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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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Quality measures", aligned quality measures established pursuant to section 16AA of chapter 6A.

"Rate of readmissions", 30-day, all cause, all payer readmission measure, as determined by the center.

"Readmissions performance improvement plan", a plan submitted to the commission by a provider organization under section 10A.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Quality measures", aligned quality measures established pursuant to section 16AA of chapter 6A.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) The department shall set fees for licensure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 2H. (a) There shall be a prevention and wellness advisory board. The board shall: (i) make recommendations to the commissioner concerning the administration and allocation of the Prevention and Wellness Trust Fund established in section 2G; (ii) establish evaluation criteria; and (iii) perform any other functions specifically granted to it by law.

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

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

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

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

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

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

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

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

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

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

"Health system", shall have the same meaning as provided in section 28 of chapter 176O.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Supervising dentist", a licensed dentist who enters into a collaborative management agreement with a dental therapist.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Insured", an individual entitled to ambulance services benefits pursuant to an insurance policy or insurance contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Health system", shall have the same meaning as "Provider Organization or Health System or System", as provided by the health policy commission.

"Hospital", a hospital licensed pursuant to section 51 of chapter 111.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 176W.

HOSPITAL ALIGNMENT AND REVIEW COUNCIL.

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

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

"Center", the center for health information and analysis established in chapter 12C.

"Commission", the health policy commission established in chapter 6D.

"Council", the hospital alignment and review council established in section 2.

"Division", the division of insurance.

"Growth in hospital spending", the annual growth in total commercial hospital inpatient and outpatient spending as reported by the center.

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

"Hospital spending", total commercial spending on hospital inpatient and outpatient services.

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

"Target growth in hospital spending", the percentage of growth in hospital spending determined by the council.

"Target hospital rate distribution", the minimum rate of a carrier's reimbursement for services provided by a hospital as determined by the council.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Behavior management monitoring", monitoring that shall include the monitoring of a child's behavior, the implementation a behavior plan and reinforcing implementation of the plan by the child's parent or other caregiver.

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

"Child" a person under the age of 26.

"Family support and training", a service provided to a parent or caretaker of a child to improve the capacity of the parent or caretaker to ameliorate or resolve the child's emotional or behavioral needs and to parent; provided, however, that such a service shall be provided where the child resides, including the child's home, including a foster home and therapeutic foster home, or another community setting.

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

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

"In-home therapy", therapeutic clinical intervention or ongoing training and therapeutic support; provided however, that the intervention or support shall be provided where the child resides, including the child's home, including a foster home and therapeutic foster home, or another community setting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 119. Sections 117 and 118 are hereby repealed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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