) The commissioner shall annually award not less than 75 per cent of the Prevention and Wellness Trust Fund through a competitive grant process to municipalities, community-based organizations, health care providers, and health plans that apply for the implementation, evaluation and dissemination of evidence-based community preventive health activities. To be eligible to receive a grant under this subsection, a recipient shall be: (i) a municipality or group of municipalities working in collaboration; (ii) a community-based organization working in collaboration with 1 or more municipalities; or (iii) a health care provider or a health plan working in collaboration with 1 or more municipalities and a community-based organization. Expenditures from the fund for such purposes shall supplement and not replace existing local, state, private or federal public health-related funding.

(e) A grant proposal submitted under subsection (d) shall include, but not be limited to: (i) a plan that defines specific goals for the reduction in preventable health conditions and health care costs over a multi-year period; (ii) the evidence-based programs the applicant shall use to meet the goals; (iii) a budget necessary to implement the plan, including a detailed description of any funding or in-kind contributions the applicant or applicants will be providing in support of the proposal; (iv) any other private funding or private sector participation the applicant anticipates in support of the proposal; and (v) the anticipated number of individuals that would be affected by implementation of the plan.

Priority may be given to proposals in a geographic region of the state with a higher than average prevalence of preventable health conditions, as determined by the commissioner of public health, in consultation with the Prevention and Wellness Advisory Board. If no proposals were offered in areas of the state with particular need, the department shall ask for a specific request for proposal for that specific region. If the commissioner determines that no suitable proposals have been received, such that the specific needs remain unmet, the department may work directly with municipalities or community-based organizations to develop grant proposals.

The department of public health shall, in consultation with the Prevention and Wellness Advisory Board, develop guidelines for an annual review of the progress being made by each grantee. Each grantee shall participate in any evaluation or accountability process implemented or authorized by the department.

(f) The commissioner of public health may annually expend not more than 10 per cent of the Prevention and Wellness Trust Fund to support the increased adoption of workplace-based wellness or health management programming. The department of public health shall expend such funds for activities including, but not limited to: (i) developing and distributing informational tool-kits for employers, including a model wellness guide developed by the department; (ii) providing technical assistance to employers implementing wellness programs; (iii) hosting informational forums for employers; (iv) promoting awareness of wellness tax credits provided through the state and federal government, including the wellness subsidy provided by the commonwealth health connector authority; (v) public information campaigns that quantify the importance of healthy lifestyles, disease prevention, care management and health promotion programs; and (vi) providing a stipend to employers to help start, grow or maintain wellness programs.

The department of public health shall develop guidelines to annually review progress toward increasing the adoption of workplace-based wellness or health management programming.

(g) The department of public health shall, annually on or before January 31, report on expenditures from the Prevention and Wellness Trust Fund. The report shall include, but not be limited to: (i) the revenue credited to the fund; (ii) the amount of fund expenditures attributable to the administrative costs of the department of public health; (iii) an itemized list of the funds expended through the competitive grant process and a description of the grantee activities; (iv) the results of the evaluation of the effectiveness of the activities funded through grants; and (v) an itemized list of expenditures used to support workplace-based wellness or health management programs. The report shall be provided to the chairs of the house and senate committees on ways and means and the joint committee on public health and shall be posted on the department of public health's website.

(h) The department of public health shall, under the advice and guidance of the Prevention and Wellness Advisory Board, annually report on its strategy for administration and allocation of the fund, including relevant evaluation criteria. The report shall set forth the rationale for such strategy, including, but not limited to: (i) a list of the most prevalent preventable health conditions in the commonwealth, including health disparities experienced by populations based on race, ethnicity, gender, disability status, sexual orientation or socio-economic status; (ii) a list of the most costly preventable health conditions in the commonwealth; (iii) a list of evidence-based or promising community-based programs related to the conditions identified in clauses (i) and (ii); and (iv) a list of evidence-based workplace wellness programs or health management programs related to the conditions in clauses (i) and (ii). The report shall recommend specific areas of focus for allocation of funds. If appropriate, the report shall reference goals and best practices established by the National Prevention and Public Health Promotion Council and the Centers for Disease Control and Prevention, including, but not limited to the national prevention strategy, the healthy people report and the community prevention guide.

(i) The department of public health may promulgate regulations to carry out this section.

Section 2H. There shall be a Prevention and Wellness Advisory Board to make recommendations to the commissioner concerning the administration and allocation of the Prevention and Wellness Trust Fund established in section 2G, establish evaluation criteria and perform any other functions specifically granted to it by law.

The board shall consist 15 members: 1 of whom shall be the commissioner of public health or a designee, who shall serve as chair; 1 of whom shall be the executive director of the institute of health care finance and policy established in chapter 12C or a designee; 1 of whom shall be the secretary of health and human services or a designee; 12 of whom shall be appointed by the governor, 1 of whom shall be a person with expertise in the field of public health economics; 1 of whom shall be a person with expertise in public health research; 1 of whom shall be a person with expertise in the field of health equity; 1 of whom shall be a person from a local board of health for a city or town with a population greater than 50,000; 1 of whom shall be a person of a board of health for a city or town with a population less than 50,000; 2 of whom shall be representatives of health insurance carriers; 1 of whom shall be a person from a consumer health organization; 1 of whom shall be a person from a hospital association; 1 of whom shall be a person from a statewide public health organization; 1 of whom shall be a representative of the interest of businesses; and 1 of whom shall be a person from an association representing community health workers.

SECTION 44. Section 4H of chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 20, the words "division of health care finance and policy" and inserting in place thereof the following words:- executive office of health and human services, or a governmental unit designated by the executive office.

SECTION 45. Said chapter 111 is hereby further amended by striking out section 25A, as so appearing, and inserting in place thereof the following section:-

Section 25A. (a) Every 4 years the department of public health, in consultation with the institute of health care finance and policy, shall submit to the governor and the general

court a 4-year health resource plan. The plan shall identify needs of the commonwealth in health care services, providers, programs and facilities; the resources available to meet those needs; and the priorities for addressing those needs on a statewide basis.

(1) The plan shall include the location, distribution and nature of all health care resources in the commonwealth and shall establish and maintain on a current basis an inventory of all such resources together with all other reasonably pertinent information concerning such resources. For purposes of this section, a health care resource shall include any resource, whether personal or institutional in nature and whether owned or operated by any person, the commonwealth or political subdivision thereof, the principal purpose of which is to provide, or facilitate the provision of, services for the prevention, detection, diagnosis or treatment of those physical and mental conditions experienced by humans which usually are the result of, or result in, disease, injury, deformity, or pain.

The plan shall identify certain categories of health care resources, including acute care units; non-acute care units; specialty care units, including, but not limited to, burn, coronary care, cancer care, neonatal care, post-obstetric and post operative recovery care, pulmonary care, renal dialysis and surgical, including trauma, intensive care units; skilled nursing facilities; home health, behavioral health and mental health services; treatment and prevention services for alcohol and other drug abuse; emergency care; ambulatory care services; primary care resources; pharmacy and pharmacological services; family planning services; obstetrics and gynecology services; allied health services including, but not limited to, optometric care, chiropractic services, dental care, midwifery services; federally qualified health centers and free clinics; numbers of technologies or equipment defined as innovative services or new technologies by the department under section 25C; and health screening and early intervention services.

(2) The plan shall make recommendations for the appropriate supply and distribution of resources, programs, capacities, technologies and services identified in paragraph (1) based on an assessment of need for the next 4 years and options for implementing such recommendations and mechanisms. The recommendations shall

reflect at least the following goals: to maintain and improve the quality of health care services; to support the state's efforts to meet the health care cost growth benchmark established under section 5 of chapter 176S; to support innovative health care delivery and alternative payment models as identified by the institute of health care finance and policy; to reduce unnecessary duplication; to support universal access to community-based preventative and patient-centered primary health care; to reduce health disparities; to support efforts to integrate mental health and substance abuse services with overall medical care; to reflect the latest trends in utilization and support the best standards of care; and to rationally distribute health care resources across geographic regions of state based on the needs of the population on a statewide basis as well as the needs of particular geographic areas of the state.

(b) To prepare the plan, the commissioner shall assemble an advisory committee of no more than 13 members who shall reflect a broad distribution of diverse perspectives on the health care system, including health care professionals, third-party payers, both public and private, and consumer representatives. The advisory committee shall review drafts and provide recommendations to the commissioner during the development of the plan.

The department, with the advisory committee, shall conduct at least 5 public hearings, in different regions of the state, with not less than 2 within the following counties: Berkshire, Franklin, Hampden, and Hampshire, on the plan as proposed and shall give interested persons an opportunity to submit their views orally and in writing. In addition, the department may create and maintain a website to allow members of the public to submit comments electronically and review comments submitted by others.

The department shall develop a mechanism for receiving ongoing public comment regarding the plan and for revising it every 4 years or as needed.

(c)The department shall issue guidelines, rules, or regulations consistent with the state health plan for making determinations of need. If the commissioner determines that statutory changes are necessary to implement the plan, the

commissioner shall submit legislative language to the joint committee on public health and the joint committee on health care financing.

(d) The inventory complied under subsection (a) and all related information shall be maintained in a form usable by the general public in a designated office of the department, shall constitute a public record and shall be coordinated with information collected by the department under other provisions of law, federal census information and other vital statistics from reliable sources; provided, however, that any item of information which is confidential or privileged in nature or under any other provision of law shall not be regarded as a public record under this section.

(e) The department may require health care resources to provide information for the purposes of this section and may prescribe by regulation uniform reporting requirements. In prescribing such regulations the department shall strive to make any reports required under this section of mutual benefit to those providing as well as those using such information and shall avoid placing any burdens on such providers which are not reasonably necessary to accomplish this section.

Agencies of the commonwealth which collect cost or other data concerning health care resources shall cooperate with the department in coordinating such data with information collected under this section.

(f) The department shall publish analyses, reports and interpretations of information collected under this section to promote awareness of the distribution and nature of health care resources in the commonwealth.

(g) In the performance of its duties, the department, subject to appropriation, may enter into such contracts with agencies of the federal government, the commonwealth or any political subdivision thereof and public or private bodies, as it deems necessary; provided, however, that no information received under such a contract shall be published or relied upon for any purpose by the department unless the department has determined such information to be reasonably accurate by statistical

sampling or other suitable techniques for measuring the reliability of information-gathering processes.

(h) The department of public health may establish an Amyotrophic Lateral Sclerosis registry, by areas and regions of the commonwealth, with specific data to be obtained from urban, low and median income communities and minority communities of the commonwealth.

SECTION 46. Section 25B of said chapter 111, as so appearing, is hereby amended by striking out, in lines 23 and 24, the words “1 of chapter 118G” and inserting in place thereof the following words:- 8 of chapter 118E.

SECTION 47. Said chapter 111 is hereby further amended by striking out section 25C, as so appearing, and inserting in place thereof the following section:-

Section 25C. (a) Notwithstanding any general or special law to the contrary, except as provided in section 25 C½, no person or agency of the commonwealth or any political subdivision thereof shall make substantial capital expenditures for construction of a health care facility or substantially change the service of such facility unless there is a determination by the department that there is need for such construction or change. No such determination of need shall be required for any substantial capital expenditure for construction or any substantial change in service which shall be related solely to the conduct of research in the basic biomedical or applied medical research areas and shall at no time result in any increase in the clinical bed capacity or outpatient load capacity of a health care facility and shall at no time be included within or cause an increase in the gross patient service revenue of a facility for health care services, supplies and accommodations, as such revenue shall be defined under section 31 of chapter 6A. Any person undertaking any such expenditure related solely to such research which shall exceed or may reasonably be regarded as likely to exceed $150,000 or any such change in service solely related to such research, shall give written notice of the expenditure or change in service to the department and the institute of health care finance and policy at least 60 days before undertaking such expenditure or change in

service. Said notice shall state that such expenditure or change shall be related solely to the conduct of research in the basic biomedical or applied medical research areas and shall at no time be included within or result in any increase in the clinical bed capacity or outpatient load capacity of a facility and shall at no time cause an increase in the gross patient service revenue, as defined in under said section 31 of said chapter 6A, of a facility for health care services, supplies and accommodations; provided, however, that if it is subsequently determined that there was a violation of this section, the applicant may be punished by a fine of not more than three times the amount of such expenditure or value of said change of service.

(b) Notwithstanding subsection (a), a determination of need shall be required for any such expenditure or change if the notice required by this section is not filed in accordance with the requirements of this section or if the department finds, after receipt of said notice, that such expenditure or change will not be related solely to research in the basic biomedical or applied medical research areas, will result in an increase in the clinical bed capacity or outpatient load capacity of a facility or will be included within or cause an increase in the gross patient service revenues of a facility. A research exemption granted under this section shall not be deemed to be evidence of need in any determination of need proceeding.

(c) No person or agency of the commonwealth or any political subdivision thereof shall provide an innovative service or use a new technology, in any location other than in a health care facility, unless the person or agency first is issued a determination of need for such innovative service or new technology by the department.

(d) No person or agency of the commonwealth or any political subdivision thereof shall acquire for location in other than a health care facility a unit of medical, diagnostic, or therapeutic equipment, other than equipment used to provide an innovative service or which is a new technology, with a fair market value in excess of $150,000 unless the person or agency notifies the department of the person’s or

agency’s intent to acquire such equipment and of the use that will be made of the equipment. Such notice shall be made in writing and shall be received by the department at least 30 days before contractual arrangements are entered into to acquire the equipment with respect to which notice is given. A determination by the department of need for such equipment shall be required for any such acquisition (i) if the notice required by this subsection is not filed in accordance with the requirements of this subsection; and (ii) if the requirements for exemption under subsection (a) of section 25 C½ are not met; provided, however, that in no event shall any person who acquires a unit of magnetic resonance imaging equipment for location other than in a health care facility refer or influence any referrals of patients to said equipment, unless said person is a physician directly providing services with that equipment; provided, however, that for the purposes of this section, no public advertisement shall be deemed a referral or an influence of referrals; and provided, further, that any person who has an ownership interest in said equipment, whether direct or indirect, shall disclose said interest to patients utilizing said equipment in a conspicuous manner.

(e) Each person or agency operating a unit of equipment described in this section shall submit annually to the department information and data in connection with utilization and volume rates of said equipment on a form or forms prescribed by the department.

(f) Except as provided in section 25 C½, no person or agency of the commonwealth or any political subdivision thereof shall acquire an existing health care facility unless the person or agency notifies the department of the person’s or agency’s intent to acquire such facility and of the services to be offered in the facility and its bed capacity. Such notice shall be made in writing and shall be received by the department at least 30 days before contractual arrangements are entered into to acquire the facility with respect to which the notice is given. A determination of need shall be required for any such acquisition if the notice required by this subsection is not filed in accordance with the requirements of this subsection or if the department finds, within 30 days after

receipt of notice under this subsection, that the services or bed capacity of the facility will be changed in being acquired.

(g) In making any such determination, the department shall encourage appropriate allocation of private and public health care resources and the development of alternative or substitute methods of delivering health care services so that adequate health care services will be made reasonably available to every person within the commonwealth at the lowest reasonable aggregate cost, shall take into account any comments from the institute of health care finance and policy pursuant to section 17 of chapter 12C, and shall take into account the special needs and circumstances of HMOs. The department shall also recognize the special needs and circumstances of projects that (1) are essential to the conduct of research in basic biomedical or health care delivery areas or to the training of health care personnel; (2) are deemed consistent with the recommendations of the state health resource plan filed by the department under section 25A; (3) are unlikely to result in any increase in the clinical bed capacity or outpatient load capacity of the facility; and (4) are unlikely to cause an increase in the total patient care charges of the facility to the public for health care services, supplies and accommodations, as such charges shall be defined under section 5 of chapter 409 of the acts of 1976.

(h) Applications for such determination shall be filed with the department, together with such other forms and information as shall be prescribed by, or acceptable to, the department. A duplicate copy of any application together with supporting documentation for such application, shall be a public record and kept on file in the department. The department may require a public hearing on any application. A reasonable fee, established by the department, shall be paid upon the filing of such application; provided, that in no event shall such fee exceed .1 per cent of the capital expenditures, if any, proposed by the applicant. The department may also require the applicant to provide an independent cost-analysis, conducted at the expense of the applicant, to demonstrate that the application is consistent with the commonwealth's

efforts to meet the health care cost-containment goals established by the institute of health care finance and policy.

(i) Except in the case of an emergency situation determined by the department as requiring immediate action to prevent further damage to the public health or to a health care facility, the department shall not act upon an application for such determination unless: (1) the application has been on file with the department for at least 30 days; (2) the institute of health care finance and policy, the state and appropriate regional comprehensive health planning agencies and, in the case of long-term care facilities only, the department of elder affairs, or in the case of any facility providing inpatient services for the mentally ill or developmentally disabled, the departments of mental health or developmental services, respectively, have been provided copies of such application and supporting documents and given reasonable opportunity to comment on such application; and (3) a public hearing has been held on such application when requested by the applicant, the state or appropriate regional comprehensive health planning agency or any 10 taxpayers of the commonwealth. If, in any filing period, an individual application is filed which would implicitly decide any other application filed during such period, the department shall not act only upon an individual.

(j) The department shall so approve or disapprove in whole or in part each such application for a determination of need within 8 months after filing with the department; provided that the department may, on 1 occasion only, delay such action for up to 2 months after the applicant has provided information which the department reasonably has requested during such 8 month period. Applications remanded to the department by the health facilities appeals board under section 25E shall be acted upon by the department within the same time limits provided in this section for the department to approve or disapprove applications for a determination of need. If an application has not been acted upon by the department within such time limits, the applicant may, within a reasonable period of time, bring an action in the nature of mandamus in the superior court to require the department to act upon the application.

(k) Determinations of need shall be based on the written record compiled by the department during its review of the application and on such criteria consistent with sections 25B to 25G, inclusive, as were in effect on the date of filing of the application. In compiling such record the department shall confine its requests for information from the applicant to matters which shall be within the normal capacity of the applicant to provide. In each case the action by the department on the application shall be in writing and shall set forth the reasons for such action; and every such action and the reasons for such action shall constitute a public record and be filed in the department.

(l) The department shall stipulate the period during which a determination of need shall remain in effect, which in no event shall originally be longer than 3 years but which may be extended by the department for cause shown. Any such determination shall continue to be effective only upon the applicant: (i) making reasonable progress toward completing the construction or substantial change in services for which need was determined to exist; (ii) complying with all other laws relating to the construction, licensure and operation of health care facilities; and (iii) complying with such further terms and conditions as the department reasonably shall require.

(m) The department shall notify the secretary of elder affairs forthwith of the pendency of any proceeding, of any public hearing and of any action to be taken under this section on any application submitted by or on behalf of any long-term care facility.

(n) No long-term care facility located in an under-bedded urban area shall be replaced or the license for said facility transferred outside an under-bedded urban area. For the purposes of this subsection, an under-bedded urban area shall mean a city or town in which: (i) the per capita income is below the state average; (ii) the percentage of the population below 100 per cent of the federal poverty level is above the state average; or (iii) the percentage of the population below 200 per cent of the federal poverty level is above the state average.

SECTION 48. Section 51 of said chapter 111, as so appearing, is hereby amended by striking out, in lines 25 and 26, the words “division of health care finance and policy”

and inserting in place thereof the following words:- commonwealth health insurance connector.

SECTION 49. Said section 51 of said chapter 111, as so appearing, is hereby further amended by striking out, in lines 25, 36 and 46, the word “division” and inserting in place thereof, in each instance, the following word:- institute.

SECTION 50. Said section 51 of said chapter 111, as so appearing, is hereby further amended by striking out, in lines 27 and 28, the words “pursuant to section 18 of chapter 118G”.

SECTION 51. Section 51G of said chapter 111, as so appearing, is hereby amended by inserting after the words “or services,”, in line 38, the following words:- conduct a public hearing on the closure of said essential services or of the hospital. The department shall.

SECTION 52. Said chapter 111 is hereby further amended by inserting after section 51H the following 2 sections:–

Section 51I. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:-

“Adverse event”, injury to a patient resulting from a medical intervention, and not to the underlying condition of the patient.

“Checklist of care”, pre-determined steps to be followed by a team of healthcare providers before, during and after a given procedure to decrease the possibility of patient harm by standardizing care.

“Facility,” a hospital, institution maintaining an Intensive Care Unit, institution providing surgical services or clinic providing ambulatory surgery.

(b) The department shall encourage the development and implementation of checklists of care that prevent adverse events and reduce healthcare-associated infection rates. The department shall develop model checklists of care, which may be implemented by facilities; provided however, that facilities may develop and implement checklists independently.

(c) Facilities shall report data and information relative to their use or non-use of checklists to the department and the Betsy Lehman center for patient safety and medical error reduction. The department may consider facilities that use similar programs to be in compliance. Reports shall be made in the manner and form established by the department. The department shall publicly report on individual hospitals' compliance rates.

Section 51J. The department shall promulgate regulations regarding limited services clinics. Such regulations shall promote the availability of limited services clinics as a point of access for health care services within the full scope of practice of a nurse practitioner or other clinician providing services.

SECTION 52A. Section 52 of chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting, after the definition of "Institution for unwed mothers" the following 2 definitions:-

"Limited services", diagnosis, treatment, management, monitoring of acute and chronic disease, wellness and preventative services of a nature that may be provided within the scope of practice of a nurse practitioner or other clinician providing services using available facilities and equipment, including shared toilet facilities for point-of-care testing.

"Limited services clinic", a clinic that provides limited services.

SECTION 53. Said chapter 111 is hereby further amended by inserting, after section 53G, the following section:-

Section 53H. No hospital shall enter into a contract or agreement, which creates or establishes a partnership, employment or any other professional relationship with a licensed physician that would prohibit or limit the ability of said physician to provide testimony in an administrative or judicial hearing, including cases of medical malpractice.

SECTION 54. Section 204 of said chapter 111, as so appearing, is hereby amended by adding the following subsection:-

(f) This section shall apply to any committee formed by an individual or group to perform the duties or functions of medical peer review, notwithstanding the fact that the formation of the committee is not required by law or regulation or that the individual or group is not solely affiliated with a public hospital, licensed hospital, nursing home or health maintenance organization.

SECTION 55. Subsection (a) of section 217 of said chapter 111, as so appearing, is hereby amended by striking out, in line 33, the word “and”.

SECTION 56. Said subsection (a) of said section 217 of said chapter 111, as so appearing, is hereby further amended by adding the following 3 paragraphs:-

(8) have the authority to promulgate regulations establishing safeguards to protect consumers from inappropriate denials of services or treatment in connection with utilization of any alternative payment methodologies, as defined in section 1 of chapter 12C;

(9) have the authority to promulgate regulations, in consultation with the division of insurance, establishing safeguards against, and penalties for, inappropriate selection of low cost patients and avoidance of high cost patients by any provider or provider organization accepting alternative payment methodologies, as such terms are defined in section 1 of chapter 12C; and

(10) regulate the appeals processes established in section 23 of chapter 176O and establish, by regulation, minimum standards for fair, fast and objective review of

consumer grievances against provider organizations registered under section 10 of chapter 12C including, but not limited to, complaint and appeals processes regarding health care personnel, facilities, treatment quality, restrictions on patient choice and denials of services or treatments.

SECTION 57. Section 1 of chapter 111M of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 46, at the end of the definition of the term "Creditable coverage" the following:-

Minimum creditable coverage, as defined by the board under the authority granted herein, shall not require, in the case of individuals subject to chapter 58 of the acts of 2006, coverage for prescription drugs.

SECTION 58. Chapter 112 of the General Laws, is hereby amended by inserting, after section 2C, the following section:-

Section 2D. No physician shall enter into a contract or agreement, which creates or establishes a partnership, employment or any other form of professional relationship that prohibits a physician from providing testimony in an administrative or judicial hearing, including cases of medical malpractice.

SECTION 58A. Section 5 of Chapter 112 of the General Laws is hereby amended by striking out paragraphs 6 through 8, inclusive, and inserting in place thereof the following four paragraphs: -

The board shall collect the following information reported to it to create individual profiles on licensees and former licensees, in a format created by the board that shall be available for dissemination to the public:

(a) a description of any criminal convictions for felonies and serious misdemeanors as determined by the board. For the purposes of this subsection, a

person shall be deemed to be convicted of a crime if he pleaded guilty or if he was found or adjudged guilty by a court of competent jurisdiction;

(b) a description of any charges for felonies and serious misdemeanors as determined by the board to which a physician pleads nolo contendere or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction;

(c) a description of any final board disciplinary actions, and a copy of any original board disciplinary orders;

(d) a description of any final disciplinary actions by licensing boards in other states;

(e) a description of revocation or involuntary restriction of privileges by a hospital, clinic or nursing home under the provisions of chapter 111, or of any employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth, for reasons related to competence or character that have been taken by the hospital, clinic or nursing home or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth governing body or any other official of the hospital, clinic or nursing home or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth after procedural due process has been afforded, or the resignation from or nonrenewal of medical staff membership or the restriction of privileges at a hospital, clinic or nursing home or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth taken in lieu of or in settlement of a pending disciplinary case related to competence or character in that hospital, clinic or nursing home or of any employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth ;

(f) all medical malpractice court judgments and all medical malpractice arbitration awards in which a payment is awarded to a complaining party and all settlements of medical malpractice claims in which a payment is made to a complaining party. Dispositions of paid claims shall be reported in a minimum of three graduated categories indicating the level of significance of the award or settlement. Information concerning paid medical malpractice claims shall be put in context by comparing an individual licensee's medical malpractice judgment awards and settlements to the experience of other physicians within the same specialty. Information concerning all settlements shall be accompanied by the following statement: "Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred." Nothing herein shall be construed to limit or prevent the board from providing further explanatory information regarding the significance of categories in which settlements are reported.

Pending malpractice claims shall not be disclosed by the board to the public. Nothing herein shall be construed to prevent the board from investigating and disciplining a licensee on the basis of medical malpractice claims that are pending.

(g) names of medical schools and dates of graduation;

(h) graduate medical education;

(i) specialty board certification;

(j) number of years in practice;

(k) names of the hospitals where the licensee has privileges;

(l) appointments to medical school faculties and indication as to whether a licensee has a responsibility for graduate medical education within the most recent ten years;

(m) information regarding publications in peer-reviewed medical literature within the most recent ten years;

(n) information regarding professional or community service activities and awards;

(o) the location of the licensee's primary practice setting;

(p) the identification of any translating services that may be available at the licensee's primary practice location;

(q) an indication of whether the licensee participates in the medicaid program.

The board shall provide individual licensees with a copy of their profiles prior to release to the public. A licensee shall be provided a reasonable time to correct factual inaccuracies that appear in such profile.

A physician may elect to have his profile omit certain information provided pursuant to clauses (l) to (n), inclusive, concerning academic appointments and teaching responsibilities, publication in peer-reviewed journals and professional and community service awards. In collecting information for such profiles and in disseminating the same, the board shall inform physicians that they may choose not to provide such information required pursuant to said clause (l) to (n), inclusive.

For physicians who are no longer licensed by the board, the board shall continue to make available the profiles of such physicians, except for those who are known by the board to be deceased. The board shall maintain the information contained in the profiles of physicians no longer licensed by the board as of the date the physician was

last licensed, and include on the profile a notice that the information is current only to that date.

SECTION 59. Said chapter 112 is hereby further amended by inserting after section 80H the following section:-

Section 80I. When a law or rule requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, when relating to physical or mental health, that requirement may be fulfilled by a nurse practitioner practicing under section 80B. Nothing in this section shall be construed to expand the scope of practice of nurse practitioners. This section shall not be construed to preclude the development of mutually agreed upon guidelines between the nurse practitioner and supervising physician under section 80E.

SECTION 60. Chapter 118E of the General Laws is hereby amended by inserting after section 9E the following section:-

Section 9F. (a) As used in this section, the following words shall have the following meanings:-

"Dual eligible", or "dually eligible person", any person age 21 or older and under age 65 who is enrolled in both Medicare and either MassHealth or CommonHealth; provided that the executive office may include within the definition of dual eligible any person enrolled in MassHealth or CommonHealth who also receives benefits under Title II of the Social Security Act on the basis of disability and will be eligible for Medicare within 24 months, provided that the executive office may limit eligibility to those who will be eligible for Medicare within a prescribed number of months that is less than 24.

"Integrated care organization" or "ICO", a comprehensive network of medical, health care and long term services and supports providers that integrates all components of care, either directly or through subcontracts and has been contracted with by the

Executive Office of Health and Human Services and designated an ICO to provide services to dually eligible individuals pursuant to this section.

(b) Members of the MassHealth dual eligible pilot program on ICOs or any successor program integrating care for dual eligible persons shall be provided an independent community care coordinator by the ICO or successor organization, who shall be a participant in the member's care team. The community care coordinator shall assist in the development of a long term support and services care plan. The community care coordinator shall:

(1) participate in initial and ongoing assessments of the health and functional status of the member, including determining appropriateness for long term care support and services, either in the form of institutional or community-based care plans and related service packages necessary to improve or maintain enrollee health and functional status;

(2) arrange and, with the agreement of the member and the care team, coordinate and authorize the provision of appropriate institutional and community long term supports and services, including assistance with the activities of daily living and instrumental activities of daily living, housing, home-delivered meals, transportation, and under specific conditions or circumstances established by the ICO or successor organization, authorize a range and amount of community-based services; and

(3) monitor the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate by the member and the care team; and track member satisfaction and the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate by the member and the care team.

(c) The ICO or successor organization shall not have a direct or indirect financial ownership interest in an entity that serves as an independent care coordinator. Providers of institutional or community based long term services and supports on a

compensated basis shall not function as an independent care coordinator, provided however that the secretary may grant a waiver of this restriction upon a finding that public necessity and convenience require such a waiver. An individual who becomes dually eligible after the age of 60 shall receive independent care coordination services pursuant to section 4B of chapter 19 A. For the purposes of this section, an organization compensated to provide only evaluation, assessment, coordination and fiscal intermediary services shall not be considered a provider of long term services and supports.

SECTION 61. Subsection (c) of section 188 of said chapter 149 is hereby amended by inserting at the end thereof the following paragraph:-

(11) For the purpose of the fair share contribution compliance test, an employer may count employees that have qualifying health insurance coverage from a spouse, a parent, a veteran's plan, Medicare, Medicaid, or a plan or plans due to a disability or retirement towards their qualifying take-up rate as a "contributing employer", as defined by the Institute of Health Care Finance and Policy. The employer is still required to offer group medical insurance and must keep and maintain proof of their employee's insurance status.

SECTION 62. Section 1 of chapter 175, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 15, after the word "commonwealth", the following definition:-

"Flexible health benefit policy" means a health insurance policy that in whole or in part, does not offer state mandated health benefits.; and

by inserting in line 30, after the word "inclusive", the following definition:

"Policy of Accident and Sickness Insurance," any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of this chapter.; and

by inserting, in line 38, after the word “context”, the following definition:

“State mandated health benefits" means coverage required or required to be offered in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;
2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or
3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

SECTION 62A. Chapter 175 of the General Laws is hereby amended by inserting after section 47AA the following section:-

Section 47BB. For the purposes of this section, “telemedicine“ as it pertains to the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. “Telemedicine” shall not include the use of audio-only telephone, facsimile machine or e-mail.

An insurer may limit coverage of telemedicine services to those health care providers in a telemedicine network approved by the insurer.

A contract that provides coverage for services under this section may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

Coverage for health care services under this section shall be consistent with coverage for health care services provided through in-person consultation.

SECTION 63. Section 108 of said chapter 175, as so appearing, is hereby amended by inserting after subsection 12 the following subsection:-

13. A carrier authorized to transact individual policies of accident or sickness insurance under this section may offer a flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the carrier shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

SECTION 64. Section 110 of said chapter 175, as so appearing, is hereby amended by inserting after subsection (P) the following:-

(Q) A carrier authorized to transact group policies of accident or sickness insurance under this section may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the carrier shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group policyholder the option of purchasing at least on health insurance policy that provides all state mandated benefits. The carrier shall provide each subscriber under a group policy upon enrollment with written notice stating that this a flexible health benefit policy and describing the state mandated health benefits that are not included in the policy.

SECTION 65. Said chapter 175, as so appearing, is hereby amended by inserting after section 111H the following:-

Section 111I. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance solely on the basis that it does not include coverage for at least 1 mandated benefit.

(b) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A) diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance that does not include coverage for at least one mandated benefit unless the carrier continues to offer at least one policy that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a policy of accident and sickness insurance to any employee within 12 months.

SECTION 65A. The requirements of section 47BB of chapter 175 of the General Laws shall apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed on or after January 1, 2013. For purposes of that section, all contracts shall be deemed to be renewed not later than the next yearly anniversary of the contract date.

SECTION 65B. Section 3 of chapter 175H of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting before the word "Any", in line 1, the following:- (a).

SECTION 65C. Said section 3 of said chapter 175H, as so appearing, is hereby further amended by inserting after word "rebate", in line 7, the following words:- , except as provided in subsection (b).

SECTION 65D. Said section 3 of said chapter 175H, as so appearing, is hereby further 7 amended by adding the following 3 subsections:-

(b) (1) This section shall not apply to any discount or free product vouchers that a retail pharmacy provides to a consumer in connection with a pharmacy service, item or prescription transfer offer or to any discount, rebate, product voucher or other reduction in an individual's out-of-pocket expenses, including co-payments and deductibles, on (i) any biological product as defined in section 351 of the Public Health Service Act, 42 USC 262, or (ii) any prescription drug provided by a pharmaceutical manufacturing company, as defined in section 1 of chapter 111N, that is made available to an individual if the discount, rebate, product voucher or other reduction is provided directly or electronically to the individual or through a point of sale or mail-in rebate, or through similar means; provided, however, that a pharmaceutical manufacturing

company shall not exclude nor favor any pharmacy in the redemption of such discount, rebate, product voucher or other expense reduction offer to a consumer.

(2) Pharmaceutical manufacturing companies are prohibited from offering any discount, rebate, product voucher or other reduction in an individual's out-of-pocket expenses, including co-payments and deductibles, for any prescription drug that has an AB rated generic equivalent as determined by the Food and Drug Administration.

(c) Subsection (b) shall not: (i) restrict a pharmaceutical manufacturing company with regard to how it distributes a prescription drug, biologic or vaccine; or (ii) restrict a carrier or a health maintenance organization, as defined in section 1 of chapter 118G, with regard to how its plan design will treat such discounts, rebates, product voucher or other reduction in out-of-pocket expenses; or (iii) affect in any way the obligations of practitioners and pharmacists pursuant to the generic substitution statute as defined in section 12D of chapter 112.

(d) For purposes of the federal Health Insurance Portability and Accountability Act of 1996, hereinafter referred to as HIPAA, and regulations promulgated under HIPAA, nothing in this section shall be deemed to require or allow the use or disclosure of health information in any manner that does not otherwise comply with HIPAA or regulations promulgated under HIPAA.

SECTION 66. Chapter 176A, as appearing in the 2010 Official Edition, is hereby amended by adding after section 1D the following sections:-

Section 1E. Definitions

The following words, as used in this chapter, unless the text otherwise requires or a different meaning is specifically required, shall mean-

"Flexible health benefit policy," a health insurance policy that in whole or in part, does not offer state mandated health benefits.

"State mandated health benefits," coverage required or required to be offered in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;
2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or
3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

“Policy of Accident and Sickness Insurance,” any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of chapter 175 of the general laws.

Section 1F. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a contract between a subscriber and the corporation under an individual or group hospital services plan solely on the basis that it does not include coverage for at least one mandated benefit.

(b) The commissioner shall not approve a contract unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A) diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided

however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a contract that does not include coverage for at least one mandated benefit unless the corporation continues to offer at least one contract that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a hospital services plan, to any employee within 12 months.

SECTION 67. Section 8 of chapter 176A, as so appearing, is hereby amended by inserting after subsection (g) the following:—

(h) A non-profit hospital service corporation authorized to transact individual policies of accident or sickness insurance under this section may offer a one flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the non-profit hospital service corporation shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

(i) A non-profit hospital service corporation authorized to transact group policies of accident or sickness insurance under this section may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the non-profit hospital service corporation shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group policyholder the option of purchasing at least on health insurance policy that provides all state mandated benefits. The non-profit hospital service corporation shall provide each subscriber under a group policy upon enrollment with written notice stating that this a flexible health benefit policy and describing the state mandated health benefits that are not included in the policy.

"SECTION 68. Section 1 of Chapter 176B, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 11, after the word "support", the following new definition:—

"Flexible health benefit policy" means a health insurance policy that in whole or in part, does not offer state mandated health benefits.

; and, further, in line 56, after the word "corporation", the following definition:

"Policy of Accident and Sickness Insurance," any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of chapter 175 of the general laws.

; and, further, in line 62, after the word "twelve", the following definition:

"State mandated health benefits" means coverage required or required to be offered in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;
2. places limitations or restrictions on deductibles, coinsurance, copayments,

or any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

SECTION 69. Section 4 of chapter 176B, as so appearing, is hereby amended by inserting the following paragraphs at the end thereof:—

A medical service corporation authorized to transact individual policies of accident or sickness insurance under this chapter may offer a one flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the medical service corporation shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

A medical service corporation authorized to transact group policies of accident or sickness insurance under this section may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the medical service corporation shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group policyholder the option of purchasing at least on health insurance policy that provides all state mandated benefits.

The medical service corporation shall provide each subscriber under a group policy upon enrollment with written notice stating that this a flexible health benefit policy and describing the state mandated health benefits that are not included in the policy.

SECTION 70. Said chapter 176B, as so appearing, is hereby amended by inserting after section 6B the following section:-

Section 6C. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a subscription certificate solely on the basis that it does not include coverage for at least one mandated benefit.

(b) The commissioner shall not approve a subscription certificate unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A) diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a subscription certificate that does not include coverage for at least 1 mandated benefit unless the corporation continues to offer at least one subscription certificate that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a subscription certificate, to any employee within 12 months.

SECTION 71. Section 1 of chapter 176G, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 42, after the word “entitled” the following new definition:—

“Flexible health benefit policy” means a health insurance policy that in whole or in part, does not offer state mandated health benefits.

; and, further, in line 102, after the words “chapter 175”, the following definitions:

“Policy of Accident and Sickness Insurance,” any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of chapter 175 of the general laws.

"State mandated health benefits" means coverage required or required to be offered in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;
2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or
3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

SECTION 72. Section 4 of chapter 176G, as appearing in the 2010 Official Edition, is hereby amended by adding the following paragraph at the end thereof:—

A health maintenance organization authorized to transact individual policies of accident or sickness insurance under this chapter may offer a one flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the health maintenance organization shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

SECTION 73. Chapter 176G, as appearing in the 2010 Official Edition is hereby amended by inserting after section 4V the following section:-

Section 4W. A health maintenance organization authorized to transact group policies of accident or sickness insurance under this chapter may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the health maintenance organization shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group policyholder the option of purchasing at least one health insurance policy that provides all state mandated benefits. The health maintenance organization shall provide each subscriber under a group policy upon enrollment with written notice stating that this a flexible health benefit policy and describing the state mandated health benefits that are not included in the policy.

SECTION 74. Chapter 176G of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after Section 16B the following section:-

Section 16C. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a health maintenance contract solely on the basis that it does not include coverage for at least 1 mandated benefit.

(b) The commissioner shall not approve a health maintenance contract unless it provides coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A) diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a health maintenance contract that does not include coverage for at least one mandated benefit unless the health maintenance organization continues to offer at least one health maintenance contract that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out the provisions of this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a health maintenance contract, to any employee within 12 months.

SECTION 75. Section 1 of chapter 176M, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 101, after the word “claims” the following new definition:—

“Flexible health benefit policy” means a health insurance that, in whole or in part, does not offer state mandated health benefits.

; and, further, in line 255, after the word “basis”, the following definition:

"State mandated health benefits" means coverage required to be offered any general or special law that:

1. includes coverage for specific health care services or benefits;
2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or
3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

SECTION 76. Section 2 of chapter 176M, as appearing in the 2010 Official Edition, is hereby further amended by striking out the first sentence of subsection (d) and inserting in place thereof the following:-

A carrier that participates in the nongroup health insurance market shall make available to eligible individuals a standard guaranteed health plan established pursuant to paragraph (c) and may additionally make available to eligible individuals no more than two alternative guaranteed issue health plans, one of which may be a flexible health benefit policy, with benefits and cost sharing requirements, including deductibles, that differ from the standard guaranteed issue health plan.

SECTION 76A. Chapter 176O is hereby amended by inserting after section 5B the following section:-

Section 5C. If the commissioner determines that a carrier is neglecting to comply with the coding standards and guidelines under this chapter in the form and within the time required the commissioner shall notify the carrier of such neglect. If the carrier does not come into compliance, within a period determined by the commissioner, the carrier shall be fined $5000 for each day during which such neglect continues.

SECTION 77. Section 16 of said chapter 176O, as so appearing, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) A carrier shall be required to pay for health care services ordered by a treating physician or a primary care provider if: (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary. A carrier may develop guidelines to be used in applying the standard of medical necessity, as defined in this subsection. Any such medical necessity guidelines utilized by a carrier in making coverage determinations shall be: (i) developed with input from practicing physicians and participating providers in the carrier's or utilization review organization's service area; (ii) developed under the standards adopted by national accreditation organizations; (iii) updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier shall consider the individual health care needs of the insured. Any such medical necessity guidelines criteria shall be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website to subscribers, health care providers and the general public. If a carrier or utilization review organization intends either to implement a new medical necessity guideline or amend an existing requirement or restriction, the carrier or utilization review organization shall ensure that the new or amended requirement or restriction shall not be implemented unless the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction.

SECTION 78. Section 21 of said chapter 176O, as so appearing, is hereby further amended by striking out subsection (d) and inserting in place thereof the following 2 subsections:-

(d) If a carrier reports a risk-based capital ratio on a combined entity basis under subsection (a) that exceeds 700 per cent, the division shall hold a public hearing within 60 days of receiving such report. The carrier shall submit testimony on how the carrier will dedicate any additional surplus above the 700 per cent level to reducing the cost of health benefit plans or for health care quality improvement, patient safety or health cost containment programs consistent with the activities of the institute of health care finance and policy. The division shall review such testimony and issue a final report on the results of the hearing.

(e) The commissioner may waive specific reporting requirements in this section for classes of carriers for which the commissioner deems such reporting requirements to be inapplicable; provided, however, that the commissioner shall provide written notice of any such waiver to the joint committee of health care financing and the house and senate committees on ways and means.

SECTION 79. Section 60K of chapter 231 of the General Laws, as so appearing, is hereby amended by striking out, in line 14, the figure “4” and inserting in place thereof the following figure:- 2.

SECTION 80. Said chapter 231 is hereby amended by inserting after section 60K, the following 3 sections:-

Section 60L. (a) Except as provided in this section, a person shall not commence an action against a provider of health care as defined in the seventh paragraph of section 60B unless the person has given the health care provider written notice under this section of not less than 182 days before the action is commenced.

(b) The notice of intent to file a claim required under subsection (a) shall be mailed to the last known professional business address or residential address of the health care provider who is the subject of the claim.

(c) The 182 day notice period in subsection (a) shall be shortened to 90 days if:

(1) the claimant has previously filed the 182 day notice required against another health care provider involved in the claim; or

(2) the claimant has filed a complaint and commenced an action alleging medical malpractice against 1 or more of the health care providers involved in the claim.

(d) The 182 day notice of intent required in subsection (a) shall not be required if the claimant did not identify and could not reasonably have identified a health care provider to which notice shall be sent as a potential party to the action before filing the complaint;

(e) The notice given to a health care provider under this section shall contain, but need not be limited to, a statement including:

(1) the factual basis for the claim;

(2) the applicable standard of care alleged by the claimant;

(3) the manner in which it is claimed that the applicable standard of care was breached by the health care provider;

(4) the alleged action that should have been taken to achieve compliance with the alleged standard of care;

(5) the manner in which it is alleged the breach of the standard of care was the proximate cause of the injury claimed in the notice; and

(6) the names of all health care providers that the claimant is notifying under this section in relation to a claim.

(f) Not later than 56 days after giving notice under this section, the claimant shall allow the health care provider receiving the notice access to all of the medical records related to the claim that are in the claimant's control and shall furnish release for any medical records related to the claim that are not in the claimant's control, but of which the claimant has knowledge. This subsection shall not restrict a patient's right of access to the patient's medical records under any other law.

(g) Within 150 days after receipt of notice under this section, the health care provider or authorized representative against whom the claim is made shall furnish to the claimant or the claimant's authorized representative a written response that contains a statement including the following:

(1) the factual basis for the defense, if any, to the claim;

(2) the standard of care that the health care provider claims to be applicable to the action;

(3) the manner in which it is claimed by the health care provider that there was or was not compliance with the applicable standard of care; and

(4) the manner in which the health care provider contends that the alleged negligence of the health care provider was or was not a proximate cause of the claimant's alleged injury or alleged damage.

(h) If the claimant does not receive the written response required under subsection (g) within the required 150 day time period, the claimant may commence an action alleging medical malpractice upon the expiration of the 150 day time period. If a provider fails to respond within 150 days and that fact is made known to the court in the plaintiffs' complaint or by any other means then interest on any judgment against that provider shall accrue and be calculated from the date that the notice was filed rather than the date that the suit is filed. At any time before the expiration of the 150 day period, the claimant and the provider may agree to an extension of the 150 day period.

(i) If at any time during the applicable notice period under this section a health care provider receiving notice under this section informs the claimant in writing that the health care provider does not intend to settle the claim within the applicable notice period, the claimant may commence an action alleging medical malpractice against the health care provider, so long as the claim is not barred by the statute of limitations or repose.

(j) A lawsuit against a health care provider filed within 6 months of the statute of limitations expiring as to any claimant, or within 1 year of the statute of repose expiring as to any claimant, shall be exempt from compliance with this section.

(k) Nothing in this section shall prohibit the filing of suit at any time in order to seek court orders to preserve and permit inspection of tangible evidence.

Section 60M. In any action for malpractice, negligence, error, omission, mistake or the unauthorized rendering of professional services against a provider licensed under section 2 of chapter 112, including actions under section 60B, an expert witness shall have been engaged in the practice of medicine at the time of the alleged wrongdoing.

Section 60N. In any action for malpractice, negligence, error, omission, mistake or the unauthorized rendering of professional services against a provider licensed under section 2 of chapter 112, including actions under section 60B, an expert witness shall be board certified in the same specialty as the defendant physician as licensed under section 2 of chapter 112.

SECTION 81. Section 85K of said chapter 231, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 8, after the word “costs”, the following words:-

; provided, however, in the context of medical malpractice claims against a non-profit charity providing health care, such cause of action shall not exceed the sum of $100,000, exclusive of interest and costs.

SECTION 82. Chapter 233 of the General Laws is hereby amended by inserting after section 79K, the following new section:-

Section 79L. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Facility", a hospital, clinic, or nursing home licensed under chapter 111, a psychiatric facility licensed under chapter 19, or a home health agency; provided, that "facility" shall also include any corporation, professional corporation, partnership, limited liability company, limited liability partnership, authority or other entity comprised of such facilities.

"Health care provider", any of the following health care professionals licensed under chapter 112: a physician, physician assistant, podiatrist, physical therapist, occupational therapist, dentist, dental hygienist, optometrist, nurse, nurse practitioner, chiropractor, psychologist, independent clinical social worker, speech-language pathologist, audiologist, marriage and family therapist or mental health counselor; provided, that "health care provider" shall also include any corporation, professional corporation, partnership, limited liability company, limited liability partnership, authority, or other entity comprised of such health care providers.

"Unanticipated outcome", the outcome of a medical treatment or procedure, whether or not resulting from an intentional act, that differs from an intended result of such medical treatment or procedure.

(b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly experiencing an unanticipated outcome of medical care, any and all statements, affirmations, gestures, activities or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error or a general sense of concern which are made by a health care provider, facility or an employee or agent of a health care provider or facility, to the patient, a relative of the patient or a representative of the patient and which relate to the unanticipated outcome

shall be inadmissible as evidence in any judicial or administrative proceeding, unless the maker of the statement, or a defense expert witness, when questioned under oath during the litigation about facts and opinions regarding any mistakes or errors that occurred, makes a contradictory or inconsistent statement as to material facts or opinions, in which case the statements and opinions made about the mistake or error shall be admissible for all purposes. In situations where a patient suffers an unanticipated outcome with significant medical complication resulting from the provider's mistake, the health care provider, facility or an employee or agent of a health care provider or facility shall fully inform the patient, and when appropriate the patient's family, about said unanticipated outcome.

SECTION 83. Clause (2) of subsection (b) of section 3 of chapter 258C of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out sub-clause (A) and inserting in place thereof the following sub-clause:- (A) Expenses incurred for hospital services as the direct result of injury to the victim shall be compensable under this chapter; provided, however, that when claiming compensation for hospital expenses, the claimant shall demonstrate an out-of-pocket loss or a legal liability for payment of said expenses. No hospital expenses shall be paid if the expense is reimbursable by Medicaid or if the services are covered by chapter 118E. Every claim for compensation for hospital services shall include a certification by the hospital that the services are not reimbursable by Medicaid and that the services are not covered by chapter 118E. In no event shall the amounts awarded for hospital services exceed the rates for services established by the executive office of health and human services or a governmental unit designated by the executive office if rates have been established for such services.

SECTION 84. The second paragraph of section 4 of chapter 260 of the General Laws, as so appearing, is hereby amended by adding the following sentence:-

The statutes of limitation and repose in this paragraph shall be tolled for a period of 180 days when a notice of intent to file a claim, under subsection (a) of section 60L of

chapter 231, is sent to a provider of health care as defined in the seventh paragraph of section 60B of chapter 231.

SECTION 85. Section 15 of chapter 305 of the acts of 2008 is hereby repealed.

SECTION 86. Section 70 of said chapter 288 is hereby amended by striking out the figure "2012" and inserting in place thereof the following figure:- 2015.

SECTION 87. Notwithstanding any general or special law to the contrary, the commissioner of public health, in consultation with the board of registration in medicine, shall promulgate regulations on or before April 1, 2013 to enforce section 226 of chapter 111 of the General Laws.

SECTION 88. Notwithstanding any general or special law or rule or regulation to the contrary, the commissioner of insurance shall promulgate regulations requiring any carrier, as defined in section 1 of chapter 176O of the General Laws, and their contractors to comply with and implement the federal Mental Health Parity and Addiction Equity Act of 2008, section 511 of Public Law 110-343. The commissioner of insurance shall promulgate said regulations not later than January 1, 2013. The regulations shall be implemented as part of any provider contracts and any carrier's health benefit plans which are delivered, issued, entered into, renewed or amended on or after July 31, 2012.

Starting on July 1, 2013, the commissioner of insurance shall require all carriers and their contractors, to submit an annual report to the division of insurance, which shall be a public record, certifying and outlining how their health benefit plans are in compliance with the federal Mental Health Parity and Addiction Equity Act and this section. The division of insurance shall forward all such reports to the attorney general for verification of compliance with the federal Mental Health Parity and Addiction Equity Act and this section.

SECTION 89. Notwithstanding any general or special law or rule or regulation to the contrary, the office of Medicaid shall promulgate regulations requiring any Medicaid health plan and managed care organization and their health plans and any behavioral health management firm and third party administrator under contract with a Medicaid managed care organization to comply with and implement the federal Mental Health Parity and Addiction Equity Act of 2008, section 511 of Public Law 110-343. The office of Medicaid shall promulgate said regulations not later than January 1, 2013. The regulations shall be implemented as part of any provider contracts and any carrier's health benefit plans which are delivered, issued, entered into, renewed or amended on or July 31, 2012.

Starting on July 1, 2013, the office of Medicaid shall submit an annual report to the house and senate chairs of the joint committee on health care financing, the house and senate chairs of the joint committee on mental health and substance abuse, the clerk of the senate and the clerk of the house of representatives certifying and outlining how the health benefit plans under the office of Medicaid, and any contractors, are in compliance with the federal Mental Health Parity and Addiction Equity Act and this section. The office of Medicaid shall forward all such reports to the department of the attorney general for verification of compliance with the federal Mental Health Parity and Addiction Equity Act and this section.

SECTION 90. Notwithstanding any general or special law to the contrary, the board of registration of medicine, established under section 10 of chapter 13 of the General Laws, shall promulgate regulations relative to the education and training of health care providers in the early disclosure of adverse events, including, but not limited to, continuing medical education requirements. Nothing in this section shall affect the total hours of continuing medical education required by the board, including the number of hours required relative to risk management.

SECTION 91. Notwithstanding any general or special law to the contrary, the department of public health, in consultation with the Betsy Lehman center for patient

safety and medical error reduction, established under section 16E of chapter 6A of the General Laws, shall create an independent task force to study and reduce the practice of defensive medicine and medical overutilization in the commonwealth, including but not limited to the overuse of imaging and screening technologies. At least 1 member of the task force shall be a health care consumer representative. The task force shall issue a report on the financial and non-financial impacts of defensive medicine and the impact of overutilization on patient safety. The task force shall file a report of its study, including its recommendations and drafts of any legislation, if necessary, by filing the same with the clerks of the senate and house of representatives who shall forward a copy of the report to the joint committee on public health and the joint committee on health care financing within 1 year of the effective date of this act.

SECTION 92. Notwithstanding any general or special law to the contrary, to the extent that the office of Medicaid, the group insurance commission, the commonwealth health insurance connector authority and any other state funded insurance program determine that accountable care organizations offer opportunities for cost-effective and high quality care, such state funded insurance programs shall prioritize provider organizations which have been certified by the institute of health care finance and policy as Beacon ACOs, under section 8 of chapter 176S, for the delivery of publicly funded health services.

SECTION 93. Any provider organization that entered a network contract prior to the effective date of chapter 12C of the General Laws, which organization receives, or represents providers who collectively receive, at least $10,000,000 in annual net patient service revenue from carriers or third-party administrators or which has entered full-risk contracts or which is corporately affiliated with a carrier, shall register under section 10 of said chapter 12C not later than December 1, 2012. Any other provider organization that entered a network contract prior to the effective date of said chapter 12C and is required under said section 10 of said chapter 12C to register shall register not later than December 1, 2013.

Notwithstanding any other provision of said chapter 12C, and as a condition of licensure under chapter 111 of the General Laws, any provider that is part of or represented by a provider organization that entered a network contract and fails to register under said section 10 of said chapter 12C shall continue to deliver care under such network contract for the duration of such contract, or a period of 5 years, whichever is longer, at the contract terms and payment levels in effect upon the date the provider organization fails to register under said section 10 of said chapter 12C.

SECTION 94. There shall be a task force comprised of 9 representatives with expertise in behavioral health treatment, service delivery, integration of behavioral health with primary care and behavioral health reimbursement systems. The institute of health care finance and policy shall appoint the members of the task force. The task force shall report to the instiute its findings and recommendations relative to: (i) the most effective and appropriate approach to including behavioral health services in the array of services provided by integrated provider organizations; (ii) how current prevailing reimbursement methods and covered behavioral health benefits may need to be modified to achieve more cost effective, integrated and high quality behavioral health outcomes; and (iii) the extent to which and how payment for behavioral health services should be included under alternative payment methods. The task force shall submit its report of findings and recommendations to the institute not later than July1, 2013.

SECTION 95. Notwithstanding any general or special law to the contrary, the department of public health shall submit a health resource plan to the governor and the general court, as required by section 25A of chapter 111 of the General Laws, not later than January 1, 2014.

SECTION 96. Notwithstanding any general or special law to the contrary, there shall be a special task force, to study issues related to the accuracy of medical diagnosis in the commonwealth, called the Massachusetts Diagnostic Accuracy Task Force. The task force shall investigate and report on: the extent to which diagnoses in the commonwealth are accurate and reliable; the underlying systematic causes of

inaccurate diagnosis; estimation of the financial cost to the state, insurers and employers of inaccurate diagnoses; the negative impact on patients caused by inaccurate diagnoses; and recommendations to reduce or eliminate the impact of inaccurate diagnoses.

The Massachusetts Diagnostic Accuracy Task Force shall be comprised of 9 members, including the commissioner of public health, or a designee, who shall act as the chair; and 8 members, who shall be appointed by the commissioner of public health, who shall reflect a broad distribution of diverse perspectives on the health care system, including health care professionals, consumer representatives, provider organizations and payers.

The task force shall file a report of its study, including its recommendations and drafts of any legislation, if necessary, with the clerks of the senate and house of representatives within 1 year of the effective date of this act.

SECTION 97. Notwithstanding any general or special law to the contrary, the institute of health care finance and policy shall, in consultation with the executive office of health and human services, the department of public health, the office of Medicaid and the division of insurance, review existing reporting and data collection requirements for health care providers, provider organizations and payers. The institute shall identify reporting and data collection requirements that are unnecessary, duplicative, which could be combined or which should be transferred to the institute in its role as the primary health care data repository for the commonwealth.

The institute shall file the results of its review, together with drafts of legislation, if any, necessary to carry out its recommendations, by filing the same with the clerks of the house of representatives and the senate who shall forward a copy of the study to the house and senate committees on ways and means and the joint committee on health care financing not later than January 1, 2014.

SECTION 98. Notwithstanding any general or special law to the contrary, beginning not later than July 1, 2014, the group insurance commission, MassHealth and any other

state funded insurance program shall, to the maximum extent feasible, implement alternative payment methodologies, as defined in section 1 of chapter 12C. The alternative payment methodologies shall be developed in consultation with the institute of health care finance and policy under section 8 of chapter 176S and all affected publically funded health plans, including, but not limited to, the Medicaid managed care organizations.

SECTION 99. Notwithstanding any general or special law or rule or regulation to the contrary, upon the adoption of national electronic prior authorization standards by the National Council for Prescription Drug Programs, the e-Health Institute shall prepare a report that identifies the appropriate administrative regulations of the commonwealth that will need to be promulgated in order to make those standards effective within 12 months of adoption of said standards by the National Council for Prescription Drug Programs, as well as any steps that should be taken to integrate information available through the Commonwealth's prescription monitoring program. The institute shall, not later than 6 months after the adoption of such standards by the National Council for Prescription Drug Programs, submit its report together with any further recommendations and draft legislative language necessary to carry out its recommendations to the joint committee on public health, the joint committee on health care financing and the governor.

SECTION 100. There shall be a special commission to review public payer reimbursement rates and payment systems for health care services and the impact of such rates and payment systems on health care providers and on health insurance premiums in the commonwealth. The commission shall consist of 11 members: 1 of whom shall be the secretary of health and human services or a designee, who shall serve as chair; 1 of whom shall be the director of the office of Medicaid; 1 of whom shall be the executive director of the institute of health care finance and policy; 1 of whom shall be appointed by the Massachusetts Hospital Association; 1 of whom shall be appointed by the Massachusetts Medical Society; 1 of whom shall be appointed by the Massachusetts Senior Care Association; 1 of whom shall be appointed by the Home

Care Alliance of Massachusetts; 1 of whom shall be appointed by the Massachusetts League of Community Health Centers; 1 of whom shall be appointed by the Massachusetts Association for Behavioral Healthcare; and 2 of whom shall be appointed by the governor, 1 of whom shall be represent managed care organizations contracting with MassHealth and 1 of whom shall be an expert in medical payment methodologies from a foundation or academic institution.

The commission shall examine whether public payer rates and rate methodologies provide fair compensation for health care services and promote high-quality, safe, effective, timely, efficient, culturally competent and patient-centered care. The commission's analysis shall include, but not be limited to, an examination of MassHealth rates and rate methodologies; current and projected federal financing, including Medicare rates; cost-shifting and the interplay between public payer reimbursement rates and health insurance premiums; and the degree to which public payer rates reflect the actual cost of care.

To conduct its review and analysis, the commission may contract with an outside organization with expertise in the analysis of health care financing. The institute of health care finance and policy and the office of Medicaid shall provide the outside organization, to the extent possible, with any relevant data necessary for the evaluation; provided, however, that such data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

The commission shall file the results of its study, together with drafts of legislation, if any, necessary to carry out its recommendations, by filing the same with the clerks of the house of representatives and the senate who shall forward a copy of the study to the house and senate committees on ways and means and the joint committee on health care financing not later than April 1, 2013.

SECTION 101. (a) There shall be an e-Health commission which shall evaluate the effectiveness of the low or zero interest loan program authorized under section 106 of this act. The commission shall consist of 17 members: 1 of whom shall be the secretary

of administration and finance or a designee, who shall serve as chair; 1 of whom shall be the secretary of health and human services or a designee; 1 of whom shall be the executive director of the institute of health care finance and policy or a designee; 1 of whom shall be the secretary of housing and economic development or a designee; 13 of whom shall be appointed by the governor, 1 of whom shall be an expert in health information technology, 1 of whom shall be an expert in state and federal health privacy laws, 1 of whom shall be an expert in health policy, 1 of whom shall be an expert in health information technology relative to privacy and security, 1 of whom shall be from an academic medical center, 1 of whom shall be from a community hospital, 1 of whom shall be from a community health center, 1 of whom shall be from a long term care facility, 1 of whom shall be from a physician group practice, 1 of whom shall be a front-line registered nurse, 1 of whom shall be from a Medicare-certified home health agency, and 2 of whom shall represent health insurance carriers.

(b) The commission shall review the Massachusetts e-Health Institute and the MassDevelop program, including an analysis of all relevant data so as to determine the effectiveness and return on investment of the loans. The report shall include specific legislative recommendations including the following:-

(1) to what extent the program increased the adoption of interoperable electronic health records, including to what extent the program increased the adoption of interoperable electronic health records for providers;

(2) to what extent the program reduced health care costs or the growth in health care cost trends on a provider-based net cost and health plan based premium basis, including an analysis of what entities benefitted or were disadvantaged from any cost reductions and the specific impact of the funding mechanism as established in subsection (a) of section 70 of chapter 118E;

(3) to what extent the program increased the number of health care providers in achieving and maintaining compliance with the standards for meaningful use, beyond stage 1, established by the United States Department of Health and Human Services ;

(4) to what extent the program should be discontinued, amended or expanded, and if so, a timetable for implementation of the recommendations; and

(5) to what extent additional public funding is needed.

(c) To conduct these studies, the commission shall contract with an outside organization with expertise in the analysis of the health care financing. In conducting its examination, the outside organization shall, to the extent possible, obtain and use actual health plan data from the all-payer claims database as administered by the institute of health care finance and policy; but such data shall be confidential and shall not be a public record for any purpose.

(d) The commission shall report the results of its investigation and study and its recommendations, if any, together with drafts of legislation necessary to carry out such recommendations by March 31, 2017. The report shall be provided to the chairs of the house and senate ways and means committees and the joint committee on health care financing and shall be posted on the department's website.

SECTION 102. (a) There shall be a commission on prevention and wellness which shall evaluate the effectiveness of the program authorized under section 2G of chapter 111 of the General Laws. The commission shall consist of 19 members: 1 of whom shall be the commissioner of public health or a designee, who shall serve as the chair; 1 of whom shall be the executive director of the institute of health care finance and policy established in chapter 12C or a designee; 1 of whom shall be the secretary of health and human services or a designee; 2 of whom shall be the house and senate chairs of the joint committee on public health; 2 of whom shall be the house and senate chairs of the joint committee on health care financing; and 12 of whom shall be appointed by the governor, 1 of whom shall be a person with expertise in the field of public health economics, 1 of whom shall be a person with expertise in public health research, 1 of whom shall be a person with expertise in the field of health equity, 1 of whom shall be a person from a local board of health for a city or town with a population greater than 50,000, 1 of whom shall be a person of a board of health for a city or town with a

population less than 50,000, 2 of whom shall be representatives of health insurance carriers, 1 of whom shall be a person from a consumer health organization, 1 of whom shall be a person from a hospital association, 1 of whom shall be a person from a statewide public health organization, 1 of whom shall be a representative of the interest of businesses, and 1 of whom shall be a person from an association representing community health workers.

(b) The commission shall review the program authorized under said section 2G of said chapter 111 and shall issue a report. The report shall include an analysis of all relevant data to determine the effectiveness and return on investment of the program including, but not limited to, an analysis of: (i) the extent to which the program impacted the prevalence of preventable health conditions; (ii) the extent to which the program reduced health care costs or the growth in health care cost trends; (iii) whether health care costs were reduced, and who benefitted from the reduction; (iv) the extent to which workplace-based wellness or health management programs were expanded, and whether those programs improved employee health, productivity and recidivism; (v) if employee health and productivity was improved or employee recidivism was reduced, the estimated statewide financial benefit to employers; (vi) recommendations for whether the program should be discontinued, amended or expanded, as well as a timetable for implementation of the recommendations; and (vii) the extent to which additional funding is needed for the Prevention and Wellness Trust Fund, as established in said section 2G of said chapter 111, and a recommendation for a funding mechanism beyond 2017.

(c) To conduct its evaluation, the commission shall contract with an outside organization with expertise in the analysis of health care financing. In conducting its evaluation, the outside organization shall, to the extent possible, obtain and use actual health plan data from the all-payer claims database as administered by the institute of health care finance and policy; provided, however, that such data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

(d) The commission shall report the results of its investigation and study and its recommendation, if any, together with drafts of legislation necessary to carry out such recommendation to the house and senate committees on ways and means, the joint committee on public health and shall be posted on the department's website not later than March 31, 2017.

SECTION 103. Notwithstanding any general or special law to the contrary, the commissioner of health care finance and policy as of the effective date of this act shall, with the approval of the governor, become the interim executive director of the institute of health care finance and policy on the effective date of this act. The interim executive director shall serve at the pleasure of the governor, and may be removed by the governor at any time. If there is a vacancy in the office of the interim executive director before January 1, 2014, the executive director of the institute of health care finance and policy shall be appointed by a majority vote of the governor, the auditor and the attorney general as required under section 2 of chapter 12C of the General Laws.

Beginning on January 1, 2014, the executive director of the institute of health care finance and policy shall be appointed by a majority vote of the governor, the auditor and the attorney general as required under section 2 of chapter 12C of the General Laws.

SECTION 104. The secretary of elder affairs, the commissioner of the department of housing and community development, and the commissioner of public health shall, in conjunction with other agencies of the commonwealth as necessary, develop a state-wide plan for the development and maintenance of assisted living facilities, so-called, long-term care facilities, home health agencies and rest homes. Said plan shall include and assessment of existing and projected need for such facilities across all income levels, available capacity of existing facilities for tenants at all income levels, and projected development of additional capacity in the next twenty-five years. Said plan shall also assess any and all means being utilized for payment by individuals for

residence in assisted living facilities and the projected availability of such means in the future for individuals at all income levels from public and private sources, including but not limited to, Medicare, Medicaid and private insurers.

Said plan, based on said assessments, shall included strategies to meet the needs identified in such assessments and to facilitate the availability of assisted living facilities for individuals of all income levels throughout the commonwealth, including the development and maintenance of capital infrastructure, program services, and public and private sources of financing assisted living residence for the citizens of the commonwealth. Said plan prescribed herein, together with any recommendations for legislation necessary to the plan, shall be filed with the clerks of the senate and house of representatives not later than two years following the passage of this act."

SECTION 105. The Secretary of Administration and Finance and the Secretary of Health and Human services are hereby authorized and directed to evaluate the feasibility of contracting for recycling durable medical equipment purchased and issued by the Commonwealth through any and all of its medical assistance programs.

Said evaluation shall include but not be limited to a request for qualifications and/or proposals for entities capable of developing, implementing and operating a system of recycling whereby an inventory of such equipment is developed and managed so as to maximize the quality of service delivery to equipment recipients and to minimize costs and losses attributable to waste, fraud and/or abuse.

The Secretary for Administration and Finance shall report the findings of said evaluation, together with cost estimates for the operation of a recycling program, estimates of the savings it would generate, and legislative recommendations, no later than October 31, 2012.

SECTION 106. MassTech Collaborative shall develop a plan for the provision of loans to providers of health care for the development, purchase and installation of information

technology systems with low or zero interest rates, provided, that such systems shall maximize interoperability with those of all other health care providers in the commonwealth, reduce to the maximum extent possible medical errors, accommodate the utilization of standardized and uniform billing codes, and maximize cost-effectiveness.

Said program shall require any applicant to demonstrate that the acquisition and utilization of technology with loan proceeds will reduce the cost of providing care, and the manner in which the saving resulting from said reduction will reduce the overall cost of health care in the commonwealth and benefit individual consumers of such care.

Said plan, together with any legislative and regulatory changes necessary to its implementation, shall be filed with the clerks of the senate and the house of representatives not later than one year following the passage of this act.

SECTION 107. The office of Medicaid and the department of unemployment assistance shall, in consultation with the executive office of health and human services, develop and implement a means by which the office of Medicaid may access information as to the status of or termination of unemployment benefits and the associated insurance coverage by the medical security plan, as administered by the executive office of labor and workforce development, for the purposes of determination of eligibility for those individuals applying for benefits through health care insurance programs administered by the executive office of health and human services. The office and the department shall implement this system not later than three months following the passage of this act; provided, however, that if legislative action is required prior to implementation, recommendations for such action shall be filed with the house and senate clerks and the joint committee on health care financing not later than two months following the passage of this act.

SECTION 108. Notwithstanding any special or general law to the contrary, the office of Medicaid shall not terminate the coverage of any commonwealth care recipient in the event that requested documentation has been provided by the recipient, and its receipt

has been acknowledged, including the eligibility review form, until the office determines the eligibility for benefits based on the submitted information. The director shall promulgate regulations to ensure the proper implementation of this provision.

SECTION 109. Notwithstanding any general or special law, rule or regulation to the contrary, no additional benefit, procedure or service shall be required for minimum creditable coverage, so- called, without prior legislative authorization therefore.

SECTION 110. The Commonwealth Connector shall develop a plan for insurance coverage which, to the greatest extent possible, minimizes mandated benefits and provides for the coverage of essential health services, provided that the contents of said plan, together with any regulatory or legislative actions necessary to its implementation, shall be filed with the clerks of the senate and house of representatives not later than six months following the passage of this act.

SECTION 111. The Secretary of Health and Human Services shall develop a plan to ensure that, to the maximum feasible extent, the care being provided to those receiving full health insurance benefits be provided through managed care programs. Said plan shall be implemented not later than one year following the passage of this act, provided that the provisions of the plan shall be reported to the clerks of the senate and the house of representatives not later than 60 days prior to its effective date.

SECTION 112. (a) There is hereby established and set upon the books of the commonwealth a separate fund to be known as the Distressed Community Hospital Trust Fund, which shall be administered by the institute of health care finance and policy established under chapter 12C of the General Laws. Expenditures from the Distressed Community Hospital Trust Fund shall be dedicated to efforts to improve and enhance the ability of qualified community hospitals to serve populations in need more effectively.

(b)The Distressed Community Hospital Trust Fund shall consist of any funds that may be appropriated or transferred for deposit into the trust fund and any funds provided from other sources.

(c)The institute shall develop a competitive grant process for awards to be distributed from said fund to qualified community hospitals. The grant process shall consider, among other factors: payer mix, uncompensated care, financial health, geographic need and population need. In assessing financial health, the institute shall take into account days cash on hand, net working capital and earnings before income tax, depreciation and amortization.

(d)A qualified community hospital shall not include a hospital that is a teaching hospital, a hospital that is receiving delivery system transformation initiative funds or a hospital whose relative prices are above the statewide median relative price.

(e)The competitive grant process shall include, at a minimum, a comprehensive uses of funds proposal and a sustainability plan. As a condition of an award, the institute may require a qualified community hospital to agree to take steps to increase its sustainability, including reconfiguration of services, changes in staffing, wages or benefits, changes in governance or a transfer of ownership.

SECTION 113. (a) There shall be a Pharmaceutical Cost Containment commission established to study methods to reduce the cost of prescription drugs for both public and private payers. The commission shall consist of 16 members: 2 of whom shall be the co-chairs of the joint committee on health care financing, 1 of whom shall be the commissioner of the group insurance commission or a designee, 1 of whom shall be the director of the division of insurance or a designee, 1 of whom shall be the director of the state office of pharmacy services or a designee, 1 of whom shall be the secretary of elder affairs or a designee, 1 of whom shall be the director of the Massachusetts medicaid program or a designee, 2 of whom shall be appointed by the president of the senate, 1 of whom shall be appointed by the minority leader of the senate, 2 of whom shall be appointed by the speaker of the house of representatives, 1 of whom shall be

appointed by the minority leader of the house of representatives, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, 1 of whom shall be a representative of the Massachusetts Hospital Association, and 1 of whom shall be a representative of Health Care For All. All necessary appointments shall be made within 60 days of the effective date of this act.

(b) The commission shall examine and report on the following: (i) the ability of the commonwealth to enter into bulk purchasing agreements, including agreements that would require the secretary of elder affairs, the commissioner of GIC, the director of the state office of pharmacy services, the commissioners of the departments of public health, mental health, and mental retardation, and any other state agencies involved in the purchase or distribution of prescription pharmaceuticals, to renegotiate current contracts; (ii) aggregate purchasing methodologies designed to lower prescription pharmaceutical costs for state and non-state providers; (iii) the ability of the commonwealth to operate as a single payer prescription pharmaceutical provider; and, (iv) the feasibility of creating a program to provide all citizens access to prescription pharmaceuticals at prices negotiated by the commonwealth.

(c) The commission shall report the results of its findings as well as any recommendations for legislation, programs, and funding to the clerks of the house of representatives and the senate who shall forward copies of the report to the house and senate committees on ways and means and the joint committee on health care financing no later than 12 months after the effective date of this act.

SECTION 114. The executive office of health and human services shall seek from the Secretary of the Department of Health and Human Services an exemption or waiver from the Medicare requirement set forth in 42 U.S.C. §1395x(i) that an admission to a skilled nursing facility be preceded by a three-day hospital stay.

SECTION 115. The institute of health care finance and policy, no later than December 31, 2015, in consultation with the department of public health, shall conduct and complete an analysis of the impact on health care costs of the use of discounts, rebate,

product voucher or other reduction for biological products and prescription drugs authorized pursuant to this Act. The report shall include, but not be limited to, a comparison of any change in utilization of generic versus brand name prescription drugs, the affect on patient adherence to prescribed drugs, patient access to innovative therapies, and an analysis of the impact on commercial health insurance premiums and on premiums associated with the group insurance commission.

The institute shall file a report of its findings with the clerks of the senate and house of representatives, the house and senate committees on ways and means and the joint committee on health care financing.

SECTION 116. The office of Medicaid shall, within six months of the passage of this act, take any and all necessary actions to ensure that social security numbers are required on all medical benefits request forms to the extent permitted by federal law and that social security numbers are provided by all applicants who possess them.

If for any reason the office determines that it is or will be unable to accomplish the foregoing within six months of the passage of this Act, it shall submit a detailed report of the reasons for such inability to the clerks of the house of representatives and the senate within three months following the passage of this act.

SECTION 117. The institute of health care finance and policy shall, within six months of the passage of this act, ensure i) that the identity, age, residence and eligibility of all applicants are verified before payments other than emergency bad debt payments are made by the Health Safety Net Trust Fund; and ii) that the Health Safety Net is the payor of last resort by performing third party liability investigations on Health Safety Net claims and by implementing other such programs as needed.

If for any reason the division determines that it is or will be unable to accomplish the foregoing within six months of the passage of this Act, it shall submit a detailed report of the reasons for such inability to the clerks of the house of representatives and the senate within three months following the passage of this act.”

REDRAFT Clerk #264

Health Benefit

Ms. Creem moves to amend the bill, (Senate, No. 2260) in by adding the following new language:

Section XXX: The Institute of Health Care Finance and Policy, in conjunction with the Division of Insurance, shall conduct a study on the disparity arising between self-insured health plans and fully insured health plans as it pertains to assessed health benefit surcharges and, if such disparities exist, the Division shall file a report of its findings, including recommendations and drafts of any legislation, if necessary, with the clerks of the Senate and House of Representatives within one year of the effective date of this act.

REDRAFT Clerk #265

Corrective Amendment

Mr. Brewer moves to amend the bill (Senate, No. 2260) by striking out, in line 132, the figure "10" and inserting in place thereof the following figure:- "20"; and

by inserting after the word "medical", in line 138, the following words:- ", behavioral health, substance use disorder, mental health"; and

by inserting after the word "medical", in line 153, the following words:- ", behavioral health, substance use disorder, mental health"; and

by inserting after the word "behavioral", in line 184, the following words:- ", substance use disorder"; and

by inserting after the word "services", in line 218, the following words:- "or as defined in regulations promulgated by the institute"; and

in section 14, in proposed subsection (a) of section 10 of chapter 12C of the General Laws, by inserting after the first sentence the following sentence:- “The institute may assess a registration or administrative fee on provider organizations in such amount to help defray the institute’s costs in complying with this section.”; and

in said section 14, in said proposed subsection (a) of said section 10 of said chapter 12C, by inserting after the second sentence the following sentence:- “The institute may specify in regulations such uniform reporting thresholds as it determines necessary.”; and

by inserting after the word “behavioral”, in line 602, the following words:- “, substance use disorder and mental” ; and

by inserting after the word “behavioral”, in line 631, the following words:- “, substance use disorder and mental” ; and

by striking out, in line 663, the words “zip code” and inserting in place thereof the following words:- “geographic region of the commonwealth as further defined in regulations promulgated by the institute”; and

by inserting after the word “behavioral”, in line 666, the following words:- “, substance use disorder and mental”; and

by striking out, in line 669, the words “risk reserves;”; and

by inserting after the word “allowances”, in line 670, the following words:- “as may be required in regulations promulgated by the institute”; and

by inserting after the word “behavioral”, in line 671, the following words:- “, substance use disorder and mental”; and

by striking out, in lines 751 and 752, the words “trends or documents that the attorney general considers necessary to evaluate” and inserting in place thereof the following words:- “trends,”; and

by striking out, in line 753, the word “to”; and

by striking out, in lines 1212 and 1213, the words “and substance abuse” and inserting in place thereof the following words:- “, behavioral and substance use disorder”; and

by inserting after the word “cost”, in line 1215, the following word:- “growth”; and

by striking out, in line 1511, the words “and substance abuse” and inserting in place thereof the following words:- “, behavioral and substance use disorder”; and

by inserting after the word “behavioral”, in line 1762, the following words:- “, substance use disorder and mental” ; and

by inserting after the word “behavioral”, in line 1767, the following words:- “, substance use disorder and mental” ; and

by striking out, in line 1770, the words “Massachusetts Association of Social Workers” and inserting in place thereof the following words:- “National Association of Social Workers Massachusetts Chapter”; and

by striking out, in line 1771, the words “Massachusetts Organization of Nurse Executives” and inserting in place thereof the following words:- “Organization of Nurse Leaders”; and

by inserting after the word “behavioral”, in line 1783, the following words:- “, substance use disorder and mental” ; and

by inserting after the word “behavioral”, in line 1804, the following words:- “, substance use disorder and mental” ; and

by inserting after the word “physical”, in line 2053, the following words:- “, behavioral, substance use disorder” ; and

by inserting after the word “physical”, in line 2092, the following words:- “, behavioral, related to a substance use disorder” ; and

by inserting after the word “medical”, in line 2122, the following words:- “, behavioral, substance use disorder, mental” ; and

by inserting after the word “medical”, in line 2140, the following words:- “, behavioral, substance use disorder, mental” ; and

by striking out, in line 2292, the word “sole”; and

by inserting after the word “standards”, in line 2296, the following words:- “; provided, that the secretary may designate another governmental unit to perform such ratemaking functions”; and

by inserting after the word “physical”, in line 2674, the following words:- “, behavioral, related to a substance use disorder” ; and

in section 125 by inserting after the word “Ratio”, in lines 3365, 3367 and 3370, in each instance, the following words:- “, on a combined entity basis,”; and

by inserting after the word “services”, in line 3422, the following words:- “or as further defined in regulations promulgated by the institute of health care finance and policy under chapter 12C”; and

by inserting after the word “stakeholders”, in line 3605, the following words:- “and shall seek to use forms that have been mutually agreed upon by payers and providers

by striking out, in line 3834, the figure “10” and inserting in place thereof the following figure:- “20”; and

by inserting after the word “a”, in line 3871, the following words:- “ physical, behavioral, substance use disorder or mental” ; and

by inserting after the word “behavioral”, in line 3881, the following words:- “substance use disorder ” ; and

by inserting after the word “services”, in line 3901, the following words:- “or as further defined in regulations promulgated by the institute of health care finance and policy under chapter 12C”; and

by inserting after the word “behavioral”, in line 3928, each time it appears, the following words:- “substance use disorder and mental” ; and

by striking out, in lines 3947 and 3948, the words “section 11A” and inserting in place thereof, in each instance, the following words:- “sections 18 to 25, inclusive,”; and

by inserting after the word “cost”, in line 3983, the following word:- “growth”; and

by inserting after the word “cost”, in line 4126, the following word:- “growth”; and

by inserting after the word “cost”, in line 4133, the following word:- “growth”; and

by inserting after the word “growth”, in line 4158, the following words:- “, including certification as a Beacon ACO”; and

by inserting after the word “cost”, in line 4255, the following word:- “growth”; and

by inserting after the words “mental health”, in line 4261, the following words:- “ , substance use disorder” ; and

by inserting after the words “mental health”, in line 4277, the following words:- “ , substance use disorder” ; and

by inserting after the word “behavioral”, in line 4278, the following words:- “, substance use disorder and mental” ; and

by inserting after the word “behavioral”, in line 4332, the following words:- “ , substance use disorder” ; and

by inserting after section 170 the following 3 sections:-

“SECTION 170D. Section 16 of chapter 257 of the acts of 2008, as most recently amended by section 27 of chapter 9 of the acts of 2011, is hereby amended by striking out the words “section 7 of chapter 118G” and inserting in place thereof the following words:- section 13D of chapter 118E.

SECTION 170E. Section 17 of said chapter 257, as most recently amended by section 28 of said chapter 9 of the acts of 2011, is hereby amended by striking out the words “section 7 of chapter 118G” and inserting in place thereof the following words:- section 13D of chapter 118E.

SECTION 170F. Section 18 of said chapter 257, as most recently amended by section 29 of said chapter 9 of the acts of 2011, is hereby amended by striking out the words “section 7 of chapter 118G” and inserting in place thereof the following words:- “section 13D of chapter 118E. ”; and

by inserting after section 173 the following section:-

“SECTION 173B. Section 48 of chapter 9 of the acts of 2011 is hereby amended by striking out the words “section 7 of chapter 118G” and inserting in place thereof the following words:- section 13D of chapter 118E.”; and

by inserting after the word “behavioral”, in line 4734, the following words:- “ , substance use disorder and mental”; and

by inserting after the word “existing”, in line 4766, the following word:- “public”; and

by inserting after the word “primary”, in line 4769, the following word:- “public”; and

by inserting after the word “behavioral”, in line 4796, the following words:- “ , substance use disorder ”.