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– 05/24/2012

SENATE . . . . No. 02262

The Commonwealth of Massachusetts

In the Year Two Thousand Twelve.

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 Sections 16J to 16L, inclusive, of said chapter 6A of the General Laws are hereby repealed.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."