xxxxx
– 05/24/2012

SENATE . . . . . No. 02268

The Commonwealth of Massachusetts

In the Year Two Thousand Twelve.

Commonwealth Health Care Quality and Finance Authority

Messrs. Hart, Rush, M. Moore, Rodrigues and moves to amend the bill (Senate, No. 2260) in Section 162 by striking said section in its entirety and inserting in place thereof the following section:-

"SECTION 162. The General Laws are hereby amended by inserting, after chapter 176R the following 2 chapters:

CHAPTER 176S

COMMONWEALTH HEALTH CARE QUALITY AND FINANCE AUTHORITY

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

"Actual economic growth benchmark," the actual annual percentage change in the per capita state's gross state product, excluding the impact of business cycles, as established under section 7H½ of chapter 29.

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

“Alternative payment contract”, any contract between a provider or provider organization and a public health care payer or a private health care payer which utilizes alternative payment methodologies.

“Alternative payment methodologies”, methods of payment that are not directly fee-for-service reimbursement for services; provided, that “alternative payment methodologies” may include, but not be limited to, global payments, shared savings arrangements, bundled payments and episodic payments.

“Authority”, the commonwealth health care quality and finance authority.

“Beacon ACO”, a certification given by the board of the authority to indicate that a provider organization meets certain standards regarding quality, cost containment and patient protection.

“Board”, the board of the commonwealth health care quality and finance authority, established by section 2.

“Business entity”, a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

“Carrier,” an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; and an organization entering into a preferred provider arrangement under chapter 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of 1 or more subsidiaries or affiliated corporations of the employer; provided that, unless otherwise noted, the term “carrier” shall not include any entity to the extent it offers a policy, certificate or contract that provides coverage solely for dental care services or visions care services.

“Facility,” a licensed institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers and rehabilitation and other therapeutic health settings.

"Fee-for-service", a form of contract under which a provider or provider organization is paid for discrete and separate units of service and each provider is separately reimbursed for each discrete service rendered to a patient; provided, however, that up to 10 per cent of total reimbursement under such contracts may depend on the achievement of certain targets of performance or conduct.

“Institute”, the institute of health care finance and policy established in chapter 12C.

“Health benefit plan”, any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; a group medical service plan issued by a non-profit medical service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; a coverage for young adults health insurance plan under section 10 of chapter 176J; provided that “health benefit plan” shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued under chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner of insurance by regulation may set, insurance arising out of a workers compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. section 55 if offered as a separate insurance policy, or any policy subject to chapter 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans; provided, further that “health benefit plan” shall not include a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A which shall be governed by said chapter 15A; provided, further that the authority may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

“Health care cost growth benchmark,” the projected annual percentage change, year over year, in total health care expenditures in the commonwealth, as established in section 5.

“Health care entity”, a provider, provider organization, or providers certified, or otherwise registered under chapter 111, carrier, or other entity that the authority identifies as a material contributor to health care expenses in the commonwealth.

“Health care professional,” a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with law.

"Health care services," services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

"Health status adjusted total medical expenses", the total cost and spending for private payer and governmental payer including but not limited to Medicaid, Medicare, and self pay, so called, for the Massachusetts patient population incurred for all categories of medical expenses including without limitation, premiums, allowed claims paid to providers, non-claims related payments to providers, including, but not limited to special payments, supplemental payments, pharmaceutical costs, medical device costs, long term care costs, labor costs, carrier administrative costs, all adjusted by age and health status, and expressed on a per member per month basis, as calculated under section 9 and the regulations promulgated by the institute.

"Major service category," a set of service categories to be established by regulation, which may include: (i) acute hospital inpatient services, by major diagnostic category, including but not limited to technology, administrative expenses and labor; (ii) outpatient and ambulatory services, by categories as defined by the Centers for Medicare and Medicaid, or as established by regulation, not to exceed 15, including a residual category for "all other" outpatient and ambulatory services that do not fall within a defined category; (iii) behavioral and mental health services by categories as defined by the Centers for Medicare and Medicaid, or as established by regulation; (iv) professional services, by categories as defined by the Centers for Medicare and Medicaid, or as established by regulation; (v) sub-acute services, by major service line or clinical offering, as defined by regulation; (vi) outpatient drugs; (vii) durable medical equipment, long term care costs, home care and hospice care.

"Medicaid program", the medical assistance program administered by the division of medical assistance under chapter 118E and in accordance with Title XIX of the Federal Social Security Act or any successor statute.

"Medicare program", the medical insurance program established by Title XVIII of the Social Security Act.

"Performance improvement plan," a plan submitted to the authority by a carrier, a provider or a provider organization under section 7, which shall be kept confidential by the board and shall not be considered a public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66.

"Projected economic growth benchmark," the long-term average projected percentage chance in the per capita state's gross state product, excluding the impact of business cycles, as established under section 7H½ of chapter 29.

"Provider," a health care professional or a facility.

"Provider organization," any corporation, partnership, business trust, association or organized group of persons whether incorporated or not that consists of or represents 1 or more providers in contracting with carriers for the payments the provider or providers receive for the provision of heath care services; provided, that "provider organization" shall include, but not be limited to, physician organizations, physician-hospital organizations, independent practice associations, accountable care organizations, provider networks and any other organization that contracts with carriers for payment for health care services.

"Specialty hospital," an acute hospital which qualifies for an exemption from the Medicare prospective payment system regulations or any acute hospital which limits its admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to children or patients under obstetrical care.

"Total health care expenditures," the annual per capita sum of all health care expenditures in the commonwealth, including spending for private payer and governmental payer including but not limited to Medicaid, Medicare, and self pay, so called, for the Massachusetts patient population incurred for all categories of medical expenses including without limitation, premiums, allowed claims paid to providers, non-claims related payments to providers, including, but not limited to special payments, supplemental payments, pharmaceutical costs, medical device costs, long term care costs, labor costs, carrier administrative costs."

Section 2. (a) There shall be a body politic and corporate and a public instrumentality to be known as the commonwealth health care quality and finance authority, which shall be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the commonwealth except as specifically provided in any general or special law. The exercise by the authority of the powers conferred by this chapter shall be considered to be the performance of an essential public function. The purpose of the authority shall be to set health care cost containment goals for the commonwealth and to foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care.

(b) There shall be a board, with duties and powers established by this chapter, that shall govern the authority. The authority's board shall consist of 11 members: the secretary of administration and finance, ex officio; the secretary of health and human services, ex officio; the secretary of housing and economic development, ex officio; 1 other member appointed by the governor whom shall be an expert in health care delivery and payment models; 3 members appointed by the attorney general, 1 of whom shall be a health economist, 1 of whom shall represent the interests of businesses and 1 of whom shall have experience in the administration of a health care provider organization; 3 members

appointed by the state auditor, 1 of whom shall be an expert in behavioral health services and behavioral health reimbursement systems, 1 of whom shall be a representative of a health consumer organization and 1 of whom shall be a representative of organized labor. The governor, attorney general and the auditor shall, by majority vote, jointly appoint 1 member who is an expert in health care finance and policy in the commonwealth, to act as the chair. All members shall serve a term of 3 years, but a member appointed to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall be eligible for reappointment. The board shall annually elect 1 of its members to serve as the vice-chairperson. Each member of the board serving ex officio may appoint a designee under section 6A of chapter 30.

(c) A member of the board shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, have a financial stake in or otherwise be a representative of a health care entity while serving on the board.

(d) Six members of the board shall constitute a quorum and the affirmative vote of 6 members of the board shall be necessary and sufficient for any action taken by the board. No vacancy in the membership of the board shall impair the right of a quorum to exercise all the rights and duties of the connector. Members shall serve without pay but shall be reimbursed for actual expenses necessarily incurred in the performance of their duties. The chairperson of the board shall report to the governor and to the general court not less frequently than annually.

(e) Any action of the authority may take effect immediately and need not be published or posted unless otherwise provided by law. Meetings of the board shall be subject to section 11A of chapter 30A; but, said section 11A shall not apply to any meeting of members of the board serving ex officio in the exercise of their duties as officers of the commonwealth if no matters relating to the official business of the authority are discussed and decided at the meeting. The authority shall be subject to all other provisions of said chapter 30A and records pertaining to the administration of the authority shall be subject to section 42 of chapter 30 and section 10 of chapter 66. All moneys of the authority shall be considered to be public funds for purposes of chapter 12A. The operations of the authority shall be subject to chapter 268A and chapter 268B.

(f) The chairperson shall hire an executive director to supervise the administrative affairs and general management and operations of the authority and also serve as secretary of the authority, ex officio. The executive director shall receive a salary commensurate with the duties of the office. The executive director may appoint other officers and employees of the authority necessary to the functioning of the authority. Sections 9A, 45, 46 and 46C of chapter 30, chapter 31 and chapter 150E shall not apply to the executive director or any other employees of the authority. The executive director shall, with the approval of the board:

(i) plan, direct, coordinate and execute administrative functions in conformity with the policies and directives of the board;

(ii) employ professional and clerical staff as necessary;

(iii) report to the board on all operations under the executive director's control and supervision;

(iv) prepare an annual budget and manage the administrative expenses of the authority; and

(v) undertake any other activities necessary to implement the powers and duties under this chapter.

Section 3. The board of the authority shall set health care cost containment goals for the commonwealth and foster the innovation of health care delivery and payment models that lower health care cost growth while improving the quality of patient care. The board shall have all powers necessary or convenient to carry out and effectuate its purposes including, but not limited to, the power to:

(a) to develop a plan of operation for the authority, which shall include, but not be limited to:

(1) establishing procedures for operations of the authority;

(2) establishing procedures for communications with the executive director;

(3) establishing procedures for setting an annual health care cost growth benchmark;

(4) holding annual hearings concerning the growth in total health care expenditures relative to the health care cost benchmark, including an examination of health care provider, provider organization and payer costs, prices and health status adjusted total medical expense trends;

(5) providing an annual report on recommendations for strategies to meet future annual health care cost growth benchmarks and to promote an efficient health delivery system;

(6) establishing procedures that, in the event the annual health care cost growth benchmark is exceeded, require certain health care entities to file a performance improvement plan and the procedures for approving said plan;

(7) establishing procedures for monitoring compliance and implementation by a health care entity of a performance improvement plan, including standards to ascertain whether a health care entity has failed to implement a performance improvement plan in good faith;

(8) establishing procedures and developing criteria for the certification of certain provider organizations as Beacon ACOs, based on standards related to cost containment, quality improvement and patient protections;

(9) establishing procedures to decertify certain provider organizations as Beacon ACOs;

(10) developing best practices and standards for alternative payment methodologies to be adopted by the office of Medicaid, the group insurance commission and other state-funded health insurance programs;

(11) fostering health care innovation by identifying, developing, supporting and evaluating health care delivery and payment reform models and best practices, in consultation with health care entities, that reduce health care cost growth while improving the quality of patient care; and

(12) administering the Healthcare Payment Reform Fund, established under section 100 of chapter 194 of the acts of 2011, to support the activities of the authority;

(b) to adopt by-laws for the regulation of its affairs and the conduct of its business;

(c) to adopt an official seal and alter the same;

(d) to maintain an office at such place or places in the commonwealth as it may designate;

(e) to sue and be sued in its own name, plead and be impleaded;

(f) to establish lines of credit, and establish 1 or more cash and investment accounts to receive payments for services rendered, appropriations from the commonwealth and for all other business activity granted by this chapter except to the extent otherwise limited by any applicable provision of the Employee Retirement Income Security Act of 1974;

(g) to approve the use of its trademarks, brand names, seals, logos and similar instruments by participating carriers, employers or organizations; and

(h) to enter into interdepartmental agreements with the institute of health care finance and policy, the executive office of health and human services, the division of insurance and any other state agencies the board considers necessary.

Section 4. There shall be an advisory board to the authority. The advisory board shall advise on the overall operation and policy of the authority. The advisory board shall consist of 7 ex-officio members, including the state auditor, the inspector general, the attorney general, the commissioner of insurance, the executive director of the institute of health care finance and policy, the commissioner of public health and the executive

director of the group insurance commission, or their designees; and 11 additional members to be appointed by the governor, 1 of whom shall be a representative of a health care quality improvement organization recognized by the federal Centers for Medicare and Medicaid Services, 1 of whom shall be a representative of the Institute for Healthcare Improvement recommended by the organization's board of directors, 1 of whom shall be a representative of the Massachusetts chapter of the National Association of Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts Association of Health Underwriters, Inc., 1 of whom shall be a representative of the Massachusetts Medicaid Policy Institute, Inc., 1 of whom shall be a expert in health care policy from a foundation or academic institution, 1 of whom shall be a representative of a non-governmental purchaser of health insurance, 1 of whom shall be an organization representing the interests of small businesses with fewer than 50 employees, 1 of whom shall be an organization representing the interests of large businesses with 50 or more employees, 1 of whom shall be a physician licensed to practice in the commonwealth and 1 of whom shall be a non-physician health care professional licensed to practice in the commonwealth.

Section 5. (a) Not later than April 15 of every year, the board shall establish a health care cost growth benchmark for the average growth in total health care expenditures in the commonwealth for the next calendar year. The authority shall establish procedures to prominently publish the annual health care cost growth benchmark on the authority’s website.

(b) For calendar years 2012-2015, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29, plus 0.5%.

(c) For calendar years 2016-2022, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29.

(c) For calendar years 2027 and thereafter, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29, plus 1%.

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

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

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

(d) Witnesses shall provide testimony under oath and subject to examination and cross examination by the board, the executive director of the institute and the attorney general at the public hearing in a manner and form to be determined by the board, including without limitation: (i) in the case of providers and provider organizations, testimony concerning payment systems, care delivery models, payer mix, cost structures, administrative and labor costs, capital and technology cost, adequacy of public payer reimbursement levels, reserve levels, utilization trends, relative price, quality improvement and care-coordination strategies, investments in health information technology, the relation of private payer reimbursement levels to public payer reimbursements for similar services, efforts to improve the efficiency of the delivery system and efforts to reduce the inappropriate or duplicative use of technology; and (ii) in the case of private and public payers, testimony concerning factors underlying premium cost and rate increases, the relation of reserves to premium costs, the payer's efforts to develop benefit design, network design and payment policies that enhance product affordability and encourage efficient use of health resources and technology including utilization of alternative payment methodologies, efforts by the payer to increase consumer access to health care information, efforts by the payer to reduce price variance between providers, efforts by the payer to promote the standardization of administrative practices and any other matters as determined by the board.

(e) In the event that the institute's annual report under section 15 of chapter 12C finds that the percentage change in total health care expenditures exceeded the health care cost benchmark in the previous calendar year, the authority may identify additional witnesses for the public hearing. Witnesses shall provide testimony subject to examination and cross examination by the board, the executive director of the institute and attorney general at the public hearing in a manner and form to be determined by the board, including without limitation: (i) testimony concerning unanticipated events that may have impacted the total health care cost expenditures, including, but not limited to, a public health crisis such as an outbreak of a disease, a public safety event or a natural disaster; (ii) testimony concerning trends in patient acuity, complexity or utilization of services; (iii) testimony concerning trends in input cost structures, including, but not limited to, the introduction of new pharmaceuticals, medical devices and other health technologies or changes in price of such items; (iv) testimony concerning the cost of providing certain specialty services, including but not limited to, the provision of health care to children, the provision of cancer-related health care and the provision of medical education; (v) testimony related to unanticipated administrative costs for carriers, including, but not limited to, costs related to information technology, administrative simplification efforts, labor costs and transparency efforts; (vi) testimony related to costs due the implementation of state or federal legislation or government regulation; and (vii) any other factors that may have led to excessive health care cost growth.

(f) The authority shall compile an annual report concerning spending trends and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system. The report shall be based on the authority's analysis of information provided at the hearings by providers, provider organizations and insurers, data collected by the institutes under sections 9, 10 and11 of chapter 12C, and any other information the authority considers necessary to fulfill its duties under this section, as further defined in regulations promulgated by the authority. The report shall address, among other things, cost drivers within health care facilities including but not limited to the cost of labor, capital, pharmaceuticals, and supplies, cost drivers within carriers including but not limited to administrative expenses, the cost of outpatient drugs, post acute care, and other costs that materially impact private sector premiums and public, government healthcare expenditures. The report shall be submitted to the chairs of the house and senate committees on ways and means, the chairs of the joint committee on health care financing and shall be published and available to the public not later than December 31 of each year. The report shall include any legislative language necessary to implement the recommendations.

Section 7. (a) If the percentage change in total health care expenditures exceeded the health care cost benchmark in the previous calendar year, then the authority shall provide public notice to all health care entities: (1) whose increase in health status adjusted total

medical expense is materially in excess of the applicable economic growth rate factor as set in accordance with section 5 of this chapter and (2) whose health status adjusted total medical expense is at a minimum one standard deviation above the statewide median. Such notice shall state that the health care entity has been identified as having an excessive increase in health status adjusted total medical expense. The authority shall post a list of all entities receiving such an notice on its web site.

(b) For calendar year 2015, in the event that the institute's annual report under section 15 of chapter 12C finds that average percentage change in cumulative total health care expenditures from 2012 to 2014 exceeded the average health care cost benchmark from 2012 to 2014, and in order to support the state's efforts to meet future health care cost growth benchmarks, as established in section 5, the authority shall establish procedures to assist health care entities to improve efficiency and reduce cost growth through the requirement of certain health care entities to file and implement a performance improvement plan.

Beginning in calendar year 2016, in the event that the institute's annual report under said section 15 of said chapter 12C finds that percentage change in total health care expenditures exceeded the health care cost benchmark in the previous calendar year, and in order to support the state's efforts to meet future health care cost growth benchmarks, as established in said section 5, the authority shall establish procedures to assist health care entities to improve efficiency and reduce the cost growth through the requirement of certain health care entities to file and implement a performance improvement plan.

(c) In addition to the confidential notice provided under subsection (a), the authority shall provide confidential notice to each such health care entity that it will be required to file a performance improvement plan. Within 45 days of receiving this notice from the authority, the health care entity shall either:

(1) file a confidential performance improvement plan with the authority; or

(2) file a confidential application with the authority to waive or extend the requirement to file a performance improvement plan. The health care entity may file any documentation or supporting evidence with the authority to support the health care entity's application to waive or extend the requirement to file a performance improvement plan. The authority shall require the health care entity to submit any other relevant information it deems necessary in considering the waiver or extension application.

All information submitted shall remain confidential and exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 and chapter 66.

(d) The authority may waive or delay the requirement for a health care entity to file a performance improvement plan in response to a waiver or extension request filed under paragraph (2) of subsection (c) based on a consideration of the following factors, in light of all information received from the health care entity:

(1) the costs, price and utilization trends of the health care entity over time, and any demonstrated improvement to reduce health status adjusted total medical expenses;

(2) any ongoing strategies or investments that the health care entity is implementing to improve future long-term efficiency and reduce cost growth, including certification as a Beacon ACO;

(3) whether the factors that led to increased costs for the health care entity can reasonably be considered to be outside of the control of the entity or unanticipated;

(4) the overall financial condition of the health care entity;

(5) the proportionate impact of the health care entity's costs on the growth of total health care medical expenses statewide;

(6) a significant deviation between the projected economic growth benchmark and the actual economic growth benchmark, as established under section 7H½ of chapter 29; and

(7) any other factors the authority considers relevant, including any information or testimony collected by the authority under the subsection (e) of section 6. The authority shall maintain records documenting all waivers and extensions granted by the authority and shall grant waivers and extensions on an equitable basis, such that similarly situated health care entities are treated on the same terms.

If the authority declines to waive or extend the requirement for the health care entity to file a performance improvement plan, the authority shall provide confidential notice to the health care entity that its application for a waiver or extension was denied and the health care entity shall file a performance improvement plan within 45 days.

(e) A health care entity shall file a performance improvement plan: (i) within 45 days of receipt of a notice under subsection (c); (ii) if the health care entity has requested a waiver or extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or (iii) if the health care entity is granted an extension, on the date given on such extension. The performance improvement plan shall be generated by the health care entity and shall identify the causes of the entity's cost growth and shall include, but not be limited to, specific strategies, adjustments and action steps the entity proposes to implement to improve cost performance, as measured by health status adjusted total medical expenses. The proposed performance improvement plan shall include specific

identified and measurable expected outcomes and a timetable for implementation. The timetable for a performance improvement plan shall not exceed 18 months.

(f) The authority shall approve any performance improvement plan that it determines is reasonably likely to address the underlying cause of the entity's cost growth and has a reasonable expectation for successful implementation.

(g) If the board determines that the performance improvement plan is unacceptable or incomplete, the authority may provide consultation on the criteria that have not been met and may allow an additional time period, up to 30 calendar days, for resubmission; provided however, that all aspects of the performance improvement plan shall be proposed by the health care entity and the authority shall not require specific elements for approval. In filing a performance improvement plan, a health care entity may document cost saving or efficiency initiatives that cannot be implemented within an 18 month period due to regulatory requirements, collective bargaining agreements, the need for capital investments or other factors.

(h) Upon approval of the proposed performance improvement plan, the authority shall notify the health care entity to begin immediate implementation of the performance improvement plan. Public notice shall be provided by the authority on its website identifying that the health care entity is implementing a performance improvement plan; provided however, that the performance improvement plan itself shall remain confidential. All health care entities implementing an approved performance improvement plan shall be subject to additional confidential reporting requirements, as determined by the authority. The authority shall provide assistance to the health care entity in the successful implementation of the performance improvement plan. If a performance improvement plan requires regulatory or other governmental approvals for implementation, the authority shall provide favorable recommendations to the relevant regulatory authority in support of such plan.

(i) All health care entities shall, in good faith, work to implement the performance improvement plan. At any point during the implementation of the performance improvement plan the health care entity may file amendments to the performance improvement plan, subject to approval of the authority.

(j) At the conclusion of the timetable established in the performance improvement plan, the health care entity shall report to the authority regarding the outcome of the performance improvement plan. If the performance improvement plan was found to be unsuccessful, the authority shall either: (i) extend the implementation timetable of the existing performance improvement plan; (ii) approve amendments to the performance improvement plan as proposed by the health care entity; (iii) require the health care entity

to submit a new performance improvement plan under subsection (e); or (iv) waive or delay the requirement to file any additional performance improvement plans.

(k) Upon the successful completion of the performance improvement plan, or a decision by the board to waive or delay the requirement to file a new performance improvement plan, the identity of the health care entity shall be removed from the authority's website.

(l) If the authority determines that a health care entity has: (i) willfully neglected to file a performance improvement plan with the authority within 45 days as required under subsection (e); (ii) failed to file an acceptable performance improvement plan in good faith with the authority; (iii) failed to implement the performance improvement plan in good faith; or (iv) knowingly failed to provide information required by this section to the authority or that knowingly falsifies the same, the authority may assess a civil penalty to the health care entity of not more than $500,000. The authority shall seek to promote compliance with this section and shall only impose a civil penalty as a last resort.

(m) The authority may submit a recommendation of proposed legislation to the joint committee on health care financing if the authority believes that further legislative authority is needed to assist health care entities to implement successful performance improvement plans or to ensure compliance under this section.

(n) The authority shall promulgate regulations as necessary to implement this section; provided however, that notice of any proposed regulations shall be filed with the joint committee on state administration and the joint committee on health care financing at least 180 days before adoption.

Section 8. (a) The authority, in consultation with the advisory board, shall develop standards and a common application form for certain provider organizations to be voluntarily certified as Beacon ACOs. The purpose of the Beacon ACO certification process shall be to encourage the adoption of certain best practices by provider organizations in the commonwealth related to cost containment, quality improvement and patient protection. Provider organizations seeking this certification shall apply directly to the authority and shall submit all necessary documentation as required by the authority. The Beacon ACO certification shall be assigned to all provider organizations that meet the standards developed by the board.

(b) In developing standards for Beacon ACO certification, the authority shall include a review of the best practices employed by health care entities in the commonwealth, and at a minimum, all applicable requirements developed by the Centers for Medicare & Medicaid Services under the Pioneer ACO model, including, but not limited to, requirements that all Beacon ACOs shall: (i) commit to entering alternative payment methodology contracts with other purchasers such that the majority of the Beacon ACO's total revenues will be derived from such arrangements; (ii) be a legal entity with its own

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

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

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

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

(3) to ensure patient access to health care services across the care continuum, including, but not limited to, access to: preventive and primary care services; emergency services; hospitalization services; ambulatory patient services; mental health and behavioral health services; access to specialty care units, including, but are not limited to, burn, coronary care, cancer care, neonatal care, post-obstetric and post operative recovery care, pulmonary care, renal dialysis and surgical, including trauma and intensive care units; pediatric services; diagnostic imaging and screening services; maternity and newborn care services; radiation therapy and treatment services; skilled nursing facilities; family planning services; home health services; treatment and prevention services for alcohol and other drug abuse; breakthrough technologies and treatments; and allied health services including, but not limited to, advance practice nurses, optometric care, direct access to chiropractic services, occupational therapists, dental care, physical therapy and midwifery services;

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

(5) to improve access to health care services and quality of care for vulnerable populations including, but not limited to, children, the elderly, low-income individuals, individuals with disabilities, individuals with chronic illnesses and racial and ethnic minorities.

(6) to promote the integration of mental health and behavioral health services with primary care services including, but not limited to, the establishment of a behavioral health medical home;

(7) to promote patient-centeredness by, including, but not limited to, establishing mechanisms to conduct patient outreach and education on the necessity and benefits of care coordination; demonstrating an ability to engage patients in shared decision making taking into account patient preferences; demonstrating an ability to effectively involve patients in care transitions to improve the continuity and quality of care across settings, with case manager follow up; demonstrating an ability to engage and activate patients at home, through methods such as home visits or telemedicine, to improve self-management; and establishing mechanisms to evaluate patient satisfaction with the access and quality of their care;

(8) to adopt certain health information technology and data analysis functions, including, but not limited to, population-based management tools and functions; the ability to aggregate and analyze clinical data; the ability to electronically exchange patient summary records across providers who are members of the Beacon ACO and other providers in the community to ensure continuity of care; the ability to provide access to multi-payer claims data and performance reports and the ability to share performance feedback on a timely basis with participating providers; and the ability to enable the beneficiary access to electronic health information;

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

(10) to promote community-based wellness programs and community health workers, consistent with efforts funded by the department of public health through the Prevention and Wellness Trust Fund established in section 2G of chapter 111;

(11) to promote worker training programs and skills training opportunities for employees of the provider organization, consistent with efforts funded by the secretary of labor and workforce development through the Health Care Workforce Transformation Trust Fund;

(12) to adopt certain governance structure standards;

(13) to adopt certain financial capacity standards, including certification under subsection (e) of section 10 of chapter 12C, to protect Beacon ACOs from assuming excess risk;

(14) to demonstrate the administrative, clinical, and financial capability to meet the primary and secondary care needs of a defined population of patients, consisting of no less than 50,000 covered lives; and

(15) any other requirements the board considers necessary.

(d) The authority shall update the standards for certification as a Beacon ACO at least every 2 years, or at such other times as the authority determines necessary. In developing the standards, the authority shall seek to allow for provider organizations of different compositions, including, but not limited to, physician group entities and independent physician organizations, to successfully apply for certification.

(e) Provider organizations that wish to maintain certification shall renew their certification as a Beacon ACO every two years. Failure to meet the requirements represented in the certification may result in decertification, as determined by the board.

Section 9. (a) The authority, in consultation with the advisory board, shall develop best practices and standards for alternative payment methodologies for use by the group insurance commission, the office of Medicaid and any other state funded insurance program. Any alternative payment methodology shall: (1) support the state's efforts to meet the health care cost benchmark established in section 5; (2) include incentives for higher quality care; (3) include a risk adjustment element based on health status; and (4) to the extent possible, include a risk adjustment element that takes into account functional status, socioeconomic status or cultural factors. The authority shall also consider methodologies to account for the following costs: (i) medical education; (ii) stand-by services and emergency services, including, but not limited to, trauma units and burn units; (iii) services provided by disproportionate share hospitals or other providers serving underserved populations; (iv) services provided to children; (v) care coordination and community based services provided by allied health professionals; (vi) the greater integration of behavioral and mental health; and (viii) the use and the continued advancement of new medical technologies, treatments, diagnostics or pharmacology products that offer substantial clinical improvements and represent a higher cost than the use of current therapies.

Any best practices and standards developed under this section shall be shared with all private health plans for their voluntary adoption.

Section 10. (a) The authority, in consultation with the advisory board, shall administer the Healthcare Payment Reform Fund, established under section 100 of chapter 194 of

the acts of 2011. The fund shall be used for the following purposes: (1) to support the activities of the authority; and (2) to foster innovation in payment and health care service delivery.

(b) The authority shall establish a competitive process for health care entities to develop, implement, or evaluate promising models in payment and health care service delivery. Assistance from the authority may take the form of incentives, grants, technical assistance, evaluation assistance or partnerships, as determined by the authority.

(c) Prior to making a request for proposals under subsection (b), the authority shall solicit ideas for payment changes and health care delivery service reforms directly from providers, provider organizations, carriers, research institutions, health professionals, public institutions of higher education, community-based organizations and private-public partnerships, or any combination thereof. The authority shall review payment and service delivery models so submitted and shall seek input from other relevant stakeholders in evaluating their potential.

(d) All approved activities funded through the Healthcare Payment Reform Fund shall support the commonwealth's efforts to meet the health care cost growth benchmark established under section 5, and shall include measurable outcomes in both cost reduction and quality improvement.

(e) To the maximum extent feasible, the authority shall seek to coordinate expenditures from the Healthcare Payment Reform Fund with other public expenditures from the Prevention and Wellness Trust Fund, the e-Health Institute Trust Fund, the Health Care Workforce Transformation Trust Fund, the executive office of health and human services and any funding available through the Medicare program and the CMS Innovation Center, established under the federal Patient Protection and Affordable Care Act.

(f) Activities funded through the Healthcare Payment Reform Fund which demonstrates measurable success in improving care or reducing costs shall be shared with other providers, provider organizations and payers as model programs which may be voluntarily adopted by such other health care entities. The authority may also incorporate any successful models and practices into its standards for the Beacon ACO certification under section 8 and for alternative payment methodologies established for state-funded programs under section 9.

(g) The authority shall, annually on or before January 31, report on expenditures from the Healthcare Payment Reform Fund. The report shall include, but not be limited to: (i) the revenue credited to the fund; (ii) the amount of fund expenditures attributable to the administrative costs of the authority; (iii) an itemized list of the funds expended through the competitive process and a description of the grantee activities; and (iv) the results of the evaluation of the effectiveness of the activities funded through grants. The report

shall be provided to the chairs of the house and senate committees on ways and means and the joint committee on health care financing and shall be posted on the authority's website.

Section 11. (a) All expenses incurred in carrying out this chapter shall be payable solely from funds provided under the authority of this chapter and no liability or obligations shall be incurred by the authority under this chapter beyond the extent to which monies shall have been provided under this chapter.

(b) The authority shall be liable on all claims made as a result of the activities, whether ministerial or discretionary, of any member, officer or employee of the authority acting as such, except for willful dishonesty or intentional violation of the law, in the same manner and to the same extent as a private person under like circumstances; provided, however, that the authority shall not be liable to levy or execution on any real or personal property to satisfy judgment, for interest prior to judgment, for punitive damages or for any amount in excess of $100,000.

(c) No person shall be liable to the commonwealth, to the authority or to any other person as a result of the person's activities, whether ministerial or discretionary, as a member, officer or employee of the authority except for willful dishonesty or intentional violation of the law; provided, however, that such person shall provide reasonable cooperation to the authority in the defense of any claim. Failure of such person to provide reasonable cooperation shall cause such person to be jointly liable with the authority, to the extent that such failure prejudiced the defense of the action.

(d) The authority may indemnify or reimburse any person, or a person's personal representative, for losses or expenses, including legal fees and costs, arising from any claim, action, proceeding, award, compromise, settlement or judgment resulting from such person's activities, whether ministerial or discretionary, as a member, officer or employee of the authority; provided, that the defense of settlement thereof shall have been made by counsel approved by the authority. The authority may procure insurance for itself and for its members, officers and employees against liabilities, losses and expenses which may be incurred by virtue of this section or otherwise.

(e) No civil action under this chapter shall be brought more than 3 years after the date upon which the cause thereof accrued.

(f) Upon dissolution, liquidation or other termination of the authority, all rights and properties of the authority shall pass to and be vested in the commonwealth, subject to the rights of lien holders and other creditors. In addition, any net earnings of the authority, beyond that necessary for retirement of any indebtedness or to implement the public purpose or purposes or program of the commonwealth, shall not inure to the benefit of any person other than the commonwealth.

Section 12. The authority shall keep an accurate account of all its activities and of all its receipts and expenditures and shall annually make a report thereof as of the end of its fiscal year to its board, to the governor, to the general court and to the state auditor, such reports to be in a form prescribed by the board, with the written approval of the auditor. The board or the auditor may investigate the affairs of the authority, may severally examine the properties and records of the authority and may prescribe methods of accounting and the rendering of periodical reports in relation to projects undertaken by the authority. The authority shall be subject to biennial audit by the state auditor.

Section 13. The authority may adopt regulations to implement this chapter.”