UNCORRECTED PROOF OF THE JOURNAL OF THE SENATE.

Thursday, May 17, 2012.

Met at four minutes past ten o'clock A.M.

The President, members, guests and staff then recited the pledge of allegiance to the flag.

Distinguished Guests.

There being no objection, during consideration of the Orders of the Day, the President handed the gavel to Messrs. Richard T. Moore and Montigny for the purpose of an introduction. They introduced, in the rear of the Chamber, the Ellsessar family from Sutton and the Symes family from Millville. Both families were visiting the State House to attend the ceremonial signing of Senate, No. 2132, known as "Michael's Law"; An Act relative to medical emergency response plans for schools. This was named after Michael Ellsessar, a Sutton High School student who died suddenly of cardiac arrest during a high school football game in November of 2010. Tyler Symes was recognized for having been hit in the chest with a hockey puck causing his heart to stop during a Milford High hockey game and quick action by trainers using a defibrillator saved his life. The Senate welcomed them with applause and they withdrew from the Chamber. They were also joined by the Messier Family.
There being no objection, during consideration of the Orders of the Day, the President handed the gavel to Messrs. Petruccelli and Brewer for the purpose of an introduction. They introduced, in the rear of the Chamber, Andrew Biggio from Winthrop. Andrew was recognized for organizing the Annual Boston Wounded Vets Ride, a charity to benefit wounded veterans. The funds raised help pay for handicapped modifications that enable them to live a better life. This past April the ride raised over $80,000. The Senate applauded his efforts, received a Senate citation on the Rostrum and withdrew from the Chamber. He was accompanied by members of the Massachusetts Motorcycle Association.

Petition.

A petition (having been transmitted to the Secretary of State under the provisions of Section 5 of Chapter 3 of the General Laws and returned by him with memoranda relative thereto) was referred, as follows:
Petition (accompanied by bill, Senate, No. 2257) of Bruce E. Tarr and Harriett L. Stanley (by vote of the town) for legislation to authorize the town of Groveland to provide for the construction and maintenance of a solar generating facility on land held for water supply and protection purposes [Local approval received];
Under Senate Rule 20, to the committee on Municipalities and Regional Government.

Reports of a Committee.

By Mr. Welch, for the committee on Municipalities and Regional Government, on petition, a Bill authorizing municipal use of the prudent investor standards (Senate, No. 1004);
Read and, under Senate Rule 26, referred to the committee on Ethics and Rules.

By Mr. Welch, for the committee on Municipalities and Regional Government, on petition, a Bill establishing a consumer compensation fund (Senate, No. 2043) [Local approval received];
Read and, under Senate Rule 26, placed in the Orders of the Day for the next session.

PAPERS FROM THE HOUSE

A Bill to prevent unlawful and unnecessary foreclosures (House, No. 4096,-- on Senate, No. 868 and House, No. 1219),-- **was read and, under Senate Rule 27, referred to the committee on Ways and Means.**

A Bill relative to payment for use of ambulance services (House, No. 3917,-- on House, No. 1179),-- **was read and, under Senate Rule 26, referred to the committee on Ethics and Rules.**

Resolutions.

The following resolutions (having been filed with the Clerk) were considered forthwith and adopted, as follows:-
Resolutions (filed by Mr. Tarr) "honoring the memory, life and service of Patricia Marshall on the dedication of the Pat Marshall Link Art Gallery."

Order Adopted.

Mr. Welch offered the following order, to wit:
Ordered, That notwithstanding the provisions of Joint Rule 10, the committee on Municipalities and Regional Government be granted until Wednesday, June 27, 2012 to make its final report on on current Senate documents numbered 1005 and 1927 relative to municipalities and local government issues.
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 Ms. Candaras, and the order was considered forthwith and adopted.
Sent to the House for concurrence.

PAPER FROM THE HOUSE

Engrossed Bill.

An engrossed Bill relative to oversight of private occupational schools (see House, No. 3625, amended) (which originated in the House), **having been certified by the Senate Clerk to be rightly and truly prepared for final passage, was passed to be enacted and signed by the President and laid before the Governor for his approbation.**

Orders of the Day.

The Orders of the Day were considered, as follow:--
The Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2260, amended),-- was considered, the main question being on ordering the bill to a third reading.
Ms. Flanagan, Ms. Spilka and Messrs. Keenan, DiDomenico and Joyce moved that the bill be amended by inserting after section _____, the following new sections:-
"SECTION 1. Section 22 of chapter 32A of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after the word 'setting', in line 85, the following words: - 'and, for persons under the age of 19, shall include collateral services'.
SECTION 2. Subsection (i) of said section 22 of said chapter 32A, as so appearing, is hereby amended by striking out the last paragraph.
SECTION 3. Said section 22 of said chapter 32A, as so appearing, is hereby amended by adding the following subsection:—
Under this section, the following words shall have the following meanings unless the context requires otherwise:-
'Collateral services', face-to-face or telephonic consultation, of at least 15 minutes in duration, by a licensed mental health professional with parties determined by the licensed mental health professional to be necessary to make a diagnosis, and develop and implement a treatment plan.
'Licensed mental health professional', a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist or a licensed marriage and family therapist.
SECTION 4. Chapter 118E of the General Laws, as so appearing, is amended by inserting after section 10F the following section:—
Section 10G. (a) The division shall provide coverage for collateral services performed by a licensed mental health professional for persons under 19 years of age. Nothing contained in this section shall be construed to abrogate any obligation to provide coverage for mental health services pursuant to any law or regulation of the commonwealth or the United States or under the terms or provisions of any policy, contract, or certificate.
(b) Under this section, the following words shall have the following meanings unless the context requires otherwise:-
'Collateral services', face-to-face or telephonic consultation, of at least 15 minutes in duration, by a licensed mental health professional with parties determined by the licensed mental health professional to be necessary to make a diagnosis, and develop and implement a treatment plan.
'Licensed mental health professional', a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist

or a licensed marriage and family therapist.
SECTION 5. Section 47B of chapter 175 of the General Laws, as so appearing , is hereby amended by inserting after the word ‘setting’, in lines 98 and 99, the following words:- ‘and, for persons under the age of 19, shall include collateral services’.
SECTION 6. Subsection (i) of said chapter 47B of said chapter 175, as so appearing, is hereby amended by striking out the second and third paragraphs.
SECTION 7. Said section 47B of said chapter 175, as so appearing, is hereby further amended by adding the following 2 subsections:—
(j) Under this section, the following words shall have the following meanings unless the context requires otherwise:-
‘Collateral services’, face-to-face or telephonic consultation, for at least 15 minutes of duration, by a licensed mental health professional with parties determined by the licensed mental health professional to be necessary to make a diagnosis, and develop and implement a treatment plan.
‘Licensed mental health professional’, a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist or a licensed marriage and family therapist.
(k) For the purposes of this section, psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered in a manner identical to all other medical services.
SECTION 8. Section 8A of chapter 176A of the General Laws, as so appearing, is hereby amended by inserting after the word ‘setting’, in lines 92 and 93, the following words: - and, for persons under the age of 19, shall include collateral services”.
SECTION 9. Subsection (i) of said section 8A of said chapter 176A, as so appearing, is hereby amended by striking out the second and third paragraphs.
SECTION 10. Said section 8A of said chapter 176A, as so appearing, is hereby further amended by adding the following 2 subsections:—
(j) Under this section, the following words shall have the following meaning unless the context requires otherwise:-
‘Collateral services’, face-to-face or telephonic consultation, of at least 15 minutes of duration, by a licensed mental health professional with parties determined by the licensed mental health professional to be necessary to make a diagnosis, and develop and implement a treatment plan.
‘Licensed mental health professional’, a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist or a licensed marriage and family therapist.
(k) For the purposes of this section, psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered in a manner identical to all other medical services.
SECTION 11. Section 4A of chapter 176B of the General Laws, as so appearing, is hereby amended by inserting after the word ‘setting’, in lines 95 and 96, the following words:- ‘and, for persons under the age of 19, shall include collateral services’.
SECTION 12. Subsection (i) of said section 4A of said chapter 176B, as so appearing, is hereby amended by striking out the second and third paragraphs.
SECTION 13. Said section 4A of said chapter 176B, as so appearing, is hereby further amended by adding the following 2 subsections:—
(j) Under this section, the following words shall have the following meanings unless the context requires otherwise:-
‘Collateral services’, face-to-face or telephonic consultation, of at least 15 minutes of duration, by a licensed mental health professional with parties determined by the licensed mental health professional to be necessary to make a diagnosis, and develop and implement a treatment plan.
‘Licensed mental health professional’, a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist or a licensed marriage and family therapist.
(k) For the purposes of this section, psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered in a manner identical to all other medical services.
SECTION 14. Section 4M of chapter 176G of the General Laws, as so appearing, is hereby amended by inserting after the word ‘setting’, in lines 89 and 90, the following words:- ‘and, for persons under the age of 19, shall include collateral services’.
SECTION 15. Subsection (i) of said section 4M of said chapter 176G, as so appearing, is hereby amended by striking out the second and third paragraphs.
SECTION 16. Said section 4M of said chapter 176G of the General Laws, as so appearing, is hereby further amended by adding the following 2 subsections:—
(j) Under this section, the following words shall have the following meanings unless the context requires otherwise:-
‘Collateral services’, face-to-face or telephonic consultation, of at least 15 minutes of duration, by a licensed mental health professional with parties determined by the licensed mental health professional to be necessary to make a diagnosis, and develop and implement a treatment plan.
‘Licensed mental health professional’, a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist or a licensed marriage and family therapist.
(k) For the purposes of this section, psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be covered in a manner identical to all other medical services.”
The amendment was *rejected*.

Ms. Flanagan, Mr. Knapik and Ms. Chandler moved that the bill be amended by inserting the following new section:-
“SECTION XX. Chapter 270 of the General Laws is hereby amended by adding the following section:-
Section 6B. Possession of cigarettes or cigarette rolling papers by minors
Whoever, being under eighteen years of age, knowingly purchases, possesses, transports or carries on his person, any tobacco or cigarette rolling papers, shall be punished by a fine of not more than twenty-five dollars for the first offense, not more than fifty dollars for a second offense, and not more than one hundred dollars for a third or subsequent offense; provided, however, that this section shall not apply to a person who knowingly possesses, transports or carries on his person, cigarettes or cigarette rolling papers in the course of his employment. The fines imposed by this section shall be directed to the Massachusetts Tobacco Cessation and Prevention Program.
A police officer shall notify the parent or guardian of a person who violates this section of the violation within forty-eight hours of the violation if the contact information of a parent or guardian is reasonably ascertainable by the officer. The notice may be made by any means reasonably calculated to give actual notice, including notice in person, by telephone, or by first-class mail. A person who violates this section shall forfeit any tobacco and any false identification in his or her possession upon the request of any police officer.”
The amendment was *rejected*.
Messrs. McGee and Joyce moved that the bill be amended in section 166, by striking out lines 4556 through 4563.
After remarks, the amendment was adopted.
Mr. Donnelly moved that the bill be amended in section 192, by striking out the number “19” and inserting in place thereof the following number:- “20"; and in line 4957, by inserting after the words” workers;” the following:- “and 1 of whom shall be a person representing frontline registered nurses".
After remarks, the amendment was adopted.
Messrs. Michael O. Moore and Knapik moved that the bill be amended by inserting, after section ___ the following section:-
“SECTION ___. Subsection (b) of section 6 of Chapter 176J of the General laws is hereby amended by adding the following subsection:-
(xi) For purposes of this section, medical loss ratios shall not include fees on commissions included in premiums that are collected solely for the purpose of passing such fees or commissions on to insurance agents or brokers to the extent such fees or commissions are actually paid.”
The amendment was *rejected*.
Mr. McGee moved that the bill be amended in section 50, line 1519, by striking out the words “and consumer representatives” and inserting in place thereof the following words:- “, consumer representatives and labor organizations”.
After remarks, the amendment was adopted.
Messrs. Rodrigues, DiDomenico, Knapik and Joyce moved that the bill be amended by striking out section 160 in its entirety and inserting in place thereof the following section:-
“SECTION 160. Chapter 176Q of the General Laws is hereby amended by striking out section 7A and inserting in place thereof the following section:-
Section 7A. (a) There shall be a small group wellness incentive pilot program to expand the prevalence of employee wellness initiatives by small businesses. The program shall be administered by the board of the connector, in consultation with the department of public health. The program shall provide subsidies and technical assistance for eligible small groups to implement evidence-based employee health and wellness programs to improve employee health, decrease employer health costs and increase productivity.
(b) An eligible small group shall be qualified to participate in the program if:
(1) the eligible small group purchases group coverage from a carrier certified by the connector to participate in the program;
(2) the eligible small group enrolls in an evidence-based, employee wellness program offered by that certified carrier;
(3) the eligible small group meets certain minimum criteria, as determined by the connector board; and
(4) the eligible small group meets certain minimum employee participation requirements in the qualified wellness program, as determined by the connector board, in collaboration with the department of public health.
(c) For eligible small groups participating in the program, the connector shall provide an annual subsidy not to exceed 15 per cent of eligible employer health care costs as calculated by the connector board. If the director determines that funds are insufficient to meet the projected costs of enrolling new eligible employers, the director shall impose a cap on enrollment in the program.
(d) The connector shall report annually to the joint committee on community development and small business, the joint committee on health care financing and the house and senate committees on ways and means on the enrollment in the small business wellness incentive program and evaluate the impact of the program on expanding wellness initiatives for small groups.
(e) The connector shall promulgate regulations to implement this section.”
The amendment was *rejected*.
Messrs. Rodrigues and Knapik moved that the bill be amended by striking out section 159 in its entirety.
The amendment was *rejected*.
Messrs. Finegold, Hart, Petruccelli and Keenan, Ms. Chandler, Ms. Chang-Diaz and Ms. Donoghue moved that the bill be amended by striking out section 23 and inserting in place thereof the following section:-
“SECTION 23. Chapter 29 of the General Laws is hereby amended by inserting after section 2EEEE the following section:-
Section 2FFFF. There shall be established upon the books of the commonwealth a separate fund to be known as the Health Care Workforce Transformation Fund to be expended, without further appropriation, by the secretary of labor and workforce development. The fund shall consist of any funds that may be appropriated or transferred for deposit into the trust fund, public

and private sources such as gifts, grants and donations to further health care workforce development and interest earned on such revenues, and other sources.
The secretary of labor and workforce development as trustee, shall administer the fund. The secretary, in consultation with the Health Care Workforce Advisory Board established in subsection (c), shall make expenditures from this account consistent with the subsections (e) and (f); provided, that not more than 10 per cent of the amounts held in the fund in any 1 year shall be used by the secretary for the combined cost of program administration, technical assistance to grantees and program evaluation.
(b) Revenues deposited in the fund that are unexpended at the end of the fiscal year shall not revert to the General Fund and shall be available for expenditure in the following fiscal year.
(c) There shall be Health Care Workforce Advisory Board constituted to make recommendations to the secretary concerning the administration and allocation of the fund, establish evaluation criteria and perform any other functions specifically granted to it by law.
The board shall consist of the following members: the secretary of labor and workforce development, who shall serve as chair; the executive director of the institute of health care finance and policy or a designee; the commissioner of public health or a designee, and no more than 13 members who shall be appointed by the secretary of labor and workforce development and who shall reflect a broad distribution of diverse perspectives on the health care system and health care workforce needs, including health care professionals, labor organizations, educational institutions, consumer representatives, providers and payers.
The secretary shall, under the advice and guidance of the Health Care Workforce Advisory Board, annually report on its strategy for administration and allocation of the fund, including relevant evaluation criteria, and short-term and long-term programmatic and policy recommendations to improve workforce performance.
(d) All expenditures from the Health Care Workforce Transformation Fund shall have 1 or more of the following purposes:-
(i) support the development and implementation of employer and work programs to enhance worker skills, income, productivity and retention rates;
(ii) address critical workforce shortages;
(iii) address workforce needs identified in the health resource plan developed under section 25A of chapter 111;
(iv) improve employment in the health care industry for the unemployed or low-income individuals and low-wage workers;
(v) provide training or educational services for currently employed or unemployed health care workers who are seeking new positions or responsibilities within the health care industry;
(vi) provide training or educational services for existing health care workers in emerging fields of care delivery models;
(vii) provide loan repayment and incentive programs for health care workers;
(viii) provide career ladder programs for health care workers; or
(ix) any other purpose the secretary, in consultation with the Health Care Workforce Advisory Board, determines.
(e) The secretary shall establish a competitive grant process funded by the Health Care Workforce Transformation Fund to eligible applicants to provide education and training to health care workers. Eligible applicants shall include: employers and employer associations; local workforce investment boards; labor organizations; joint labor-management partnerships; community-based organizations; institutions of higher education; vocational education institutions; one-stop career centers; local workforce development entities; and any partnership or collaboration between eligible applicants. Expenditures from the fund for such purposes shall complement and not replace existing local, state, private, or federal funding for training and educational programs.
(f) A grant proposal submitted under subsection (e) shall include, but not be limited to:
(i) a plan that defines specific goals for health care workforce training and educational improvements over a multi-year period in specific areas;
(ii) the evidence-based programs the applicant shall use to meet the goals;
(iii) a budget necessary to implement the plan, including a detailed description of any funding or in-kind contributions the applicant or applicants will be providing in support of the proposal;
(iv) any other private funding or private sector participation the applicant anticipates in support of the proposal; and
(v) the anticipated number of individuals who would receive a benefit due to the implementation of the plan.
Priority may be given to proposals that target areas of critical labor needs for the health care industry or that are projected to be critical labor needs of the health care industry in the near future. Priority may also be given to proposals that target geographic areas with specific health care workforce needs or that target geographic areas with unemployment levels higher than the state average. If no proposals were offered in areas of particular need, the secretary may provide technical assistance and planning grant funding directly to eligible applicants in order to develop grant proposals.
The secretary shall, in consultation with the Health Care Workforce Advisory Board, develop guidelines for an annual review of the progress being made by each grantee. Each grantee shall participate in any evaluation or accountability process implemented by or authorized by the secretary.
(g) The secretary shall annually expend not less than 20 per cent of available funds in the Health Care Workforce Transformation Fund to expand training and loan forgiveness programs for primary care providers in the commonwealth. The training and loan forgiveness programs for primary care providers shall include, but not be limited to:
(i) The secretary shall establish a competitive primary care residency grant process funded by the Health Care Workforce Transformation Fund to eligible applicants for the purpose of financing the training of primary care providers at teaching community health centers. Eligible applicants shall include teaching community health centers accredited through affiliations with a commonwealth funded medical school or licensed as part of a teaching hospital with a residency program in primary care or family medicine and teaching health centers that are the independently accredited sponsoring organization for the residency

program and whose residents are employed by the health center.
To receive funding, an applicant shall (a) include a review of recent graduates of the teaching community health center's residency program, including information regarding what type of practice said graduates are involved in 2 years following graduation from the residency program; and (b) achieve a threshold of at least 50 per cent for the percentage of graduates practicing primary care within 2 years after graduation. Graduates practicing (a) more than 50 per cent inpatient care or (b) more than 50 per cent specialty care, as listed in the American Medical Association Masterfile, shall not qualify as graduates practicing primary care.
Awardees of the primary care residency grant program shall maintain their teaching accreditation as either an independent teaching community health center or as a teaching community health center accredited through affiliation with a commonwealth funded medical school or licensed as part of a teaching hospital.
(ii) A primary care workforce development and loan forgiveness grant program at community health centers, for the purpose of enhancing recruitment and retention of primary care physicians and other clinicians at community health centers throughout the commonwealth. The grant program shall be administered by the department of public health; provided, that the department may contract with an organization to administer the grant program. Funds for the grant program shall be matched by other public or private funds.
(iii) The health care provider workforce loan repayment program, established in section 25N of chapter 111, as administered by the department of public health.
(h) The comptroller shall annually transfer not less than 10 per cent of available funds in the Health Care Workforce Transformation Fund to the Massachusetts Nursing and Allied Health Workforce Development Trust Fund established in section 33 of chapter 305 of the acts of 2008 to develop and support strategies that increase the number of public higher education faculty members and students who participate in programs that support careers in fields related to nursing and allied health.
(i) The secretary shall, annually on or before January 31, report on expenditures from the Health Care Workforce Transformation Fund. The report shall include, but shall not be limited to: (i) the revenue credited to the fund; (ii) the amount of fund expenditures attributable to the administrative costs of the secretary of labor and workforce development; (iii) an itemized list of the funds expended through the competitive grant process and a description of the grantee activities; and (iv) the results of the evaluation of the effectiveness of the activities funded through grants. The report shall be provided to the chairs of the house and senate committees on ways and means, the joint committee on public health, the joint committee on health care financing and the joint committee on labor and workforce development and shall be posted on the department of public health's website.
(j) The secretary of labor and workforce development may promulgate appropriate regulations to carry out this section.".
After remarks, the amendment was adopted.
Mr. Hart moved that the bill be amended in Section 150 by inserting at the end thereof the following:-
"Section 25. The division shall promulgate regulations under which a carrier may move members into and out of different payment methodologies, including without limitation different product types, without mutual agreement from the participating provider."
After remarks, the question on adoption of the amendment was determined by a call of the yeas and the nays at two minutes before eleven o'clock A.M., on motion of Mr. Tarr, as follows, to wit (yeas 35 – nays 0) **[Yeas and Nays No. 184]:**

YEAS

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
Downing, Benjamin B.	Rodrigues, Michael J.

Eldridge, James B.	Rosenberg, Stanley C.
Fargo, Susan C.	Ross, Richard J.
Finegold, Barry R.	Rush, Michael F.
Flanagan, Jennifer L.	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

Berry, Frederick E.	Donoghue, Eileen M. **— 3.**
Donnelly, Kenneth J.	

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

There being no objection, during consideration of the Orders of the Day, the following matter was considered, to wit:

PAPER FROM THE HOUSE

Emergency Preamble.

An engrossed Bill relative to an exclusive and perpetual easement within Monroe State Forest (see Senate, No. 1988, amended), having been certified by the Senate Clerk to be rightly and truly prepared for final passage and containing an emergency preamble,-- was laid before the Senate; and, a separate vote being taken in accordance with the requirements of Article LXVII of the Amendments to the Constitution, the preamble was adopted in concurrence, by a vote of 11 to 0.
The bill was signed by the President and sent to the House for enactment.

Orders of the Day.

The Orders of the Day were further considered, as follow:--
The Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2260, amended),-- was considered, the main question being on ordering the bill to a third reading.
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 shall conduct a comprehensive study to investigate barriers to individuals seeking to change health insurance plans, either upon a qualifying status change or during an open-enrollment period. Said study shall include, but not be limited to, the identification and review of such barriers, such as the impact of a change in insurance plans on consumers who have used some or all of their yearly plan deductibles, as well as recommendations for alleviating any barriers. The Institute shall file a report of its study, including recommendations and drafts of any legislation, if necessary, with the clerks of the Senate and House of Representatives within one year of the effective date of this act."
After remarks, the amendment was adopted.
Messrs. Timilty, Downing and Keenan moved that the bill be amended in Section 29, in subsection (b) of proposed section 6D of chapter 40J of the General Laws, by striking out the third paragraph and inserting in place thereof the following paragraph:-

“The council shall consist of 18 members: 1 of whom shall be the secretary of administration and finance, who shall serve as chair; 1 of whom shall be the secretary of health and human services; 1 of whom shall be the executive director of the institute of health care finance and policy or a designee; 1 of whom shall be the secretary of housing and economic development or a designee; 14 of whom shall be appointed by the governor, at least 1 of whom shall be an expert in health information technology, 1 of whom shall be an expert in state and federal health privacy laws, 1 of whom shall be an expert in health policy, 1 of whom shall be an expert in health information technology relative to privacy and security, 1 of whom shall be from an academic medical center, 1 of whom shall be from a community hospital, 1 of whom shall be from a community health center, 1 of whom shall be from a long term care facility, 1 of whom shall be from a physician group practice, 1 of whom shall be a non-physician health care provider, 1 of whom shall be a registered nurse, 1 of whom shall be a member from a behavioral health, substance abuse disorder or mental health services organization and 2 of whom shall represent the health insurance carriers. The council may consult with such parties, public or private, as it deems desirable in exercising its duties under this section, including persons with expertise and experience in the development and dissemination of interoperable electronic health records systems and the implementation of interoperable electronic health record systems by small physician groups or ambulatory care providers as well as persons representing organizations within the commonwealth interested in and affected by the development of networks and interoperable electronic health records systems, including, but not limited to, persons representing local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, community-based behavioral providers, substance use disorder and mental health care providers, the medical and nursing professions, physicians, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with expertise in health information technology and other stakeholders as identified by the secretary of health and human services. Appointive members of the council shall serve for terms of 2 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation.”.

After remarks, the amendment was adopted.

Mr. Wolf moved that the bill be amended by inserting after section 198 the following section:-

“SECTION 198C. Subsection (c) of section 25A of chapter 111 of the General Laws and clause (2) of subsection (g) of section 25C of said chapter 111 shall not apply to the review of an application for a determination of need that is filed with the department of public health under said chapter 111 until (i) October 1, 2013 or (ii) the date on which the department of public health submits for the first time a health resource plan under said section 25A of said chapter 111, whichever occurs first.”.

After remarks, the amendment was adopted.

Ms. Chandler, Messrs. Eldridge and Brownsberger, Ms. Creem and Messrs. Knapik, Welch, McGee and Joyce moved that the bill be amended, in line 4579 by inserting after the word “nurse practitioner,” the following words: “Physician assistant”; and in line 4578 by inserting after the word “dentist” the following words: “dental hygienist”.

After remarks, the amendment was adopted.

Mr. Rodrigues moved that the bill be amended in section 14, by striking out the words “and satisfaction”, in line 847, and inserting in place thereof the following words:- “, satisfaction and confidence”; and in said section 14, in the fourth paragraph of proposed section 20 of chapter 12C of the General Laws by adding the following 2 sentences:- “In establishing and maintaining the website, the institute shall rely on industry standards for usability, including standards which are relevant for low-income consumers and consumers with limited literacy. The website shall comply with the Americans with Disabilities Act, and shall indicate which provider services are physically and programmatically accessible, including access to physical examination equipment for people with disabilities.”.

After remarks, the amendment was adopted.

Ms. Spilka moved that the bill be amended in section 3 of chapter 12C, as inserted by Section 14, by inserting after the words “consumer representatives,”, in line 293, the following:- “medical device manufacturers, representatives of the biotechnology industry, pharmaceutical manufacturers,”.

After remarks, the amendment was adopted.

Mr. Petruccelli, Ms. Donoghue and Messrs. Michael O. Moore and Berry moved that the bill be amended in section 14, by inserting after the word “, surgical”, in line 138, the word “chiropractic,”; and in section 90, by inserting after the word “, surgical”, in line 2122 , the word “chiropractic,”.

After remarks, the amendment was adopted.

Ms. Spilka moved that the bill be amended by inserting at the end thereof the following new sections:-

“SECTION XX. Subsection (a) of section 3 of chapter 17, as appearing in the 2010 Official Edition, is hereby amended by striking out the figure ‘14’, in line 4, and inserting in place thereof the following figure:- ‘15’.

SECTION XX. Subsection (c) of section 3 of chapter 17, as appearing in the 2010 Official Edition, is hereby amended by striking out the word ‘Four’, in line 17, and inserting in place thereof the following new word:- ‘Five’.

SECTION XX. Said subsection (c) of section 3 of chapter 17, as so appearing, is hereby amended by inserting after the words, ‘1 of whom shall have expertise in home or community-based care management,’, in lines 20 and 21, the following:- ‘1 of whom shall appointed from among a list of three nominated by the Massachusetts Society of Optometrists;’.”

The amendment was *rejected*.

Ms. Spilka moved that the bill be amended by inserting at the end thereof the following new section:-

“SECTION XX. Notwithstanding any general or special law to the contrary, the health care quality and finance authority shall conduct a study on the feasibility and potential healthcare cost and quality impacts of implementing reforms related to cancer recovery. Such study shall examine the quality of care received in diagnosing breast cancer and in recovering from procedures including, but not limited to, mastectomy, lumpectomy, and lymph node dissection for treatment of breast cancer, as well as the

short- and long-term costs associated with re-hospitalization of patients recovering from such procedures.
The study shall analyze the healthcare cost and quality impacts of potential reforms including, but not limited to:
(i) requiring carriers to provide coverage for a minimum hospital stay for such period as determined by the attending physician in consultation with the patient to be medically appropriate for patients undergoing a lymph node dissection, lumpectomy or a mastectomy for the treatment of breast cancer;
(ii) requiring every policy which provides hospital, medical, major medical, or similar comprehensive-type coverage to provide coverage for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation of a course of treatment for cancer;
(iii) requiring every policy which provides hospital, medical, major medical, or similar comprehensive-type coverage to provide the following coverage for breast reconstruction surgery after a mastectomy: (1) all stages of reconstruction of the breast on which the mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications of mastectomy, including lymphedemas;
(iv) requiring every policy which provides hospital, medical, major medical, or similar comprehensive-type coverage to provide coverage which includes benefits for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema;
(v) prohibiting carriers and their providers from taking any action intended to reduce or limit coverage for cancer recovery treatments.
The study shall also examine the extent to which recovering patients are negatively impacted by carrier policies that limit coverage for minimum hospital stays and secondary medical opinions, including, but not limited to, the incidence of re-injury or re-hospitalization resulting from such policies and the healthcare costs associated with such re-injury and re-hospitalization. The institute shall submit the study to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and the clerks of the house and senate by January 1, 2013."
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended in Section 14 by striking proposed Section 8 of chapter 12C and inserting in place thereof the following section:-
"Section 8. The institute shall file a report 6 months after the effective date of this act with the clerks of the house and the senate and the house and senate committees on ways and means detailing any additional funding requirements to achieve the goals set forth in this bill.".
After debate, the question on adoption of the amendment was determined by a call of the yeas and the nays at twenty-seven minutes before twelve o'clock noon, on motion of Mr. Tarr, as follows, to wit (yeas 5 – nays 30) **[Yeas and Nays No. 185]:**

YEAS

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

NAYS

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,	Pacheco, Marc

Sal N. Downing,	R. Petruccelli,
Benjamin B. Eldridge,	Anthony Rodrigues,
James B. Fargo,	Michael J. Rosenberg,
Susan C. Flanagan,	Stanley C. Rush,
Jennifer L. Finegold,	Michael F. Spilka,
Barry R. Hart,	Karen E. Welch,
John A., Jr. Jehlen,	James T. Wolf,
Patricia D.	Daniel A. **— 30.**

ABSENT OR NOT VOTING

Berry, Frederick E. Donnelly,	Donoghue, Eileen M. **— 3.**
Kenneth J.	

The yeas and nays having been completed at twenty-three minutes before twelve o'clock noon, The amendment was *rejected*.

Ms. Spilka and Ms. Flanagan moved that the bill be amended by inserting at the end thereof the following new section:-
"SECTION XX. Notwithstanding any general or special law to the contrary, where an insured child is directed by a court to participate in mental or behavioral health treatment or services which are eligible for coverage by an insurance plan under section 22 of chapter 32A, section 10F of chapter 118E, section 47B of chapter 175, section 8A of chapter 176A, or section 4A of chapter Ch.176B Sec.4A, payment for such treatment or services shall not be denied if the treatment or services otherwise meet the criteria for health plan coverage."
The amendment was *rejected*.
Mr. Petruccelli, Ms. Donoghue and Messrs. Michael O. Moore and Berry moved that the bill be amended in section 162, by inserting after the words "specialist care", in line 4451, the following words":- "and chiropractic care".
After remarks, the amendment was adopted.
Mr. Petruccelli, Ms. Donoghue and Messrs. Michael O. Moore, Berry and Joyce moved that the bill be amended in section 54, by striking out the number "16", in line 1763, and inserting in place thereof the number "17"; and by inserting after the words "Massachusetts Hospital Association, Inc.;" in line 1774, the words "the Massachusetts Chiropractic Society, Inc.;".
After remarks, the amendment was adopted.
Ms. Creem moved that the bill be amended by striking section 170.
The amendment was *rejected*.
Mr. Kennedy moved that the bill be amended by adding at the end of thereof the following new section:
"SECTION_¬___: Chapter 112 Section 5 of the Massachusetts General Laws as appearing in the 2008 Official edition is hereby amended by the insertion after the word 'years.' in line 78 of the following: Provided, however, that payments made as part of a disclosure, apology and early offer program and made on behalf of a system, (a participating hospital, clinic, health or liability insurer or similar entity) shall not be construed to be reportable against a physician identified during the root cause analysis conducted as part of a disclosure, apology and early offer program, absent a determination of substandard care rendered on the part of said physician."
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended in Section 14 by striking proposed section 8 of chapter 12C of the General Laws and inserting in place thereof the following section:-
"Section 8. The institute shall be funded by the HealthCare Payment Reform Fund as appearing in section 100 of chapter 194 of the Acts of 2011. Any further funds necessary to the operations of the institute shall be subject to appropriation."
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by striking sections 158 and 159, inclusive, and inserting in place thereof the following section:-
"SECTION__. Section 3 of chapter 176Q, as so appearing, is hereby further amended by adding the following subsection:-
(u) to publish a comprehensive directory of providers of health insurance available in the Commonwealth, which shall be posted

prominently on the board's website and made readily available to the public."
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by striking, in lines 1362-1363, the words "health system benefit surcharge revenues collected by the commonwealth under section 68 of chapter 118E", and inserting in place thereof the following words:- "10% of the proceeds in the HealthCare Payment Reform Fund as appearing in section 100 of chapter 194 of the Acts of 2011"; and by striking in section 104 proposed section 70 of chapter 118E of the general laws and inserting in place thereof the following section:-
"70(a). 10% of the proceeds in the HealthCare Payment Reform Fund shall be evenly divided, 5% shall be deposited in the Prevention and Wellness Trust Fund, established in section 2G of chapter 111, 5% shall be deposited in the e-Health Institute Fund, established in section 6E of chapter 40J."
After debate, the question on adoption of the amendment was determined by a call of the yeas and the nays at twenty-three minutes past twelve o'clock noon, on motion of Mr. Knapik, as follows, to wit (yeas 5 – nays 31) **[Yeas and Nays No. 186]:**

YEAS

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

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
Downing, Benjamin B.	Rodrigues, Michael J.
Eldridge, James B.	Rosenberg, Stanley C.
Fargo, Susan C.	Rush, Michael F.
Flanagan, Jennifer L.	Spilka, Karen E.
Finegold, Barry R.	Welch, James T.
Hart, John A.,	Wolf, Daniel A.

Jr. **— 31.**
Jehlen, Patricia D.

ABSENT OR NOT VOTING

Donnelly, Kenneth J.
Donoghue, Eileen M. **— 2.**

The yeas and nays having been completed at twenty-seven minutes past twelve o'clock noon, The amendment was *rejected*.

Ms. Creem and Mr. Joyce moved that the bill be amended by inserting in Section 14, at line 850, the following :-
"Section xx. "The Institute shall promulgate regulations requiring actual costs and prices of health care services submitted to the consumers health information website to be readily understandable by consumers. The Institute shall determine the frequency by which providers should submit such information in order to ensure the continued accuracy of information."
The amendment was *rejected*.
Messrs. Berry, Welch, Brownsberger and Knapik moved that the bill be amended by inserting after section 205 the following:-
"Section XXX:
Section 9E of chapter 112 of the General Laws, as so appearing, is hereby amended by striking out, in lines 5 and 6, the words 'A registered physician shall supervise no more than 4 physician assistants at any one time.'
Section 9E of chapter 112 is hereby amended by striking out, in lines 15 through 17, the words 'Any prescription of medication made by a physician assistant must include the name of the supervising physician.'.
Section 9C of chapter 112 of the General Laws, as so appearing, is hereby amended by striking the definition of 'physician assistant' and inserting in place thereof the following definition:-
'Physician assistant,' a person who is duly registered and licensed by the board."
After remarks, the amendment was adopted.
Mr. Tarr moved that the bill be amended by inserting after section __ the following new section:-
"SECTION __. The Secretary of Health and Human Services shall develop a plan to ensure that, to maximum feasible extent, the care being provided to those receiving full health insurance benefits be provided through managed care programs. Said plan shall be implemented not later than one year following the passage of this act, provided that the provisions of the plan shall be reported to the clerks of the senate and the house of representatives not later than 60 days prior to its effective date."
After debate, the question on adoption of the amendment was determined by a call of the yeas and the nays at twenty-one minutes before one o'clock P.M., on motion of Mr. Tarr as follows, to wit (yeas 4 – nays 32) **[Yeas and Nays No. 187]:**

YEAS

Hedlund, Robert L.
Ross, Richard J.
Knapik, Michael R.
Tarr, Bruce E. **— 4.**

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,
Pacheco, Marc R.

Cynthia Stone	
DiDomenico, Sal N.	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.
Flanagan, Jennifer L.	Timilty, James E
Hart, John A., Jr.	Welch, James T.
Jehlen, Patricia D.	Wolf, Daniel A.
	— 32.

ABSENT OR NOT VOTING

Donnelly, Kenneth J.	Donoghue, Eileen M. **— 2.**

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

Mr. Berry moved that the bill be amended in subsection 17(a) of Section 14 by striking the first paragraph and inserting in place thereof the following paragraph:-
"Section 17. (a) No provider organization may negotiate network contracts with any carrier or third-party administrator except for provider organizations which are registered under this chapter and regulations promulgated under this chapter; provided, however, that nothing in this chapter shall require a provider organization which receives, or which represents providers who collectively receive, less than $500,000 in annual net patient service revenue from carriers or third-party administrators and which has fewer than 5 affiliated physicians to be registered if such provider organization does not accept risk."
The amendment was adopted.
Mr. Tarr moved that the bill be amended by striking out all after the enacting clause and inserting in place thereof the text of Senate document numbered 2262, relative to reducing health care costs.
After debate, the question on adoption of the amendment was determined by a call of the yeas and the nays at fourteen minutes past one o'clock P.M., on motion of Mr. Knapik as follows, to wit (yeas 5 – nays 31) **[Yeas and Nays No. 188]:**

YEAS

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

NAYS

Berry, Frederick E.	Joyce, Brian A.
Brewer, Stephen M.	Keenan, John F.
Brownsberger, William N.	Kennedy, Thomas P.
Candaras, Gale	McGee, Thomas

D.	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
Downing, Benjamin B.	Rodrigues, Michael J.
Eldridge, James B.	Rosenberg, Stanley C.
Fargo, Susan C.	Rush, Michael F.
Flanagan, Jennifer L.	Spilka, Karen E.
Finegold, Barry R.	Welch, James T.
Hart, John A., Jr.	Wolf, Daniel A. **— 31.**
Jehlen, Patricia D.	

ABSENT OR NOT VOTING

Donnelly, Kenneth J.	Donoghue, Eileen M. **— 2.**

Mr. Hart in the Chair, The yeas and nays having been completed at seventeen minutes past one o'clock P.M., The amendment was *rejected*.

There being no objection, at nineteen minutes past one o'clock P.M., the Chair (Mr. Hart) declared a recess subject to the call of the Chair; and, at ten minutes before three o'clock P.M., the Senate reassembled, the President in the Chair.

Orders of the Day.

The Orders of the Day were further considered, as follow:--
The Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2260, amended),-- was considered, the main question being on ordering the bill to a third reading.
Mr. Tarr moved that the bill be amended by inserting after section 188 the following section:-
"SECTION 188B. Notwithstanding any general or special law to the contrary, the office of Medicaid shall not terminate the coverage of any commonwealth care recipient if: (i) the office has requested documentation, including the eligibility review form; (ii) the recipient has provided such documentation on or before the date the office stated, in writing, that such documentation was to be submitted; and (iii) the office has acknowledged receipt of the documentation, until the office determines the eligibility for benefits based on the submitted information. The director shall promulgate regulations to ensure the proper implementation of this section."
The amendment was adopted.

There being no objection, during consideration of the Orders of the Day, the following items were considered, as follows, to wit:

Communication.

COMMONWEALTH OF MASSACHUSETTS
MASSACHUSETTS SENATE

May 17, 2012

William Welch, *Clerk*
Massachusetts State House
State House, Room 335
Boston, MA 02133

Dear Mr. Clerk:

Due to personal reasons, on May 15, 2012 I was away from the State House and unable to participate in several roll call votes. Had I been present, I would have voted in the following manner on roll call votes on amendments in Senate Bill 2260, An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation.
1. No, Amendment 164, Prescription Drug Mandate;
2. No, Amendment 188, Flexible Benefit Options;
3. No, Amendment 191, Inspector General Audit of Medicaid;
I respectfully request that a copy of this letter be printed in the Senate Journal as part of the official record for May 15, 2012.
Thank you in advance for your attention to this important matter.
Sincerely,
CYNTHIA S. CREEM
State Senator
On motion of Mr. Downing, the above communication was ordered printed in the Journal of the Senate.

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 State Administration and Regulatory Oversight shall be granted until Saturday, June 30, 2012, within which to report on current House documents numbered 821, 828, 1735, 1736, 1737, 1753, 2587, 3031, 3040, 3041, 3043, 3209 and current Senate documents numbered 1563, 1575, 1576 and 2053.

There being no objection, at twenty-seven minutes past three o'clock P.M., the President declared a recess subject to the call of the Chair; and, at six minutes before five o'clock P.M., the Senate reassembled, the President in the Chair.

Orders of the Day.

The Orders of the Day were further considered, as follow:--
The Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2260, amended),-- was considered, the main question being on ordering the bill to a third reading.
Messrs. Joyce, Tarr, Eldridge, Knapik, Rodrigues, Wolf, Donnelly, DiDomenico and Montigny, Ms. Jehlen and Ms. Chang-Diaz moved that the bill be amended by adding at the end therof the following section:
"SECTION _____. Chapter 118E of the General Laws is hereby amended by inserting after section 9E the following section:
Section 9F. (a) As used in this section, the following words shall have the following meanings:--
'Dual eligible', or 'dually eligible person', any person age 21 or older and under age 65 who is enrolled in both Medicare and MassHealth.
'Integrated care organization' or 'ICO', a comprehensive network of medical, health care and long term services and supports providers that integrates all components of care, either directly or through subcontracts and has been contracted with by the Executive Office of Health and Human Services and designated an ICO to provide services to dually eligible individuals pursuant to this section.
(b) Members of the MassHealth dual eligible pilot program on ICOs or any successor program integrating care for dual eligible persons shall be provided an independent community care coordinator by the ICO or successor organization, who shall be a participant in the member's care team. The community care coordinator shall assist in the development of a long term support and services care plan. The community care coordinator shall:
(1) participate in initial and ongoing assessments of the health and functional status of the member, including determining appropriateness for long term care support and services, either in the form of institutional or community-based care plans and related service packages necessary to improve or maintain enrollee health and functional status;

(2) arrange and, with the agreement of the member and the care team, coordinate the provision of appropriate institutional and community long term supports and services, including assistance with the activities of daily living and instrumental activities of daily living, housing, home-delivered meals, transportation, and under specific conditions or circumstances established by the ICO or successor organization, authorize a range and amount of community-based services; and
(3) monitor the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate by the member and the care team; and track member satisfaction and the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate by the member and the care team.
(c) The ICO or successor organization shall not have a direct or indirect financial ownership interest in an entity that serves as an independent care coordinator. Providers of institutional or community based long term services and supports on a compensated basis shall not function as an independent care coordinator, provided however that the secretary may grant a waiver of this restriction upon a finding that public necessity and convenience require such a waiver. An individual who becomes dually eligible after the age of 60 shall receive independent care coordination services pursuant to section 4B of chapter 19 A. For the purposes of this section, an organization compensated to provide only evaluation, assessment, coordination and fiscal intermediary services shall not be considered a provider of long term services and supports."
The amendment was adopted.
Mr. Rodrigues moved that the bill be amended in section 14, by inserting after the word "networks;", in line 735, the following words:- "(iv) the impact of any assessments including, but not limited to, the health system benefit surcharge collected under section 68 of chapter 118E, on health insurance premiums;".
The amendment was adopted.
Ms. Chandler and Ms. Chang-Diaz moved that the bill be amended in section 192, by striking out subsection (b) and inserting in place thereof the following subsection:-
"(b) The commission shall review the program authorized under said section 2G of said chapter 111 and shall issue a report. The report shall include an analysis of all relevant data to determine the effectiveness and return on investment of the program including, but not limited to, an analysis of: (i) the extent to which the program impacted the prevalence of preventable health conditions; (ii) the extent to which the program reduced health care costs or the growth in health care cost trends; (iii) whether health care costs were reduced, and who benefitted from the reduction; (iv) the extent to which workplace-based wellness or health management programs were expanded, and whether those programs improved employee health, productivity and recidivism; (v) if employee health and productivity was improved or employee recidivism was reduced, the estimated statewide financial benefit to employers; (vi) recommendations for whether the program should be discontinued, amended or expanded, as well as a timetable for implementation of the recommendations; and (vii) recommendations for whether the funding mechanism for the Prevention and Wellness Trust Fund, as established under section 68 of chapter 118E of the General Laws, should be extended beyond 2017, or whether an alternative funding mechanism should be established.".
The amendment was adopted.
Mr. Petruccelli moved that the bill be amended by inserting after section 124, the following new language:-
"SECTION 125. Section 6 of chapter 176J of the General Laws is hereby amended by striking subsection (c), as most recently amended by section 31A of chapter 359 of the acts of 2010, and inserting in place thereof the following subsection:--
(c) Notwithstanding any general or special law to the contrary, the commissioner may require carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or 176G, to file all changes to small group product base rates and to small group rating factors at least 90 days before their proposed effective date. The commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged. The commissioner shall disapprove any change to small group rating factors that is discriminatory or not actuarially sound. The determination of the commissioner shall be supported by sound actuarial assumptions and methods, which shall be provided in writing to the carrier. Rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt regulations to carry out this section."
After remarks, the amendment was adopted.
Ms. Candaras moved that the bill be amended by striking out section 13 and inserting in place thereof the following section:-
"SECTION 13. Chapter 12 of the General Laws is hereby amended by inserting after section 11M the following section:-
Section 11N. (a) The attorney general shall monitor trends in the health care market including, but not limited to, trends in provider organization size and composition, consolidation in the provider market, payer contracting trends and patient access and quality issues in the health care market. The attorney general may obtain the following information from a private health care payer, public health care payer, provider or provider organization, as those terms are defined in section 1 of chapter 12C: (i) any information that is required to be submitted under sections 9, 10 and 11 of chapter 12C, (ii) filings, applications and supporting documentation related to any material change subject to a cost, market impact and solvency review under section 10 of chapter 12C and (iii) filings, applications and supporting documentation related to a determination of need application filed under section 25C of chapter 111. Under section 15 of chapter 12C and section 6 of chapter 176S, and subject to the limitations stated in those sections, the attorney general may require that any provider, provider organization, private health care payer or public health care payer produce documents, answer interrogatories and provide testimony under oath related to health care costs and cost trends, the factors that contribute to cost growth within the commonwealth's health care system and the relationship between provider costs and payer premium rates.
(b) The attorney general shall, in consultation with the institute of health care finance and policy, take appropriate action within

existing statutory authority to: (i)prevent excess consolidation or collusion of provider organizations and to remedy these or other related anti-competitive dynamics in the health care market; (ii) prevent unreasonable increases in health care rates, charges, medical expenses or prices; and (iii) prevent or mitigate adverse effects on patient access and quality in the health care market.
(c) The attorney general may intervene or otherwise participate in efforts by the commonwealth to obtain exemptions or waivers from certain federal laws regarding provider market conduct, including, from the federal Office of the Inspector General, a waiver of, or expansion of, the 'safe harbors' provided for under 42 U.S.C. section 1320a-7b and obtaining from the federal Office of the Inspector General a waiver of, or exemption from, 42 U.S.C. section 1395nn subsections (a) to (e).
(d) The attorney general may act under existing authority including, but not limited to, subsection (b) of section 15 of chapter 12C and section 6 of chapter 176S to carry out this section.";
By inserting after the words "chapter 12C," in line 1638, the following words:- "shall take into account any comments from the attorney general"; and
by inserting after the word "application" in line 1651, the following words:- "at its discretion or at the request of the attorney general. The attorney general may intervene in any hearing under this section.".
After remarks, the amendment was adopted.
Mr. Rush moved that the bill be amended in Section 14, in subsection (a) of proposed section 11 of chapter 12C of the General Laws by adding the following sentence:- "The institute shall adopt regulations to require private and public health care payers which utilize alternative payment methodologies to report on the extent to which such alternative payment methodologies conform with the best practices developed by the authority under section 9 of chapter 176S including, but not limited to, whether such methodologies include the risk adjustment elements set out in said section 9 of said chapter 176S."
The amendment was adopted.
Ms. Creem and Ms. Spilka moved that the bill be amended by striking out section 184 and inserting in place thereof the following section:-
"SECTION 184. There shall be a special task force to study issues related to the accuracy of medical diagnosis in the commonwealth, called the Massachusetts Diagnostic Accuracy Task Force. The task force shall investigate and report on: (a) the extent to which diagnoses in the commonwealth are accurate and reliable, including the extent to which different diagnoses and inaccurate diagnoses arise from the biological differences between the sexes; (b) the underlying systematic causes of inaccurate diagnosis; (c) estimation of the financial cost to the state, insurers and employers of inaccurate diagnoses; (d) the negative impact on patients caused by inaccurate diagnoses; and (e) recommendations to reduce or eliminate the impact of inaccurate diagnoses. The Massachusetts Diagnostic Accuracy Task Force shall be comprised of 9 members: 1 of whom shall be the secretary of health and human services, who shall chair the task force; 1 of whom shall be the commissioner of public health, or a designee; 1 of whom shall be the chair of the board of registration in medicine, or a designee; 1 of whom shall be the chair of the board of registration in nursing, or a designee; and 5 members chosen by the governor: 1 of whom shall be a provider with experience in the area of diagnostic accuracy,1 of whom shall be a representative of a Massachusetts health plan, 1 of whom shall be an employer with experience in implementing programs to address diagnostic inaccuracy, 1 whom shall represent an organization based in the commonwealth with experience creating and supporting the implementation of programs on diagnostic accuracy and value-based benefit design, and 1 of whom shall be a non-physician health care provider."
The amendment was adopted.
Mr. DiDomenico, Ms. Jehlen, Mr. Hart and Ms. Fargo moved that the bill be amended in section 162, by striking out section 9 and inserting in place thereof the following section:-
"Section 9. The authority, in consultation with the advisory board, shall develop best practices and standards for alternative payment methodologies for use by the group insurance commission, the office of Medicaid and any other state funded insurance program. Any alternative payment methodology shall: (1) support the state's efforts to meet the health care cost benchmark established in section 5; (2) include incentives for high quality, coordinated care, including wellness services, primary care services and behavioral health services; (3) include a risk adjustment element based on health status; (4) to the extent possible, include a risk adjustment element that takes into account functional status, socioeconomic status or cultural factors; (5) preserve the use of intergovernmental transfer financing mechanisms by the governmental acute public hospital consistent with the Medical Assistance Trust Fund provisions in effect as of fiscal year 2012; and (6) recognize the unique circumstances of high Medicaid disproportionate share hospitals and other safety net providers with concentrated care in government programs. The authority shall also consider methodologies to account for the following costs: (i) medical education; (ii) stand-by services and emergency services, including, but not limited to, trauma units and burn units; ; (iii) services provided by disproportionate share hospitals or other providers serving underserved populations, including but not limited to, groups which suffer adverse health outcomes based on race, sex, ethnicity, disability, housing type, income level, primary language or educational attainment; (iv) services provided to children; (v) research; (vi) care coordination and community based services provided by allied health professionals, including, but not limited to, community health workers, legal advocates, medical interpreters, clinical prevention specialists, human services workers, social workers and licensed alcohol and drug counselors; (vii) the greater integration of behavioral and mental health; (viii) the use and the continued advancement of new medical technologies, treatments, diagnostics or pharmacology products that offer substantial clinical improvements and represent a higher cost than the use of current therapies; (ix) culturally and linguistically appropriate services; (x) interpreter services; (xi) dedicated care management responsibilities and administrative responsibilities in alternative payment methodologies; and (xii) costs associated with the services of a comprehensive cancer center, as defined in section 8 of chapter 118E
Any best practices and standards developed under this section shall be shared with all private health plans for their voluntary adoption."; and in section 186, by adding the following sentence:- "Any alternative payment methodology shall be consistent

with the best practices and standards developed by the health care quality and finance authority under subsection (a) of section 9 of said chapter 176S.".
After remarks, the amendment was adopted.
Messrs. Downing, Michael O. Moore and Keenan, Ms. Spilka and Ms. Fargo moved that the bill be amended by striking out section 48 and inserting in place thereof the following section:-
"SECTION 48. Said chapter 111 is hereby further amended by inserting after section 2F the following 2 sections:–
Section 2G. (a) There shall be established and set upon the books of the commonwealth a separate fund to be known as the Prevention and Wellness Trust Fund to be expended, without further appropriation, by the department of public health. The fund shall consist of health system benefit surcharge revenues collected by the commonwealth under section 68 of chapter 118E, public and private sources such as gifts, grants and donations to further community-based prevention activities, interest earned on such revenues and any funds provided from other sources.
The commissioner of public health, as trustee, shall administer the fund. The commissioner, in consultation with the Prevention and Wellness Advisory Board established under section 2H, shall make expenditures from the fund consistent with subsections (d) and (e); provided, that not more than 15 per cent of the amounts held in the fund in any 1 year shall be used by the department for the combined cost of program administration, technical assistance to grantees or program evaluation.
(b) Revenues deposited in the fund that are unexpended at the end of the fiscal year shall not revert to the General Fund and shall be available for expenditure in the following fiscal year.
(c) All expenditures from the Prevention and Wellness Trust Fund shall support the state's efforts to meet the health care cost growth benchmark established in section 5 of chapter 176S and any activities funded by the Healthcare Payment Reform Fund, and 1 or more of the following purposes: (i) reduce rates of the most prevalent and preventable health conditions, including substance abuse ; (ii) increase healthy behaviors, including the management of chronic diseases; (iii) increase the adoption of workplace-based wellness or health management programs that result in positive returns on investment for employees and employers; (iv) address health disparities; or (v) develop a stronger evidence-base of effective prevention programming.
(d) The commissioner shall annually award not less than 75 per cent of the Prevention and Wellness Trust Fund through a competitive grant process to municipalities, community-based organizations, health care providers, regional-planning agencies, and health plans that apply for the implementation, evaluation and dissemination of evidence-based community preventive health activities. To be eligible to receive a grant under this subsection, a recipient shall be: (i) a municipality or group of municipalities working in collaboration; (ii) a community-based organization working in collaboration with 1 or more municipalities; (iii) a health care provider or a health plan working in collaboration with 1 or more municipalities and a community-based organization; or (iv) a regional planning agency. Expenditures from the fund for such purposes shall supplement and not replace existing local, state, private or federal public health-related funding.
(e) A grant proposal submitted under subsection (d) shall include, but not be limited to: (i) a plan that defines specific goals for the reduction in preventable health conditions and health care costs over a multi-year period; (ii) the evidence-based programs the applicant shall use to meet the goals; (iii) a budget necessary to implement the plan, including a detailed description of any funding or in-kind contributions the applicant or applicants will be providing in support of the proposal; (iv) any other private funding or private sector participation the applicant anticipates in support of the proposal; (v) a commitment to include women, racial and ethnic minorities and low income individuals; and (vi) the anticipated number of individuals that would be affected by implementation of the plan.
Priority may be given to proposals in a geographic region of the state with a higher than average prevalence of preventable health conditions, as determined by the commissioner of public health, in consultation with the Prevention and Wellness Advisory Board. If no proposals were offered in areas of the state with particular need, the department shall ask for a specific request for proposal for that specific region. If the commissioner determines that no suitable proposals have been received, such that the specific needs remain unmet, the department may work directly with municipalities or community-based organizations to develop grant proposals.
The department of public health shall, in consultation with the Prevention and Wellness Advisory Board, develop guidelines for an annual review of the progress being made by each grantee. Each grantee shall participate in any evaluation or accountability process implemented or authorized by the department.
(f) The commissioner of public health may annually expend not more than 10 per cent of the Prevention and Wellness Trust Fund to support the increased adoption of workplace-based wellness or health management programming. The department of public health shall expend such funds for activities including, but not limited to: (i) developing and distributing informational tool-kits for employers, including a model wellness guide developed by the department; (ii) providing technical assistance to employers implementing wellness programs; (iii) hosting informational forums for employers; (iv) promoting awareness of wellness tax credits provided through the state and federal government, including the wellness subsidy provided by the commonwealth health connector authority; (v) public information campaigns that quantify the importance of healthy lifestyles, disease prevention, care management and health promotion programs; and (vi) providing stipends or grants to employers for the implementation and administration of workplace wellness programs in an amount up to 50 per cent of the costs associated with implementing the plan, subject to a cap as established by the commissioner based on available funds.
The department of public health shall develop guidelines to annually review progress toward increasing the adoption of workplace-based wellness or health management programming.
(g) The department of public health shall, annually on or before January 31, report on expenditures from the Prevention and Wellness Trust Fund. The report shall include, but not be limited to: (i) the revenue credited to the fund; (ii) the amount of fund expenditures attributable to the administrative costs of the department of public health; (iii) an itemized list of the funds expended

through the competitive grant process and a description of the grantee activities; (iv) the results of the evaluation of the effectiveness of the activities funded through grants; and (v) an itemized list of expenditures used to support workplace-based wellness or health management programs. The report shall be provided to the chairs of the house and senate committees on ways and means and the joint committee on public health and shall be posted on the department of public health's website.
(h) The department of public health shall, under the advice and guidance of the Prevention and Wellness Advisory Board, annually report on its strategy for administration and allocation of the fund, including relevant evaluation criteria. The report shall set forth the rationale for such strategy, including, but not limited to: (i) a list of the most prevalent preventable health conditions in the commonwealth, including health disparities experienced by populations based on race, ethnicity, gender, disability status, sexual orientation or socio-economic status; (ii) a list of the most costly preventable health conditions in the commonwealth; (iii) a list of evidence-based or promising community-based programs related to the conditions identified in clauses (i) and (ii); and (iv) a list of evidence-based workplace wellness programs or health management programs related to the conditions in clauses (i) and (ii). The report shall recommend specific areas of focus for allocation of funds. If appropriate, the report shall reference goals and best practices established by the National Prevention and Public Health Promotion Council and the Centers for Disease Control and Prevention, including, but not limited to the national prevention strategy, the healthy people report and the community prevention guide.
(i) The department of public health may promulgate regulations to carry out this section.
Section 2H. There shall be a Prevention and Wellness Advisory Board to make recommendations to the commissioner concerning the administration and allocation of the Prevention and Wellness Trust Fund established in section 2G, establish evaluation criteria and perform any other functions specifically granted to it by law.
The board shall consist 17 members: 1 of whom shall be the commissioner of public health or a designee, who shall serve as chair; 1 of whom shall be the executive director of the institute of health care finance and policy established in chapter 12C or a designee; 1 of whom shall be the secretary of health and human services or a designee; 14 of whom shall be appointed by the governor, 1 of whom shall be a person with expertise in the field of public health economics; 1 of whom shall be a person with expertise in public health research; 1 of whom shall be a person with expertise in the field of health equity; 1 of whom shall be a person from a local board of health for a city or town with a population greater than 50,000; 1 of whom shall be a person of a board of health for a city or town with a population less than 50,000; 2 of whom shall be representatives of health insurance carriers; 1 of whom shall be a person from a consumer health organization; 1 of whom shall be a person from a hospital association; 1 of whom shall be a person from a statewide public health organization; 1 of whom shall be a representative of the interest of businesses; 1 of whom shall administer an employee assistance program; 1 of whom shall be a public health nurse or a school nurse; and 1 of whom shall be a person from an association representing community health workers."
After remarks, the amendment was adopted.
Ms. Chang-Díaz moved that the bill be amended by striking out section 202 and section 205.
The amendment was *rejected*.
Mr. Finegold moved that the bill be amended by inserting after section 190, the following section:-
"SECTION 190A. There shall be a special commission to examine: (1) the feasibility of implementing required co-pays for MassHealth services, the proceeds of which shall be deposited into a trust fund to restore MassHealth Adult Dental Benefits; and (2) methods to encourage health care providers to accept patients covered by MassHealth on a limited basis. The commission shall consist of 9 members: 1 of whom shall be the secretary of health and human services or a designee, who shall serve as chair; 1 of whom shall be the director of the office of Medicaid; 1 of whom shall be the executive director of the institute of health care finance and policy; 1 of whom shall be appointed by the Massachusetts Medical Society; 1 of whom shall be appointed by the Massachusetts Dental Society; 1 of whom shall be appointed by the Massachusetts Senior Care Association; 1 of whom shall be appointed by the Massachusetts League of Community Health Centers; 1 of whom shall be the executive director of Health Care For All, Inc.; and 2 of whom shall be appointed by the governor, 1 of whom shall represent managed care organizations contracting with MassHealth.
The commission shall file the results of its study, together with drafts of legislation, if any, necessary to carry out its recommendations, by filing the same with the clerks of the house of representatives and the senate who shall forward a copy of the study to the house and senate committees on ways and means and the joint committee on health care financing not later than October 1, 2013."
After remarks, the amendment was adopted.
Mr. Richard T. Moore moved that the bill be amended in Section 162, by striking out section 8 and inserting in place thereof the following section:-
"Section 8. (a) The authority, in consultation with the advisory board, shall develop standards and a common application form for certain provider organizations to be voluntarily certified as Beacon ACOs. The purpose of the Beacon ACO certification process shall be to encourage the adoption of certain best practices by provider organizations in the commonwealth related to cost containment, quality improvement and patient protection. Provider organizations seeking this certification shall apply directly to the authority and shall submit all necessary documentation as required by the authority. The Beacon ACO certification shall be assigned to all provider organizations that meet the standards developed by the board.
(b) In developing standards for Beacon ACO certification, the authority shall review the best practices employed by health care entities in the commonwealth and the standards included in models developed by the Centers for Medicare & Medicaid Services, including the Pioneer ACO, the Medicare Shared Savings Model and any safety net accountable care organization models, and shall include, at a minimum, a requirement that all Beacon ACOs shall: (i) commit to entering alternative payment methodology contracts with other purchasers; (ii) be a legal entity with its own tax identification number, recognized and authorized under the

laws of the commonwealth; (iii) include patient and consumer representation on its governance; and (iv) commit to ensuring at least 50 per cent of the Beacon ACO's primary care providers are meaningfully using certified EHR technology as defined in the HITECH Act and subsequent Medicare regulations.

(c) The board shall develop additional standards necessary to be certified as a Beacon ACO, related to quality improvement, cost containment and patient protections. In developing additional standards, the board shall consider, at a minimum, the following requirements for Beacon ACOs:

(1) to reduce the growth of health status adjusted total medical expenses over time, consistent with the state's efforts to meet the health care cost benchmark established under section 5;

(2) to improve the quality of health services provided, as measured by the statewide quality measure set and other appropriate measures;

(3) to ensure patient access to health care services across the care continuum, including, but not limited to, access to: preventive and primary care services; emergency services; hospitalization services; ambulatory patient services; mental health and behavioral health services; access to specialty care units, including, but are not limited to, burn, coronary care, cancer care, including the services of a comprehensive cancer center, as defined in section 8 of chapter 118E, neonatal care, post-obstetric and post operative recovery care, pulmonary care, renal dialysis and surgical, including trauma and intensive care units; pediatric services;obstetrics and gynecology services; diagnostic imaging and screening services; clinical laboratory and pathology services; maternity and newborn care services and related mental health outcomes; radiation therapy and treatment services; skilled nursing facilities; family planning services; home health services; treatment and prevention services for alcohol and other drug abuse; breakthrough technologies and treatments; allied health services including, but not limited to, advance practice nurses, optometric care, direct access to chiropractic services and physical therapy, occupational therapists, dental care, midwifery services, and end-of-life care services, including hospice and palliative care; and establishing mechanisms to protect patient provider choice, including parameters for out of Beacon ACO arrangements;

(4) to accept and promote alternative payment methodologies consistent with the standards developed by the authority under section 9 and the adoption of payment incentives that improve quality and care coordination, including, but not limited to, incentives to reduce avoidable hospitalizations, avoidable readmissions, adverse events and unnecessary emergency room visits; incentives to reduce racial, ethnic and linguistic health disparities in the patient population; and in all cases ensuring that alternative payment methodologies do not create any incentive to deny or limit medically necessary care, especially for patients with high risk factors or multiple health conditions;

(5) to improve access to certain primary care services, including but not limited to, by having a demonstrated primary care and care coordination capacity and a minimum number of practices engaged in becoming patient centered medical homes;

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

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

(8) to promote patient-centeredness by, including, but not limited to, establishing mechanisms to conduct patient outreach and education on the necessity and benefits of care coordination, including group visits and chronic disease self-management programs; demonstrating an ability to engage patients in shared decision making taking into account patient preferences; demonstrating an ability to effectively involve patients in care transitions to improve the continuity and quality of care across settings, with case manager follow up; demonstrating an ability to engage and activate patients at home, through methods such as home visits or telemedicine, to improve self-management; establishing mechanisms to evaluate patient satisfaction with the access and quality of their care; establishing mechanismss between payers and the provider organization such that any shared savings between the provider and the payer shall contain a mechanism to return a percentage of the savings to the Beacon ACO participants; and establishing mechanisms to protect patient provider choice, including parameters for accessing care outside of the provider organization;

(9) to adopt certain health information technology,data analysis functions and performance management programs, including, but not limited to, population-based management tools and functions; data stratification by sex and sex-race groups; the ability to aggregate and analyze clinical data; the ability to electronically exchange patient summary records across providers who are members of the Beacon ACO and other providers in the community to ensure continuity of care; the ability to provide access to multi-payer claims data and performance reports and the ability to share performance feedback on a timely basis with participating providers; the ability to enable the beneficiary access to electronic health information; and the utilization of a proven performance management program, including, but not limited to, participation in the 2011-2012 Health Care Criteria for Performance Excellence as developed in conjunction with the Baldrige Criteria for Performance Excellence administered by the National Institutes of Standards and Technology of the United States Department of Commerce;

(10) to demonstrate excellence in the area of quality improvement and care coordination, as evidenced by the success of previous or existing care coordination, pay for performance, patient centered medical home, quality improvement or health outcomes improvement initiatives, including, but not limited to, a demonstrated commitment to reducing avoidable hospitalizations, adverse events and unnecessary emergency room visits;

(11) to adopt protocols to promote provider integration, both with providers within and outside of the provider organization, including, but not limited to, clinical integration of the medical director of the laboratory, accredited or certified under the federal

Clinical Laboratory Improvements Act of 1988, providing these services to the organization;
(12) to promote community-based wellness programs and community health workers, consistent with efforts funded by the department of public health through the Prevention and Wellness Trust Fund established in section 2G of chapter 111 and to promote other activities that integrate community public health interventions with an emphasis on the social determinants of health and which have been proven to improve health;
(13) to promote worker training programs and skills training opportunities for employees of the provider organization, consistent with efforts funded by the secretary of labor and workforce development through the Health Care Workforce Transformation Trust Fund;
(14) to adopt certain governance structure standards, including standards related to financial conflicts of interest and transparency;
(15) to adopt certain financial capacity standards, including certification under subsection (e) of section 10 of chapter 12C, to protect Beacon ACOs from assuming excess risk; and
(16) to demonstrate the administrative, clinical and financial capability to meet the primary and secondary care needs of a defined population of patients, consisting of a minimum number of covered lives, as established by the authority;
(17) any other requirements the board considers necessary.
(d) The authority shall update the standards for certification as a Beacon ACO at least every 2 years, or at such other times as the authority determines necessary. In developing the standards, the authority shall seek to allow for provider organizations of different compositions, including, but not limited to, hospital and physician organizations, physician group entities and independent physician organizations, to successfully apply for certification. The authority may waive certain Beacon ACO financial capacity standards for provider organizations composed of safety net providers, including community hospitals, high Medicaid disproportionate share hospitals and their affiliated providers, if the authority determines that such standards represent an insurmountable barrier to successful certification. The Authority shall not deny a Beacon ACO certification based solely on the geographic location or size of the provider organization.
(e) Provider organizations seeking to maintain certification shall renew their certification as a Beacon ACO every 2 years. Failure to meet the requirements represented in the certification may result in decertification, as determined by the board.”.
The amendment was adopted.
Mr. Keenan moved to amend the bill by striking out section 131 and inserting in place thereof the following section: -
“SECTION 131. Section 1 of chapter 176O of the General Laws, as so appearing, is hereby amended by inserting after the definition of ‘Adverse determination’ the following definition:-
‘Allowed amount,’ the contractually agreed upon amount paid by a carrier to a health care provider for health care services provided to an insured.”;
By striking the definition of “Behavioral health manager” and inserting in place thereof the following definition:
“‘Behavioral health manager’, a company, organized under the law of the commonwealth or organized under the laws of another state and qualified to do business in the commonwealth, that has entered into a contractual arrangement with a carrier to provide or arrange for the provision of behavioral, substance use disorder and mental health services to voluntarily enrolled member of the carrier.”;
By striking the definition of “Emergency medical condition” and inserting in place thereof the following definition:
“‘Emergency medical condition’, a medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).”; and
By striking the definition of “Health care services” and inserting in place thereof the following definition:
“‘Health care services’, services for the diagnosis, prevention, treatment, cure or relief of a physical, behavioral, substance use disorder or mental health condition, illness, injury or disease.”
The amendment was adopted.
Messrs. Keenan and Michael O. Moore and Ms. Fargo moved that the bill be amended by striking out section 182 and inserting in place thereof the following section:-
“SECTION 182. There shall be a special task force to examine behavioral, substance use disorder and mental health treatment, service delivery, integration of behavioral health with primary care and behavioral health reimbursement systems. The task force shall consist of 13 members: 1 of whom shall be the commissioner of mental health, who shall serve as chair; 1 of whom shall be a representative of the Massachusetts Hospital Association; 1 of whom shall be a representative of the Massachusetts Organization for Addiction Recovery; 1 of whom shall be a representative of the Massachusetts Recovery Home Collaborative; 1 of whom shall be a representative of the Massachusetts Association of Behavioral Health Systems; 1 of whom shall be a representative of the Home Care Alliance of Massachusetts; 1 of whom shall be a representative of the Children’s Mental Health Campaign; 1 of whom shall be a representative of the Association for Behavioral Healthcare; 1 of whom shall be a representative of the Massachusetts Chapter of the National Association of Social Workers; and 4 of whom shall be appointed by the governor: 1 of whom shall be a provider with experience serving hard to reach populations; 1 of whom shall be a provider with experience in serving dually diagnosed patients; 1 of whom shall be a registered nurse; and 1 of whom shall be a school nurse. In its examination, the task force shall review: (a) the most effective and appropriate approach to including behavioral, substance use and mental health disorder, and services in the array of services provided by integrated provider organizations, including

transition planning for providers and maintaining continuity of care; (b) how current prevailing reimbursement methods and covered behavioral, substance use, and mental health benefits may need to be modified to achieve more cost effective, integrated and high quality behavioral, substance use, and mental health outcomes, particularly with respect to the effects of cardiovascular disease, diabetes and obesity on patients with serious mental illness, (c) the extent to which and how payment for behavioral health services should be included under alternative payment methodologies, including how mental health parity and patient choice of providers and services could be achieved and the design and use of medical necessity criteria and protocols; (d) how best to educate all providers to recognize behavioral, substance use and mental health conditions and make appropriate decisions regarding referral to behavioral health services; and (e) the unique privacy factors required for the integration of behavioral, substance use and mental health information into interoperative electronic health records. The task force shall submit its report, findings and recommendations along with any proposed legislation and regulatory changes to the health care quality and finance authority, the clerks of the senate and house of representatives, the house and senate chairs of the joint committee on mental health and substance abuse and the house and senate chairs of the joint committee on health care financing not later than July 1, 2013.".

The amendment was adopted.

Mr. Keenan moved that the bill be amended by striking out sections 176 and 177 and inserting in place thereof the following 2 sections:-

"SECTION 176. Notwithstanding any general or special law or rule or regulation to the contrary, the commissioner of insurance shall promulgate regulations requiring any carrier, as defined in section 1 of chapter 176O of the General Laws, and their contractors to comply with and implement the federal Mental Health Parity and Addiction Equity Act of 2008, section 511 of Public Law 110-343 and applicable state mental health parity laws including section 22 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter 176G of the General Laws. The commissioner of insurance shall promulgate said regulations not later than January 1, 2013. The regulations shall be implemented as part of any provider contracts and any carrier's health benefit plans which are delivered, issued, entered into, renewed or amended on or after July 31, 2012.

Starting on July 1, 2013, the commissioner of insurance shall require all carriers and their contractors, to submit an annual report to the division of insurance and to the attorney general, which shall be a public record, certifying and outlining how their health benefit plans are in compliance with the federal Mental Health Parity and Addiction Equity Act, applicable state mental health parity laws, including said section 22 of said chapter 32A, said section 47B of said chapter 175, said section 8A of said chapter 176A, said section 4A of said chapter 176B and said sections 4, 4B and 4M of said chapter 176G, and this section. The division of insurance may, at the request of the attorney general or in its own discretion, hold a public hearing on a carrier's annual report.

SECTION 177. Notwithstanding any general or special law or rule or regulation to the contrary, the office of Medicaid shall promulgate regulations requiring any Medicaid health plan and managed care organization and their health plans and any behavioral health management firm and third party administrator under contract with a Medicaid managed care organization to comply with and implement the federal Mental Health Parity and Addiction Equity Act of 2008, section 511 of Public Law 110-343 and applicable state mental health parity laws including section 22 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter 176G of the General Laws. The office of Medicaid shall promulgate said regulations not later than January 1, 2013. The regulations shall be implemented as part of any provider contracts and any carrier's health benefit plans which are delivered, issued, entered into, renewed or amended on or July 31, 2012.

Starting on July 1, 2013, the office of Medicaid shall submit an annual report to the house and senate chairs of the joint committee on health care financing, the house and senate chairs of the joint committee on mental health and substance abuse, the clerk of the senate, the clerk of the house of representatives and the attorney general certifying and outlining how the health benefit plans under the office of Medicaid, and any contractors, are in compliance with the federal Mental Health Parity and Addiction Equity Act, applicable state mental health parity laws, including said section 22 of said chapter 32A, said section 47B of said chapter 175, said section 8A of said chapter 176A, said section 4A of said chapter 176B and said sections 4, 4B and 4M of said chapter 176G, and this section. The office of Medicaid may hold a hearing on a health benefit plan's compliance with this section.".

The amendment was adopted.

Mr. Richard T. Moore moved to amend the bill by striking section 180 and inserting in place thereof the following:-

"SECTION 180. Notwithstanding any general or special law to the contrary, the health care quality and finance authority shall collaborate with the office of Medicaid, the group insurance commission, the commonwealth health insurance connector authority and any other state funded insurance programs to evaluate whether contracting with certain provider organizations for the delivery of publicly funded health services of such beneficiaries offer opportunities for cost-effective and high quality care. To the extent such opportunities exist, the health care quality and finance authority shall assist state funded insurance programs in holding a competitive bidding process, with priority given to provider organizations which have been certified by the board of the health care quality and finance authority as Beacon ACOs, under section 8 of chapter 176S, for the delivery of publicly funded health services. In awarding any contracts, state funded insurance programs shall take into account the continuity of patient care."

After remarks, the amendment was adopted.

Ms. Chandler moved that the bill be amended by inserting after Section ___, the following section:-

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

Section 70H. Notwithstanding any provision in chapter 93A, sections 70E, 72E and 73 of chapter 111 of the General Laws, and

940 Code of Massachusetts Regulations section 4.09, a facility or institution licensed by the department of public health pursuant to General Laws chapter 111, section 71 may move a resident to different living quarters or to a different room within the facility or institution if, as documented in the resident's clinical record and as certified by a physician, the resident's clinical needs have changed such that the resident either (1) requires specialized accommodations, care, services, technologies, staffing not customarily provided in connection with the resident's living quarters or room, or (2) ceases to require the specialized accommodations, care, services, technologies or staffing customarily provided in connection with the resident's living quarters or room; provided, however, that nothing in this section shall obviate a resident's notice and hearing rights when movement to different living quarters involves a resident moving from a Medicare-certified unit to a non-Medicare-certified unit or involves a resident moving from a non-Medicare-certified unit to a Medicare-certified unit and, provided, however, that the resident shall have the right to appeal to the facility's or institution's medical director a decision to move the resident to a different living quarter or to a different room within the facility or institution."

The amendment was adopted.

Mr. Hart moved to amend the bill in section 14, in proposed section 15 of chapter 12C of the General Laws, by striking out, in lines 735 and 736, the following words:-

"(iv) price variance between providers and any efforts undertaken by payers to reduce such variance;";

In said section 14, in subsection (a) of said proposed section 15 of said chapter 12C, by inserting after the first paragraph the following paragraph:-

"As part of its annual report, the institute shall report on price variation between health care providers, by payer and provider type. The institute's report shall include: (i) baseline information about price variation between health care providers by payer including, but not limited to, identifying providers or provider organizations that are paid more than 10 per cent above or more than 10 per cent below the weighted average relative price and identifying payers which have entered into alternative payment contracts that vary by more than 10 per cent; (ii) the annual change in price variation, by payer, among the payer's participating providers; (iii) factors that contribute to price variation in the commonwealth's health care system; (iv) the impact of price variations on disproportionate share hospitals and other safety net providers; and (v) the impact of health reform efforts on price variation including, but not limited to, the impact of increased price transparency, increased prevalence of alternative payment contracts and provider organizations with integrated care networks."; and

In section 162, in proposed chapter 176S of the General Laws, by striking out proposed section 6 and inserting in place thereof the following section:-

"Section 6. (a) Not later than October 1 of every year, the board shall hold public hearings based on the report submitted by the institute under section 15 of chapter 12C comparing the growth in total health care expenditures to the health care cost growth benchmark for the previous calendar year. The hearings shall examine health care provider, provider organization and private and public health care payer costs, prices, and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system. The attorney general may intervene in such hearings.

(b) Public notice of any hearing shall be provided at least 60 days in advance.

(c) The authority shall identify as witnesses for the public hearing a representative sample of providers, provider organizations, payers and others, including: (i) at least 3 academic medical centers, including the 2 acute hospitals with the highest level of net patient service revenue; (ii) at least 3 disproportionate share hospitals, including the 2 hospitals whose largest per cent of gross patient service revenue is attributable to Title XVIII and XIX of the federal Social Security Act or other governmental payers; (iii) community hospitals from at least 3 separate regions of the state; (iv) freestanding ambulatory surgical centers from at least 3 separate regions of the state; (v) community health centers from at least 3 separate regions of the state; (vi) the 5 private health care payers with the highest enrollments in the state; (vii) any managed care organization that provides health benefits under Title XIX or under the commonwealth care health insurance program; (viii) the group insurance commission; (ix) at least 3 municipalities that have adopted chapter 32B; (x) at least 3 provider organizations, at least 1 of which shall be a physician organization and at least 1 of which has been certified as a Beacon ACO; and (xii) any witness identified by the attorney general or the institute of health care finance and policy.

(d) Witnesses shall provide testimony under oath and subject to examination and cross examination by the board, the executive director of the institute and the attorney general at the public hearing in a manner and form to be determined by the board, including without limitation: (i) in the case of providers and provider organizations, testimony concerning payment systems, care delivery models, payer mix, cost structures, administrative and labor costs, capital and technology cost, adequacy of public payer reimbursement levels, reserve levels, utilization trends, relative price, quality improvement and care-coordination strategies, investments in health information technology, the relation of private payer reimbursement levels to public payer reimbursements for similar services, efforts to improve the efficiency of the delivery system and efforts to reduce the inappropriate or duplicative use of technology; and (ii) in the case of private and public payers, testimony concerning factors underlying premium cost and rate increases, the relation of reserves to premium costs, the payer's efforts to develop benefit design, network design and payment policies that enhance product affordability and encourage efficient use of health resources and technology including utilization of alternative payment methodologies, efforts by the payer to increase consumer access to health care information, efforts by the payer to promote the standardization of administrative practices and any other matters as determined by the board. The board shall solicit testimony from any payer which has been identified by the institute's annual report under section 15 of chapter 12C as (i) paying providers more than 10 per cent above or more than 10 percent below the weighted average relative price or (ii) entering into alternative payment contracts that vary by more than 10 per cent. Any payer identified by the institute's report shall explain the extent of price variation between the payer's participating providers and describe any efforts to reduce such price variation.

(e) In the event that the institute's annual report under section 15 of chapter 12C finds that the percentage change in total health care expenditures exceeded the health care cost benchmark in the previous calendar year, the authority may identify additional witnesses for the public hearing. Witnesses shall provide testimony subject to examination and cross examination by the board, the executive director of the institute and attorney general at the public hearing in a manner and form to be determined by the board, including without limitation: (i) testimony concerning unanticipated events that may have impacted the total health care cost expenditures, including, but not limited to, a public health crisis such as an outbreak of a disease, a public safety event or a natural disaster; (ii) testimony concerning trends in patient acuity, complexity or utilization of services; (iii) testimony concerning trends in input cost structures, including, but not limited to, the introduction of new pharmaceuticals, medical devices and other health technologies; (iv) testimony concerning the cost of providing certain specialty services, including but not limited to, the provision of health care to children, the provision of cancer-related health care and the provision of medical education; (v) testimony related to unanticipated administrative costs for carriers, including, but not limited to, costs related to information technology, administrative simplification efforts, labor costs and transparency efforts; (vi) testimony related to costs due the implementation of state or federal legislation or government regulation; and (vii) any other factors that may have led to excessive health care cost growth.
(f) The authority shall compile an annual report concerning spending trends and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system. The report shall be based on the authority's analysis of information provided at the hearings by providers, provider organizations and insurers, data collected by the institutes under sections 9, 10 and 11 of chapter 12C, and any other information the authority considers necessary to fulfill its duties under this section, as further defined in regulations promulgated by the authority. The report shall be submitted to the chairs of the house and senate committees on ways and means, the chairs of the joint committee on health care financing and shall be published and available to the public not later than December 31 of each year. The report shall include any legislative language necessary to implement the recommendations.".
The amendment was adopted.

There being no objection, during consideration of the Orders of the Day, the following matter was considered, as follows, to wit:

PAPER FROM THE HOUSE

Engrossed Bill—Land Taking for Conservation Etc.

An engrossed Bill authorizing the town of Essex to sell or lease certain real property at Conomo Point (see Senate, No. 2246) (which originated in the Senate), having been certified by the Senate Clerk to be rightly and truly prepared for final passage,-- was put upon its final passage; and, this being a bill providing for the taking of land or other easements used for conservation purposes, etc., as defined by Article XCVII of the Amendments to the Constitution, the question on passing it to be enacted was determined by a call of the yeas and nays, at twenty-six minutes past five o'clock P.M., as follows, to wit (yeas 34 - nays 0) **[Yeas and Nays No. 189]:**

YEAS

Brownsberger, William N.	Kennedy, Thomas P.
Candaras, Gale D.	Knapik, Michael R.
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.
Downing, Benjamin B.	Petruccelli, Anthony
Eldridge,	Rodrigues,

James B. Fargo, Susan C.	Michael J. Rosenberg, Stanley C.
Finegold, Barry R.	Ross, Richard J.
Flanagan, Jennifer L.	Rush, Michael F.
Hart, John A., Jr.	Spilka, Karen E.
Hedlund, Robert L.	Tarr, Bruce E.
Jehlen, Patricia D.	Timilty, James E
Joyce, Brian A.	Welch, James T.
Keenan, John F.	Wolf, Daniel A. **— 34.**

NAYS — 0.

ABSENT OR NOT VOTING

Berry, Frederick E.	Donnelly, Kenneth J
Brewer, Stephen M.	Donoghue, Eileen M. .— **4.**

The yeas and nays having been completed at a half past five o'clock P.M., the bill was passed to be enacted, two-thirds of the members present having agreed to pass the same, and it was signed by the President and laid before the Governor for his approbation.

Orders of the Day.

The Orders of the Day were further considered, as follow:--

The Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2260, amended),-- was considered, the main question being on ordering the bill to a third reading.

Mr. Brownsberger moved that the bill be amended in section 150, in the first paragraph of proposed section 23 of chapter 176O of the General Laws by adding the following sentence: "The decision on the appeal shall be in writing and shall notify the patient of the right to file a further external appeal."; and in said section 150, in said proposed section 23 of chapter 176O of the General Laws, by striking out the second paragraph and inserting in place thereof the following paragraph:-

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

After remarks, the amendment was adopted.

Mr. Hart moved that the bill be amended in section 14, in subsection (a) of proposed section 9 of chapter 12C of the General Laws, by adding the following sentence:- "The institute shall also promulgate regulations to require providers to report the existence of any agreements through which 1 provider agrees to furnish another provider with a discount, rebate or any other type of refund or remuneration in exchange for, or in any way related to, the provision of heath care services."

The amendment was adopted.

Messrs. Montigny and Eldridge moved that the bill be amended by inserting at the end thereof the following new sections:-

"SECTION_____. Section 271 of Chapter 127 of the acts of 1999 is hereby amended by inserting in the first paragraph after the words 'the secretary of the executive office of elder affairs' the following words:- ', the executive director of the Commonwealth Health Insurance Connector Authority'.

SECTION_____. Section 271 of Chapter 127 of the acts of 1999 is hereby amended by striking out in the first paragraph the following words;- '(i) participants in the Senior Pharmacy program, so-called, pursuant to section 16B of chapter 118E of the

General Laws' and inserting in place thereof the following words: '(i) enrollees in Commonwealth Care pursuant to chapter 176Q of the General Laws'.
SECTION _____. Section 62 of Chapter 177 of the Acts of 2001 is hereby amended in the first paragraph by inserting after the words 'the Commissioner of the group insurance commission' the following words: - ', the executive director of the Commonwealth Health Insurance Connector Authority'.
SECTION _____. The provisions of Section 271 of Chapter 127 of the acts of 1999, as amended, and Section 62 of Chapter 177 of the Acts of 2001, as amended, shall be fully implemented by January 1, 2013."
After remarks, the amendment was adopted.
Mr. Welch moved that the bill be amended in section 14 by striking out proposed subsections (g) and (h) of section 10 of chapter 12C of the General Laws and inserting in place thereof the following 2 subsections:-
"(g) Every provider organization shall, before making any change to its operations or governance structure affecting the provider organization's registration, submit notice to the institute and the attorney general of such change. The institute may promulgate regulations prescribing the contents of any notices required to be filed under this section. The institute may promulgate regulations further defining material change and not material change.
If the change is not material, the notice shall be filed not fewer than 15 days before the date of the change. A change that is not material may proceed on the date identified in the notice once the notice has been accepted by the institute. Changes that are not material, for purposes of this section, shall include, at a minimum, changes in board membership except when such changes are related to a corporate affiliation, changes involving employment decisions by the provider organization, changes that are subject to review by a state agency through any other administrative process and changes that are necessary to comply with state or federal law. The institute may promulgate regulations defining additional categories of changes that it shall consider not material.
If the change is material, the notice shall be filed not fewer than 60 days before the date of the proposed change. Within 30 days of receipt of a notice filed under the institute's regulations, the institute shall conduct a preliminary review to determine whether the change is likely to result in a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, established in section 5 of chapter 176S, on the competitive market or on a provider organization's solvency. The institute shall notify the attorney general that it is conducting a preliminary review. Material changes that are likely to result in a significant impact shall include, but not be limited to: a corporate affiliation between a provider organization and a carrier; mergers or acquisitions of hospitals or hospital systems; acquisition of insolvent provider organizations; and mergers or acquisitions of provider organizations which will result in a provider organization having a near-majority of market share in a given service or region. The institute shall specify, through regulations, other categories of material changes likely to result in significant impact. The institute may require supplementary submissions from the provider organization to provide data necessary to carry out this preliminary review. A provider organization's supplementary submissions shall be confidential and shall not be considered a public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66 until the issuance of the institute's report on its findings as a result of the preliminary review.
If the institute finds that the material change is unlikely to have a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, established in section 5 of chapter 176S, on the competitive market or on the provider organization's solvency, then the institute shall notify the provider organization of the outcome of its preliminary review and the material change may proceed on the date identified in the notice. If the institute finds that the material change is likely to have a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, on the competitive market or on the provider organization's solvency, the institute shall conduct a cost, market impact and solvency review under subsection (h).
(h) The institute shall establish by regulation rules for conducting cost, market impact and solvency reviews where there has been a material change to a provider organization's registration which the institute determines is likely to have a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, on the competitive market or on the provider organization's solvency under subsection (g).
Within 60 days of receipt of a notice of a material change filed under subsection (g), the institute shall initiate a cost, market impact and solvency review by sending the provider organization a notice of a cost, market impact and solvency review which shall explain the particular factors that the institute seeks to examine through the review. The institute shall notify the attorney general and the division of insurance whenever it initiates a cost, market impact and solvency review and shall issue a public notice soliciting comments to inform its review. The attorney general may intervene in the cost, market impact and solvency review and may require documents and testimony under oath from the provider organization, other providers or provider organizations, private health care payers and public health care payers to inform the review. The provider organization shall submit to the institute and the attorney general, within 21 days of the institute's notice, a written response to the notice, including, but not limited to, any information or documents sought by the institute or the attorney general which are described in the institute's notice. A provider organization's written response and information provided to the attorney general under this section shall be confidential and shall not be considered a public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66 only until such time as the executive director determines the response is complete.
A cost, market impact and solvency review may examine factors including, but not limited to: (i) the provider organization's size and market share within its primary service areas by major service category, and within its dispersed service areas; (ii) provider price, including its relative prices filed with the institute; (iii) provider quality, including patient experience; (iv) provider cost and cost trends in comparison to total health care expenditures statewide; (v) the availability and accessibility of services similar to those provided, or proposed to be provided, through the provider organization within its primary service areas and dispersed service areas; (vi) the provider organization's impact on competing options for the delivery of health care services within its

primary service areas and dispersed service areas including, if applicable, the impact on existing service providers of a provider organization's expansion, affiliation, merger or acquisition, to enter a primary or dispersed service area in which it did not previously operate; (vii) the methods used by the provider organization to attract patient volume and to recruit or acquire health care professionals or facilities; (viii) the role of the provider organization in serving at-risk, underserved and government payer patient populations, including those with behavioral, substance use disorder and mental health conditions, within its primary service areas and dispersed service areas; (ix) the role of the provider organization in providing low margin or negative margin services within its primary service areas and dispersed service areas; (x) the financial solvency of the provider organization; (xi) consumer concerns, including but not limited to, complaints or other allegations that the provider organization has engaged in any unfair method of competition or any unfair or deceptive act or practice; and (xii) any other factors that the institute determines to be in the public interest.

The institute shall make factual findings and issue a final report on the cost, market impact and solvency review within 60 days of initiating the cost, market impact and solvency review. The institute shall forward a copy of the final report to the attorney general and the division of insurance.

If the institute finds in its report that the provider organization proposed material change will have an adverse cost, market or solvency impact, the institute shall require the provider organization to submit, within 60 days, to the institute and the attorney general, a written response to the institute's report. Nothing in this section shall prohibit a proposed material change; provided, however, that any proposed material change that the institute determined will have an adverse cost, market or solvency impact shall not be completed until at least 30 days after the provider organization has submitted its written response.".

The amendment was adopted.

At nine minutes past six o'clock P.M., at the request of Mr. Tarr, for the purpose of a minority party caucus, the President declared a recess; and, at five minutes past seven o'clock P.M., the Senate reassembled, the President in the Chair.

Orders of the Day.

The Orders of the Day were further considered, as follow:--

The Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2260, amended),-- was considered, the main question being on ordering the bill to a third reading.

Messrs. Donnelly and DiDomenico moved that the bill be amended in section 189, by striking out, in line 4825, the figure "11", and inserting in place thereof the following figure:- 12; and in said section 189, by adding, in line 4833, after the words "Massachusetts Association for Behavioral Healthcare;" the following words:- "1 of whom shall be appointed by the Massachusetts division of 1199SEIU-HealthCare Workers East;".

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

The amendment was *rejected*.

Ms. Fargo moved that the bill be amended by inserting the following new sections:-

"SECTION XX. Said chapter 6A is hereby amended by inserting after section 16S the following section: –

Section 16T. There shall be an office of health equity within the executive office of health and human services. The office shall be in the charge of a director, who shall report directly to the secretary of health and human services. The health disparities council, described in section 16O, shall serve as an advisory board to the office of health equity.

SECTION XXX. The General Laws are hereby amended by inserting after chapter 111N the following chapter:–

CHAPTER 111O. OFFICE OF HEALTH EQUITY.

Section 1. As used in this chapter the following words shall, unless the context clearly requires otherwise, have the following meanings: –

'Disparities' or 'Racial and ethnic health and health care disparities', differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific racial and ethnic groups.

'Office', the office of health equity, as established by section 16T of chapter 6A.

Section 2. The office, subject to appropriation, shall coordinate all activities of the commonwealth to eliminate racial and ethnic health and health care disparities. The office shall set goals for the reduction of disparities and prepare an annual plan for the commonwealth to eliminate disparities.

Section 3. The office, subject to appropriation, shall collaborate with other state agencies of the commonwealth on disparities reduction initiatives to address the social factors that influence health inequality. These state agencies shall include, but shall not be limited to, the executive office of health and human services, the executive office of housing and economic development, the executive office of public safety and security, the executive office of energy and environmental affairs, the Massachusetts Department of Transportation, the executive office of labor and workforce development and the executive office of education. The office shall facilitate communication and partnership between these agencies to develop greater understanding of the intersections between agency activities and health outcomes. The office shall facilitate development of interagency initiatives to address the social and economic determinants of health and key health disparities issues including, but not limited to, healthcare access and quality; housing availability and quality; transportation availability, location and cost; community policing and safe spaces; air, water, land usage and quality; employment and workforce development; and education access and quality.
Section 4. The office, subject to appropriation, shall evaluate the effectiveness of programs and interventions to eliminate health disparities, identifying best practices and model programs for the state.
Section 5. (a) The office shall, subject to appropriation, administer a community-based agency disparities reduction grant program. The grants shall support efforts by community-based agencies to eliminate racial and ethnic health disparities among predominantly underserved populations, including efforts addressing social factors integral to such disparities. Grants shall be awarded following a competitive application process. In awarding grants, the office shall give priority to programs replicable by other community-based agencies. Grants shall be provided to a broad range of agencies that support diverse communities throughout the state. No community-based agency may receive more than one grant concurrently. All grants shall include an evaluation component.
(b) The program shall provide grants to community-based agencies and non-profit community organizations to address key disparities issues including but not limited to: the social and economic barriers that impact health outcomes, the development of a diverse healthcare workforce across wide range of healthcare professions, increasing the access, utilization and quality of healthcare services, and supporting community health workers to facilitate the use of health and human services
(c) For the purposes of this section, a ‘community-based agency’ shall include agencies that provide direct services, education, or support to underserved populations, including community health centers and hospitals, social service organizations, community nonprofit organizations, educational institutions, faith based organizations and other non-governmental agencies and other organizations as defined by the office.
Section 6. The secretary of health and human services shall annually, on the day assigned for submission of the budget to the general court under section 7H of chapter 29, designate major initiatives of the commonwealth affecting the health and health care of residents of the commonwealth. These initiatives may include any activity of the commonwealth including, but not limited to, activities of the executive office of health and human services, the executive office of housing and economic development, the executive office of public safety and security, the executive office of energy and environmental affairs, the Massachusetts Department of Transportation, the executive office of labor and workforce development and the executive office of education.
For each major initiative, the office shall prepare a disparities impact statement evaluating the likely positive or negative impact of each initiative on eliminating or reducing racial and ethnic health disparities. The statements shall, to the extent possible, include quantifiable impacts and evaluation benchmarks. The statements shall be posted on the official internet site of the executive office of health and human services and submitted to the clerks of the house of representatives and senate, members of the health disparities council, appropriate legislative committees and the house and senate committees on ways and means.
Section 7. The office, subject to appropriation, shall prepare an annual health disparities report card. The report card shall evaluate the progress of the commonwealth toward eliminating racial and ethnic health disparities, using, where possible, quantifiable measures and comparative benchmarks. The report card shall report on progress on a regional basis, based on regions designated by the office. The office shall hold public hearings in several regions of the state to get public information on the topics of the report card. The report card shall be delivered to the governor, speaker of the house of representatives and president of the senate and the members of the health disparities council, established under section 16O of chapter 6A, before July 1 of each year and shall be posted on the official internet site of the office or executive office of health and human services.
Section 8. Section 16K of Chapter 6A of the General Laws, as so appearing, is hereby amended by striking out, in subsection (h), as amended by section 3 of chapter 288 of the acts of 2010, the third sentence and inserting in place thereof the following sentence:- The council shall also establish goals that are intended to reduce health care disparities in racial, ethnic and disabled communities and in doing so shall seek to incorporate the recommendations of the health disparities council and the office of health equity.
Section 9. The second paragraph of Section 16 of Chapter 6A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out the words, ‘and, (7) the health facilities appeals board;’ and inserting in place thereof the following words :-
‘(7) the health facilities appeal board; and (8) the office of health equity.’
Section 10. Section 16O of said chapter 6A, as so appearing, is hereby amended by inserting after the word, ‘recommendations,’ in line 3, the following words: - ‘to the direct of the office of health equity’.
Section 11. Said section 16O of said chapter 6A, as so appearing, is hereby further amended by striking out, in line 15, the ‘37’ and inserting in place thereof the following figure : - ‘38’.
Section 12. Said section 16O of said chapter 6A, as so appearing, is hereby further amended by inserting after word ‘offio’, in line 19, the following words : - ‘the direct of the office of health equity, or the director’s designee’.”
The amendment was *rejected*.

Ms. Fargo moved that the bill be amended in section 4 of chapter 176S, line 3921 by striking out the number “11” and inserting in place thereof the following number “12”; and in section 2(b) of chapter 176S, line 3924, by inserting after the word “model” the following words: - “and 1 other member whom shall be an expert in racial and ethnic health disparity,”.
The amendment was *rejected*.
Mr. Montigny moved that the bill be amended in section 162, by striking out, in line 4300, the words, “avoidable hospitalizations, adverse events and unnecessary emergency room visits” and inserting in place thereof the words, “avoidable hospitalizations, avoidable readmissions, adverse events and unnecessary emergency room visits through the use of payment incentives”.
The amendment was *rejected*.
Mr. Montigny moved that the bill be amended in section 162, by inserting after line 4249, after the words “subsequent Medicare regulations.”, the following paragraph:
“Members of the governance body shall not have any financial conflicts of interest. The governance body shall have a transparent governing process. The authority shall develop standards to implement the provisions of this paragraph.”
The amendment was *rejected*.
Ms. Candaras and Messrs. Welch and Knapik moved that the bill be amended in section 162, line 4341, by adding the following, after the word “delivery”: “and (3) to support safety-net provider participation in new payment and healthcare service delivery models.”; and in said section 162, line 4345, by adding the following, after the word “authority”: “Provided that, in providing assistance from the Fund the Authority shall give preference to entities that include hospitals that receive greater than 63% of their gross patient service revenue from governmental payers”.
The amendment was *rejected*.
Ms. Creem moved that the bill be amended by inserting at the end of the bill the following new section:-
“Section XXX. The Department of Elementary and Secondary Education, in consultation with the Institute of Health Care Finance and Policy and the Office of the State Auditor, shall conduct a comprehensive study to investigate the cost to municipalities of providing medically necessary treatments for disease, illness, injury or bodily dysfunction which are required by a student’s individual education program, individualized family service plan, individualized service plan or the federal Individuals with Disabilities Act. The study shall include, but not be limited to, possible barriers of transitioning medically necessary costs from municipalities to insurance companies, as well as the potential savings to municipalities. The Department shall file a report of its findings, including recommendations and drafts of any legislation, if necessary, with the clerks of the Senate and House of Representatives within one year of the effective date of this act.”
The amendment was *rejected*.
Messrs. Hart and Rush moved that the bill be amended by striking out section 162 and inserting in place thereof the text of Senate document numbered 2268, relative to Commonwealth health care quality and finance authority.
The amendment was *rejected*.
Ms. Fargo moved that the bill be amended in section 48, line 1457 by striking out the number “15” and inserting in place thereof the following number “16”; and in said section 48, line 1470 after the words "community health care workers" by adding the following “and 1 of whose shall be a public health nurse".
The amendment was *rejected*.
Mr. Berry moved that the bill be amended in section 162, subsection 8, in line 4269, by inserting after the words “direct access to chiropractic services” the following: “ as well as to physical therapy,”; and in line 4270 by striking out the words : “physical therapy”.
The amendment was *rejected*.
Mr. Hart moved that the bill be amended in section 14, in section 1 of proposed chapter 12C of the General Laws, by inserting, after the definition of “Medicare program” the following definition:-
“‘Net cost of private health insurance,’ the difference between health premiums earned and benefits incurred, which shall consist of: (i) all categories of administrative expenditures, as included in medical loss ratio regulations promulgated by the division of insurance; (ii) net additions to reserves; (iii) rate credits and dividends; and (iv) profits or losses, or as otherwise defined by regulations promulgate by the institute.”;
In said section 14, in said section 1 of proposed chapter 12C of the General Laws, by striking out the definition of “Total health care expenditures” and inserting in place thereof the following definition:-
“‘Total health care expenditures’, the annual per capita sum of all health care expenditures in the commonwealth from public and private sources, including: (i) all categories of medical expenses and all non-claims related payments to providers, as included in the health status adjusted total medical expenses reported by the institute under subsection (d) of section 9; (ii) all patient cost-sharing amounts, such as, deductibles and copayments; and (iv) the net cost of private health insurance, or as otherwise defined in regulations promulgated by the institute.”;
In section 162, in proposed section 1 of chapter 176S of the General Laws, by inserting after the definition of “Medicare program” the following definition:-
“‘Net cost of private health insurance,’ the difference between health premiums earned and benefits incurred, which shall consist of: (i) all categories of administrative expenditures, as included in medical loss ratio regulations promulgated by the division of insurance; (ii) net additions to reserves; (iii) rate credits and dividends; and (iv) profits or losses, or as otherwise defined by regulations promulgated by the institute under chapter 12C.”; and
In said section 162, in said proposed section 1 of said chapter 176S, by striking out the definition of “Total health care expenditures” and inserting in place thereof the following definition:-
“‘Total health care expenditures’, the annual per capita sum of all health care expenditures in the commonwealth from public and

private sources, including: (i) all categories of medical expenses and all non-claims related payments to providers, as included in the health status adjusted total medical expenses reported by the institute under subsection (d) of section 9 of chapter 12C; (ii) all patient cost-sharing amounts, such as, deductibles and copayments; and (iv) the net cost of private health insurance, or as otherwise defined by the institute in regulations promulgated under said chapter 12C.".
The amendment was adopted.
Mr. Berry moved that the bill be amended in section 14, subsection 3, in line 293, by adding the following:- "The council shall include at least five (5) member health care professionals in preventive health care and wellness initiatives. Those members shall be nominated to the executive director by their associations and shall be at a minimum be representative of the following organizations: the American Physical Therapy Association of Massachusetts, the Massachusetts Association of Occupational Therapy, the Massachusetts Society of Orthotics and Prosthetics, the Massachusetts Dietetic Association and the Massachusetts Speech Language Hearing Association."; and in section 48, in line 1457 by striking out the figure "15" and inserting in place thereof the figure "20"; and by adding after the words "community health workers", in line 1470, the following: "; and five (5) health care professionals in health care and wellness initiatives. Such representatives shall be representative from the following organizations: American Physical Therapy Association of Massachusetts, the Massachusetts Association of Occupational Therapy, the Massachusetts Society of Orthotics and Prosthetics, the Massachusetts Dietetic Association and the Massachusetts Speech Language Hearing Association".
The amendment was *rejected*.
Ms. Fargo moved that the bill be amended in section 6D(b) of Section 29, line 1078 by striking out the number "15" and inserting in place thereof the following number "16"; in said section 6D(b), line 1082 by striking out the number "11" and inserting in place thereof the following number "12"; and in said section 6D(b), line 1088, by inserting after the word "practice," the following words: - "1 of whom shall be an expert in racial and ethnic health disparity,".
The amendment was *rejected*.
Ms. Fargo moved that the bill be amended in section 184, line 4759 by inserting after the word "payers" the following words: - "and racial and ethnic health disparity experts".
The amendment was *rejected*.
Ms. Fargo moved that the bill be amended in section 4 of chapter 176S, line 4023 by striking out the number "7" and inserting in place thereof the following number "8"; in said section 4 of chapter 176S, line 4027 by striking out the number "11" and inserting in place thereof the following number "12"; and in said section 4 of chapter 176S, line 4039, by inserting after the word "commonwealth" the following words: - "1 of whom shall be an expert in racial and ethnic health disparity,".
The amendment was *rejected*.
Mr. Brownsberger moved that the bill be amended by striking, in section 14, in line 786, the word "No," and by inserting in its place the following:- "Except for a comprehensive cancer center, as defined in Section 8 of Chapter 118E, no"; by inserting, in section 162, in line 4263, after the words "cancer care," the words "the services of a comprehensive cancer center, as defined in section 8 of Chapter 118E,"; by striking out, in said section 162, in line 4332, the word "and"; and by inserting after the word "therapies" in section 162, in line 4335, the following:- "; and (ix) costs associated with the services of a comprehensive cancer center, as defined in section 8 of Chapter 118E".
The amendment was *rejected*.
Messrs. Timilty and Ross moved that the bill be amended in section 14, in line 77, by inserting after the words "episodic payments" the following:- "and other payment methods appropriate for providers in smaller service areas with populations less than 250,000 where the majority of residents are served by PCPs that have been designated as Level 3 Patient Centered Medical Homes by the National Committee for Quality Assurance'"; and in section 162, in line 3810, by inserting after the words "episodic payments" the following:- "and other payment methods appropriate for providers in smaller service areas with populations less than 250,000 where the majority of residents are served by PCPs that have been designated as Level 3 Patient Centered Medical Homes by the National Committee for Quality Assurance".
The amendment was *rejected*.
Messrs. Timilty and Ross moved that the bill be amended in section 180, in line 4716, by inserting after the words "chapter 176S," the following:- "and providers in smaller service areas with populations less than 250,000 where the majority of residents are served by PCPs that have been designated as Level 3 Patient Centered Medical Homes by the National Committee for Quality Assurance".
The amendment was *rejected*.
Ms. Fargo moved that the bill be amended in section 8(b), in line 4246 and 4247, by striking the following words, "include patient and consumer representation on its governance" and inserting in place thereof the following words :- "include patient and consumer representation and racial and ethnic health disparity experts on its governance;".
The amendment was *rejected*.
Mr. Brownsberger moved that the bill be amended in section 2G(d), in line 1384, after the word "municipalities", by inserting the following words:- "regional planning agency,"; and in line 1388, after the word "organization", by inserting the following words:- "or regional planning agency".
The amendment was *rejected*.
Ms. Fargo moved that the bill be amended in section 8(c), in line 4303 by inserting after "111" the following words: - "and calculate the return on investment made in compensating non-clinician services and community activities, particularly those efforts with an emphasis on the social determinants of health, that integrate community public health interventions and which have been proven to improve health and well-being over the long term;".

The amendment was *rejected*.
Ms. Fargo moved that the bill be amended in section 8, in line 4249, by inserting, after the word “regulations”, the following words:- “and (v) ensure that payment methods to accountable care organizations and other health care entities shall reward reduction of racial, ethnic, and linguistic health disparities in their patient population and health professionals shall not insure monetary or other penalties for serving patients with high risk factors”.
The amendment was *rejected*.
Ms. Fargo moved that the bill be amended in section 8(c), in line 4251, by inserting, after the word “protections.”, the following words:- “It shall be unlawful for accountable care organizations or other health care entities to ration care for patients with multiple or serious risk factors under the health care payment systems’ payment methodologies”.
The amendment was *rejected*.
Ms. Fargo moved that the bill be amended in section 9, in line 4330, by inserting, after the word “premiums;”, the following words: - “Culturally and Linguistically Appropriate Services (hereafter referred to as CLAS), be recognized as standards issued by the United States Department of Health Human Services, and be adopted by the Commonwealth to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner;”.
The amendment was *rejected*.
Ms. Fargo moved that the bill be amended in section 9, in line 4331, by inserting, after the word “professionals”, the following words: - “who are to be defined as health professionals whose services are utilized in care models for the purpose of helping a patient achieve whole health, including but not limited to community health workers, legal advocates, medical interpreters, clinical prevention specialists, human services workers, social workers, and licensed alcohol and drug counselors”.
The amendment was *rejected*.
Ms. Fargo moved that the bill be amended in section 9, in line 4327, by inserting, after the word “factors”, the following words: - “here defined as characteristics of an individual or population that may create disincentives for accountable care organizations or other health care providers because of the real or perceived likelihood that said characteristics correlate to a higher monetary cost in providing health care to the individual or population”.
The amendment was *rejected*.
Ms. Fargo moved that the bill be amended in section 9, in line 4330, by inserting, after the word “populations”, the following words:- “that are defined as populations including but not limited to the following groups, which suffer adverse health outcomes based on race, ethnicity, disability, housing type, income level, primary language, or educational attainment”.
The amendment was *rejected*.
Ms. Jehlen and Mr. DiDomenico moved that the bill be amended in section 189, line 4825, by striking out the number “11” and replacing it with the number “12”; in line 4833, by adding the following, after the word “Healthcare;” the following:- “1 of whom shall be a representative of a high Medicaid and low-income public payer disproportionate share hospital;” and in line 4840, by adding the following, after the word “methodologies” the following:- “including their impact on high Medicaid and low-income public payer disproportionate share hospitals and other safety net providers with concentrated patient care in low-income public payers; the impacts and policy options for addressing Medicaid and low-income public payer reimbursement deficiencies in establishing the baseline for alternative payment models for said public payers set forth in section 186 of this act and section 1 of chapter 12C”.
The amendment was *rejected*.
Ms. Jehlen moved that the bill be amended in section 189, line 4825, by striking out the number “11” and replacing it with the number “12”; in line 4826, by adding the following, after the word “chair;”: “1 of whom shall be the Secretary of Elder Affairs or a designee;”; in line 4823 by inserting after the word “health care services”: “including long term support services”; and in line 4824 by inserting after the word “health care providers”: “and long term support services”.
The amendment was *rejected*.
Mr. Pacheco moved that the bill be amended in section 14, by inserting after the word “appropriate,” in line 475, the following words:- “, including but not limited to plans to monitor any impacts on reductions in annual costs as it relates to patient quality of care and access to services”.
The amendment was *rejected*.
Ms. Jehlen and Mr. Hedlund moved that the bill be amended in section 189, line 4825, by striking out the number “11” and inserting in place thereof the number “12”; in line 4826, by adding the following, after the word “chair;”: “1 of whom shall be the Secretary of Elder Affairs or a designee;”; and in line 4823 by inserting after the word “health care services”: “including residential care facilities”; and in line 4824 by inserting after the word “health care providers”: “and residential care facilities”.
The amendment was *rejected*.
Ms. Jehlen moved that the bill be amended in section 162, by striking out in line 4310 the word, “and” and inserting after the number “(14)” the following words, “to adopt requirements that all contracts between payers and ACOs that contain a provision for shared savings between the provider and the payer shall contain a mechanism to return a percentage of the savings to the ACO participants; and (15)”.
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended in section 162 in proposed chapter 176S of the General Laws by inserting after the word “protections”, in line 3996, the following words:- “provided, however, that no certificate is rejected because of geography or volume”.
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by inserting after section 198 the following 2 sections:-

“SECTION 198E. The office of Medicaid shall, within 6 months of the passage of this act, take any and all necessary actions to ensure that social security numbers are required on all medical benefits request forms to the extent permitted by federal law and that social security numbers are provided by all applicants who possess them.
If for any reason the office of Medicaid determines that it is or will be unable to accomplish the foregoing within 6 months of the passage of this act, the office shall submit a detailed report of the reasons for such inability to the clerks of the house of representatives and the senate within 6 months following the passage of this act.
SECTION 198F. The institute of health care finance and policy shall, within 6 months of the passage of this act, ensure (i) that the identity, age, residence and eligibility of all applicants are verified before payments, other than emergency bad debt payments, are made by the Health Safety Net Trust Fund; and (ii) that the health safety net is the payor of last resort by performing third party liability investigations on health safety net claims and by implementing other such programs as needed.
If for any reason the institute determines that it is or will be unable to accomplish the foregoing within 6 months of the passage of this act, the institute t shall submit a detailed report of the reasons for such inability to the clerks of the house of representatives and the senate within 6 months following the passage of this act.”
The amendment was adopted.
Mr. Kennedy moved that the bill be amended by striking out section 189 and inserting in place thereof the following words:-
“SECTION 189. There shall be a special commission to review public payer reimbursement rates and payment systems for health care services and the impact of such rates and payment systems on health care providers and on health insurance premiums in the commonwealth. The commission shall consist of 12 members: 1 of whom shall be the secretary of health and human services or a designee, who shall serve as chair; 1 of whom shall be the director of the office of Medicaid; 1 of whom shall be the executive director of the institute of health care finance and policy; 1 of whom shall be appointed by the Massachusetts Hospital Association; 1 of whom shall represent a high Medicaid and low income public payer disproportionate share hospital 1 of whom shall be appointed by the Massachusetts Medical Society; 1 of whom shall be appointed by the Massachusetts Senior Care Association; 1 of whom shall be appointed by the Home Care Alliance of Massachusetts; 1 of whom shall be appointed by the Massachusetts League of Community Health Centers; 1 of whom shall be appointed by the Massachusetts Association for Behavioral Healthcare; and 2 of whom shall be appointed by the governor, 1 of whom shall be represent managed care organizations contracting with MassHealth and 1 of whom shall be an expert in medical payment methodologies from a foundation or academic institution. The commission shall examine whether public payer rates and rate methodologies provide fair compensation for health care services and promote high-quality, safe, effective, timely, efficient, culturally competent and patient-centered care. The commission’s analysis shall include, but not be limited to, an examination of MassHealth rates and rate methodologies; current and projected federal financing, including Medicare rates; cost-shifting and the interplay between public payer reimbursement rates and health insurance premiums; and the degree to which public payer rates reflect the actual cost of care. To conduct its review and analysis, the commission may contract with an outside organization with expertise in the analysis of health care financing. The institute of health care finance and policy and the office of Medicaid shall provide the outside organization, to the extent possible, with any relevant data necessary for the evaluation; provided, however, that such data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws. The commission shall file the results of its study, together with drafts of legislation, if any, necessary to carry out its recommendations, by filing the same with the clerks of the house of representatives and the senate who shall forward a copy of the study to the house and senate committees on ways and means and the joint committee on health care financing not later than April 1, 2013.”
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by inserting, after section__ the following new section:-
“SECTION__. Notwithstanding any general or special law to the contrary, any provider of health care subject to a contract of insurance with a carrier, as definite in section 1 of chapter 12C of the general laws, which receives a rate of payment for a particular service or procedure that is less than the rate paid to one or more other providers for consumers in the same geographic region may request and receive in writing from said insurer the explanation and justification therefore, together with any actions which the provider may take to address this discrepancy.”
The amendment was *rejected*.
Mr. Knapik moved that the bill be amended in section 190, in line 4878, by inserting after the word “coordination,” the following:- “, the impact of affiliation agreements on acute-care hospitals licensed for 200 beds or less,”.
The amendment was *rejected*.
Mr. McGee moved that the bill be amended in section 162, line 4265, by adding after the words “maternity and newborn care services” the following:- “and mental health outcomes”.
The amendment was *rejected*.
Mr. Keenan moved that the bill be amended in section 90, by adding in line 2170 after the word “shall” the following words:- “include behavioral, substance use disorder and mental health inpatient and outpatient services; and provided further, shall”; and in section 154, by adding in line 3632 after the word “shall” the following words:- “include behavioral, substance use disorder and mental health inpatient and outpatient services; and provided further, shall”.
The amendment was *rejected*.
Ms. Spilka moved that the bill be amended in section 8 of chapter 176S, as inserted by Section 162, by inserting after the words, “preventive and primary care services”, in line 4260, the following words:- “including, but not limited to, obstetrics and gynecology;”.
The amendment was *rejected*.

Ms. Spilka moved that the bill be amended in section 8 of chapter 176S, as inserted by Section 162, by inserting after the words, "population-based management tools and functions;", in line 4289, the following words:- "data stratification by sex and sex-race groups;".
The amendment was *rejected*.
Mr. Keenan moved that the bill be amended in section 29, in line 1078, by striking the number "15" and inserting in place thereof the following number:- "16"; in line 1082 by striking the number "11" and inserting in place thereof the following number:- "12"; in said section 29 by adding in line 1089 after the word "carriers" the following words:- "1 of whom shall be from a behavioral health, substance use disorder or mental health services organization"; and in line 1097 after the word "purchasers" the following words:- "community-based behavioral, substance use disorder and mental health care providers".
The amendment was *rejected*.
Mr. Keenan moved that the bill be amended in section 29, by striking out the second paragraph of subsection (b) in its entirety and inserting in its place the following:-
"The council shall consist of 16 members: 1 of whom shall be the secretary of administration and finance, who shall serve as chair; 1 of whom shall be the secretary of health and human services; 1 of whom shall be the executive director of the institute of health care finance and policy or a designee; 1 of whom shall be the secretary of housing and economic development or a designee; 12 of whom shall be appointed by the governor, of whom at least 1 shall be an expert in health information technology, 1 of whom shall be an expert in state and federal health privacy laws, 1 of whom shall be an expert in the health policy, 1 of whom shall be an expert in health information technology relative to privacy and security, 1 of whom shall be from an academic medical center, 1 of whom shall be from a community hospital, 1 of whom shall be from a community health center, 1 of whom shall be from a long term care facility, 1 of whom shall be from a physician group practice, 1 of whom shall be from a behavioral, substance abuse disorder, and mental health organization, and 2 of whom shall represent the health insurance carriers. The council may consult with such parties, public or private, as it deems desirable in exercising its duties under this section, including persons with expertise and experience in the development and dissemination of interoperable electronic health records systems, and the implementation of interoperable electronic health record systems by small physician groups or ambulatory care providers, as well as persons representing organizations within the commonwealth interested in and affected by the development of networks and interoperable electronic health records systems, including, but not limited to, persons representing local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, physicians, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with expertise in health information technology and other stakeholders as identified by the secretary of health and human services. Appointive members of the council shall serve for terms of 2 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation."
The amendment was *rejected*.
Mr. Keenan moved that the bill be amended in Section 14, by striking section 3 in its entirety and inserting in its place thereof the following:-
"Section 3. There shall be an institute of health care finance and policy council. The council shall consist of 7 members and advise on the overall operation and policy of the institute. The governor shall appoint three members, the attorney general shall appoint two members, and the auditor shall appoint two members. Members shall reflect a broad distribution of diverse perspectives on the health care system, including health care professionals, educational institutions, consumer representatives, providers, provider organizations and public and private payers. The council shall not be compensated for their services and shall serve at the pleasure of the appointing authority."
The amendment was *rejected*.
Messrs. Keenan and Donnelly and Ms. Jehlen moved that the bill be amended by striking section 147 in its entirety and inserting in its place thereof the following:-
"SECTION 147. Section 16 of said chapter 176O, as so appearing, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-
(b) A carrier shall be required to pay for health care services ordered by a treating physician or a primary care provider if: (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary; provided, however, that in making an adverse determination for mental health or substance abuse treatment, the carrier or its designated utilization review organization shall defer to the judgment of the treating clinician unless there is a preponderance of evidence that the requested admission, continued stay or other health care service does not meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness. A carrier may develop guidelines to be used in applying the standard of medical necessity, as defined in this subsection. Any such medical necessity guidelines utilized by a carrier in making coverage determinations shall be: (i) developed with input from practicing physicians and participating providers in the carrier's or utilization review organization's service area; (ii) developed under the standards adopted by national accreditation organizations; (iii) updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier shall consider the individual health care needs of the insured. Any such medical necessity guidelines criteria shall be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website to subscribers, health care providers and the general public. If a carrier or utilization review organization intends either to implement a new medical necessity guideline or amend an existing requirement or restriction, the carrier or utilization review organization shall ensure that the new or amended requirement or restriction shall not be implemented unless the carrier's or utilization review organization's website has been updated to reflect the new or

amended requirement or restriction."
The amendment was *rejected*.
Mr. Keenan moved that the bill be amended in Section 48, by striking out section 2H in its entirety and inserting in its place thereof the following:-
"Section 2H. There shall be a Prevention and Wellness Advisory Board to make recommendations to the commissioner concerning the administration and allocation of the Prevention and Wellness Trust Fund established in section 2G, establish evaluation criteria and perform any other functions specifically granted to it by law.
The board shall consist 16 members: 1 of whom shall be the commissioner of public health or a designee, who shall serve as chair; 1 of whom shall be the executive director of the institute of health care finance and policy established in chapter 12C or a designee; 1 of whom shall be the secretary of health and human services or a designee; 13 of whom shall be appointed by the governor, 1 of whom shall be a person with expertise in the field of public health economics; 1 of whom shall be a person with expertise in public health research; 1 of whom shall be a person with expertise in the field of health equity; 1 of whom shall be a person from a local board of health for a city or town with a population greater than 50,000; 1 of whom shall be a person of a board of health for a city or town with a population less than 50,000; 2 of whom shall be representatives of health insurance carriers; 1 of whom shall be a person from a consumer health organization; 1 of whom shall be a person from a hospital association; 1 of whom shall be a person from a statewide public health organization; 1 of whom shall be a representative of the interest of businesses; 1 of whom shall be an administer of an employee assistance program; and 1 of whom shall be a person from an association representing community health workers."
The amendment was *rejected*.
Mr. Keenan moved that the bill be amended in section 189, by striking the words "11 members" and inserting the following in place thereof:- "12 members"; by striking, in line 4833, after the word "the" the following:- "Massachusetts"; and by adding after the words " Massachusetts Medical Society" the following " 1 appointed by the Massachusetts Association of Behavioral Health Systems".
The amendment was *rejected*.
Mr. Keenan moved that the bill be amended in section 48 by striking out subsections (c) and (d) in their entirety and inserting in their place the following two subsections:-
"(c) All expenditures from the Prevention and Wellness Trust Fund shall support the state's efforts to meet the health care cost growth benchmark established in section 5 of chapter 176S and any activities funded by the Healthcare Payment Reform Fund, and 1 or more of the following purposes: (i) reduce rates of the most prevalent and preventable health conditions, including substance abuse; (ii) increase healthy behaviors; (iii) increase the adoption of workplace-based wellness or health management programs that result in positive returns on investment for employees and employers; (iv) address health disparities; or (v) develop a stronger evidence-base of effective prevention programming.
(d) The commissioner shall annually award not less than 75 per cent of the Prevention and Wellness Trust Fund through a competitive grant process to municipalities, community-based organizations, health care providers, and health plans that apply for the implementation, evaluation and dissemination of evidence-based substance abuse awareness and prevention programs and community preventive health activities. To be eligible to receive a grant under this subsection, a recipient shall be: (i) a municipality or group of municipalities working in collaboration; (ii) a community-based organization working in collaboration with 1 or more municipalities; or (iii) a health care provider or a health plan working in collaboration with 1 or more municipalities and a community-based organization. Expenditures from the fund for such purposes shall supplement and not replace existing local, state, private or federal public health-related funding."
The amendment was *rejected*.
Ms. Spilka moved that the bill be amended in section 184 by inserting after the word "diagnoses;", in line 4751, the following:- "the sex differences in disease arising from the biological differences between the sexes and the resulting differences in diagnosis for the same disease in different sexes".
The amendment was *rejected*.
Mr. Keenan moved that the bill be amended in section 23, by striking the number "15" as it appears in line 959, and inserting in its place the following:- "10".
The amendment was *rejected*.
Ms. Spilka moved that the bill be amended in section 2G(e) of chapter 111, as inserted by section 48, by inserting after the word "plan", in line 1400, the following:- "and (vi) a commitment to include women, racial and ethnic minorities and low income individuals; and (vii) a plan to stratify data by sex, sex-race groups, and by socio-economic status and to include stratified data in all final reports".
The amendment was *rejected*.
Mr. Knapik and Ms. Jehlen moved that the bill be amended in section 190, by striking out, in line 4856, the figure "14" and inserting in place thereof the following figure:- "15"; and in said section 190, in line 4864, inserting after the word "teaching hospital" the following:- ", 1 of whom shall represent an acute-care hospital licensed with a capacity less than 200 beds;".
The amendment was *rejected*.
Mr. Kennedy moved that the bill be amended by inserting after line 4477 the following section:-
"Chapter 176U:
SECTION 1: Chapter 176O is hereby amended by inserting after section 5 the following section:-
Section 5A. (a) A contract or agreement between a carrier and a health care provider,
including a hospital or physician group practice, effective January 1,

2013, shall adhere to the following:
(1) A carrier with contracts for payment between the carrier and a Disproportionate share hospital, as defined in section 1 of Chapter 118 G, and its Affiliated physician group practices, shall not contain rates that are less than the carrier's statewide average rate, as defined by the previous year of October 1 to September 30 plus an annual adjustment for the projected change of the Consumer Price Index for Medical Care Services for the New England region.
2) Each carrier shall be required to report and explain to the Division of Insurance what actions they have taken to remedy the relative rate disparity identified in the Attorney General's July 31, 2011 Findings From Examinations of Health Care Cost Trends and Cost Drivers which concluded that said disproportionate share hospitals are paid considerably less than other Acute hospital providers.".
The amendment was *rejected*.
Mr. Keenan moved that the bill be amended by adding the following new section:
"SECTION XX. Section 1 of chapter 176O of the General Laws, as so appearing, is hereby amended by striking the definition of 'Medical necessity' or 'medically necessary' and inserting in place thereof the following:
'Medical necessity' or 'medically necessary', behavioral, substance use disorder, mental health and other health care services that are recommended by the treating physician or licensed practitioner that reflect the most appropriate supply or level of service, considering potential benefits and harms to the patient, and known to be effective in improving behavioral, substance use disorder, mental health and other health care conditions, illnesses or injuries."
The amendment was *rejected*.
Mr. Michael O. Moore moved that the bill be amended by inserting after section 114 the following section:-
"SECTION 114A. Said subsection (c) of said section 188 of said chapter 149, as so amended, is hereby further amended by adding the following clause:-
(11) In calculating the fair share assessment, employees who have qualifying health insurance coverage from a spouse, parent, veteran's plan, Medicare, Medicaid or a plan or plans due to a disability or retirement shall not be included in the numerator or denominator for purposes of determining whether an employer is a contributing employer, as defined in 114.5 CMR 16.02."; and by inserting after section 202 the following new section:-
"SECTION 202A. Section 114A shall take effect on February 1, 2013.".
After remarks, the amendment was adopted.
Mr. Tarr moved that the bill be amended by inserting after section 112 the following section:-
"SECTION ___. Subsection (b) of said section 188 of said chapter 149, as amended by section 134 of chapter 3 of the acts of 2011, is hereby further amended by striking out, in line 19, the number '11' and inserting in place thereof the following number:- 50."
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by inserting after section 115 the following new section:-
"SECTION ___. Subsection (c) of section 188 of said chapter 149 is hereby amended by inserting at the end thereof the following paragraph:-
(11) For the purpose of the fair share contribution compliance test, an employer may count employees that have qualifying health insurance coverage from a spouse, a parent, a veteran's plan, Medicare, Medicaid, or a plan or plans due to a disability or retirement towards their qualifying take-up rate as a "contributing employer", as defined by the Institute of Health Care Finance and Policy. The employer is still required to offer group medical insurance and must keep and maintain proof of their employee's insurance status.".
The amendment was *rejected*.
Mr. Tarr moved that the bill be amended by adding the following section:-
"SECTION ___. The Commonwealth Health Insurance Connector Authority shall investigate and study the financial implications of non-residents to contributing employers under section 188 of chapter 149 of the General Laws. The study shall include an analysis of the amount of non-resident employees enrolled in employer sponsored health insurance plans, those non-resident employees not enrolled in employer sponsored plans, and the extent to which non-residents contribute to assessments upon employers pursuant to section 188 of chapter 149 of the general laws. The study shall consider any current adverse impacts from non-residents participating in employer-sponsored plans and include recommendations to prevent such adverse impacts. The Authority shall submit a report to the clerks of the house and senate, the joint committee on health care financing, and the house and senate committee on ways and means before June 30, 2013."
The amendment was adopted.

Suspension of Senate Rule 38A.

Mr. Downing moved that Senate Rule 38A be suspended to allow the Senate to meet beyond the hour of 8:00 P.M.; and the same Senator requested unanimous consent that the rules be suspended without a call of the yeas and nays. There being no objection, the motion was considered forthwith, and it was adopted.

Orders of the Day.

The Orders of the Day were further considered, as follow:--
The Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2260, amended),-- was considered, the main question being on ordering the bill to a third reading.
Mr. Wolf and Ms. Candaras moved that the bill be amended in Section 162 in proposed chapter 176S of the General Laws by striking out section 10 and inserting in place thereof the following section:-
"Section 10. (a) The authority, in consultation with the advisory board, shall administer the Healthcare Payment Reform Fund, established under section 100 of chapter 194 of the acts of 2011. The fund shall be used for the following purposes: (1) to support the activities of the authority; and (2) to foster innovation in payment and health care service delivery.
(b) The authority shall establish a competitive process for health care entities to develop, implement, or evaluate promising models in payment and health care service delivery. Assistance from the authority may take the form of incentives, grants, technical assistance, evaluation assistance or partnerships, as determined by the authority.
(c) Prior to making a request for proposals under subsection (b), the authority shall solicit ideas for payment changes and health care delivery service reforms directly from providers, provider organizations, carriers, research institutions, health professionals, public institutions of higher education, community-based organizations and private-public partnerships, or any combination thereof. The authority shall review payment and service delivery models so submitted and shall seek input from other relevant stakeholders in evaluating their potential.
(d) The authority shall consider proposals that achieve the following goals: (i) to support safety-net provider and disproportionate share hospital participation in new payment and health care service delivery models; (ii) to support the successful implementation of performance improvement plans by health care entities under section 7; (iii) to support cooperative effort between representatives of employees and management that are focused on controlling costs and improving the quality of care through workforce engagement; (iv) to support the evaluation of mobile health and connected health technologies to improve health outcomes among under-served patients with chronic diseases; and (v) to develop the capacity to safely and effectively treat chronic, common and complex diseases in rural and underserved areas and to monitor outcomes of those treatments.
(e) All approved activities funded through the Healthcare Payment Reform Fund shall support the commonwealth's efforts to meet the health care cost growth benchmark established under section 5, and shall include measurable outcomes in both cost reduction and quality improvement.
(f) To the maximum extent feasible, the authority shall seek to coordinate expenditures from the Healthcare Payment Reform Fund with other public expenditures from the Prevention and Wellness Trust Fund, the e-Health Institute Trust Fund, the Health Care Workforce Transformation Trust Fund, the Distressed Community Hospital Fund, the executive office of health and human services, any funding available through the Medicare program and the CMS Innovation Center, established under the federal Patient Protection and Affordable Care Act and any funding expended under the Delivery System Transformation Initiative Master Plan and hospital-specific plans approved in the MassHealth section 1115 demonstration waiver.
(g) Activities funded through the Healthcare Payment Reform Fund which demonstrates measurable success in improving care or reducing costs shall be shared with other providers, provider organizations and payers as model programs which may be voluntarily adopted by such other health care entities. The authority may also incorporate any successful models and practices into its standards for the Beacon ACO certification under section 8 and for alternative payment methodologies established for state-funded programs under section 9.
(h) The authority shall, annually on or before January 31, report on expenditures from the Healthcare Payment Reform Fund. The report shall include, but not be limited to: (i) the revenue credited to the fund; (ii) the amount of fund expenditures attributable to the administrative costs of the authority; (iii) an itemized list of the funds expended through the competitive process and a description of the grantee activities; and (iv) the results of the evaluation of the effectiveness of the activities funded through grants. The report shall be provided to the chairs of the house and senate committees on ways and means and the joint committee on health care financing and shall be posted on the authority's website.".
The amendment was adopted.
Messrs. Berry, Welch and Brownsberger moved that the bill be amended by striking out section 53 and inserting in place thereof the following section:-
"SECTION 53. Said chapter 111 is hereby further amended by striking out section 25L, as amended by section 114 of chapter 3 of the acts of 2011, and inserting in place thereof the following section:-
Section 25L. (a) There shall be in the department a health care provider workforce center to improve access to health and behavioral, substance use disorder and mental health care services. The center, in consultation with the healthcare provider workforce advisory council established by section 25M and the secretary of labor and workforce development, shall: (i) coordinate the department's health care workforce activities with other state agencies and public and private entities involved in health care workforce training, recruitment and retention, including with the activities of the Health Care Workforce Transformation Fund; (ii) monitor trends in access to primary care providers, nurse practitioners and physician assistants practicing as primary care providers, behavioral, substance use disorder and mental health providers and other physician and nursing providers, through activities including: (1) review of existing data and collection of new data as needed to assess the capacity of the health care and behavioral, substance use disorder and mental health care workforce to serve patients, including patient access and regional disparities in access to physicians, physician assistants, nurses and behavioral, substance use disorder and mental health professionals and to examine physician, physician assistant, nursing and behavioral, substance use disorder and mental health professionals' satisfaction; (2) review existing laws, regulations, policies, contracting or reimbursement practices and other factors that influence recruitment and retention of physicians, physician assistants, nurses and behavioral, substance use disorder and mental health professionals; (3) making projections on the ability of the workforce to meet the needs of patients over

time; (4) identifying strategies currently being employed to address workforce needs, shortages, recruitment and retention; (5) studying the capacity of public and private medical, nursing and behavioral, substance use disorder and mental health professional schools in the commonwealth to expand the supply of primary care physicians, nurse practitioners and physician assistants practicing as primary care providers, and licensed behavioral, substance use disorder and mental health professionals; (iii) establish criteria to identify underserved areas in the commonwealth for administering the loan repayment program established under section 25N and for determining statewide target areas for health care provider placement based on the level of access; and (iv) address health care workforce shortages by: (1) coordinating state and federal loan repayment and incentive programs for health care providers; (2) providing assistance and support to communities, physician groups, community health centers, community based behavioral, substance use disorder and mental health organizations and community hospitals in developing cost-effective and comprehensive recruitment initiatives; (3) maximizing all sources of public and private funds for recruitment initiatives; (4) designing pilot programs and make regulatory and legislative proposals to address workforce needs, shortages, recruitment and retention; and (5) making short-term and long-term programmatic and policy recommendations to improve workforce performance, address identified workforce shortages and recruit and retain physicians, physician assistants, nurses and behavioral, substance use disorder and mental health professionals.

(b) The center shall communicate and coordinate with the institute for health care finance and policy, the health care quality and finance authority, the secretary of labor and workforce development, and the health disparities council, established by section 16O of said chapter 6A.

(c) The center shall annually submit a report, not later than March 1, to the governor; and the general court, by filing the report with the clerks of the house of representatives and the senate, the joint committee on labor and workforce development, the joint committee on health care financing and the joint committee on public health. The report shall include: (i) data on patient access and regional disparities in access to physicians, by specialty and sub-specialty, behavioral, substance use disorder and mental health professionals and nurses; (ii) data on factors influencing recruitment and retention of physicians, nurses and behavioral, substance use disorder and mental health professionals; (iii) short and long-term projections of physicians, nurses and behavioral, substance use disorder and mental health professionals supply and demand; (iv) strategies being employed by the council or other entities to address workforce needs, shortages, recruitment and retention; (v) recommendations for designing, implementing and improving programs or policies to address workforce needs, shortages, recruitment and retention; and (vi) proposals for statutory or regulatory changes to address workforce needs, shortages, recruitment and retention."; by striking out, in line 1763 the figure "16" and inserting in place thereof the following figure:- "17";and by inserting after the words "the Massachusetts Nurses Association;", in line 1773, the following words:- "the Massachusetts Association of Physician Assistants;".

The amendment was adopted.

Messrs. Finegold and Knapik, Ms. Spilka and Ms. Donoghue moved that the bill be amended by striking out section 190 and inserting in place thereof the following section:-

"SECTION 190. There shall be a special commission to review variation in prices among providers. The commission shall consist of 22 members: 1 of whom shall be the executive director of the institute of health care finance and policy or a designee, who shall serve as chair; 1 of whom shall be the secretary of administration and finance or a designee; 1 of whom shall be the executive director of the group insurance commission or a designee; 1 of whom shall be the secretary of health and human services or a designee; 1 of whom shall be the attorney general or a designee; 8 of whom shall be appointed by the governor, 1 of whom shall be a health economist, 1 of whom shall have expertise in the area of health care payment methodology, 1 of whom shall represent non-physician health care providers, 1 of whom shall represent an academic medical center or teaching hospital, 1 of whom shall represent a high Medicaid and low-income public payer disproportionate share hospital, 1 of whom shall represent a hospital with 200 beds or less, 1 of whom shall be a nurse practitioner; 1 of whom shall represent frontline nurses, and 1 of whom shall represent pharmaceutical manufacturers; 1 of whom shall be appointed by the senate president and shall be a health economist or have expertise in the area of health care payment methodology; 1 of whom shall be appointed by the speaker of the house of representatives and shall be a health economist or have expertise in the area of health care payment methodology; 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc.; 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc.; 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc.; 1 of whom shall be a representative of the Massachusetts Medical Society; 1 of whom shall be a representative of the Massachusetts Medical Device Industry Council; and 1 of whom shall be a representative of the Conference of Boston Teaching Hospitals.

The commission shall conduct a rigorous analysis to identify the acceptable and unacceptable factors contributing to price variation in physician, hospitals, diagnostic testing and ancillary services. The analysis shall include, but not be limited to, an examination of the following factors: quality, medical education, stand-by service capacity, emergency service capacity, special services provided by disproportionate share hospitals and other providers serving underserved or unique populations, market share of individual providers and affiliated providers, provider size, advertising, location, research, costs, care coordination, community-based services provided by allied health professionals and use of and continued advancement of medical technology and pharmacology. The analysis shall also include a comparison of price variation between providers in the commonwealth and providers in other states.

After identifying such factors, the commission shall recommend steps to reduce provider price variation and shall recommend the maximum reasonable adjustment to a commercial insurer's median rate for individual or groupings of services for each acceptable factor.

To conduct its review and analysis, the commission may contract with an outside organization with expertise in the analysis of health care financing and provider payment methodologies. The institute of health care finance and policy shall provide the

commission and any contracted outside organization, to the extent possible, relevant data necessary for the evaluation; provided, however, that such data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.
The commission shall file the results of its study, together with drafts of legislation, if any, necessary to carry out its recommendations, by filing the same with the clerks of the house of representatives and the senate who shall forward a copy of the study to the house and senate committees on ways and means and the joint committee on health care financing not later than January 1, 2014.".
The amendment was adopted.
Mr. Tarr moved that the bill be amended by adding the following section:-
"SECTION __. Notwithstanding any special or general law to the contrary, any fee imposed pursuant to this act shall not be incorporated or reflect in any charge or cost imposed directly or indirectly on those with health care insurance coverage in the commonwealth."
After remarks, The amendment was *rejected*.
Mr. DiDomenico moved that the bill be amended in section 162, line 4027, by striking the figure "11" and inserting in place thereof the figure:- "17"; and in line 4040, by inserting after the word "commonwealth" the following:- "1 of whom shall be an expert in racial and ethnic health disparities; 1 of whom shall be a representative of an organization representing the interests of academic medical centers; 1 of whom shall be a member of MassMEDIC; and 1 of whom shall be selected from a list of 2 names provided by the President of the Massachusetts AFL-CIO".
The amendment was adopted.
Subsequently, Mr. Brewer moved that the bill be amended by striking out, in line 132, the figure "10" and inserting in place thereof the following figure:- "20"; by inserting after the word "medical", in line 138, the following words:- ", behavioral health, substance use disorder, mental health"; by inserting after the word "medical", in line 153, the following words:- ", behavioral health, substance use disorder, mental health"; by inserting after the word "behavioral", in line 184, the following words:- ", substance use disorder"; by inserting after the word "services", in line 218, the following words:- "or as defined in regulations promulgated by the institute"; in section 14, in proposed subsection (a) of section 10 of chapter 12C of the General Laws, by inserting after the first sentence the following sentence:- "The institute may assess a registration or administrative fee on provider organizations in such amount to help defray the institute's costs in complying with this section."; in said section 14, in said proposed subsection (a) of said section 10 of said chapter 12C, by inserting after the second sentence the following sentence:- "The institute may specify in regulations such uniform reporting thresholds as it determines necessary."; by inserting after the word "behavioral", in line 602, the following words:- ", substance use disorder and mental"; by inserting after the word "behavioral", in line 631, the following words:- ", substance use disorder and mental"; by striking out, in line 663, the words "zip code" and inserting in place thereof the following words:- "geographic region of the commonwealth as further defined in regulations promulgated by the institute"; by inserting after the word "behavioral", in line 666, the following words:- ", substance use disorder and mental"; by striking out, in line 669, the words "risk reserves;"; by inserting after the word "allowances", in line 670, the following words:- "as may be required in regulations promulgated by the institute"; by inserting after the word "behavioral", in line 671, the following words:- ", substance use disorder and mental"; by striking out, in lines 751 and 752, the words "trends or documents that the attorney general considers necessary to evaluate" and inserting in place thereof the following words:- "trends,"; by striking out, in line 753, the word "to"; by striking out, in lines 1212 and 1213, the words "and substance abuse" and inserting in place thereof the following words:- ", behavioral and substance use disorder"; by inserting after the word "cost", in line 1215, the following word:- "growth"; by striking out, in line 1511, the words "and substance abuse" and inserting in place thereof the following words:- ", behavioral and substance use disorder"; by inserting after the word "behavioral", in line 1762, the following words:- ", substance use disorder and mental"; by inserting after the word "behavioral", in line 1767, the following words:- ", substance use disorder and mental"; by striking out, in line 1770, the words "Massachusetts Association of Social Workers" and inserting in place thereof the following words:- "National Association of Social Workers Massachusetts Chapter"; by striking out, in line 1771, the words "Massachusetts Organization of Nurse Executives" and inserting in place thereof the following words:- "Organization of Nurse Leaders"; by inserting after the word "behavioral", in line 1783, the following words:- ", substance use disorder and mental"; by inserting after the word "behavioral", in line 1804, the following words:- ", substance use disorder and mental"; by inserting after the word "physical", in line 2053, the following words:- ", behavioral, substance use disorder" ; by inserting after the word "physical", in line 2092, the following words:- ", behavioral, related to a substance use disorder"; by inserting after the word "medical", in line 2122, the following words:- ", behavioral, substance use disorder, mental"; by inserting after the word "medical", in line 2140, the following words:- ", behavioral, substance use disorder, mental" ; by striking out, in line 2292, the word "sole"; by inserting after the word "standards", in line 2296, the following words:- "; provided, that the secretary may designate another governmental unit to perform such ratemaking functions"; by inserting after the word "physical", in line 2674, the following words:- ", behavioral, related to a substance use disorder"; in section 125 by inserting after the word "Ratio", in lines 3365, 3367 and 3370, in each instance, the following words:- ", on a combined entity basis,"; by inserting after the word "services", in line 3422, the following words:- "or as further defined in regulations promulgated by the institute of health care finance and policy under chapter 12C"; by inserting after the word "stakeholders", in line 3605, the following words:- "and shall seek to use forms that have been mutually agreed upon by payers and providers"; by striking out, in line 3834, the figure "10" and inserting in place thereof the following figure:- "20"; by inserting after the word "a", in line 3871, the following words:- "physical, behavioral, substance use disorder or mental"; by inserting after the word "behavioral", in line 3881, the following words:- "substance use disorder"; by inserting after the word "services", in line 3901, the following words:- "or as further defined in regulations promulgated by the institute of health care

finance and policy under chapter 12C"; by inserting after the word "behavioral", in line 3928, each time it appears, the following words:- "substance use disorder and mental"; by striking out, in lines 3947 and 3948, the words "section 11A" and inserting in place thereof, in each instance, the following words:- "sections 18 to 25, inclusive,"; by inserting after the word "cost", in line 3983, the following word:- "growth"; by inserting after the word "cost", in line 4126, the following word:- "growth"; by inserting after the word "cost", in line 4133, the following word:- "growth"; by inserting after the word "growth", in line 4158, the following words:- ", including certification as a Beacon ACO"; by inserting after the word "cost", in line 4255, the following word:- "growth"; by inserting after the words "mental health", in line 4261, the following words:- " , substance use disorder"; by inserting after the words "mental health", in line 4277, the following words:- " , substance use disorder"; by inserting after the word "behavioral", in line 4278, the following words:- ", substance use disorder and mental"; by inserting after the word "behavioral", in line 4332, the following words:- " , substance use disorder"; by inserting after section 170 the following 3 sections:-

"SECTION 170D. Section 16 of chapter 257 of the acts of 2008, as most recently amended by section 27 of chapter 9 of the acts of 2011, is hereby amended by striking out the words 'section 7 of chapter 118G' and inserting in place thereof the following words:- section 13D of chapter 118E.

SECTION 170E. Section 17 of said chapter 257, as most recently amended by section 28 of said chapter 9 of the acts of 2011, is hereby amended by striking out the words 'section 7 of chapter 118G' and inserting in place thereof the following words:- section 13D of chapter 118E.

SECTION 170F. Section 18 of said chapter 257, as most recently amended by section 29 of said chapter 9 of the acts of 2011, is hereby amended by striking out the words 'section 7 of chapter 118G' and inserting in place thereof the following words:- "section 13D of chapter 118E. ";

By inserting after section 173 the following section:-

"SECTION 173B. Section 48 of chapter 9 of the acts of 2011 is hereby amended by striking out the words "section 7 of chapter 118G" and inserting in place thereof the following words:- section 13D of chapter 118E.";

By inserting after the word "behavioral", in line 4734, the following words:- " , substance use disorder and mental"; by inserting after the word "existing", in line 4766, the following word:- "public"; by inserting after the word "primary", in line 4769, the following word:- "public"; and by inserting after the word "behavioral", in line 4796, the following words:- " , substance use disorder ".

After remarks, the amendment was adopted.

The bill, as amended, was then ordered to a third reading and read a third time.

After remarks, the question on passing the bill to be engrossed was determined by a call of the yeas and nays, at twenty-five minutes before nine o'clock P.M., on motion of Mr. Richard T. Moore, as follows, to wit (yeas 35 – nays 2) **[Yeas and Nays No. 190]:**

YEAS

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	Murray. Therese
DiDomenico, Sal N.	Pacheco, Marc R.
Downing, Benjamin B.	Petruccelli, Anthony
Donoghue, Eileen M.	Rodrigues, Michael J.
Eldridge,	Rosenberg,

James B.	Stanley C.
Fargo, Susan C.	Ross, Richard J.
Finegold, Barry R.	Rush, Michael F.
Flanagan, Jennifer L.	Spilka, Karen E.
Hart, John A., Jr.	Timilty, James E
Jehlen, Patricia D.	Welch, James T.
Joyce, Brian A.	Wolf, Daniel A.
Keenan, John F.	**— 35.**

NAYS

Hedlund, Robert L.	Tarr, Bruce E. — **0.**

ABSENT OR NOT VOTING

Berry, Frederick E.	Donnelly, Kenneth J

The yeas and nays having been completed at twenty-three minutes before nine o'clock P.M., the bill was passed to be engrossed [See Senate, No. 2270, printed as amended].
Sent to the House for concurrence.

The Senate Committee Bill relative to the right to repair (Senate, No. 2204) (having been placed at the end of the Calendar),-- was considered, the main question being on ordering it to a third reading.
The pending motion, previously moved by Ms. Fargo, to lay the matter on the table,-- was considered; and it was *negatived*.
The pending amendment, previously moved by Mr. Keenan, in section 2, subsection (c), by inserting, in line 17, after the word "system" the following words:- "upon such terms and at a cost no greater than the fair market value for such access and shall not discriminate against such owners or independent repair facilities as compared with the terms and costs charged to dealers or authorized repair facilities.",-- was withdrawn, at the request of Mr. Keenan.
Mr. Kennedy offered an amendment in section 1 by striking out, in line 30, the words "and (vii) any vehicle excluded from the definition of "motor vehicle" in chapter 90" and inserting in place thereof the following words:-
"(vii) any vehicle excluded from the definition of "motor vehicle" in chapter 90; and (viii) a motorcycle, as defined in section 1 of chapter chapter 90.".
Pending the question on adoption of the amendment, Mr. Kennedy offered a further amendment substituting a new draft with the same title (Senate, No. 2267).
After remarks, the further amendment (Kennedy) was adopted. The pending amendment (Kennedy), as amended (Kennedy) was then adopted.
The bill (Senate, No. 2267) was then ordered to a third reading and read a third time.
After remarks, the bill was passed to be engrossed.
Sent to the House for concurrence.

Order Adopted.

On motion of Mr. Brewer,--
Ordered, That when the Senate adjourns today, it adjourn to meet again on Monday next 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-one minutes before nine o'clock P.M., the Senate adjourned to meet again on Monday next at eleven o'clock A.M.