UNCORRECTED PROOF OF THE JOURNAL OF THE SENATE.

Tuesday, May 15, 2012.

Met according to adjournment at one o'clock P.M. (Mr. Rosenberg in the Chair).

Distinguished Guests.

There being no objection, during consideration of the Orders of the Day, the President handed the gavel to Ms. Creem for the purpose of an introduction. Ms. Creem then introduced, in the rear of the Chamber, a group of government officials visiting from Pakistan as part of an international training program through the Institute for Training and Development. Sibtain Ahmad is the Deputy Commissioner overseeing the Gilgit-Baltistan district. Some of his duties include administering their criminal justice system, developing health and educational programs, and is responsible for the provision of social services. Ishtiaq Ahmed is the Commissioner of Income Tax Appeals, serving as appellate authority for about fifty thousand income tax and sales tax payers in Azad Kashmir, which is a separate tax jurisdiction from Pakistan. His current responsibilities include oversight of all taxpayer appeals, and responding to complaints of corruption and unfair treatment by tax officials. Faih Ullah Khan is the current Deputy Director of Public Relations for Pakistan's Ministry of Information & Broadcasting in Islamabad. He is responsible for managing the publicity and media for the President, alerting him to national and international issues of vital importance. The group was accompanied by Newton Mayor Setti Warren. The Senate welcomed them with applause and they withdrew from the Chamber. There being no objection, during consideration of the Orders of the Day, the President handed the gavel to Ms. Clark and Mr. DiDomenico for the purpose of an introduction. They introduced, in the rear of the Chamber, James Massone from Wakefield. James was recognized for making it to the quarterfinals on the TV show, "The Voice". He has been singing since the age of two, when he started doing karaoke in his grandfather's basement. James was presented with a citation on the Rostrum, the Senate applauded his accomplishments and he withdrew from the Chamber. He was accompanied by his parents, Jim and Janet.

Report of a Committee.

By Mr. Pacheco, for the committee on Environment, Natural Resources and Agriculture, on Senate, Nos. 329, 337, 349, 351, 355, 365, 369, 370, 385, 386, 389, 390, 392, 393, 394, 399, 400 and 1973, an Order relative to authorizing the joint committee on Environment, Natural Resources and Agriculture to make an investigation and study of certain current Senate documents relative to oceans, fisheries, water quality and other water issues (Senate, No. 2261);
Referred, under Joint Rule 29, to the committees on Rules of the two branches, acting concurrently.

Committees Discharged.

Mr. Berry, for the committees on Rules of the two branches, acting concurrently, reported, asking to be discharged from further consideration of the Senate Order relative to authorizing the joint committee on Environment, Natural Resources and Agriculture to make an investigation and study of certain current Senate documents relative to agriculture, forestry and other land issues (Senate, No. 2259),-- **and recommending that the same be referred to the Senate committee on Ethics and Rules.**
Under Senate Rule 36, the report was considered forthwith and accepted.

PAPERS FROM THE HOUSE

A message from His Excellency the Governor recommending legislation relative to further improvements to the Commonwealth's transportation system (House, No. 4084),-- **was referred, in concurrence, to the committee on Transportation.**

Bills
Authorizing the town of Natick to allow a lease for the former East School (House, No. 3332,-- on petition) [Local approval received];
Authorizing the town of Natick to lease certain town-owned property (House, No. 3870,-- on petition) [Local approval received]; and
Authorizing the town of Natick to lease certain town-owned land (House, No. 3871,-- on petition) [Local approval received];
Were severally read and, under Senate Rule 26, placed in the Orders of the Day for the next session.

Recess.

There being no objection, at one minute past one o'clock P.M., the Chair (Mr. Rosenberg) declared a recess subject to the call of the Chair; and, at twenty-eight minutes before two o'clock P.M., the Senate reassembled, the President in the Chair.
The President, members, guests and staff then recited the pledge of allegiance to the flag.

Petition.

On motion of Mr. Brewer, Senate Rule 20 and Joint Rule 12 were suspended on the petition, presented by Ms. Murray (accompanied by bill) of Therese Murray and Thomas J. Calter for legislation to establish a sick leave bank for Julie Nantais, an employee of the Department of Public Health,— **and the same was referred to the committee on Public Service.**
Sent to the House for concurrence.

Order Adopted.

Mr. McGee offered the following order:
Ordered, That notwithstanding the provisions of Joint Rule 10, the Committee on Transportation be granted until June 29, 2012 within which to make its final report on the residue of current House document numbered 4011 relative to transportation matters.
Under Joint Rule 29, referred to the committees on Rules of the two branches, acting concurrently.
Subsequently, Mr. Berry, for the said committees, reported, recommending that the order ought to be adopted.
The rules were suspended, on motion of Mr. Brewer, and the order was considered forthwith and adopted.
Sent to the House for concurrence.

PAPER FROM THE HOUSE

A petition (accompanied by bill, House, No. 4094) of James J. O'Day for legislation to establish a sick leave bank for Patricia Chasse, an employee of the Executive Office of Health and Human Services,-- **was referred, in concurrence, under suspension of Joint Rule 12, to the committee on Public Service.**

Orders of the Day.

The Orders of the Day were considered, as follows:
The Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2260),-- was read a second time.
Pending the question on ordering the bill to a third reading, Mr. Tarr offered the following order, to wit:
Ordered, that notwithstanding the provisions of any previously adopted order, the Senate shall not consider Senate Bill 2260, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation", or any amendments thereto, until such time as a decision is issued by the United States Supreme Court in the case of Department of Health and Human Services v. Florida (Docket 11-398); and ordered further, that the senate committee on ethics and rules shall place the matter of senate Bill 2260 and any filed amendments thereto in the orders of the day for consideration by the senate in a full formal session within thirty days of the issuance of a decision by the court in the case referenced above.
Mr. Tarr moved that the rules be suspended so that the order may be considered forthwith; and, after debate, the motion was negatived, by a vote of 4 to 23.
Under the rules, the order was referred to the committee on Ethics and Rules.
Mr. Tarr then moved that further consideration of the bill be postponed until Thursday, June 7th.
After debate, the question on adoption of the order was determined by a call of the yeas and nays, at two minutes past two o'clock P.M., on motion of Mr. Tarr, as follows, to wit (yeas 4 – nays 32) **[Yeas and Nays No. 176]:**

YEAS

Hedlund, Robert L.	Ross, Richard J.

Knapik, Michael R.	Tarr, Bruce E. — **4.**

NAYS

Berry, Frederick E.	Jehlen, Patricia D.
Brewer, Stephen M.	Joyce, Brian A.
Brownsberger, William N.	Keenan, John F.
Candaras, Gale D.	Kennedy, Thomas P.
Chandler, Harriette L.	McGee, Thomas M.
Chang-Diaz, Sonia	Montigny, Mark C.
Clark, Katherine M.	Moore, Michael O.
Creem, Cynthia Stone	Moore, Richard T.
DiDomenico, Sal N.	Pacheco, Marc R.
Donnelly, Kenneth J.	Petruccelli, Anthony
Downing, Benjamin B.	Rodrigues, Michael J.
Eldridge, James B.	Rosenberg, Stanley C.
Fargo, Susan C.	Spilka, Karen E.
Finegold, Barry R.	Timilty, James E
Flanagan, Jennifer L.	Welch, James T.
Hart, John A., Jr.	Wolf, Daniel A. — **32.**

ABSENT OR NOT VOTING

Donoghue, Eileen M.	Rush, Michael F. — **2.**

The yeas and nays having been completed at five minutes past two o'clock P.M., the motion to postpone was *rejected*.

Ms. Flanagan moved that the bill be amended in section 20, line 835, by adding at the end thereof the following language: "(v) data concerning the nurse staffing levels at each facility."
The amendment was *rejected*.
Ms. Clark and Mr. Rosenberg moved that the bill be amended by striking out section 191 and inserting in place thereof the following section:-
"SECTION 191. (a) There shall be an e-Health commission which shall evaluate the effectiveness of expenditures authorized under section 6D of chapter 40J of the General Laws. The commission shall consist of 17 members: 1 of whom shall be the secretary of administration and finance or a designee, who shall serve as chair; 1 of whom shall be the secretary of health and human services or a designee; 1 of whom shall be the executive director of the institute of health care finance and policy or a designee; 1 of whom shall be the secretary of housing and economic development or a designee; 13 of whom shall be appointed

by the governor, 1 of whom shall be an expert in health information technology, 1 of whom shall be an expert in state and federal health privacy laws, 1 of whom shall be an expert in health policy, 1 of whom shall be an expert in health information technology relative to privacy and security, 1 of whom shall be from an academic medical center, 1 of whom shall be from a community hospital, 1 of whom shall be from a community health center, 1 of whom shall be from a long term care facility, 1 of whom shall be from a physician group practice, 1 of whom shall be a front-line registered nurse, 1 of whom shall be from a Medicare-certified home health agency, and 2 of whom shall represent health insurance carriers.
(b) The commission shall review the Massachusetts e-Health Institute, including an analysis of all relevant data so as to determine the effectiveness and return on investment of funding under said section 6D of said chapter 40J. The commission's review shall include specific findings and legislative recommendations including the following:-
(1) to what extent the program increased the adoption of interoperable electronic health records, including to what extent the program increased the adoption of interoperable electronic health records for providers;
(2) to what extent the program reduced health care costs or the growth in health care cost trends on a provider-based net cost and health plan based premium basis, including an analysis of what entities benefitted from, or were disadvantaged by, any cost reductions and the specific impact of the funding mechanism as established in subsection (a) of section 70 of chapter 118E;
(3) to what extent the program increased the number of health care providers in achieving and maintaining compliance with the standards for meaningful use, beyond stage 1, established by the United States Department of Health and Human Services;
(4) to what extent the program should be discontinued, amended or expanded, and if so, a timetable for implementation of the recommendations; and
(5) to what extent additional public funding is needed for the e-Health Institute Fund, as established in section 6E of chapter 40J of the General Laws.
(c) To conduct these studies, the commission shall contract with an outside organization with expertise in the analysis of the health care financing. In conducting its examination, the outside organization shall, to the extent possible, obtain and use actual health plan data from the all-payer claims database as administered by the institute of health care finance and policy; but such data shall be confidential and shall not be a public record for any purpose.
(d) The commission shall report the results of its review and its recommendations, if any, together with drafts of legislation necessary to carry out such recommendations by March 31, 2017. The report shall be provided to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and shall be posted on the department's website."
After remarks, the amendment was adopted.
Mr. Donnelly moved that the bill be amended in section 2(f) of Section 162, by striking, in line 3960, the words "or any other employees".
After remarks, the amendment was adopted.
Mr. Michael O. Moore moved that the bill be amended in section 144, in proposed subsection (a) of section 12 of chapter 176O, by adding the following sentence:- "The disclosure of utilization review criteria required by this section shall not apply to licensed, proprietary criteria purchased by a carrier or utilization review organization.".
After remarks, the amendment was adopted.
Mr. McGee moved that the bill be amended in section 14, line 293, by inserting "and labor organizations" after the words "and public and private payers".
After remarks, the amendment was adopted.
Messrs. Rosenberg, Downing and McGee moved that the bill be amended in section 178, by striking out, in line 4698, the words "health care providers" and inserting in place thereof the following word:-"physicians"; and in said section 178, by inserting, in line 467, after the word "management." the following:- "Notwithstanding any general or special law to the contrary, the board of registration in nursing, established under section 13 of chapter 13 of the General Laws, shall promulgate regulations relative to the education and training of advanced practice nurses authorized to practice consistent with section 80B of chapter 112, in the early disclosure of adverse events, including but not limited to, continuing education requirements. Nothing in this section shall affect the total hours of continuing education required by the board.".
The amendment was adopted.
Mr. Michael O. Moore moved to amend the bill by inserting after section ___, the following section:-
"SECTION XX. There shall be a special commission to examine the economic, social and educational value of graduate medical education in the commonwealth and to recommend a fair and sustainable model for the future funding of graduate medical education in the commonwealth.
The commission shall consist of 13 members: 1 of whom shall be the secretary of health and human services or a designee, who shall serve as chair; 1 of whom shall be the secretary of administration and finance or a designee; 1 of whom shall be the secretary of labor and workforce development or a designee; 1 of whom shall be the commissioner of public health or a designee; 1 of whom shall be a representative of the Massachusetts Hospital Association; 1 of whom shall be a representative of the Massachusetts Medical Society; 1 of whom shall be a representative of the Massachusetts League of Community Health Centers; 4 of whom shall represent each of the commonwealth's 4 medical schools; 1 of whom shall be a representative of the Conference of Boston Teaching Hospitals; and 1 of whom shall be a resident in training at a Massachusetts hospital, appointed by the secretary of health and human services.
The commission shall investigate and report on the following issues:
1.The role of residents and medical faculty in the provision of health care in the commonwealth and throughout the United States.
2. The relationship of graduate medical education to the state's physician workforce and emerging models of delivery of care.

3. The current availability and adequacy of all sources of revenue to support graduate medical education and potential additional or alternate sources of funding for graduate medical education. Such review shall include the availability of federal graduate medical education funding to different types of institutes where training takes place.
4. Approaches taken by other states to fund graduate medical education through Medicaid programs, including, but not limited to:
(a) establishment of medical education trust funds, and(b) efforts to link payments to state policy goals, including:
i. Increasing the number of high demand specialties or fellowships;
ii. Enhancing retention of physicians in Massachusetts practice;
iii. Promoting practice in medically underserved areas of the state and reducing disparities in health care;
iv. Increasing the primary care workforce;
v. Increasing the behavioral health care workforce; and
vi. Increasing racial and ethnic diversity within the physician workforce.
The commission shall file a report of its findings and recommendations, together with drafts of legislation, if any, necessary to carry out its recommendations by filing the same with the clerks of the house and senate who shall forward a copy of the report to the house and senate committees on ways and means and the joint committee on health care financing not later than April 1, 2013."
After remarks, the amendment was adopted.
Ms. Candaras moved that the bill be amended by inserting after section X, the following new language:-
"SECTION XXX: Section 25B of Chapter 111 of the General Laws, is hereby further amended by striking out, in lines 23, 28, 29, and 44, of the 2008 official edition the words 'acute care'."
After remarks, the amendment was *rejected*.
Ms. Fargo and Ms. Donoghue moved that the bill be amended by adding the following section:-
"SECTION XXX .The General Laws are hereby amended by inserting after chapter 175K the following chapter:-

Chapter 175L
Regulation of Pharmacy Audits

Section 1. Definitions.
For purposes of this chapter the following terms shall have the following meanings:
'Pharmacy Benefits Manager', any person or entity that administers the prescription drug, prescription device, pharmacist services or prescription drug and device and pharmacist services portion of a health benefit plan on behalf of plan sponsors such as self-insured employers, insurance companies, and labor unions. A health benefit plan that does not contract with a pharmacy benefit manager shall be considered a pharmacy benefit manager for the purposes of this chapter unless specifically exempted. The provisions of this chapter shall not apply to a public health care payer as defined in section 1 of chapter 118G.
'Commissioner', the commissioner of insurance or his designee.
Section 2. Certification of Pharmacy Benefits Managers
(a) Except as provided in subsection (d) of this section, no person shall act as a pharmacy benefits manager without first obtaining a certificate of registration from the commissioner.
(b) Any person seeking a certificate of registration shall apply to the commissioner, in writing, on a form provided by the commissioner. The application form shall state (1) the name, address, official position and professional qualifications of each individual responsible for the conduct of the affairs of the pharmacy benefits manager, including all members of the board of directors, board of trustees, executive committee, other governing board or committee, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association and any other person who exercises control or influence over the affairs of the pharmacy benefits manager, and (2) the name and address of the applicant's agent for service of process in the Commonwealth.
(c) Each application for a certificate of registration shall be accompanied by a nonrefundable fee set by the Commissioner of no less than five hundred dollars.
(d) A health benefit plan that does not contract with a pharmacy benefit manager shall not be required to obtain a certificate of registration. Such health benefit plan shall notify the commissioner annually, in writing that it is affiliated with or operating a business as a pharmacy benefits manager.
(e) Any person acting as a pharmacy benefits manager on January 1, 2011, and required to obtain a certificate of registration under subsection (a) of this section, shall obtain a certificate of registration from the commissioner not later than April 1, 2011.
Section 3. Audit Scope and Procedures.
(a) Notwithstanding any general or special law to the contrary, an audit of the records of a pharmacy conducted by a pharmacy benefit manager shall conform to the standards set forth by the January 2012 report: Model Audit Guidelines for Pharmacy Claims by the Academy of Managed Care Pharmacy.
Section 4. The provisions of this chapter shall not apply to any audit or investigation that involves potential fraud, willful misrepresentation, or abuse, including, but not limited to, investigative audits or any other statutory or regulatory provision that authorizes investigations relating to insurance fraud.
Section 5. The commissioner may promulgate regulations to enforce the provisions of this chapter."
After remarks, the amendment was *rejected*.
Mr. Montigny moved that the bill be amended by inserting after section 122 the following section:-
"SECTION 122A. Chapter 175 of the General Laws is hereby amended by inserting after section 47AA, the following section:

Section 47BB
For the purposes of this section, 'telemedicine' as it pertains to the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. 'Telemedicine' shall not include the use of audio-only telephone, facsimile machine or e-mail.
An insurer may limit coverage of telemedicine services to those health care providers in a telemedicine network approved by the insurer.
A contract that provides coverage for services under this section may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.
Coverage for health care services under this section shall be consistent with coverage for health care services provided through in-person consultation."; and
by inserting after section 202 the following section:-
"SECTION 202A. The requirements of section 47BB of chapter 175 of the General Laws shall apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed on or after January 1, 2013. For purposes of that section, all contracts shall be deemed to be renewed not later than the next yearly anniversary of the contract date."
After remarks, the amendment was adopted.
Mr. Petruccelli moved that the bill be amended in section 150 by adding the following subsection:-
"(f) Nothing in this section shall limit a health plan from requiring prior authorization for services."
After remarks, the amendment was adopted.
Ms. Creem moved that the bill be amended by inserting at the end of the bill the following new section:-
"SECTION XXX. The Institute of Health Care Finance and Policy, in conjunction with the Division of Insurance, is hereby directed and authorized to conduct a comprehensive study to investigate disparities in the provision of health care coverage to individuals and/or their spouses when there is a change in marital status. Said study shall include, but not be limited to, the identification and review of disparities in both insured and self-insured plans, as well as recommendations for alleviating disparities. The Institute shall file a report of its study, including recommendations and drafts of any legislation, if necessary, with the clerks of the Senate and House of Representatives within one year of the effective date of this act."
The amendment was *rejected*.
Mr. Rush moved that the bill be amended by inserting after section 173 the following section:-
"SECTION 173. (a) There is hereby established and set upon the books of the commonwealth a separate fund to be known as the Distressed Community Hospital Trust Fund, which shall be administered by the institute of health care finance and policy established under chapter 12C of the General Laws. Expenditures from the Distressed Community Hospital Trust Fund shall be dedicated to efforts to improve and enhance the ability of qualified community hospitals to serve populations in need more effectively.
(b) The Distressed Community Hospital Trust Fund shall consist of any funds that may be appropriated or transferred for deposit into the trust fund and any funds provided from other sources.
(c) The institute shall develop a competitive grant process for awards to be distributed from said fund to qualified community hospitals. The grant process shall consider, among other factors: payer mix, uncompensated care, financial health, geographic need and population need. In assessing financial health, the institute shall take into account days cash on hand, net working capital and earnings before income tax, depreciation and amortization.
(d) A qualified community hospital shall not include a hospital that is a teaching hospital, a hospital that is receiving delivery system transformation initiative funds or a hospital whose relative prices are above the statewide median relative price.
(e) The competitive grant process shall include, at a minimum, a comprehensive uses of funds proposal and a sustainability plan. As a condition of an award, the institute may require a qualified community hospital to agree to take steps to increase its sustainability, including reconfiguration of services, changes in staffing, wages or benefits, changes in governance or a transfer of ownership.".
After remarks, the amendment was adopted.
Ms. Chandler and Mr. Brownsberger moved that the bill be amended by inserting after SECTION___, the following section:-
"SECTION__. In order to determine, as a basis for legislative and administrative action, the resources and approaches needed to achieve the healthcare and wellness goals of the Commonwealth, a committee, known as the Massachusetts Prevention Council, shall be established. The commission shall consist of the Commissioner of the Department of Public Health, or his designee; the Secretary of the Executive Office of Health and Human Services, or her designee; the Secretary of the Executive Office of Energy and Environmental Affairs, or his designee; the Secretary of Executive Office of Education, or his designee; the Secretary of the Executive Office of Transportation, or his designee; the Secretary of Executive Office of Housing and Economic Development, or his designee; the Secretary of Executive Office of Public Safety, or her designee; the Secretary of Executive Office of Elder Affairs, or her designee; the Commissioner of the Department of Conservation and Recreation, or his designee; the Commissioner of the Department of Environmental Protection, or his designee; the chairs of the Joint Committee on Health Care Financing, or their designees and the chairs of the Joint Committee on Public Health, or their designee. An advisory council to the commission will consist of 1) designees from a representative sample of communities with a population over 125,000, and a representative sample of communities with a population under 125,000; 2) public health advocacy groups; 3) healthcare providers from a representative sample of large hospital systems, small hospitals, and community health centers; 4) other governmental departments. Using the model of the National Prevention Council, the commission shall create Massachusetts Prevention Strategy to work in parallel with federal efforts, as well as to best integrate the ongoing state and local efforts in the

Commonwealth. The Massachusetts Prevention Strategy would work to integrate and align policies among federal, state and local governments, as well as promote public and private cooperation and partnerships to achieve a healthier Massachusetts. The commission may hold hearings and invite testimony from experts and the public. The commission shall review and identify best practices learned from similar efforts in other states, and from the federal government, in order to lower health care costs and improve quality of care. Members of the commission shall be named and the commission shall commence its work within 60 days of the effective date of this act. The commission shall report to the general court the results of its investigation and study, and recommendations, if any, together with drafts of legislation necessary to carry its recommendations into effect by filing the same with the Clerks of the Senate and the House of Representatives on or before January 2, 2014. The Clerks of the House and Senate shall make the report available to the public through the Internet."

The amendment was *rejected*.

Mr. Rodrigues moved that the bill be amended in section 97, line 2535, by inserting after the words "financial requirements" the following:- "and disproportionate share hospital's, as defined in section 1, of Chapter 118 G, shall receive payments that include adjustments in each disproportionate share hospital's rates, which rates shall not be less than 90% of such hospital's reasonable financial requirements".

After debate, the amendment was *rejected*.

Mr. Berry moved that the bill be amended by adding at the end the following:-

"SECTION XXX.

Section 34 of Chapter 118G of the General Laws is hereby amended by striking it in its entirety and replacing it with the following:-

Section 34. As used in sections 34 to 39, inclusive, the following words shall, unless the context clearly requires otherwise, have the following meanings:

'Acute hospital', the teaching hospital of the University of Massachusetts medical school and any hospital licensed under section 51 of chapter 111 and which contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of public health.

'Allowable reimbursement', payment to acute hospitals and community health centers for health services provided to uninsured or underinsured patients of the commonwealth under section 39 and any further regulations promulgated by the health safety net office.

'Ambulatory surgical center', a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and meets the requirements of the federal Health Care Financing Administration for participation in the Medicare program.

'Ambulatory surgical center services', notwithstanding any provision of general or special law or regulation to the contrary, shall be defined as services described for purposes of the Medicare program under 42 U.S.C. 1395k(a)(2)(F)(I). These services include both facility services and surgical and other related medical procedures.

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

'Community health center', a health center operating in conformance with the requirements of Section 330 of United States Public Law 95-626, including all community health centers which file cost reports as requested by the division of health care finance and policy.

'Critical access services', those health services which are generally provided only by acute hospitals, as further defined in regulations promulgated by the division.

'Director', the director of the health safety net office.

'DRG', a patient classification scheme known as diagnosis related grouping, which provides a means of relating the type of patients a hospital treats, such as its case mix, to the cost incurred by the hospital.

'Emergency bad debt', bad debt resulting from emergency services provided by an acute hospital to an uninsured or underinsured patient or other individual who has an emergency medical condition that is regarded as uncollectible, following reasonable collection efforts consistent with regulations of the office.

'Emergency medical condition', a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of anybody organ or part or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. 1295dd(e)(1)(B).

'Emergency services', medically necessary health care services provided to an individual with an emergency medical condition.

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

'Fund', the Health Safety Net Trust Fund established under section 36.

'Fund fiscal year', the 12-month period starting in October and ending in September.

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

'Health services', medically necessary inpatient and outpatient services as mandated under Title XIX of the federal Social Security Act. Health services shall not include: (1) nonmedical services, such as social, educational and vocational services; (2)

cosmetic surgery; (3) canceled or missed appointments; (4) telephone conversations and consultations; (5) court testimony; (6) research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-surgery hormone therapy; and (7) the provision of whole blood, but the administrative and processing costs associated with the provision of blood and its derivatives shall be payable.

‘Laboratory’, shall be defined for these purposes as a laboratory that is licensed by the department of public health and pursuant to M.G.L. c. 111D section 1(1) that is not operated by a community health center.

‘Office’, the health safety net office established under section 35.

‘Payments subject to surcharge’, notwithstanding any provision of general or special law or regulation to the contrary, shall be defined as all amounts paid, directly or indirectly, by surcharge payors to acute hospitals for health care services, to ambulatory surgical centers for ambulatory surgical center services, to specialty health care providers for specialty health care services, and to laboratories as defined in this section; and provided, however, that payments subject to surcharge shall not include: (i) payments, settlements and property or casualty insurance policies; (ii) payments made on behalf of Medicaid recipients, Medicare beneficiaries or persons enrolled in policies issued under chapter 176K or similar policies issued on a group basis; and provided further, that payments subject to surcharge may exclude amounts established by regulations promulgated by the division for which the costs and efficiency of billing a surcharge payor or enforcing collection of the surcharge from a surcharge payor would not be cost effective.

‘Pediatric hospital’, an acute care hospital which limits services primarily to children and which qualifies as exempt from the Medicare Prospective Payment system regulations.

‘Pediatric specialty unit’, a pediatric unit of an acute care hospital in which the ratio of licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeded 0.20. In calculating that ratio, licensed pediatric beds shall include the total of all pediatric service beds, and the total of all licensed hospital beds shall include the total of all licensed acute care hospital beds, consistent with Medicare's acute care hospital reimbursement methodology as put forth in the Provider Reimbursement Manual Part 1, Section 2405.3G.

‘Private sector charges’, gross patient service revenue attributable to all patients less gross patient service revenue attributable to Titles XVIII and XIX, other public-aided patients, reimbursable health services and bad debt.

‘Reimbursable health services’, health services provided to uninsured and underinsured patients who are determined to be financially unable to pay for their care, in whole or part, under applicable regulations of the office; provided that the health services are emergency, urgent and critical access services provided by acute hospitals or services provided by community health centers; and provided further, that such services shall not be eligible for reimbursement by any other public or private third-party payer.

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

‘Specialty health care provider’, shall be defined as any entity including a physician practice providing outpatient services typically provided in a hospital setting, including but not limited to: (1) an entity providing anesthesia, conscious sedation and/or diagnostic injection services (including endoscopy services and excluding dental facilities); (ii) an entity employing major medical, diagnostic and/or therapeutic equipment, including but not limited to equipment defined as new technology or as providing an innovative service, pursuant to chapter 111, section 25B and excluding x-ray equipment; and (iii) which is not a hospital, ambulatory surgical center or community health center. The department shall promulgate regulations with respect to the classification of specialty health care providers.

‘Surcharge payor’, notwithstanding any provision of general or special law or regulation to the contrary, shall be defined as an individual or entity that pays for or arranges for the purchase of health care services provided by acute hospitals, ambulatory surgical center services provided by ambulatory surgical centers, specialty health care services provided by specialty health care providers, and laboratory services provided by laboratories, as defined in this section; provided, however, that the term surcharge payor shall not include Title XVIII and Title XIX programs and their beneficiaries or recipients, other governmental programs of public assistance and their beneficiaries or recipients and the workers compensation program established by chapter 152

‘Underinsured patient’, a patient whose health insurance plan or self-insurance health plan does not pay, in whole or in part, for health services that are eligible for reimbursement from the health safety net trust fund, provided that such patient meets income eligibility standards set by the office.

‘Uninsured patient’, a patient who is a resident of the commonwealth, who is not covered by a health insurance plan or a self-insurance health plan and who is not eligible for a medical assistance program.

SECTION 2. Section 35 of Chapter 118G of the General Laws is hereby amended by inserting after the phrase acute hospitals the following :- , ambulatory surgical centers, specialty health care providers, laboratories,.

SECTION 3. Section 36 of Chapter 118G of the General Laws is hereby amended by inserting after the phrase all amounts paid by acute hospitals the following :- , ambulatory surgical centers, specialty health care providers, laboratories,.

SECTION 4. Section 37 of Chapter 118G of the General Laws is hereby amended by adding the following subsection prior to subsection (a):-

(a) Ambulatory surgical centers, specialty health care providers, and laboratories, notwithstanding any provision of general or special law or regulation to the contrary, shall be liable to the health safety net trust fund in the same manner as acute care hospitals. The division of health care finance and policy, in consultation with the office of Medicaid, shall establish through implementing regulations the mechanism by which the liability of said providers is to be assessed, paid, monitored, and enforced.

SECTION 5. The General Laws are hereby amended, after each appearance of the term acute hospital, by inserting the following phrase:- and ambulatory surgical center, specialty health care provider, and laboratory.
SECTION 6. The General Laws are hereby amended, after each appearance of the term ambulatory surgical center, by inserting the following phrase:- , specialty health care provider, and laboratory.
SECTION 7: (A) Section 25B of chapter 111 of the general laws, as appearing in the 2006 official edition, is hereby amended, in line 22, by inserting, after the words as defined in section fifty-two the following: - specialty health care providers as defined in this section.
(B) said section 25B of said chapter 111, as so appearing, is hereby further amended, within the definition of expenditure minimum with respect to substantial capital expenditures after the clause other than ambulatory surgery the following: - or other than expenditures with respect to a specialty health care provider.
(C) Said section 25B of said chapter 111, as so appearing, is hereby further amended by adding, at the end thereof, the following: 'Specialty health care provider', any entity including a physician practice providing outpatient services typically provided in a hospital setting, including but not limited to: (1) an entity providing anesthesia, conscious sedation and/or diagnostic injection services (including endoscopy services and excluding dental facilities); (ii) an entity employing major medical, diagnostic and/or therapeutic equipment, including but not limited to equipment defined as new technology or as providing an innovative service, pursuant to chapter 111 , section 25B and excluding x-ray equipment; and (iii) which is not a hospital, ambulatory surgical center or community health center. The department shall promulgate regulations with respect to the classification of specialty health care providers.
(D) Said chapter 111 of the general laws, is hereby amended by inserting after section 53G, as added by section 11 of chapter 305 of the acts of 2008, the following new section:-
'Section 53H. Notwithstanding any general or special law or regulation to the contrary, any specialty health care provider shall be a clinic for the purpose of licensure under section 51 and no original license shall be issued pursuant to said section 51 to establish any such specialty health care provider clinic unless there is a determination by the department that there is a need for such a facility. The department shall promulgate regulations to implement this section, including with respect to the classification and grandfathering of existing specialty health care providers.'."
The amendment was *rejected*.
Ms. Fargo and Mr. DiDomenico moved that the bill be amended in section 25A, in line 1490, by inserting, after the word "pain.", the following words:- "The Department of Public Health shall establish by regulation procedures and rules relating to the unlawful practice for a health care resource to discriminate again a patient or an applicant because of race, color, religious creed, national origin, sex, sexual orientation, disability, genetic information, or ancestry of any individual, or to discriminate against such individual in the terms, conditions or privileges of health care payment coverage."
The amendment was *rejected*.
Messrs. Timilty and Knapik moved that the bill be amended by adding the following new section:-
"SECTION X. Notwithstanding any general or special law to the contrary, the state Medicaid office is hereby authorized to establish a pilot program with an external service provider to determine the effectiveness of various fraud management tools to identify potential fraud at claims submission and validation in order to reduce Medicaid fraud prior to payment; provided further, that said pilot program shall evaluate current Medicaid spending programs and utilize said fraud management services to determine the efficacy of current practices. The pilot program shall utilize only vendors currently engaged in systemic waste and fraud detection services. Selected vendor(s) shall not use any data provided to them for any other purpose than waste and fraud detection, shall destroy all data after the completion of their evaluation(s) and may not share the results of the data analysis with any outside entities. The executive office of health and human services shall submit 2 reports to the house and senate committees on ways and means detailing recoveries and offsets generated by said audits; provided that the first report shall be delivered no later than February 1, 2014 and that the second report shall be delivered no later than December 31, 2015."
The amendment was *rejected*.
Mr. Timilty moved that the bill be amended in section 14, in line 475, by inserting after the word "appropriate" the following:-
"(xi) all accountable care organizations registered with the institute shall publish cost and quality criteria used by the ACO, to determine inclusion of any registered provider in the preferred tier of any benefit design offered to the public. The ACO shall certify that they applied their quality and efficiency equally to all licensed providers. Providers excluded from the preferred tier of a health plan offered by an ACO shall have a right of appeal. A provider who requests an appeal shall have 60 days to review the ACO's cost and quality criteria. Disputes unresolved by the parties shall be filed with the Institute. The provisions of (xi) shall apply to all health benefit products offered by ACOs, ACOs sponsored by licensed insurers, HMOs, PPOs, enrolling both private and publically sponsored members".
The amendment was *rejected*.
Mr. Rush moved that the bill be amended in section 52 by striking, in line 1670, the figure "8" and inserting in place thereof the figure "4".
After remarks, the amendment was adopted.
Ms. Fargo moved that the bill be amended by adding a new section:-
"SECTION XX: Chapter 149 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after section 105D, the following section:-
Section 105E. (a) For purposes of this section, the following words shall have the following meanings:-
'Employee', an employee as defined in section 1 of chapter 151B.
'Employer', an employer as defined in section 1 of chapter 151B.

‘Labor organization’, a labor organization as defined in section 1 of chapter 151B.
(b) No employer or labor organization shall prohibit an employee from expressing breast milk during any meal period or other break period required by law to be provided by the employer or required by a collective bargaining agreement. Employers and labor organizations shall also provide reasonable unpaid break time each day to an employee who needs to express breast milk for her child. If possible, the break time for breastfeeding shall run concurrently with any break time already provided to the employee. The employer or labor organization shall make reasonable efforts to provide a room or other location in close proximity to the work area, other than a toilet stall, where the employee can express her breast milk in privacy. An employer or labor organization is not required to provide break time for breastfeeding by an employee under this section if to do so would unduly disrupt the operations of the employer or labor organization.
(c) It shall be an unlawful discriminatory practice for any employer or labor organization, because an employee expresses milk at the workplace, to refuse to hire or employ or to bar or to discharge from employment such employee or to discriminate against such employee in compensation or in terms, conditions or privileges of employment, unless based upon a bona fide occupational qualification.
(d) Violation of this section shall be subject to the second paragraph of section 150 and to section 180. An employer or labor organization shall be not liable for a violation of this section if reasonable efforts have been made to comply with its provisions. Nothing in this section shall prohibit employers or labor organizations from establishing internal rules and guidelines for employees who may wish to breastfeed or express breast milk in the workplace.
Section 2. (a) The executive office of health and human services shall maintain and make available for public inspection a list of businesses in the commonwealth and covered by this act that it designates as accommodating the needs of lactating women in the workplace. A business seeking such designation may submit its lactation policies to the executive office of health and human services.
(b) The executive office of health and human services shall develop a unique identifying mark or name to distinguish those designated businesses that accommodating the needs of lactating women in the workplace and a business may use such mark or name in its promotional materials, if the business develops and implements a written policy supporting the practice of workplace lactation which includes the following elements:
(1) work schedule flexibility, including scheduling breaks and work patterns to provide time for expression of milk;
(2) the provision of accessible locations allowing privacy other than a bathroom stall;
(3) access to an electrical outlet; and
(4) access near to a clean, safe water source and a sink for washing hands and any needed breast-pumping equipment; and
(5) access to hygienic storage in the workplace for the mother's breast milk.”
After remarks, The amendment was *rejected*.
Mr. Berry moved that the bill be amended in section 104 by striking out “and” in line 2815, inserting a comma in its place, and by adding, following “Community Health Centers” the following:- “and the Conference of Boston Teaching Hospitals”.
The amendment was adopted.
Mr. Berry moved that the bill be amended in section 162 by striking out, in line 3925, the words “health economist” and inserting in their place the following:- “representative of an academic medical center”; by striking out, in line 3927, the word “auditor” and inserting in its place the following:-“treasurer”; by striking out in line 3930, the word “auditor” and inserting in its place the following:-“treasurer”; and by striking out in line 3931, the words “an expert in health care finance and policy” and inserting in their place the following:- “a health economist”.
The amendment was *rejected*.
Mr. Richard T. Moore moved that the bill be amended by inserting at the end thereof the following new section:-
“SECTION __. Section 5 of Chapter 112 of the General Laws is hereby amended by striking out paragraphs 6 through 8, inclusive, and inserting in place thereof the following four paragraphs: -
The board shall collect the following information reported to it to create individual profiles on licensees and former licensees, in a format created by the board that shall be available for dissemination to the public:
(a) a description of any criminal convictions for felonies and serious misdemeanors as determined by the board. For the purposes of this subsection, a person shall be deemed to be convicted of a crime if he pleaded guilty or if he was found or adjudged guilty by a court of competent jurisdiction;
(b) a description of any charges for felonies and serious misdemeanors as determined by the board to which a physician pleads nolo contendere or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction;
(c) a description of any final board disciplinary actions, and a copy of any original board disciplinary orders;
(d) a description of any final disciplinary actions by licensing boards in other states;
(e) a description of revocation or involuntary restriction of privileges by a hospital, clinic or nursing home under the provisions of chapter 111, or of any employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth, for reasons related to competence or character that have been taken by the hospital, clinic or nursing home or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth governing body or any other official of the hospital, clinic or nursing home or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth after procedural due process has been afforded, or the resignation from or nonrenewal of medical staff membership or the restriction of privileges at a hospital, clinic or nursing home or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth taken in lieu of or in settlement of a pending disciplinary case related to

competence or character in that hospital, clinic or nursing home or of any employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine or employer who employs physicians licensed by the board for the purpose of engaging in the practice of medicine in the commonwealth ;
(f) all medical malpractice court judgments and all medical malpractice arbitration awards in which a payment is awarded to a complaining party and all settlements of medical malpractice claims in which a payment is made to a complaining party. Dispositions of paid claims shall be reported in a minimum of three graduated categories indicating the level of significance of the award or settlement. Information concerning paid medical malpractice claims shall be put in context by comparing an individual licensee's medical malpractice judgment awards and settlements to the experience of other physicians within the same specialty. Information concerning all settlements shall be accompanied by the following statement: 'Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.' Nothing herein shall be construed to limit or prevent the board from providing further explanatory information regarding the significance of categories in which settlements are reported.
Pending malpractice claims shall not be disclosed by the board to the public. Nothing herein shall be construed to prevent the board from investigating and disciplining a licensee on the basis of medical malpractice claims that are pending.
(g) names of medical schools and dates of graduation;
(h) graduate medical education;
(i) specialty board certification;
(j) number of years in practice;
(k) names of the hospitals where the licensee has privileges;
(l) appointments to medical school faculties and indication as to whether a licensee has a responsibility for graduate medical education within the most recent ten years;
(m) information regarding publications in peer-reviewed medical literature within the most recent ten years;
(n) information regarding professional or community service activities and awards;
(o) the location of the licensee's primary practice setting;
(p) the identification of any translating services that may be available at the licensee's primary practice location;
(q) an indication of whether the licensee participates in the medicaid program.
The board shall provide individual licensees with a copy of their profiles prior to release to the public. A licensee shall be provided a reasonable time to correct factual inaccuracies that appear in such profile.
A physician may elect to have his profile omit certain information provided pursuant to clauses (l) to (n), inclusive, concerning academic appointments and teaching responsibilities, publication in peer-reviewed journals and professional and community service awards. In collecting information for such profiles and in disseminating the same, the board shall inform physicians that they may choose not to provide such information required pursuant to said clause (l) to (n), inclusive.
For physicians who are no longer licensed by the board, the board shall continue to make available the profiles of such physicians, except for those who are known by the board to be deceased. The board shall maintain the information contained in the profiles of physicians no longer licensed by the board as of the date the physician was last licensed, and include on the profile a notice that the information is current only to that date."
After remarks, the question on adoption of the amendment was determined by a call of the yeas and nays, at fourteen minutes past three o'clock P.M., on motion of Mr. Tarr, as follows (yeas 37 -– nays 0) **[Yeas and Nays No. 177]**:

YEAS

Berry, Frederick E.	Keenan, John F.
Brewer, Stephen M.	Kennedy, Thomas P.
Brownsberger, William N.	Knapik, Michael R.
Candaras, Gale D.	McGee, Thomas M.
Chandler, Harriette L.	Montigny, Mark C.
Chang-Diaz, Sonia	Moore, Michael O.
Clark, Katherine M.	Moore, Richard T.
Creem, Cynthia Stone	Pacheco, Marc R.

DiDomenico, Sal N.	Petruccelli, Anthony
Donnelly, Kenneth J.	Rodrigues, Michael J.
Downing, Benjamin B.	Rosenberg, Stanley C.
Eldridge, James B.	Ross, Richard J.
Fargo, Susan C.	Rush, Michael F.
Finegold, Barry R.	Spilka, Karen E.
Flanagan, Jennifer L.	Tarr, Bruce E.
Hart, John A., Jr.	Timilty, James E
Hedlund, Robert L.	Welch, James T.
Jehlen, Patricia D.	Wolf, Daniel A. **— 37.**
Joyce, Brian A.	

NAYS — 0.

ABSENT OR NOT VOTING

Donoghue, Eileen M. **— 1.**

The yeas and nays having been completed at eighteen minutes past three o'clock P.M., the amendment was adopted.

Ms. Fargo moved that the bill be amended by adding a new section:-
"SECTION XX: Chapter 112 of the Massachusetts General Laws is hereby amended at the end thereof by inserting after section 61 the following new section:
'Section 61A (a) Definitions.
'Health care institution' as used in this section shall mean any individual, partnership, association, corporation or trust or any person or group of persons that provides health care services and employs health care providers licensed or subject to licensing by the Massachusetts Department of Health under this chapter. This definition includes but is not limited to hospitals, clinics, health centers, pharmacies, and doctors' and dentists' offices.
'Retail establishment' as used in this section shall mean any store that sells goods or articles of personal services to the public.
'Tobacco products' as used in this section shall mean any substance containing tobacco leaf, including but not limited to cigarettes, cigars, pipe tobacco, snuff, chewing tobacco and dipping tobacco.
(b) Prohibition of Tobacco Sales
(1) No health care institution located in Massachusetts shall sell or cause to be sold tobacco products.
(2) No retail establishment that operates or has a health care institution within it, shall sell or cause to be sold tobacco products, except that this prohibition shall not apply to buildings or sites where tobacco sales are conducted at a site with separate street entrances which are more than 75 feet from the site where health services are offered, and, where no interior hallways or other passageways provide access to both the health care facility and the site of tobacco sales.
(3) The Board of Registration in Medicine and each board of registration within the Division of Health Professions Licensure, including but not limited to the Board of Registration in Nursing, the Board of Registration in Podiatry, the Board of Registration in Pharmacy, the Board of Registration in Optometry, and the Board of Registration of Chiropractors, shall promulgate regulations within 90 days of the effective date of this legislation which prohibit their licensees from working in their professional capacity in any retail establishment where tobacco products are sold or in workspaces leased within or from such retail establishment."
The amendment was *rejected*.
Ms. Fargo moved that the bill be amended by adding a new section:-
"SECTION XX: Chapter 111 of the General Laws is hereby amended by inserting after section 224, the following section:-
Section 225. The department shall provide educational information to the public on the health benefits of breastfeeding. All such

information shall be compatible with the nutritional requirements to be provided by the department under section 1 of chapter 111I. The department shall post such information on its public internet site and may make the information available in written format, to local boards of health and to any state department, division or agency that administers a maternal or child health service or program, for public dissemination."

The amendment was *rejected*.

Ms. Fargo moved that the bill be amended in section 9, in line 370, by inserting, after the word "costs.", the following words:- "The data collection tool shall be the Behavioral Factor Surveillance System (hereinafter referred to as BRFSS), an annual telephone survey that collects data on emerging public health issues, health conditions, risk factors and behaviors, including racial discrepancies in health and health care, trends in chronic diseases and health risk factors, where the results are used for health care policy planning, as a guide for developing preventive health interventions, and as an assessment of health status."

The amendment was *rejected*.

Ms. Fargo moved to amend the bill in section 2G(h) in Section 48, in line 1443, by inserting, after the word "status", the following words: - "The Office of Health Equity, in conjunction with accountable care organizations, other health care entities and other stakeholders (Department of Public Health/Prevention and Wellness Advisory Board), shall set benchmarks to measure the continued improvement in health disparities reduction among racial, ethnic and linguistic populations;".

The amendment was *rejected*.

Messrs. Rosenberg and Eldridge and Ms. Jehlen moved that the bill be amended by inserting after section 192 the following new section:-

"SECTION 192A. (a) There shall be a Pharmaceutical Cost Containment commission established to study methods to reduce the cost of prescription drugs for both public and private payers. The commission shall consist of 16 members: 2 of whom shall be the co-chairs of the joint committee on health care financing, 1 of whom shall be the commissioner of the group insurance commission or a designee, 1 of whom shall be the director of the division of insurance or a designee, 1 of whom shall be the director of the state office of pharmacy services or a designee, 1 of whom shall be the secretary of elder affairs or a designee, 1 of whom shall be the director of the Massachusetts medicaid program or a designee, 2 of whom shall be appointed by the president of the senate, 1 of whom shall be appointed by the minority leader of the senate, 2 of whom shall be appointed by the speaker of the house of representatives, 1 of whom shall be appointed by the minority leader of the house of representatives, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, 1 of whom shall be a representative of the Massachusetts Hospital Association, and 1 of whom shall be a representative of Health Care For All. All necessary appointments shall be made within 60 days of the effective date of this act.

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

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

After remarks, the amendment was adopted.

Ms. Creem and Messrs. Downing, Eldridge and Rosenberg, Ms. Spilka and Mr. Finegold moved that the bill be amended in section 29, by inserting after the words "decision support" in line 1125, the following words:- "and image exchange".

After remarks, the amendment was adopted.

Ms. Fargo moved that the bill be amended in section 1, of chapter 176S in line 3867, by striking "a provider, provider organization or carrier" and inserting in place thereof the following words: - "All entities, other than accountable care organizations, that provide reimbursements to health care providers in exchange for the health care providers providing medical care and services to patient."

The amendment was *rejected*.

Ms. Fargo moved that the bill be amended in section 25A, in line 1490, by inserting, after the word "law", the following words:- "and health professionals whose services are utilized in care models for the purpose of helping a patient achieve whole health, including but not limited to community health workers, legal advocates, medical interpreters, clinical prevention specialists, human services workers, social workers and licensed alcohol and drug counselors".

The amendment was *rejected*.

Mr. Berry moved that the bill be amended in section 200, line 5074, by striking out the date "2015" and inserting in its place the following:- "2017".

The amendment was *rejected*.

Mr. Kennedy moved that the bill be amended by adding at the end of thereof the following new section:

"SECTION _¬___: the executive office of health and human services shall seek from the Secretary of the Department of Health and Human Services an exemption or waiver from the Medicare requirement set forth in 42 U.S.C. §1395x(i) that an admission to a skilled nursing facility be preceded by a three-day hospital stay".

After remarks, the amendment was adopted.
Mr. Richard T. Moore moved that the bill be amended by inserting at the end thereof the following new section:-
"SECTION __. Chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended, by inserting at the end thereof, the following new section:
Section 226. (a) As used in this section the following terms shall, unless the context clearly requires otherwise, have the following meanings:
'Appropriate', consistent with applicable legal, health and professional standards, the patient's clinical and other circumstances and the patient's reasonably known wishes and beliefs.
'Attending health care practitioner', a physician or nurse practitioner who has primary responsibility for the care and treatment of the patient. Where more than 1 physician or nurse practitioner share that responsibility, each of them has a responsibility under this section, unless they agree to assign that responsibility to 1 of them.
'Palliative care', a health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including hospice care.
'Terminal illness or condition', an illness or condition which can reasonably be expect to cause death within 6 months, whether or not treatment is provided.
(b) The commissioner shall adopt regulations requiring each licensed hospital, skilled nursing facility, health center or assisted living facility to distribute to appropriate patients in its care information regarding the availability of palliative care and end-of-life options.
(c) If a patient is diagnosed with a terminal illness or condition, the patient's attending health care practitioner shall offer to provide the patient with information and counseling regarding palliative care and end-of-life options appropriate to the patient, including, but not limited to: (i) the range of options appropriate to the patient; (ii) the prognosis, risks and benefits of the various options; and (iii) the patient's legal rights to comprehensive pain and symptom management at the end of life. The information and counseling may be provided orally or in writing. Where the patient lacks capacity to reasonably understand and make informed choices relating to palliative care, the attending health care practitioner shall provide information and counseling under this section to a person with authority to make health care decisions for the patient. The attending health care practitioner may arrange for information and counseling under this section to be provided by another professionally qualified individual.
Where the attending health care practitioner is not willing to provide the patient with information and counseling under this section, the attending health care practitioner shall arrange for another physician or nurse practitioner to do so, or shall refer or transfer the patient to another physician or nurse practitioner willing to do so.
(d) The department shall consult with the Hospice and Palliative Care Federation of Massachusetts, in developing educational documents, rules and regulations related to this section."
The amendment was adopted.
Messrs. Eldridge, Rosenberg, Downing, Wolf and Brownsberger, Ms. Fargo, Ms. Chang-Díaz, and Ms. Jehlen moved that the bill be amended in section 14:
By adding the following definition:-
"'Single payer health care,' a system that guarantees continuous, high-quality, publicly-financed health coverage for all state residents in a manner regardless of income, assets, health status, or availability of other health coverage. A single payer health care system shall, therefore, be guided by the following principles:
Health care coverage must be universal;
Health care coverage must be continuous;
Health care coverage must be affordable;
Health care costs must be affordable and sustainable for the Commonwealth as a whole; and
Health care coverage must support patient-centered care, protecting the relationship between patients and their health care practitioners."; and by adding the following new section at the end thereof:-
"Section 23. The institute shall monitor, review, and evaluate reports related to single payer health care; provided, however, that the institute shall also monitor the performance of single payer health care systems in other states and countries.
The institute shall establish a single payer benchmark which shall be the cost in total health care expenditures of providing continuous, high-quality, publicly-financed health coverage for all Massachusetts residents in a manner regardless of income, assets, health status, or availability of other health coverage.
The institute shall submit annual written reports on all findings, evaluations, and recommendations from its monitoring obligations related to the single payer health care benchmark to the governor, president of the senate, the speaker of the house of representatives, to the joint committee on health care financing, and the house and senate committees on ways and means. This report shall include a plan of action, timeline, funding recommendations (subject to legislative approval), and specific legislative and regulatory measures needed to achieve a single payer health care system in Massachusetts. The institute shall post the report on its public website.
If at the outset of state fiscal year 2015, the institute determines that the single payer health care benchmark has outperformed the 'health care cost growth benchmark', as defined in chapter 176S section 5 of the general laws, the Executive Office of Health and Human Services shall, no later than June 30, 2016, submit a 'Single Payer health care Implementation Plan' to the legislature after holding public hearings and meetings, which shall be consistent with the principles of 'single payer health care' as defined in this chapter and the annual reports of the institute.
After debate, the question on adoption of the amendment was determined by a call of the yeas and nays, at seventeen minutes before five o'clock P.M., on motion of Mr. Eldridge, as follows, to wit (yeas 15 – nays 22) **[Yeas and Nays No. 178]:**

YEAS

Brownsberger, William N.	Fargo, Susan C.
Chang-Diaz, Sonia	Jehlen, Patricia D.
Clark, Katherine M.	McGee, Thomas M.
Creem, Cynthia Stone	Montigny, Mark C.
DiDomenico, Sal N.	Pacheco, Marc R.
Donnelly, Kenneth J.	Rosenberg, Stanley C.
Downing, Benjamin B.	Wolf, Daniel A.
Eldridge, James B.	**— 15.**

NAYS

Berry, Frederick E.	Knapik, Michael R.
Brewer, Stephen M.	Moore, Michael O.
Candaras, Gale D.	Moore, Richard T.
Chandler, Harriette L.	Petruccelli, Anthony
Finegold, Barry R.	Rodrigues, Michael J.
Flanagan, Jennifer L.	Ross, Richard J.
Hart, John A., Jr.	Rush, Michael F.
Hedlund, Robert L.	Spilka, Karen E.
Joyce, Brian A.	Tarr, Bruce E.
Keenan, John F.	Timilty, James E
Kennedy, Thomas P.	Welch, James T.
	— 22.

ABSENT OR NOT VOTING

Donoghue, Eileen M. **— 1.**

The yeas and nays having been completed at thirteen minutes before five o'clock P.M., The amendment was *rejected*.

Mr. Welch moved that the bill be amended in line 1522, by inserting after the word "state" the following words:- "with not less than 2 within the following counties: Berkshire, Franklin, Hampden, and Hampshire".
After remarks, the amendment was adopted.
Mr. Welch moved that the bill be amended in section 145 by adding at the end thereof the following sentence:-"Nothing in this provision shall restrict the ability of a carrier or utilization review organization to deny a claim for an admission, procedure or

service if the admission, procedure or service was not medically necessary, based on information provided at the time of claim. Nothing in this provision shall restrict the ability of a carrier or utilization review organization to deny a claim for an admission, procedure or service if other terms and conditions of coverage are not met at the time of service or time of claim."
The amendment was adopted.
Ms. Jehlen moved that the bill be amended in section 190, in line 4856, by striking the word, "14" and inserting the following:, "15"; and in section 190, in line 4870 by inserting after the words "Association, Inc.:" the following: "1 of whom shall be a representative of the Massachusetts Coalition of Nurse Practitioners;".
The amendment was *rejected*.
Ms Jehlen moved that the bill be amended in section 60, in lines 1852 to 1854, by striking out the sentence "Individual reports shall be kept confidential by the department and the Betsy Lehman Center, but aggregated compliance rates shall be posted publicly." and inserting in place thereof the following sentence: "The department shall publicly report on individual hospitals' compliance rates."
After remarks, the amendment was adopted.
Mr. Downing moved that the bill be amended by inserting, after section 9 of the new chapter 176S, the following new section:-
"SECTION 9A; The authority shall annually certify that the office of Medicaid, the group insurance commission, the commonwealth health insurance connector authority and any other state funded health insurance program offers health insurance coverage of a range of providers that is adequate to serve the needs of subscribers in all geographic regions of the Commonwealth. The commissioner of insurance shall promulgate regulations for the administration and enforcement of this section."
The amendment was *rejected*.
Mr. Downing moved that the bill be amended by inserting the following new section:-
"SECTION 206. Chapter 118H of the General Laws is hereby amended by striking out Section 3(b), and inserting in place thereof the following section:-
Section 3(b)
(1) The board may waive clause (4) of subsection (a) if:
i. The individual's employer complies with section 110 of chapter 175, section 81/2 of chapter 176A, section 3B of chapter 176B or section 6A of chapter 176G.
ii. The individual is self-employed as defined in Section 1 of Chapter 12C, and the increase in that individual's private insurance premium exceeds the average premium increase for private insurers in the state, as determined by the division of insurance, by more than 10 percent.
(2) The employer's health insurance premium contribution for the applying individual, which shall be the cash equivalent of the premium contribution that would otherwise be made by an employer on behalf of the applying individual for the plan and rate basis type for which the individual would be eligible or, in cases where the individual is eligible to participate in more than 1 plan, the cash equivalent of the premium contribution for the most popular plan and rate basis type for which the individual is eligible, shall be paid to the connector. The connector shall use the employer's health insurance premium contribution payment for the individual to first offset the commonwealth's premium assistance payment for the individual with any residual amount offsetting the individual."
The amendment was *rejected*.
Ms. Jehlen and Mr. Eldridge moved that the bill be amended by adding a new section being the text of Senate document numbered 2263, relative to duel eligible's under 65.
The amendment was *rejected*.
Mr. Michael O. Moore moved that the bill be amended by inserting after section ___, the following section:-
"SECTION ___. Notwithstanding any law or rule the contrary, the department of higher education shall investigate the possibility of dedicating funds for joint appointments for clinicians with clinical agencies and universities. As part of the arrangement, clinicians pursuing doctoral education would receive tuition and fee reimbursement from a Massachusetts public higher education institution for maintaining a clinical position and teaching at the entry level of the academic program while pursuing their doctoral degree or after receiving their doctoral degree."
The amendment was *rejected*.
Mr. Michael O. Moore moved that the bill be amended by inserting after section __, the following section:-
"SECTION __. Notwithstanding any general or special law to the contrary, there shall be a special task force to evaluate, but not limited to, changes in health care resulting in new and changing roles for providers and support personnel and to develop models for the delivery of care that consider existing needs as well as emerging roles such as expanded home care, e-medical records support, technology advances. The Task Force would be comprised of three members appointed by the Governor, one of whom will be appointed by the Governor chairman, three members of the House of Representatives appointed by the Speaker, three members of the Senate appointed by the Senate President, one member selected by each of the following: Commissioner of Higher Education, Massachusetts Hospital Association, Nursing Home Association, Association for Massachusetts Health Centers, Massachusetts Medical Society, Massachusetts Nurses Association."
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by adding the following section:-
"SECTION___. Notwithstanding any general or special law to the contrary, a moratorium on any new mandated health benefit shall exist until December 31, 2013."

Mr. Hart in the Chair, after debate, the question on adoption of the amendment was determined by a call of the yeas and nays, at twenty minutes past five o'clock P.M., on motion of Mr. Tarr, as follows, to wit (yeas 6 – nays 30) **[Yeas and Nays No. 179]:**

YEAS

Finegold, Barry R.	Ross, Richard J.
Hedlund, Robert L.	Tarr, Bruce E.
Knapik, Michael R.	Timilty, James E. **— 6.**

NAYS

Berry, Frederick E.	Joyce, Brian A.
Brewer, Stephen M.	Keenan, John F.
Brownsberger, William N.	Kennedy, Thomas P.
Candaras, Gale D.	McGee, Thomas M.
Chandler, Harriette L.	Montigny, Mark C.
Chang-Diaz, Sonia	Moore, Michael O.
Clark, Katherine M.	Moore, Richard T.
Creem, Cynthia Stone	Pacheco, Marc R.
DiDomenico, Sal N.	Petruccelli, Anthony
Donnelly, Kenneth J.	Rodrigues, Michael J.
Downing, Benjamin B.	Rosenberg, Stanley C.
Eldridge, James B.	Rush, Michael F.
Fargo, Susan C.	Spilka, Karen E.
Hart, John A., Jr.	Welch, James T.
Jehlen, Patricia D.	Wolf, Daniel A. **— 30.**

ABSENT OR NOT VOTING

Donoghue, Eileen M.	Flanagan, Jennifer L. **— 2.**

The yeas and nays having been completed at twenty-four minutes past five o'clock P.M., The amendment was *rejected*.

Mr. Tarr moved that the bill be amended by inserting after section 85 the following section:-
"SECTION __. Section 1 of chapter 111M of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 46, at the end of the definition of the term 'Creditable coverage' the following:- Minimum creditable coverage,

as defined by the board under the authority granted herein, shall not require, in the case of individuals subject to chapter 58 of the acts of 2006, coverage for prescription drugs."
After debate, the question on adoption of the amendment was determined by a call of the yeas and nays, at twenty-one minutes before six o' clock P.M., on motion of Mr. Knapik, as follows, to wit (yeas 5 – nays 30) **[Yeas and Nays No. 180]:**

YEAS

Hedlund, Robert L.	Tarr, Bruce E.
Knapik, Michael R.	Timilty, James E. **— 5.**
Ross, Richard J.	

NAYS

Berry, Frederick E.	Joyce, Brian A.
Brewer, Stephen M.	Keenan, John F.
Brownsberger, William N.	Kennedy, Thomas P.
Candaras, Gale D.	McGee, Thomas M.
Chandler, Harriette L.	Montigny, Mark C.
Chang-Diaz, Sonia	Moore, Michael O.
Clark, Katherine M.	Moore, Richard T.
DiDomenico, Sal N.	Pacheco, Marc R.
Donnelly, Kenneth J.	Petruccelli, Anthony
Downing, Benjamin B.	Rodrigues, Michael J.
Eldridge, James B.	Rosenberg, Stanley C.
Fargo, Susan C.	Rush, Michael F.
Finegold, Barry R.	Spilka, Karen E.
Hart, John A., Jr.	Welch, James T.
Jehlen, Patricia D.	Wolf, Daniel A. **— 30.**

ABSENT OR NOT VOTING

Creem, Cynthia Stone	Flanagan, Jennifer L. **— 3.**
Donoghue, Eileen M.	

The yeas and nays having been completed at seventeen minutes before six o'clock P.M., The amendment was *rejected*.

Ms. Spilka and Mr. Richard T. Moore moved that the bill be amended by inserting after section 136 the following section:- "SECTION 136A. Said chapter 176O, as so appearing, is hereby amended by inserting after section 5B the following section:- Section 5C. If the commissioner determines that a carrier is neglecting to comply with the coding standards and guidelines under this chapter in the form and within the time required 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.".

After remarks, the question on adoption of the amendment was determined by a call of the yeas and nays, at ten minutes before six o'clock P.M., on motion of Mr. Tarr, as follows, to wit (yeas 35 – nays 0) **[Yeas and Nays No. 181]:**

YEAS

Berry, Frederick E.	Kennedy, Thomas P.
Brewer, Stephen M.	Knapik, Michael R.
Brownsberger, William N.	McGee, Thomas M.
Candaras, Gale D.	Montigny, Mark C.
Chandler, Harriette L.	Moore, Michael O.
Chang-Diaz, Sonia	Moore, Richard T.
Clark, Katherine M.	Pacheco, Marc R.
DiDomenico, Sal N.	Petruccelli, Anthony
Donnelly, Kenneth J.	Rodrigues, Michael J.
Downing, Benjamin B.	Rosenberg, Stanley C.
Eldridge, James B.	Ross, Richard J.
Fargo, Susan C.	Rush, Michael F.
Finegold, Barry R.	Spilka, Karen E.
Hart, John A., Jr.	Tarr, Bruce E.
Hedlund, Robert L.	Timilty, James E
Jehlen, Patricia D.	Welch, James T.
Joyce, Brian A.	Wolf, Daniel A. **— 35.**
Keenan, John F.	

NAYS — 0.

ABSENT OR NOT VOTING

Creem, Cynthia Stone	Flanagan, Jennifer L. **— 3.**

Donoghue,
Eileen M.

The yeas and nays having been completed at six minutes before six o'clock P.M., the amendment was adopted.

Mr. Kennedy moved that the bill be amended in section 10 by striking out, in line 475, the words, "(x) such other information as the institute considers appropriate" and inserting in place thereof the following words:- "(x) such other information as the institute considers appropriate; and (xi) all accountable care organizations, registered with the institute shall publish cost and quality criteria used by the accountable care organizations, to determine inclusion of any registered provider in the preferred tier of any benefit design offered to the public. The accountable care organizations shall certify that they applied their quality and efficiency equally to all licensed providers. Providers excluded from the preferred tier of a health plan offered by an accountable care organizations shall have a right of appeal. A provider who requests an appeal shall have sixty days to review the accountable care organizations' cost and quality criteria. Disputes unresolved the the parties shall be filed with the Institute.
The provisions of (xi) of subsection (c) of section (10) shall apply to all health benefit products offered by accountable care organizations, accountable care organizations sponsored by licensed insurers, health maintenance organization, preferred provider organization, enrolling both private and publically sponsored members.".
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by inserting after section __ the following new section:-
"SECTION __. The office of Medicaid and the department of unemployment assistance shall, in consultation with the executive office of health and human services, develop and implement a means by which the office of Medicaid may access information as to the status of or termination of unemployment benefits and the associated insurance coverage by the medical security plan, as administered by the executive office of labor and workforce development, for the purposes of determination of eligibility for those individuals applying for benefits through health care insurance programs administered by the executive office of health and human services. The office and the department shall implement this system not later than three months following the passage of this act; provided, however, that if legislative action is required prior to implementation, recommendations for such action shall be filed with the house and senate clerks and the joint committee on health care financing not later than two months following the passage of this act."
The amendment was adopted.
Mr. Tarr moved that the bill be amended by inserting after section 88 the following section:-
"SECTION __. Section 12B of chapter 112, is hereby amended by striking the section in its entirety and replacing it with the following:
Section 12B. No physician duly registered under the provisions of section two, two A, nine, nine A or nine B, no physician assistant duly registered under the provisions of section nine I or his employing or supervising physician, no nurse duly registered or licensed under the provisions of section seventy-four, seventy-four A or seventy-six, no pharmacist duly registered under the provisions of section twenty-four, no pharmacy technician duly registered under the provisions of section twenty-four C, no dentist duly registered under the provisions of section forty-five, or forty-five A, no psychologist duly licensed under the provisions of sections one hundred and eighteen through one hundred and twenty-nine, no social worker duly licensed under the provisions of sections one hundred and thirty through one hundred and thirty-seven, no marriage and family therapist or mental health counselor duly licensed under the provisions of sections 165 through 171, and no radiologic technologist duly licensed under the provisions of section 5L of chapter 111, or resident in another state, in the District of Columbia or in a province of Canada, and duly registered or licensed therein, who, in good faith, as a volunteer and without fee, renders emergency care or treatment, other than in the ordinary course of his practice, shall be liable in a suit for damages as a result of his acts or omissions, nor shall he be liable to a hospital for its expenses if, under such emergency conditions, he orders a person hospitalized or causes his admission."
The amendment was adopted.
Mr. Tarr moved to amend the bill in Section 166 by inserting after proposed section 60N of chapter 231 of the General Laws, the following sections:-
"Section 60O. In every action for malpractice, negligence, error, omission, mistake or the unauthorized rendering of professional services against a provider of health care the court may, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds $50,000 in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages, and court shall require a defendant who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the defendant.
(a)(1) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Such payments shall only be subject to modification in the event of the death of the judgment creditor.
(2) In the event that the court finds that the defendant has exhibited a continuing pattern of failing to make the payments as specified in paragraph (1), the court shall find the defendant in contempt of court and, in addition to the required periodic payments, shall order the defendant to pay the plaintiff all damages caused by the failure to make such periodic payments,

including court costs and attorney's fees.
(b) Money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the plaintiff, but shall be paid to persons to whom the plaintiff owed a duty of support, as provided by law, immediately prior to his death, or to whom the plaintiff assigned, transferred, or bequeathed his right to receive payment. In such cases the court which rendered the original judgment, may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subdivision.
(c) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the defendant to make future payments shall cease and any security given, pursuant to this section shall revert to the defendant.
Section 60P. In any action for malpractice, error, omission, mistake or the unauthorized rendering of professional services against a provider of health care, the liability of each defendant for damages shall be several only and shall not be joint. Each defendant shall be liable only for the amount of damages allocated to that defendant in direct proportion to that defendant's percentage of fault, and a separate judgment shall be rendered against that defendant for that amount.".
The amendment was *rejected*.
Mr. Kennedy moved that the bill be amended in section 13 by striking out, in line 57, the words "(d) The attorney general may act under subsection (b) of section 15 of chapter 12C to carry out this section" and inserting in place thereof the following words:-
"(d) The attorney general may act under subsection (b) of section 15 of chapter 12C to carry out this section; and
(e) Notwithstanding any general or special law or rule or regulation to the contrary, no health care facility as defined in Section 187 of chapter 149, no carrier as defined in Section 1 of chapter 176R, nor any person or legal entity, that employs or contracts with a health care provider licensed under chapter 112, shall restrict the ability of said health care provider to provide general or specialty medical or other health services, within that health care provider's respective scope of practice. Any person or legal entity taking action to restrict the lawful practice of a licensed health care provider's profession through contract or in employment, including but not limited to adverse internal policies; by-laws; membership; term or condition of employment or contract; guideline; protocol; or referral; inconsistent with a licensed health care provider practicing his profession in accordance with applicable state health care provider licensure law or regulation, shall be considered to have engaged in an unfair and deceptive practice and shall be in violation of chapter 93A.
(f) Nothing in the section shall be construed to exclude any private right of action by a health care provider licensed under chapter 112.".
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by inserting after section 198 the following new section:-
"SECTION 198A. The secretary of administration and finance and the secretary of health and human services shall evaluate the feasibility of contracting for recycling durable medical equipment purchased and issued by the commonwealth through any and all of its medical assistance programs.
Said evaluation shall include but not be limited to a request for qualifications or proposals for entities capable of developing, implementing and operating a system of recycling whereby an inventory of such equipment is developed and managed so as to maximize the quality of service delivery to equipment recipients and to minimize costs and losses attributable to waste, fraud or abuse.
The secretary of administration and finance shall report to the joint committee on health care financing, the house committee on ways and means and the senate committee on ways and means the findings of said evaluation, together with cost estimates for the operation of a recycling program, estimates of the savings it would generate, and legislative recommendations, not later than October 31, 2012.".
After remarks, the amendment was adopted.
Mr. Tarr moved that the bill be amended by inserting after section __ the following new sections:-
"SECTION __. The division of health care finance and policy shall, within eight months of the passage of this act, develop regulations to ensure the following: i) that Medicare-like claims editing is fully and effectively implemented and used to determine reimbursements from the Health Safety Net Trust Fund; and ii) that claims editing is effectively used to reduce the occurrence of payments for medically unnecessary services, medically unlikely events, and duplicate services.
SECTION __. The office of Medicaid shall, within eight months of the passage of this act, develop regulations to ensure that incentives or regulations are implemented to increase competition among MassHealth managed care organizations, reduce the size of some provider networks offered by managed care organizations, and/or to reduce cost of managed care organizations."
The amendment was *rejected*.
Mr. Berry moved that the bill be amended in section 14 by striking out section 10(e) of the new chapter 12C of the general laws and inserting in place thereof the following:-
"(e) The institute shall, in collaboration with the division of insurance, establish by regulation a certification process for any provider organization which enters into alternative payment contracts. Such certification process shall be designed to determine whether a provider organization has adequate reserves and other measures of financial solvency to meet its risk arrangements. The standards for such certification may vary based on the provider organization size, the type of alternative payment methodology employed, the amount and type of risk assumed and such other criteria as the commissioner of insurance considers appropriate to ensure that provider organizations do not assume excess risk; provided, that said institution in collaboration with the division of insurance shall establish a level of certification that is sufficient to authorize a Beacon ACO to establish business arrangements for self insured employee health insurance coverage, products or other arrangements including but not limited to global payments arrangements with such self-insured employers. The institute, in collaboration with the division of insurance,

shall establish a schedule to renew such certification. The institute and the commissioner of insurance shall create and administer the program under which one or more Beacon ACOs shall directly contract with self-insured employers, so-called, on a global payment basis for the delivery of accountable care to persons employed or covered by such employers. The institute shall establish such other criteria for such program after holding a public hearing and seeking the input of employers and Beacon ACOs. An agreement between a self-insured employer, so-called, and a Beacon ACO certified under section 8 of Chapter 176S, under which the accountable care organization is paid in whole or in part, on a global payment or risk-based basis, or other alternative payment methodology, shall not be deemed to be a contract of insurance; and a Beacon ACO participating in the program shall not be deemed an insurer or a health maintenance organization under chapter 175 or chapter 176, respectively, of the General Laws."

The amendment was *rejected*.

Mr. Tarr moved that the bill be amended by inserting after section 175 the text of Senate document numbered 2264, relative to flexible benefit options.

After debate, the question on adoption of the amendment was determined by a call of the yeas and nays, at thirteen minutes past six o'clock P.M., on motion of Mr. Knapik, as follows, to wit (yeas 5 – nays 30) **[Yeas and Nays No. 182]:**

YEAS

Hedlund, Robert L.	Tarr, Bruce E.
Knapik, Michael R.	Timilty, James E. **— 5.**
Ross, Richard J.	

NAYS

Berry, Frederick E.	Jehlen, Patricia D.
Brewer, Stephen M.	Joyce, Brian A.
Brownsberger, William N.	Keenan, John F.
Candaras, Gale D.	Kennedy, Thomas P.
Chandler, Harriette L.	Montigny, Mark C.
Chang-Diaz, Sonia	Moore, Michael O.
Clark, Katherine M.	Moore, Richard T.
DiDomenico, Sal N.	Pacheco, Marc R.
Donnelly, Kenneth J.	Petruccelli, Anthony
Donoghue, Eileen M.	Rodrigues, Michael J.
Downing, Benjamin B.	Rosenberg, Stanley C.
Eldridge, James B.	Rush, Michael F.
Fargo, Susan C.	Spilka, Karen E.
Finegold, Barry R.	Welch, James T.

Hart, John A., Jr.	Wolf, Daniel A. **— 30.**

ABSENT OR NOT VOTING

Creem, Cynthia Stone	McGee, Thomas M. **— 3.**
Flanagan, Jennifer L.	

The yeas and nays having been completed at seventeen minutes past six o'clock P.M., The amendment was *rejected*.

Mr. Kennedy moved that the bill be amended by iinserting in place thereof the following:-
Section 1. By deleting in line 216, the number "1" and the inserting in place thereof the following: "10";
Section 2. By inserting after the word "organization" in line 220 the following" "of ten or more providers";
Section 3. By inserting after the word "provider" in line 315 by the following: "organization";
Section 4. By deleting the word "providers" in line 362 and inserting in place there of the following: "provider organizations and licensed facilities";
Section 5. By inserting after the word "organization" in line 780 the following: ",as defined in Section One of Chapter 12C";
Section 6. By deleting lines 868 through 892 commencing with "(2)";
Section 7, By deleting the word "provider" in line 1948 and inserting in place thereof the following: "accountable care";
Section 8. By deleting the number "1" in line 3420 and inserting in place there of the following: "10"; and
Section 9. By insertion after the word "organization" in line 3424 the following: "of ten or more providers".
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by inserting after section __ the following new section:-
"SECTION __. In hospital fiscal year 2013, the office of the inspector general may expend funds from the the HealthCare Payment Reform Fund as appearing in section 100 of chapter 194 of the Acts of 2011, for the costs associated with conducting an audit of the Commonwealth's Medicaid program. The inspector general may examine the practices utilized in all hospitals including, but not limited to, the care of the insured receiving health care services reimbursed pursuant to the Commonwealth's Medicaid system. The inspector general shall submit a report to the house and senate committees on ways and means containing the findings of any audits so conducted and any other completed analyses not later than 6 months after funds are deposited into the HealthCare Payment Reform Fund. For the purposes of such audits, health care services shall be defined pursuant to said chapter 118G and any regulations adopted there under."
After debate, the question on adoption of the amendment was determined by a call of the yeas and nays, at a half past six o'clock P.M., on motion of Mr. Tarr, as follows, to wit (yeas 7 – nays 28) **[Yeas and Nays No. 183]:**

YEAS

Hedlund, Robert L.	Ross, Richard J.
Knapik, Michael R.	Tarr, Bruce E.
Moore, Michael O.	Timilty, James E**— 7.**
Rodrigues, Michael J.	

NAYS

Berry, Frederick E.	Hart, John A., Jr.
Brewer, Stephen M.	Jehlen, Patricia D.
Brownsberger, William N.	Joyce, Brian A.
Candaras, Gale D.	Keenan, John F.
Chandler, Harriette L.	Kennedy, Thomas P.

Chang-Diaz, Sonia	Montigny, Mark C.
Clark, Katherine M.	Moore, Richard T.
DiDomenico, Sal N.	Pacheco, Marc R.
Donnelly, Kenneth J.	Petruccelli, Anthony
Donoghue, Eileen M.	Rosenberg, Stanley C.
Downing, Benjamin B.	Rush, Michael F.
Eldridge, James B.	Spilka, Karen E.
Fargo, Susan C.	Welch, James T.
Finegold, Barry R.	Wolf, Daniel A. — **28.**

ABSENT OR NOT VOTING

Creem, Cynthia Stone	McGee, Thomas M. .— **3.**
Flanagan, Jennifer L	

The yeas and nays having been completed at twenty-seven minutes before seven o'clock P.M., The amendment was *rejected*.

Mr. Knapik moved that the bill be amended by inserting the following new section:-
"SECTION XX. This act shall be effective not less than 30 days after the Supreme Court of the United States renders a decision in the matter of Thomas More Law Center, Jann DeMars, John Ceci, Steven Hyder, and Salina Hyder v. Barack Hussein Obama, in his official capacity as President of the United States, et al."
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by inserting after section 2 the following section:-
"SECTION__. Paragraph (1) of Subsection (d) of said section 38C of said chapter 3, as so appearing, is hereby further amended by striking paragraph (1) and inserting in place thereof the following:-
(1) the financial impact of mandating the benefit, including the extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years, the extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years, the extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service, the extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next 5 years, the effects of mandating the benefit on the cost of health care, particularly the premium, administrative expenses and indirect costs of municipalities, large employers, small employers, employees and nongroup purchasers, the potential benefits and savings to municipalities, large employers, small employers, employees and nongroup purchasers, the effect of the proposed mandate on cost shifting between private and public payors of health care coverage, the cost to health care consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed treatment and the effect on the overall cost of the health care delivery system in the commonwealth;".
The amendment was *rejected*.
Mr. Richard T. Moore moved that the bill be amended by inserting at the end thereof the following new sections:-
"SECTION __. Chapter 111 of the General Laws is hereby amended by inserting after section 51H the following section:-
Section 51I. The department shall promulgate regulations regarding limited services clinics. Such regulations shall promote the availability of limited services clinics as a point of access for health care services within the full scope of practice of a nurse practitioner or other clinician providing services.
SECTION __. Section 52 of chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting, after the definition of 'Institution for unwed mothers' the following 2 definitions:-

‘Limited services’, diagnosis, treatment, management, monitoring of acute and chronic disease, wellness and preventative services of a nature that may be provided within the scope of practice of a nurse practitioner or other clinician providing services using available facilities and equipment, including shared toilet facilities for point-of-care testing.
‘Limited services clinic’, a clinic that provides limited services.”
After remarks, the amendment was adopted.
Mr. Tarr moved that the bill be amended by inserting after section ___ the following new section:-
“SECTION __. Section 4 of Chapter 32A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting, after the first paragraph, the following:- Among the policies purchased by the commission, at least one shall include a health savings account in its design.”
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by striking sections 2000 through 205, inclusive; and by inserting at the end thereof the following new section:--
“SECTION ___. No provision of this act shall take effect before January 1, 2014.”
After debate, The amendment was *rejected*.
Mr. Kennedy moved that the bill be amended by striking out section 190 and inserting in place thereof the following words:-
“SECTION 190. There shall be a special commission to review variation in prices among providers. The commission shall consist of 14 members: 1 of whom shall be the executive director of the institute of health care finance and policy or a designee, who shall serve as chair; 1 of whom shall be the secretary of administration and finance or a designee; 1 of whom shall be the executive director of the group insurance commission or a designee; 1 of whom shall be the secretary of health and human services or a designee; 1 of whom shall be the attorney general or a designee; 4 of whom shall be appointed by the governor, 1 of whom shall be a health economist, 1 of whom shall have expertise in the area of health care payment methodology, 1 of whom shall represent non-physician health care providers and 1 of whom shall represent an academic medical center or teaching hospital; 1 of whom shall represent a high Medicaid and low income public payer disproportionate share hospital. 1 of whom shall be appointed by the senate president and shall be a health economist or have expertise in the area of health care payment methodology; 1 of whom shall be appointed by the speaker of the house of representatives and shall be a health economist or have expertise in the area of health care payment methodology; 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc.; 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc.; 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc.; and 1 of whom shall be a representative of the Massachusetts Medical Society.”.
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by inserting after section __ the following new sections:-
“SECTION __. The Massachusetts Health Connector shall establish a special small business commission composed solely of small business owners and their employees to (a) identify those mandates that unduly increase the cost of small business insurance (b) make recommendations to the legislature on mandates that need to be rescinded or revised and (c) submit a report to the general court on any proposed mandated health benefit bill; provided however that no new mandated health benefit mandate is approved until 90 days after the clerks of the house and senate are in receipt of such report.”
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by inserting at the beginning thereof the following section:-
“SECTION__. Section 38C of chapter 3 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking subsection (a) and inserting in place thereof the following:-
(a) For the purposes of this section, a mandated health benefit proposal is one that mandates health insurance coverage for specific health services, specific diseases or certain providers of health care services or that affects the operations of health insurers in the administration of health insurance coverage as part of a policy or policies of group life and accidental death and dismemberment insurance covering persons in the service of the commonwealth, and group general or blanket insurance providing hospital, surgical, medical, dental, and other health insurance benefits covering persons in the service of the commonwealth, and their dependents organized under chapter 32A , individual or group health insurance policies offered by an insurer licensed or otherwise authorized to transact accident or health insurance organized under chapter 175, a nonprofit hospital service corporation organized under chapter 176A, a nonprofit medical service corporation organized under chapter 176B, a health maintenance organization organized under chapter 176G, or an organization entering into a preferred provider arrangement under chapter 176I, any health plan issued, renewed, or delivered within or without the commonwealth to a natural person who is a resident of the commonwealth, including a certificate issued to an eligible natural person which evidences coverage under a policy or contract issued to a trust or association for said natural person and his dependent, including said person's spouse organized under chapter 176M.”.
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by inserting after section ___ the following new section:-
“SECTION __. The institute shall develop a plan for the authorization, implementation and regulation of so-called ‘consumer-directed health care’ in the commonwealth for the purpose of empowering consumers with the knowledge, ability and incentives to make choices in the purchase of health care which facilitate sound health outcomes and the cost-effective delivery of services. For the purposes of this section, consumer-directed health care shall include, by not be limited to, the utilization of health savings accounts, insurance coverage with deductibles of dollar amounts greater than the state average for such amounts, and expanded access to information detailing the actual cost of services being provided to the consumer.
Said plan, together with any legislative and regulatory actions necessary to its implementation and maintenance, shall be filed

with the clerks of the House and Senate no later than one year following the passage of this act."
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by inserting after section __ the following new section:-
"SECTION __. The institute shall, within 120 days following the passage of this act, design and develop measures to penalize those receiving state subsidized health care benefits for personal actions which contribute to the increased cost of health care, which are avoidable, such as the failure to appear for schedules appointments with providers without proper justification therefore.
Said institute shall also design and develop methodologies to incent and reward personal decisions and behaviors that are proven to improve health, such as smoking cessation, weight loss, and dietary planning.
Such measures and methodologies shall be reported, together with any legislative and regulatory actions necessary to their implementation, to the clerks of the house and senate not later than nine months following the passage of this act."
The amendment was *rejected*.
Ms. Fargo moved that the bill be amended in section 189, in line 4843, by inserting, after the word "care" following words: -
"The analysis shall also include a determination of the health care payment system's payment methodologies' impact on: (1) vulnerable populations, including but not limited to the homeless, the disabled, women, the elderly and children; (2) racial, ethnic and socioeconomic health disparities; and (3) applicants to and patients of accountable care organizations and other health care entities, and difference to acceptance, care and treatment based on race, color, religious creed, national origin, sex, sexual orientation, disability, genetic information or ancestry. Data collected as part of the commission's evaluation of the health care payment system shall include state BRFSS data and shall comply with standard data standards, including but not limited to nationally comparable collection of data on disability and minorities. Data collected shall meet both state and federal CLAS standards."
The amendment was *rejected*.
Mr. Keenan moved that the bill be amended in section 10, by adding in line 568 after the words "patient populations" the following words:- ", including those with behavioral, substance use disorder and mental health conditions,".
After remarks, the amendment was adopted.
Mr. Tarr moved that the bill be amended by inserting after section __ the following new section:-
"SECTION __. Notwithstanding any general or special law, rule or regulation to the contrary, no additional benefit, procedure or service shall be required for minimum creditable coverage, so- called, without prior legislative authorization therefore."
The amendment was *rejected*.
Mr. Keenan moved that the bill be amended in section 29, in line 1145, by adding after the word "centers" the following words:- "and community-based behavioral, substance use disorder and mental health care providers"; by adding in line 1191 of said section after the word "facilities" the following words:- "and community-based behavioral, substance use disorder and mental health care providers"; and in line 1215 of said section by adding after (7) the following new section"- (8) whether the provider serves a high proportion of public payer clients", and in line 1216 by deleting the number "(8)" and adding in its place the number "(9)".
After remarks, the amendment was adopted.
Mr. Keenan moved that the bill be amended in section 54, in line 1789, by adding after the word "for" the following words:- ", undergraduate, graduate and"; in line 1781 by adding after the word "schools" the following words:- "or accredited colleges, universities or graduate schools"; and in line 1791 after the words "obstetrics/gynecology" the following words:-"behavioral health,".
After remarks, the amendment was adopted.
Mr. Keenan moved to amend the bill in section 54, in line 1763 by striking the number "16" and inserting in place thereof the following number: - "17"; and in said section by adding in line 1769 after the words "Behavioral Healthcare" the following words:- "the Massachusetts Psychiatric Society,".
After remarks, the amendment was adopted.
Mr. Keenan moved that the bill be amended in section 168, in line 4573, by adding after the number "111" the following words:- "a psychiatric facility licensed under chapter 19,".
The amendment was adopted.
Mr. Keenan moved that the bill be amended in section 52 by striking out subsection (i) in its entirety and inserting in its place thereof the following:-
"(i) Except in the case of an emergency situation determined by the department as requiring immediate action to prevent further damage to the public health or to a health care facility, the department shall not act upon an application for such determination unless: (1) the application has been on file with the department for at least 30 days; (2) the institute of health care finance and policy, the state and appropriate regional comprehensive health planning agencies and, in the case of long-term care facilities only, the department of elder affairs, or in the case of any facility providing inpatient services for the mentally ill or developmentally disabled, the departments of mental health or developmental services, respectively, have been provided copies of such application and supporting documents and given reasonable opportunity to comment on such application; and (3) a public hearing has been held on such application when requested by the applicant, the state or appropriate regional comprehensive health planning agency or any 10 taxpayers of the commonwealth. If, in any filing period, an individual application is filed which would implicitly decide any other application filed during such period, the department shall not act only upon an individual."; and by striking out subsection (m) in its entirety and inserting in its place thereof the following:-
"(m) The department shall notify the secretary of elder affairs forthwith of the pendency of any proceeding, of any public hearing

and of any action to be taken under this section on any application submitted by or on behalf of any long-term care facility. In instances involving applications submitted on behalf of any facility providing inpatient services for the mentally ill or developmentally disabled, the department shall notify the appropriate commissioner."
After remarks, the amendment was adopted.
Ms. Chang-Díaz moved that the bill be amended in section 162, in proposed chapter 176S, by striking out Section 5 and inserting in place thereof the following section:-
"Section 5. (a) Not later than April 15 of every year, the board shall establish a health care cost growth benchmark for the average growth in total health care expenditures in the commonwealth for the next calendar year. The authority shall establish procedures to prominently publish the annual health care cost growth benchmark on the authority's website.
(b) For calendar years 2012-2015, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29, plus 0.5%.
(c) For calendar years 2016 and thereafter, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29."
After remarks, the amendment was adopted.
Mr. Keenan moved that the bill be amended in section 50, by striking in line 1495 after the word "health" the word "and"; and adding following words:- "; behavioral health and".
After remarks, the amendment was adopted.
Ms. Spilka moved that the bill be amended in section 25A(a)(1) of chapter 111, as inserted by Section 50, by inserting after the words "family planning services;", in line 1497, the following words:- "obstetrics and gynecology services;".
After remarks, the amendment was adopted.
Mr. Keenan and Ms. Jehlen moved that the bill be amended in section 18, in line 793, by adding after the word "expenditure" the following words:- "and substantial"; in section 52, in line 1568, by adding after the word "construction" the following words:- "or alteration"; in line 1562 by adding after the word "substantially" the following words:- "increase, reduce or otherwise"; in line 1587 in said section by adding after the word "increase" the following words:- "or decrease"; in line 1588 in said section by adding after the word "increase" the following words:- "or decrease"; in line 1643 of said section by adding after the word "increase" the following words:- "or decrease"; in line 1644 by adding after the word "increase" the following words:- "or decrease"; and by striking out section 58 in its entirety and replacing in place thereof the following section:-
"Section 58. Chapter 111 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking Section 51G(4) and inserting in place thereof the following section:—
(4) Any hospital shall inform the department 180 days prior to the closing of the hospital or the discontinuance of any essential health service provided therein. The department shall by regulation define "essential health service" for the purposes of this section. The department shall, in the event that a hospital proposes to discontinue an essential health service or services, determine whether any such discontinued services are necessary for preserving access and health status in the hospital's service area, require hospitals to submit a plan for assuring access to such necessary services following the hospital's closure of the service, and assure continuing access to such services in the event that the department determines that their closure will significantly reduce access to necessary services. The department shall conduct a public hearing prior to a determination on the closure of said essential services or of the hospital. No original license shall be granted to establish or maintain an acute-care hospital, as defined by section 25B, unless the applicant submits a plan, to be approved by the department, for the provision of community benefits, including the identification and provision of essential health services. In approving the plan, the department may take into account the applicant's existing commitment to primary and preventive health care services and community contributions as well as the primary and preventive health care services and community contributions of the predecessor hospital. In approving the plan, the department shall consider the financial health and capacity of the hospital and/or of the network which owns said hospital, and shall deny or delay said plan if the hospital's and/or network's net profit at the time of such application exceeds 5 percent. The department may waive this requirement, in whole or in part, at the request of the applicant which has provided or at the time the application is filed, is providing, substantial primary and preventive health care services and community contributions in its service area."
After remarks, The amendment was *rejected*.
Mr. Keenan moved that the bill be amended in section 188 by inserting after the words "National Council for Prescription Drug Programs" as they appear in line 4817 the following:- ", as well as any steps that should be taken to integrate information available through the Commonwealth's prescription monitoring program".
After remarks, the amendment was adopted.
Mr. Tarr moved that the bill be amended by inserting after section __ the following new section:-
"SECTION __. The Commonwealth Connector shall develop a plan for insurance coverage which, to the greatest extent possible, minimizes mandated benefits and provides for the coverage of essential health services, provided that the contents of said plan, together with any regulatory or legislative actions necessary to its implementation, shall be filed with the clerks of the senate and house of representatives not later than six months following the passage of this act."
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended in section 162, by striking lines 4041 through 4051, inclusive, and inserting in place thereof the following language:-
"Section 5. (a) Not later than April 15 of every odd-numbered year, the board shall establish a health care cost growth benchmark for the average growth in total health care expenditures in the commonwealth for the next two calendar years. The authority shall establish procedures to prominently publish the biennial health care cost growth benchmark on the authority's website.

Prior to setting a health care cost growth benchmark, the board shall convene one or more public hearings for the purposes of soliciting input to facilitate the development of a consensus benchmark figure. At the conclusion of these hearings, the board shall submit its recommendation for a health care cost growth benchmark in writing to the clerks of the house and the senate for final legislative approval, along with supporting documentation on how the board arrived at its figure. If the house and the senate fail to act on the board's recommendation within 60 days of its receipt by the clerks of the house and the senate, the board's recommended benchmark figure shall be deemed approved and in full force and effect for the next two calendar years.
To the maximum extent possible, the health care cost growth benchmark should reflect the following goals:
(b) For calendar years 2012-2015, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29.
(c) For calendar years 2016-2026, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29, plus 1%.
(c) For calendar years 2027 and thereafter, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29."
The amendment was *rejected*.
The President in the Chair, Mr. Tarr moved that the bill be amended by inserting after section __ the following new section:-
"SECTION ___. The secretary of elder affairs, the commissioner of the department of housing and community development, and the commissioner of public health shall, in conjunction with other agencies of the commonwealth as necessary, develop a state-wide plan for the development and maintenance of assisted living facilities, so-called, long-term care facilities, home health agencies and rest homes. Said plan shall include and assessment of existing and projected need for such facilities across all income levels, available capacity of existing facilities for tenants at all income levels, and projected development of additional capacity in the next twenty-five years. Said plan shall also assess any and all means being utilized for payment by individuals for residence in assisted living facilities and the projected availability of such means in the future for individuals at all income levels from public and private sources, including but not limited to, Medicare, Medicaid and private insurers.
Said plan, based on said assessments, shall included strategies to meet the needs identified in such assessments and to facilitate the availability of assisted living facilities for individuals of all income levels throughout the commonwealth, including the development and maintenance of capital infrastructure, program services, and public and private sources of financing assisted living residence for the citizens of the commonwealth. Said plan prescribed herein, together with any recommendations for legislation necessary to the plan, shall be filed with the clerks of the senate and house of representatives not later than two years following the passage of this act."
The amendment was adopted.
Pending the main question on ordering the bill to a third reading, on motion of Ms. Chandler, the further consideration thereof was postponed until the next session.

PAPER FROM THE HOUSE

Order.

The following House Order (approved by the committees on Rules of the two branches, acting concurrently) was considered forthwith and, after remarks, was adopted in concurrence, as follows:
Ordered, that notwithstanding the provisions of Joint Rule 10, the committee on Consumer Protection and Professional Licensure shall be granted until Thursday, May 17, 2012, within which to report on current House documents numbered 102, 116, 1006, 1016, 1027, 1029, 1850, 1877, 1882, 1883, 1893, 2027, 3266, 3348, 3404, 3405, 3498, 3677, 3760, 3851 and 3903.

Order Adopted.

On motion of Mr. Brewer,--
Ordered, That when the Senate adjourns today, it adjourn to meet again tomorrow at eleven o'clock A.M., and that the Clerk be directed to dispense with the printing of a calendar.

On motion of Mr. Hart, at twenty-eight minutes past seven o'clock P.M., the Senate adjourned to meet again tomorrow at eleven o'clock A.M.