# SENATE . . . . . No. 2202

## The Commonwealth of Massachusetts

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

SENATE, Thursday, November 2, 2017

The Committee on Ways and Means, to whom was referred the Committee Bill furthering health empowerment and affordability by leveraging transformative health care (Senate, No. 2190),-- reports, recommending that the same ought to pass with an amendment substituting a new draft with the same title (Senate, No. 2202).

For the committee,
Karen E. Spilka

# SENATE . . . . . No. 2202

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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.

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

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

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

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

33 The task force shall be convened by the secretary of health and human services and the
34 executive director of the health policy commission, or their designees, who shall serve as co-
35 chairs, and shall include the following members or their designees: the commissioner of public
36 health; the executive director of the center for health information and analysis; the executive
37 director of the group insurance commission; the assistant secretary for MassHealth; the
38 commissioner of insurance; and 10 members who shall be appointed by the governor, 1 of whom
39 shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom
40 shall be a representative the Massachusetts Medical Society, 1 of whom shall be a behavioral
41 health provider, 1 of whom shall be a long-term supports and services provider, 1 of whom shall
42 be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a
43 representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a

44 representative of a Medicaid managed care organization, 1 of whom shall be a represent for
45 persons with disabilities, 1 of whom shall be a representative for consumers and 1 of whom shall
46 be an expert in establishing health system performance measures. Members appointed to the task
47 force shall have experience with and expertise in health care quality measurement.

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

53 The task force shall make recommendations on aligned quality measures for use in: (i)
54 contracts between payers, including the commonwealth and carriers, and health care providers,
55 provider organizations and accountable care organizations, which incorporate quality measures
56 into payment terms, including the designation of a set of core measures and a set of non-core
57 measures; (ii) assigning tiers to health care providers in the design of any health plan; (iii)
58 consumer transparency websites and other methods of providing consumer information; and (iv)
59 monitoring system-wide performance.

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

69 (b) Annually, not later than July 1, the secretary of health and human services shall
70 establish an aligned measure set to be used by the commonwealth and carriers in contracts with
71 health care providers that incorporate quality measures into the payment terms pursuant to
72 section 28 of chapter 32A, section 81 of chapter 118E, section 108N of chapter 175, section 40

73 of chapter 176A, section 26 of chapter 176B, section 35 of chapter 176G, section 14 of chapter
74 176I and for assigning tiers to health care providers in tiered network plans pursuant to section
75 11 of chapter 176J. The aligned measure set shall designate: (i) core measures that shall be used
76 in contracts between payers, including the commonwealth and carriers, and health care
77 providers, including provider organizations and accountable care organizations, that incorporate
78 quality measures into payment terms; and (ii) non-core measures that may be used in such
79 contracts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

153 Section 9A. (a) The commission shall establish an annual statewide readmissions
154 reduction benchmark. In establishing the benchmark, the commission shall consider: (i) the data

155 collected by the center on hospital and provider organization readmission rates from the 3 most
156 recent years for which the center has data; (ii) the distribution of readmissions volume among
157 provider types; (iii) available evidence on feasible interventions to reduce readmissions rates;
158 and (iv) any other relevant information identified by the commission.

159 (b) Prior to establishing the annual statewide readmissions reduction benchmark pursuant
160 to subsection (a), the commission shall hold a public hearing and hear testimony from payers,
161 providers and other interested parties. The hearing shall examine state and national readmission
162 rates and trends, rates and trends for different provider types, successful care delivery models
163 and interventions to reduce readmission rates, barriers to successful implementation of such
164 models and interventions and other information identified by the commission. Following the
165 hearing, the commission shall provide a report to the clerks of the senate and house of
166 representatives and the joint committee on health care financing that summarizes the testimony
167 received and the data and information reviewed by the commission to establish the benchmark.

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

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

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

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

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

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

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

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

210 (2) The commission may waive or delay the requirement for a provider
211 organization to file a readmissions performance improvement plan, if requested under subsection

212 (d), in light of all information received from the provider organization, including any new
213 information, based on a consideration of the factors described in subjection (b).

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

218 (f) A provider organization shall file a readmissions performance improvement plan not
219 later than 45 days after receipt of a notice under subsection (b); provided, however, that if the
220 provider organization has requested a waiver or extension, it shall file the plan not later than 45
221 days after receipt of a notice that the waiver or extension was denied or, if the provider
222 organization is granted an extension, on the date given on the extension. The readmissions
223 performance improvement plan shall be generated by the provider organization, identify the
224 causes of the provider organization's excessive readmissions rate and include, but shall not be
225 limited to, specific strategies, adjustments and action steps that the provider organization
226 proposes to implement to improve performance in reducing readmissions which may include
227 coordination with a community health center. The proposed readmissions performance
228 improvement plan shall include specific identifiable and measurable expected outcomes and a
229 timetable for implementation. The timetable for a performance improvement plan shall not
230 exceed 24 months.

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

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

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

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

253 (i) At the conclusion of the timetable established in the readmissions performance
254 improvement plan, the provider organization shall report to the commission regarding the
255 outcome of the readmissions performance improvement plan. If the commission finds that the
256 readmissions performance improvement plan was unsuccessful, the commission shall take at
257 least 1 of the following actions: (i) extend the implementation timetable of the existing
258 readmissions performance improvement plan; (ii) approve amendments to the readmissions
259 performance improvement plan as proposed by the provider organization; (iii) require the
260 provider organization to submit a new readmissions performance improvement plan under
261 subsection (f); or (iv) waive or delay the requirement to file any additional readmissions
262 performance improvement plans.

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

265 (k) The commission may assess a civil penalty of not more than $500,000 on a provider
266 organization if the commission determines that the provider organization: (i) willfully neglected
267 to file a readmissions performance improvement plan with the commission as required under
268 subsection (f); (ii) failed to file an acceptable readmissions performance improvement plan in
269 good faith with the commission; (iii) failed to implement the readmissions performance

270 improvement plan in good faith; or (iv) knowingly failed to provide information required under
271 this section to the commission or knowingly falsified such information. A civil penalty assessed
272 under this subsection shall be deposited into the Distressed Hospital Trust Fund established in
273 section 2GGGG of chapter 29.

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

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

280 If the statewide readmission reduction benchmark is not met in any year, in addition to
281 requiring a readmissions performance improvement plan pursuant to subsection (c), the
282 commission may assess a civil penalty on a provider organization identified by the commission
283 as a provider organization that has not met the readmission reduction benchmark in the current
284 year and at least once in the previous 5 years and the provider organization has been notified by
285 the commission under subsection (d). The civil penalty shall be an amount not greater than the
286 total cost attributable to the provider organization's excess readmissions in the most recent year
287 for which data is available and shall be deposited into the Healthcare Payment Reform Fund and
288 administered by the commission pursuant to section 7. If a provider organization is subject to an
289 additional state or federal penalty related to readmission reduction milestones or benchmarks,
290 any amount assessed by the commission shall be reduced by the amount of the additional
291 penalty.

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

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

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

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

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

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

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

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

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

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

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

338 The commission shall, to the extent possible, utilize or incorporate into its program other
339 independent educational resources or models proven effective in promoting high quality,
340 evidenced-based, cost-effective information regarding the effectiveness and safety of
341 prescription drugs including, but not limited to: (i) the Pennsylvania Pharmaceutical Assistance
342 Contract for the Elderly Independent Drug Information Service affiliated with Harvard
343 University; (ii) the Academic Detailing Program through the University of Vermont Larner
344 College of Medicine's Office of Primary Care and Area Health Education Centers Program; (iii)
345 the Drug Effectiveness Review Project coordinated by the Center for Evidence-based Policy at
346 Oregon Health and Science University; and (iv) the North Carolina evidence-based peer-to-peer
347 education program outreach program.

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

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

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

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

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

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

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

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

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

384 (c) The commission shall assess pharmaceutical manufacturing companies for the
385 implementation of this section in a similar manner to the annual registration fees and other
386 assessments related to the annual marketing disclosure reports required under section 2A of
387 chapter 111N.

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

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

393 Section 16A. (a) The commission shall, upon consideration of advice or any other
394 pertinent evidence, recommend the noncontracted commercial rate for emergency services and
395 the noncontracted commercial rate for nonemergency services, as defined in section 1 of chapter
396 176O. The noncontracted commercial rate for emergency services and the noncontracted
397 commercial rate for nonemergency services shall be in effect for a term of 5 years and shall
398 apply to payments under clauses (ii) and (iv) of section 28 of said chapter 176O.

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

406 (c) If the board approves the recommendations pursuant to subsection (b), the
407 commission shall submit the recommendations to the division of insurance. The division may,
408 not later than 30 days after the proposal has been submitted, hold a public hearing on the

409 proposal. The division shall issue any findings within 20 days after the public hearing and shall
410 make public those findings and any proposed regulation to implement those findings with respect
411 to the recommendations of the commission. If the division does not issue final regulations with
412 respect to the recommendations within 65 days after the commission submits the
413 recommendations to division, the recommendations shall be adopted by the division as the
414 noncontracted commercial rate for emergency services and noncontracted commercial rate for
415 nonemergency services in effect for the applicable 5-year term.

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

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

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

431 Section 19. (a) The commission, in consultation with the office of Medicaid, the
432 department of public health, the department of mental health and the department of
433 developmental services, shall develop and implement standards of certification for health care
434 trailblazer organizations for innovative practices that can be translated to similar organizations or
435 impact the health care delivery system. The standards developed by the commission shall be
436 based on the following: (i) demonstrated cost savings to the organization or the health care
437 delivery system; (ii) evidence of quality care improvement at a sustained or lower relative cost;

438 (iii) the actual and scalable impact of the innovative practices on the health care delivery system;
439 (iv) documented feedback from the individuals or patients targeted by the innovation; and (v)
440 such other criteria as determined by the commission.

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

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

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

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

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

462 "Pharmacy benefit manager", a person or entity that administers: (i) a prescription drug,
463 prescription device or pharmacist services or (ii) a prescription drug and device and pharmacist
464 services portion of a health benefit plan on behalf of a plan sponsor including, but not limited to,
465 self-insured employers, insurance companies and labor unions; provided, however, that

466 “Pharmacy benefit manager” shall include a health benefit plan that does not contract with a
467 pharmacy benefit manager and administers its own: (a) prescription drug, prescription device or
468 pharmacist services; or (b) prescription drug and device and pharmacist services portion, unless
469 specifically exempted by the center.

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

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

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

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

480 SECTION 27. Said section 5 of said chapter 12C, as so appearing, is hereby further
481 amended by inserting after the word “organizations”, in line 15, the following words:- , affected
482 pharmaceutical manufacturing companies, affected pharmacy benefit managers.

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

485 To the extent that the analysis of pharmaceutical manufacturing companies and pharmacy
486 benefit managers pursuant to section 10A increases the expenses of the center, the estimated
487 increase in the center’s expenses shall be fully assessed to pharmaceutical manufacturing
488 companies and pharmacy benefit managers in the same manner as the assessment under section
489 68 of chapter 118E. A pharmacy benefit manager that is a surcharge payor subject to the
490 preceding paragraph and administers either its own: (i) prescription drug, prescription device or
491 pharmacist services; or (ii) prescription drug and device and pharmacist services portion shall not
492 be subject to additional assessment under this paragraph.

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

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

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

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

514 Section 10A. (a) The center shall promulgate regulations necessary to ensure the uniform
515 analysis of information regarding pharmaceutical manufacturing companies and pharmacy
516 benefit managers and that enable the center to analyze: (i) year-over-year wholesale acquisition
517 cost changes; (ii) year-over-year trends in net expenditures; (iii) net expenditures on subsets of
518 brand and generic pharmaceuticals identified by the center; (iv) information regarding trends of
519 estimated aggregate drug rebates and other price reductions paid by a pharmaceutical
520 manufacturing company in connection with utilization of all pharmaceutical drug products
521 offered by the pharmaceutical manufacturing company; (v) information regarding trends of

522 estimated aggregate drug rebates and other price reductions paid by a pharmacy benefit manager
523 in connection with utilization of all drugs offered through the pharmacy benefit manager; (vi)
524 information regarding pharmacy benefit manager practices in passing drug rebates or other price
525 reductions received by the pharmacy benefit manager to a private or public health care payer or
526 the consumer; (vii) information regarding discount or free product vouchers that a retail
527 pharmacy provides to a consumer in connection with a pharmacy service, item or prescription
528 transfer offer or to any discount, rebate, product voucher or other reduction in an individual's
529 out-of-pocket expenses, including co-payments and deductibles under section 3 of chapter 175H;
530 and (viii) any other information deemed necessary by the center.

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

539 (c) Except as specifically provided otherwise by the center or under this chapter, data
540 collected by the center pursuant to this section from pharmaceutical manufacturing companies
541 and pharmacy benefit managers shall not be a public record under clause Twenty-sixth of section
542 7 of chapter 4 or under chapter 66.

543 SECTION 31. Section 11 of said chapter 12C, as so appearing, is hereby amended by
544 striking out, in line 2, the words “and 10” and inserting in place thereof the following words:- ,
545 10 and 10A.

546 SECTION 32. Section 12 of said chapter 12C, as so appearing, is hereby amended by
547 striking out, in line 2, the words “and 10” and inserting in place thereof the following words:- ,
548 10 and 10A.

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

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

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

558 SECTION 35. Subsection (a) of section 16 of said chapter 12C, as so appearing, is hereby
559 amended by striking out the first sentence and inserting in place thereof the following sentence:-
560 The center shall publish an annual report based on the information submitted under sections 8, 9,
561 10 and 10A concerning health care provider, provider organization, private and public health
562 care payer, pharmaceutical manufacturing company and pharmacy benefit manager costs and
563 cost trends, under section 13 of chapter 6D relative to market power reviews and under section
564 15 relative to quality data.

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

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

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

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

578 Section 24. The center shall annually, not later than February 1, prepare and file a public
579 health program beneficiary employer report to identify the 50 employers that have the highest
580 number of employees who receive medical assistance, medical benefits or assistance through the
581 Health Safety Net Trust Fund under chapter 118E. The report shall be filed with the clerks of the
582 senate and the house of representatives, the joint committee on health care financing and the
583 senate and house committees on ways and means. The report shall also be made available on the
584 center's website.

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

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

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

602 Section 19A. (a) For the purposes of this section and unless the context clearly indicates
603 otherwise, the words "behavioral health urgent care facility" shall mean a private, county or
604 municipal facility or any department or ward of such a facility that offers behavioral health

605 urgent care services to the public or represents itself as providing behavioral health urgent care
606 treatment.

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

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

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

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

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

628 SECTION 40. Section 2GGGG of chapter 29 of the General Laws, as appearing in the
629 2016 Official Edition, is hereby amended by inserting after the word “commission”, in line 66,
630 the following words:- or developed by a health care trailblazer.

631 SECTION 41. Said chapter 29 is hereby further amended by inserting after section
632 2XXXX the following 2 sections:-

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

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

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

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

655 (b) The fund shall consist of: (i) revenue generated from fees, fines and penalties imposed
656 under chapter 176W; (ii) revenue from appropriations or other money authorized by the general
657 court and specifically designated to be credited to the fund; and (iii) funds public or private
658 sources including, but not limited to, gifts, grants, donations, rebates and settlements received by
659 the commonwealth that are specifically designated to be credited to the fund. The council may
660 incur expenses and the comptroller may certify for payment amounts in anticipation of expected
661 receipts; provided, however, that an expenditure shall not be made from the fund that shall cause

662 the fund to be deficient at the close of a fiscal year. Amounts credited to the fund shall not be
663 subject to further appropriation and money remaining in the fund at the close of a fiscal year
664 shall not revert to the General Fund and shall be available for expenditure in the following fiscal
665 year.

666 (c) The council may expend funds collected under clause (i) of subsection (b) of section 4
667 of chapter 176W to support hospitals that meet criteria established by the council. When
668 determining hospital criteria, the council shall consider whether a hospital: (i) has a history of
669 receiving rates below the statewide commercial relative price; (ii) has a demonstrated record of
670 providing quality care; (iii) provides essential services to the region in which it is located; (iv)
671 has participated in cost-reduction efforts; (v) has provided sufficient information to the
672 commission to demonstrate its eligibility; and (vi) has provided all required financial reporting
673 information to the center for health information and analysis.

674 (d) The council may expend funds collected under clause (ii) of subsection (b) of section
675 4 of chapter 176W to defray premium costs for individuals and employers through a competitive
676 grant program established by the council.

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

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

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

688 Section 28. (a) As used in this section, “facility fee”, “health system”, “hospital” and
689 “hospital-based facility” shall have the same meanings as provided in section 28 of chapter
690 176O.

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

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

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

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

708 (b) Coverage offered by the commission to an active or retired employee of the
709 commonwealth insured under the group insurance commission shall provide coverage for health
710 care services through the use of telemedicine by a contracted health care provider if the health
711 care services are covered by way of in-person consultation or delivery. Health care services
712 delivered by way of telemedicine shall be covered to the same extent as if they were provided via
713 in-person consultation or delivery.

714 (c) Coverage may include utilization review, including preauthorization, to determine the
715 appropriateness of telemedicine as a means of delivering a health care service, provided that the

716 determination shall be made in the same manner as if the service was delivered in person. A
717 carrier shall not be required to reimburse a health care provider for a health care service that is
718 not a covered benefit under the plan nor reimburse a health care provider not contracted under
719 the plan.

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

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

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

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

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

744 established by the secretary to assign health care providers, provider organization or accountable
745 care organization to tiers in the design of a health plan.

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

751 SECTION 45. Said section 6D of said chapter 40J, as so appearing, is hereby further
752 amended by striking out, in lines 16 to 18, inclusive, the words "and (3) develop a plan to
753 complete the implementation of electronic health records systems by all providers in the
754 commonwealth" and inserting in place thereof the following words:- (3) develop a plan to
755 complete the implementation of electronic health records systems by all providers in the
756 commonwealth; and (4) advance the commonwealth's economic competitiveness by supporting
757 the digital health industry, including the digital health industry's role in improving the quality of
758 health care delivery and patient outcomes.

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

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

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

769 "Medication Order", an order for medication entered on a patient's medical record
770 maintained at a hospital, other health facility or ambulatory health care setting registered under
771 this chapter; provided, however, that the order is dispensed only for immediate administration at

772 the facility to the ultimate user by an individual who administers such medication under this
773 chapter.

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

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

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

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

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

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

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

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

801 SECTION 53. Said subsection (g) of said section 7 of said chapter 94C, as so appearing,
802 is hereby further amended by striking out the last paragraph.

803 SECTION 54. Said section 7 of said chapter 94C is hereby further amended by striking
804 out, in line 213, as so appearing, the words "and 66B" and inserting in place thereof the
805 following words:- , 66B and 66C.

806 SECTION 55. Section 9 of said chapter 94C, as so appearing, is hereby amended by
807 inserting after the word "podiatrist", in line 1, the following words:- , nurse practitioner, nurse
808 anesthetist, psychiatric nurse mental health clinical specialist.

809 SECTION 56. Said section 9 of said chapter 94C, as so appearing, is hereby further
810 amended by striking out, in line 2, the words "and 66B" and inserting in place thereof the
811 following words:- , 66B and 66C.

812 SECTION 57. Said section 9 of said chapter 94C, as so appearing, is hereby further
813 amended by striking out, in lines 3 to 5, inclusive, the words ", nurse practitioner and psychiatric
814 nurse mental health clinical specialist as limited by subsection (g) of said section 7 and section
815 80E of said chapter 112".

816 SECTION 58. Said section 9 of said chapter 94C, as so appearing, is hereby further
817 amended by striking out, in lines 8 and 9, the words ", nurse anesthetist, as limited by subsection
818 (g) of said section 7 and section 80H of said chapter 112".

819 SECTION 59. Subsection (a) of said section 9 of said chapter 94C, as so appearing, is
820 hereby amended by adding the following paragraph:-

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

824 SECTION 60. Said section 9 of said chapter 94C, as so appearing, is hereby further
825 amended by inserting after the word “nurse-midwifery”, in line 32, the following words:- ,
826 advanced practice nursing.

827 SECTION 61. Said section 9 of said chapter 94C, as so appearing, is hereby further
828 amended by inserting after the word “podiatrist”, in lines 72 and 80, each time it appears, the
829 following word:- , optometrist.

830 SECTION 62. Subsection (c) of said section 9 of said chapter 94C, as so appearing, is
831 hereby amended by adding the following paragraph:-

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

835 SECTION 63. Said section 9 of said chapter 94C, as so appearing, is hereby further
836 amended by inserting after the word “practitioner”, in lines 100 and 107, each time it appears,
837 the following words:- , nurse anesthetist, psychiatric nurse mental health clinical specialist.

838 SECTION 64. Section 18 of said chapter 94C is hereby amended by striking out, in lines
839 10, 39 and 72, as so appearing, the words “to practice medicine” and inserting in place thereof, in
840 each instance, the following words:- and authorized to engage in prescriptive practice.

841 SECTION 65. Said section 18 of said chapter 94C, as so appearing, is hereby further
842 amended by striking out the word “physician”, in lines 25, 38, 72 and 74, and inserting in place
843 thereof, in each instance, the following word:- practitioner.

844 SECTION 66. Said section 18 of said chapter 94C, as so appearing, is hereby further
845 amended by striking out, in lines 27, 54 and 55, and in line 88, the word “medicine”.

846 SECTION 67. Said chapter 94C is hereby further amended by inserting after section 21B
847 the following section:-

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

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

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

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

859 (b) A pharmacy shall post a notice informing consumers that a consumer may request, at
860 the point of sale, the current pharmacy retail price for each prescription medication the consumer
861 intends to purchase. If the consumer’s cost-sharing amount for a prescription medication exceeds
862 the current pharmacy retail price, the pharmacist, or an authorized individual at the direction of a
863 pharmacist, shall notify the consumer that the pharmacy retail price is less than the patient’s cost-
864 sharing amount. The pharmacist shall charge the consumer the applicable cost-sharing amount
865 or the current pharmacy retail price for that prescription medication, as directed by the consumer.

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

868 (c) A contractual obligation shall not prohibit a pharmacist from complying with this
869 section; provided, however, that a pharmacist shall submit a claim to the consumer’s health
870 benefit plan or its pharmacy benefit manager if the pharmacist has knowledge that the
871 prescription medication is covered under the consumer’s health benefit plan.

872 (d) A violation of this section shall be an unfair or deceptive act or practice under chapter
873 93A.

874 SECTION 68. Section 24A of said chapter 94C, as appearing in the 2016 Official
875 Edition, is hereby amended by striking out subsection (g) and inserting in place thereof the
876 following subsection:-

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

889 SECTION 69. Chapter 111 of the General Laws is hereby amended by striking out
890 sections 2G and 2H, as so appearing, and inserting in place thereof the following 2 sections:-

891 Section 2G. (a) There shall be a Prevention and Wellness Trust Fund to be expended,
892 without further appropriation, by the department of public health. The fund shall consist of
893 revenues collected by the commonwealth, including: (i) revenue from appropriations or other
894 money authorized by the general court and specifically designated to be credited to the fund; (ii)
895 fines and penalties allocated to the fund; (iii) funds from public and private sources, including
896 gifts, grants, donations and settlements received by the commonwealth to further community-
897 based prevention activities; (iv) funds provided from any other source; and (v) interest earned on
898 revenues in the fund . The commissioner of public health, as trustee, shall administer the fund.
899 The commissioner, in consultation with the prevention and wellness advisory board established
900 in section 2H, shall make expenditures from the fund consistent with subsections (d) and (e);
901 provided, however, that not more than 5 per cent of the amounts held in the fund in any 1 year
902 shall be used by the department for the cost of program administration and not more than 10 per
903 cent of amounts held in the fund in any 1 year shall be used for technical assistance to grantees,
904 program evaluation and data analytics.

905 (b) The department may incur expenses and the comptroller may certify for payment
906 amounts in anticipation of expected receipts; provided, however, that an expenditure shall not be

907 made from the fund if it would cause the fund to be in deficit at the close of a fiscal year.
908 Revenues deposited in the fund that are unexpended at the end of a fiscal year shall not revert to
909 the General Fund and shall be available for expenditure in the following fiscal year.

910 (c) Expenditures from the fund shall support the commonwealth's efforts to meet the
911 health care cost growth benchmark established in section 9 of chapter 6D and at least 1 of the
912 following: (i) increase access to community-based preventive services and interventions that
913 complement and expand the ability of MassHealth to promote coordinated care, integrate
914 community-based services with clinical care and develop innovative ways to address social
915 determinants of health; (ii) reduce the impact of health conditions that are the largest drivers of
916 poor health, health disparities, reduced quality of life and high health care costs through
917 community-based interventions; or (iii) develop a stronger evidence-base of effective prevention
918 interventions.

919 (d) Using a competitive grant process, the commissioner shall annually award not less
920 than 85 per cent of the money in the fund to municipalities, community-based organizations,
921 health care providers, regional planning agencies and health plans that apply for the
922 implementation, evaluation and dissemination of evidence-based community preventive health
923 activities. To be eligible to receive a grant under this subsection, a recipient shall be a partnership
924 that includes, at a minimum: (i) a municipality or regional planning agency; (ii) a community-
925 based health or social service provider; (iii) a public health or community action agency with
926 expertise in implementing community-wide health interventions; (iv) a health care provider or a
927 health plan; and (v) where feasible, a Medicaid-certified accountable care organization or a
928 Medicaid-certified community partner organization. Expenditures from the fund pursuant to this
929 subsection shall supplement and not replace existing local, state, private or federal public health-
930 related funding. An entity that is awarded funds through this program shall demonstrate the
931 ability to: (A) utilize best practices in accounting; (B) contract with a fiscal agent who shall
932 perform accounting functions on its behalf; or (C) be provided with technical assistance by the
933 department to ensure that best practices are followed.

934 (e) (1) A grant proposal submitted under subsection (d) shall include, but shall not be
935 limited to: (i) a plan that defines specific goals for the reduction in preventable health conditions
936 and health care costs over a multi-year period; (ii) the evidence-based or evidence-informed

937 programs the applicant shall use to meet the goals; (iii) a budget necessary to implement the
938 plan, including a detailed description of the funding or in-kind contributions the applicant will be
939 providing in support of the proposal; (iv) any other private funding or private sector participation
940 that the applicant anticipates in support of the proposal; (v) a commitment to include women,
941 racial and ethnic minorities and low-income individuals; and (vi) the anticipated number of
942 individuals that would be affected by the implementation of the plan.

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

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

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

965 (g) With the advice and guidance of the prevention and wellness advisory board, the
966 department shall report annually on its strategy for the administration and allocation of the fund,
967 including relevant evaluation criteria. The report shall set forth the rationale for the strategy,
968 which may include, but shall not be limited to including: (i) a list of the most prevalent
969 preventable health conditions in the commonwealth, including health disparities experienced by
970 populations based on race, ethnicity, gender, disability status, sexual orientation or
971 socioeconomic status; (ii) a list of the most costly preventable health conditions in the
972 commonwealth; and (iii) a list of evidence-based or promising community-based programs
973 related to the conditions identified in clauses (i) and (ii). The report shall recommend specific
974 areas of focus for the allocation of funds. If appropriate, the report shall reference goals and best
975 practices established by the National Prevention, Health Promotion and Public Health Council
976 and the Centers for Disease Control and Prevention including, but not limited to, the Health
977 Impact in 5 Years initiative, the National Prevention Strategy, the Healthy People report and the
978 Guide to Community Preventive Services.

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

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

984 (b) The board shall consist of: the commissioner of public health or a designee, who shall
985 serve as chair; the senate and house chairs of the joint committee on public health or their
986 designees; the senate and house chairs of the joint committee on health care financing or their
987 designees; the secretary of health and human services or a designee; the executive director of the
988 center for health information and analysis or a designee; the executive director of the health
989 policy commission or a designee; and 15 persons to be appointed by the governor, 1 of whom
990 shall be a person with expertise in the field of public health economics, 1 of whom shall be a
991 person with expertise in public health research, 1 of whom shall be a person with expertise in the
992 field of health equity, 1 of whom shall be a person from a local board of health for a city or town
993 with a population of not less than 50,000, 1 of whom shall be a member of a board of health for a
994 city or town with a population of less than 50,000, 2 of whom shall be representatives of health

995 insurance carriers, 1 of whom shall be a person from a consumer health advocacy organization, 1
996 of whom shall be a person from a hospital association, 1 of whom shall be a person from a
997 statewide public health organization, 1 of whom shall be a representative of business interests, 1
998 of whom shall be a public health nurse or a school nurse, 1 of whom shall be a person from an
999 association representing community health workers, 1 of whom shall represent a statewide
1000 association of community-based service providers addressing public health and 1 of whom shall
1001 be a person with expertise in the design and implementation of communitywide public health
1002 interventions.

1003 (c) (1) The board shall evaluate the grant program under section 2G and shall issue a
1004 report at intervals to be determined by the board but not less than every 5 years from the
1005 beginning of each grant period. The report shall include an analysis of all relevant data to
1006 determine the effectiveness of the program including, but not limited to: (i) the extent to which
1007 the program impacted the prevalence, severity or control of preventable health conditions and the
1008 extent to which the program is projected to impact those factors in the future; (ii) the extent to
1009 which the program reduced health care costs or the growth in health care cost trends and the
1010 extent to which the program is projected to reduce those costs in the future; (iii) whether health
1011 care costs were reduced and who benefited from the reduction; (iv) the extent to which health
1012 outcomes or health behaviors were positively impacted; (v) the extent to which access to
1013 evidence-based community services was increased; (vi) the extent to which social determinants
1014 of health or other community-wide risk factors for poor health were reduced or mitigated; (vii)
1015 the extent to which grantees increased their ability to collaborate, share data and align services
1016 with other providers and community-based organizations for greater impact; (viii) the extent to
1017 which health disparities experienced by populations based on race, ethnicity, gender, disability
1018 status, sexual orientation or socioeconomic status were reduced across all metrics; and (ix)
1019 recommendations for whether the program should be discontinued, amended or expanded and a
1020 timetable for implementation of those recommendations.

1021 (2) The department of public health shall coordinate with grantees to contract with
1022 an outside organization that has expertise in the analysis of public health and health care
1023 financing to assist the board in conducting its evaluation. The outside organization shall be
1024 provided with access to actual health plan data from the all-payer claims database administered

1025 by the center for health information and analysis and to data from MassHealth, to the extent
1026 permitted by law; provided, however, that such data shall be confidential and shall not be a
1027 public record under clause Twenty-sixth of section 7 of chapter 4.

1028 (3) The board shall report the results of its evaluation and its recommendations, if
1029 any, and submit drafts of legislation necessary to carry out the recommendations to the senate
1030 and house committees on ways and means, the joint committee on public health and the joint
1031 committee on health care financing and shall post the board's report on the department's website.

1032 SECTION 70. Said chapter 111 is hereby further amended by inserting after section 51K
1033 the following section:-

1034 Section 51L. (a) For the purposes of this section, the following terms shall have the
1035 following meanings unless the context clearly indicates otherwise:

1036 "Campus", the physical area immediately adjacent to a hospital's main buildings and
1037 other areas and structures that are not strictly contiguous to the main buildings but are located not
1038 more than 250 yards from the main buildings or other area that has been determined on an
1039 individual case basis by the Centers for Medicare & Medicaid Services to be part of a hospital's
1040 campus.

1041 "Carrier", shall have the same meaning as provided in section 1 of chapter 176O.

1042 "Facility fee", shall have the same meaning as provided in section 28 of chapter 176O.

1043 "Health system", shall have the same meaning as provided in section 28 of chapter 176O.

1044 "Hospital-based facility", shall have the same meaning as provided in section 28 of
1045 chapter 176O.

1046 (b) A hospital, health system or hospital-based facility shall not charge, bill or collect a
1047 facility fee for services utilizing a current procedural terminology evaluation and management
1048 code if the service was provided by a hospital-based facility located off of a campus. A violation
1049 of this subsection shall be an unfair trade practice under chapter 93A.

1050 (c) The department may identify additional conditions or factors that would prohibit a
1051 hospital, health system or hospital-based facility from charging, billing or collecting a facility fee
1052 for health care services. Additional conditions or factors may include, but shall not be limited to:
1053 (i) additional current procedural terminology codes for which a hospital, health system or
1054 hospital-based facility shall not charge, bill or collect a facility fee; (ii) health care services for
1055 which a hospital, health system or hospital-based facility shall not charge, bill or collect a facility
1056 fee; (iii) limitations on physical locations, including whether on a campus or not, for which a
1057 hospital, health system or hospital-based facility shall not charge, bill or collect a facility fee; and
1058 (iv) other conditions or factors. The department shall forward any recommendations under this
1059 subsection to the joint committee on health care financing and the house and senate committees
1060 on ways and means.

1061 SECTION 71. Said chapter 111 is hereby further amended by striking out section 228, as
1062 appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

1063 Section 228. (a) For the purposes of this section, “allowed amount” shall mean the
1064 contractually agreed-upon amount paid by a carrier to a health care provider for health care
1065 services provided to an insured.

1066 (b) Prior to an admission, procedure or service, and upon request by a patient or
1067 prospective patient, a health care provider shall, not later than 2 working days after receipt of the
1068 request, disclose the allowed amount or charge for the admission, procedure or service, including
1069 the amount of any facility fees. If a health care provider is unable to quote a specific amount in
1070 advance due to the health care provider's inability to predict the specific treatment or diagnostic
1071 code, the health care provider shall disclose the estimated maximum allowed amount or charge
1072 for a proposed admission, procedure or service, including the amount of any facility fees.

1073 (c) If a patient or prospective patient is covered by a health plan, a health care provider
1074 who participates as a network provider shall, at the time of scheduling a procedure or service: (i)
1075 provide sufficient information regarding the proposed admission, procedure or service for the
1076 patient or prospective patient to make an informed decision about the costs associated with that
1077 admission, procedure or service based on information available to the provider at that time,
1078 including the amount of any facility fees; and (ii) inform the patient or prospective patient that

1079 the patient or prospective patient may obtain additional information about any applicable out-of-
1080 pocket costs, pursuant to section 23 of chapter 176O. A health care provider may assist a patient
1081 or prospective patient in using the health plan's toll-free number and website pursuant to said
1082 section 23 of said chapter 176O.

1083 (d) A health care provider referring a patient to another provider shall disclose: (i) if the
1084 provider to whom the patient is being referred is part of or represented by the same provider
1085 organization, as used in section 11 of chapter 6D; (ii) the network status of the referred provider
1086 based on information available to the provider at the time of the referral; and (iii) sufficient
1087 information about the referred provider for the patient to obtain additional information about that
1088 provider's network status under the patient's health plan and any applicable out-of-pocket costs
1089 for that referral pursuant to section 23 of chapter 176O, based on information available to the
1090 provider at that time.

1091 SECTION 72. Section 1 of chapter 111O of the General Laws, as so appearing, is hereby
1092 amended by inserting after the definition of "Mobile integrated health care" the following
1093 definition:-

1094 "Mobile integrated health care provider" or "MIH provider", a licensed health care
1095 professional delivering medical care and services to patients in an out-of-hospital environment in
1096 coordination with health care facilities or other health care providers; provided, however, that
1097 medical care and services shall include, but shall not be limited to, community paramedic
1098 provider services, chronic disease management, behavioral health, preventative care, post-
1099 discharge follow-up visits or transport or referral to facilities other than hospital emergency
1100 departments; provided further, that medical care and services shall be delivered under a mobile
1101 integrated health care program approved by the department using mobile health care resources.

1102 SECTION 73. Section 2 of said chapter 111O, as so appearing, is hereby amended by
1103 adding the following 2 subsections:-

1104 (c) The department shall issue guidance, in consultation with the advisory council, on
1105 best practices for structuring mobile integrated health care programs to obtain reimbursement for
1106 the care and services delivered to patients who are covered by public or private payers.

1107 (d) Annually, not later than March 1, the department shall report the data collected from
1108 MIH programs pursuant to subsection (b). The report shall include, but not be limited to, an
1109 analysis of the impact of MIH programs on: (i) 30-day readmission rates; (ii) siting of post-acute
1110 care treatment; (iii) incidence of emergency department presentment for behavioral health
1111 conditions; (iv) incidence of emergency department presentment for chronic conditions; and (v)
1112 the variance in each of the preceding metrics within and between Medicaid claims and
1113 commercial claims, respectively. The department may consult with the center for health
1114 information and analysis in developing the report. The report shall be made publicly available
1115 and easily searchable on the department's website.

1116 SECTION 74. Said chapter 111O is hereby further amended by adding the following 2
1117 sections:-

1118 Section 5. (a) The department shall by regulation establish application fees that shall
1119 include, but shall not limited to, an initial application surcharge in addition to a general
1120 application or renewal fee, and a timeline for reviewing applications for mobile integrated health
1121 care or community EMS programs.

1122 Section 6. (a) The department shall allow applicants for MIH programs and Community
1123 EMS programs and approved MIH and Community EMS programs to seek a waiver from
1124 transporting a patient to the closest appropriate health care facility as required by the department;
1125 provided, that any such program that obtains a waiver shall have a point-of-entry plan that fits
1126 the design and purpose of the program seeking the waiver; provided further, that the department
1127 shall only approve a waiver if it demonstrates a point-of-entry plan that provides flexibility on
1128 the basis of the medical direction associated with a patient and does not include an explicit
1129 requirement that a patient be transported only to a health care facility owned or operated by, or
1130 affiliated with, an MIH program or Community EMS program.

1131 (b) Application fees and surcharges collected pursuant to this section shall be deposited
1132 into the Mobile Integrated Health Care Trust Fund established in section 2YYYY of chapter 29.

1133 (c) The department shall prioritize the review and processing of mobile integrated health
1134 care program applicants who have been approved as a MassHealth accountable care organization
1135 or targeted patient populations served by MassHealth accountable care organizations.

1136 SECTION 75. Section 2 of chapter 112 of the General Laws, as appearing in the 2016
1137 Official Edition, is hereby amended by adding the following 3 paragraphs:-

1138 For the purposes of this section, “telemedicine” shall mean the use of audio, video or
1139 other electronic media for a diagnosis, consultation or treatment of a patient's physical, oral or
1140 mental health; provided, however, that ”telemedicine” shall not include audio-only telephone,
1141 facsimile machine, online questionnaire, texting or text-only e-mail.

1142 Notwithstanding any other provision of this chapter, the board shall allow a physician to
1143 obtain proxy credentialing and privileging for telemedicine services with other health care
1144 providers, as defined in section 1 of chapter 111, or facilities consistent with Medicare conditions
1145 of participation telemedicine standards.

1146 The board shall promulgate regulations regarding the appropriate use of telemedicine to
1147 provide health care services. These regulations shall provide for and include, but shall not be
1148 limited to: (i) prescribing medications; (ii) services that are not appropriate to provide through
1149 telemedicine; (iii) establishing a patient-provider relationship; (iv) consumer protections; and (v)
1150 ensuring that services comply with appropriate standards of care.

1151 SECTION 76. Said chapter 112 is hereby further amended by striking out section 13, as
1152 so appearing, and inserting in place thereof the following section:-

1153 Section 13. (a) As used in this chapter, “podiatry” shall mean the diagnosis and treatment,
1154 by medical, mechanical, electrical or surgical means, of ailments of the human foot and lower
1155 leg.

1156 (b) As used in sections 12B, 12G and 80B, “physician” shall include a podiatrist
1157 registered under section 16.

1158 (c) Sections 13 to 18, inclusive, shall not apply to surgeons of the United States army,
1159 United States navy or of the United States Public Health Service or to physicians registered in
1160 the commonwealth.

1161 SECTION 77. Section 43A of said chapter 112, as so appearing, is hereby amended by
1162 inserting after the definition of “Appropriate supervision” the following 2 definitions:-

1163 “Board”, the board of registration in dentistry established pursuant to section 19 of
1164 chapter 13 or a committee or subcommittee of the board.

1165 “Collaborative management agreement”, a written agreement between a local, state or
1166 federal government agency or institution or a licensed dentist and a dental therapist outlining the
1167 procedures, services, responsibilities and limitations of the therapist.

1168 SECTION 78. Said section 43A of said chapter 112, as so appearing, is hereby further
1169 amended by inserting after the definition of “Dental supervision” the following definition:-

1170 “Dental therapist”, a person who: (i) is registered by the board to practice as a dental
1171 therapist pursuant to section 51B and as a dental hygienist pursuant to section 51; and (ii)
1172 provides oral health care services pursuant to said section 51B.

1173 SECTION 79. Said section 43A of said chapter 112, as so appearing, is hereby further
1174 amended by adding the following definition:-

1175 “Supervising dentist”, a licensed dentist who enters into a collaborative management
1176 agreement with a dental therapist.

1177 SECTION 80. Said chapter 112 is hereby further amended by inserting after section 51A
1178 the following section:-

1179 Section 51B. (a) A person of good moral character shall be registered as a dental therapist
1180 and given a certificate allowing the therapist to practice in this capacity if the person: (i) has
1181 completed a dental therapist education program that meets the standards of the Commission on
1182 Dental Accreditation, has graduated from a dental therapist education program that meets the
1183 standards of the Commission on Dental Accreditation provided by a post-secondary institution
1184 accredited by the New England Association of Schools and Colleges, Inc. or is certified by the
1185 federal Indian Health Service pursuant to the Indian Health Care Improvement Act, 25 U.S.C.
1186 1601 et seq.; (ii) passes a comprehensive, competency-based clinical examination that is
1187 approved by the board of registration in dentistry and administered independently of an
1188 institution providing registered dental therapy education; and (iii) maintains a policy of
1189 professional liability insurance and shows proof of the insurance as required by applicable
1190 regulations. A dental therapist shall also be registered as a dental hygienist and possess a

1191 certificate to practice dental hygiene pursuant to section 51. A dental therapist shall have
1192 practiced under the direct supervision of a supervising dentist for not less than 500 hours or shall
1193 have completed 1 year of residency before practicing under general supervision.

1194 (b) The educational curriculum for a dental therapist shall include training on how to
1195 serve certain patients including, but not limited to: (i) people with developmental disabilities,
1196 including autism spectrum disorders, mental illness, cognitive impairment, complex medical
1197 problems or significant physical limitations; and (ii) the elderly.

1198 (c) A dental therapist shall enter into a collaborative management agreement with a
1199 licensed dentist before performing a procedure or providing a service under this paragraph. The
1200 agreement shall address: (i) practice settings; (ii) limitations on services established by the
1201 supervising dentist; (iii) the level of supervision required for various services or treatment
1202 settings; (iv) patient populations that may be served by the dental therapist; (v) practice
1203 protocols; (vi) record keeping; (vii) management of medical emergencies; (viii) quality
1204 assurance; (ix) administration and dispensing of medications; and (x) supervision of dental
1205 assistants and dental hygienists. A dental therapist may provide services authorized in practice
1206 settings where the supervising dentist is not on-site and has not previously examined the patient
1207 if such a service is authorized by the supervising dentist in the collaborative management
1208 agreement and the supervising dentist is available for consultation and supervision by telephone
1209 or other means of communication.

1210 The collaborative management agreement shall include specific protocols to govern
1211 situations in which the dental therapist encounters a patient who requires treatment that exceeds
1212 the authorized scope of practice of the dental therapist. A collaborative management agreement
1213 shall be signed and maintained by the supervising dentist and the dental therapist and shall be
1214 submitted to the board upon request. The board shall establish appropriate guidelines for a
1215 collaborative management agreement. The collaborative management agreement may be updated
1216 from time to time. A supervising dentist may have a collaborative management agreement with
1217 not more than 4 dental therapists at the same time.

1218 A dental therapist may perform: (i) acts of a public health dental hygienist under section
1219 51; (ii) acts provided for in the Commission on Dental Accreditation's dental therapy standards;

1220 and (iii) the following services and procedures pursuant to the collaborative management
1221 agreement without the supervision or direction of a dentist: (1) interpretation of radiographs; (2)
1222 placement of space maintainers; (3) pulpotomy on primary teeth; (4) oral evaluation and
1223 assessment of dental disease and the formulation of an individualized treatment plan authorized
1224 by the collaborating dentist; and (5) nonsurgical extraction of permanent teeth except as limited
1225 under this section.

1226 A dental therapist shall not perform a service or procedure described in this section
1227 except as authorized by the collaborating dentist. A dental therapist may perform nonsurgical
1228 extractions of periodontally-diseased permanent teeth with tooth mobility of +3 under general
1229 supervision if authorized in advance by the collaborating dentist. A dental therapist shall not
1230 extract a tooth for a patient if the tooth is unerupted, impacted or needs to be sectioned for
1231 removal. The collaborating dentist shall be responsible for directly providing or arranging for
1232 another dentist or specialist to provide necessary advanced services needed by the patient.

1233 A dental therapist shall, in accordance with the collaborative management agreement,
1234 refer patients to another qualified dental or health care professional to receive needed services
1235 that exceed the scope of practice of the dental therapist. The collaborating dentist shall ensure
1236 that a dentist is available to the dental therapist for timely consultation during treatment if needed
1237 and shall either provide or arrange with another dentist or specialist to provide the necessary
1238 treatment to a patient who requires more treatment than the dental therapist is authorized to
1239 provide.

1240 A dental therapist may dispense and administer analgesics, anti-inflammatories and
1241 antibiotics within the scope of the dental therapist's practice and the collaborative management
1242 agreement and with the authorization of the collaborating dentist. The authority to dispense
1243 under this paragraph shall include the authority to dispense sample drugs within the categories
1244 identified in this paragraph if permitted by the collaborative management agreement. A dental
1245 therapist shall not dispense or administer a narcotic drug.

1246 (d) A dental therapist shall be reimbursed for services covered by Medicaid and other
1247 third-party payers. A dental therapist shall not operate independently of a dentist unless the
1248 dental therapist works for a local, state or federal government agency or a non-profit institution

1249 or practices in a mobile or portable prevention program licensed or certified by the department of
1250 public health.

1251 (e) A dental therapist may supervise dental assistants to the extent permitted in the
1252 collaborative management agreement and in accordance with section 51½.

1253 SECTION 81. Said chapter 112 is hereby further amended by striking out section 66, as
1254 appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

1255 Section 66. As used in this chapter, "practice of optometry" shall mean the diagnosis,
1256 prevention, correction, management or treatment of optical deficiencies, optical deformities,
1257 visual anomalies, muscular anomalies, ocular diseases and ocular abnormalities of the human eye
1258 and adjacent tissue, including removal of superficial foreign bodies and misaligned eyelashes, by
1259 utilization of pharmaceutical agents, by the prescription, adaptation and application of
1260 ophthalmic lenses, devices containing lenses, prisms, contact lenses, orthoptics, vision therapy,
1261 prosthetic devices and other optical aids and the utilization of corrective procedures to preserve,
1262 restore or improve vision, consistent with sections 66A, 66B and 66C.

1263 SECTION 82. Section 66B of said chapter 112, as so appearing, is hereby amended by
1264 striking out, in line 31, the following words:- , except glaucoma.

1265 SECTION 83. Said chapter 112 is hereby further amended by inserting after section 66B
1266 the following section:-

1267 Section 66C. (a) A registered optometrist who is qualified by an examination for practice
1268 under section 68, certified under section 68C and registered to issue written prescriptions
1269 pursuant to subsection (h) of section 7 of chapter 94C, may: (i) use and prescribe topical and oral
1270 therapeutic pharmaceutical agents, as defined in section 66B, that are used in the practice of
1271 optometry, including those placed in schedules III, IV, V and VI pursuant to section 2 of said
1272 chapter 94C, for the purpose of diagnosing, preventing, correcting, managing or treating
1273 glaucoma and other ocular abnormalities of the human eye and adjacent tissue; and (ii) prescribe
1274 all necessary eye-related medications, including oral anti-infective medications; provided,
1275 however, that a registered optometrist shall not use or prescribe: (1) therapeutic pharmaceutical
1276 agents for the treatment of systemic diseases; (2) surgical procedures; (3) pharmaceutical agents

1277 administered by subdermal injection, intramuscular injection, intravenous injection,
1278 subcutaneous injection or retrobulbar injection; or (4) an opioid substance or drug product. For
1279 the purposes of this section, "surgical procedures" shall not include the use of ophthalmic
1280 medical devices approved by the federal Food and Drug Association for diagnostic purposes
1281 under Subpart B of 21 CFR 886.

1282 (b) If an optometrist, while examining or treating a patient with the aid of a diagnostic or
1283 therapeutic pharmaceutical agent and exercising professional judgment and the degree of
1284 expertise, care and knowledge ordinarily possessed and exercised by optometrists under like
1285 circumstances, encounters a sign of a previously unevaluated disease that would require
1286 treatment not included in the scope of the practice of optometry, the optometrist shall refer the
1287 patient to a licensed physician or other qualified health care practitioner.

1288 (c) If an optometrist diagnoses a patient with congenital glaucoma or if, during the course
1289 of examining, managing or treating a patient with glaucoma, the optometrist determines that
1290 surgical treatment is indicated, the optometrist shall refer the patient to a qualified health care
1291 provider for treatment.

1292 (d) An optometrist licensed under this chapter shall participate in any relevant state or
1293 federal report or data collection effort relative to patient safety and medical error reduction
1294 coordinated by the Betsy Lehman center for patient safety and medical error reduction
1295 established in section 15 of chapter 12C.

1296 SECTION 84. Said chapter 112 is hereby further amended by inserting after section 68B
1297 the following section:-

1298 Section 68C. (a) The board of registration in optometry shall administer an examination
1299 to permit the use and prescription of therapeutic pharmaceutical agents as authorized in section
1300 66C. The examination shall: (i) be held in conjunction with examinations provided for in
1301 sections 68, 68A and 68B; and (ii) include any portion of the examination administered by the
1302 National Board of Examiners in Optometry or other appropriate examination covering the
1303 subject matter of therapeutic pharmaceutical agents as authorized in said section 66C. The board
1304 may administer a single examination to measure the qualifications necessary under said sections
1305 68, 68A, 68B and this section. The board shall qualify optometrists to use and prescribe

1306 therapeutic pharmaceutical agents in accordance with said sections 68, 68A, 68B and this
1307 section.

1308 (b) Examination for the use and prescription of therapeutic pharmaceutical agents placed
1309 in schedules III, IV, V and VI under section 2 of chapter 94C and defined in section 66C shall,
1310 upon application, be open to an optometrist registered under section 68, 68A or 68B and to any
1311 person who meets the qualifications for examination under said sections 68, 68A and 68B. An
1312 applicant registered as an optometrist under said section 68, 68A or 68B shall: (i) be registered
1313 pursuant to paragraph (h) of section 7 to use or prescribe pharmaceutical agents for the purpose
1314 of diagnosing or treating glaucoma and other ocular abnormalities of the human eye and adjacent
1315 tissue; and (ii) furnish to the board of registration in optometry evidence of the satisfactory
1316 completion of 40 hours of didactic education and 20 hours of supervised clinical education
1317 relating to the use and prescription of therapeutic pharmaceutical agents under section 66C;
1318 provided, however, that such education shall: (1) be administered by the Massachusetts Society
1319 of Optometrists, Inc.; (2) be accredited by a college of optometry or medicine; and (3) meet the
1320 guidelines and requirements of the board of registration in optometry. The board of registration
1321 in optometry shall provide to each successful applicant a certificate of qualification in the use
1322 and prescription of all therapeutic pharmaceutical agents as authorized under said section 66C
1323 and shall forward to the department of public health notice of such certification for each
1324 successful applicant.

1325 (c) An optometrist licensed in another jurisdiction shall be deemed an applicant under
1326 this section by the board of registration in optometry. An optometrist licensed in another
1327 jurisdiction may submit evidence to the board of registration in optometry of practice equivalent
1328 to that required in section 68, 68A or 68B and the board, in its discretion, may accept the
1329 evidence in order to satisfy any of the requirements of this section. An optometrist in another
1330 jurisdiction licensed to utilize and prescribe therapeutic pharmaceutical agents for treating
1331 glaucoma and other ocular abnormalities of the human eye and adjacent tissue may submit
1332 evidence to the board of registration in optometry of equivalent didactic and supervised clinical
1333 education, and the board, in its discretion, may accept the evidence in order to satisfy any of the
1334 requirements of this section.

1335 (d) A licensed optometrist who has completed a postgraduate residency program
1336 approved by the Accreditation Council on Optometric Education of the American Optometric
1337 Association may submit an affidavit to the board of registration in optometry from the licensed
1338 optometrist's residency supervisor or the director of residencies at the affiliated college of
1339 optometry attesting that the optometrist has completed an equivalent level of instruction and
1340 supervision and the board, in its discretion, may accept the evidence in order to satisfy any of the
1341 requirements of this section.

1342 (e) As a condition of license renewal, an optometrist licensed under this section shall
1343 submit to the board of registration in optometry evidence attesting to the completion of 3 hours
1344 of continuing education specific to glaucoma and the board, in its discretion, may accept the
1345 evidence to satisfy this condition for license renewal.

1346 SECTION 85. Section 80B of said chapter 112, as appearing in the 2016 Official Edition,
1347 is hereby amended by inserting after the word "practitioners", in line 12, the following words:- ,
1348 nurse anesthetists.

1349 SECTION 86. Said section 80B of said chapter 112, as so appearing, is hereby further
1350 amended by striking out the seventh paragraph and inserting in place thereof the following
1351 paragraph:-

1352 The board shall promulgate advanced practice nursing regulations which govern the
1353 provision of advanced practice nursing services and related care including, but not limited to, the
1354 ordering and interpreting of tests, the ordering and evaluation of treatment and the use of
1355 therapeutics.

1356 SECTION 87. Said section 80B of said chapter 112, as so appearing, is hereby further
1357 amended by striking out, in lines 64 and 65, the words "in the ordering of tests, therapeutics and
1358 the prescribing of medications, to" and inserting in place thereof the following word:- to.

1359 SECTION 88. Said chapter 112 is hereby further amended by striking out section 80E, as
1360 so appearing, and inserting in place thereof the following section:-

1361 Section 80E. (a) A nurse practitioner or psychiatric nurse mental health clinical specialist
1362 may issue written prescriptions and medication orders and order tests and therapeutics pursuant

1363 to guidelines mutually developed and agreed upon by the nurse and either a supervising nurse
1364 practitioner or psychiatric nurse mental health clinical specialist who has independent practice
1365 authority or a supervising physician, in accordance with regulations promulgated by the board. A
1366 prescription issued by a nurse practitioner or psychiatric nurse mental health clinical specialist
1367 under this subsection shall include the name of the nurse practitioner or the psychiatric nurse
1368 mental health clinical specialist who has independent practice authority or the supervising
1369 physician with whom the nurse practitioner or psychiatric nurse mental health clinical specialist
1370 developed and signed mutually agreed upon guidelines.

1371 A nurse practitioner or psychiatric nurse mental health clinical specialist shall have
1372 independent practice authority to issue written prescriptions and medication orders and order
1373 tests and therapeutics without the supervision described in this subsection if the nurse
1374 practitioner or psychiatric nurse mental health clinical specialist has completed not less than 2
1375 years of supervised clinical practice following certification from a board-recognized certifying
1376 body; provided, however, that supervision of clinical practice shall be conducted by a health
1377 care professional who meets minimum qualification criteria promulgated by the board, which
1378 shall include a minimum number of years of independent clinical practice experience.

1379 The board may allow a nurse practitioner or psychiatric nurse mental health clinical
1380 specialist to exercise such independent practice authority upon satisfactory demonstration of not
1381 less than 2 years of alternative professional experience; provided, however, that the board
1382 determines that the nurse practitioner or psychiatric nurse mental health clinical specialist has a
1383 demonstrated record of safe prescribing and good conduct consistent with professional licensure
1384 obligations required by each jurisdiction in which the nurse practitioner or psychiatric nurse
1385 mental health clinical specialist has been licensed.

1386 (b) The board shall promulgate regulations to implement this section.

1387 SECTION 89. Said chapter 112 is hereby further amended by striking out section 80H,
1388 as so appearing, and inserting in place thereof the following section:-

1389 Section 80H. (a) A nurse anesthetist may issue written prescriptions and medication
1390 orders and order tests and therapeutics pursuant to guidelines mutually developed and agreed
1391 upon by the nurse and either a supervising nurse anesthetist with independent practice authority

1392 or a supervising physician, in accordance with regulations promulgated by the board; provided,
1393 however, that supervision under this section by a nurse anesthetist with independent practice
1394 authority or by a physician shall be limited to written prescriptions and medication orders and the
1395 ordering of tests and therapeutics. A prescription issued by a nurse anesthetist under this
1396 subsection shall include the name of the nurse anesthetist with independent practice authority or
1397 the supervising physician with whom the nurse anesthetist developed and signed mutually agreed
1398 upon guidelines.

1399 A nurse anesthetist shall have independent practice authority to issue written
1400 prescriptions and medication orders and order tests and therapeutics without the supervision
1401 described in this subsection if the nurse anesthetist has completed not less than 2 years of
1402 supervised clinical practice following certification from a board-recognized certifying body;
1403 provided, however, that supervision of clinical practice shall be conducted by a health care
1404 professional who meets minimum qualification criteria promulgated by the board which shall
1405 include a minimum number of years of independent clinical practice experience.

1406 The board, in its discretion, may allow a nurse anesthetist to exercise such independent
1407 practice authority upon satisfactory demonstration of alternative professional experience if the
1408 board determines that the nurse anesthetist has a demonstrated record of safe prescribing and
1409 good conduct consistent with professional licensure obligations required by each jurisdiction in
1410 which the nurse anesthetist has been licensed.

1411 (b) The board shall promulgate regulations to implement this section.

1412 SECTION 90. Section 80I of said chapter 112, as so appearing, is hereby amended by
1413 striking out the second and third sentences.

1414 SECTION 91. Said chapter 112 is hereby further amended by inserting after section 80I
1415 the following 2 sections:-

1416 Section 80J. A nurse authorized to practice as a psychiatric nurse mental health clinical
1417 specialist pursuant to section 80B, may order and interpret tests, therapeutics and prescribe
1418 medications in accordance with regulations promulgated by the board and subject to the
1419 provisions of subsection (g) of section 7 of chapter 94C.

1420 Section 80K. The board shall promulgate regulations, which shall be subject to approval
1421 by the commissioner, to ensure that nurse practitioners, nurse anesthetists and psychiatric nurse
1422 mental health clinical specialists under the board of registration in nursing are subject to
1423 requirements commensurate to those that physicians are subject to under the board of registration
1424 in medicine pursuant to the sixth and seventh paragraphs of section 5 and sections 5A to 5M,
1425 inclusive, as they apply to the creation and public dissemination of individual profiles and
1426 licensure restrictions, disciplinary actions and reports, claims or reports of malpractice,
1427 communication with professional organizations, physical and mental examinations, investigation
1428 of complaints and other aspects of professional conduct and discipline

1429 SECTION 92. Section 66 of chapter 118E of the General Laws, as appearing in the 2016
1430 Official Edition, is hereby amended by striking out, in line 28, the first time it appears, the word
1431 "and".

1432 SECTION 93. Said section 66 of said chapter 118E, as so appearing, is hereby further
1433 amended by inserting after the word "thereon", in line 29, the following words:- ; and (v) any
1434 fines collected under section 10 of chapter 6D.

1435 SECTION 94. Said chapter 118E is hereby further amended by adding the following 4
1436 sections:-

1437 Section 78. (a) Upon request from the division, an employer shall provide, under oath,
1438 health insurance information about an employee who has applied for benefits from a state
1439 subsidized health insurance program. An employer receiving information that identifies or may
1440 be used to identify a MassHealth member or recipient of subsidized health insurance shall not
1441 use or disclose such information except as authorized by the division.

1442 (b) Information reported under this section that identifies an individual employee by
1443 name or health insurance status or is health information protected under state and federal privacy
1444 laws shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under
1445 chapter 66. Reported information may be exchanged among the executive office of health and
1446 human services, the commonwealth health insurance connector authority, the department of
1447 unemployment assistance, the center for health information and analysis and the department of
1448 revenue for the exclusive purpose of determining an individual's eligibility for benefits from a

1449 state subsidized health insurance program. An employer who knowingly falsifies or fails to file
1450 any information required by this section or by any regulation issued pursuant to this section shall
1451 be subject to a fine of not more than $5,000 for each violation

1452 Section 79. (a) The division shall create a health insurance responsibility disclosure form.
1453 An employer with 6 or more employees and doing business in the commonwealth shall annually
1454 complete and submit the form under oath. The form shall indicate whether the employer has
1455 offered to pay for or arrange for the purchase of health care insurance and information about
1456 such health care insurance including, but not limited to: (i) the premium cost; (ii) benefits
1457 offered; (iii) cost sharing details; (iv) eligibility criteria; and (v) any other information deemed
1458 necessary by the division.

1459 The division may make arrangements with other agencies, including the department of
1460 revenue and the department of unemployment assistance, to assist with the administration of this
1461 section. Employers shall provide supplemental information that is deemed necessary by the
1462 division or its designee upon request by the division. An employer receiving information that
1463 identifies or may be used to identify a MassHealth member or recipient of subsidized health
1464 insurance shall not use or disclose such information except as authorized by the division to
1465 implement this section.

1466 (b) Information reported under subsection (a) that identifies an individual employee by
1467 name or health insurance status or that is protected health information shall not be a public
1468 record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66. Reported
1469 information may be exchanged among the executive office of health and human services, the
1470 commonwealth health insurance connector authority, the department of unemployment
1471 assistance, the center for health information and analysis and the department of revenue if
1472 necessary to implement this section or section 24 of chapter 12C. An employer who knowingly
1473 falsifies or fails to file any information required by this section or by any regulation issued
1474 pursuant to this section shall be subject to a fine of not less than $1,000 not more than $5,000 for
1475 each violation.

1476 Section 80. (a) For the purposes of this section, “telemedicine” shall mean the use of
1477 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a

1478 patient's physical, oral or mental health; provided, however, that "telemedicine" shall not include
1479 audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

1480 (b) The division and its contracted health insurers, health plans, health maintenance
1481 organizations, behavioral health management firms and third party administrators under contract
1482 to a Medicaid managed care organization or primary care clinician plan may provide coverage
1483 for health care services appropriately provided through telemedicine by a contracted provider.

1484 (c) The division may undertake utilization review, including preauthorization, to
1485 determine the appropriateness of telemedicine as a means of delivering a health care service;
1486 provided, however, that determinations shall be made in the same manner as if service was
1487 delivered in person. The division, a contracted health insurer, health plan, health maintenance
1488 organization, behavioral health management firm or third party administrators under contract to a
1489 Medicaid managed care organization or primary care clinician plan shall not be required to
1490 reimburse a health care provider for a health care service that is not a covered benefit under the
1491 plan nor reimburse a health care provider not contracted under the plan.

1492 A health care provider shall not be required to document a barrier to an in-person visit,
1493 nor shall the type of setting where telemedicine is provided be limited for health care services
1494 provided through telemedicine.

1495 (d) A contract that provides coverage for telemedicine services may include a deductible,
1496 copayment or coinsurance requirement for a health care service provided through telemedicine as
1497 long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or
1498 coinsurance applicable to an in-person consultation or in-person delivery of services. Coverage
1499 that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall
1500 account for the provision of telemedicine services in setting that global payment amount.

1501 (e) Health care services provided by telemedicine shall conform to the standards of care
1502 applicable to the telemedicine provider's profession. Such services shall also conform to
1503 applicable federal and state health information privacy and security standards as well as
1504 standards for informed consent.

1505 Section 81. The division and its contracted health insurers, health plans, health
1506 maintenance organizations, behavioral health management firms and third party administrators
1507 under contract with a Medicaid managed care organization or primary care clinician plan shall
1508 use the aligned measure set established by the secretary pursuant to section 16AA of chapter 6A
1509 as follows: (i) the measures designated by the secretary as core measures shall be used in any
1510 contract with a health care provider, provider organization or accountable care organization that
1511 incorporates quality measures into payment terms; (ii) the measures designated by the secretary
1512 as non-core measures may be used in any contract with a health care provider, provider
1513 organization or accountable care organization that incorporate quality measures into payment
1514 terms and shall not use any measures not designated as non-core measures; (iii) only measures
1515 included in the aligned measure set shall be used to assign health care providers, provider
1516 organizations or accountable care organizations to tiers in the design of a program of medical
1517 benefits to a beneficiary under section 9A.

1518 SECTION 95. Section 47BB of chapter 175 of the General Laws is hereby repealed.

1519 SECTION 96. Said chapter 175 is hereby further amended by inserting after section
1520 47BB the following section:-

1521 Section 47CC. (a) For the purposes of this section, “telemedicine” shall mean the use of
1522 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
1523 patient's physical, oral or mental health; provided, however, that “telemedicine” shall not include
1524 audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

1525 (b) An individual policy of accident and sickness insurance issued under section 108 that
1526 provides hospital expense and surgical expense insurance and any group blanket or general
1527 policy of accident and sickness insurance issued under section 110 that provides hospital expense
1528 and surgical expense insurance which is issued or renewed within or without the commonwealth,
1529 shall not decline to provide coverage for health care services solely on the basis that those
1530 services were delivered through the use of telemedicine by a contracted health care provider.
1531 Health care services delivered by way of telemedicine shall be covered to the same extent as if
1532 they were provided by way of in-person consultation or in-person delivery.

1533 (c) Coverage may include utilization review, including preauthorization, to determine the
1534 appropriateness of telemedicine as a means of delivering a health care service; provided,
1535 however, that the determinations shall be made in the same manner as if the service was
1536 delivered in person. A policy, contract, agreement, plan or certificate of insurance issued,
1537 delivered or renewed within the commonwealth, shall not be required to reimburse a health care
1538 provider for a health care service that is not a covered benefit under the plan nor reimburse a
1539 health care provider not contracted under the plan.

1540 A health care provider shall not be required to document a barrier to an in-person visit,
1541 nor shall the type of setting where telemedicine is provided be limited for health care services
1542 provided through telemedicine.

1543 A contract that provides coverage for telemedicine services may include a deductible,
1544 copayment or coinsurance requirement for a health care service provided through telemedicine as
1545 long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or
1546 coinsurance applicable to an in-person consultation or in-person delivery of services.

1547 (d) Coverage that reimburses a provider with a global payment, as defined in section 1 of
1548 chapter 6D, shall account for the provision of telemedicine services in setting that global
1549 payment amount.

1550 (e) Health care services provided by telemedicine shall conform to the standards of care
1551 applicable to the telemedicine provider's profession. Such services shall also conform to
1552 applicable federal and state health information privacy and security standards as well as
1553 standards for informed consent.

1554 SECTION 97. Said chapter 175 is hereby further amended by inserting after section
1555 108M the following 2 sections:-

1556 Section 108N. Upon request by a network provider, a carrier and, if applicable, a
1557 specialty organization subcontracted by a carrier to manage behavioral health services, shall
1558 disclose the methodology used for a provider's tier placement, including: (i) the criteria,
1559 measures, data sources and provider-specific information used in determining the provider's
1560 quality score; (ii) how the provider's quality performance compares to other in-network

1561 providers; and (iii) the data used in calculating the provider's cost-efficiency. A carrier may
1562 require a network provider to hold information received under this section confidential.

1563 Section 108O. An insurer licensed or otherwise authorized to transact accident or health
1564 insurance under this chapter shall use the aligned measure set established by the secretary of
1565 health and human services pursuant to section 16AA of chapter 6A as follows: (i) the insurer
1566 shall use the measures designated by the secretary as core measures in any contract with a health
1567 care provider, provider organization or accountable care organization that incorporates quality
1568 measures into payment terms; (ii) the insurer may use the measures designated by the secretary
1569 as non-core measures in any contract with a health care provider, provider organization or
1570 accountable care organization that incorporates quality measures into payment terms and shall
1571 not use any measures not designated as non-core measures; (iii) the insurer shall only use the
1572 measures in the aligned measure set established by the secretary to assign health care providers,
1573 provider organizations or accountable care organizations to tiers in the design of an accident or
1574 health plan.

1575 SECTION 98. Chapter 176A is hereby amended by adding the following 3 sections:-

1576 Section 38. Upon request by a network provider, a nonprofit hospital service corporation
1577 and, if applicable, a specialty organization subcontracted by a nonprofit hospital service
1578 corporation to manage behavioral health services, shall disclose the methodology used for a
1579 provider's tier placement, including: (i) the criteria, measures, data sources and provider-specific
1580 information used in determining the provider's quality score; (ii) how the provider's quality
1581 performance compares to other in-network providers; and (iii) the data used in calculating the
1582 provider's cost-efficiency. A carrier may require a network provider to hold information received
1583 under this section confidential.

1584 Section 39. (a) For purposes of this section, “telemedicine” shall mean the use of
1585 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
1586 patient's physical, oral or mental health; provided, however, that “telemedicine” shall not include
1587 audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

1588 (b) A contract between a subscriber and a nonprofit hospital service corporation under an
1589 individual or group hospital service plan shall not decline to provide coverage for health care

1590 services solely on the basis that those services were delivered by way of telemedicine by a
1591 contracted health care provider. Health care services delivered by way of telemedicine shall be
1592 covered to the same extent as if they were provided by way of in-person consultation or in-
1593 person delivery.

1594 (c) Coverage may include utilization review, including preauthorization, to determine the
1595 appropriateness of telemedicine as a means of delivering a health care service, provided that the
1596 determinations shall be made as if the service was delivered in person. A carrier shall not be
1597 required to reimburse a health care provider for a health care service that is not a covered benefit
1598 under the plan nor reimburse a health care provider not contracted under the plan.

1599 Coverage for telemedicine services may include a provision for a deductible, copayment
1600 or coinsurance requirement for a health care service provided through telemedicine as long as the
1601 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance
1602 applicable to an in-person consultation or in-person delivery of services.

1603 Coverage that reimburses a provider with a global payment, as defined in section 1 of
1604 chapter 6D, shall account for the provision of telemedicine services in setting that global
1605 payment amount.

1606 (d) A health care provider shall not be required to document a barrier to an in-person
1607 visit, nor shall the type of setting where telemedicine is provided be limited for health care
1608 services provided through telemedicine.

1609 (e) Health care services provided by telemedicine shall conform to the standards of care
1610 applicable to the telemedicine provider's profession. Such services shall also conform to
1611 applicable federal and state health information privacy and security standards as well as
1612 standards for informed consent.

1613 Section 40. A nonprofit hospital service corporation organized under this chapter shall
1614 use the standard quality measure set established by the secretary of health and human services
1615 pursuant to section 16AA of chapter 6A as follows: (i) a nonprofit hospital service corporation
1616 shall use the measures designated by the secretary as core measures in any contract with a health
1617 care provider, provider organization or accountable care organization that incorporates quality

1618 measures into payment terms; (ii) a nonprofit hospital service corporation may use the measures
1619 designated by the secretary as non-core measures in any contract with a health care provider,
1620 provider organization or accountable care organization that incorporates quality measures into
1621 payment terms and shall not use any measures not designated as non-core measures; (iii) a
1622 nonprofit hospital service corporation shall only use the measures in the aligned measure set
1623 established by the secretary to assign health care providers, provider organizations or
1624 accountable care organizations to tiers in the design of a group hospital service plan.

1625 SECTION 99. Chapter 176B is hereby amended by adding the following 3 sections:-

1626 Section 25. Upon request by a network provider, a medical service corporation and, if
1627 applicable, a specialty organization subcontracted by a medical service corporation to manage
1628 behavioral health services, shall disclose the methodology used for a provider's tier placement,
1629 including: (i) the criteria, measures, data sources and provider-specific information used in
1630 determining the provider's quality score; (ii) how the provider's quality performance compares to
1631 other in-network providers; and (iii) the data used in calculating the provider's cost-efficiency. A
1632 carrier may require a network provider to hold information received under this section
1633 confidential.

1634 Section 26. (a) For the purposes of this section, “telemedicine” shall mean the use of
1635 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
1636 patient's physical, oral or mental health; provided, however, that “telemedicine” shall not include
1637 audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

1638 (b) A contract between a subscriber and a medical service corporation shall not decline to
1639 provide coverage for health care services solely on the basis that those services were delivered
1640 by way e of telemedicine by a contracted health care provider. Health care services delivered by
1641 way of telemedicine shall be covered to the same extent as if they were provided by way of in-
1642 person consultation or in-person delivery.

1643 (c) Coverage may include utilization review, including preauthorization, to determine the
1644 appropriateness of telemedicine as a means of delivering a health care service, provided that the
1645 determinations shall be made as if the service was delivered in person. A carrier is not required
1646 to reimburse a health care provider for a health care service that is not a covered benefit under

1647 the plan nor reimburse a health care provider not contracted under the plan. Coverage that
1648 reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall account
1649 for the provision of telemedicine services in setting that global payment amount. A contract that
1650 provides coverage for telemedicine services may contain a provision for a deductible, copayment
1651 or coinsurance requirement for a health care service provided through telemedicine as long as the
1652 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance
1653 applicable to an in-person consultation or in-person delivery of services.

1654 (d) A health care provider shall not be required to document a barrier to an in-person
1655 visit, nor shall the type of setting where telemedicine is provided be limited for health care
1656 services provided through telemedicine.

1657 (e) Health care services provided by telemedicine shall conform to the standards of care
1658 applicable to the telemedicine provider's profession. Such services shall also conform to
1659 applicable federal and state health information privacy and security standards as well as
1660 standards for informed consent.

1661 Section 27. A nonprofit medical service corporation organized under this chapter shall
1662 use the standard quality measure set established by the secretary of health and human services
1663 pursuant to section 16AA of chapter 6A as follows: (i) a nonprofit medical service corporation
1664 shall use the measures designated by the secretary as core measures in any contract with a health
1665 care provider, provider organization or accountable care organization that incorporates quality
1666 measures into payment terms; (ii) a nonprofit medical service corporation may use the measures
1667 designated by the secretary as non-core measures in any contract with a health care provider,
1668 provider organization or accountable care organization that incorporates quality measures into
1669 payment terms and shall not use any measures not designated as non-core measures; (iii) a
1670 nonprofit medical service corporation shall only use the measures in the aligned measure set
1671 established by the secretary to assign health care providers, accountable care organizations or
1672 provider organizations to tiers in the design of a group medical service plan.

1673 SECTION 100. Chapter 176G is hereby amended by adding the following 3 sections:-

1674 Section 33. Upon request by a network provider, a health maintenance organization and,
1675 if applicable, a specialty organization subcontracted by a health maintenance organization to

1676 manage behavioral health services, shall disclose the methodology used for a provider's tier
1677 placement, including: (i) the criteria, measures, data sources and provider-specific information
1678 used in determining the provider's quality score; (ii) how the provider's quality performance
1679 compares to other in-network providers; and (iii) the data used in calculating the provider's cost-
1680 efficiency. A carrier may require a network provider to hold information received under this
1681 section confidential.

1682 Section 34. (a) For the purposes of this section, “telemedicine” shall mean the use of
1683 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
1684 patient's physical, oral or mental health; provided, however, that “telemedicine” shall not include
1685 audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

1686 (b) A contract between a member and a health maintenance organization shall not decline
1687 to provide coverage for health care services solely on the basis that those services were delivered
1688 by way of telemedicine by a contracted health care provider. Health care services delivered by
1689 way of telemedicine shall be covered to the same extent as if they were provided by way of in-
1690 person consultation or in-person delivery.

1691 (c) A carrier may undertake utilization review, including preauthorization, to determine
1692 the appropriateness of telemedicine as a means of delivering a health care service, provided that
1693 the determinations shall be made as if the service was delivered in person. A carrier is not
1694 required to reimburse a health care provider for a health care service that is not a covered benefit
1695 under the plan nor reimburse a health care provider not contracted under the plan. A contract
1696 that provides coverage for telemedicine services may contain a provision for a deductible,
1697 copayment or coinsurance requirement for a health care service provided through telemedicine as
1698 long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or
1699 coinsurance applicable to an in-person consultation or in-person delivery of services. Coverage
1700 that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall
1701 account for the provision of telemedicine services in setting that global payment amount.

1702 (d) A health care provider shall not be required to document a barrier to an in-person
1703 visit, nor shall the type of setting where telemedicine is provided be limited for health care
1704 services provided through telemedicine.

1705 (e) Health care services provided by telemedicine shall conform to the standards of care
1706 applicable to the telemedicine provider's profession. Such services shall also conform to
1707 applicable federal and state health information privacy and security standards as well as
1708 standards for informed consent.

1709 Section 35. A health maintenance organization organized under this chapter shall use the
1710 standard quality measure set established by the secretary of health and human services pursuant
1711 to section 16AA of chapter 6A as follows: (i) a health maintenance organization shall use the
1712 measures designated by the secretary as core measures in any contract with a health care
1713 provider, provider organization or accountable care organization that incorporates quality
1714 measures into payment terms; (ii) a health maintenance organization may use the measures
1715 designated by the secretary as non-core measures in any contract with a health care provider,
1716 provider organization or accountable care organization that incorporates quality measures into
1717 payment terms and shall not use any measures not designated as non-core measures; (iii) a health
1718 maintenance organization shall only use the measures in the aligned measure set established by
1719 the secretary to assign health care providers, accountable care organizations or provider
1720 organizations to tiers in the design of any health maintenance contract.

1721 SECTION 101. Chapter 176I of the General Laws is hereby amended by adding the
1722 following 2 sections:-

1723 Section 13. (a) For the purposes of this section, "telemedicine" shall mean the use of
1724 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
1725 patient's physical, oral or mental health; provided, however, that "telemedicine" shall not include
1726 audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

1727 (b) A preferred provider contract between a covered person and an organization shall not
1728 decline to provide coverage for health care services solely on the basis that those services were
1729 delivered by way of telemedicine by a contracted health care provider. Health care services
1730 delivered by way of telemedicine shall be covered to the same extent as if they were provided by
1731 way of in-person consultation or in-person delivery.

1732 (c) An organization may undertake utilization review, including preauthorization, to
1733 determine the appropriateness of telemedicine as a means of delivering a health care service,

1734 provided that the determinations shall be made in the same manner as those regarding the same
1735 service when it is delivered in person. An organization is not required to reimburse a health care
1736 provider for a health care service that is not a covered benefit under the plan nor reimburse a
1737 health care provider not contracted under the plan.

1738 A preferred provider contract that provides coverage for telemedicine services may
1739 contain a provision for a deductible, copayment or coinsurance requirement for a health care
1740 service provided through telemedicine as long as the deductible, copayment or coinsurance does
1741 not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or
1742 in-person delivery of services. Coverage that reimburses a provider with a global payment, as
1743 defined in section 1 of chapter 6D, shall account for the provision of telemedicine services in
1744 setting that global payment amount.

1745 (d) A health care provider shall not be required to document a barrier to an in-person
1746 visit, nor shall the type of setting where telemedicine is provided be limited for health care
1747 services provided through telemedicine.

1748 (e) Health care services provided by telemedicine shall conform to the standards of care
1749 applicable to the telemedicine provider's profession. Such services shall also conform to
1750 applicable federal and state health information privacy and security standards as well as
1751 standards for informed consent.

1752 Section 14. An organization shall use the standard quality measure set established by the
1753 secretary of health and human services pursuant to section 16AA of chapter 6A as follows: (i) an
1754 organization shall use the measures designated by the secretary as core measures in any contract
1755 with a health care provider, provider organization or accountable care organization that
1756 incorporates quality measures into payment terms; (ii) an organization may use the measures
1757 designated by the secretary as non-core measures in any contract with a health care provider,
1758 provider organization or accountable care organization that incorporates quality measures into
1759 payment terms and shall not use any measures not designated as non-core measures; (iii) an
1760 organization shall only use the measures in the aligned measure set established by the secretary
1761 to assign health care providers, accountable care organizations or provider organizations to tiers
1762 in the design of a health benefit plan.

1763 SECTION 102. Chapter 176J of the General Laws is hereby amended by striking out
1764 section 11, as appearing in the 2016 Official Edition, and inserting in place thereof the following
1765 section:-

1766 Section 11. (a) For the purposes of this section, the following words shall have the
1767 following meanings unless the context clearly requires otherwise:

1768 "High-value health care services", a set of services that yield improved management of
1769 chronic conditions or meaningfully reduce the occurrence of high-cost care episodes related to
1770 the underlying condition that the service is meant to treat, as identified by the division of
1771 insurance, in consultation with the health policy commission and the center for health
1772 information and analysis;

1773 "Shoppable health care services", a set of services deemed sufficiently substitutable
1774 across providers for which there is adequate information on cost and quality to inform a patient's
1775 decision on where to obtain those health care services as identified by the division of insurance
1776 in consultation with the health policy commission and the center for health information and
1777 analysis.

1778 (b) A carrier that offers a health benefit plan that provides or arranges for the delivery of
1779 health care services through a closed network of health care providers and, as of the close of any
1780 preceding calendar year, has a combined total of not less than 5,000 eligible individuals, eligible
1781 employees and eligible dependents who are enrolled in health benefit plans sold, issued,
1782 delivered, made effective or renewed to qualified small businesses or eligible individuals shall
1783 offer to all eligible individuals and small businesses in not less than 2 geographic areas at least 1
1784 of the following plans:

1785 (i) a plan with a reduced or selective network of providers;

1786 (ii) a plan in which providers are tiered and member cost-sharing is based on the tier
1787 placement of the provider that includes a base premium discount of not less than 19 per cent;

1788 (iii) a plan in which an enrollee's premium varies based on the primary care provider
1789 selected at the time of enrollment;

1790 (iv) a plan in which a separate cost-sharing differential is applied to shoppable health care
1791 services among the network of providers; or

1792 (v) a plan in which there is a separate reduced or eliminated cost-sharing differential for
1793 high value health care services relative to other services covered by the plan.

1794 (c) Annually, the commissioner shall determine the base premium rate discount compared
1795 to the base premium of the carrier's most actuarially-similar plan with the carrier's non-selective
1796 or non-tiered network of providers under clauses (i) and (ii) of subsection (b). The savings may
1797 be achieved by means including, but not limited to: (i) the exclusion of providers with similar or
1798 lower quality based on the standard quality measure set with higher health status adjusted total
1799 medical expenses or relative prices, as determined pursuant to the methodology under section 52
1800 of chapter 288 of the Acts of 2010; or (ii) increased member cost-sharing for members who
1801 utilize providers for non-emergency services with similar or lower quality based on the standard
1802 quality measure set and with higher health status adjusted total medical expenses or relative
1803 prices, as determined pursuant to the methodology under said section 52 of chapter 288 of the
1804 Acts of 2010.

1805 The commissioner may apply waivers to the base premium rate discount determined by
1806 the commissioner under this section to carriers that receive not less than 80 per cent of their
1807 incomes from government programs or that have service areas that do not include an area within
1808 the boundaries of the abolished counties of Suffolk or Middlesex and that were first admitted to
1809 do business by the division of insurance not later than January 1, 1986 as health maintenance
1810 organizations under chapter 176G.

1811 (d) The commissioner shall require a plan under paragraph (iii) of subsection (b) to have
1812 at least 1 tier that provides the base premium rate discount. A carrier may include a provider in a
1813 plan under paragraph (iii) of subsection (b) only if a provider receives reasonable information on
1814 plan performance from the carrier pursuant to the plan.

1815 (e) A tiered network plan shall only include variations in member cost-sharing among
1816 provider tiers that are reasonable in relation to the premium charged and shall ensure adequate
1817 access to covered services. Carriers shall tier providers based on quality performance as
1818 measured by the standard quality measure set and by cost performance as measured by health

1819 status adjusted total medical expenses and relative prices. If applicable quality measures are not
1820 available, tiering may be based solely on health status adjusted total medical expenses or relative
1821 prices or both.

1822 The commissioner shall promulgate regulations requiring the uniform reporting of tiering
1823 information by carriers. The regulations shall include, but not be limited to, a requirement that a
1824 carrier that is implementing a tiered network plan or is modifying the tiering methodology for an
1825 existing tiered network plan shall report a detailed description of the methodology used for the
1826 tiering of providers to the commissioner not less than 90 days before the effective date of the
1827 plan or modification. The description shall include, but not be limited to: (i) the statistical basis
1828 for tiering; (ii) a list of providers to be tiered at each member cost-sharing level; (iii) a
1829 description of how the methodology and resulting tiers shall be communicated to each network
1830 provider, eligible individuals and small groups; (iv) a description of the appeals process a
1831 provider may pursue to challenge the assigned tier level; and (v) the utilization of a variable
1832 premium amount based on tier designation for the primary care provider selected by the member,
1833 if any.

1834 (f) The commissioner shall determine network adequacy: (i) for a tiered network plan
1835 based on the availability of sufficient network providers in the carrier's overall network of
1836 providers; and (ii) for a selective network plan based on the availability of sufficient network
1837 providers in the carrier's selective network.

1838 In determining network adequacy under this section, the commissioner may consider
1839 factors including the location of providers participating in the plan and employers or members
1840 that enroll in the plan, the range of services provided by providers in the plan and plan benefits
1841 that recognize and provide for extraordinary medical needs of members that may not be
1842 adequately dealt with by the providers within the plan network.

1843 (g) A carrier may reclassify provider tiers and determine provider participation in
1844 selective and tiered plans not more than once per calendar year; provided, however, that a carrier
1845 may reclassify a provider from a higher cost tier to a lower cost tier or add a provider to a
1846 selective network at any time. If a carrier reclassifies provider tiers or providers participating in a
1847 selective plan during the course of an account year, the carrier shall provide notice to affected

1848 members of the account that shall include information regarding the plan changes not less than
1849 30 days before the changes are to take effect. A carrier shall provide information on the carrier's
1850 website about any tiered or selective plan including, but not limited to, the providers
1851 participating in the plan, the selection criteria for those providers and, where applicable, the tier
1852 in which each provider is classified.

1853 (h) The commissioner shall review plans under clauses (iv) and (v) of subsection (b) in a
1854 manner consistent with other products offered in the commonwealth. The commissioner may
1855 disapprove a plan established pursuant to clause (iv) or (v) of subsection (b) if it determines that
1856 the carrier-differentiated cost-sharing obligations are solely based on the provider. There shall be
1857 a rebuttable presumption that a plan has violated this subsection if the cost-sharing obligation for
1858 the services provided by a provider, including a health care facility, accountable care
1859 organization, patient-centered medical home or provider organization, is the same cost-sharing
1860 obligation without regard for the types of services provided pursuant to clause (iv) or (v).

1861 When reviewing a plan established pursuant to clauses (iv) and (v) of subsection (b), the
1862 commissioner shall ensure that the plan promotes: (i) the avoidance of consumer confusion; (ii)
1863 the minimization of administrative burdens on payers and providers in implementing the plan;
1864 and (iii) allowing for patients to receive services in appropriate locations.

1865 (i) The commissioner shall make publicly available on the commissioner's website: (i) a
1866 description of each plan offered under this section, including a list of providers or services by tier
1867 or a list of providers included in a selective network plan; (ii) membership trends for each plan
1868 offered under this section; (iii) the extent to which plans offered under this section have reduced
1869 health care costs for patients and employers; and (iv) the effect of plans offered under this
1870 section on provider mix and other factors impacting overall state health care costs. The
1871 commissioner shall ensure that the information is updated not less than annually.

1872 Nothing in this section shall exempt an insurance carrier or product from state and federal
1873 mental health parity and addiction equity laws, including those codified at 42 U.S. Code §
1874 300gg-26, and regulations implemented pursuant to section 8K of chapter 26. Nothing in this
1875 section shall create a lesser standard of scrutiny for parity compliance for any reduced, tiered or
1876 discounted plan established pursuant to this section.

1877 SECTION 103. Said chapter 176J is hereby further amended by adding the following
1878 section:-

1879 Section 18. Upon request by a network provider, a carrier and, if applicable, a specialty
1880 organization subcontracted by a carrier to manage behavioral health services, shall disclose the
1881 methodology used for a provider's tier placement, including: (i) the criteria, measures, data
1882 sources and provider-specific information used in determining the provider's quality score; (ii)
1883 how the provider's quality performance compares to other in-network providers; and (iii) the data
1884 used in calculating the provider's cost-efficiency. A carrier may require a network provider to
1885 hold information received under this section confidential.

1886 SECTION 104. Section 1 of chapter 176O of the General Laws, as appearing in the 2016
1887 Official Edition, is hereby amended by inserting after the definition of "Incentive plan" the
1888 following definition:-

1889 "In-network contracted rate", the rate contracted between an insured's carrier and a
1890 network health care provider for the reimbursement of health care services delivered by that
1891 health care provider to the insured.

1892 SECTION 105. Said section 1 of said chapter 176O, as so appearing, is hereby further
1893 amended by inserting after the definition of "Network" the following 3 definitions:-

1894 "Noncontracted commercial rate for emergency services", the amount set pursuant to
1895 section 16A of chapter 6D and used to determine the rate of payment to a health care provider for
1896 the provision of emergency health care services to an insured when the health care provider is
1897 not in the carrier's network.

1898 "Noncontracted commercial rate for nonemergency services", the amount set pursuant to
1899 section 16A of chapter 6D and used to determine the rate of payment to a health care provider for
1900 the provision of nonemergency health care services to an insured when the health care provider
1901 is not in the carrier's network.

1902 "Nonemergency services", health care services rendered to an insured experiencing a
1903 condition other than an emergency medical condition.

1904 SECTION 106. Clause (a) of section 7 of said chapter 176O, as so appearing, is hereby
1905 amended by striking out clause (1) and inserting in place thereof the following clause:-

1906 (1) a list of health care providers in the carrier's network, organized by specialty and by
1907 location, along with a summary on its internet website for each provider that shall include: (i) the
1908 method used to compensate or reimburse the provider, including details of measures and
1909 compensation percentages tied to any incentive plan or pay for performance provision; (ii) the
1910 provider price relativity, as reported under section 10 of chapter 12C ; (iii) the provider's health
1911 status adjusted total medical expenses, as defined in and reported under said section 10 of said
1912 chapter 12C; and (iv) current measures of the provider's quality using the measures established
1913 by the secretary of health and human services pursuant to section 16AA of chapter 6A; provided,
1914 however, that if any specific provider or type of provider requested by an insured is not available
1915 in the network or is not a covered benefit, the information shall be provided in an easily
1916 obtainable manner; provided further, that the carrier shall prominently promote providers based
1917 on quality performance as measured by the measures established by the secretary of health and
1918 human services pursuant to said section 16AA of said chapter 6A and cost performance as
1919 measured by health status adjusted total medical expenses and relative prices.

1920 SECTION 107. Section 9A of said chapter 176O, as so appearing, is hereby amended by
1921 inserting after the word “approval”, in line 15, the following words:- unless the provider is
1922 included in a tier for a set of shoppable health care services pursuant to clause (iv) of subsection
1923 (b) of section 11 of chapter 176J.

1924 SECTION 108. Section 23 of said chapter 176O, as so appearing, is hereby amended by
1925 inserting after the word “time”, in line 3, the following words:- , the network status of an
1926 identified health care provider.

1927 SECTION 109. Said section 23 of said chapter 176O, as so appearing, is hereby further
1928 amended by adding the following sentence:- The information provided on the website shall
1929 conform to the uniform methodology for a provider’s tier designation developed pursuant to
1930 section 20A of chapter 12C.

1931 SECTION 110. Said chapter 176O is hereby further amended by adding the following 3
1932 sections:-

1933 Section 28. (a) As used in this section, the following words shall have the following
1934 meanings unless the context clearly requires otherwise:

1935 "Facility fee", a fee charged or billed by a hospital or health system for outpatient
1936 hospital services provided in a hospital-based facility that is intended to compensate the hospital
1937 or health system for the operational expenses of the hospital or health system and is separate and
1938 distinct from a professional fee.

1939 "Health system", shall have the same meaning as "Provider Organization or Health
1940 System or System", as provided by the health policy commission.

1941 "Hospital", a hospital licensed pursuant to section 51 of chapter 111.

1942 "Hospital-based facility", a facility that is owned or operated, in whole or in part, by a
1943 hospital or health system where hospital or professional medical services are provided.

1944 "Professional fee", a fee charged or billed by a provider, hospital or health system for
1945 professional medical services provided in a hospital-based facility.

1946 (b) If a hospital or health system charges a facility fee for services that are not subject to
1947 the limitations of section 51L of chapter 111, the hospital or health system shall provide any
1948 patient receiving such a service with written notice of the fee. The notice shall include a
1949 statement that the patient may be billed separately for that facility fee and the expected amount
1950 of the facility fee.

1951 (c) If a hospital or health system is required to provide a patient with notice under
1952 subsection (b) and a patient's appointment is scheduled to occur not less than 10 days after the
1953 appointment is made, the hospital or health system shall provide written notice and explanation
1954 to the patient by first class mail, encrypted electronic means or a secure patient Internet portal
1955 not less than 3 days after the appointment is made. If an appointment is scheduled to occur less
1956 than 10 days after the appointment is made or if the patient arrives without an appointment, the
1957 notice shall be provided to the patient on the hospital-based facility's premises.

1958 For emergency care, a hospital or health system shall provide written notice and
1959 explanation to the patient prior to the care if practicable, or if notice is not practicable, the

1960 hospital or health system shall provide an explanation of the fee to the patient within a
1961 reasonable period of time; provided, however, that the explanation of the fee shall be provided
1962 before the patient leaves the hospital-based facility. If the patient is incapacitated or otherwise
1963 unable to read, understand and act on the patient's rights, the notice and explanation of the fee
1964 shall be provided to the patient's representative within a reasonable period of time.

1965 (d) A hospital-based facility shall clearly identify itself as being hospital-based, including
1966 by stating the name of the hospital or health system in its signage, marketing materials, Internet
1967 web sites and stationery.

1968 (e) If a hospital-based facility charges a facility fee, notice shall be posted informing
1969 patients that they the patient may incur additional financial liability due to the hospital-based
1970 facility's status. Notice shall be prominently displayed in locations accessible to and visible by
1971 patients, including in patient waiting areas.

1972 (f) (1) If a hospital or health system designates a location as a hospital-based facility,
1973 the hospital or health system shall provide written notice of the designation to all patients who
1974 received services at the now designated hospital-based facility during the previous calendar year.
1975 The written notice shall be provided not later than 30 days after the designation and shall state
1976 that: (i) the location is now considered to be a hospital-based facility; (ii) certain health care
1977 services delivered at the facility will result in separate bills for services from the hospital and the
1978 provider; and (iii) patients seeking care at the facility may incur additional financial liability at
1979 that location due its hospital-based facility status.

1980 (2) If a hospital or health system designates a location as a hospital-based facility,
1981 the hospital or health system shall not collect a facility fee for a service provided at the now
1982 designated hospital-based facility until not less than 30 days after the written notice required in
1983 paragraph (1) is mailed.

1984 (3) A notice required or provided under paragraph (1) or (2) shall be filed with the
1985 health policy commission established under section 2 of chapter 6D not later than 30 days after
1986 its issuance.

1987 (g) A violation of this section shall be an unfair trade practice under chapter 93A.

1988 (h) The commissioner may promulgate regulations that are necessary to implement this
1989 section subject to the limitations of section 16A of chapter 6D.

1990 Section 29. (a) As used in this section, “facility fee”, “health system”, “hospital” and
1991 “hospital-based facility” shall have the meanings as provided in section 28.

1992 (b) A carrier shall not impose a separate copayment on an insured or provide
1993 reimbursement to a hospital, health system or hospital-based facility for services provided at a
1994 hospital, health system or a hospital-based facility or for reimbursement to such a hospital, health
1995 system or hospital-based facility for a facility fee for services utilizing a current procedural
1996 terminology evaluation and management code or otherwise prohibited pursuant to section 51L of
1997 chapter 111.

1998 (c) Nothing in this section shall prohibit a carrier from restricting the reimbursement of
1999 facility fees beyond the limitations set forth in section 51K of chapter 111.

2000 Section 30. (a)(1) A carrier shall reimburse a health care provider as follows:

2001 (i) where the health care provider is a member of an insured’s carrier’s
2002 network but not a participating provider in the insured’s health benefit plan and the health care
2003 provider has delivered health care services to the insured to treat an emergency medical
2004 condition, the carrier shall pay that provider the in-network contracted rate for each delivered
2005 service; provided, however, that such payment shall constitute payment in full to that health care
2006 provider and the provider shall not bill the insured except for any applicable copayment,
2007 coinsurance or deductible that would be owed if the insured received such service or services
2008 from a participating health care provider under the terms of the insured’s health benefit plan;

2009 (ii) where the health care provider is not a member of an insured’s
2010 carrier’s network and the health care provider has delivered health care services to the insured to
2011 treat an emergency medical condition, the carrier shall pay that provider the noncontracted
2012 commercial rate for emergency services for each delivered service; provided, however, that such
2013 payment shall constitute payment in full to the health care provider and the provider shall not bill
2014 the insured except for any applicable copayment, coinsurance or deductible that would be owed

2015 if the insured received such service or services from a participating health care provider under
2016 the terms of the insured's health benefit plan;

2017 (iii) where the health care provider is a member of an insured's carrier's
2018 network but not a participating provider in the insured's health benefit plan and the health care
2019 provider has delivered nonemergency health care services to the insured and a participating
2020 provider in the insured's health benefit plan is unavailable or the health care provider renders
2021 those nonemergency health care services without the insured's knowledge, the carrier shall pay
2022 that provider the in-network contracted rate for each delivered service; provided, however, that
2023 such payment shall constitute payment in full to the health care provider and the provider shall
2024 not bill the insured except for any applicable copayment, coinsurance or deductible that would be
2025 owed if the insured received such service from a participating health care provider under the
2026 terms of the insured's health benefit plan; and

2027 (iv) where the health care provider is not a member of an insured's
2028 carrier's network and the health care provider has delivered nonemergency services to the
2029 insured and a participating provider in the insured's health benefit plan is unavailable or the
2030 health care provider renders those nonemergency health care services without the insured's
2031 knowledge, the carrier shall pay the provider the noncontracted commercial rate for
2032 nonemergency services for each delivered service; provided, however, that such payment shall
2033 constitute payment in full to the health care provider and the provider shall not bill the insured
2034 except for any applicable copayment, coinsurance or deductible that would be owed if the
2035 insured received such service or services from a participating health care provider under the
2036 terms of the insured's health benefit plan.

2037 (2) It shall be an unfair and deceptive act or practice, in violation of section 2 of
2038 chapter 93A, for any health care provider or carrier to request payment from an enrollee, other
2039 than the applicable coinsurance, copayment, deductible or other out-of-pocket expense, for the
2040 services described in paragraph (1).

2041 (b) Nothing in this section shall require a carrier to pay for health care services delivered
2042 to an insured that are not covered benefits under the terms of the insured's health benefit plan.

2043 (c) Nothing in this section shall require a carrier to pay for nonemergency health care
2044 services delivered to an insured if the insured had a reasonable opportunity to choose to have the
2045 service performed by a network provider participating in the insured's health benefit plan.
2046 Evidence that an insured had a reasonable opportunity to choose to have the service performed
2047 by a network provider may include, but not be limited to, a written acknowledgement submitted
2048 with any claim for reimbursement from the carrier that: (i) is signed by the insured; and (ii) was
2049 provided by the health care provider to the insured before the delivery of nonemergency health
2050 care services and provided the insured a reasonable amount of time to seek health care services
2051 from a participating provider in the insured's health benefit plan.

2052 (d) The commissioner shall promulgate regulations that are necessary to implement this
2053 section.

2054 SECTION 111. Chapter 176Q of the General Laws is hereby amended by striking out
2055 section 7A, as appearing in the 2016 Official Edition, and inserting in place thereof the following
2056 section:-

2057 Section 7A. (a) There shall be a small group incentive program to expand the prevalence
2058 of employee health plans offered by small businesses that shall be administered by the board, in
2059 consultation with the department of public health. The program shall provide subsidies and
2060 technical assistance for eligible small groups that offer health plans to employees. A small group
2061 shall be eligible to participate in the program if the small group purchases group coverage
2062 through the connector and meets certain criteria determined by the board. In determining such
2063 criteria, the board may consider, but not be limited to considering, the following factors: (i) the
2064 size of the employer group; (ii) the amount of an employer's subsidy for the cost of employee
2065 coverage; (iii) the average salary of employees in the group; (iv) enrollment in a high-value plan
2066 that promotes employee wellness; and (v) participation in a plan-administered or employer-
2067 administered wellness program.

2068 (b) The connector shall provide an annual subsidy of up to 50 per cent of eligible
2069 employer health care costs, calculated by the board, for eligible small groups participating in the
2070 program. The connector may seek a state innovation waiver under 42 U.S.C. 18052 to fund this
2071 program.

2072 (c) If the director determines that available funds are insufficient to meet the projected
2073 costs of enrolling new eligible employers, the director may impose a cap on enrollment in the
2074 program or on the subsidy amounts available to eligible small groups.

2075 (d) The connector shall provide a report on the enrollment in the small group incentive
2076 program and an evaluation of the impact of the program on expanding health plan participation
2077 for small groups annually, not later than March 1, to the clerks of the senate and house of
2078 representatives, the chairs of the joint committee on community development and small
2079 businesses, the chairs of the joint committee on health care financing and the chairs of the house
2080 and senate committees on ways and means.

2081 (e) The connector shall promulgate regulations necessary to implement this section.

SECTION 112. The General Laws are hereby amended by inserting after chapter 176V the following chapter:-

CHAPTER 176W.

HOSPITAL ALIGNMENT AND REVIEW COUNCIL.

2082 Section 1. For the purposes of this chapter, the following words shall have the following
2083 meanings unless the context clearly requires otherwise:

2084 "Carrier", an insurer licensed or otherwise authorized to transact accident or health
2085 insurance under chapter 175, a nonprofit hospital service corporation organized under chapter
2086 176A, a nonprofit medical service corporation organized under chapter 176B, a health
2087 maintenance organization organized under chapter 176G and an organization entering into a
2088 preferred provider arrangement under chapter 176I; provided, however, that "carrier" shall not
2089 include an employer purchasing coverage or acting on behalf of its employees or the employees
2090 of any subsidiary or affiliated corporation of the employer; provided further, that unless
2091 specifically stated otherwise, "carrier" shall not include an entity that offers a policy, certificate
2092 or contract that provides coverage solely for dental care services or vision care services.

2093 "Center", the center for health information and analysis established in chapter 12C.

2094 "Commission", the health policy commission established in chapter 6D.

2095 “Council”, the hospital alignment and review council established in section 2.

2096 “Division”, the division of insurance.

2097 “Growth in hospital spending”, the annual growth in total commercial hospital inpatient
2098 and outpatient spending as reported by the center.

2099 “Hospital”, the teaching hospital of the University of Massachusetts medical school and
2100 any hospital licensed under section 51 of chapter 111 that contains a majority of medical-
2101 surgical, pediatric, obstetric and maternity beds, as defined by the department of public health.

2102 “Hospital spending”, total commercial spending on hospital inpatient and outpatient
2103 services.

2104 “Relative price”, the contractually negotiated amounts paid to providers by each private
2105 and public carrier for health care services, including nonclaims-related payments, and expressed
2106 in the aggregate relative to the payer's networkwide average amount paid to providers, as
2107 determined pursuant to the methodology under section 52 of chapter 288 of the acts of 2010.

2108 “Target growth in hospital spending”, the percentage of growth in hospital spending
2109 determined by the council.

2110 “Target hospital rate distribution”, the minimum rate of a carrier’s reimbursement for
2111 services provided by a hospital as determined by the council.

2112 Section 2. (a) There shall be a hospital alignment and review council. The council shall
2113 consist of the following members or their designee: (i) the commissioner of insurance, who shall
2114 serve as chair; (ii) the executive director of the center for health information and analysis; and
2115 (iii) the executive director of the health policy commission.

2116 The council shall review growth in hospital spending and receive information from the
2117 center, commission and division for its overall consideration.

2118 (b) The council may: (i) make, amend and repeal rules and regulations for the
2119 management of its affairs; (ii) make contracts and execute all instruments necessary or
2120 convenient for the carrying on of its business; (iii) enter into agreements or transactions with any

2121 federal, state or municipal agency or other public institution or with any private individual,
2122 partnership, firm, corporation, association or other entity; and (iv) enter into interdepartmental
2123 agreements with any other state agencies the council considers necessary to implement this
2124 chapter.

2125 (c) Information received by the council from the center, commission and division shall be
2126 confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4
2127 or chapter 66 unless the information received by the council is otherwise made publicly
2128 available.

2129 (d) The council shall be subject to chapter 30A.

2130 The center, commission and division shall enter into a memorandum of understanding
2131 that outlines the information authorized to be shared between each agency for use pursuant to
2132 this chapter and ensures that any information received by an agency that it would not otherwise
2133 receive shall be used solely for the purposes of this chapter.

2134 Section 3. (a) The council shall review the progress of carriers and hospitals towards
2135 demonstrating: (i) the target hospital rate distribution; and (ii) growth in hospital spending that
2136 does not exceed target growth in hospital spending.

2137 (b) The council shall review the growth in hospital spending and the statewide
2138 commercial relative price distribution for the previous year to determine whether the carriers and
2139 hospitals have met the goals established under subsection (a).

2140 (c) Annually, the center, in consultation with the commission, shall submit a report to the
2141 council on the statewide commercial relative price distribution and growth in hospital spending
2142 not later than October 1. The council shall review the report and certify, not later than December
2143 1, whether the conditions established under subsection (a) were satisfied for the previous year.

2144 Section 4. (a) Carriers shall annually certify to the division that: (i) all rates filed comply
2145 with the target hospital rate distribution; and (ii) if any hospital has received an increase in its
2146 rate of reimbursement, all hospitals contracting with the carrier have received an increase greater
2147 than 0 per cent.

2148 If the division determines that a carrier does not meet the certification requirements, the
2149 division shall notify the carrier and presumptively disapprove the rates filed by the carrier.

2150 (b) In any year that the council determines that either carriers have not demonstrated the
2151 target hospital rate distribution or the growth in hospital spending exceeded the target growth in
2152 hospital spending, the council shall:

2153 (i) assess a carrier referred to the council by the division that did not meet the
2154 certification requirements of subsection (a) in an amount equal to the product of: (i) the total
2155 change in rates for the fewest number of contracted hospitals necessary for the carrier to achieve
2156 the target hospital rate distribution; and (ii) the projected utilization of those same hospitals
2157 provided, however, that a carrier shall not be assessed unless the division certifies that the carrier
2158 was notified that the carrier's rates did not meet the certification requirements of said subsection
2159 (a) and did not refile compliant rates; or

2160 (ii) assess a penalty on the top 3 hospitals that contributed to hospital spending
2161 that equals in its aggregate the difference between the growth in hospital spending and the target
2162 growth in hospital spending; provided, however, that each hospital shall be responsible for a
2163 proportionate share of the penalty commensurate to its share of commercial hospital spending.

2164 (c) In any year that the council determines that carriers and hospitals have not
2165 demonstrated the target hospital rate distribution or growth in hospital spending that does not
2166 exceed target growth in hospital spending, the council may define "target hospital rate
2167 distribution" and "target growth in hospital spending"; provided, however, that the council shall
2168 solicit input from the advisory committee, receive testimony and solicit public input and review
2169 the definition every 3 years. The council shall submit proposed definitions to the clerks of the
2170 senate and house of representatives, the joint committee on health care financing and the senate
2171 and house committees on ways and means not less than 4 months prior to their effective date.

2172 The joint committee on health care financing may, not later than 30 days after the
2173 submission of the proposed definitions with the clerks of the senate and house of representatives,
2174 the joint committee on health care financing and the senate and house committees on ways and
2175 means, hold a public hearing on the proposed definitions. The joint committee may report its
2176 findings to the general court, together with drafts of legislation necessary to implement those

2177 findings. In the report, the joint committee may include its recommendation on whether to affirm
2178 or modify the proposed definitions. The joint committee shall issue any findings not later than
2179 20 days after the public hearing and shall provide a copy of the findings and any proposed
2180 legislation to the board. If the general court does not enact legislation with respect to the
2181 recommendations within 65 days after the commission has submitted the recommendations to the
2182 joint committee, the proposed definitions shall be in effect until the definitions proposed take
2183 effect.

2184 (d) If the council amends the definition of "target hospital rate distribution" or "target
2185 growth in hospital spending", the council shall consider: (i) factors resulting in a hospital's
2186 relative price and any weighting assigned by the council to those factors; (ii) alternative payment
2187 methodologies in place between a hospital and carrier; (iii) the volume and mix of services
2188 provided; (iv) a hospital's patient population and payer mix; (v) hospital inpatient and outpatient
2189 rates as compared to the commercial relative price levels; and (vi) any other information deemed
2190 necessary by the council.

2191 (e) Amounts assessed by the council under this section shall be deposited into the
2192 Hospital Alignment and Review Trust Fund established in section 2ZZZZ of chapter 29.

2193 (f) Any amounts assessed by the council and then distributed through the Hospital
2194 Alignment and Review Trust Fund shall be excluded from the calculation of growth in hospital
2195 spending for a year in which the funds are distributed.

2196 Section 5. There shall be an advisory committee to the council. The committee shall
2197 support its responsibilities under this section. The council shall be chosen by the council and
2198 shall ensure broad representation of carriers and hospitals across regions, of different sizes and, if
2199 a hospital, payer mix and other stakeholders.

2200 Section 6. The council may establish regulations or guidance to implement this chapter.

2201 SECTION 113. Section 79L of chapter 233 of the General Laws, as appearing in the
2202 2016 Official Edition, is hereby amended by inserting after the word "dentist", in line 12, the
2203 following words:- , dental therapist.

2204 SECTION 114. Chapter 224 of the acts of 2012 is hereby amended by inserting after
2205 section 254 the following section:-

2206 Section 254A. (a) For the purposes of this section, the following words shall have the
2207 following meanings unless the context clearly requires otherwise:

2208 "Behavior management monitoring", monitoring that shall include the monitoring of a
2209 child's behavior, the implementation a behavior plan and reinforcing implementation of the plan
2210 by the child's parent or other caregiver.

2211 "Behavior management therapy", therapy that addresses challenging behaviors that
2212 interfere with a child's successful functioning; provided, however, that "behavior management
2213 therapy" may include short-term counseling and assistance; provided further, that "behavior
2214 management therapy" shall include assessment, development of a behavior plan and supervision
2215 and coordination of interventions to address specific behavioral objectives or performance,
2216 including the development of a crisis-response strategy.

2217 "Child" a person under the age of 26.

2218 "Family support and training", a service provided to a parent or caretaker of a child to
2219 improve the capacity of the parent or caretaker to ameliorate or resolve the child's emotional or
2220 behavioral needs and to parent; provided, however, that such a service shall be provided where
2221 the child resides, including the child's home, including a foster home and therapeutic foster
2222 home, or another community setting.

2223 "In-home behavioral services", a combination of behavior management therapy and
2224 behavior management monitoring; provided, however, that such a service shall be provided
2225 where the child resides, including the child's home, including a foster home and therapeutic
2226 foster home or another community setting.

2227 "In-home therapy", therapeutic clinical intervention or ongoing training and therapeutic
2228 support; provided however, that the intervention or support shall be provided where the child
2229 resides, including the child's home, including a foster home and therapeutic foster home, or
2230 another community setting.

2231 “Mobile crisis intervention”, a short-term, mobile, on-site, face-to-face therapeutic
2232 response service that is available 24 hours a day, 7 days a week to a child experiencing a
2233 behavioral health crisis to identify, assess, treat and stabilize a situation and reduce the
2234 immediate risk of danger to the child or others; provided, however, that the intervention shall be
2235 consistent with the child’s risk management or safety plan, if any.

2236 “Ongoing therapeutic training and support”, services that support implementation of a
2237 treatment plan pursuant to therapeutic clinical intervention that shall include, but shall not
2238 limited to, teaching the child to understand, direct, interpret, manage and control feelings and
2239 emotional responses to situations and assistance to the family in supporting the child and
2240 addressing the child’s emotional and mental health needs.

2241 “Therapeutic clinical intervention”, intervention that shall include: (i) a structured and
2242 consistent therapeutic relationship between a licensed clinician and a child and the child’s family
2243 to treat the child’s mental health needs, including improvement of the family’s ability to provide
2244 effective support for the child and promotion of healthy functioning of the child within the
2245 family; (ii) the development of a treatment plan; and (iii) using established psychotherapeutic
2246 techniques, working with the family or a subset of the family to enhance problem-solving, limit-
2247 setting, communication, emotional support or other family or individual functions.

2248 “Therapeutic mentoring services”, services provided to a child designed to support age-
2249 appropriate social functioning or ameliorate deficits in the child’s age-appropriate social
2250 functioning; provided, however, that such a service may include supporting, coaching and
2251 training the child in age-appropriate behaviors, interpersonal communication, problem-solving,
2252 conflict resolution and relating appropriately to other children and adolescents and adults in
2253 recreational and social activities; provided further, that such a service shall be provided where
2254 the child resides including the child’s home, including a foster home and therapeutic foster
2255 home, or another community setting.

2256 (b) The annual report submitted by carriers and contractor pursuant to section 254 shall
2257 include a certification whether their coverage includes the following mental health home-based
2258 and community-based services for a child: (i) intensive care coordination for child with serious
2259 emotional disturbance; (ii) mobile crisis intervention; (iii) family support and training; (iv) in-

2260 home therapy; (v) therapeutic mentoring services; and (vi) in-home behavioral services. The
2261 certification shall substantiate that networks for provided services, if offered, are active and
2262 adequate to ensure access.

2263 (c) The commissioner may promulgate regulations or guidelines to implement this
2264 section.

2265 SECTION 115. Notwithstanding any general or special law to the contrary, the hospital
2266 assessment and review council established under section 2 of chapter 176W of the General Laws
2267 shall define "target hospital growth rate" to have the same meaning as "market basket percentage
2268 increase" as defined under 42 U.S.C. section 1395ww and "target hospital rate distribution" as
2269 90 per cent of the statewide commercial relative price in the previous calendar year unless
2270 otherwise amended under section 4 of said chapter 176W after January 1, 2022.

2271 SECTION 116. Notwithstanding any general or special law to the contrary, the executive
2272 office of health and human services, in collaboration with the executive office of elder affairs,
2273 the office of Medicaid and the department of public health, shall develop a post-acute care
2274 referral consultation program, subject to appropriation, of regional consultation teams to: (i)
2275 assist providers and consumers in determining appropriate post-acute care settings and
2276 coordinating patient care and (ii) share best practices among providers. The program shall also
2277 ensure education and outreach on provider pre-admission counseling required under section 9 of
2278 chapter 118E of the General Laws.

2279 A regional consultation team shall include regional representation from: (i) aging service
2280 access points; (ii) senior care organization members of the MassHealth Senior Care Options
2281 program; (iii) Program of All-inclusive Care for the Elderly plans; (iv) One Care plans; (v) the
2282 Massachusetts council on aging; (vi) the Massachusetts Healthy Aging Collaborative; (vii)
2283 skilled nursing facilities; (viii) and other entities or individuals deemed appropriate by the
2284 executive office of health and human services. A regional consultation team may be based within
2285 an aging service access point.

2286 The executive office of health and human services shall submit an initial report to the
2287 joint committee on health care financing, the joint committee on elder affairs and the senate and
2288 house committees on ways and means not later than March 15, 2018, that details: (i) the

2289 anticipated structure for the program; (ii) estimated cost estimates for the implementation and
2290 maintenance of the program; (iii) a breakdown of the state investment and anticipated alternate
2291 funding sources; and (iv) a timeline for program implementation.

2292 Beginning in 2019, the executive office of health and human services shall submit an
2293 annual report not later than March 15 to the joint committee on health care financing, the joint
2294 committee on elder affairs and the senate and house committees on ways and means that shall
2295 include, but not be limited to: (i) education and outreach efforts on preadmission counseling; (ii)
2296 the number of providers accessing the program; (iii) the estimated cost estimates for the
2297 implementation and maintenance of the program; and (iv) a breakdown of referrals based on the
2298 site of post-acute care.

2299 SECTION 117. Notwithstanding any general or special law to the contrary, the
2300 department of public health and the office of consumer affairs and business regulation shall
2301 allow licensees to obtain proxy credentialing and privileging for telemedicine services with other
2302 health care providers as defined in section 1 of chapter 111 of the General Laws or facilities that
2303 comply with the Centers for Medicare & Medicaid Services' conditions of participation for
2304 telemedicine services.

2305 For the purposes of this section, "telemedicine" shall mean the use of interactive audio,
2306 video or other electronic media for the purposes of a diagnosis, consultation or treatment of a
2307 patient's physical, oral or mental health; provided, however, that "telemedicine" shall not include
2308 an audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

2309 SECTION 118. Notwithstanding any general or special law to the contrary, all
2310 commercial insurers, hospital service corporations, medical service corporations and health
2311 maintenance organizations shall:

2312 (i) not later than July 1, 2019, reimburse for health care services with alternative payment
2313 methodologies for not less than 50 per cent of its enrollees; provided, however, that 25 per cent
2314 of its enrollees shall be under alternative payment methodologies that require providers to bear
2315 downside risk at a level not less than the amount required of a MassHealth accountable care
2316 organization;

2317 (ii) not later than July 1, 2022, reimburse for health care services with alternative
2318 payment methodologies for not less than 65 per cent of its enrollees; provided, however, that 45
2319 per cent of its enrollees shall be under alternative payment methodologies that require providers
2320 to bear downside risk at a level not less than the amount required of a MassHealth accountable
2321 care organization; and

2322 (iii) not later than July 1, 2025, reimburse for health care services with alternative
2323 payment methodologies for not less than 85 per cent of its enrollees; provided, however, that 65
2324 per cent of its enrollees shall be under alternative payment methodologies that require providers
2325 to bear downside risk at a level not less than the amount required of a MassHealth accountable
2326 care organization.

2327 All providers shall work with commercial insurers, hospital service corporations, medical
2328 service corporations and health maintenance organizations to meet the goals described in this
2329 section.

2330 SECTION 119. Notwithstanding any general or special law to the contrary, the
2331 noncontracted commercial rate for nonemergency services under chapter 176O of the General
2332 Laws shall be not more than the eightieth percentile of all allowed charges for a particular health
2333 care service performed by a health care provider in the same or similar specialty and provided in
2334 the same geographical area, as reported in a benchmarking database by a nonprofit organization
2335 specified by the division of insurance. Such an organization shall not be affiliated with a health
2336 carrier.

2337 SECTION 120. Notwithstanding any general or special law to the contrary, the
2338 noncontracted commercial rate for emergency services under chapter 176O of the General Laws
2339 shall be not more than the eightieth percentile of all allowed charges for a particular health care
2340 service performed by a health care provider in the same or similar specialty and provided in the
2341 same geographical area, as reported in a benchmarking database by a nonprofit organization
2342 specified by the division of insurance. Such an organization shall not be affiliated with any
2343 health carrier.

2344 SECTION 121. Sections 119 and 120 are hereby repealed.

2345 SECTION 122. Notwithstanding any general or special law to the contrary, the executive
2346 office of health and human services shall apply for a federal waiver of the requirements of
2347 section 1886(q) of the federal Social Security Act.

2348 SECTION 123. Notwithstanding any general or special law to the contrary, the
2349 readmission reduction benchmark under chapter 6D of the General Laws shall be a 20 per cent
2350 reduction of readmission rates, as measured by the health policy commission in consultation with
2351 the center for health information and analysis, between those rates observed in the year 2017 and
2352 those rates observed in the year 2020.

2353 SECTION 124. Notwithstanding any general or special law to the contrary, the health
2354 policy commission shall identify health care trailblazers under section 19 of chapter 6D of the
2355 General Laws that have either: (i) demonstrated success in patient placement in the appropriate
2356 care setting through the development of care plans that include education on appropriate use of
2357 emergency services for patients who are deemed high utilizers of emergency departments; or (ii)
2358 established an employer-sponsored insurance plan in which an employer shares an increased
2359 percentage of an employee's premium or cost sharing for employees who receive a lower salary
2360 compared to other employees.

2361 SECTION 125. Notwithstanding any general or special law to the contrary, the office of
2362 Medicaid may establish and offer an optional expanded Medicaid plan for purchase by an
2363 individual or by an employer as an employer-sponsored insurance plan. The optional expanded
2364 plan may set alternate eligibility and cost-sharing standards beyond those established by section
2365 9A of chapter 118E of the General Laws and may condition participation in the program;
2366 provided, however, that any optional expanded plan offered to an employer shall require the
2367 employer to pay not less than 50 per cent of the projected cost of coverage for participating
2368 employees. The office may adjust benefits offered through an optional plan under this section;
2369 provided, however, that the office shall maintain the benefit and cost-sharing standards for those
2370 individuals and employees that meet the eligibility standards established by said section 9A of
2371 said chapter 118E.

2372 The office may establish premiums or cost-sharing requirements for an optional
2373 expanded plan that are equal to or exceed the costs of covering participating members based on

2374 the per-member-per-month expenditures or other measures. Additional revenue generated in
2375 excess of the cost to administer the expanded plan may be used to increase provider payment
2376 rates within the optional expanded plan and the MassHealth program under said section 9A of
2377 said chapter 118E or otherwise may be applied to the sustainability of the MassHealth program.

2378 An individual eligible for MassHealth under said section 9A of said chapter 118E shall
2379 receive commensurate cost sharing, coverage and benefits as they would receive under said
2380 section 9A of said chapter 118E, regardless of participation in the optional expanded plan
2381 through their employer. Nothing in this section shall preclude the office from requiring an
2382 employee to participate in the premium assistance program or a commensurate program.

2383 The office may, in addition to premiums or cost sharing required from employers for
2384 employees on the optional expanded plan, require contributions from an employer that
2385 participates in the optional expanded plan as employer-sponsored insurance, for an employee
2386 that meets the eligibility standards under said section 9A of said chapter 118E.

2387 The office may apply for federal authorization to permit the application of available
2388 subsidies for participation in the optional expanded plan including, but not limited to, advance
2389 premium tax credits, cost-sharing reductions or state wrap funds applicable to the purchase of
2390 MassHealth coverage through the commonwealth health insurance connector authority.

2391 Not later than October 1, 2018, the office shall file a plan outlining: (i) whether the office
2392 plans to implement an optional expanded plan; (ii) recommended statutory language, if any; (iii)
2393 expected benefits and cost sharing to be offered through the optional expanded plan; (iv)
2394 expected start-up costs to implement the optional expanded plan; (v) expected revenue from the
2395 optional expanded plan to support the full MassHealth program; and (vi) expected savings to the
2396 MassHealth program related to the implementation of an optional expanded plan.

2397 SECTION 126. Notwithstanding any general or special law to the contrary, the office of
2398 Medicaid shall seek federal approval to amend its state plan amendment and regulations to
2399 permit member access to urgent care facilities for emergency services without requiring a
2400 referral or prior authorization. The office shall provide a progress report to the joint committee
2401 on health care financing and the senate and house committees on ways and means not later than
2402 July 1, 2018 and shall issue updated regulations not later than January 1, 2019.

2403 SECTION 127. Notwithstanding any general or special law to the contrary, the secretary
2404 of health and human services may seek approval from Centers for Medicare & Medicaid
2405 Services to claim expenditures necessary to establish mobile integrated health care programs
2406 certified under chapter 111O of the General Laws as an allowable expenditure under the delivery
2407 system reform incentive program pursuant to requirement 57 of the Special Terms and
2408 Conditions for the MassHealth demonstration waiver under section 1115(a) of the Social
2409 Security Act.

2410 SECTION 128. Notwithstanding any general or special law to the contrary, the office of
2411 Medicaid shall establish a plan outlining the office's method for collecting, maintaining and
2412 sharing data with providers to ensure compliance with benchmarks associated with the
2413 MassHealth accountable care program, including ways to coordinate measures of social
2414 determinants of health that provide breakdowns by special populations within and across
2415 programs.

2416 The plan shall be filed with the clerks of the senate and house of representatives, the joint
2417 committee on health care financing and the senate and house committees on ways and means not
2418 later than August 1, 2018.

2419 SECTION 129. Notwithstanding any general or special law to the contrary, the executive
2420 office of health and human services, in consultation with the Massachusetts eHealth Institute,
2421 shall maximize information sharing, to the extent permissible under relevant privacy law,
2422 between the senior information management system operated by the executive office of elder
2423 affairs and electronic health records systems operated by health care providers.

2424 Not later than October 1, 2018, the executive office of health and human services shall
2425 provide a report on electronic information sharing efforts between the senior information
2426 management system and other electronic health records systems, any existing barriers to
2427 electronic information sharing and planned efforts to reduce such barriers to the clerks of the
2428 senate and house of representatives, the joint committee on elder affairs, the joint committee on
2429 health care financing and the senate and house committees on ways and means.

2430 SECTION 130. Notwithstanding any general or special law to the contrary, the executive
2431 office of health and human services shall apply for a federal waiver to permit passive enrollment

2432 of individuals eligible for Medicare into the MassHealth senior care options program. The
2433 executive office may also apply for a federal waiver to: (i) permit a Medicare member, who does
2434 not meet the financial eligibility standards for Medicaid but demonstrates insufficient income
2435 and assets to pay for 135 days of skilled nursing facility care, to prospectively enroll in the
2436 MassHealth senior care options program using Medicare or other funding; and (ii) receive
2437 Medicaid matching funds for a Medicare recipient or member of the executive office of elder
2438 affairs home care program who is not otherwise eligible for Medicaid and lacks income and
2439 assets to pay for 135 days of skilled nursing facility care.

2440 The executive office of health and human services may engage the technical assistance
2441 and program design expertise of an external evaluator, if available, and share relevant data with
2442 such an evaluator, in order to implement this section in accordance with rigorous evaluation for
2443 program impact and cost-effectiveness. Any completed evaluation shall be filed with the clerks
2444 of the senate and house of representatives, the joint committee on health care financing and the
2445 senate and house committees on ways and means.

2446 SECTION 131. The office of Medicaid shall report on the role of long-term services and
2447 supports within MassHealth and MassHealth accountable care organizations in each year of the
2448 accountable care organization demonstration. The report shall include: (i) the baseline number of
2449 accountable care organization-attributed MassHealth members receiving long-term services and
2450 supports, disaggregated by age category, disability status, service type, and any other relevant
2451 categories; (ii) total MassHealth spending on long-term services and supports and number of
2452 members receiving long-term services and supports disaggregated by age category, disability
2453 status, service type, and any other relevant categories; (iii) MassHealth average per member, per
2454 month long-term services and supports costs by service type; (iv) any projected changes in
2455 utilization of long-term services and supports in the coming year and the rationale for such
2456 changes; (v) any estimated shift in spending between medical and long-term services and
2457 supports or social services spending within the accountable care organization program in the
2458 prior year of the demonstration; (vi) the process for determination of long-term services and
2459 supports needs for members attributed to the accountable care organization program,
2460 disaggregated by accountable care organization if processes differ; and (vii) the appeals process
2461 for accountable care organization members denied long-term services and supports. This report

2462 shall be filed with the clerks of the senate and house of representatives, the joint committee on
2463 health care financing and the senate and house committees on ways and means not later than
2464 April 1, 2018, and thereafter annually by April 1 for each year of the accountable care
2465 organization demonstration.

2466 SECTION 132. Notwithstanding any general or special law to the contrary, the executive
2467 office of health and human services shall enroll MassHealth-eligible consumers who are enrolled
2468 in the executive office of elder affairs home care program, subject to exceptions based on level
2469 of acuity or continuity of care, in the MassHealth senior care options program.

2470 The executive office of health and human services and the secretary of elder affairs shall
2471 transfer funds between item 9110-1630 of section 2 of chapter 47 of the acts of 2017 and item
2472 4000-0601 of said section 2 of said chapter 47 for the costs of consumers enrolled in the home
2473 care program who enroll in the MassHealth senior care options program or for the costs of senior
2474 care options enrollees who opt out of senior care options and return to the home care program.
2475 The amount transferred to said item 4000-0601 of said section 2 of said chapter 47 shall not
2476 exceed the estimated annual cost of care in the home care program for participating senior care
2477 options enrollees and funds shall not be transferred in any fiscal year if it results in a waiting list
2478 for services provided by said item 9110-1630 of said section 2 of said chapter 47.

2479 Not later than October 1, 2018, the executive office of health and human services shall
2480 provide a report on the number of MassHealth-eligible home care consumers enrolled in the
2481 senior care options program, the number of consumers planned to be enrolled, the timeline for
2482 the enrollment, the amount of transferred funds associated with the enrollment and the amount of
2483 federal matching funds projected to accrue to the senior care options program. The report shall
2484 be filed with the clerks of the senate and the house of representatives and the senate and house
2485 committees on ways and means.

2486 SECTION 133. The executive office of health and human services may develop a pilot
2487 program to certify supportive housing and affordable housing providers, in coordination with
2488 plans that service individuals eligible for Medicaid, Medicare or both, including but not limited
2489 to program for all-inclusive care for the elderly, senior care options and other managed care
2490 organizations, and in consultation with aging services access points, community partners and

2491 other stakeholders, to: (i) establish coordinated care teams and supports within housing sites that
2492 are funded with pooled resources, financing models including social impact bonds or other
2493 sources; or (ii) subject to federal authorization, passively enroll residents in senior care options,
2494 Medicaid-managed care or other globally-budgeted health care plans to establish care
2495 coordination between the housing provider and plans and to provide a critical mass of plan
2496 members necessary for care coordination and targeted investment within the housing site.
2497 Housing providers and plans shall not enter into exclusive relationships, but shall conduct
2498 passive enrollment into not less than 2 plans within each housing site. A resident choosing to opt
2499 out from such a coordinated plan shall continue to have access to any plan regardless of housing
2500 site. The executive office of health and human services may engage the technical assistance and
2501 program design expertise of an external evaluator, if available, and share relevant data with the
2502 evaluator to implement this section in accordance with a rigorous evaluation of program impact
2503 and cost-effectiveness. Any completed evaluation shall be filed with the clerks of the senate and
2504 house of representatives, the joint committee on health care financing and the senate and house
2505 committees on ways and means.

2506 SECTION 134. Notwithstanding any general or special law to the contrary, the secretary
2507 of health and human services shall develop a strategic plan outlining changes to provider funding
2508 sources, including those related to the adoption of new financing and delivery models of care as
2509 well as current supplemental payment streams to acute care hospitals. The strategic plan shall
2510 provide a breakdown of payment sources to providers, including payments authorized under the
2511 current MassHealth section 1115 demonstration waiver, by payment sources identified as: (i)
2512 time limited and as ongoing, along with expected benchmarks for providers to demonstrate
2513 sustainability due to the expiration of a time limited payment source; and (ii) included in an
2514 alternative payment model or a current supplemental payment.

2515 In developing the strategic plan, the secretary shall consult with a diverse set of providers
2516 that represent differing regional perspectives, patient volume and acuity and payment structures.

2517 The strategic plan shall identify: (i) regional disparities in funding; (ii) metrics for
2518 allocating funds that align with new health care financing and delivery models; (iii) opportunities
2519 to maximize federal financial participation; and (iv) any other factor pertinent to the evaluation
2520 of different approaches to the allocation of these funds.

2521 The secretary may identify an independent third-party to analyze and evaluate the
2522 allocation of the funds described in this section. The strategic plan and any underlying analysis
2523 by the independent third-party shall be filed with the senate and house committees on ways and
2524 means and the joint committee on health care financing not later than January 1, 2020.

2525 SECTION 135. Not later than July 1, 2018, the office of Medicaid shall provide a report
2526 on the proposed eligibility changes to the MassHealth program included in the Section 1115
2527 amendment request that was submitted on September 8, 2017, based on information received
2528 under section 79 of chapter 118E of the General Laws. The report shall include: (i) the number of
2529 members who received an offer of employer-sponsored health insurance; (ii) the number of
2530 members who received an offer of affordable employer-sponsored health insurance; (iii) details
2531 on the most frequently occurring cost-sharing arrangements for members offered affordable
2532 employer-sponsored health insurance; (iv) the number of members who would be transitioned
2533 from MassHealth to the ConnectorCare program; (v) the estimated cost savings attributed to the
2534 eligibility changes to the MassHealth program included in the amendment submitted on
2535 September 8, 2017; and (vi) the number of members who have been deemed eligible for
2536 premium assistance. The office shall submit its report to the clerks of the senate and house of
2537 representatives, the joint committee on health care financing and the senate and house
2538 committees on ways and means.

2539 SECTION 136. Notwithstanding any general or special law to the contrary, the center for
2540 health information and analysis shall conduct a review of a mandated health benefit proposal to
2541 require coverage of services rendered by a mobile integrated health care provider pursuant to
2542 chapter 111O of the General Laws. The review shall be performed by the center consistent with
2543 section 38C of chapter 3 of the General Laws. The center shall evaluate the impact of such a
2544 mandate as a requirement for all of the health plans and policies under subsection (a) of said
2545 section 38C of said chapter 3. The center shall file its review with the clerks of the senate and
2546 house of representatives, the joint committee on health care financing and the senate and house
2547 committees on ways and means not later July 1, 2020.

2548 SECTION 137. Notwithstanding any general or special law to the contrary, the health
2549 policy commission, in consultation with the center for health information and analysis and with
2550 the technical assistance of an external evaluator, if available, shall review the impact of this act

2551 on: (i) reduction in hospital readmissions; (ii) emergency department utilization; (iii) reduction in
2552 post-acute institutional care; (iv) prescription drug cost trends; (v) movement of patients toward
2553 high-value provider settings; and (vi) provider price variation.

2554 The commission's review shall be made in 2 parts and include, but not be limited to: (i)
2555 system wide aggregate savings; (ii) cost savings broken down by provider, payer, consumer and
2556 the commonwealth; and (iii) impact on consumer choice of providers that are lower-cost, high
2557 quality or both lower-cost and high quality.

2558 The commission shall issue its first report not later than July 1, 2025 and its final report
2559 not later than July 1, 2030 and file the report with the clerks of the senate and house of
2560 representatives, the joint committee on health care financing, the joint committee on public
2561 health and the senate and house committees on ways and means.

2562 SECTION 138. Notwithstanding any general or special law to the contrary, the board of
2563 registration in dentistry, in consultation with the executive office of health and human services,
2564 shall perform an evaluation of the impact of this act on dental therapists in terms of patient
2565 safety, cost-effectiveness and access to dental services over the first 5 years of the act's
2566 implementation. The board shall report on its findings and the report shall include: (i) the number
2567 of new patients served; (ii) the impact on waiting times for needed services; (iii) the impact on
2568 travel time for patients; (iv) the impact on emergency room usage for dental care; and (v) the
2569 impact on costs to the public health care system. The report shall be submitted not later than July
2570 1, 2023 to the joint committee on public health, the joint committee on health care financing and
2571 the senate and house committees on ways and means.

2572 SECTION 139. There shall be a task force to investigate the impact to state agencies of
2573 joining a nonMedicaid, multistate prescription drug bulk purchase consortium. The task force
2574 shall consider: (i) the estimated costs savings related to joining a non-Medicaid, multistate
2575 consortium; (ii) the opportunity for counties, municipalities and nonprofit organizations to
2576 participate in a nonMedicaid multistate consortium; (iii) the potential administrative savings and
2577 efficiencies for participants as a result of joining a nonMedicaid, multistate consortium; (iv)
2578 other bulk purchase discounts or rebates for prescription drugs, medical supplies or other medical
2579 goods purchased by state agencies, other governmental units and nonprofit organizations; and (v)

2580 means of receiving rebates or discounts for medical supplies or medications not included under
2581 the federal 340B Drug Pricing Program for eligible entities. The task force may consider non-
2582 Medicaid, multistate consortiums that are not available to the group insurance commission.

2583 The task force shall consist of: (i) the commissioner of public health or a designee, who
2584 shall serve as chair; (ii) the chief of pharmacy or a designee; (iii) the commissioner of mental
2585 health or a designee; (iv) the commissioner of developmental services or a designee; (v) the
2586 secretary of veterans' services or a designee; (vi) the commissioner of correction or a designee;
2587 (vii) the president of the Massachusetts Sheriffs Association or a designee; (viii) the president of
2588 the Massachusetts Biotechnology Council, Inc. or a designee; (ix) the chairperson of the
2589 Massachusetts Chamber of Commerce Inc. or a designee; (x) the executive director of the group
2590 insurance commission or a designee; and (xi) 5 persons to be appointed by the governor, 1 of
2591 whom shall be a health care economist, 1 of whom shall be a pharmacist registered by the board
2592 of registration in pharmacy, 1 of whom shall be a county or municipal representative, 1 of whom
2593 shall be a representative of a nonprofit community health center and 1 of whom shall have
2594 experience with multistate bulk purchasing consortiums for prescription drugs. The task force
2595 shall file its report, including drafts of any proposed legislation, with the clerks of the senate and
2596 the house of representatives, the joint committee on health care financing and the senate and
2597 house committees on ways and means not later than November 1, 2018.

2598 SECTION 140. The office of Medicaid shall report on potential cost savings for
2599 prescription medications by the office if it joined a multistate Medicaid bulk purchasing
2600 consortium. The report shall include: (i) an analysis of increased efficiency in the receipt of
2601 discounts through participation in a multistate Medicaid bulk purchasing consortium; (ii) the
2602 estimated cost savings related to joining a multistate Medicaid bulk purchasing consortium; (iii)
2603 the estimated administrative savings or other increased efficiencies related to joining a multistate
2604 Medicaid bulk purchasing consortium; (iv) opportunities for managed care organizations to
2605 receive rebates or discounts; and (v) a review of any identified alternative approaches to
2606 multistate Medicaid bulk purchasing consortiums that provide cost savings relative to
2607 prescription medications. The office shall file the report with the clerks of the senate and house
2608 of representatives, the joint committee on health care financing and the senate and house
2609 committees on ways and means not later than November 1, 2018.

2610 SECTION 141. Notwithstanding any general or special law to the contrary, the
2611 Massachusetts e-Health Institute shall report projects that leverage the commonwealth's
2612 investment in electronic health record deployment and the statewide health information exchange
2613 and that are likely to have a meaningful impact on cost or quality of care. The report shall
2614 identify and support such projects and include recommended funding amounts for the projects.
2615 The institute shall file the report with the clerks of the senate and house of representatives, the
2616 joint committee on health care financing and the senate and house committees on ways and
2617 means not later than January 1, 2019.

2618 SECTION 142. The center for health information and analysis shall report on the
2619 implementation of facility fee protections under section 28 of chapter 32A, section 51L of
2620 chapter 111 and sections 28 and 29 of chapter 176O of the General Laws. The report shall
2621 include: (i) facility fees charged or billed to provide a baseline report on facility fees that were
2622 charged or billed; and (ii) a 5-year status report.

2623 The reports shall include: (i) the number of hospital-based facilities owned or operated by
2624 a hospital or health system that provides services for which a facility fee was charged or billed,
2625 broken down by hospital or health system; (ii) the number of patient visits provided at hospital
2626 based facility for which a facility fee was charged or billed; (iii) the number of claims, total
2627 amount and range of allowable facility fees paid at each facility by Medicare, Medicaid and
2628 private insurance policies, including any cost sharing, as applicable; (iv) the total amount of
2629 revenue from hospital-based facility fees received by a hospital or health system, categorized by
2630 whether a hospital-based facility is on a campus; (v) a description of the 10 procedures or
2631 services that generated the greatest amount of facility fee revenue at hospital-based facilities and,
2632 for each such procedure or service, the total amount of revenue received by a hospital or health
2633 system from the facility fees for the services; and (vi) the top 10 procedures or services for which
2634 facility fees were charged based on volume of claims.

2635 The center for health information and analysis shall make the information publicly
2636 available on its website. The baseline report shall be made available on December 31, 2018 and
2637 the 5-year status report shall be made available on January 1, 2024.

2638 SECTION 143. There shall be a task force to investigate methods to increase efficiency
2639 in the health care system through regulatory simplification. The task force shall consist of: the
2640 secretary of health and human services or a designee, who shall serve as chair; the commissioner
2641 of public health or a designee; the assistant secretary of the office of Medicaid or a designee; the
2642 chair of the health policy commission or a designee; 1 member appointed by the senate
2643 president; 1 member appointed by the speaker of the house; and 7 members appointed by the
2644 governor, 1 of whom shall be a representative of the Massachusetts Health and Hospital
2645 Association, Inc., 1 of whom shall be a representative of the Massachusetts League of
2646 Community Health Centers, 1 of whom shall be a representative of the Massachusetts Medical
2647 Society, 1 of whom shall be a representative of Association for Behavioral Healthcare, Inc., 1 of
2648 whom shall be a representative of the Massachusetts Association of Behavioral Health Systems,
2649 Inc., 1 of whom shall be a representative of the Massachusetts Nurses Association and 1 of
2650 whom shall be a representative of the Home Care Alliance of Massachusetts, Inc.

2651 The task force shall consider: (i) the cost and benefit of establishing an office of care
2652 coordination to provide cross-agency coordination for providers to improve patient access to
2653 needed services; (ii) the feasibility of a regulatory waiver process within the office of Medicaid
2654 for payers and providers seeking flexibility to implement innovative initiatives resulting in
2655 increased access to care and cost savings; (iii) the feasibility of a regulatory waiver process
2656 within the department of public health for providers seeking flexibility to implement innovative
2657 initiatives resulting in increased access to care and cost savings; and (iv) recommendations for
2658 regulatory changes needed to support the development of global payments.

2659 The task force shall file its report not later than October 1, 2019 with the clerks of the
2660 senate and house of representatives, the joint committee on health care financing, the joint
2661 committee on public health and the senate and house committee on ways and means.

2662 SECTION 144. There shall be a special commission to study and make recommendations
2663 on how to license foreign-trained medical professionals to expand and improve access to medical
2664 services in rural and underserved areas.

2665 The commission shall consist of: (i) the secretary of health and human services or a
2666 designee, who shall serve as chair; (ii) the commissioner of public health or a designee; (iii) 1

2667 member appointed by the senate president; (iv) 1 member appointed by the speaker of the house;
2668 (v) 1 member appointed by the minority leader of the senate; (vi) 1 member appointed by the
2669 minority leader of the house; (vii) the house and senate chairs of the joint committee on public
2670 health; and (viii) 9 members appointed by the governor, 1 of whom shall be a member of the
2671 governor's advisory council for refugees and immigrants, 1 of whom shall be a representative of
2672 the Massachusetts Immigrant and Refugee Advocacy Coalition, Inc., 1 of whom shall be a
2673 representative of the division of health professional licensure, 1 whom shall be a member of the
2674 board of registration in medicine, 1 of whom shall be a member of the board of registration in
2675 dentistry, 1 member of the board of registration in pharmacy, 1 of whom shall be a member of
2676 the board of registration in nursing, 1 of whom shall be a member of the board of registration of
2677 psychologists and 1 of whom shall be a member of the board of allied health professionals

2678 The commission shall examine and make recommendations on topics including, but not
2679 limited to: (i) ways to implement strategies to integrate foreign-trained medical professionals into
2680 rural and underserved areas that are in need of access to medical services; (ii) ways to identify
2681 state and national licensing regulations that pose barriers to practice for foreign-trained medical
2682 professionals; (iii) state licensing requirements that pose barriers to practice for foreign-trained
2683 medical professionals; (iv) alternate approaches by other states to integrate foreign-trained
2684 medical professionals into rural and underserved areas; and (v) other matters pertaining to
2685 licensing foreign-trained medical professionals. The commission may hold hearings and invite
2686 testimony from experts and the public to gather information. The report may include
2687 recommended guidelines for full licensure and conditional licensing of foreign-trained medical
2688 professionals.

2689 The commission shall file its recommendations, including any drafts of legislation or
2690 regulations necessary to carry out its recommendations, to the clerks of the senate and house of
2691 representatives, the joint committee on public health and the joint committee on health care
2692 financing not later than March 1, 2019.

2693 SECTION 145. There shall be a housing security task force to investigate methods to
2694 encourage housing security as a social determinant of health. The task force shall consist of: the
2695 secretary of housing and economic development or a designee, who shall serve as co-chair; the
2696 secretary of health and human services or a designee, who shall serve as co-chair; the

2697 commissioner of public health or a designee; the executive director of the health policy
2698 commission or a designee; the undersecretary of housing and community development or a
2699 designee; the commissioner of mental health or a designee; the commissioner of developmental
2700 services or a designee; and 14 members appointed by the governor, 1 of whom shall be a
2701 representative of a public housing authority, 1 of whom shall be a representative of
2702 Massachusetts Senior Care Association, Inc., 1 of whom shall be an expert on affordable
2703 housing, 1 of whom shall be a representative of the Massachusetts Law Reform Institute, Inc., 1
2704 of whom shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1
2705 of whom shall be an expert in case management, 1 of whom shall be a representative of the
2706 Home Care Alliance of Massachusetts, Inc., 1 of whom shall be a representative of Arc
2707 Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Coalition for the
2708 Homeless, Inc., 1 of whom shall be a representative of the Massachusetts Housing and Shelter
2709 Alliance, Inc., 1 of whom shall be a representative of the Association for Behavioral Healthcare,
2710 Inc., 1 of whom shall be a representative of Health Care for All, Inc., 1 of whom shall be a
2711 representative of the Massachusetts Association of Behavioral Health Systems, Inc. and 1 of
2712 whom shall be a representative of Citizens Housing And Planning Association, Inc. Members
2713 shall be selected to ensure broad geographic representation.

2714 The task force shall consider: (i) ways to develop priority designation for shelter beds for
2715 individuals eligible for discharge from an emergency department or inpatient setting; (ii) ways to
2716 locate affordable housing for individuals who are homeless or at risk of homelessness; (iii)
2717 recommended policies to increase the amount of affordable housing; (iv) gaps that exist in
2718 providing post-acute care to individuals residing in shelter beds; and (v) opportunities to
2719 integrate care coordination or other health services into housing authorities or other housing
2720 models.

2721 The task force shall hold its first meeting not later than April 1, 2018 and shall meet not
2722 less than 4 times. The task force may consult with the interagency council on housing and
2723 homelessness and solicit stakeholder feedback or public testimony. The task force shall file its
2724 report not later than November 1, 2018 with the clerks of the senate and house of representatives,
2725 the joint committee on housing, the joint committee on health care financing; the joint committee
2726 on public health and the senate and house committees on ways and means.

2727 SECTION 146. The department of public health shall promulgate rules or regulation
2728 necessary to implement 47 to 49, inclusive, 51 to 58, inclusive, 60, 63, 76 and 81 to 91,
2729 inclusive, not later than January 1, 2019.

2730 SECTION 147. The department of public health shall issue regulations under section 51L
2731 of chapter 111 of the General Laws not later than January 1, 2019.

2732 SECTION 148. Notwithstanding any special or general law to the contrary, a hospital
2733 licensed pursuant to section 51 of chapter 111 of the General Laws on or before January 1, 2019,
2734 shall not be required to comply with section 51L of said chapter 111 until notice of the hospital's
2735 licensure renewal pursuant to said section 51 of said chapter 111.

2736 SECTION 149. Notwithstanding section 28 of chapter 32A of the General Laws and
2737 section 51L of chapter 111 of the General Laws, an insurance contract that provides for
2738 reimbursement for facility fees prohibited under said section 51L of said chapter 111 to a
2739 hospital or health system shall remain in effect until the next standard negotiation of contracted
2740 rates; provided, however, that a plan submitted to the division of insurance after January 1, 2018
2741 shall not be approved by the division if the plan does not comply with said section 51L of said
2742 chapter 111.

2743 SECTION 150. Section 66C of chapter 112 of the General Laws shall apply to registered
2744 optometrists who are qualified by an examination for practice under section 68 after January 1,
2745 2013.

2746 SECTION 151. An applicant for examination to permit the use and prescription of
2747 therapeutic agents pursuant to section 68C of chapter 112 of the General Laws who presents
2748 satisfactory evidence of graduation from a school or college of optometry approved by the board
2749 after January 1, 2013 shall be deemed to have satisfied sections 68 to 68B, inclusive, of said
2750 chapter 112.

2751 SECTION 152. Subsection (d) of section 68C of chapter 112 of the General Laws shall
2752 apply to licensed optometrists who have completed a postgraduate residency program approved
2753 by the Accreditation Council on Optometric Education of the American Optometric Association
2754 after July 31, 1997.

2755 SECTION 153. The task force established pursuant to section 16AA of chapter 6A of the
2756 General Laws shall be first convened in 2019.

2757 SECTION 154. Section 30 of chapter 32A of the General Laws, section 81 of chapter
2758 118E of the General Laws, section 108O of chapter 175 of the General Laws, section 40 of
2759 chapter 176A of the General Laws, section 27 of chapter 176B of the General Laws, section 35
2760 of chapter 176G of the General Laws and section 14 of chapter 176I of the General Laws shall
2761 apply to contracts entered or renewed on or after January 1, 2020.

2762 SECTION 155. Sections 22, 102 and 107 shall apply to plans submitted to the division of
2763 insurance on or after January 1, 2020.

2764 SECTION 156. Section 2ZZZZ of chapter 29 of the General Laws and sections 4 and 5
2765 of chapter 176W of the General Laws shall take effect on January 1, 2022.

2766 SECTION 157. Sections 2, 5, 6, 8, 11, 13, 15, 17, 25, 34, 36, 43, 47 to 49, inclusive, 51
2767 to 58, inclusive, 60, 61, 63, 65, 66, 70, 76, 81 to 91, inclusive, 95, 113 and 123 and sections 28
2768 and 29 of chapter 176O of the General Laws shall take effect on January 1, 2019.

2769 SECTION 158. Sections 9, 23, 40 shall take effect on May 1, 2018.

2770 SECTION 159. Sections 16 and 122 shall take effect on January 1, 2021.

2771 SECTION 160. Sections 50, 59, 62, 75, 77 to 80, inclusive, 101, 117, 119 and 120,
2772 section 29 of chapter 32A of the General Laws, section 80 of chapter 118E of the General Laws,
2773 section 39 of chapter 176A of the General Laws, section 26 of chapter 176B of the General Laws
2774 and section 34 of 176G of the General Laws shall take effect on July 1, 2018.

2775 SECTION 161. Section 121 shall take effect on December 31, 2019.