

SENATE No. 2190

Senate, October 26, 2017 -- Pursuant to a special order, the Special Senate Committee on Health Care Cost Containment and Reform reports the following committee bill (Senate, No. 2190).

The Commonwealth of Massachusetts

**In the One Hundred and Ninetieth General Court
(2017-2018)**

An Act furthering health empowerment and affordability by leveraging transformative health care..

Whereas, The deferred operation of this act would tend to defeat its purpose, which is to further health empowerment and affordability while leveraging transformative health care, therefore, it is hereby declared to be an emergency law, necessary for the immediate preservation of the public health.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 SECTION 1. Section 16T of chapter 6A of the General Laws, as appearing in the 2016
2 Official Edition, is hereby amended by adding the following subsection:-

3 (g)(1)The health planning council shall, subject to appropriation, assemble 5 regional
4 health policy councils in geographically diverse areas. Each regional council shall have not more
5 than 15 members. The members shall reflect a broad distribution of diverse perspectives on the
6 health care system including, but not limited to, health care providers and provider organizations,
7 including community health centers, organizations with expertise in health care workforce
8 development, accountable care organizations, third-party payers, both public and private, local
9 governments and schools and institutions in the communities in a council’s region.

10 (2) Each regional council shall: (i) identify innovations and best practices in health care
11 within the region; (ii) identify interventions that improve population health at the regional or
12 community level, including social determinants that impact health outcomes; (iii) identify
13 shortages of health care resources in the region; and (iii) facilitate implementation of
14 innovations, best practices and interventions throughout the region.

15 (3) Regional councils shall report annually to the health planning council on
16 interventions, best practices and innovations that have been identified and provide information
17 about steps that have been taken towards broader implementation throughout the region not later
18 than August 1.

19 (4) The health planning council shall annually produce a summary report of the reports
20 produced by the regional councils under paragraph (3) not later than November 1. The report
21 shall be made available on the council's public website and filed with the clerks of the senate and
22 house of representatives, the senate and house committees on ways and means and the joint
23 committee on health care financing.

24 SECTION 2. Said chapter 6A is hereby further amended by inserting after section 16Z
25 the following section:-

26 Section 16AA. (a) There shall be a task force to make recommendations on aligned
27 measures of health care provider quality and health system performance to ensure consistency in
28 the use of quality measures in contracts between payers, including the commonwealth and
29 carriers, and health care providers in the commonwealth, ensure consistency in methods for
30 evaluating providers for tiered network products, reduce administrative burden, improve

31 transparency for consumers, improve health system monitoring and oversight by relevant state
32 agencies and improve quality of care.

33 The task force shall be convened by the commissioner of public health and the executive
34 director of the health policy commission, who shall serve as co-chairs, and shall include the
35 following members or their designees: the executive director of the center for health information
36 and analysis; the executive director of the group insurance commission; the assistant secretary
37 for MassHealth; the commissioner of insurance; and the following members who shall be
38 appointed by the governor, 1 of whom shall represent the Massachusetts Health and Hospital
39 Association, Inc., 1 of whom shall represent the Massachusetts Medical Society, 1 of whom shall
40 be a behavioral health provider, 1 of whom shall be a long term supports and services provider, 1
41 of whom shall represent Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall
42 represent the Massachusetts Association of Health Plans, Inc., 1 of whom shall represent
43 individuals with disabilities, 1 of whom shall represent consumers and 1 of whom shall be an
44 expert in establishing health system performance measures. Members appointed to the task force
45 shall have experience with and expertise in health care quality measurement.

46 The task force shall be convened annually not later than January 15 and the task force
47 shall submit a report with its recommendations, including any changes or updates to aligned
48 measures of health care provider quality and health system performance, to the secretary of
49 health and human services and the joint committee on health care financing annually not later
50 than May 1.

51 The task force shall make recommendations on aligned quality measures for use in: (i)
52 contracts between payers, including the commonwealth and carriers, and health care providers,

53 provider organizations and accountable care organizations, which incorporate quality measures
54 into payment terms, including the designation of a set of core measures and a set of non-core
55 measures; (ii) assigning tiers to health care providers in the design of any health plan; (iii)
56 consumer transparency websites and other methods of providing consumer information; and (iv)
57 monitoring system-wide performance.

58 In developing its recommendations, the task force shall consider nationally recognized
59 quality measures including, but not limited to, measures used by the Centers for Medicare
60 Medicaid Services, the group insurance commission, carriers and providers and provider
61 organizations in the commonwealth and other states, as well as other valid measures of health
62 care provider performance, outcomes, including patient-reported outcomes and functional status,
63 patient experience, disparities and population health. The task force shall consider measures
64 applicable to primary care providers, specialists, hospitals, provider organizations, accountable
65 care organizations and other types of providers and measures applicable to different patient
66 populations.

67 (b) Annually, not later than July 1, the secretary of health and human services shall
68 establish an aligned measure set to be used by the commonwealth and carriers in contracts with
69 health care providers that incorporate quality measures into the payment terms pursuant to
70 section 28 of chapter 32A, section 81 of chapter 118E, section 108N of chapter 175, section 40
71 of chapter 176A, section 26 of chapter 176B, section 35 of chapter 176G, section 14 of chapter
72 176I and for assigning tiers to health care providers in tiered network plans pursuant to section
73 11 of chapter 176J. The aligned measure set shall designate: (i) core measures that shall be used
74 in contracts between payers, including the commonwealth and carriers, and health care
75 providers, including provider organizations and accountable care organizations, that incorporate

76 quality measures into payment terms; and (ii) non-core measures that may be used in such
77 contracts.

78 SECTION 3. Section 1 of chapter 6D of the General Laws, as appearing in the 2016
79 Official Edition, is hereby amended by inserting after the definition of “Performance penalty” the
80 following 2 definitions:-

81 “Pharmaceutical manufacturing company”, an entity engaged in the production,
82 preparation, propagation, conversion or processing of prescription drugs, directly or indirectly,
83 by extraction from substances of natural origin or independently by means of chemical synthesis
84 or by a combination of extraction and chemical synthesis or an entity engaged in the packaging,
85 repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that
86 "Pharmaceutical manufacturing company" shall not include a wholesale drug distributor licensed
87 under section 36B of chapter 112 or a retail pharmacist registered under section 39 of said
88 chapter 112.

89 “Pharmacy benefit manager”, a person or entity that administers: (i) a prescription drug,
90 prescription device or pharmacist services; or (ii) a prescription drug and device and pharmacist
91 services portion of a health benefit plan on behalf of a plan sponsor including, but not limited to,
92 self-insured employers, insurance companies and labor unions; provided, however, that
93 “Pharmacy benefit manager” shall include a health benefit plan that does not contract with a
94 pharmacy benefit manager and administers its own: (a) prescription drug, prescription device or
95 pharmacist services; or (b) prescription drug and device and pharmacist services portion, unless
96 specifically exempted by the center.

97 SECTION 4. Said section 1 of said chapter 6D, as so appearing, is hereby further
98 amended by inserting after the definition of “Physician” the following definition:-

99 “Pipeline drugs”, prescription drug products containing a new molecular entity for which
100 the sponsor has submitted a new drug application or biologics license application and received an
101 action date from the federal Food and Drug Administration.

102 SECTION 5. Said section 1 of said chapter 6D, as so appearing, is hereby further
103 amended by striking out the definition of “Quality measures” and inserting in place thereof the
104 following 4 definitions:-

105 “Quality measures”, aligned quality measures established pursuant to section 16AA of
106 chapter 6A.

107 “Rate of readmissions”, 30-day, all cause, all payer readmission measure, as determined
108 by the center.

109 “Readmissions performance improvement plan”, a plan submitted to the commission by a
110 provider organization under section 10A.

111 “Readmissions reduction benchmark”, the projected annual percentage change in the
112 statewide rate of readmissions as measured by the center pursuant to section 10A.

113 SECTION 6. Section 2A of said chapter 6D, as so appearing, is hereby amended by
114 inserting after the figure “10”, in lines 5 and 9, each time it appears, the following figure:- , 10A.

115 SECTION 7. Section 6 of said chapter 6D, as so appearing, is hereby amended by adding
116 the following paragraph:-

117 If the analysis of spending trends with respect to the pharmaceutical or biopharmaceutical
118 products increases the expenses of the commission, the estimated increases in the commission’s
119 expenses shall be assessed fully to pharmaceutical manufacturing companies and pharmacy
120 benefit managers in the same manner as the assessment under section 68 of chapter 118E. A
121 pharmacy benefit manager that is a surcharge payor subject to the preceding paragraph and
122 administers its own prescription drug, prescription device or pharmacist services or prescription
123 drug and device and pharmacist services portion shall not be subject to additional assessment
124 under this paragraph.

125 SECTION 8. Section 7 of said chapter 6D, as so appearing, is hereby amended by
126 striking out, in lines 5 and 6, the words “and (2) to foster innovation in health care payment and
127 service delivery” and inserting in place thereof the following words:- (2) to foster innovation in
128 health care payment and delivery; and (3) to foster innovation in reducing readmissions,
129 including in addressing social determinants of health and improving behavioral health
130 integration.

131 SECTION 9. Said section 7 of said chapter 6D, as so appearing, is hereby further
132 amended by inserting after the word “organizations”, in line 17, the following words:- , health
133 care trailblazers.

134 SECTION 10. Section 8 of said chapter 6D, as so appearing, is hereby amended by
135 striking out, in line 32, the words “ and (xi) ” and inserting in place thereof the following words:-
136 (xi) not less than 3 representatives of the pharmaceutical industry; (xii) at least 1 pharmacy
137 benefit manager; and (xiii).

138 SECTION 11. Said section 8 of said chapter 6D, as so appearing, is hereby further
139 amended by striking out the word “that”, in line 92, and inserting in place thereof the following
140 words:- , including a provider organization’s rate of readmissions, that.

141 SECTION 12. Subsection (g) of said section 8 of said chapter 6D, as so appearing, is
142 hereby amended by striking out the second sentence and inserting in place thereof the following
143 sentence:- The report shall be based on the commission's analysis of information provided at the
144 hearings by providers, provider organizations, insurers, pharmaceutical manufacturing
145 companies and pharmacy benefit managers, registration data collected under section 11, data
146 collected or analyzed by the center under sections 8, 9, 10 and 10A of chapter 12C and any other
147 available information that the commission considers necessary to fulfill its duties under this
148 section as defined in regulations promulgated by the commission.

149 SECTION 13. Said chapter 6D is hereby further amended by inserting after section 9 the
150 following section:-

151 Section 9A. (a) The commission shall establish an annual statewide readmissions
152 reduction benchmark. In establishing the benchmark, the commission shall consider: (i) the data
153 collected by the center on hospital and provider organization readmission rates from the 3 most
154 recent years for which the center has data; (ii) the distribution of readmissions volume among
155 provider types; (iii) available evidence on feasible interventions to reduce readmissions rates;
156 and (iv) any other relevant information identified by the commission.

157 (b) Prior to establishing the annual statewide readmissions reduction benchmark pursuant
158 to subsection (a), the commission shall hold a public hearing and hear testimony from payers,
159 providers and other interested parties. The hearing shall examine state and national readmission

160 rates and trends, rates and trends for different provider types, successful care delivery models
161 and interventions to reduce readmission rates, barriers to successful implementation of such
162 models and interventions and other information identified by the commission. Following the
163 hearing, the commission shall provide a report to the clerks of the senate and house of
164 representatives and the joint committee on health care financing that summarizes the testimony
165 received and the data and information reviewed by the commission to establish the benchmark.

166 SECTION 14. Section 10 of said chapter 6D, as appearing in the 2016 Official Edition, is
167 hereby amended by inserting after the figure “\$500,000”, in line 152, the following words:- the
168 first time that a determination is made and not more than \$750,000 for a second or subsequent
169 determination; provided, however, that a civil penalty assessed under 1 of the above clauses shall
170 be a first offense if a previously assessed penalty was assessed pursuant to a different clause. A
171 civil penalty assessed under this subsection shall be deposited into the Health Safety Net Trust
172 Fund established in section 66 of chapter 118E.

173 SECTION 15. Said chapter 6D is hereby further amended by inserting after section 10
174 the following section:-

175 Section 10A. (a) The commission shall, based on the most recent data provided by the
176 center, identify provider organizations that have rates of readmission that are excessive and
177 threaten the ability of the commonwealth to meet the annual readmission benchmark. The
178 commission shall provide notice to all provider organizations that have been so identified. The
179 notice shall state that the commission may require the provider organization to develop and
180 implement a readmissions performance improvement plan.

181 (b) The commission shall review the performance of the provider organizations identified
182 pursuant to subsection (a) and consider: (i) the trends of the provider organization's readmission
183 rates; (ii) the payer mix of the provider organization; (iii) the demographics and health status of
184 the provider organization's patient population; (iv) the status of the provider organization as an
185 accountable care organization or a participant in an accountable care organization; (v) the
186 percentage of the provider organization's revenue and patient population subject to alternative
187 payment arrangements; (vi) the provider organization's ongoing strategies or investments
188 designed to reduce readmissions; and (vii) any other factor that the commission considers
189 relevant.

190 In reviewing the provider organization's performance under this subsection, the
191 commission shall use data from the center and may seek information or documents from the
192 provider organization or payers.

193 (c) If after a review under in subsection (b) the commission identifies significant
194 concerns about a provider organization's readmissions rate and determines that a readmissions
195 performance improvement plan could result in meaningful cost and quality improvement, the
196 commission may require the provider organization to file and implement a readmissions
197 performance improvement plan.

198 (d) The commission shall provide written notice to an identified provider organization
199 that it is required to file a readmissions performance improvement plan. Not later than 45 days
200 after receipt of the notice, the provider organization shall file: (i) a readmissions performance
201 improvement plan with the commission; or (ii) an application with the commission to waive or
202 extend the requirement to file a readmissions performance improvement plan.

203 (e)(1) The provider organization may file any documentation or supporting evidence with
204 the commission to support the provider organization's application to waive or extend the
205 requirement to file a readmissions performance improvement plan pursuant to subsection (d).
206 The commission shall require the provider organization to submit any other relevant information
207 it deems necessary in considering the waiver or extension application.

208 (2) The commission may waive or delay the requirement for a provider organization to
209 file a readmissions performance improvement plan, if requested under subsection (d), in light of
210 all information received from the provider organization, including any new information, based
211 on a consideration of the factors described in subsection (b).

212 (3) If the commission declines to waive or extend the requirement for the provider
213 organization to file a readmissions performance improvement plan, the commission shall provide
214 written notice to the provider organization that its application for a waiver or extension was
215 denied and the provider organization shall file a readmissions performance improvement plan.

216 (f) A provider organization shall file a readmissions performance improvement plan not
217 later than 45 days after receipt of a notice under subsection (b); provided, however, that if the
218 provider organization has requested a waiver or extension, it shall file the plan not later than 45
219 days after receipt of a notice that the waiver or extension was denied or, if the provider
220 organization is granted an extension, on the date given on the extension. The readmissions
221 performance improvement plan shall be generated by the provider organization, identify the
222 causes of the provider organization's excessive readmissions rate and include, but shall not be
223 limited to, specific strategies, adjustments and action steps that the provider organization
224 proposes to implement to improve performance in reducing readmissions which may include

225 coordination with a community health center. The proposed readmissions performance
226 improvement plan shall include specific identifiable and measurable expected outcomes and a
227 timetable for implementation. The timetable for a performance improvement plan shall not
228 exceed 24 months.

229 (g) (1) The commission shall approve any readmissions performance improvement plan
230 that it determines is reasonably likely to address the underlying cause of the provider
231 organization's excessive readmission rates and has a reasonable expectation for successful
232 implementation.

233 (2) If the board determines that the readmissions performance improvement plan
234 approved by the commission is unacceptable or incomplete, the commission may provide
235 consultation on the criteria that have not been met and may allow an additional time period, not
236 more than 30 calendar days, for resubmission; provided, however, that all aspects of the
237 readmissions performance improvement plan shall be proposed by the provider organization and
238 the commission shall not require specific elements for approval.

239 (3) Upon approval of the readmissions proposed performance improvement plan, the
240 commission shall notify the provider organization to begin immediate implementation of the
241 readmissions performance improvement plan. Public notice shall be provided by the commission
242 on its website, identifying that the provider organization is implementing a readmissions
243 performance improvement plan. A provider organization implementing an approved performance
244 improvement plan shall be subject to additional reporting requirements and compliance
245 monitoring, as determined by the commission. The commission shall provide assistance to the
246 provider organization in order to implement the performance improvement plan successfully.

247 (h) A provider organization shall, in good faith, work to implement the readmissions
248 performance improvement plan. At any point during the implementation of the readmissions
249 performance improvement plan, the provider organization may file amendments to the
250 readmissions performance improvement plan, subject to approval of the commission.

251 (i) At the conclusion of the timetable established in the readmissions performance
252 improvement plan, the provider organization shall report to the commission regarding the
253 outcome of the readmissions performance improvement plan. If the commission finds that the
254 readmissions performance improvement plan was unsuccessful, the commission shall: (i) extend
255 the implementation timetable of the existing readmissions performance improvement plan; (ii)
256 approve amendments to the readmissions performance improvement plan as proposed by the
257 provider organization; (iii) require the provider organization to submit a new readmissions
258 performance improvement plan under subsection (f); or (iv) waive or delay the requirement to
259 file any additional readmissions performance improvement plans.

260 (j) Upon the successful completion of the readmissions performance improvement plan,
261 the identity of the provider organization shall be removed from the commission's website.

262 (k) The commission may assess a civil penalty of not more than \$500,000 on a provider
263 organization if the commission determines that the provider organization: (i) willfully neglected
264 to file a readmissions performance improvement plan with the commission as required under
265 subsection (f); (ii) failed to file an acceptable readmissions performance improvement plan in
266 good faith with the commission; (iii) failed to implement the readmissions performance
267 improvement plan in good faith; or (iv) knowingly failed to provide information required under
268 this section to the commission or knowingly falsified such information. A civil penalty assessed

269 under this subsection shall be deposited into the Distressed Hospital Trust Fund established in
270 section 2GGGG of chapter 29.

271 (l) The commission shall promulgate the regulations necessary to implement this section.
272 In developing the regulations, the commission shall consult with experts on regional and national
273 readmissions trends and readmission reduction strategies, the advisory council established
274 pursuant to section 4, payers and providers and provider organizations.

275 SECTION 16. Subsection (a) of section 10A of chapter 6D, as appearing in section 15, is
276 hereby amended by adding the following paragraph:-

277 If the statewide readmission reduction benchmark is not met in any year, in addition to
278 requiring a readmissions performance improvement plan pursuant to subsection (c), the
279 commission may assess a civil penalty on a provider organization identified by the commission.
280 The civil penalty shall be an amount not greater than the total cost attributable to the provider
281 organization's excess readmissions in the most recent year for which data is available and shall
282 be deposited into the Healthcare Payment Reform Fund and administered by the commission
283 pursuant to section 7.

284 SECTION 17. Section 14 of said chapter 6D, as appearing in the 2016 Official Edition, is
285 hereby amended by striking out, in lines 62 and 63, the words "the standard quality measure set
286 established by section 14 of chapter 12C" and inserting in place thereof the following words:- the
287 aligned quality measures recommended by the task force and established by the secretary
288 pursuant to section 16AA of chapter 6A.

289 SECTION 18. Subsection (c) of section 15 of said chapter 6D, as so appearing, is hereby
290 amended by striking out clause (10) and inserting in place thereof the following clause:-

291 (10) to demonstrate excellence in the area of managing chronic disease, care coordination
292 and the right siting of care, as managed by a physician, nurse practitioner, registered nurse,
293 physician assistant, community paramedic or social worker and as evidenced by the success of
294 previous or existing care coordination, pay-for-performance, patient-centered medical home,
295 quality improvement or health outcomes improvement initiatives including, but not limited to, a
296 demonstrated commitment to reducing avoidable hospitalizations, adverse events, rates of
297 institutional post-acute care and unnecessary emergency room visits or extended emergency
298 department boarding.

299 SECTION 19. Said section 15 of said chapter 6D, as so appearing, is hereby further
300 amended by striking out, in line 167, the word “and”.

301 SECTION 20. Subsection (c) of said section 15 of said chapter 6D, as so appearing, is
302 hereby amended by striking out clause (16) and inserting in place thereof the following 2
303 clauses:-

304 (16) to demonstrate evidence-based care delivery programs designed to reduce: (i) 30-day
305 readmission rates; (ii) avoidable emergency department use, including extended emergency
306 department boarding; or (iii) unwarranted institutional post-acute care; provided, however, that a
307 mobile integrated health care program certified under chapter 111O shall satisfy this requirement
308 for the purposes of the commission; and

309 (17) any other goals that the commission considers necessary.

310 SECTION 21. Said chapter 6D is hereby amended by inserting after section 15 the
311 following 2 sections:-

312 Section 15A. (a) The commission may develop, implement and promote an evidence-
313 based outreach and education program to support the therapeutic and cost-effective utilization of
314 prescription drugs for physicians, podiatrists, pharmacists and other health care professionals
315 authorized to prescribe and dispense prescription drugs. In developing the program, the
316 commission shall consult with physicians, podiatrists, pharmacists, nurses, private insurers,
317 hospitals, pharmacy benefit managers, the MassHealth drug utilization review board and the
318 University of Massachusetts medical school.

319 (b) The program shall arrange for physicians, podiatrists, pharmacists and nurses to
320 conduct face-to-face visits with prescribers, utilizing evidence-based materials and borrowing
321 methods from behavioral science, educational theory and, where appropriate, pharmaceutical
322 industry data and outreach techniques; provided, however, that, to the extent possible, the
323 program shall inform prescribers about drug marketing that is intended to circumvent
324 competition from generic or other therapeutically-equivalent pharmaceutical alternatives or other
325 evidence-based treatment options.

326 The program shall be designed to provide outreach to: physicians, podiatrists and other
327 health care practitioners who participate in MassHealth, the subsidized catastrophic prescription
328 drug insurance program established in section 39 of chapter 19A, other publicly-funded,
329 contracted or subsidized health care programs, academic medical centers and other prescribers.

330 The commission shall, to the extent possible, utilize or incorporate into its program other
331 independent educational resources or models proven effective in promoting high quality,
332 evidenced-based, cost-effective information regarding the effectiveness and safety of
333 prescription drugs including, but not limited to: (i) the Pennsylvania Pharmaceutical Assistance

334 Contract for the Elderly Independent Drug Information Service affiliated with Harvard
335 University; (ii) the Academic Detailing Program through the University of Vermont Larner
336 College of Medicine’s Office of Primary Care and Area Health Education Centers Program; (iii)
337 the Drug Effectiveness Review Project coordinated by the Center for Evidence-based Policy at
338 Oregon Health and Science University; and (iv) the North Carolina evidence-based peer-to-peer
339 education program outreach program.

340 (c) The commission shall make an annual report, not later than April 1, on the operation
341 of the program. The report shall be made publicly available on the commission’s website and
342 include information on the outreach and education components of the program, revenues,
343 expenditures and balances and savings attributable to the program in health care programs
344 funded by the commonwealth.

345 (d) The commission shall undertake a public education initiative to inform residents of
346 the commonwealth about clinical trials and drug safety information.

347 (e) The commission may establish and collect fees for subscriptions and contracts with
348 private health care payers related to this section. The commission may seek funding from
349 nongovernmental health access foundations and undesignated drug litigation settlement funds
350 associated with pharmaceutical marketing and pricing practices.

351 Section 15B. (a) The commission shall conduct an annual study of pharmaceutical
352 manufacturing companies with pipeline drugs, generic drugs or biosimilar drug products that
353 may have a significant impact on statewide health care expenditures; provided, however, that the
354 commission may issue interim studies if it deems it necessary. The commission may contract
355 with a third-party entity to implement this section.

356 (b) A pharmaceutical manufacturing company shall, provide early notice to the
357 commission for: (i) a pipeline drug; (ii) an abbreviated new drug application for generic drugs,
358 upon submission to the federal Food and Drug Administration; or (iii) a biosimilar biologics
359 license application upon the receipt of an action date from the federal Food and Drug
360 Administration. The commission shall make early notice information available to the office of
361 Medicaid or another agency, as deemed appropriate.

362 Early notice shall be submitted to the commission not later than 60 days after receipt of
363 the federal Food and Drug Administration action date or after the submission of an abbreviated
364 new drug application to the federal Food and Drug Administration action.

365 For each prescription drug product, early notice shall include a brief description of the: (i)
366 primary disease, health condition or therapeutic area being studied and the indication; (ii) route
367 of administration being studied; (iii) clinical trial comparators; and (iv) estimated year of market
368 entry. To the extent possible, information shall be collected using data fields consistent with
369 those used by the federal National Institutes of Health for clinical trials.

370 For each pipeline drug, early notice shall include whether the drug has been designated
371 by the federal Food and Drug Administration: (i) orphan drug; (ii) fast track; (iii) breakthrough
372 therapy; (iv) for accelerated approval; or (v) priority review for a new molecular entity.

373 Notwithstanding the foregoing, submissions for drugs in development that receive such a
374 designation by the federal Food and Drug Administration for new molecular entities shall be
375 provided as soon as practical upon receipt of the relevant designation.

376 (c) The commission shall assess pharmaceutical manufacturing companies for the
377 implementation of this section in a similar manner to the annual registration fees and other

378 assessments related to the annual marketing disclosure reports required under section 2A of
379 chapter 111N.

380 (d) Notwithstanding any general or special law to the contrary, information provided
381 under this section shall be protected as confidential and shall not be a public record under clause
382 Twenty-sixth of section 7 of chapter 4 or under chapter 66.

383 SECTION 22. Said chapter 6D is hereby further amended by inserting after section 16
384 the following section:-

385 Section 16A. (a) The commission shall, upon consideration of advice or any other
386 pertinent evidence, recommend the noncontracted commercial rate for emergency services and
387 the noncontracted commercial rate for nonemergency services, as defined in section 1 of chapter
388 176O. The noncontracted commercial rate for emergency services and the noncontracted
389 commercial rate for nonemergency services shall be in effect for a term of 5 years and shall
390 apply to payments under clauses (ii) and (iv) of section 28 of said chapter 176O.

391 (b) In recommending rates, the commission shall consider: (i) the impact of each rate on
392 the growth of total health care expenditures; (ii) the impact of each rate on in-network
393 participation by health care providers; and (iii) whether each rate is easily understandable and
394 administrable by health care providers and carriers. The commission shall not issue its
395 recommendations for the noncontracted commercial rate for emergency services and the
396 noncontracted commercial rate for nonemergency services without the approval of the board
397 established under subsection (b) of section 2.

398 (c) If the board approves the recommendations pursuant to subsection (b), the
399 commission shall submit the recommendations to the division of insurance. The division may,

400 not later than 30 days after the proposal has been submitted, hold a public hearing on the
401 proposal. The division shall issue any findings within 20 days after the public hearing and shall
402 make public those findings and any proposed regulation to implement those findings with respect
403 to the recommendations of the commission. If the division does not issue final regulations with
404 respect to the recommendations within 65 days after the commission submits the
405 recommendations to division, the recommendations shall be adopted by the division as the
406 noncontracted commercial rate for emergency services and noncontracted commercial rate for
407 nonemergency services in effect for the applicable 5-year term.

408 (d) Prior to recommending the rates, the commission shall hold a public hearing. The
409 hearing shall examine current rates paid for in- and out-of-network services and the impact of
410 those rates on the operation of the health care delivery system and determine, based on the
411 testimony, information and data, an appropriate noncontracted commercial rate for emergency
412 services and noncontracted commercial rate for nonemergency services consistent with
413 subsection (b). The commission shall provide public notice of the hearing not less than 45 days
414 before the date of the hearing, including notice to the division of insurance. The division may
415 participate in the hearing. The commission shall identify as witnesses for the public hearing a
416 representative sample of providers, provider organizations, payers and other interested parties as
417 the commission may determine. Any interested party may testify at the hearing.

418 (e) The commission shall conduct a review of established rates in the fourth year of the
419 rates' operation. The commission shall further hold a public hearing under subsection (d) in said
420 fourth year and recommend rates consistent with this section to be effective for the next 5-year
421 term.

422 SECTION 23. Said chapter 6D is hereby further amended by adding following section:-

423 Section 19. (a) The commission, in consultation with the office of Medicaid, the
424 department of public health, the department of mental health and the department of
425 developmental services, shall develop and implement standards of certification for health care
426 trailblazer organizations for innovative practices that can be translated to similar organizations or
427 impact the health care delivery system. The standards developed by the commission shall be
428 based on the following: (i) demonstrated cost savings to the organization or the health care
429 delivery system; (ii) evidence of quality care improvement at a sustained or lower relative cost;
430 (iii) the actual and scalable impact of the innovative practices on the health care delivery system;
431 (iv) documented feedback from the individuals or patients targeted by the innovation; and (v)
432 such other criteria as determined by the commission.

433 When developing standards, the commission shall consult with national and local
434 organizations working on health care cost containment, relevant state agencies, health plans,
435 physicians, nurse practitioners, behavioral health providers, hospitals, community health centers,
436 social workers, other health care providers and consumers.

437 (b) Certification as a health care trailblazer organization shall be voluntary. An
438 organization may use its certification in advertising or promotional materials. An organization
439 certified by the commission as a health care trailblazer organization shall renew its certification
440 every 2 years under like terms.

441 (c) The commission may establish and require an organization to demonstrate continued
442 sustainability or improvement upon the identified innovations.

443 SECTION 24. Section 1 of chapter 12C of the General Laws, as appearing in the 2016
444 Official Edition, is hereby amended by inserting after the definition of “Patient-centered medical
445 home” the following 2 definitions:

446 “Pharmaceutical manufacturing company”, an entity engaged in the production,
447 preparation, propagation, conversion or processing of prescription drugs, directly or indirectly,
448 by extraction from substances of natural origin or independently by means of chemical synthesis
449 or by a combination of extraction and chemical synthesis or an entity engaged in the packaging,
450 repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that
451 “Pharmaceutical manufacturing company” shall not include a wholesale drug distributor licensed
452 under section 36B of chapter 112 or a retail pharmacist registered under section 39 of said
453 chapter 112.

454 “Pharmacy benefit manager”, a person or entity that administers: (i) a prescription drug,
455 prescription device or pharmacist services or (ii) a prescription drug and device and pharmacist
456 services portion of a health benefit plan on behalf of a plan sponsor including, but not limited to,
457 self-insured employers, insurance companies and labor unions; provided, however, that
458 “Pharmacy benefit manager” shall include a health benefit plan that does not contract with a
459 pharmacy benefit manager and administers its own: (a) prescription drug, prescription device or
460 pharmacist services; or (b) prescription drug and device and pharmacist services portion, unless
461 specifically exempted by the center.

462 SECTION 25. Said section 1 of said chapter 12C, as so appearing, is hereby further
463 amended by striking out the definition for “Quality measures” and inserting in place thereof the
464 following 2 definitions:-

465 “Quality measures”, aligned quality measures established pursuant to section 16AA of
466 chapter 6A.

467 “Readmission reduction benchmark”, the projected annual percentage change in the
468 statewide rate of readmissions as measured by the center pursuant to section 10A of chapter 6D.

469 SECTION 26: Section 5 of said chapter 12C, as so appearing, is hereby amended by
470 inserting after the word “payers”, in line 11, the following words:- , pharmaceutical
471 manufacturing companies, pharmacy benefit managers.

472 SECTION 27. Said section 5 of said chapter 12C, as so appearing, is hereby further
473 amended by striking out, in line 15, the word “and” and inserting in place thereof the following
474 words:- affected pharmaceutical manufacturing companies, affected pharmacy benefit managers
475 and.

476 SECTION 28. Section 7 of said chapter 12C, as so appearing, is hereby amended by
477 adding the following paragraph:-

478 To the extent that the analysis of pharmaceutical manufacturing companies and pharmacy
479 benefit managers pursuant to section 10A increases the expenses of the center, the estimated
480 increase in the center’s expenses shall be fully assessed to pharmaceutical manufacturing
481 companies and pharmacy benefit managers in the same manner as the assessment under section
482 68 of chapter 118E. A pharmacy benefit manager that is a surcharge payor subject to the
483 preceding paragraph and administers either its own (a) prescription drug, prescription device or
484 pharmacist services or (b) prescription drug and device and pharmacist services portion shall not
485 be subject to additional assessment under this paragraph.

486 SECTION 29. Section 10 of said chapter 12C, as so appearing, is hereby amended by
487 striking out subsection (e) and inserting in place thereof the following 2 subsections:-

488 (e) The center, in consultation with the executive office of health and human services,
489 shall develop a process for reporting health care prices and related information from providers
490 for use by consumers, employers and other stakeholders. The center shall develop and
491 periodically update a list of the most common procedures and services and a list of the most
492 common behavioral health services based on data collected pursuant to this section and sections
493 8 and 9. The center shall require private and public health care payers to submit the payment
494 rates for procedures and services and other information necessary for the center to determine the
495 rate for every provider with which the payer has contracted or has a compensation arrangement.
496 The center shall make the prices and related information publicly available on the consumer
497 health information website required by section 20. The center shall keep confidential all
498 nonpublic data obtained pursuant to this subsection and shall not disclose such data to any person
499 without the consent of the provider or payer that produced the data; provided, however, that the
500 center may disclose such data in an aggregated format. The center shall promulgate regulations
501 necessary to implement this subsection.

502 (f) Except as specifically provided otherwise by the center or pursuant to this chapter,
503 insurer data collected by the center pursuant to this section shall not be a public record under
504 clause Twenty-sixth of section 7 of chapter 4 or under chapter 66.

505 SECTION 30: Said chapter 12C is hereby further amended by inserting after section 10
506 the following section:-

507 Section 10A. (a) The center shall promulgate regulations necessary to ensure the uniform
508 analysis of information regarding pharmaceutical manufacturing companies and pharmacy
509 benefit managers and that enable the center to analyze: (i) year-over-year wholesale acquisition
510 cost changes; (ii) year-over-year trends in net expenditures; (iii) net expenditures on subsets of
511 brand and generic pharmaceuticals identified by the center; (iv) information regarding trends of
512 estimated aggregate drug rebates and other price reductions paid by a pharmaceutical
513 manufacturing company in connection with utilization of all pharmaceutical drug products
514 offered by the pharmaceutical manufacturing company; (v) information regarding trends of
515 estimated aggregate drug rebates and other price reductions paid by a pharmacy benefit manager
516 in connection with utilization of all drugs offered through the pharmacy benefit manager; (vi)
517 information regarding pharmacy benefit manager practices in passing drug rebates or other price
518 reductions received by the pharmacy benefit manager to a private or public health care payer or
519 the consumer; (vii) information regarding discount or free product vouchers that a retail
520 pharmacy provides to a consumer in connection with a pharmacy service, item or prescription
521 transfer offer or to any discount, rebate, product voucher or other reduction in an individual's
522 out-of-pocket expenses, including co-payments and deductibles under section 3 of chapter 175H;
523 and (viii) any other information deemed necessary by the center.

524 (b) The center shall require the submission of available data and other information
525 from pharmaceutical manufacturing companies and pharmacy benefit managers including, but
526 not limited to: (i) changes in wholesale acquisition costs for prescription drug products, as
527 identified by the center; (ii) aggregate, company-level research and development and other
528 relevant capital expenditures for the most recent year for which final audited data are available
529 for prescription drug products as identified by the center; (iii) a description, suitable for public

530 release, of factors that contributed to reported changes in wholesale acquisition costs for
531 prescription drug products identified by the center.

532 (c) Except as specifically provided otherwise by the center or under this chapter, data
533 collected by the center pursuant to this section from pharmaceutical manufacturing companies
534 and pharmacy benefit managers shall not be a public record under clause Twenty-sixth of section
535 7 of chapter 4 or under chapter 66.

536 SECTION 31. Section 11 of said chapter 12C, as so appearing, is hereby amended by
537 striking out, in line 2, the words “and 10” and inserting in place thereof the following figures:- ,
538 10 and 10A.

539 SECTION 32. Section 12 of said chapter 12C, as so appearing, is hereby amended by
540 striking out, in line 2, the words “and 10” and inserting in place thereof the following figures:- ,
541 10 and 10A.

542 SECTION 33. Section 12 of chapter 12C of the General Laws, as so appearing, is hereby
543 amended by striking out, in lines 11 and 12, the words “the operation of the database or its
544 functions” and inserting in place thereof the following words:- control of the database.

545 SECTION 34. Said chapter 12C is hereby amended by striking out section 14, as so
546 appearing, and inserting in place thereof the following section:-

547 Section 14. The center shall develop the uniform reporting of the aligned measure set for
548 each health care provider facility, medical group, provider organization or provider group using
549 those quality measures recommended by the task force and established by the secretary pursuant
550 to section 16AA of chapter 6A.

551 SECTION 35. Subsection (a) of section 16 of said chapter 12C, as so appearing, is hereby
552 amended by striking out the first sentence and inserting in place thereof the following sentence:-
553 The center shall publish an annual report based on the information submitted under sections 8, 9,
554 10 and 10A concerning health care provider, provider organization, private and public health
555 care payer, pharmaceutical manufacturing company and pharmacy benefit manager costs and
556 cost trends, under section 13 of chapter 6D relative to market power reviews and under section
557 15 relative to quality data.

558 SECTION 36. Section 20 of said chapter 12C, as so appearing, is hereby amended by
559 striking out, in lines 22 and 23, the words “as determined by the center” and inserting in place
560 thereof the following words:- consistent with the recommendations of the taskforce pursuant to
561 section 16AA of chapter 6A.

562 SECTION 37. Said chapter 12C is hereby further amended by inserting after section 20
563 the following section:-

564 Section 20A. The center shall, in collaboration with carriers, develop a uniform
565 methodology to communicate information on a provider’s tier designation for use by patients,
566 purchasers and employers to easily understand the differences between tiered health insurance
567 plans and a provider’s tier designation within a tiered health insurance plan.

568 SECTION 38. Said chapter 12C is hereby further amended by adding the following
569 section:-

570 Section 24. The center shall annually, not later than February 1, prepare and file a public
571 health program beneficiary employer report to identify the 50 employers that have the highest
572 number of employees who receive medical assistance, medical benefits or assistance through the

573 Health Safety Net Trust Fund under chapter 118E. The report shall be filed with the clerks of the
574 senate and the house of representatives, the joint committee on health care financing and the
575 senate and house committees on ways and means. The report shall also be made available on the
576 center's website.

577 The report shall include: (i) the name and address of the employer; (ii) the size of the
578 employer; (iii) the number of public health program beneficiaries who are an employee of that
579 employer; (iv) the number of public health program beneficiaries who are a spouse or dependent
580 of an employee of that employer; (v) whether the employer offers health benefits to its
581 employees; (v) the cost to the commonwealth of providing public health program benefits for
582 their employees and enrolled dependents, if available; and (vi) whether the employer offered
583 health benefits to its employees who are public health program beneficiaries and, if so, the
584 number of such employees.

585 The report shall not include the names of any individual public health access program
586 beneficiaries and shall be subject to privacy standards pursuant to Public Law 104-191 and the
587 Health Insurance Portability and Accountability Act of 1996. The center may establish
588 interagency agreements to collect information to fulfill the requirements of this section
589 including, but not limited to, an interagency agreement to access and utilize information
590 collected through the health insurance responsibility disclosure form established under section 79
591 of chapter 118E.

592 SECTION 39. Chapter 19 of the General Laws is hereby amended by inserting after
593 section 19 the following section:-

594 Section 19A. (a) For the purposes of this section and unless the context clearly indicates
595 otherwise, the words “behavioral health urgent care facility” shall mean a private, county or
596 municipal facility or any department or ward of such a facility that offers behavioral health
597 urgent care services to the public or represents itself as providing behavioral health urgent care
598 treatment.

599 (b) The department shall issue a license for a term of 2 years to a behavioral health urgent
600 care facility. The license may be renewed for like terms. The department may suspend, revoke,
601 limit, restrict or refuse to grant or renew a license, subject to the procedural requirements of
602 section 13 of chapter 30A, for cause or any violation of its regulations or standards. The
603 department may temporarily suspend a license before a hearing in the case of an emergency if
604 the department deems that the suspension is in the public interest; provided, however, that upon
605 the request of an aggrieved party, a hearing under said section 13 of said chapter 30A shall be
606 held after the license is suspended. A party aggrieved by a decision of the department under this
607 section may appeal in accordance with section 14 of said chapter 30A.

608 (c) A facility, department or ward shall not provide behavioral health urgent care services
609 unless it has obtained a license under this section. The superior court shall have jurisdiction,
610 upon petition of the department, to restrain a violation of this section or to take such other action
611 as equity and justice may require. A violation of this section shall be punished for a first offense
612 by a fine of not more than \$1,000 and for a second or subsequent offense by a fine of not more
613 than \$2,000 or by imprisonment for not more than 2 years.

614 (d) A behavioral health urgent care facility shall maintain and make available to the
615 department statistical and diagnostic data as required by the department.

616 (e) The department shall set fees for licensure.

617 (f) A behavioral health urgent care facility shall be subject to the supervision, visitation
618 and inspection by the department and the department shall promulgate regulations for the proper
619 operation of a behavioral health urgent care facility and the implementation of this section.

620 SECTION 40. Section 2GGGG of chapter 29 of the General Laws, as appearing in the
621 2016 Official Edition, is hereby amended by inserting after the word “commission”, in line 66,
622 the following words:- or developed by a health care trailblazer.

623 SECTION 41. Said chapter 29 is hereby amended by inserting after section 2XXXX the
624 following 2 sections:-

625 Section 2YYYY. There shall be a Mobile Integrated Health Care Trust Fund. The
626 commissioner of public health shall administer the fund and may make expenditures from the
627 fund to support the administration and oversight of programs certified under chapter 111O.

628 The fund shall consist of: (i) revenue generated from fees, fines and penalties imposed
629 under chapter 111O; (ii) revenue from appropriations or other money authorized by the general
630 court and specifically designated to be credited to the fund; and (iii) funds public or private
631 sources for mobile integrated health care including, but not limited to, gifts, grants, donations,
632 rebates and settlements received by the commonwealth that are specifically designated to be
633 credited to the fund. The department may incur expenses and the comptroller may certify for
634 payment amounts in anticipation of expected receipts; provided, however, that an expenditure
635 shall not be made from the fund that shall cause the fund to be deficient at the close of a fiscal
636 year. Amounts credited to the fund shall not be subject to further appropriation and money

637 remaining in the fund at the close of a fiscal year shall not revert to the General Fund and shall
638 be available for expenditure in the following fiscal year.

639 The commissioner shall report annually, not later than October 1, to the house and senate
640 committees on ways and means on the fund's activity. The report shall include, but not be limited
641 to, revenue received by the fund, revenue and expenditure projections for the next fiscal year and
642 details of the expenditures by the fund.

643 Section 2ZZZZ. (a) There shall be a Hospital Alignment and Review Trust Fund. The
644 hospital alignment and review council established under section 2 of chapter 176W shall
645 administer the fund and may make expenditures from the fund to support hospitals that meet
646 criteria established under subsection (c).

647 (b) The fund shall consist of: (i) revenue generated from fees, fines and penalties imposed
648 under chapter 176W; (ii) revenue from appropriations or other money authorized by the general
649 court and specifically designated to be credited to the fund; and (iii) funds public or private
650 sources including, but not limited to, gifts, grants, donations, rebates and settlements received by
651 the commonwealth that are specifically designated to be credited to the fund. The council may
652 incur expenses and the comptroller may certify for payment amounts in anticipation of expected
653 receipts; provided, however, that an expenditure shall not be made from the fund that shall cause
654 the fund to be deficient at the close of a fiscal year. Amounts credited to the fund shall not be
655 subject to further appropriation and money remaining in the fund at the close of a fiscal year
656 shall not revert to the General Fund and shall be available for expenditure in the following fiscal
657 year.

658 (c) The council may expend funds to support hospitals that meet criteria established by
659 the council. When determining hospital criteria, the council shall consider whether a hospital: (i)
660 has a history of receiving rates below the statewide commercial relative price; (ii) has a
661 demonstrated record of providing quality care; (iii) provides essential services to the region in
662 which it is located; (iv) has participated in cost-reduction efforts; (v) has provided sufficient
663 information to the commission to demonstrate its eligibility; and (vi) has provided all required
664 financial reporting information to the center for health information and analysis.

665 (d) The council shall report annually, not later than October 1, to the senate and house
666 committees on ways and means on the fund's activity. The report shall include, but shall not be
667 limited to, revenue received by the fund, revenue and expenditure projections for the next fiscal
668 year and details of the expenditures by the fund.

669 SECTION 42. Section 4 of chapter 32A of the General Laws, as appearing in the 2016
670 Official Edition, is hereby amended by inserting after the word "commonwealth", in line 12, the
671 following words:- ; provided, however, that the carrier or third-party health care administrator
672 website shall conform to the uniform methodology for a provider's tier designation pursuant to
673 section 20A of chapter 12C.

674 SECTION 43. Said chapter 32A is hereby further amended by adding the following 3
675 sections:-

676 Section 28. (a) As used in this section, "facility fee", "health system", "hospital" and
677 "hospital-based facility" shall have the same meanings as provided in section 28 of chapter
678 176O.

679 (b) Coverage offered by the commission to an active or retired employee of the
680 commonwealth insured under the group insurance commission shall not impose a separate
681 copayment on an insured or provide reimbursement to a hospital, health system or hospital-based
682 facility for services provided at a hospital, a health system or a hospital-based facility or for
683 reimbursement to such a hospital, health system or hospital-based facility for a facility fee for
684 services utilizing a current procedural terminology evaluation and management code or which is
685 otherwise limited pursuant to section 51L of chapter 111.

686 A hospital, health system or hospital-based facility shall not charge, bill or collect from
687 an insured a facility fee greater than the facility fee reimbursement rate agreed to by the carrier
688 pursuant to an insured's policy.

689 (c) Nothing in this section shall prohibit the commission from offering coverage that
690 restricts the reimbursement of facility fees beyond the limitations set forth in section 51L of
691 chapter 111.

692 Section 29. (a) For the purposes of this section, "telemedicine" shall mean the use of
693 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
694 patient's physical, oral or mental health; provided, however, that "telemedicine" shall not include
695 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

696 (b) Coverage offered by the commission to an active or retired employee of the
697 commonwealth insured under the group insurance commission shall provide coverage for health
698 care services through the use of telemedicine by a contracted health care provider if the health
699 care service is covered via in-person consultation or delivery. Health care services delivered by

700 way of telemedicine shall be covered to the same extent as if they were provided via in-person
701 consultation or delivery.

702 (c) Coverage may include utilization review, including preauthorization, to determine the
703 appropriateness of telemedicine as a means of delivering a health care service, provided that the
704 determination shall be made in the same manner as if the service was delivered in person. A
705 carrier shall not be required to reimburse a health care provider for a health care service that is
706 not a covered benefit under the plan nor reimburse a health care provider not contracted under
707 the plan.

708 A health care provider shall not be required to document a barrier to an in-person visit,
709 nor shall the type of setting where telemedicine is provided be limited for health care services
710 provided through telemedicine.

711 Coverage for telemedicine services may include a deductible, copayment or coinsurance
712 requirement for a health care service provided through telemedicine as long as the deductible,
713 copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable
714 to an in-person consultation or in-person delivery of services.

715 (d) Coverage that reimburses a provider with a global payment, as defined in section 1 of
716 chapter 6D, shall account for the provision of telemedicine services to set the global payment
717 amount.

718 (e) Health care services provided by telemedicine shall conform to the standards of care
719 applicable to the telemedicine provider's profession. Such services shall also conform to
720 applicable federal and state health information privacy and security standards as well as
721 standards for informed consent.

722 Section 30. The commission shall require a carrier or a third party administrator with
723 whom a carrier contracts to use the aligned measure set established by the secretary pursuant to
724 section 16AA of chapter 6A as follows: (i) the carrier or third party administrator shall use the
725 measures designated by the secretary as core measures in any contract between a health care
726 provider, provider organization or accountable care organization that incorporates quality
727 measures into payment terms; (ii) the carrier or third party administrator may use the measures
728 designated by the secretary as non-core measures in any contract with a health care provider,
729 provider organization or accountable care organizations that incorporates quality measures into
730 payment terms and shall not use any measures not designated as non-core measures; (iii) the
731 carrier or third party administrator shall only use the measures in the aligned measure set
732 established by the secretary to assign health care providers, provider organization or accountable
733 care organization to tiers in the design of a health plan.

734 SECTION 44. Subsection (a) of section 6D of chapter 40J of the General Laws, as
735 appearing in the 2016 Official Edition, is hereby amended by inserting after the third sentence
736 the following sentence:- The institute shall partner with the health care and technology
737 community to accelerate the creation and adoption of digital health to drive economic growth
738 and improve health care outcomes and efficiency.

739 SECTION 45. Said section 6D of said chapter 40J, as so appearing, is hereby further
740 amended by striking out, in lines 16 to 18, inclusive, the words “and (3) develop a plan to
741 complete the implementation of electronic health records systems by all providers in the
742 commonwealth” and inserting in place thereof the following words:- (3) develop a plan to
743 complete the implementation of electronic health records systems by all providers in the
744 commonwealth; and (4) advance the commonwealth’s economic competitiveness by supporting

745 the digital health industry, including the digital health industry’s role in improving the quality of
746 health care delivery and patient outcomes.

747 SECTION 46. Said section 6D of said chapter 40J, as so appearing, is hereby further
748 amended by adding the following subsection:-

749 (h) Notwithstanding any provision of this section to the contrary, if a significant portion
750 of health care providers, as determined by the institute’s director, implement and use
751 interoperable electronic health records systems, the institute shall prioritize achieving the goal of
752 improving the commonwealth’s economic competitiveness in digital health through
753 implementation of subsections (f) and (g).

754 SECTION 47. Section 1 of chapter 94C of the General Laws is hereby amended by
755 inserting after the definition for “Marihuana”, as amended by section 14 of chapter 55 of the acts
756 of 2017, the following definition:-

757 “Medication Order”, an order for medication entered on a patient's medical record
758 maintained at a hospital, other health facility or ambulatory health care setting registered under
759 this chapter; provided, however, that the order is dispensed only for immediate administration at
760 the facility to the ultimate user by an individual who administers such medication under this
761 chapter.

762 SECTION 48. Said section 1 of said chapter 94C is hereby further amended by striking
763 out, in line 308, as appearing in the 2016 Official Edition, the words “and 66B” and inserting in
764 place thereof the following words:- , 66B and 66C.

765 SECTION 49. The definition of “Practitioner” in said section 1 of said chapter 94C, as so
766 appearing, is hereby amended by adding the following 3 clauses:-

767 (d) a nurse practitioner registered pursuant to subsection (f) of section 7 and authorized
768 by section 80E of chapter 112 to distribute, dispense, conduct research with respect to or use in
769 teaching or chemical analysis a controlled substance in the course of professional practice or
770 research in the commonwealth.

771 (e) a nurse anesthetist registered pursuant to subsection (f) of section 7 and authorized by
772 section 80H of chapter 112 to distribute, dispense, conduct research with respect to or use in
773 teaching or chemical analysis a controlled substance in the course of professional practice or
774 research in the commonwealth.

775 (f) a psychiatric nurse mental health clinical specialist registered pursuant to subsection
776 (f) of section 7 and authorized by section 80J of chapter 112 to distribute, dispense, conduct
777 research with respect to or use in teaching or chemical analysis a controlled substance in the
778 course of professional practice or research in the commonwealth.

779 SECTION 50. Section 7 of said chapter 94C is hereby amended by inserting after the
780 word “nurse”, in line 80, the second time it appears, as so appearing, the following words:- , a
781 licensed dental therapist under the supervision of a practitioner for the purposes of administering
782 analgesics, anti-inflammatories and antibiotics.

783 SECTION 51. Said section 7 of said chapter 94C is hereby further amended by inserting
784 after the word “podiatrist”, in line 122, and in lines 125 and 126, each time it appears, as so
785 appearing, the following words:- , nurse practitioner, nurse anesthetist, psychiatric nurse mental
786 health clinical specialist.

787 SECTION 52. Subsection (g) of said section 7 of said chapter 94C, as so appearing, is
788 hereby further amended by striking out the second paragraph.

789 SECTION 53. Said section 7 of said chapter 94C is hereby further amended by striking
790 out, in line 213, as so appearing, the words “and 66B” and inserting in place thereof the
791 following words:- , 66B and 66C.

792 SECTION 54. Section 9 of said chapter 94C, as so appearing, is hereby amended by
793 inserting after the word “podiatrist”, in line 1, the following words:- , nurse practitioner, nurse
794 anesthetist, psychiatric nurse mental health clinical specialist.

795 SECTION 55. Said section 9 of said chapter 94C, as so appearing, is hereby further
796 amended by striking out, in line 2, the words “and 66B” and inserting in place thereof the
797 following words:- , 66B and 66C.

798 SECTION 56. Said section 9 of said chapter 94C, as so appearing, is hereby further
799 amended by striking out, in lines 3 to 5, inclusive, the words “, nurse practitioner and psychiatric
800 nurse mental health clinical specialist as limited by subsection (g) of said section 7 and section
801 80E of said chapter 112”.

802 SECTION 57. Said section 9 of said chapter 94C, as so appearing, is hereby further
803 amended by striking out, in lines 8 and 9, the words “, nurse anesthetist, as limited by subsection
804 (g) of said section 7 and section 80H of said chapter 112”.

805 SECTION 58. Subsection (a) of section 9 of said chapter 94C, as so appearing, is hereby
806 amended by adding the following paragraph:-

807 A practitioner may cause controlled substances to be administered under the
808 practitioner’s direction by a licensed dental therapist, for the purposes of administering
809 analgesics, anti-inflammatories and antibiotics.

810 SECTION 59. Said section 9 of said chapter 94C, as so appearing, is hereby further
811 amended by inserting after the word “nurse-midwifery”, in line 32, the following words:- ,
812 advanced practice nursing.

813 SECTION 60. Said section 9 of said chapter 94C, as so appearing, is hereby further
814 amended by inserting after the word “podiatrist”, in lines 72 and 80, each time it appears, the
815 following word:- , optometrist.

816 SECTION 61. Subsection (c) of said section 9 of said chapter 94C, as so appearing, is
817 hereby amended by adding the following paragraph:-

818 A licensed dental therapist who has obtained a controlled substance from a practitioner
819 for dispensing to an ultimate user under subsection (a) shall return any unused portion of the
820 substance that is no longer required by the patient to the practitioner.

821 SECTION 62. Said section 9 of said chapter 94C, as so appearing, is hereby further
822 amended by inserting after the word “practitioner”, in lines 100 and 107, each time it appears,
823 the following words:- , nurse anesthetist, psychiatric nurse mental health clinical specialist.

824 SECTION 63. Section 18 of said chapter 94C is hereby amended by striking out, in lines
825 10, 27, 39, 54, 55, 72 and 88, the words “practice medicine”, as so appearing, and inserting in
826 place thereof, in each instance, the following words:- licensed and authorized to engage in
827 prescriptive practice.

828 SECTION 64. Said section 18 of said chapter 94C, as so appearing, is hereby further
829 amended by striking out the word “physician”, in lines 25, 38, 72 and 74, and inserting in place
830 thereof, in each instance, the following word:- practitioner.

831 SECTION 65. Said chapter 94C is hereby further amended by inserting after section 21B
832 the following section:-

833 Section 21C. (a) For the purposes of this section, the following words shall have the
834 following meanings unless the context clearly requires otherwise:

835 “Cost sharing”, amounts owed by a consumer under the terms of the consumer’s health
836 benefit plan as defined in section 1 of chapter 176O or as required by a pharmacy benefit
837 manager as defined in subsection (a) of section 226 of chapter 175.

838 “Pharmacy retail price”, the amount an individual would pay for a prescription
839 medication at a pharmacy if the individual purchased that prescription medication at that
840 pharmacy without using a health benefit plan as defined in section 1 of chapter 176O or any
841 other prescription medication benefit or discount.

842 “Registered pharmacist”, a pharmacist who holds a valid certificate of registration issued
843 by the board of registration in pharmacy pursuant to section 24 of chapter 112.

844 (b) A pharmacy shall post a notice informing consumers that a consumer may request, at
845 the point of sale, the current pharmacy retail price for each prescription medication the consumer
846 intends to purchase. If the consumer’s cost-sharing amount for a prescription medication exceeds
847 the current pharmacy retail price, the pharmacist, or an authorized individual at the direction of a
848 pharmacist, shall notify the consumer that the pharmacy retail price is less than the patient’s cost-

849 sharing amount. The pharmacist shall charge the consumer the applicable cost-sharing amount
850 or the current pharmacy retail price for that prescription medication, as directed by the consumer.

851 A pharmacist shall not be subject to a penalty by the board of registration in pharmacy or
852 a third party for failure to comply with this section.

853 (c) A contractual obligation shall not prohibit a pharmacist from complying with this
854 section.

855 (d) A violation of this section shall be an unfair or deceptive act or practice under chapter
856 93A.

857 SECTION 66. Section 24A of said chapter 94C, as appearing in the 2016 Official
858 Edition, is hereby amended by striking out subsection (g) and inserting in place thereof the
859 following subsection:-

860 (g) The department may provide data from the prescription monitoring program to
861 practitioners in accordance with section 24; provided, however, that health care providers, as
862 defined in section 1 of chapter 111, shall be able to access the data directly through a secure
863 electronic medical record, health information exchange or other similar software or information
864 systems connected to the prescription monitoring program to: (i) improve ease of access and
865 utilization of such data for treatment, diagnosis or health care operations; (ii) support integration
866 of such data within the electronic health records of a health care provider for treatment, diagnosis
867 or health care operations; or (iii) allow health care providers and their vendors to maintain such
868 data for the purposes of compiling and visualizing such data within the electronic health records
869 of a health care provider that supports treatment, diagnosis or health care operations.

870 SECTION 67. Chapter 111 of the General Laws is hereby amended by striking out
871 sections 2G and 2H, as so appearing, and inserting in place thereof the following 2 sections:-

872 Section 2G. (a) There shall be a Prevention and Wellness Trust Fund to be expended,
873 without further appropriation, by the department of public health. The fund shall consist of
874 revenues collected by the commonwealth, including: (i) revenue from appropriations or other
875 money authorized by the general court and specifically designated to be credited to the fund; (ii)
876 fines and penalties allocated to the fund; (iii) funds from public and private sources, including
877 gifts, grants, donations and settlements received by the commonwealth to further community-
878 based prevention activities; (iv) funds provided from any other source; and (v) interest earned on
879 revenues in the fund . The commissioner of public health, as trustee, shall administer the fund.
880 The commissioner, in consultation with the prevention and wellness advisory board established
881 in section 2H, shall make expenditures from the fund consistent with subsections (d) and (e);
882 provided, however, that not more than 10 per cent of the amounts held in the fund in any 1 year
883 shall be used by the department for the combined cost of program administration, technical
884 assistance to grantees and program evaluation.

885 (b) The department may incur expenses and the comptroller may certify for payment
886 amounts in anticipation of expected receipts; provided, however, that an expenditure shall not be
887 made from the fund if it would cause the fund to be in deficit at the close of a fiscal year.
888 Revenues deposited in the fund that are unexpended at the end of a fiscal year shall not revert to
889 the General Fund and shall be available for expenditure in the following fiscal year.

890 (c) Expenditures from the fund shall support the commonwealth's efforts to meet the
891 health care cost growth benchmark established in section 9 of chapter 6D and at least 1 of the

892 following: (i) increase access to community-based preventive services and interventions that
893 complement and expand the ability of MassHealth to promote coordinated care, integrate
894 community-based services with clinical care and develop innovative ways to address social
895 determinants of health; (ii) reduce the impact of health conditions that are the largest drivers of
896 poor health, health disparities, reduced quality of life and high health care costs through
897 community-based interventions; or (iii) develop a stronger evidence-base of effective prevention
898 interventions.

899 (d) Using a competitive grant process, the commissioner shall annually award not less
900 than 90 per cent of the money in the fund to municipalities, community-based organizations,
901 health care providers, regional planning agencies and health plans that apply for the
902 implementation, evaluation and dissemination of evidence-based community preventive health
903 activities. To be eligible to receive a grant under this subsection, a recipient shall be a partnership
904 that includes, at a minimum: (i) a municipality or regional planning agency; (ii) a community-
905 based health or social service provider; (iii) a public health or community action agency with
906 expertise in implementing community-wide health interventions; (iv) a health care provider or a
907 health plan; and (v) where feasible, a Medicaid-certified accountable care organization or a
908 Medicaid-certified community partner organization. Expenditures from the fund pursuant to this
909 subsection shall supplement and not replace existing local, state, private or federal public health-
910 related funding. An entity that is awarded funds through this program shall demonstrate the
911 ability to: (A) utilize best practices in accounting; (B) contract with a fiscal agent who shall
912 perform accounting functions on its behalf; or (C) be provided with technical assistance by the
913 department to ensure that best practices are followed.

914 (e)(1) A grant proposal submitted under subsection (d) shall include, but shall not be
915 limited to: (i) a plan that defines specific goals for the reduction in preventable health conditions
916 and health care costs over a multi-year period; (ii) the evidence-based or evidence-informed
917 programs the applicant shall use to meet the goals; (iii) a budget necessary to implement the
918 plan, including a detailed description of the funding or in-kind contributions the applicant will be
919 providing in support of the proposal; (iv) any other private funding or private sector participation
920 that the applicant anticipates in support of the proposal; (v) a commitment to include women,
921 racial and ethnic minorities and low-income individuals; and (vi) the anticipated number of
922 individuals that would be affected by the implementation of the plan.

923 (2) Priority may be given to proposals in a geographic region of the commonwealth with
924 a higher than average prevalence of preventable health conditions as determined by the
925 commissioner of public health, in consultation with the prevention and wellness advisory board.
926 If no proposals from an area of the commonwealth with particular need are offered, the
927 department shall ask for a specific request for proposals for that specific region. If the
928 commissioner determines that a suitable proposal has not been received and the particular need
929 remains unmet, the department may work directly with municipalities or community-based
930 organizations to develop grant proposals to address particular needs in the geographic region.

931 (3) The department of public health, in consultation with the prevention and wellness
932 advisory board, shall develop guidelines for an annual review of the progress being made by
933 each grantee. Each grantee shall participate in an evaluation or accountability process
934 implemented or authorized by the department.

935 (f) Annually, not later than November 1, the department shall report on expenditures
936 from the fund from the previous fiscal year and anticipated revenues for the next fiscal year. The
937 report shall include, but not be limited to: (i) the revenue credited to the fund; (ii) revenue and
938 expenditure projections and details of the anticipated expenditures from the fund for the next
939 fiscal year; (iii) the amount of fund expenditures attributable to the administrative costs of the
940 department of public health; (iv) an itemized list of the funds expended through the competitive
941 grant process and a description of the grantee activities; and (v) the results of the evaluation of
942 the effectiveness of the activities funded through the grants. The report shall be provided to the
943 senate and house committees on ways and means, the joint committee on public health and the
944 joint committee on health care financing and shall be posted on the department's website.

945 (g) With the advice and guidance of the prevention and wellness advisory board, the
946 department shall report annually on its strategy for the administration and allocation of the fund,
947 including relevant evaluation criteria. The report shall set forth the rationale for the strategy,
948 which may include, but shall not be limited to including: (i) a list of the most prevalent
949 preventable health conditions in the commonwealth, including health disparities experienced by
950 populations based on race, ethnicity, gender, disability status, sexual orientation or
951 socioeconomic status; (ii) a list of the most costly preventable health conditions in the
952 commonwealth; and (iii) a list of evidence-based or promising community-based programs
953 related to the conditions identified in clauses (i) and (ii). The report shall recommend specific
954 areas of focus for the allocation of funds. If appropriate, the report shall reference goals and best
955 practices established by the National Prevention, Health Promotion and Public Health Council
956 and the Centers for Disease Control and Prevention including, but not limited to, the Health

957 Impact in 5 Years initiative, the National Prevention Strategy, the Healthy People report and the
958 Guide to Community Preventive Services.

959 (h) The department shall promulgate regulations necessary to carry out this section.

960 Section 2H. (a) There shall be a prevention and wellness advisory board. The board shall:

961 (i) make recommendations to the commissioner concerning the administration and allocation of
962 the Prevention and Wellness Trust Fund established in section 2G; (ii) establish evaluation
963 criteria; and (iii) perform any other functions specifically granted to it by law.

964 (b) The board shall consist of: the commissioner of public health or a designee, who shall
965 serve as chair; the senate and house chairs of the joint committee on public health or their
966 designees; the senate and house chairs of the joint committee on health care financing or their
967 designees; the secretary of health and human services or a designee; the executive director of the
968 center for health information and analysis or a designee; the executive director of the health
969 policy commission or a designee; and 15 persons to be appointed by the governor, 1 of whom
970 shall be a person with expertise in the field of public health economics, 1 of whom shall be a
971 person with expertise in public health research, 1 of whom shall be a person with expertise in the
972 field of health equity, 1 of whom shall be a person from a local board of health for a city or town
973 with a population of not less than 50,000, 1 of whom shall be a member of a board of health for a
974 city or town with a population of less than 50,000, 2 of whom shall be representatives of health
975 insurance carriers, 1 of whom shall be a person from a consumer health advocacy organization, 1
976 of whom shall be a person from a hospital association, 1 of whom shall be a person from a
977 statewide public health organization, 1 of whom shall be a representative of business interests, 1
978 of whom shall be a public health nurse or a school nurse, 1 of whom shall be a person from an

979 association representing community health workers, 1 of whom shall represent a statewide
980 association of community-based service providers addressing public health and 1 of whom shall
981 be a person with expertise in the design and implementation of communitywide public health
982 interventions.

983 (c)(1) The board shall evaluate the grant program under section 2G and shall issue a
984 report at intervals to be determined by the board but not less than every 5 years from the
985 beginning of each grant period. The report shall include an analysis of all relevant data to
986 determine the effectiveness of the program including, but not limited to: (i) the extent to which
987 the program impacted the prevalence, severity or control of preventable health conditions and the
988 extent to which the program is projected to impact those factors in the future; (ii) the extent to
989 which the program reduced health care costs or the growth in health care cost trends and the
990 extent to which the program is projected to reduce those costs in the future; (iii) whether health
991 care costs were reduced and who benefited from the reduction; (iv) the extent to which health
992 outcomes or health behaviors were positively impacted; (v) the extent to which access to
993 evidence-based community services was increased; (vi) the extent to which social determinants
994 of health or other community-wide risk factors for poor health were reduced or mitigated; (vii)
995 the extent to which grantees increased their ability to collaborate, share data and align services
996 with other providers and community-based organizations for greater impact; (viii) the extent to
997 which health disparities experienced by populations based on race, ethnicity, gender, disability
998 status, sexual orientation or socioeconomic status were reduced across all metrics; and (ix)
999 recommendations for whether the program should be discontinued, amended or expanded and a
1000 timetable for implementation of those recommendations.

1001 (2) The department of public health shall contract with an outside organization that has
1002 expertise in the analysis of public health and health care financing to assist the board in
1003 conducting its evaluation. The outside organization shall be provided with access to actual health
1004 plan data from the all-payer claims database administered by the center for health information
1005 and analysis and to data from MassHealth, to the extent permitted by law; provided, however,
1006 that such data shall be confidential and shall not be a public record under clause Twenty-sixth of
1007 section 7 of chapter 4.

1008 (3) The board shall report the results of its evaluation and its recommendations, if any,
1009 and submit drafts of legislation necessary to carry out the recommendations to the senate and
1010 house committees on ways and means, the joint committee on public health and the joint
1011 committee on health care financing and shall post the board's report on the department's website.

1012 SECTION 68. Said chapter 111 is hereby further amended by inserting after section 51K
1013 the following section:-

1014 Section 51L. (a) For the purposes of this section, the following terms shall have the
1015 following meanings unless the context clearly indicates otherwise:

1016 "Campus", the physical area immediately adjacent to a hospital's main buildings and
1017 other areas and structures that are not strictly contiguous to the main buildings but are located not
1018 more than 250 yards from the main buildings or other area that has been determined on an
1019 individual case basis by the Centers for Medicare & Medicaid Services to be part of a hospital's
1020 campus.

1021 "Carrier", shall have the same meaning as provided in section 1 of chapter 176O.

1022 “Facility fee”, shall have the same meaning as provided in section 28 of chapter 176O.

1023 “Health system”, shall have the same meaning as provided in section 28 of
1024 chapter 176O.

1025 “Hospital-based facility”, shall have the same meaning as provided in section 28 of
1026 chapter 176O.

1027 (b) A hospital, health system or hospital-based facility shall not charge, bill or collect a
1028 facility fee for services utilizing a current procedural terminology evaluation and management
1029 code or other current procedural terminology code as determined by the department. A violation
1030 of this subsection shall be an unfair trade practice under chapter 93A.

1031 (c) The department shall identify additional conditions or factors that would prohibit a
1032 hospital, health system or hospital-based facility from charging, billing or collecting a facility fee
1033 for health care services. Additional conditions or factors may include, but shall not be limited to:
1034 (i) additional current procedural terminology codes for which a hospital, health system or
1035 hospital-based facility shall not charge, bill or collect a facility fee; (ii) health care services for
1036 which a hospital, health system or hospital-based facility shall not charge, bill or collect a facility
1037 fee; (iii) limitations on physical locations, including whether on a campus or not, for which a
1038 hospital, health system or hospital-based facility shall not charge, bill or collect a facility fee; and
1039 (iv) other conditions or factors .

1040 SECTION 69. Said chapter 111 is hereby further amended by striking out section 228, as
1041 appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

1042 Section 228. (a) For the purposes of this section, “allowed amount” shall mean the
1043 contractually agreed-upon amount paid by a carrier to a health care provider for health care
1044 services provided to an insured.

1045 (b) Prior to an admission, procedure or service, and upon request by a patient or
1046 prospective patient, a health care provider shall, not later than 2 working days after receipt of the
1047 request, disclose the allowed amount or charge for the admission, procedure or service, including
1048 the amount of any facility fees. If a health care provider is unable to quote a specific amount in
1049 advance due to the health care provider's inability to predict the specific treatment or diagnostic
1050 code, the health care provider shall disclose the estimated maximum allowed amount or charge
1051 for a proposed admission, procedure or service, including the amount of any facility fees.

1052 (c) If a patient or prospective patient is covered by a health plan, a health care provider
1053 who participates as a network provider shall, at the time of scheduling a procedure or service: (i)
1054 provide sufficient information regarding the proposed admission, procedure or service for the
1055 patient or prospective patient to make an informed decision about the costs associated with that
1056 admission, procedure or service based on information available to the provider at that time,
1057 including the amount of any facility fees; and (ii) inform the patient or prospective patient that
1058 the patient or prospective patient may obtain additional information about any applicable out-of-
1059 pocket costs, pursuant to section 23 of chapter 176O. A health care provider may assist a patient
1060 or prospective patient in using the health plan’s toll-free number and website pursuant to said
1061 section 23 of said chapter 176O.

1062 (d) A health care provider referring a patient to another provider shall disclose: (i) if the
1063 provider to whom the patient is being referred is part of or represented by the same provider

1064 organization, as used in section 11 of chapter 6D; (ii) the network status of the referred provider
1065 based on information available to the provider at the time of the referral; and (iii) sufficient
1066 information about the referred provider for the patient to obtain additional information about that
1067 provider's network status under the patient's health plan and any applicable out-of-pocket costs
1068 for that referral pursuant to section 23 of chapter 176O, based on information available to the
1069 provider at that time.

1070 SECTION 70. Section 1 of chapter 111O of the General Laws, as so appearing, is hereby
1071 amended by inserting after the definition of "Mobile integrated health care" the following
1072 definition:-

1073 "Mobile integrated health care provider" or "MIH provider", a licensed health care
1074 professional delivering medical care and services to patients in an out-of-hospital environment in
1075 coordination with health care facilities or other health care providers; provided, however, that
1076 medical care and services shall include, but shall not be limited to, community paramedic
1077 provider services, chronic disease management, behavioral health, preventative care, post-
1078 discharge follow-up visits or transport or referral to facilities other than hospital emergency
1079 departments; provided further, that medical care and services shall be delivered under a mobile
1080 integrated health care program approved by the department using mobile health care resources.

1081 SECTION 71. Section 2 of said chapter 111O, as so appearing, is hereby amended by
1082 adding the following 2 subsections:-

1083 (c) The department shall issue guidance, in consultation with the advisory council, on
1084 best practices for structuring mobile integrated health care programs to obtain reimbursement for
1085 the care and services delivered to patients who are covered by public or private payers.

1086 (d) Annually, not later than March 1, the department shall report the data collected from
1087 MIH programs pursuant to subsection (b). The report shall include, but not be limited to, an
1088 analysis of the impact of MIH programs on: (i) 30-day readmission rates; (ii) siting of post-acute
1089 care treatment; (iii) incidence of emergency department presentment for behavioral health
1090 conditions; (iv) incidence of emergency department presentment for chronic conditions; and (v)
1091 the variance in each of the preceding metrics within and between Medicaid claims and
1092 commercial claims, respectively. The department may consult with the center for health
1093 information and analysis in developing the report. The report shall be made publicly available
1094 and easily searchable on the department's website.

1095 SECTION 72. Said chapter 111O is hereby further amended by adding the following 2
1096 sections:-

1097 Section 5. (a) The department shall by regulation establish application fees that shall
1098 include, but shall not be limited to, an initial application surcharge in addition to a general
1099 application or renewal fee, and a timeline for reviewing applications for mobile integrated health
1100 care or community EMS programs.

1101 Section 6. (a) The department shall allow applicants for MIH programs and Community
1102 EMS programs and approved MIH and Community EMS programs to seek a waiver from
1103 transporting a patient to the closest appropriate health care facility as required by the
1104 department; provided, that any such program that obtains a waiver shall have a point-of-entry
1105 plan that fits the design and purpose of the program seeking the waiver; provided further, that the
1106 department shall only approve a waiver if it demonstrates a point-of-entry plan that provides
1107 flexibility on the basis of the medical direction associated with a patient and does not include an

1108 explicit requirement that a patient be transported only to a health care facility owned or operated
1109 by, or affiliated with, an MIH program or Community EMS program.

1110 (b) Application fees and surcharges collected pursuant to this section shall be deposited
1111 into the Mobile Integrated Health Care Trust Fund established in section 2YYYYY of chapter 29.

1112 (c) The department shall prioritize the review and processing of mobile integrated health
1113 care program applicants who have been approved as a MassHealth accountable care organization
1114 or targeted patient populations served by MassHealth accountable care organizations.

1115 SECTION 73. Section 2 of chapter 112 of the General Laws, as appearing in the 2016
1116 Official Edition, is hereby amended by adding the following 3 paragraphs:-

1117 For the purposes of this section, “telemedicine” shall mean the use of audio, video or
1118 other electronic media for a diagnosis, consultation or treatment of a patient's physical, oral or
1119 mental health; provided, that “telemedicine” shall not include audio-only telephone, facsimile
1120 machine, online questionnaires, texting or text-only e-mail.

1121 Notwithstanding any other provision of this chapter, the board shall allow a physician to
1122 obtain proxy credentialing and privileging for telemedicine services with other health care
1123 providers, as defined in section 1 of chapter 111, or facilities consistent with Medicare conditions
1124 of participation telemedicine standards.

1125 The board shall promulgate regulations regarding the appropriate use of telemedicine to
1126 provide health care services. These regulations shall provide for and include, but shall not be
1127 limited to: (i) prescribing medications; (ii) services that are not appropriate to provide through

1128 telemedicine; (iii) establishing a patient-provider relationship; (iv) consumer protections; and (v)
1129 ensuring that services comply with appropriate standards of care.

1130 SECTION 74. Said chapter 112 is hereby further amended by striking out section 13, as
1131 so appearing, and inserting in place thereof the following section:-

1132 Section 13. (a) As used in this chapter, “podiatry” shall mean the diagnosis and treatment,
1133 by medical, mechanical, electrical or surgical means, of ailments of the human foot and lower
1134 leg.

1135 (b) As used in sections 12B, 12G and 80B, “physician” shall include a podiatrist
1136 registered under section 16.

1137 (c) Sections 13 to 18, inclusive, shall not apply to surgeons of the United States army,
1138 United States navy or of the United States Public Health Service or to physicians registered in
1139 the commonwealth.

1140 SECTION 75. Section 43A of said chapter 112, as so appearing, is hereby amended by
1141 inserting after the definition of “Appropriate supervision” the following 2 definitions:-

1142 “Board”, the board of registration in dentistry established pursuant to section 19 of
1143 chapter 13 or a committee or subcommittee of the board.

1144 “Collaborative management agreement”, a written agreement between a local, state or
1145 federal government agency or institution or a licensed dentist and a dental therapist outlining the
1146 procedures, services, responsibilities and limitations of the therapist.

1147 SECTION 76. Said section 43A of said chapter 112, as so appearing, is hereby further
1148 amended by inserting after the definition of “Dental supervision” the following definition:-

1149 “Dental therapist”, a person who: (i) is registered by the board to practice as a dental
1150 therapist pursuant to section 51B and as a dental hygienist pursuant to section 51; and (ii)
1151 provides oral health care services pursuant to said section 51B.

1152 SECTION 77. Said section 43A of said chapter 112, as so appearing, is hereby further
1153 amended by adding the following definition:-

1154 “Supervising dentist”, a licensed dentist who enters into a collaborative management
1155 agreement with a dental therapist.

1156 SECTION 78. Said chapter 112 is hereby further amended by inserting after section 51A
1157 the following section:-

1158 Section 51B. (a) A person of good moral character shall be registered as a dental therapist
1159 and given a certificate allowing the therapist to practice in this capacity if the person: (i) has
1160 completed a dental therapist education program that meets the standards of the Commission on
1161 Dental Accreditation, has graduated from a dental therapist education program that meets the
1162 standards of the Commission on Dental Accreditation provided by a post-secondary institution
1163 accredited by the New England Association of Schools and Colleges, Inc. or is certified by the
1164 federal Indian Health Service pursuant to the Indian Health Care Improvement Act, 25 U.S.C.
1165 1601 et seq.; (ii) passes a comprehensive, competency-based clinical examination that is
1166 approved by the board of registration in dentistry and administered independently of an
1167 institution providing registered dental therapy education; and (iii) maintains a policy of
1168 professional liability insurance and shows proof of the insurance as required by applicable
1169 regulations. A dental therapist shall also be registered as a dental hygienist and possess a
1170 certificate to practice dental hygiene pursuant to section 51. A dental therapist shall have

1171 practiced under the direct supervision of a supervising dentist for not less than 500 hours or shall
1172 have completed 1 year of residency before practicing under general supervision.

1173 (b) The educational curriculum for a dental therapist shall include training on how to
1174 serve certain patients including, but not limited to: (i) people with developmental disabilities,
1175 including autism spectrum disorders, mental illness, cognitive impairment, complex medical
1176 problems or significant physical limitations; and (ii) the elderly.

1177 (c) A dental therapist shall enter into a collaborative management agreement with a
1178 licensed dentist before performing a procedure or providing a service under this paragraph. The
1179 agreement shall address: (i) practice settings; (ii) limitations on services established by the
1180 supervising dentist; (iii) the level of supervision required for various services or treatment
1181 settings; (iv) patient populations that may be served by the dental therapist; (v) practice
1182 protocols; (vi) record keeping; (vii) management of medical emergencies; (viii) quality
1183 assurance; (ix) administration and dispensing of medications; and (x) supervision of dental
1184 assistants and dental hygienists. A dental therapist may provide services authorized in practice
1185 settings where the supervising dentist is not on-site and has not previously examined the patient
1186 if such a service is authorized by the supervising dentist in the collaborative management
1187 agreement and the supervising dentist is available for consultation and supervision by telephone
1188 or other means of communication.

1189 The collaborative management agreement shall include specific protocols to govern
1190 situations in which the dental therapist encounters a patient who requires treatment that exceeds
1191 the authorized scope of practice of the dental therapist. A collaborative management agreement
1192 shall be signed and maintained by the supervising dentist and the dental therapist and shall be

1193 submitted to the board upon request. The board shall establish appropriate guidelines for a
1194 collaborative management agreement. The collaborative management agreement may be updated
1195 from time to time. A supervising dentist may have a collaborative management agreement with
1196 not more than 4 dental therapists at the same time.

1197 A dental therapist may perform: (i) acts of a public health dental hygienist under section
1198 51; (ii) acts provided for in the Commission on Dental Accreditation's dental therapy standards;
1199 and (iii) the following services and procedures pursuant to the collaborative management
1200 agreement without the supervision or direction of a dentist: (1) interpretation of radiographs; (2)
1201 placement of space maintainers; (3) pulpotomy on primary teeth; (4) oral evaluation and
1202 assessment of dental disease and the formulation of an individualized treatment plan authorized
1203 by the collaborating dentist; and (5) nonsurgical extraction of permanent teeth except as limited
1204 under this section.

1205 A dental therapist shall not perform a service or procedure described in this section
1206 except as authorized by the collaborating dentist. A dental therapist may perform nonsurgical
1207 extractions of periodontally-diseased permanent teeth with tooth mobility of +3 under general
1208 supervision if authorized in advance by the collaborating dentist. A dental therapist shall not
1209 extract a tooth for a patient if the tooth is unerupted, impacted or needs to be sectioned for
1210 removal. The collaborating dentist shall be responsible for directly providing or arranging for
1211 another dentist or specialist to provide necessary advanced services needed by the patient.

1212 A dental therapist shall, in accordance with the collaborative management agreement,
1213 refer patients to another qualified dental or health care professional to receive needed services
1214 that exceed the scope of practice of the dental therapist. The collaborating dentist shall ensure

1215 that a dentist is available to the dental therapist for timely consultation during treatment if needed
1216 and shall either provide or arrange with another dentist or specialist to provide the necessary
1217 treatment to a patient who requires more treatment than the dental therapist is authorized to
1218 provide.

1219 A dental therapist may dispense and administer analgesics, anti-inflammatories and
1220 antibiotics within the scope of the dental therapist's practice and the collaborative management
1221 agreement and with the authorization of the collaborating dentist. The authority to dispense
1222 under this paragraph shall include the authority to dispense sample drugs within the categories
1223 identified in this paragraph if permitted by the collaborative management agreement. A dental
1224 therapist shall not dispense or administer a narcotic drug.

1225 (d) A dental therapist shall be reimbursed for services covered by Medicaid and other
1226 third-party payers. A dental therapist shall not operate independently of a dentist unless the
1227 dental therapist works for a local, state or federal government agency or a non-profit institution
1228 or practices in a mobile or portable prevention program licensed or certified by the department of
1229 public health.

1230 (e) A dental therapist may supervise dental assistants to the extent permitted in the
1231 collaborative management agreement and in accordance with section 51½.

1232 SECTION 79. Said chapter 112 is hereby further amended by striking out section 66, as
1233 appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

1234 Section 66. As used in this chapter, the practice of optometry shall mean the diagnosis,
1235 prevention, correction, management or treatment of optical deficiencies, optical deformities,
1236 visual anomalies, muscular anomalies, ocular diseases and ocular abnormalities of the human eye

1237 and adjacent tissue, including removal of superficial foreign bodies and misaligned eyelashes, by
1238 utilization of pharmaceutical agents, by the prescription, adaptation and application of
1239 ophthalmic lenses, devices containing lenses, prisms, contact lenses, orthoptics, vision therapy,
1240 prosthetic devices and other optical aids and the utilization of corrective procedures to preserve,
1241 restore or improve vision, consistent with sections 66A, 66B and 66C.

1242 SECTION 80. Section 66B of said chapter 112, as so appearing, is hereby amended by
1243 striking out, in line 31, the following words:- , except glaucoma.

1244 SECTION 81. Said chapter 112 is hereby further amended by inserting after section 66B
1245 the following section:-

1246 Section 66C. (a) A registered optometrist who is qualified by an examination for practice
1247 under section 68, certified under section 68C and registered to issue written prescriptions
1248 pursuant to subsection (h) of section 7 of chapter 94C, may: (i) use and prescribe topical and oral
1249 therapeutic pharmaceutical agents, as defined in section 66B, that are used in the practice of
1250 optometry, including those placed in schedules III, IV, V and VI pursuant to section 2 of said
1251 chapter 94C, for the purpose of diagnosing, preventing, correcting, managing or treating
1252 glaucoma and other ocular abnormalities of the human eye and adjacent tissue; and (ii) prescribe
1253 all necessary eye-related medications, including oral anti-infective medications; provided,
1254 however, that a registered optometrist shall not use or prescribe: (1) therapeutic pharmaceutical
1255 agents for the treatment of systemic diseases; (2) surgical procedures; (3) pharmaceutical agents
1256 administered by subdermal injection, intramuscular injection, intravenous injection,
1257 subcutaneous injection or retrobulbar injection; or (4) an opioid substance or drug product. For
1258 the purposes of this section, “surgical procedures” shall not include the use of ophthalmic

1259 medical devices approved by the federal Food and Drug Association for diagnostic purposes
1260 under Subpart B of 21 CFR 886.

1261 (b) If an optometrist, while examining or treating a patient with the aid of a diagnostic or
1262 therapeutic pharmaceutical agent and exercising professional judgment and the degree of
1263 expertise, care and knowledge ordinarily possessed and exercised by optometrists under like
1264 circumstances, encounters a sign of a previously unevaluated disease that would require
1265 treatment not included in the scope of the practice of optometry, the optometrist shall refer the
1266 patient to a licensed physician or other qualified health care practitioner.

1267 (c) If an optometrist diagnoses a patient with congenital glaucoma or if, during the course
1268 of examining, managing or treating a patient with glaucoma, the optometrist determines that
1269 surgical treatment is indicated, the optometrist shall refer the patient to a qualified health care
1270 provider for treatment.

1271 (d) An optometrist licensed under this chapter shall participate in any relevant state or
1272 federal report or data collection effort relative to patient safety and medical error reduction
1273 coordinated by the Betsy Lehman center for patient safety and medical error reduction
1274 established in section 15 of chapter 12C.

1275 SECTION 82. Said chapter 112 is hereby further amended by inserting after section 68B
1276 the following section:-

1277 Section 68C. (a) The board of registration in optometry shall administer an examination
1278 to permit the use and prescription of therapeutic pharmaceutical agents as authorized in section
1279 66C. The examination shall: (i) be held in conjunction with examinations provided for in
1280 sections 68, 68A and 68B; and (ii) include any portion of the examination administered by the

1281 National Board of Examiners in Optometry or other appropriate examination covering the
1282 subject matter of therapeutic pharmaceutical agents as authorized in said section 66C. The board
1283 may administer a single examination to measure the qualifications necessary under said sections
1284 68, 68A, 68B and this section. The board shall qualify optometrists to use and prescribe
1285 therapeutic pharmaceutical agents in accordance with said sections 68, 68A, 68B and this
1286 section.

1287 (b) Examination for the use and prescription of therapeutic pharmaceutical agents placed
1288 in schedules III, IV, V and VI under section 2 of chapter 94C and defined in section 66C shall,
1289 upon application, be open to an optometrist registered under section 68, 68A or 68B and to any
1290 person who meets the qualifications for examination under said sections 68, 68A and 68B. An
1291 applicant registered as an optometrist under said section 68, 68A or 68B shall: (i) be registered
1292 pursuant to paragraph (h) of section 7 to use or prescribe pharmaceutical agents for the purpose
1293 of diagnosing or treating glaucoma and other ocular abnormalities of the human eye and adjacent
1294 tissue; and (ii) furnish to the board of registration in optometry evidence of the satisfactory
1295 completion of 40 hours of didactic education and 20 hours of supervised clinical education
1296 relating to the use and prescription of therapeutic pharmaceutical agents under section 66C;
1297 provided, however, that such education shall: (1) be administered by the Massachusetts Society
1298 of Optometrists, Inc.; (2) be accredited by a college of optometry or medicine; and (3) meet the
1299 guidelines and requirements of the board of registration in optometry. The board of registration
1300 in optometry shall provide to each successful applicant a certificate of qualification in the use
1301 and prescription of all therapeutic pharmaceutical agents as authorized under said section 66C
1302 and shall forward to the department of public health notice of such certification for each
1303 successful applicant.

1304 (c) An optometrist licensed in another jurisdiction shall be deemed an applicant under
1305 this section by the board of registration in optometry. An optometrist licensed in another
1306 jurisdiction may submit evidence to the board of registration in optometry of practice equivalent
1307 to that required in section 68, 68A or 68B and the board, in its discretion, may accept the
1308 evidence in order to satisfy any of the requirements of this section. An optometrist in another
1309 jurisdiction licensed to utilize and prescribe therapeutic pharmaceutical agents for treating
1310 glaucoma and other ocular abnormalities of the human eye and adjacent tissue may submit
1311 evidence to the board of registration in optometry of equivalent didactic and supervised clinical
1312 education, and the board, in its discretion, may accept the evidence in order to satisfy any of the
1313 requirements of this section.

1314 (d) A licensed optometrist who has completed a postgraduate residency program
1315 approved by the Accreditation Council on Optometric Education of the American Optometric
1316 Association may submit an affidavit to the board of registration in optometry from the licensed
1317 optometrist's residency supervisor or the director of residencies at the affiliated college of
1318 optometry attesting that the optometrist has completed an equivalent level of instruction and
1319 supervision and the board, in its discretion, may accept the evidence in order to satisfy any of the
1320 requirements of this section.

1321 (e) As a condition of license renewal, an optometrist licensed under this section shall
1322 submit to the board of registration in optometry evidence attesting to the completion of 3 hours
1323 of continuing education specific to glaucoma and the board, in its discretion, may accept the
1324 evidence to satisfy this condition for license renewal.

1325 SECTION 83. Section 80B of said chapter 112, as appearing in the 2016 Official Edition,
1326 is hereby amended by inserting after the word “practitioners”, in line 12, the following words:- ,
1327 nurse anesthetists.

1328 SECTION 84. Said section 80B of said chapter 112, as so appearing, is hereby further
1329 amended by striking out the seventh paragraph and inserting in place thereof the following
1330 paragraph:-

1331 The board shall promulgate advanced practice nursing regulations which govern the
1332 provision of advanced practice nursing services and related care including, but not limited to, the
1333 ordering and interpreting of tests, the ordering and evaluation of treatment and the use of
1334 therapeutics.

1335 SECTION 85. Said section 80B of said chapter 112, as so appearing, is hereby further
1336 amended by striking out, in lines 64 and 65, the words “in the ordering of tests, therapeutics and
1337 the prescribing of medications, to” and inserting in place thereof the following word:- to.

1338 SECTION 86. Said chapter 112 is hereby further amended by striking out section 80E,
1339 as so appearing, and inserting in place thereof the following section:-

1340 Section 80E. (a) A nurse practitioner or psychiatric nurse mental health clinical specialist
1341 may issue written prescriptions and medication orders and order tests and therapeutics pursuant
1342 to guidelines mutually developed and agreed upon by the nurse and either a supervising nurse
1343 practitioner or psychiatric nurse mental health clinical specialist who has independent practice
1344 authority or a supervising physician, in accordance with regulations promulgated by the board.
1345 A prescription issued by a nurse practitioner or psychiatric nurse mental health clinical specialist
1346 under this subsection shall include the name of the nurse practitioner or the psychiatric nurse

1347 mental health clinical specialist who has independent practice authority or the supervising
1348 physician with whom the nurse practitioner or psychiatric nurse mental health clinical specialist
1349 developed and signed mutually agreed upon guidelines.

1350 A nurse practitioner or psychiatric nurse mental health clinical specialist shall have
1351 independent practice authority to issue written prescriptions and medication orders and order
1352 tests and therapeutics without the supervision described in this subsection if the nurse
1353 practitioner or psychiatric nurse mental health clinical specialist has completed not less than 2
1354 years of supervised clinical practice and then receives certification from a board recognized
1355 certifying body; provided, however, that supervised clinical practice shall be conducted by a
1356 health care professional who meets minimum qualification criteria promulgated by the board,
1357 which shall include a minimum number of years of independent clinical practice experience.

1358 The board may allow a nurse practitioner or psychiatric nurse mental health clinical
1359 specialist to exercise such independent practice authority upon satisfactory demonstration of not
1360 less than 2 years of alternative professional experience; provided, however, that the board
1361 determines that the nurse practitioner or psychiatric nurse mental health clinical specialist has a
1362 demonstrated record of safe prescribing and good conduct consistent with professional licensure
1363 obligations required by each jurisdiction in which the nurse practitioner or psychiatric nurse
1364 mental health clinical specialist has been licensed.

1365 (b) The board shall promulgate regulations to implement this section.

1366 SECTION 87. Said chapter 112 is hereby further amended by striking out section 80H,
1367 as so appearing, and inserting in place thereof the following section:-

1368 Section 80H. (a) A nurse anesthetist may issue written prescriptions and medication
1369 orders and order tests and therapeutics pursuant to guidelines mutually developed and agreed
1370 upon by the nurse and either a supervising nurse anesthetist with independent practice authority
1371 or a supervising physician, in accordance with regulations promulgated by the board. A
1372 prescription issued by a nurse anesthetist under this subsection shall include the name of the
1373 nurse anesthetist with independent practice authority or the supervising physician with whom the
1374 nurse anesthetist developed and signed mutually agreed upon guidelines.

1375 A nurse anesthetist shall have independent practice authority to issue written
1376 prescriptions and medication orders and order tests and therapeutics, without the supervision
1377 described in this subsection, if the nurse anesthetist has completed not less than 2 years of
1378 supervised clinical practice and then receives certification from a board recognized certifying
1379 body; provided, however, that supervised clinical practice shall be conducted by a health care
1380 professional who meets minimum qualification criteria promulgated by the board, which shall
1381 include a minimum number of years of independent clinical practice experience.

1382 The board, in its discretion, may allow a nurse anesthetist to exercise such independent
1383 practice authority upon satisfactory demonstration of alternative professional experience if the
1384 board determines that the nurse anesthetist has a demonstrated record of safe prescribing and
1385 good conduct consistent with professional licensure obligations required by each jurisdiction in
1386 which the nurse anesthetist has been licensed.

1387 (b) The board shall promulgate regulations to implement this section.

1388 SECTION 88. Section 80I of said chapter 112, as so appearing, is hereby amended by
1389 striking out the second and third sentences.

1390 SECTION 89. Said chapter 112 is hereby further amended by inserting after section 80I
1391 the following 2 sections:-

1392 Section 80J. A nurse authorized to practice as a psychiatric nurse mental health clinical
1393 specialist pursuant to section 80B, may order and interpret tests, therapeutics and prescribe
1394 medications in accordance with regulations promulgated by the board and subject to the
1395 provisions of subsection (g) of section 7 of chapter 94C.

1396 Section 80K. The board shall promulgate regulations, which shall be subject to approval
1397 by the commissioner, to ensure that nurse practitioners, nurse anesthetists and psychiatric nurse
1398 mental health clinical specialists under the board of registration in nursing are subject to
1399 requirements commensurate to those that physicians are subject to under the board of registration
1400 in medicine pursuant to the sixth and seventh paragraphs of section 5 and sections 5A to 5M,
1401 inclusive, as they apply to the creation and public dissemination of individual profiles and
1402 licensure restrictions, disciplinary actions and reports, claims or reports of malpractice,
1403 communication with professional organizations, physical and mental examinations, investigation
1404 of complaints and other aspects of professional conduct and discipline

1405 SECTION 90. Section 66 of chapter 118E of the General Laws, as appearing in the 2016
1406 Official Edition, is hereby amended by striking out, in line 28, the first time it appears, the word
1407 “and”.

1408 SECTION 91. Said section 66 of said chapter 118E, as so appearing, is hereby further
1409 amended by inserting after the word “thereon”, in line 29, the following words:- ; and (v) any
1410 fines collected under section 10 of chapter 6D.

1411 SECTION 92. Said chapter 118E is hereby further amended by adding the following 4
1412 sections:-

1413 Section 78. (a) Upon request from the division, an employer shall provide, under oath,
1414 health insurance information about an employee who has applied for benefits from a state
1415 subsidized health insurance program. An employer receiving information that identifies or may
1416 be used to identify a MassHealth member or recipient of subsidized health insurance shall not
1417 use or disclose such information except as authorized by the division.

1418 (b) Information reported under this section that identifies an individual employee by
1419 name or health insurance status or is health information protected under state and federal privacy
1420 laws shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under
1421 chapter 66. Reported information may be exchanged among the executive office of health and
1422 human services, the commonwealth health insurance connector authority, the department of
1423 unemployment assistance, the center for health information and analysis and the department of
1424 revenue for the exclusive purpose of determining an individual's eligibility for benefits from a
1425 state subsidized health insurance program. An employer who knowingly falsifies or fails to file
1426 any information required by this section or by any regulation issued pursuant to this section shall
1427 be subject to a fine of not more than \$5,000 for each violation

1428 Section 79. (a) The division shall create a health insurance responsibility disclosure form.
1429 An employer with 6 or more employees and doing business in the commonwealth shall annually
1430 complete and submit the form under oath. The form shall indicate whether the employer has
1431 offered to pay for or arrange for the purchase of health care insurance and information about
1432 such health care insurance including, but not limited to: (i) the premium cost; (ii) benefits

1433 offered; (iii) cost sharing details; (iv) eligibility criteria; and (v) any other information deemed
1434 necessary by the division.

1435 The division may make arrangements with other agencies, including the department of
1436 revenue and the department of unemployment assistance, to assist with the administration of this
1437 section. Employers shall provide supplemental information that is deemed necessary by the
1438 division or its designee upon request by the division. An employer receiving information that
1439 identifies or may be used to identify a MassHealth member or recipient of subsidized health
1440 insurance shall not use or disclose such information except as authorized by the division to
1441 implement this section.

1442 (b) Information reported under subsection (a) that identifies an individual employee by
1443 name or health insurance status or that is protected health information shall not be a public
1444 record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66. Reported
1445 information may be exchanged among the executive office of health and human services, the
1446 commonwealth health insurance connector authority, the department of unemployment
1447 assistance, the center for health information and analysis and the department of revenue if
1448 necessary to implement this section or section 24 of chapter 12C. An employer who knowingly
1449 falsifies or fails to file any information required by this section or by any regulation issued
1450 pursuant to this section shall be subject to a fine of not less than \$1,000 not more than \$5,000 for
1451 each violation.

1452 Section 80. (a) For the purposes of this section, “telemedicine” shall mean the use of
1453 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a

1454 patient’s physical, oral or mental health; provided, however, that “telemedicine” shall not include
1455 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1456 (b) The division and its contracted health insurers, health plans, health maintenance
1457 organizations, behavioral health management firms and third party administrators under contract
1458 to a Medicaid managed care organization or primary care clinician plan may provide coverage
1459 for health care services appropriately provided through telemedicine by a contracted provider.

1460 (c) The division may undertake utilization review, including preauthorization, to
1461 determine the appropriateness of telemedicine as a means of delivering a health care service;
1462 provided, however, that determinations shall be made in the same manner as if service was
1463 delivered in person. The division, a contracted health insurer, health plan, health maintenance
1464 organization, behavioral health management firm or third party administrators under contract to a
1465 Medicaid managed care organization or primary care clinician plan shall not be required to
1466 reimburse a health care provider for a health care service that is not a covered benefit under the
1467 plan nor reimburse a health care provider not contracted under the plan.

1468 A health care provider shall not be required to document a barrier to an in-person visit,
1469 nor shall the type of setting where telemedicine is provided be limited for health care services
1470 provided through telemedicine.

1471 (d) A contract that provides coverage for telemedicine services may include a deductible,
1472 copayment or coinsurance requirement for a health care service provided through telemedicine as
1473 long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or
1474 coinsurance applicable to an in-person consultation or in-person delivery of services. Coverage

1475 that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall
1476 account for the provision of telemedicine services in setting that global payment amount.

1477 (e) Health care services provided by telemedicine shall conform to the standards of care
1478 applicable to the telemedicine provider's profession. Such services shall also conform to
1479 applicable federal and state health information privacy and security standards as well as
1480 standards for informed consent.

1481 Section 81. The division and its contracted health insurers, health plans, health
1482 maintenance organizations, behavioral health management firms and third party administrators
1483 under contract with a Medicaid managed care organization or primary care clinician plan shall
1484 use the aligned measure set established by the secretary pursuant to section 16AA of chapter 6A
1485 as follows: (i) the measures designated by the secretary as core measures shall be used in any
1486 contract with a health care provider, provider organization or accountable care organization that
1487 incorporates quality measures into payment terms; (ii) the measures designated by the secretary
1488 as non-core measures may be used in any contract with a health care provider, provider
1489 organization or accountable care organization that incorporate quality measures into payment
1490 terms and shall not use any measures not designated as non-core measures; (iii) only measures
1491 included in the aligned measure set shall be used to assign health care providers, provider
1492 organizations or accountable care organizations to tiers in the design of a program of medical
1493 benefits to a beneficiary under section 9A.

1494 SECTION 93. Section 47BB of chapter 175 of the General Laws is hereby repealed.

1495 SECTION 94. Said chapter 175 is hereby further amended by inserting after section
1496 47BB the following section:-

1497 Section 47CC. (a) For the purposes of this section, “telemedicine” shall mean the use of
1498 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
1499 patient's physical, oral or mental health; provided, however, that “telemedicine” shall not include
1500 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1501 (b) An individual policy of accident and sickness insurance issued under section 108 that
1502 provides hospital expense and surgical expense insurance and any group blanket or general
1503 policy of accident and sickness insurance issued under section 110 that provides hospital expense
1504 and surgical expense insurance, which is issued or renewed within or without the
1505 commonwealth, shall not decline to provide coverage for health care services solely on the basis
1506 that those services were delivered through the use of telemedicine by a contracted health care
1507 provider. Health care services delivered by way of telemedicine shall be covered to the same
1508 extent as if they were provided via in-person consultation or in-person delivery.

1509 (c) Coverage may include utilization review, including preauthorization, to determine the
1510 appropriateness of telemedicine as a means of delivering a health care service; provided,
1511 however, that the determinations shall be made in the same manner as if the service was
1512 delivered in person. A policy, contract, agreement, plan or certificate of insurance issued,
1513 delivered or renewed within the commonwealth, shall not be required to reimburse a health care
1514 provider for a health care service that is not a covered benefit under the plan nor reimburse a
1515 health care provider not contracted under the plan.

1516 A health care provider shall not be required to document a barrier to an in-person visit,
1517 nor shall the type of setting where telemedicine is provided be limited for health care services
1518 provided through telemedicine.

1519 A contract that provides coverage for telemedicine services may include a deductible,
1520 copayment or coinsurance requirement for a health care service provided through telemedicine as
1521 long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or
1522 coinsurance applicable to an in-person consultation or in-person delivery of services.

1523 (d) Coverage that reimburses a provider with a global payment, as defined in section 1 of
1524 chapter 6D, shall account for the provision of telemedicine services in setting that global
1525 payment amount.

1526 (e) Health care services provided by telemedicine shall conform to the standards of care
1527 applicable to the telemedicine provider's profession. Such services shall also conform to
1528 applicable federal and state health information privacy and security standards as well as
1529 standards for informed consent.

1530 SECTION 95. Said chapter 175 is hereby further amended by inserting after section
1531 108M the following 2 sections:-

1532 Section 108N. Upon request by a network provider, a carrier and, if applicable, a
1533 specialty organization subcontracted by a carrier to manage behavioral health services, shall
1534 disclose the methodology used for a provider's tier placement, including: (i) the criteria,
1535 measures, data sources and provider-specific information used in determining the provider's
1536 quality score; (ii) how the provider's quality performance compares to other in-network
1537 providers; and (iii) the data used in calculating the provider's cost-efficiency. A carrier may
1538 require a network provider to hold information received under this section confidential.

1539 Section 108O. An insurer licensed or otherwise authorized to transact accident or health
1540 insurance under this chapter shall use the aligned measure set established by the secretary of

1541 health and human services pursuant to section 16AA of chapter 6A as follows: (i) the insurer
1542 shall use the measures designated by the secretary as core measures in any contract with a health
1543 care provider, provider organization or accountable care organization that incorporates quality
1544 measures into payment terms; (ii) the insurer may use the measures designated by the secretary
1545 as non-core measures in any contract with a health care provider, provider organization or
1546 accountable care organization that incorporates quality measures into payment terms and shall
1547 not use any measures not designated as non-core measures; (iii) the insurer shall only use the
1548 measures in the aligned measure set established by the secretary to assign health care providers,
1549 provider organizations or accountable care organizations to tiers in the design of an accident or
1550 health plan.

1551 SECTION 96. Chapter 176A is hereby amended by adding the following 3 sections:-

1552 Section 38. Upon request by a network provider, a nonprofit hospital service corporation
1553 and, if applicable, a specialty organization subcontracted by a nonprofit hospital service
1554 corporation to manage behavioral health services, shall disclose the methodology used for a
1555 provider's tier placement, including: (i) the criteria, measures, data sources and provider-specific
1556 information used in determining the provider's quality score; (ii) how the provider's quality
1557 performance compares to other in-network providers; and (iii) the data used in calculating the
1558 provider's cost-efficiency. A carrier may require a network provider to hold information received
1559 under this section confidential.

1560 Section 39. (a) For purposes of this section, "telemedicine" shall mean the use of
1561 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
1562 patient's physical, oral or mental health; provided, however, that "telemedicine" shall not

1563 include audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-
1564 mail.

1565 (b) A contract between a subscriber and a nonprofit hospital service corporation under an
1566 individual or group hospital service plan shall not decline to provide coverage for health care
1567 services solely on the basis that those services were delivered through the use of telemedicine by
1568 a contracted health care provider. Health care services delivered by way of telemedicine shall be
1569 covered to the same extent as if they were provided via in-person consultation or in-person
1570 delivery.

1571 (c) Coverage may include utilization review, including preauthorization, to determine the
1572 appropriateness of telemedicine as a means of delivering a health care service, provided that the
1573 determinations shall be made as if the service was delivered in person. A carrier shall not be
1574 required to reimburse a health care provider for a health care service that is not a covered benefit
1575 under the plan nor reimburse a health care provider not contracted under the plan.

1576 Coverage for telemedicine services may include a provision for a deductible, copayment
1577 or coinsurance requirement for a health care service provided through telemedicine as long as the
1578 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance
1579 applicable to an in-person consultation or in-person delivery of services.

1580 Coverage that reimburses a provider with a global payment, as defined in section 1 of
1581 chapter 6D, shall account for the provision of telemedicine services in setting that global
1582 payment amount.

1583 (d) A health care provider shall not be required to document a barrier to an in-person
1584 visit, nor shall the type of setting where telemedicine is provided be limited for health care
1585 services provided through telemedicine.

1586 (e) Health care services provided by telemedicine shall conform to the standards of care
1587 applicable to the telemedicine provider's profession. Such services shall also conform to
1588 applicable federal and state health information privacy and security standards as well as
1589 standards for informed consent.

1590 Section 40. A nonprofit hospital service corporation organized under this chapter shall
1591 use the standard quality measure set established by the secretary of health and human services
1592 pursuant to section 16AA of chapter 6A as follows: (i) a nonprofit hospital service corporation
1593 shall use the measures designated by the secretary as core measures in any contract with a health
1594 care provider, provider organization or accountable care organization that incorporates quality
1595 measures into payment terms; (ii) a nonprofit hospital service corporation may use the measures
1596 designated by the secretary as non-core measures in any contract with a health care provider,
1597 provider organization or accountable care organization that incorporates quality measures into
1598 payment terms and shall not use any measures not designated as non-core measures; (iii) a
1599 nonprofit hospital service corporation shall only use the measures in the aligned measure set
1600 established by the secretary to assign health care providers, provider organizations or
1601 accountable care organizations to tiers in the design of a group hospital service plan.

1602 SECTION 97. Chapter 176B is hereby amended by adding the following 3 sections:-

1603 Section 25. Upon request by a network provider, a medical service corporation and, if
1604 applicable, a specialty organization subcontracted by a medical service corporation to manage

1605 behavioral health services, shall disclose the methodology used for a provider's tier placement,
1606 including: (i) the criteria, measures, data sources and provider-specific information used in
1607 determining the provider's quality score; (ii) how the provider's quality performance compares to
1608 other in-network providers; and (iii) the data used in calculating the provider's cost-efficiency. A
1609 carrier may require a network provider to hold information received under this section
1610 confidential.

1611 Section 26. (a) For the purposes of this section, “telemedicine” shall mean the use of
1612 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
1613 patient's physical, oral or mental health; provided, however, that “telemedicine” shall not include
1614 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1615 (b) A contract between a subscriber and a medical service corporation shall not decline to
1616 provide coverage for health care services solely on the basis that those services were delivered
1617 through the use of telemedicine by a contracted health care provider. Health care services
1618 delivered by way of telemedicine shall be covered to the same extent as if they were provided via
1619 in-person consultation or in-person delivery.

1620 (c) Coverage may include utilization review, including preauthorization, to determine the
1621 appropriateness of telemedicine as a means of delivering a health care service, provided that the
1622 determinations shall be made as if the service was delivered in person. A carrier is not required
1623 to reimburse a health care provider for a health care service that is not a covered benefit under
1624 the plan nor reimburse a health care provider not contracted under the plan. Coverage that
1625 reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall account
1626 for the provision of telemedicine services in setting that global payment amount. A contract that

1627 provides coverage for telemedicine services may contain a provision for a deductible, copayment
1628 or coinsurance requirement for a health care service provided through telemedicine as long as the
1629 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance
1630 applicable to an in-person consultation or in-person delivery of services.

1631 (d) A health care provider shall not be required to document a barrier to an in-person
1632 visit, nor shall the type of setting where telemedicine is provided be limited for health care
1633 services provided through telemedicine.

1634 (e) Health care services provided by telemedicine shall conform to the standards of care
1635 applicable to the telemedicine provider's profession. Such services shall also conform to
1636 applicable federal and state health information privacy and security standards as well as
1637 standards for informed consent.

1638 Section 27. A nonprofit medical service corporation organized under this chapter shall
1639 use the standard quality measure set established by the secretary of health and human services
1640 pursuant to section 16AA of chapter 6A as follows: (i) a nonprofit medical service corporation
1641 shall use the measures designated by the secretary as core measures in any contract with a health
1642 care provider, provider organization or accountable care organization that incorporates quality
1643 measures into payment terms; (ii) a nonprofit medical service corporation may use the measures
1644 designated by the secretary as non-core measures in any contract with a health care provider,
1645 provider organization or accountable care organization that incorporates quality measures into
1646 payment terms and shall not use any measures not designated as non-core measures; (iii) a
1647 nonprofit medical service corporation shall only use the measures in the aligned measure set

1648 established by the secretary to assign health care providers, accountable care organizations or
1649 provider organizations to tiers in the design of a group medical service plan.

1650 SECTION 98. Chapter 176D of the General Laws is hereby amended by inserting after
1651 section 3B the following section:-

1652 Section 3C. (a) As used in this section, the following words shall have the following
1653 meanings unless the context clearly requires otherwise:

1654 “Ambulance service provider”, a person or entity licensed by the department of public
1655 health pursuant to section 6 of chapter 111C to establish or maintain an ambulance service;
1656 provided, however, that an “ambulance provider” shall not include a “municipal ambulance
1657 service provider”.

1658 “Emergency ambulance services”, emergency services that an ambulance service
1659 provider may render under its ambulance service license when there is a condition or situation in
1660 which an individual has a need, or is perceived to have a need by the individual, a bystander or
1661 an emergency medical services provider, for immediate medical attention.

1662 “Insurance policy” and “insurance contract”, a policy, contract, agreement, plan or
1663 certificate of insurance issued, delivered or renewed within the commonwealth that provides
1664 coverage for expenses incurred by an insured for transportation services rendered by an
1665 ambulance service provider.

1666 “Insured”, an individual entitled to ambulance services benefits pursuant to an insurance
1667 policy or insurance contract.

1668 “Insurer”, (i) a Person as defined in section 1 of chapter 176D; (ii) any “Health
1669 maintenance organization” as defined in section 1 of chapter 176G; (iii) a nonprofit hospital
1670 service corporation organized under chapter 176A; (iv) any “Organization”, as defined in section
1671 1 of chapter 176I, that participates in a “Preferred provider arrangement” as defined in said
1672 section 1 of said chapter 176I; (v) any “Carrier”, as defined in section 1 of chapter 176J, that
1673 offers a small group health insurance plan under said chapter 176J; (vi) any “Company” as
1674 defined in section 1 chapter 175; (vii) any employee benefit trust; (viii) any self-insurance plan;
1675 and (ix) any company that is certified under sections 34A to 34N, inclusive, of chapter 90, is
1676 authorized to issue a policy of motor vehicle liability insurance under section 113A of chapter
1677 175 and that provides insurance for the expense of medical coverage.

1678 “Municipal ambulance service provider”, an entity operated by a municipality licensed by
1679 the department of public health pursuant to section 6 of chapter 111C to establish or maintain an
1680 ambulance service.

1681 (b) If an ambulance service provider provides an emergency ambulance service to an
1682 insured but is not an ambulance service provider under contract to the insurer that maintains or
1683 provides the insured’s insurance policy or insurance contract, the insurer that maintains or
1684 provides the insurance policy or insurance contract shall pay the ambulance service provider,
1685 pursuant to section 31 of chapter 176O, directly and promptly for the emergency ambulance
1686 service rendered to the insured. An ambulance service provider shall not be considered to have
1687 been paid for an emergency ambulance service rendered to an insured if the insurer makes
1688 payment for the emergency ambulance service to the insured. An ambulance service provider
1689 shall have a right of action against an insurer that fails to make a payment to it pursuant to this
1690 subsection.

1691 (c) With the exception of non-profit corporations licensed to operate critical care
1692 ambulance services that perform both ground and air transports, payment to an ambulance
1693 service provider under subsection (b) shall be the greater of: (i) the in-network contracted rate; or
1694 (ii) the payment determined according to the pricing schedules established under section 31 of
1695 chapter 176O.

1696 (d) An ambulance service provider shall be paid-in-full for an ambulance service
1697 provided to an insured under subsections (b) and (c) if paid in accordance with said subsections
1698 (b) and (c) and the provider shall not have any right or recourse to further bill the insured for the
1699 provided ambulance service, except for coinsurance, co-payments or deductibles for which the
1700 insured is responsible under the insured's insurance policy or insurance contract.

1701 (e) This section shall not limit or adversely affect an insured's right to receive benefits
1702 under an insurance policy or insurance contract that provides insurance coverage for ambulance
1703 services. This section shall not create an entitlement on behalf of an insured to coverage for
1704 ambulance services if the insured's insurance policy or insurance contract does not provide
1705 coverage for ambulance services.

1706 (f) A municipal ambulance service provider shall be subject to this section; provided,
1707 however, that a municipal ambulance service provider may apply for a waiver from the secretary
1708 of health and human services and the ambulance service advisory council established pursuant to
1709 section 31 of chapter 176O.

1710 SECTION 99. Chapter 176G is hereby amended by adding the following 3 sections:-

1711 Section 33. Upon request by a network provider, a health maintenance organization and,
1712 if applicable, a specialty organization subcontracted by a health maintenance organization to

1713 manage behavioral health services, shall disclose the methodology used for a provider's tier
1714 placement, including: (i) the criteria, measures, data sources and provider-specific information
1715 used in determining the provider's quality score; (ii) how the provider's quality performance
1716 compares to other in-network providers; and (iii) the data used in calculating the provider's cost-
1717 efficiency. A carrier may require a network provider to hold information received under this
1718 section confidential.

1719 Section 34. (a) For the purposes of this section, “telemedicine” shall mean the use of
1720 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
1721 patient's physical, oral or mental health; provided, however, that “telemedicine” shall not include
1722 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1723 (b) A contract between a member and a health maintenance organization shall not decline
1724 to provide coverage for health care services solely on the basis that those services were delivered
1725 through the use of telemedicine by a contracted health care provider. Health care services
1726 delivered by way of telemedicine shall be covered to the same extent as if they were provided via
1727 in-person consultation or in-person delivery.

1728 (c) A carrier may undertake utilization review, including preauthorization, to determine
1729 the appropriateness of telemedicine as a means of delivering a health care service, provided that
1730 the determinations shall be made as if the service was delivered in person. A carrier is not
1731 required to reimburse a health care provider for a health care service that is not a covered benefit
1732 under the plan nor reimburse a health care provider not contracted under the plan. A contract
1733 that provides coverage for telemedicine services may contain a provision for a deductible,
1734 copayment or coinsurance requirement for a health care service provided through telemedicine as

1735 long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or
1736 coinsurance applicable to an in-person consultation or in-person delivery of services. Coverage
1737 that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall
1738 account for the provision of telemedicine services in setting that global payment amount.

1739 (d) A health care provider shall not be required to document a barrier to an in-person
1740 visit, nor shall the type of setting where telemedicine is provided be limited for health care
1741 services provided through telemedicine.

1742 (e) Health care services provided by telemedicine shall conform to the standards of care
1743 applicable to the telemedicine provider's profession. Such services shall also conform to
1744 applicable federal and state health information privacy and security standards as well as
1745 standards for informed consent.

1746 Section 35. A health maintenance organization organized under this chapter shall use the
1747 standard quality measure set established by the secretary of health and human services pursuant
1748 to section 16AA of chapter 6A as follows: (i) a health maintenance organization shall use the
1749 measures designated by the secretary as core measures in any contract with a health care
1750 provider, provider organization or accountable care organization that incorporates quality
1751 measures into payment terms; (ii) a health maintenance organization may use the measures
1752 designated by the secretary as non-core measures in any contract with a health care provider,
1753 provider organization or accountable care organization that incorporates quality measures into
1754 payment terms and shall not use any measures not designated as non-core measures; (iii) a health
1755 maintenance organization shall only use the measures in the aligned measure set established by

1756 the secretary to assign health care providers, accountable care organizations or provider
1757 organizations to tiers in the design of any health maintenance contract.

1758 SECTION 100. Chapter 176I of the General Laws is hereby amended by adding the
1759 following 2 sections:-

1760 Section 13. (a) For the purposes of this section, “telemedicine” shall mean the use of
1761 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
1762 patient's physical, oral or mental health; provided, however, that “telemedicine” shall not include
1763 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1764 (b) A preferred provider contract between a covered person and an organization shall not
1765 decline to provide coverage for health care services solely on the basis that those services were
1766 delivered through the use of telemedicine by a contracted health care provider. Health care
1767 services delivered by way of telemedicine shall be covered to the same extent as if they were
1768 provided via in-person consultation or in-person delivery.

1769 (c) An organization may undertake utilization review, including preauthorization, to
1770 determine the appropriateness of telemedicine as a means of delivering a health care service,
1771 provided that the determinations shall be made in the same manner as those regarding the same
1772 service when it is delivered in person. An organization is not required to reimburse a health care
1773 provider for a health care service that is not a covered benefit under the plan nor reimburse a
1774 health care provider not contracted under the plan.

1775 A preferred provider contract that provides coverage for telemedicine services may
1776 contain a provision for a deductible, copayment or coinsurance requirement for a health care
1777 service provided through telemedicine as long as the deductible, copayment or coinsurance does

1778 not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or
1779 in-person delivery of services. Coverage that reimburses a provider with a global payment, as
1780 defined in section 1 of chapter 6D, shall account for the provision of telemedicine services in
1781 setting that global payment amount.

1782 (d) A health care provider shall not be required to document a barrier to an in-person
1783 visit, nor shall the type of setting where telemedicine is provided be limited for health care
1784 services provided through telemedicine.

1785 (e) Health care services provided by telemedicine shall conform to the standards of care
1786 applicable to the telemedicine provider's profession. Such services shall also conform to
1787 applicable federal and state health information privacy and security standards as well as
1788 standards for informed consent.

1789 Section 14. An organization shall use the standard quality measure set established by the
1790 secretary of health and human services pursuant to section 16AA of chapter 6A as follows: (i) an
1791 organization shall use the measures designated by the secretary as core measures in any contract
1792 with a health care provider, provider organization or accountable care organization that
1793 incorporates quality measures into payment terms; (ii) an organization may use the measures
1794 designated by the secretary as non-core measures in any contract with a health care provider,
1795 provider organization or accountable care organization that incorporates quality measures into
1796 payment terms and shall not use any measures not designated as non-core measures; (iii) an
1797 organization shall only use the measures in the aligned measure set established by the secretary
1798 to assign health care providers, accountable care organizations or provider organizations to tiers
1799 in the design of a health benefit plan.

1800 SECTION 101. Chapter 176J of the General Laws is hereby amended by striking out
1801 section 11, as appearing in the 2016 Official Edition, and inserting in place thereof the following
1802 section:-

1803 Section 11. (a) For the purposes of this section, the following words shall have the
1804 following meanings unless the context clearly requires otherwise:

1805 “High-value health care services”, a set of services that yield improved management of
1806 chronic conditions or meaningfully reduce the occurrence of high-cost care episodes related to
1807 the underlying condition that the service is meant to treat, as identified by the division of
1808 insurance, in consultation with the health policy commission and the center for health
1809 information and analysis;

1810 “Shoppable health care services”, a set of services deemed sufficiently substitutable
1811 across providers for which there is adequate information on cost and quality to inform a patient’s
1812 decision on where to obtain those health care services as identified by the division of insurance
1813 in consultation with the health policy commission and the center for health information and
1814 analysis.

1815 (b) A carrier that offers a health benefit plan that provides or arranges for the delivery of
1816 health care services through a closed network of health care providers and, as of the close of any
1817 preceding calendar year, has a combined total of not less than 5,000 eligible individuals, eligible
1818 employees and eligible dependents who are enrolled in health benefit plans sold, issued,
1819 delivered, made effective or renewed to qualified small businesses or eligible individuals shall
1820 offer to all eligible individuals and small businesses in not less than 2 geographic areas at least 1
1821 of the following plans:

1822 (i) a plan with a reduced or selective network of providers;

1823 (ii) a plan in which providers are tiered and member cost-sharing is based on the tier
1824 placement of the provider that includes a base premium discount of not less than 19 per cent;

1825 (iii) a plan in which an enrollee's premium varies based on the primary care provider
1826 selected at the time of enrollment;

1827 (iv) a plan in which a separate cost-sharing differential is applied to shoppable health care
1828 services among the network of providers; or

1829 (v) a plan in which there is a separate reduced or eliminated cost-sharing differential for
1830 high value health care services relative to other services covered by the plan.

1831 (c) Annually, the commissioner shall determine the base premium rate discount compared
1832 to the base premium of the carrier's most actuarially-similar plan with the carrier's non-selective
1833 or non-tiered network of providers under clauses (i) and (ii) of subsection (b). The savings may
1834 be achieved by means including, but not limited to: (i) the exclusion of providers with similar or
1835 lower quality based on the standard quality measure set with higher health status adjusted total
1836 medical expenses or relative prices, as determined pursuant to the methodology under section 52
1837 of chapter 288 of the Acts of 2010; or (ii) increased member cost-sharing for members who
1838 utilize providers for non-emergency services with similar or lower quality based on the standard
1839 quality measure set and with higher health status adjusted total medical expenses or relative
1840 prices, as determined pursuant to the methodology under said section 288 of the Acts of 2010.

1841 The commissioner may apply waivers to the base premium rate discount determined by
1842 the commissioner under this section to carriers that receive not less than 80 per cent of their

1843 incomes from government programs or that have service areas that do not include an area within
1844 the boundaries of the abolished counties of Suffolk or Middlesex and that were first admitted to
1845 do business by the division of insurance not later than January 1, 1986 as health maintenance
1846 organizations under chapter 176G.

1847 (d) The commissioner shall require a plan under paragraph (iii) of subsection (b) to have
1848 at least 1 tier that provides the base premium rate discount. A carrier may include a provider in a
1849 plan under paragraph (iii) of subsection (b) only if a provider receives reasonable information on
1850 plan performance from the carrier pursuant to the plan.

1851 (e) A tiered network plan shall only include variations in member cost-sharing among
1852 provider tiers that are reasonable in relation to the premium charged and shall ensure adequate
1853 access to covered services. Carriers shall tier providers based on quality performance as
1854 measured by the standard quality measure set and by cost performance as measured by health
1855 status adjusted total medical expenses and relative prices. If applicable quality measures are not
1856 available, tiering may be based solely on health status adjusted total medical expenses or relative
1857 prices or both.

1858 The commissioner shall promulgate regulations requiring the uniform reporting of tiering
1859 information by carriers. The regulations shall include, but not be limited to, a requirement that a
1860 carrier that is implementing a tiered network plan or is modifying the tiering methodology for an
1861 existing tiered network plan shall report a detailed description of the methodology used for the
1862 tiering of providers to the commissioner not less than 90 days before the effective date of the
1863 plan or modification. The description shall include, but not be limited to: (i) the statistical basis
1864 for tiering; (ii) a list of providers to be tiered at each member cost-sharing level; (iii) a

1865 description of how the methodology and resulting tiers shall be communicated to each network
1866 provider, eligible individuals and small groups; (iv) a description of the appeals process a
1867 provider may pursue to challenge the assigned tier level; and (v) the utilization of a variable
1868 premium amount based on tier designation for the primary care provider selected by the member,
1869 if any.

1870 (f) The commissioner shall determine network adequacy: (i) for a tiered network plan
1871 based on the availability of sufficient network providers in the carrier's overall network of
1872 providers; and (ii) for a selective network plan based on the availability of sufficient network
1873 providers in the carrier's selective network.

1874 In determining network adequacy under this section, the commissioner may consider
1875 factors including the location of providers participating in the plan and employers or members
1876 that enroll in the plan, the range of services provided by providers in the plan and plan benefits
1877 that recognize and provide for extraordinary medical needs of members that may not be
1878 adequately dealt with by the providers within the plan network.

1879 (g) A carrier may reclassify provider tiers and determine provider participation in
1880 selective and tiered plans not more than once per calendar year; provided, however, that a carrier
1881 may reclassify a provider from a higher cost tier to a lower cost tier or add a provider to a
1882 selective network at any time. If a carrier reclassifies provider tiers or providers participating in a
1883 selective plan during the course of an account year, the carrier shall provide notice to affected
1884 members of the account that shall include information regarding the plan changes not less than
1885 30 days before the changes are to take effect. A carrier shall provide information on the carrier's
1886 website about any tiered or selective plan including, but not limited to, the providers

1887 participating in the plan, the selection criteria for those providers and, where applicable, the tier
1888 in which each provider is classified.

1889 (h) The commissioner shall review plans under clauses (iv) and (v) of subsection (b) in a
1890 manner consistent with other products offered in the commonwealth. The commissioner may
1891 disapprove a plan established pursuant to clause (iv) or (v) of subsection (b) if it determines that
1892 the carrier-differentiated cost-sharing obligations are solely based on the provider. There shall be
1893 a rebuttable presumption that a plan has violated this subsection if the cost-sharing obligation for
1894 the services provided by a provider, including a health care facility, accountable care
1895 organization, patient-centered medical home or provider organization, is the same cost-sharing
1896 obligation without regard for the types of services provided pursuant to clause (iv) or (v).

1897 When reviewing a plan established pursuant to clauses (iv) and (v) of subsection (b), the
1898 commissioner shall ensure that the plan promotes: (i) the avoidance of consumer confusion; (ii)
1899 the minimization of administrative burdens on payers and providers in implementing the plan;
1900 and (iii) allowing for patients to receive services in appropriate locations.

1901 (i) The commissioner shall make publicly available on the commissioner's website: (i) a
1902 description of each plan offered under this section, including a list of providers or services by tier
1903 or a list of providers included in a selective network plan; (ii) membership trends for each plan
1904 offered under this section; (iii) the extent to which plans offered under this section have reduced
1905 health care costs for patients and employers; and (iv) the effect of plans offered under this
1906 section on provider mix and other factors impacting overall state health care costs. The
1907 commissioner shall ensure that the information is updated not less than annually.

1908 Nothing in this section shall exempt an insurance carrier or product from state and federal
1909 mental health parity and addiction equity laws, including those codified at 42 U.S. Code §
1910 300gg-26, and regulations implemented pursuant to section 8K of chapter 26. Nothing in this
1911 section shall create a lesser standard of scrutiny for parity compliance for any reduced, tiered or
1912 discounted plan established pursuant to this section.

1913 SECTION 102. Said chapter 176J is hereby further amended by adding the following
1914 section:-

1915 Section 18. Upon request by a network provider, a carrier and, if applicable, a specialty
1916 organization subcontracted by a carrier to manage behavioral health services, shall disclose the
1917 methodology used for a provider's tier placement, including: (i) the criteria, measures, data
1918 sources and provider-specific information used in determining the provider's quality score; (ii)
1919 how the provider's quality performance compares to other in-network providers; and (iii) the data
1920 used in calculating the provider's cost-efficiency. A carrier may require a network provider to
1921 hold information received under this section confidential.

1922 SECTION 103. Section 1 of chapter 176O of the General Laws, as appearing in the 2016
1923 Official Edition, is hereby amended by inserting after the definition of “Incentive plan” the
1924 following definition:-

1925 “In-network contracted rate”, the rate contracted between an insured's carrier and a
1926 network health care provider for the reimbursement of health care services delivered by that
1927 health care provider to the insured.

1928 SECTION 104. Said section 1 of said chapter 176O, as so appearing, is hereby further
1929 amended by inserting after the definition of “Network” the following 3 definitions:-

1930 “Noncontracted commercial rate for emergency services”, the amount set pursuant to
1931 section 16A of chapter 6D and used to determine the rate of payment to a health care provider for
1932 the provision of emergency health care services to an insured when the health care provider is
1933 not in the carrier’s network.

1934 “Noncontracted commercial rate for nonemergency services”, the amount set pursuant to
1935 section 16A of chapter 6D and used to determine the rate of payment to a health care provider for
1936 the provision of nonemergency health care services to an insured when the health care provider
1937 is not in the carrier’s network.

1938 “Nonemergency services”, health care services rendered to an insured experiencing a
1939 condition other than an emergency medical condition.

1940 SECTION 105. Clause (a) of section 7 of said chapter 176O, as so appearing, is hereby
1941 amended by striking out clause (1) and inserting in place thereof the following clause:-

1942 (1) a list of health care providers in the carrier's network, organized by specialty and by
1943 location, along with a summary on its internet website for each provider that shall include: (i) the
1944 method used to compensate or reimburse the provider, including details of measures and
1945 compensation percentages tied to any incentive plan or pay for performance provision; (ii) the
1946 provider price relativity, as reported under section 10 of chapter 12C ; (iii) the provider's health
1947 status adjusted total medical expenses, as defined in and reported under said section 10 of said
1948 chapter 12C; and (iv) current measures of the provider's quality using the measures established
1949 by the secretary of health and human services pursuant to section 16AA of chapter 6A; provided,
1950 however, that if any specific provider or type of provider requested by an insured is not available
1951 in the network or is not a covered benefit, the information shall be provided in an easily

1952 obtainable manner; provided further, that the carrier shall prominently promote providers based
1953 on quality performance as measured by the measures established by the secretary of health and
1954 human services pursuant to said section 16AA of said chapter 6A and cost performance as
1955 measured by health status adjusted total medical expenses and relative prices;.

1956 SECTION 106. Section 9A of said chapter 176O, as so appearing, is hereby amended by
1957 inserting after the word “approval”, in line 15, the following words:- unless the provider is
1958 included in a tier for a set of shoppable health care services pursuant to clause (iv) of subsection
1959 (b) of section 11 of chapter 176J.

1960 SECTION 107. Section 23 of said chapter 176O, as so appearing, is hereby amended by
1961 inserting after the word “time”, in line 3, the following words:- , the network status of an
1962 identified health care provider.

1963 SECTION 108. Said section 23 of said chapter 176O, as so appearing, is hereby further
1964 amended by adding the following sentence:- The information provided on the website shall
1965 conform to the uniform methodology for a provider’s tier designation developed pursuant to
1966 section 20A of chapter 12C.

1967 SECTION 109. Said chapter 176O is hereby further amended by adding the following 4
1968 sections:-

1969 Section 28. (a) As used in this section, the following words shall have the following
1970 meanings unless the context clearly requires otherwise:

1971 “Facility fee”, a fee charged or billed by a hospital or health system for outpatient
1972 hospital services provided in a hospital-based facility that is intended to compensate the hospital

1973 or health system for the operational expenses of the hospital or health system and is separate and
1974 distinct from a professional fee.

1975 “Health system”, shall have the same meaning as “Provider Organization or Health
1976 System or System”, as provided by the health policy commission.

1977 “Hospital”, a hospital licensed pursuant to section 51 of chapter 111.

1978 “Hospital-based facility”, a facility that is owned or operated, in whole or in part, by a
1979 hospital or health system where hospital or professional medical services are provided.

1980 “Professional fee”, a fee charged or billed by a provider, hospital or health system for
1981 professional medical services provided in a hospital-based facility.

1982 (b) If a hospital or health system charges a facility fee for services subject to the
1983 requirements of section 51L of chapter 111, the hospital or health system shall provide any
1984 patient receiving such a service with written notice of the fee. The notice shall include a
1985 statement that the patient may be billed separately for that facility fee and the expected amount
1986 of the facility fee.

1987 (c) If a hospital or health system is required to provide a patient with notice under
1988 subsection (b) and a patient's appointment is scheduled to occur not less than 10 days after the
1989 appointment is made, the hospital or health system shall provide written notice and explanation
1990 to the patient by first class mail, encrypted electronic means or a secure patient Internet portal
1991 not less than 3 days after the appointment is made. If an appointment is scheduled to occur less
1992 than 10 days after the appointment is made or if the patient arrives without an appointment, the
1993 notice shall be provided to the patient on the hospital-based facility’s premises.

1994 For emergency care, a hospital or health system shall provide written notice and
1995 explanation to the patient prior to the care if practicable, or if notice is not practicable, the
1996 hospital or health system shall provide an explanation of the fee to the patient within a
1997 reasonable period of time; provided, however, that the explanation of the fee shall be provided
1998 before the patient leaves the hospital-based facility. If the patient is incapacitated or otherwise
1999 unable to read, understand and act on the patient's rights, the notice and explanation of the fee
2000 shall be provided to the patient's representative within a reasonable period of time.

2001 (d) A hospital-based facility shall clearly identify itself as being hospital-based, including
2002 by stating the name of the hospital or health system in its signage, marketing materials, Internet
2003 web sites and stationery.

2004 (e) If a hospital-based facility charges a facility fee, notice shall be posted informing
2005 patients that they the patient may incur additional financial liability due to the hospital-based
2006 facility's status. Notice shall be prominently displayed in locations accessible to and visible by
2007 patients, including in patient waiting areas.

2008 (f)(1) If a hospital or health system designates a location as a hospital-based facility, the
2009 hospital or health system shall provide written notice of the designation to all patients who
2010 received services at the now designated hospital-based facility during the previous calendar year.
2011 The written notice shall be provided not later than 30 days after the designation and shall state
2012 that: (i) the location is now considered to be a hospital-based facility; (ii) certain health care
2013 services delivered at the facility will result in separate bills for services from the hospital and the
2014 provider; and (iii) patients seeking care at the facility may incur additional financial liability at
2015 that location due its hospital-based facility status.

2016 (2) If a hospital or health system designates a location as a hospital-based facility, the
2017 hospital or health system shall not collect a facility fee for a service provided at the now
2018 designated hospital-based facility until not less than 30 days after the written notice required in
2019 paragraph (1) is mailed.

2020 (3) A notice required or provided under paragraph (1) or (2) shall be filed with the health
2021 policy commission established under section 2 of chapter 6D not later than 30 days after its
2022 issuance.

2023 (g) A violation of this section shall be an unfair trade practice under chapter 93A.

2024 (h) The commissioner may promulgate regulations that are necessary to implement this
2025 section subject to the limitations of section 16A of chapter 6D.

2026 Section 29. (a) As used in this section, “facility fee”, “health system”, “hospital” and
2027 “hospital-based facility” shall have the meanings as provided in section 28.

2028 (b) A carrier shall not impose a separate copayment on an insured or provide
2029 reimbursement to a hospital, health system or hospital-based facility for services provided at a
2030 hospital, health system or a hospital-based facility or for reimbursement to such a hospital, health
2031 system or hospital-based facility for a facility fee for services utilizing a current procedural
2032 terminology evaluation and management code or otherwise prohibited pursuant to section 51L of
2033 chapter 111.

2034 (c) Nothing in this section shall prohibit a carrier from restricting the reimbursement of
2035 facility fees beyond the limitations set forth in section 51K of chapter 111.

2036 Section 30. (a)(1) A carrier shall reimburse a health care provider as follows:

2037 (i) where the health care provider is a member of an insured's carrier's network but not a
2038 participating provider in the insured's health benefit plan and the health care provider has
2039 delivered health care services to the insured to treat an emergency medical condition, the carrier
2040 shall pay that provider the in-network contracted rate for each delivered service; provided,
2041 however, that such payment shall constitute payment in full to that health care provider and the
2042 provider shall not bill the insured except for any applicable copayment, coinsurance or
2043 deductible that would be owed if the insured received such service or services from a
2044 participating health care provider under the terms of the insured's health benefit plan;

2045 (ii) where the health care provider is not a member of an insured's carrier's network and
2046 the health care provider has delivered health care services to the insured to treat an emergency
2047 medical condition, the carrier shall pay that provider the noncontracted commercial rate for
2048 emergency services for each delivered service; provided, however, that such payment shall
2049 constitute payment in full to the health care provider and the provider shall not bill the insured
2050 except for any applicable copayment, coinsurance or deductible that would be owed if the
2051 insured received such service or services from a participating health care provider under the
2052 terms of the insured's health benefit plan;

2053 (iii) where the health care provider is a member of an insured's carrier's network but not
2054 a participating provider in the insured's health benefit plan and the health care provider has
2055 delivered nonemergency health care services to the insured and a participating provider in the
2056 insured's health benefit plan is unavailable or the health care provider renders those
2057 nonemergency health care services without the insured's knowledge, the carrier shall pay that
2058 provider the in-network contracted rate for each delivered service; provided, however, that such
2059 payment shall constitute payment in full to the health care provider and the provider shall not bill

2060 the insured except for any applicable copayment, coinsurance or deductible that would be owed
2061 if the insured received such service from a participating health care provider under the terms of
2062 the insured's health benefit plan; and

2063 (iv) where the health care provider is not a member of an insured's carrier's network and
2064 the health care provider has delivered nonemergency services to the insured and a participating
2065 provider in the insured's health benefit plan is unavailable or the health care provider renders
2066 those nonemergency health care services without the insured's knowledge, the carrier shall pay
2067 the provider the noncontracted commercial rate for nonemergency services for each delivered
2068 service; provided, however, that such payment shall constitute payment in full to the health care
2069 provider and the provider shall not bill the insured except for any applicable copayment,
2070 coinsurance or deductible that would be owed if the insured received such service or services
2071 from a participating health care provider under the terms of the insured's health benefit plan.

2072 (2) It shall be an unfair and deceptive act or practice, in violation of section 2 of chapter
2073 93A, for any health care provider or carrier to request payment from an enrollee, other than the
2074 applicable coinsurance, copayment, deductible or other out-of-pocket expense, for the services
2075 described in paragraph (1).

2076 (b) Nothing in this section shall require a carrier to pay for health care services delivered
2077 to an insured that are not covered benefits under the terms of the insured's health benefit plan.

2078 (c) Nothing in this section shall require a carrier to pay for nonemergency health care
2079 services delivered to an insured if the insured had a reasonable opportunity to choose to have the
2080 service performed by a network provider participating in the insured's health benefit plan.

2081 Evidence that an insured had a reasonable opportunity to choose to have the service performed

2082 by a network provider may include, but not be limited to, a written acknowledgement submitted
2083 with any claim for reimbursement from the carrier that: (i) is signed by the insured; and (ii) was
2084 provided by the health care provider to the insured before the delivery of nonemergency health
2085 care services and provided the insured a reasonable amount of time to seek health care services
2086 from a participating provider in the insured's health benefit plan.

2087 (d) The commissioner shall promulgate regulations that are necessary to implement this
2088 section.

2089 Section 31. (a) For the purposes of this section, "Ambulance service provider",
2090 "Emergency ambulance services" and "Municipal ambulance service provider" shall have the
2091 same meanings as provided in section 3C of chapter 176D.

2092 (b) There shall be an ambulance service advisory council to advise the secretary of health
2093 and human services on the ambulance service pricing schedule established under subsection (c)
2094 and provide payment under subsection (c) of section 3C of chapter 176D. The council shall be
2095 appointed by the secretary and consist of the following members or their designees: (i) the
2096 secretary of public safety and security; (ii) the commissioner of the group insurance commission;
2097 (iii) a representative of the Fire Chiefs' Association of Massachusetts, Inc.; (iv) the president of
2098 the Massachusetts Municipal Association, Inc.; (v) the president of the Massachusetts
2099 Association of Health Plans, Inc.; (vi) the president of Blue Cross and Blue Shield of
2100 Massachusetts, Inc.; (vii) the president of the Professional Fire Fighters of Massachusetts; (viii) a
2101 representative of the Massachusetts Ambulance Association, Incorporated; and (ix) the president
2102 of a commercial insurer.

2103 (c) The secretary of health and human services, in consultation with the center for health
2104 information and analysis, health policy commission and ambulance service advisory council,
2105 shall establish, and review every 3 years, an ambulance service pricing schedule that is: (i) not
2106 more than 160 per cent of the national fee schedule for ambulance services established under
2107 subsection l of 42 U.S.C. 1395m; or (ii) an alternate methodology established in consultation
2108 with the center, commission and ambulance service advisory council.

2109 The alternate methodology, if established, shall reflect: (i) any new costs for compliance
2110 with new state or federal statutory or regulatory compliance; (ii) services offered by the
2111 ambulance service provider; (iii) personnel cost; (iv) cost differences associated with differences
2112 in geography that impact services; (v) differences in distances travelled for services; and (vi) the
2113 actual cost of providing services.

2114 (d) The secretary of health and human services, in consultation with the ambulance
2115 service advisory council, shall establish a process to review waivers submitted by municipal
2116 ambulance service providers under section 3C of chapter 176D. A waiver application shall
2117 include, but shall not be limited to: (i) the reason for requesting the waiver; (ii) an alternative
2118 payment methodology or pricing schedule; and (iii) an affidavit of support from the municipality.
2119 A waiver granted under this section shall be for at least 1 year and shall be not more than 3 years;
2120 provided, however, that a waiver may be renewed for subsequent periods of time of not more
2121 than 3 years.

2122 SECTION 110. Chapter 176Q of the General Laws is hereby amended by striking out
2123 section 7A, as appearing in the 2016 Official Edition, and inserting in place thereof the following
2124 section:-

2125 Section 7A. (a) There shall be a small group incentive program to expand the prevalence
2126 of employee health plans offered by small businesses that shall be administered by the board, in
2127 consultation with the department of public health. The program shall provide subsidies and
2128 technical assistance for eligible small groups that offer health plans to employees. A small group
2129 shall be eligible to participate in the program if the small group purchases group coverage
2130 through the connector and meets certain criteria determined by the board. In determining such
2131 criteria, the board may consider, but not be limited to considering, the following factors: (i) the
2132 size of the employer group; (ii) the amount of an employer's subsidy for the cost of employee
2133 coverage; (iii) the average salary of employees in the group; (iv) enrollment in a high-value plan
2134 that promotes employee wellness; and (v) participation in a plan-administered or employer-
2135 administered wellness program.

2136 (b) The connector shall provide an annual subsidy of up to 50 per cent of eligible
2137 employer health care costs, calculated by the board, for eligible small groups participating in the
2138 program. The connector may seek a state innovation waiver under 42 U.S.C. 18052 to fund this
2139 program.

2140 (c) If the director determines that available funds are insufficient to meet the projected
2141 costs of enrolling new eligible employers, the director may impose a cap on enrollment in the
2142 program or on the subsidy amounts available to eligible small groups.

2143 (d) The connector shall provide a report on the enrollment in the small group incentive
2144 program and an evaluation of the impact of the program on expanding health plan participation
2145 for small groups annually, not later than March 1, to the clerks of the senate and house of
2146 representatives, the chairs of the joint committee on community development and small

2147 businesses, the chairs of the joint committee on health care financing and the chairs of the house
2148 and senate committees on ways and means.

2149 (e) The connector shall promulgate regulations necessary to implement this section.

2150 SECTION 111. The General Laws are hereby amended by inserting after chapter 176V
2151 the following chapter:-

2152 CHAPTER 176W.

2153 HOSPITAL ALIGNMENT AND REVIEW COUNCIL.

2154 Section 1. For the purposes of this chapter, the following words shall have the following
2155 meanings unless the context clearly requires otherwise:

2156 “Carrier”, an insurer licensed or otherwise authorized to transact accident or health
2157 insurance under chapter 175, a nonprofit hospital service corporation organized under chapter
2158 176A, a nonprofit medical service corporation organized under chapter 176B, a health
2159 maintenance organization organized under chapter 176G and an organization entering into a
2160 preferred provider arrangement under chapter 176I; provided, however, that “carrier” shall not
2161 include an employer purchasing coverage or acting on behalf of its employees or the employees
2162 of any subsidiary or affiliated corporation of the employer; provided further, that unless
2163 specifically stated otherwise, “carrier” shall not include an entity that offers a policy, certificate
2164 or contract that provides coverage solely for dental care services or vision care services.

2165 “Center”, the center for health information and analysis established in chapter 12C.

2166 “Commission”, the health policy commission established in chapter 6D.

2167 “Council”, the hospital alignment and review council established in section 2.

2168 “Division”, the division of insurance.

2169 “Growth in hospital spending”, the annual growth in total commercial hospital inpatient
2170 and outpatient spending as reported by the center.

2171 “Hospital”, the teaching hospital of the University of Massachusetts medical school and
2172 any hospital licensed under section 51 of chapter 111 that contains a majority of medical-
2173 surgical, pediatric, obstetric and maternity beds, as defined by the department of public health.

2174 “Hospital spending”, total commercial spending on hospital inpatient and outpatient
2175 services.

2176 “Relative price”, the contractually negotiated amounts paid to providers by each private
2177 and public carrier for health care services, including nonclaims-related payments, and expressed
2178 in the aggregate relative to the payer's networkwide average amount paid to providers, as
2179 determined pursuant to the methodology under section 52 of section 288 of the acts of 2010.

2180 “Target growth in hospital spending”, the percentage of growth in hospital spending
2181 determined by the council.

2182 “Target hospital rate distribution”, the minimum rate of a carrier’s reimbursement for
2183 services provided by a hospital as determined by the council.

2184 Section 2. (a) There shall be a hospital alignment and review council. The council
2185 shall consist of 3 members or their designee: (i) the commissioner of insurance, who shall serve
2186 as chair; (ii) the executive director of the center for health information and analysis; and (iii) the
2187 executive director of the health policy commission.

2188 The council shall review growth in hospital spending and receive information from the
2189 center, commission and division for its overall consideration.

2190 (b) The council may: (i) make, amend and repeal rules and regulations for the
2191 management of its affairs; (ii) make contracts and execute all instruments necessary or
2192 convenient for the carrying on of its business; (iii) enter into agreements or transactions with any
2193 federal, state or municipal agency or other public institution or with any private individual,
2194 partnership, firm, corporation, association or other entity; and (iv) enter into interdepartmental
2195 agreements with any other state agencies the council considers necessary to implement this
2196 chapter.

2197 (c) Information received by the council from the center, commission and division shall be
2198 confidential information and shall not be a public record under clause Twenty-sixth of section 7
2199 of chapter 4 or chapter 66 unless the information received by the council is otherwise made
2200 publicly available.

2201 (d) The council shall be subject to chapter 30A.

2202 The center, commission and division shall enter into a memorandum of understanding
2203 that outlines the information authorized to be shared between each agency for use pursuant to
2204 this chapter and ensures that any information received by an agency that it would not otherwise
2205 receive shall be used solely for the purposes of this chapter.

2206 Section 3. (a) The council shall review the progress of carriers and hospitals towards
2207 demonstrating: (i) the target hospital rate distribution; and (ii) growth in hospital spending that
2208 does not exceed target growth in hospital spending.

2209 (b) The council shall review the growth in hospital spending and the statewide
2210 commercial relative price distribution for the previous year to determine whether the carriers and
2211 hospitals have met the goals established under subsection (a).

2212 (c) Annually, the center, in consultation with the commission, shall submit a report to the
2213 council on the statewide commercial relative price distribution and growth in hospital spending
2214 not later than October 1. The council shall review the report and certify, not later than December
2215 1, whether the conditions established under subsection (a) were satisfied for the previous year.

2216 Section 4. (a) Carriers shall annually certify to the division that: (i) all rates filed comply
2217 with the target hospital rate distribution; and (ii) if any hospital has received an increase in its
2218 rate of reimbursement, all hospitals contracting with the carrier have received an increase greater
2219 than 0 per cent.

2220 If the division determines that a carrier does not meet the certification requirements, the
2221 division shall notify the carrier and presumptively disapprove the rates filed by the carrier.

2222 (b) In any year that the council determines that either carriers have not demonstrated the
2223 target hospital rate distribution or the growth in hospital spending exceeded the target growth in
2224 hospital spending, the council shall:

2225 (i) assess a carrier referred to the council by the division that did not meet the
2226 certification requirements of subsection (a) in an amount equal to the product of: (i) the total
2227 change in rates for the fewest number of contracted hospitals necessary for the carrier to achieve
2228 the target hospital rate distribution; and (ii) the projected utilization of those same hospitals
2229 provided, however, that a carrier shall not be assessed unless the division certifies that the carrier

2230 was notified that the carrier's rates did not meet the certification requirements of said subsection
2231 (a) and did not refile compliant rates; or

2232 (ii) assess a penalty on the top 3 hospitals that contributed to hospital spending that
2233 equals in its aggregate the difference between the growth in hospital spending and the target
2234 growth in hospital spending; provided, however, that each hospital shall be responsible for a
2235 proportionate share of the penalty commensurate to its share of commercial hospital spending.

2236 (c) In any year that the council determines that carriers and hospitals have not
2237 demonstrated the target hospital rate distribution or growth in hospital spending that does not
2238 exceed target growth in hospital spending, the council may define "target hospital rate
2239 distribution" and "target growth in hospital spending"; provided, however, that the council shall
2240 solicit input from the advisory committee, receive testimony and solicit public input and review
2241 the definition every 3 years. The council shall submit proposed definitions to the clerks of the
2242 senate and house of representatives, the joint committee on health care financing and the senate
2243 and house committees on ways and means not less than 4 months prior to their effective date.

2244 The joint committee on health care financing may, not later than 30 days after the
2245 submission of the proposed definitions with the clerks of the senate and house of representatives,
2246 the joint committee on health care financing and the senate and house committees on ways and
2247 means, hold a public hearing on the proposed definitions. The joint committee may report its
2248 findings to the general court, together with drafts of legislation necessary to implement those
2249 findings. In the report, the joint committee may include its recommendation on whether to affirm
2250 or modify the proposed definitions. The joint committee shall issue any findings not later than
2251 20 days after the public hearing and shall provide a copy of the findings and any proposed

2252 legislation to the board. If the general court does not enact legislation with respect to the
2253 recommendations within 65 days after the commission has submitted the recommendations to the
2254 joint committee, the proposed definitions shall be in effect until the definitions proposed take
2255 effect.

2256 (d) If the council amends the definition of “target hospital rate distribution” or “target
2257 growth in hospital spending”, the council shall consider: (i) factors resulting in a hospital’s
2258 relative price and any weighting assigned by the council to those factors; (ii) alternative payment
2259 methodologies in place between a hospital and carrier; (iii) the volume and mix of services
2260 provided; (iv) a hospital’s patient population and payer mix; (v) hospital inpatient and outpatient
2261 rates as compared to the commercial relative price levels; and (vi) any other information deemed
2262 necessary by the council.

2263 (e) Amounts assessed by the council under this section shall be deposited into the
2264 Hospital Alignment and Review Trust Fund established in section 2ZZZZ of chapter 29.

2265 (f) Any amounts assessed by the council and then distributed through the Hospital
2266 Alignment and Review Trust Fund shall be excluded from the calculation of growth in hospital
2267 spending for a year in which the funds are distributed.

2268 Section 5. There shall be an advisory committee to the council. The committee shall
2269 support its responsibilities under this section. The council shall be chosen by the council and
2270 shall ensure broad representation of carriers and hospitals across regions, of different sizes and, if
2271 a hospital, payer mix and other stakeholders.

2272 Section 6. The council may establish regulations or guidance to implement this chapter.

2273 SECTION 112. Chapter 224 of the acts of 2012 is hereby amended by inserting after
2274 section 254 the following section:-

2275 Section 254A. (a) For the purposes of this section, the following words shall have the
2276 following meanings unless the context clearly requires otherwise:

2277 “Behavior management monitoring”, monitoring that shall include the monitoring of a
2278 child’s behavior, the implementation a behavior plan and reinforcing implementation of the plan
2279 by the child’s parent or other caregiver.

2280 “Behavior management therapy”, therapy that addresses challenging behaviors that
2281 interfere with a child’s successful functioning; provided, however, that “behavior management
2282 therapy” may include short-term counseling and assistance; provided further, that “behavior
2283 management therapy” shall include assessment, development of a behavior plan and supervision
2284 and coordination of interventions to address specific behavioral objectives or performance,
2285 including the development of a crisis-response strategy.

2286 “Child” a person under the age of 26.

2287 “Family support and training”, a service provided to a parent or caretaker of a child to
2288 improve the capacity of the parent or caretaker to ameliorate or resolve the child’s emotional or
2289 behavioral needs and to parent; provided, however, that such a service shall be provided where
2290 the child resides, including the child’s home, including a foster home and therapeutic foster
2291 home, or another community setting.

2292 “In-home behavioral services”, a combination of behavior management therapy and
2293 behavior management monitoring; provided, however, that such a service shall be provided

2294 where the child resides, including the child’s home, including a foster home and therapeutic
2295 foster home or another community setting.

2296 “In-home therapy”, therapeutic clinical intervention or ongoing training and therapeutic
2297 support; provided however, that the intervention or support shall be provided where the child
2298 resides, including the child’s home, including a foster home and therapeutic foster home, or
2299 another community setting.

2300 “Mobile crisis intervention”, a short-term, mobile, on-site, face-to-face therapeutic
2301 response service that is available 24 hours a day, 7 days a week to a child experiencing a
2302 behavioral health crisis to identify, assess, treat and stabilize a situation and reduce the
2303 immediate risk of danger to the child or others; provided, however, that the intervention shall be
2304 consistent with the child’s risk management or safety plan, if any.

2305 “Ongoing therapeutic training and support”, services that support implementation of a
2306 treatment plan pursuant to therapeutic clinical intervention that shall include, but shall not
2307 limited to, teaching the child to understand, direct, interpret, manage and control feelings and
2308 emotional responses to situations and assistance to the family in supporting the child and
2309 addressing the child’s emotional and mental health needs.

2310 “Therapeutic clinical intervention”, intervention that shall include: (i) a structured and
2311 consistent therapeutic relationship between a licensed clinician and a child and the child’s family
2312 to treat the child’s mental health needs, including improvement of the family’s ability to provide
2313 effective support for the child and promotion of healthy functioning of the child within the
2314 family; (ii) the development of a treatment plan; and (iii) using established psychotherapeutic

2315 techniques, working with the family or a subset of the family to enhance problem-solving, limit-
2316 setting, communication, emotional support or other family or individual functions.

2317 “Therapeutic mentoring services”, services provided to a child designed to support age-
2318 appropriate social functioning or ameliorate deficits in the child’s age-appropriate social
2319 functioning; provided, however, that such a service may include supporting, coaching and
2320 training the child in age-appropriate behaviors, interpersonal communication, problem-solving,
2321 conflict resolution and relating appropriately to other children and adolescents and adults in
2322 recreational and social activities; provided further, that such a service shall be provided where
2323 the child resides including the child’s home, including a foster home and therapeutic foster
2324 home, or another community setting.

2325 (b) The annual report submitted by carriers and contractor pursuant to section 254, shall
2326 include a certification that their coverage includes the following mental health home-based and
2327 community-based services for a child: (i) intensive care coordination for child with serious
2328 emotional disturbance; (ii) mobile crisis intervention; (iii) family support and training; (iv) in-
2329 home therapy; (v) therapeutic mentoring services; and (vi) in-home behavioral services. The
2330 certification shall substantiate that networks for the provided services are active and adequate to
2331 ensure access.

2332 (c) The commissioner may promulgate regulations or guidelines to implement this
2333 section.

2334 SECTION 113. Notwithstanding any general or special law to the contrary, the hospital
2335 assessment and review council established under section 2 of chapter 176W of the General Laws
2336 shall define “target hospital growth rate” to have the same meaning as “market basket percentage

2337 increase” as defined under 42 U.S.C. section 1395ww and “target hospital rate distribution” as
2338 90 per cent of the statewide commercial relative price in the previous calendar year unless
2339 otherwise amended under section 4 of said chapter 176W after January 1, 2022.

2340 SECTION 114. Notwithstanding any general or special law to the contrary, the executive
2341 office of health and human services, in collaboration with the executive office of elder affairs,
2342 the office of Medicaid and the department of public health, shall develop a post-acute care
2343 referral consultation program, subject to appropriation, of regional consultation teams to: (i)
2344 assist providers and consumers in determining appropriate post-acute care settings and
2345 coordinating patient care and (ii) share best practices among providers. The program shall also
2346 ensure education and outreach on provider pre-admission counseling required under section 9 of
2347 chapter 118E of the General Laws.

2348 A regional consultation team shall include regional representation from: (i) aging service
2349 access points; (ii) senior care organization members of the MassHealth Senior Care Options
2350 program; (iii) Program of All-inclusive Care for the Elderly plans; (iv) One Care plans (v) the
2351 Massachusetts council on aging; (vi) the Massachusetts Healthy Aging Collaborative; (vii)
2352 skilled nursing facilities; (viii) and other entities or individuals deemed appropriate by the
2353 executive office of health and human services. A regional consultation team may be based within
2354 an aging service access point.

2355 The executive office of health and human services shall submit an initial report to the
2356 joint committee on health care financing, the joint committee on elder affairs and the senate and
2357 house committees on ways and means not later than March 15, 2018, that details: (i) the
2358 anticipated structure for the program; (ii) estimated cost estimates for the implementation and

2359 maintenance of the program; (iii) a breakdown of the state investment and anticipated alternate
2360 funding sources; and (iv) a timeline for program implementation.

2361 Beginning in 2019, the executive office of health and human services shall submit an
2362 annual report not later than March 15 to the joint committee on health care financing, the joint
2363 committee on elder affairs and the senate and house committees on ways and means that shall
2364 include, but not be limited to: (i) education and outreach efforts on preadmission counseling; (ii)
2365 the number of providers accessing the program; (iii) the estimated cost estimates for the
2366 implementation and maintenance of the program; and (iv) a breakdown of referrals based on the
2367 site of post-acute care.

2368 SECTION 115. Notwithstanding any general or special law to the contrary, the
2369 department of public health and the office of consumer affairs and business regulation shall
2370 allow licensees to obtain proxy credentialing and privileging for telemedicine services with other
2371 health care providers as defined in section 1 of chapter 111 of the General Laws or facilities that
2372 comply with the Centers for Medicare & Medicaid Services' conditions of participation for
2373 telemedicine services.

2374 For the purposes of this section, "telemedicine" shall mean the use of interactive audio,
2375 video or other electronic media for the purposes of a diagnosis, consultation or treatment of a
2376 patient's physical, oral or mental health; provided, however, that "telemedicine" shall not include
2377 an audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

2378 SECTION 116. Notwithstanding any general or special law to the contrary, all
2379 commercial insurers, hospital service corporations, medical service corporations and health
2380 maintenance organizations shall:

2381 (i) not later than July 1, 2019, reimburse for health care services with alternative payment
2382 methodologies for not less than 50 per cent of its enrollees; provided, however, that 25 per cent
2383 of its enrollees shall be under alternative payment methodologies that require providers to bear
2384 downside risk at a level not less than the amount required of a MassHealth accountable care
2385 organization;

2386 (ii) not later than July 1, 2022, reimburse for health care services with alternative
2387 payment methodologies for not less than 65 per cent of its enrollees; provided, however, that 45
2388 per cent of its enrollees shall be under alternative payment methodologies that require providers
2389 to bear downside risk at a level not less than the amount required of a MassHealth accountable
2390 care organization; and

2391 (iii) not later than July 1, 2025, reimburse for health care services with alternative
2392 payment methodologies for not less than 85 per cent of its enrollees; provided, however, that 65
2393 per cent of its enrollees shall be under alternative payment methodologies that require providers
2394 to bear downside risk at a level not less than the amount required of a MassHealth accountable
2395 care organization.

2396 SECTION 117. Notwithstanding any general or special law to the contrary, the
2397 noncontracted commercial rate for nonemergency services under chapter 176O of the General
2398 Laws shall be not more than the eightieth percentile of all allowed charges for a particular health
2399 care service performed by a health care provider in the same or similar specialty and provided in
2400 the same geographical area, as reported in a benchmarking database by a nonprofit organization
2401 specified by the division of insurance. Such an organization shall not be affiliated with a health
2402 carrier.

2403 SECTION 118. Notwithstanding any general or special law to the contrary, the
2404 noncontracted commercial rate for emergency services under chapter 176O of the General Laws
2405 shall be not more than the eightieth percentile of all allowed charges for a particular health care
2406 service performed by a health care provider in the same or similar specialty and provided in the
2407 same geographical area, as reported in a benchmarking database by a nonprofit organization
2408 specified by the division of insurance. Such an organization shall not be affiliated with any
2409 health carrier.

2410 SECTION 119. Sections 117 and 118 are hereby repealed.

2411 SECTION 120. Notwithstanding any general or special law to the contrary, the executive
2412 office of health and human services shall apply for a federal waiver of the requirements of
2413 section 1886(q) of the federal Social Security Act.

2414 SECTION 121. Notwithstanding any general or special law to the contrary, the
2415 readmission reduction benchmark under chapter 6D of the General Laws shall be a 20 per cent
2416 reduction of readmission rates, as measured by the health policy commission in consultation with
2417 the center for health information and analysis, between those rates observed in the year 2017 and
2418 those rates observed in the year 2020.

2419 SECTION 122. Notwithstanding any general or special law to the contrary, the health
2420 policy commission shall identify health care trailblazers under section 19 of chapter 6D of the
2421 General Laws that have demonstrated success in patient placement in the appropriate care setting
2422 through the development of care plans that include education on appropriate use of emergency
2423 services for patients who are deemed high utilizers of emergency departments.

2424 SECTION 123. Notwithstanding any general or special law to the contrary, the office of
2425 Medicaid may establish and offer an optional expanded Medicaid plan for purchase by an
2426 individual or by an employer as an employer-sponsored insurance plan. The optional expanded
2427 plan may set alternate eligibility and cost-sharing standards beyond those established by section
2428 9A of chapter 118E of the General Laws and may condition participation in the program;
2429 provided, however, that any optional expanded plan offered to an employer shall require the
2430 employer to pay not less than 50 per cent of the projected cost of coverage for participating
2431 employees. The office may adjust benefits offered through an optional plan under this section;
2432 provided, however, that the office shall maintain the benefit and cost-sharing standards for those
2433 individuals and employees that meet the eligibility standards established by said section 9A of
2434 said chapter 118E.

2435 The office may establish premiums or cost-sharing requirements for an optional
2436 expanded plan that are equal to or exceed the costs of covering participating members based on
2437 the per-member-per-month expenditures or other measures. Additional revenue generated in
2438 excess of the cost to administer the expanded plan may be used to increase provider payment
2439 rates within the optional expanded plan and the MassHealth program under said section 9A of
2440 said chapter 118E or otherwise may be applied to the sustainability of the MassHealth program.

2441 An individual eligible for MassHealth under said section 9A of said chapter 118E shall
2442 receive commensurate cost sharing, coverage and benefits as they would receive under said
2443 section 9A of said chapter 118E, regardless of participation in the optional expanded plan
2444 through their employer. Nothing in this section shall preclude the office from requiring an
2445 employee to participate in the premium assistance program or a commensurate program.

2446 The office may, in addition to premiums or cost sharing required from employers for
2447 employees on the optional expanded plan, require contributions from an employer that
2448 participates in the optional expanded plan as employer-sponsored insurance, for an employee
2449 that meets the eligibility standards under said section 9A of said chapter 118E.

2450 The office may apply for federal authorization to permit the application of available
2451 subsidies for participation in the optional expanded plan including, but not limited to, advance
2452 premium tax credits, cost-sharing reductions or state wrap funds applicable to the purchase of
2453 MassHealth coverage through the commonwealth health insurance connector authority.

2454 Not later than October 1, 2018, the office shall file a plan outlining: (i) whether the office
2455 plans to implement an optional expanded plan; (ii) recommended statutory language, if any; (iii)
2456 expected benefits and cost sharing to be offered through the optional expanded plan; (iv)
2457 expected start-up costs to implement the optional expanded plan; (v) expected revenue from the
2458 optional expanded plan to support the full MassHealth program; and (vi) expected savings to the
2459 MassHealth program related to the implementation of an optional expanded plan.

2460 SECTION 124. Notwithstanding any general or special law to the contrary, the office of
2461 Medicaid shall seek federal approval to amend its state plan amendment and regulations to
2462 permit member access to urgent care facilities for emergency services without requiring a
2463 referral or prior authorization. The office shall provide a progress report to the joint committee
2464 on health care financing and the senate and house committees on ways and means not later than
2465 July 1, 2018 and shall issue updated regulations not later than January 1, 2019.

2466 SECTION 125. Notwithstanding any general or special law to the contrary, the secretary
2467 of health and human services may seek approval from Centers for Medicare & Medicaid

2468 Services to claim expenditures necessary to establish mobile integrated health care programs
2469 certified under chapter 111O of the General Laws as an allowable expenditure under the delivery
2470 system reform incentive program pursuant to requirement 57 of the Special Terms and
2471 Conditions for the MassHealth demonstration waiver under section 1115(a) of the Social
2472 Security Act.

2473 SECTION 126. Notwithstanding any general or special law to the contrary, the office of
2474 Medicaid shall establish a plan outlining the office's method for collecting, maintaining and
2475 sharing data with providers to ensure compliance with benchmarks associated with the
2476 MassHealth accountable care program, including ways to coordinate measures of social
2477 determinants of health that provide breakdowns by special populations within and across
2478 programs.

2479 The plan shall be filed with the clerks of the senate and house of representatives, the joint
2480 committee on health care financing and the senate and house committees on ways and means not
2481 later than August 1, 2018.

2482 SECTION 127. Notwithstanding any general or special law to the contrary, the executive
2483 office of health and human services, in consultation with the Massachusetts eHealth Institute,
2484 shall maximize information sharing, to the extent permissible under relevant privacy law,
2485 between the senior information management system operated by the executive office of elder
2486 affairs and electronic health records systems operated by medical providers.

2487 Not later than October 1, 2018, the executive office of health and human services shall
2488 provide a report on electronic information sharing efforts between the senior information
2489 management system and other electronic health records systems, any existing barriers to

2490 electronic information sharing and planned efforts to reduce such barriers to the clerks of the
2491 senate and house of representatives, the joint committee on elder affairs, the joint committee on
2492 health care financing and the senate and house committees on ways and means.

2493 SECTION 128. Notwithstanding any general or special law to the contrary, the executive
2494 office of health and human services shall apply for a federal waiver to permit passive enrollment
2495 of individuals eligible for Medicare into the MassHealth senior care options program. The
2496 executive office may also apply for a federal waiver to: (i) permit a Medicare member, who does
2497 not meet the financial eligibility standards for Medicaid but demonstrates insufficient income
2498 and assets to pay for 135 days of skilled nursing facility care, to prospectively enroll in the
2499 MassHealth senior care options program using Medicare or other funding; and (ii) receive
2500 Medicaid matching funds for a Medicare recipient or member of the executive office of elder
2501 affairs home care program who is not otherwise eligible for Medicaid and lacks income and
2502 assets to pay for 135 days of skilled nursing facility care.

2503 The executive office of health and human services may engage the technical assistance
2504 and program design expertise of an external evaluator, if available, and share relevant data with
2505 such an evaluator, in order to implement this section in accordance with rigorous evaluation for
2506 program impact and cost-effectiveness. Any completed evaluation shall be filed with the clerks
2507 of the senate and house of representatives, the joint committee on health care financing and the
2508 senate and house committees on ways and means.

2509 SECTION 129. The office of Medicaid shall report on the role of long-term services and
2510 supports within MassHealth and MassHealth accountable care organizations in each year of the
2511 accountable care organization demonstration. The report shall include: (i) the baseline number of

2512 accountable care organization-attributed MassHealth members receiving long-term services and
2513 supports, disaggregated by age category, disability status, service type, and any other relevant
2514 categories; (ii) total MassHealth spending on long-term services and supports and number of
2515 members receiving long-term services and supports disaggregated by age category, disability
2516 status, service type, and any other relevant categories; (iii) MassHealth average per member, per
2517 month long-term services and supports costs by service type; (iv) any projected changes in
2518 utilization of long-term services and supports in the coming year and the rationale for such
2519 changes; (v) any estimated shift in spending between medical and long-term services and
2520 supports or social services spending within the accountable care organization program in the
2521 prior year of the demonstration; (vi) the process for determination of long-term services and
2522 supports needs for members attributed to the accountable care organization program,
2523 disaggregated by accountable care organization if processes differ; and (vii) the appeals process
2524 for accountable care organization members denied long-term services and supports. This report
2525 shall be filed with the clerks of the senate and house of representatives, the joint committee on
2526 health care financing and the senate and house committees on ways and means not later than
2527 April 1, 2018, and thereafter annually by April 1 for each year of the accountable care
2528 organization demonstration.

2529 SECTION 130. Notwithstanding any general or special law to the contrary, the executive
2530 office of health and human services shall enroll MassHealth-eligible consumers who are enrolled
2531 in the executive office of elder affairs home care program, subject to exceptions based on level
2532 of acuity or continuity of care, in the MassHealth senior care options program.

2533 The secretary of elder affairs shall transfer funds appropriated in item 9110-1630 of
2534 section 2 of chapter 47 of the acts of 2017 to item 4000-0601 of said section 2 of said chapter 47

2535 for the costs of consumers enrolled in the home care program who enroll in the MassHealth
2536 senior care options program. The amount transferred to said item 4000-0601 shall not exceed the
2537 estimated annual cost of care in the home care program for participating senior care options
2538 enrollees.

2539 Not later than October 1, 2018, the executive office of health and human services shall
2540 provide a report on the number of MassHealth-eligible home care consumers enrolled in the
2541 senior care options program, the number of consumers planned to be enrolled, the timeline for
2542 the enrollment, the amount of transferred funds associated with the enrollment and the amount of
2543 federal matching funds projected to accrue to the senior care options program. The report shall
2544 be filed with the clerks of the senate and the house of representatives and the senate and house
2545 committees on ways and means.

2546 SECTION 131. The executive office of health and human services may develop a pilot
2547 program to certify supportive housing and affordable housing providers, in coordination with
2548 plans that service individuals eligible for Medicaid, Medicare or both , including but not limited
2549 to program for all-inclusive care for the elderly, senior care options and other managed care
2550 organizations, and in consultation with aging services access points, community partners and
2551 other stakeholders, to: (i) establish coordinated care teams and supports within housing sites that
2552 are funded with pooled resources, financing models including social impact bonds or other
2553 sources; or (ii) subject to federal authorization, passively enroll residents in senior care options,
2554 Medicaid-managed care or other globally-budgeted health care plans to establish care
2555 coordination between the housing provider and plans and to provide a critical mass of plan
2556 members necessary for care coordination and targeted investment within the housing site.
2557 Housing providers and plans shall not enter into exclusive relationships, but shall conduct

2558 passive enrollment into not less than 2 plans within each housing site. A resident choosing to opt
2559 out from such a coordinated plan shall continue to have access to any plan regardless of housing
2560 site.

2561 The executive office of health and human services may engage the technical assistance
2562 and program design expertise of an external evaluator, if available, and share relevant data with
2563 such an evaluator, in order to implement this section in accordance with rigorous evaluation for
2564 program impact and cost-effectiveness. Any completed evaluation shall be filed with the clerks
2565 of the senate and house of representatives, the joint committee on health care financing and the
2566 senate and house committees on ways and means.

2567 SECTION 132. Notwithstanding any general or special law to the contrary, the secretary
2568 of health and human services shall develop a strategic plan outlining changes to provider funding
2569 sources, including those related to the adoption of new financing and delivery models of care as
2570 well as current supplemental payment streams to acute care hospitals. The strategic plan shall
2571 provide a breakdown of payment sources to providers, including payments authorized under the
2572 current MassHealth section 1115 demonstration waiver, by payment sources identified as: (i)
2573 time limited and as ongoing, along with expected benchmarks for providers to demonstrate
2574 sustainability due to the expiration of a time limited payment source; and (ii) included in an
2575 alternative payment model or a current supplemental payment.

2576 In developing the strategic plan, the secretary shall consult with a diverse set of providers
2577 that represent differing regional perspectives, patient volume and acuity and payment structures.

2578 The strategic plan shall identify: (i) regional disparities in funding; (ii) metrics for
2579 allocating funds that align with new health care financing and delivery models; (iii) opportunities

2580 to maximize federal financial participation; and (iv) any other factor pertinent to the evaluation
2581 of different approaches to the allocation of these funds.

2582 The secretary shall identify an independent third-party to analyze and evaluate the
2583 allocation of the funds described in this section. The strategic plan and any underlying analysis
2584 by the independent third-party shall be filed with the clerks of the senate and house of
2585 representatives, the senate and house committees on ways and means and the joint committee on
2586 health care financing not later than January 1, 2020.

2587 SECTION 133. Not later than July 1, 2018, the office of Medicaid shall provide a report
2588 on the proposed eligibility changes to the MassHealth program included in the Section 1115
2589 amendment request that was submitted on September 8, 2017, based on information received
2590 under section 79 of chapter 118E of the General Laws. The report shall include: (i) the number of
2591 members who received an offer of employer-sponsored health insurance; (ii) the number of
2592 members who received an offer of affordable employer-sponsored health insurance; (iii) details
2593 on the most frequently occurring cost-sharing arrangements for members offered affordable
2594 employer-sponsored health insurance; (iv) the number of members who would be transitioned
2595 from MassHealth to the ConnectorCare program; (v) the estimated cost savings attributed to the
2596 eligibility changes to the MassHealth program included in the amendment submitted on
2597 September 8, 2017; and (vi) the number of members who have been deemed eligible for
2598 premium assistance. The office shall submit its report to the clerks of the senate and house of
2599 representatives, the joint committee on health care financing and the senate and house
2600 committees on ways and means.

2601 SECTION 134. Notwithstanding any general or special law to the contrary, the center for
2602 health information and analysis shall conduct a review of a mandated health benefit proposal to
2603 require coverage of services rendered by a mobile integrated health care provider pursuant to
2604 chapter 111O of the General Laws. The review shall be performed by the center consistent with
2605 section 38C of chapter 3 of the General Laws. The center shall evaluate the impact of such a
2606 mandate as a requirement for all of the health plans and policies under subsection (a) of said
2607 section 38C of said chapter 3. The center shall file its review with the clerks of the senate and
2608 house of representatives, the joint committee on health care financing and the senate and house
2609 committees on ways and means not later July 1, 2020.

2610 SECTION 135. Notwithstanding any general or special law to the contrary, the health
2611 policy commission, in consultation with the center for health information and analysis and with
2612 the technical assistance of an external evaluator, if available, shall review the impact of this act
2613 on: (i) reduction in hospital readmissions; (ii) emergency department utilization; (iii) reduction in
2614 post-acute institutional care; (iv) prescription drug cost trends; (v) movement of patients toward
2615 high-value provider settings; and (vi) provider price variation.

2616 The commission's review shall be made in 2 parts and include, but not be limited to: (i)
2617 system wide aggregate savings; (ii) cost savings broken down by provider, payer, consumer and
2618 the commonwealth; and (iii) impact on consumer choice of providers that are lower-cost, high
2619 quality or both lower-cost and high quality.

2620 The commission shall issue its first report not later than July 1, 2025 and its final report
2621 not later than July 1, 2030 and file the report with the clerks of the senate and house of

2622 representatives, the joint committee on health care financing, the joint committee on public
2623 health and the senate and house committees on ways and means.

2624 SECTION 136. Notwithstanding any general or special law to the contrary, the board of
2625 registration in dentistry, in consultation with the executive office of health and human services,
2626 shall perform an evaluation of the impact of this act on dental therapists in terms of patient
2627 safety, cost-effectiveness and access to dental services over the first 5 years of the act's
2628 implementation. The board shall report on its findings and the report shall include: (i) the number
2629 of new patients served; (ii) the impact on waiting times for needed services; (iii) the impact on
2630 travel time for patients; (iv) the impact on emergency room usage for dental care; and (v) the
2631 impact on costs to the public health care system. The report shall be submitted not later than July
2632 1, 2023 to the joint committee on public health, the joint committee on health care financing and
2633 the senate and house committees on ways and means.

2634 SECTION 137. There shall be a task force to investigate the impact to state agencies of
2635 joining a nonMedicaid, multistate prescription drug bulk purchase consortium. The task force
2636 shall consider: (i) the estimated costs savings related to joining a non-Medicaid, multistate
2637 consortium; (ii) the opportunity for counties, municipalities and nonprofit organizations to
2638 participate in a nonMedicaid multistate consortium; (iii) the potential administrative savings and
2639 efficiencies for participants as a result of joining a nonMedicaid, multistate consortium; (iv)
2640 other bulk purchase discounts or rebates for prescription drugs, medical supplies or other medical
2641 goods purchased by state agencies, other governmental units and nonprofit organizations; and (v)
2642 means of receiving rebates or discounts for medical supplies or medications not included under
2643 the federal 340B Drug Pricing Program for eligible entities. The task force may consider non-
2644 Medicaid, multistate consortiums that are not available to the group insurance commission.

2645 The task force shall consist of: (i) the commissioner of public health or a designee, who
2646 shall serve as chair; (ii) the chief of pharmacy or a designee; (iii) the commissioner of mental
2647 health or a designee; (iv) the commissioner of developmental services or a designee; (v) the
2648 secretary of veterans' services or a designee; (vi) the commissioner of correction or a designee;
2649 (vii) the president of the Massachusetts Sheriffs Association or a designee; (viii) the president of
2650 the Massachusetts Biotechnology Council, Inc. or a designee; (ix) the chairperson of the
2651 Massachusetts Chamber of Commerce Inc. or a designee; (x) the executive director of the group
2652 insurance commission or a designee; and (xi) 5 persons to be appointed by the governor, 1 of
2653 whom shall be a health care economist, 1 of whom shall be a pharmacist registered by the board
2654 of registration in pharmacy, 1 of whom shall be a county or municipal representative, 1 of whom
2655 shall be a representative of a nonprofit community health center and 1 of whom shall have
2656 experience with multistate bulk purchasing consortiums for prescription drugs. The task force
2657 shall file its report, including drafts of any proposed legislation, with the clerks of the senate and
2658 the house of representatives, the joint committee on health care financing and the senate and
2659 house committees on ways and means not later than November 1, 2018.

2660 SECTION 138. The office of Medicaid shall report on potential cost savings for
2661 prescription medications by the office if it joined a multistate Medicaid bulk purchasing
2662 consortium. The report shall include: (i) an analysis of increased efficiency in the receipt of
2663 discounts through participation in a multistate Medicaid bulk purchasing consortium; (ii) the
2664 estimated cost savings related to joining a multistate Medicaid bulk purchasing consortium; (iii)
2665 the estimated administrative savings or other increased efficiencies related to joining a multistate
2666 Medicaid bulk purchasing consortium; (iv) opportunities for managed care organizations to
2667 receive rebates or discounts; and (v) a review of any identified alternative approaches to

2668 multistate Medicaid bulk purchasing consortiums that provide cost savings relative to
2669 prescription medications. The office shall file the report with the clerks of the senate and house
2670 of representatives, the joint committee on health care financing and the senate and house
2671 committees on ways and means not later than November 1, 2018.

2672 SECTION 139. Notwithstanding any general or special law to the contrary, the
2673 Massachusetts e-Health Institute shall report projects that leverage the commonwealth's
2674 investment in electronic health record deployment and the statewide health information exchange
2675 and that are likely to have a meaningful impact on cost or quality of care. The report shall
2676 identify and support such projects and include recommended funding amounts for the projects.
2677 The institute shall file the report with the clerks of the senate and house of representatives, the
2678 joint committee on health care financing and the senate and house committees on ways and
2679 means not later than January 1, 2019.

2680 SECTION 140. The center for health information and analysis shall report on the
2681 implementation of facility fee protections under section 28 of chapter 32A, section 51L of
2682 chapter 111 and sections 28 and 29 of chapter 176O of the General Laws. The report shall
2683 include: (i) facility fees charged or billed to provide a baseline report on facility fees that were
2684 charged or billed; and (ii) a 5-year status report.

2685 The reports shall include: (i) the number of hospital-based facilities owned or operated by
2686 a hospital or health system that provides services for which a facility fee was charged or billed,
2687 broken down by hospital or health system; (ii) the number of patient visits provided at hospital
2688 based facility for which a facility fee was charged or billed; (iii) the number of claims, total
2689 amount and range of allowable facility fees paid at each facility by Medicare, Medicaid and

2690 private insurance policies, including any cost sharing, as applicable; (iv) the total amount of
2691 revenue from hospital-based facility fees received by a hospital or health system, categorized by
2692 whether a hospital-based facility is on a campus; (v) a description of the 10 procedures or
2693 services that generated the greatest amount of facility fee revenue at hospital-based facilities and,
2694 for each such procedure or service, the total amount of revenue received by a hospital or health
2695 system from the facility fees for the services; and (vi) the top 10 procedures or services for which
2696 facility fees were charged based on volume of claims.

2697 The center for health information and analysis shall make the information publicly
2698 available on its website. The baseline report shall be made available on December 31, 2018 and
2699 the 5-year status report shall be made available on January 1, 2024.

2700 SECTION 141. There shall be a task force to investigate methods to increase efficiency
2701 in the health care system through regulatory simplification. The task force shall consist of: the
2702 secretary of health and human services or a designee, who shall serve as chair; the commissioner
2703 of public health or a designee; the assistant secretary of the office of Medicaid or a designee; the
2704 chair of the health policy commission or a designee; 1 member appointed by the senate
2705 president; 1 member appointed by the speaker of the house; and 7 members appointed by the
2706 governor, 1 of whom shall be a representative of the Massachusetts Health and Hospital
2707 Association, Inc., 1 of whom shall be a representative of the Massachusetts League of
2708 Community Health Centers, 1 of whom shall be a representative of the Massachusetts Medical
2709 Society, 1 of whom shall be a representative of Association for Behavioral Healthcare, Inc., 1 of
2710 whom shall be a representative of the Massachusetts Association of Behavioral Health Systems,
2711 Inc., 1 of whom shall be a representative of the Massachusetts Nurses Association and 1 of
2712 whom shall be a representative of the Home Care Alliance of Massachusetts, Inc.

2713 The task force shall consider: (i) the cost and benefit of establishing an office of care
2714 coordination to provide cross-agency coordination for providers to improve patient access to
2715 needed services; (ii) the feasibility of a regulatory waiver process within the office of Medicaid
2716 for payers and providers seeking flexibility to implement innovative initiatives resulting in
2717 increased access to care and cost savings; (iii) the feasibility of a regulatory waiver process
2718 within the department of public health for providers seeking flexibility to implement innovative
2719 initiatives resulting in increased access to care and cost savings; and (iv) recommendations for
2720 regulatory changes needed to support the development of global payments.

2721 The task force shall file its report not later than October 1, 2019 with the clerks of the
2722 senate and house of representatives, the joint committee on health care financing, the joint
2723 committee on public health and the senate and house committee on ways and means.

2724 SECTION 142. There shall be a special commission to study and make recommendations
2725 on how to license foreign-trained medical professionals to expand and improve access to medical
2726 services in rural and underserved areas.

2727 The commission shall consist of: (i) the secretary of health and human services or a
2728 designee, who shall serve as chair; (ii) the commissioner of public health or a designee; (iii) 1
2729 member appointed by the senate president; (iv) 1 member appointed by the speaker of the house;
2730 (v) 1 member appointed by the minority leader of the senate; (vi) 1 member appointed by the
2731 minority leader of the house; (vii) the house and senate chairs of the joint committee on public
2732 health; and (viii) 9 members appointed by the governor, 1 of whom shall be a member of the
2733 governor's advisory council for refugees and immigrants, 1 of whom shall be a representative of
2734 the Massachusetts Immigrant and Refugee Advocacy Coalition, Inc., 1 of whom shall be a

2735 representative of the division of health professional licensure, 1 whom shall be a member of the
2736 board of registration in medicine, 1 of whom shall be a member of the board of registration in
2737 dentistry, 1 member of the board of registration in pharmacy, 1 of whom shall be a member of
2738 the board of registration in nursing, 1 of whom shall be a member of the board of registration of
2739 psychologists and 1 of whom shall be a member of the board of allied health professionals

2740 The commission shall examine and make recommendations on topics including, but not
2741 limited to: (i) ways to implement strategies to integrate foreign-trained medical professionals into
2742 rural and underserved areas that are in need of access to medical services; (ii) ways to identify
2743 state and national licensing regulations that pose barriers to practice for foreign-trained medical
2744 professionals; (iii) state licensing requirements that pose barriers to practice for foreign-trained
2745 medical professionals; (iv) alternate approaches by other states to integrate foreign-trained
2746 medical professionals into rural and underserved areas; and (v) other matters pertaining to
2747 licensing foreign-trained medical professionals. The commission may hold hearings and invite
2748 testimony from experts and the public to gather information. The report may include
2749 recommended guidelines for full licensure and conditional licensing of foreign-trained medical
2750 professionals.

2751 The commission shall file its recommendations, including any drafts of legislation or
2752 regulations necessary to carry out its recommendations, to the clerks of the senate and house of
2753 representatives, the joint committee on public health and the joint committee on health care
2754 financing not later than March 1, 2019.

2755 SECTION 143. There shall be a housing security task force to investigate methods to
2756 encourage housing security as a social determinant of health. The task force shall consist of: the

2757 secretary of housing and economic development or a designee, who shall serve as co-chair; the
2758 secretary of health and human services or a designee, who shall serve as co-chair; the
2759 commissioner of public health or a designee; the executive director of the health policy
2760 commission or a designee; the undersecretary of housing and community development or a
2761 designee; the commissioner of mental health or a designee; the commissioner of developmental
2762 services or a designee; and 14 members appointed by the governor, 1 of whom shall be a
2763 representative of a public housing authority, 1 of whom shall be a representative of
2764 Massachusetts Senior Care Association, Inc., 1 of whom shall be an expert on affordable
2765 housing, 1 of whom shall be a representative of the Massachusetts Law Reform Institute, Inc., 1
2766 of whom shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1
2767 of whom shall be an expert in case management, 1 of whom shall be a representative of the
2768 Home Care Alliance of Massachusetts, Inc., 1 of whom shall be a representative of Arc
2769 Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Coalition for the
2770 Homeless, Inc., 1 of whom shall be a representative of the Massachusetts Housing and Shelter
2771 Alliance, Inc., 1 of whom shall be a representative of the Association for Behavioral Healthcare,
2772 Inc., 1 of whom shall be a representative of Health Care for All, Inc., 1 of whom shall be a
2773 representative of the Massachusetts Association of Behavioral Health Systems and 1 of whom
2774 shall be a representative of Citizens' Housing And Planning Association. Members shall be
2775 selected to ensure broad geographic representation.

2776 The task force shall consider: (i) ways to develop priority designation for shelter beds for
2777 individuals eligible for discharge from an emergency department or inpatient setting; (ii) ways to
2778 locate affordable housing for individuals who are homeless or at risk of homelessness; (iii)
2779 recommended policies to increase the amount of affordable housing; (iv) gaps that exist in

2780 providing post-acute care to individuals residing in shelter beds; and (v) opportunities to
2781 integrate care coordination or other health services into housing authorities or other housing
2782 models.

2783 The task force shall hold its first meeting not later than April 1, 2018 and shall meet not
2784 less than 4 times. The task force may consult with the interagency council on housing and
2785 homelessness and solicit stakeholder feedback or public testimony. The task force shall file its
2786 report not later than November 1, 2018 with the clerks of the senate and house of representatives,
2787 the joint committee on housing, the joint committee on health care financing; the joint committee
2788 on public health and the senate and house committees on ways and means.

2789 SECTION 144. The department of public health shall promulgate rules or regulation
2790 necessary to implement 47 to 49, inclusive, 51 to 57, inclusive, 59, 60, 62, 74 and 79 to 89,
2791 inclusive, not later than January 1, 2019.

2792 SECTION 145. The department of public health shall issue regulations under section 51L
2793 of chapter 111 of the General Laws not later than January 1, 2019.

2794 SECTION 146. Notwithstanding any special or general law to the contrary, a hospital
2795 licensed pursuant to section 51 of chapter 111 of the General Laws on or before January 1, 2019,
2796 shall not be required to comply with section 51L of said chapter 111 until notice of the hospital's
2797 licensure renewal pursuant to said section 51 of said chapter 111.

2798 SECTION 147. Notwithstanding section 28 of chapter 32A of the General Laws and
2799 section 51L of chapter 111 of the General Laws, an insurance contract that provides for
2800 reimbursement for facility fees prohibited under said section 51L of said chapter 111 to a
2801 hospital or health system shall remain in effect until the next standard negotiation of contracted

2802 rates; provided, however, that a plan submitted to the division of insurance after January 1, 2018
2803 shall not be approved by the division if the plan does not comply with said section 51L of said
2804 chapter 111.

2805 SECTION 148. Section 66C of chapter 112 of the General Laws shall apply to registered
2806 optometrists who are qualified by an examination for practice under section 68 after January 1,
2807 2013.

2808 SECTION 149. An applicant for examination to permit the use and prescription of
2809 therapeutic agents pursuant to section 68C of chapter 112 of the General Laws who presents
2810 satisfactory evidence of graduation from a school or college of optometry approved by the board
2811 after January 1, 2013 shall be deemed to have satisfied sections 68 to 68B, inclusive, of said
2812 chapter 112.

2813 SECTION 150. Subsection (d) of section 68C of chapter 112 of the General Laws shall
2814 apply to licensed optometrists who have completed a postgraduate residency program approved
2815 by the Accreditation Council on Optometric Education of the American Optometric Association
2816 after July 31, 1997.

2817 SECTION 151. The task force established pursuant to section 16AA of chapter 6A of the
2818 General Laws shall be first convened in 2019.

2819 SECTION 152. Section 30 of chapter 32A of the General Laws, section 81 of chapter
2820 118E of the General Laws, section 108O of chapter 175 of the General Laws, section 40 of
2821 chapter 176A of the General Laws, section 27 of chapter 176B of the General Laws, section 35
2822 of chapter 176G of the General Laws and section 14 of chapter 176I of the General Laws shall
2823 apply to contracts entered or renewed on or after January 1, 2020.

2824 SECTION 153. Sections 22, 101 and 106 shall take effect for plans submitted to the
2825 division of insurance on or after January 1, 2020.

2826 SECTION 154. Section 2ZZZZ of chapter 29 of the General Laws and sections 4 and 5
2827 of chapter 176W of the General Laws shall take effect on January 1, 2022.

2828 SECTION 155. Sections 2, 5, 6, 8, 11, 13, 15, 17, 25, 34, 36, 43, 47 to 49, inclusive, 51
2829 to 57, inclusive, 59, 60, 62, 64, 68, 74, 79 to 89, inclusive, 93 and 121 and sections 28 and 29 of
2830 chapter 176O of the General Laws shall take effect on January 1, 2019.

2831 SECTION 156. Sections 9, 23, 40 shall take effect on May 1, 2018.

2832 SECTION 157. Sections 16 and 120 shall take effect on January 1, 2021.

2833 SECTION 158. Sections 50, 58, 61, 73, 75 to 78, inclusive, 100, 115, 117 and 118,
2834 section 29 of chapter 32A of the General Laws, section 80 of chapter 118E of the General Laws,
2835 section 39 of chapter 176A of the General Laws, section 26 of chapter 176B of the General Laws
2836 and section 34 of 176G of the General Laws shall take effect on July 1, 2018.

2837 SECTION 159. Section 119 shall take effect on December 31, 2019.