



Chapter 224 of the Acts Of 2012
An Act Improving The Quality Of Health Care And Reducing Costs Through Increased Transparency, Efficiency And Innovation Section By Section Analysis

Section 1 - 13. Technical. Relative to the Center for Health Information and Analysis

Section 14. Establishes the Health Planning Council under EOHHS, and a 13 member Advisory Committee. Council holds 5 public hearings and develops a State Health Plan to inventory resources and make recommendations for appropriate supply and demand. Regs with uniform reporting requirements and “avoid placing burdens on providers which are not reasonably necessary to accomplish goals.” DoN should be consistent with state health plan.

Section 15. Establishes the independent Health Policy Commission with 11 member board and provider based Advisory Council to set health care cost growth benchmark, enhance transparency, monitor ACO’s and medical homes, foster innovation and monitor and review impact of changes in HC system.

Cost growth benchmarks for calendar years 2013-2017 equal to potential gross state product. PGSP for 2013 is 3.6%.

For calendar years 2018-2022, equal to PGSP minus 0.5%.

For 2023 and beyond equal to PGSP. Board can modify after 2018.

Commission holds public hearings, can call witnesses, and can solicit testimony from providers 10 percent above or below average relative price or entering into alternative payment contracts that vary by more than 10 percent.

Commission paid for by an assessment on hospitals, ASC’s, and insurers (line 517). Creates Healthcare Payment Reform Fund to provide incentives, grants, technical assistance, etc to healthcare entities to develop, implement or evaluate models in HC payment and service delivery.

Commission may require HC entities exceeding benchmarks to file performance improvement plan, and may be posted on web. Many provisions for timely modifications to plans, etc. If final plan is still not acceptable, Commission can assess civil penalty of \$500,000 as a last resort.

Commission develops and administers a registration program for provider organizations (line 860). Must submit organizational charts, number of HC professionals, and other info as commission deems appropriate. Commission may assess registration or administrative fee. Risk bearing organizations must get DoI risk certificate. Provider organizations cannot negotiate network contracts without a risk certificate. Exempts provider or provider organizations with a patient panel of 15,000 or fewer which represents providers who collectively receive less than \$25 million in annual net patient service revenue if they do not take risk.

Requires provider organizations to submit notice to the commission of material changes to its operations or governance structure, including but not limited to mergers, acquisitions, etc which will result in a near majority of market share.

The commission may initiate cost and market impact reviews of providers and provider organizations relative to market position, and can refer reports to the Attorney General for further investigation.

Commission develops and implements standards for certification of patient centered medical homes, using NCQA standards (line 990). Certification as a medical home is voluntary. Primary care providers, behavioral health providers or specialty care providers may be certified as medical homes if they meet the standards set by the commission or are recognized by the NCQA as a medical home. Medical homes may enter into agreements with other medical homes, primary care practices, limited service clinics, etc for after hours care for their patients. Commission develops payment system for medical homes by January 1, 2014.

Commission shall establish a voluntary process for certain registered provider organizations to be certified as ACO's (line 1061), and minimum standards and goals for ACO's. Allows medically necessary services that are not available internally to be provided to patients through services outside the ACO. ACO's must get risk certificate through DoI.

ACOs must publish the standards used to determine which providers of free-standing ancillary services shall be approved to provide services to ACO patients. Free-standing ancillary services shall include, but shall not be limited to, durable medical equipment services, laboratory services, imaging services, dialysis centers, and services provided by free-standing diagnostic, non-hospital surgery centers. A provider of these services shall be informed in writing by the ACO of the standards by which they were accepted or rejected as an approved provider of these free-standing ancillary services for ACO patients.

The commission must create a review process for aggrieved providers under this subsection that are denied approval by an ACO as a provider of free-standing ancillary services. For such process, the commission may review the following: (1) a comparison of the costs of services between an aggrieved provider and the costs of services provided within the ACO; (2) a comparison of the quality of services between an aggrieved provider and the quality of services provided within the ACO; (3) a comparison of the efficiency of services between an aggrieved provider and efficiency of services provided within the ACO; and (4) the extent to which the aggrieved provider meets the published standards used by the ACO to determine inclusion as an approved provider for ACO (line 1194).

Commission establishes Office of Patient Protection to establish regulations relative to appeals by consumers aggrieved by ACO actions, and an external review system.

Section 16 and 17. Technical

Section 18. Empowers the Attorney General to monitor trends in health care market, obtain information from insurers and providers and investigate unfair methods of competition.

Section 19. Establishes the Center for Health Information and Analysis to be the sole depository for healthcare data. Hospitals, ASC's and surcharge payors pay for the Center (line 1633). Center collects and analyzes data necessary to protect public's interest in monitoring the financial conditions of acute hospitals. Center reports and publicizes financial info on website. May assess administrative fees on provider organizations to defray the center's costs.

Center shall require registered provider organizations and public and private health payors to report annual info, including organizational charts, affiliated health care professionals, comprehensive financial statements, in coordination with the Commission and the DoI. Very broad reporting requirements. Data should be available to payers and providers and consumers. Center, with Public Health Council and Boards of Registration, develops a uniform and interoperable electronic system of public reporting for providers as a condition of licensure. Creates a statewide advisory committee to develop a standard quality measure set. Transfers Betsy Lehman Center for Patient Safety and Medical Error Reduction and Board to Center for Health Information and Analysis. Center reviews and comments on all capital expenditure projects requiring a DoN. Center maintains consumer health information website.

Requires providers that accept workers compensation reimbursement to file cost reports with the Center. Does not eliminate provider's ability to negotiate rates.

Section 20, 21 and 22. Technical.

Section 23. Requires the Commissioner of Insurance to enforce federal mental health parity provisions.

Section 24 - 27. Technical

Section 28. Establishes the Health Care Workforce Transformation Fund and Advisory Board. Funds healthcare workforce loan repayment program, the primary care residency grant program and the primary care workforce development and loan forgiveness grant program at community health centers.

Section 29. Establishes the Distressed Hospital Trust Fund to provide grants to certain non-profit community hospitals. Funded by public and private sources, grants and donations, interest earned on revenues and funds from other sources.

Section 30. On or before January 15, Secretary of A&F, and House and Senate Ways and Means jointly develop growth rate of potential gross state product for ensuing calendar year and report such to Health Policy Commission.

Section 31 – 33. Technical.

Section 34. Inserts following definition of primary care provider into GIC statutes: a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.

Section 35. Technical

Section 36. Insurers contracting with GIC must toll free phone number and website for cost and benefit info.

Section 37. Requires such into to be in real time.

Section 38. Establishes the Mass e-Health Institute to develop a plan to complete the implementation of electronic health records systems by all providers in the commonwealth, and to facilitate health care providers in achieving and maintaining compliance with the standards for meaningful use, beyond stage 1, established by regulation by the United States Department of Health and Human Services under the Health Information Technology for Economic and Clinical Health Act and referred to in this section as "meaningful use"; and (5) promoting to patients, providers and the general public, a broad understanding of the benefits of interoperable electronic health records systems for care delivery, care coordination, improved quality and ultimately greater cost efficiency in the health care delivery system. Funded thru the e-Health Institute Fund and appropriations and other monies authorized by the General Court.

Section 39. Establishes the Mass Health Information Technology Revolving Loan Fund to provide zero interest loans to health care providers and community based behavioral health organizations to implement health information technology.

Section 40. Technical

Section 41. Establishes the Mass Wellness Program Tax Credit. DPH determines criteria.

Section 41A – 55. Technical

Section 56. Mass Wellness Program Tax Credit.

Section 56A – 58. Technical

Section 59. Inserts definition of primary care provider into DPH statutes.

Section 60. Establishes Prevention and Wellness Trust Fund and Advisory Board under DPH.

Section 61 – 66. Technical

Section 67. Amends the definition of ambulatory surgery for DoN purposes to include procedures conducted in an ASC or a clinic within an acute care hospital.

Section 68. Changes the DoN definition of “Innovative Service” from enumerated list to “a service or procedure, which for reasons of quality, access or cost is determined to be innovative by DPH.”

Section 69. Changes the DoN definition of “New Technology” from an enumerated list to “equipment such as magnetic resonance imagers and linear accelerators, as defined by the department, or a service, as defined by the department, which for reasons of quality, access or cost is determined to be new technology by the department.”

Section 70. Technical

Section 71. DoN. Adds in Center for Health Information and Analysis and the Health Policy Commission to DoN notification requirements. Imposes a penalty for violations by a fine of not more than 3 times the amount of the expenditure or the value of the change of service. Raises the threshold of new technology and innovative services from \$150,000 to \$250,000. Eliminates MRI’s from innovative service or new technology. Adds in that DoN determinations shall be guided by state health plan. Adds in ability of AG to intervene in the DoN process. Increases the DoN fee from .1% to .2%. Allows DPH to require some applicants to get an independent cost analysis at their own expense. Changes time period for DPH to act on DoN applications from eight months to four months.

Section 72. Establishes Health Care Workforce Center and Advisory Council within DPH to improve access to health and behavioral, substance use disorder and mental health services. Advisory Council includes one representative of MMS and one representative of the Mass Academy of Family Physicians.

Establishes Health Care Workforce Loan Repayment Program to provide repayment assistance for graduate and medical school loans to participants who: (1) are graduates of medical, nursing, or physician assistant schools or accredited graduate schools; (2) specialize in family health or medicine, internal medicine, pediatrics, obstetrics/gynecology, psychiatry, behavioral health, mental health or substance use disorder treatment; (3) demonstrate competency in health information technology, at least equivalent to federal meaningful use standards as set forth in 45 C.F.R. Part 170, including use of electronic medical records, computerized physician order entry and e-prescribing; and (4) meet other eligibility criteria, including service requirements, established by the board. Recipients must enter into contracts of not less than 2 years in medically underserved areas.

Establishes a primary care residency grant program for primary care providers at 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. Eligible residency programs shall be accredited by the Accreditation Council for Graduate Medical Education (line 3320).

Establishes a primary care workforce development and loan forgiveness grant program at community health centers to enhance recruitment and retention of primary care physicians and other clinicians at community health centers.

Section 73 – 78. Technical

Section 79. Requires DPH to transmit data to Betsy Lehman Center.

Section 80. Requires DPH to develop and implement checklists of care that prevent adverse events and reduce healthcare associated infection rates.

Requires DPH to promulgate regulations to promote the availability of limited services clinics as a point of access for health care services within the full scope of practice of a nurse practitioner. Prohibits limited service clinics from serving as a patient's primary care provider and from referring patients to a non-primary care provider, unless the limited service clinic is a satellite of, or is otherwise affiliated with a hospital or other licensed practitioners and the non-primary care provider practice in the facility or is a licensed practitioner.

Section 81. Defines "Limited services" as "diagnosis, treatment, management and monitoring of acute and chronic disease, wellness and preventative services of a nature that may be provided within the scope of practice of a nurse practitioner using available facilities and equipment, including shared toilet facilities for point-of-care testing."

Section 82. Prohibits hospitals from contracting or entering into agreements with physicians that would prohibit or limit their ability to provide testimony in an administrative or judicial hearing, including cases of medical malpractice.

Section 83 – 86. Technical

Section 87. Allows facilities and institutions licensed by DPH to move residents to different living quarters or a different room under certain circumstances.

Section 88 – 99. Technical.

Section 100. DPH develops seal of approval for wellness programs.

Section 101. Requires DPH Office of Patient Protection to establish a website to make info available to consumers.

Section 102. Technical.

Section 103. Conditions for billing for anatomic Pathology services.

Prohibits mandatory overtime for nurses in hospital settings, except for emergency situations as defined by the Health Policy Commission.

Requires DPH to adopt regulations on the availability of palliative care and end of life options. Requires patient's attending health care practitioner to offer info to patient, or if unwilling to do so, arrange for another practitioner to do so.

Requires healthcare providers to disclose within 2 working days disclose the allowed amount or charge of the admission, procedure or service, including the amount for any facility fees required; provided, however, that if a health care provider is unable to quote a specific amount in advance due to the health care provider's inability to predict the specific treatment or diagnostic code, the health care provider shall disclose the estimated maximum allowed amount or charge for a proposed admission, procedure or service, including the amount for any facility fees required.

If a patient or prospective patient is covered by a health plan, a health care provider who participates as a network provider shall, upon request of a patient or prospective patient, provide, based on the information available to the provider at the time of the request, sufficient information regarding the proposed admission, procedure or service for the patient or prospective patient to use the applicable toll-free telephone number and website of the health plan established to disclose out-of-pocket costs. A health care provider may assist a patient or prospective patient in using the health plan's toll-free number and website.

A health care provider referring a patient to another provider that is part of or represented by the same provider organization shall disclose that the providers are part of or represented by the same provider organization.

Section 104 – 107. Technical

Section 108. Requires physicians to be proficient in the use of health information technology as a condition of licensure. Proficiency, at a minimum means complying with the “meaningful use” requirements as set forth in 45 CFR, Part 170.

Section 109. Physicians can’t be prohibited from providing testimony in an administrative or judicial hearing, including medical malpractice.

Section 110. Technical change relative to physician assistants.

Section 111. Eliminates current restriction that a registered physician shall supervise no more than 4 physician assistants at any one time.

Section 112. Strikes out current requirement that a PA’s prescription include the name of the supervising physician.

Section 113. Allows nurse practitioners to sign, certify, stamp and verify documents previously requiring a physician’s signature.

Section 114. Inserts definition of primary care provider into MassHealth.

Section 115. Inserts definitions into MassHealth.

Section 116. Technical.

Section 117. Requires members of MassHealth dual eligible pilot program be provided an independent community care coordinator.

Section 118 - 122. Technical.

Section 123. Relative to MassHealth rates for hospitals, social service programs, nursing homes, nursing pools and rest homes.

Section 124 – 130. Technical.

Section 131. Relative to nursing home assessments.

Establishes health safety net office and health care safety net trust fund within Medicaid.

Establishes Personal Care Attendant quality home care workforce Council.

Section 132. Technical

Section 133. Commonwealth care shall attribute every member to a primary care provider.

Section 134. Establishes the Health Information Technology Council within EOHHS to develop statewide health information exchange. Requires every patient to have electronic access to their health records. Requires all providers to implement fully interoperable electronic health records that connect to the statewide health information exchange. Penalties for non-compliance. Exemptions for providers who do not have broadband internet access. Establishes the Mass Health Information Exchange Fund. Patients allowed to opt in or out at any time. Patients can

request that a provider give them a list of individuals and entities that have accessed their health information, and develop a list of authorized users.

Section 135 – 138. Technical.

Section 139. Prohibits an employer from firing an employee who accesses the Health Safety Net Fund.

Section 140, 141 and 142. Employer fair share contribution.

Section 143 - 153. Technical.

Section 154. Rate discounts for employers whose employees participate in qualified wellness programs.

Section 155. To the maximum extent possible, insurers must attribute members to a primary care provider and disclose patient level data to providers. DoI develops procedures and standard format for disclosing patient level information.

Sections 156 and 157 missing.

Section 158. Standards for insurers coverage of telemedicine services. Telemedicine network must be approved by the insurer; deductibles, copayments and coinsurance must be equal to or less than those applicable to in-person consultations; and consistent with coverage for health care services provided in person.

Section 159 - 164. Technical.

Section 165. Blue Cross must attribute every member to a primary care provider and disclose patient level data to providers. DoI develops procedures and standard format for disclosing patient level information.

Section 166. Inserts definition of primary care provider into Blues statutes.

Section 167 – 168. Technical.

Section 169. Blue Shield must attribute every member to a primary care provider and disclose patient level data to providers. DoI develops procedures and standard format for disclosing patient level information.

Section 170. Inserts definition of primary care provider into managed care statutes.

Section 171 and 172. Technical.

Section 173. HMO's must attribute every member to a primary care provider and disclose patient level data to providers. DoI develops procedures and standard format for disclosing patient level information. DoI may require HMO's to disclose info thru all payer claims database.

Section 174. Carriers shall apply wellness program rate discounts.

Section 175 and 176. Technical.

Section 177. Allows insurers to offer limited service networks; and smart tiering plans where services are tiered, or smart tiering plans where providers are tiered, with member cost sharing. Commissioner of Insurance promulgates regs requiring the uniform reporting of tiering information; determines adequacy of networks. A smart tiering plan is a tiering product which offers a cost sharing differential based on services rather than facilities providing services. Covered services may be reimbursed thru bundled payments for acute and chronic diseases.

Section 178. Technical

Section 179. Relative to rates offered by carriers to certified group purchasing cooperatives.

Section 180. Small group health insurance carriers shall attribute every member to a primary care provider, and disclose patient level data to providers. DoI develops procedures and standard format for disclosing patient level information.

Section 181 – 182. Technical.

Section 183. Amends the definition of “Behavioral health manager” under Health Insurance Consumer Protection statutes by adding in substance use disorder and mental health services.

Section 184. Inserts definition of “Downside Risk” into Health Insurance Consumer Protection statutes. Defined as “the risk taken on by a provider organization as part of an alternate payment contract with a carrier or other payer where the provider organization is responsible for either the full or partial costs of treating a group of patients that exceeds a contract’s budgeted payment arrangements.

Section 185. Amends the definition of “Emergency Medical Condition” under Consumer Protection statutes by adding in behavioral health and substance abuse disorders.

Section 186. Amends the definition of “Health Care Services” under Consumer Protection statutes by adding in behavioral health and substance abuse disorders.

Section 187. Adds definition of “primary care provider” to Consumer Protection statutes.

Section 188. Adds definition of “Risk-Bearing Provider Organization” into Consumer Protection statutes, defined as “a provider organization that manages the treatment of a group of patients and bears the downside risk according to the terms of an alternate payment contract. “

Section 189 and 190. Technical.

Section 191. Fines for violations of 176O.

Section 192. Amends consumer protection statutes to include patient’s access to cost and coverage information via the website.

Section 193 – 196. Technical.

Section 197. Amends consumer protection statutes to prohibit anything from limiting carriers or providers from disclosing allowed amounts, fees and out of pocket expenses to an insured

Section 198. Prohibits insurers from entering into arrangements involving downside risk with a provider organization that has not received a risk certificate from the DoI.

Section 199. Utilization review must be under the supervision of a physician and staffed by appropriately trained and qualified staff, standardized criteria, scientifically derived and evidence-based. Available to all on website.

Section 200. Carriers and UR organizations must make determinations within 7 working days after receipt of all info.

Section 201. Insureds must be notified at least 30 days before disenrollment of a provider. Pregnant woman and terminally ill can continue treatment. Allows for standing referrals for specialty health care services. No referrals or prior authorizations needed for certain services provided by providers in network.

Section 202. Amends consumer protection statutes to include medically necessary services insurers have to pay for if in network.

Section 203 – 204. Technical.

Section 205. DPH Commissioner may waive specific reporting requirements when inapplicable.

Section 206. Insurers must establish a toll free number and website for consumer cost information. All risk bearing organizations must establish an internal appeals process, available to the public in written format and by request in electronic format. Internal appeals must be completed within 14 days, procedure for expedited appeals. Patients have the right to designate a third party to advocate on their behalf.

Section 207. Consumer protection website should be real time.

Section 207A. There should be uniform prior authorization forms required for use by payers. Forms should be 2 or less pages, electronic.

Section 208 – 214. Technical and definitions only.

Section 215. Connector prepares employer health insurance responsibility disclosure form. Relative to free rider surcharge.

Section 216. Consumer choice of Physician Assistants. Allows PA's to be chosen as primary care providers.

Section 217. Adds Risk-Bearing Provider Organizations to Division of Insurance statutes. Requires registered provider organizations that accept downside risk to get risk certificate from DoI. Those that don't accept significant downside risk apply for waiver. Risk certificate renewed annually and includes list of insurers the provider organization contracts with, financial statements, financial plan, utilization plan, and actuarial certification attesting to financial solvency. DoI notified of changes to information. Application fees may be imposed. DoI examines the affairs, including assets and liabilities, of risk-bearing provider organizations at least every 3 years, which may include an on-site examination. May be charged for each such examination. DoI can accept or reject applications for risk-bearing certificates and examination reports, ask for more info, make modifications, suspend or refuse to renew, or, for examination reports, call for investigatory hearing. All info in risk-bearing reports to DoI is confidential.

Section 218 and 219. Technical.

Section 220. Lowers judgment interest from Treasury rate plus 4% to plus 2%.

Section 221. "Cooling Off Period". 182 day written notice to provider prior to commencing legal action, conditions for suspension of requirement.

Section 222. Hospital liability cap raised to \$100,000, exclusive of interest and costs.

Section 223. Provider apologies inadmissible as evidence in judicial and administrative proceedings.

Section 224. Expenses incurred for hospital services as a direct result of injury to the victim are compensable. Medicare and Medicaid don't pay for medical errors.

Section 225 – 233. Technical.

Section 234. Relative to small group base rate factors.

Section 235 – 237. Technical.

Section 238. Commissioner of Revenue reviews wellness program tax credit.

Section 239. Wellness program tax credit capped at \$15 million.

Section 240. Health Information Technology Council and Mass e-Health Institute evaluates effectiveness of Mass Health Information Exchange Fund and Mass Health Information Technology Revolving Loan Fund, respectively.

Section 241. Health Policy Commission establishes a one-time surcharge assessment on all acute hospitals. Exempts hospitals and hospital systems with more than \$1 billion in total net assets and less than 50% of revenues from public payors. Conditions for assessment mitigation. Penalties for non-compliance.

Section 242. Third party administrators must disclose to self-insured or self-funded employer group health plan clients the contracted prices of services of in-network providers.

Section 243. Provider organizations certified as ACO's or medical homes, and risk-bearing provider organizations must have interoperable electronic medical records by December 31, 2016.

Section 244. Health Care Workforce Center shall investigate possibility of dedicating funds for joint appointments for clinicians with clinical agencies and universities.

Section 245. EOHHS seeks Medicare waiver from requirement that admission to skilled nursing facility be preceded by a 3 day hospital stay.

Section 246. Can't terminate MassHealth coverage to a recipient while the office is determining eligibility.

Section 247. EOHHS studies feasibility of contracting for recycling durable medical equipment purchased by the commonwealth.

Section 248. Medicaid and Department of Unemployment Assistance develop and implement means by which information can be accessed relative to unemployment benefits for the purpose of determining eligibility.

Section 249. DoI and Board of Registration in Medicine study potential for out of state physicians to practice telemedicine in the commonwealth.

Section 250. EOHHS studies methods to improve access to veteran's benefits.

Section 251. State Auditor conducts a comprehensive review and investigation of the impact of this act.

Section 252. Clarifies that consumers can obtain additional insurance coverage or pay out of pocket for medical services not otherwise covered.

Section 253. Medicaid pays critical access hospitals at least 101% of allowable costs for both inpatient and outpatient services.

Section 254. DoI promulgates regulations to enforce federal mental health parity laws for private insurers and require submission of annual reports attesting to such.

Section 255. DoN applications filed on or before December 31, 2013 grandfathered in.

Section 256. Health Planning Council submits state health plan on or before January 2, 2014.

Section 257. Health care providers that receive written notice from DPH prior to December 31, 2013 that they do not need a DoN for a project are grandfathered in.

Section 258. Board of Registration in Medicine may promulgate regulations relative to education and training of physicians in the early disclosure of adverse events, including but not limited to CME's.

Section 259. DPH and DoI study best practices and successful models of wellness and health management programs for payors, employers and consumers.

Section 260. Board of Registration in Nursing may promulgate regulations relative to education and training of nurses in the early disclosure of adverse events, including but not limited to CME's.

Section 261. Medicaid must develop alternative payment methodologies by July 1, 2013 for at least 25% of enrollees; by July 1, 2014 for at least 50% of enrollees; and by July 1, 2015 for at least 80%.

Section 262. 2% MassHealth rate increase for providers of primary care services that accept alternative payment methodologies.

Section 263. Health Policy Commission studies and makes recommendations relative to flexible spending accounts, health reimbursement arrangements, health savings accounts, etc.

Section 264. Department of Revenue studies and makes recommendations relative to flexible spending accounts, health reimbursement arrangements, health savings accounts, etc for public employees and recipients of state subsidized health benefits.

Section 265. Medicaid must promulgate regulations to ensure compliance with federal mental health parity laws. Must file annual report to the legislature attesting to such.

Section 266. Medicaid must require social security numbers on all medical benefits request forms.

Section 267. EOHHS must make reasonable efforts to automatically renew eligible children and families into MassHealth programs through adoption of "express lane eligibility option."

Section 268. Provider organizations certified as ACO's and designated as model ACO's receive priority in contracting for delivery of publically funded healthcare services.

Section 269. Technical.

Section 270. Special commission, including MMS, to review public payor 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. Recommendations, including draft legislation, if any, by April 1, 2013.

Section 271. Relative to Medicaid rates for inpatient services provided by chronic disease rehab hospitals serving children and adolescents.

Section 272. DPH and Betsy Lehman Center create independent task force to study and reduce the practice of defensive medicine and medical overutilization. Report back within one year from effective date of this act.

Section 273. Establishes pharmaceutical cost containment commission to study methods to reduce the cost of prescription drugs for public and private payors.

Section 274. Creates special task force to study and investigate issues related to the accuracy of medical diagnoses.

Section 275. Creates 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, substance use

disorder and mental health reimbursement systems. Includes Mass Psychiatric Society. Report back by July 1, 2013.

Section 276. Creates a commission on prevention and wellness.

Section 277. Special commission, including MMS, to examine the economic, social and educational value of graduate medical education in the commonwealth and to recommend a fair and sustainable model of future funding of GME. Report back by April 1, 2013.

Section 278. GIC, MassHealth and other state funded insurance must implement alternative payment methodologies to maximum extent feasible.

Section 279. Creates a special commission, including MMS, to review variation in prices among providers and recommend steps to reduce variation. Report back by January 1, 2014.

Section 280. EOHHS shall seek Medicare waiver as necessary to implement alternative payment methodologies.

Section 281. Technical – transfer of employees, proceedings, rules and regulations between DHCFP, Medicaid, Center for Health Information Analysis and Health Policy Commission.

Section 281A – 308. Effective Dates.