SENATE . . . . . No. 2573

Senate, June 21, 2018 – Text of the Senate amendment (Senator Welch) to the House Bill establishing the Honorable Peter V. Kocot Act to enhance access to high quality, affordable and transparent healthcare in the commonwealth (House, No. 4639)

The Commonwealth of Massachusetts

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

SECTION 1. Chapter 6 of the General Laws is hereby amended by inserting after section 15DDDDDD, inserted by chapter 53 of the acts of 2017, the following section:-

Section 15EEEEEE. The governor shall annually issue a proclamation setting apart May 6th as Moyamoya Awareness Day, to raise awareness of the occurrence of this rare neurovascular condition seen in children and adults in which the walls of the internal carotid arteries become thickened and narrowed resulting in reduced blood flow and an increased risk of transient ischemic attacks and strokes, and recommending that the day be observed in an appropriate manner by the people.

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

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

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

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

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

SECTION 3. Said chapter 6A is hereby further amended by inserting after section 16Z the following section:-

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

The task force shall be convened by the secretary of health and human services and the executive director of the health policy commission, or their designees, who shall serve as co-chairs, and shall include the following members or their designees: the commissioner of public health; the executive director of the center for health information and analysis; the executive director of the group insurance commission; the assistant secretary for MassHealth; the commissioner of insurance; and 10 members who shall be appointed by the governor, 1 of whom

shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom shall be a representative the Massachusetts Medical Society, 1 of whom shall be a behavioral health provider, 1 of whom shall be a long-term supports and services provider, 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of a Medicaid managed care organization, 1 of whom shall be a represent for persons with disabilities, 1 of whom shall be a representative for consumers and 1 of whom shall be an expert in establishing health system performance measures. Members appointed to the task force shall have experience with and expertise in health care quality measurement.

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

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

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

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

SECTION 4. Section 1 of chapter 6D of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the definition of “Performance penalty” the following 2 definitions:-

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

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

SECTION 5. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of “Physician” the following definition:-

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

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

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

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

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

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

SECTION 7. Section 2A of said chapter 6D, as so appearing, is hereby amended by inserting after the figure “10”, in lines 5 and 9, each time it appears, the following figure:- , 10A.

SECTION 8. Section 6 of said chapter 6D, as so appearing, is hereby amended by adding the following paragraph:-

If the analysis of spending trends with respect to the pharmaceutical or biopharmaceutical products increases the expenses of the commission, the estimated increases in the commission’s expenses shall be assessed fully to pharmaceutical manufacturing companies and pharmacy benefit managers in the same manner as the assessment under section 68 of chapter 118E. A pharmacy benefit manager that is a surcharge payor subject to the preceding paragraph and administers its own prescription drug, prescription device or pharmacist services or prescription

drug and device and pharmacist services portion shall not be subject to additional assessment under this paragraph.

SECTION 9. Section 7 of said chapter 6D, as so appearing, is hereby amended by striking out, in lines 5 and 6, the words “and (2) to foster innovation in health care payment and service delivery” and inserting in place thereof the following words:- (2) to foster innovation in health care payment and delivery; and (3) to foster innovation in reducing readmissions, including in addressing social determinants of health and improving behavioral health integration.

SECTION 10. Said section 7 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word “organizations”, in line 17, the following words:- , health care trailblazers.

SECTION 11. Section 8 of said chapter 6D, as so appearing, is hereby amended by striking out, in line 32, the words “ and (xi) ” and inserting in place thereof the following words:- (xi) not less than 3 representatives of the pharmaceutical industry; (xii) at least 1 pharmacy benefit manager; and (xiii).

SECTION 12. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word “system”, in line 46, the following words:- , information on ongoing provider efforts and initiatives that demonstrate planning and investment in worker readiness, including maintaining the engagement of the workforce and any significant workforce changes implemented during the reporting year.

SECTION 13. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 48, the word “and”.

SECTION 14. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word “commission”, in line 59, the first time it appears, the following words:- ; and (iii) in the case of pharmacy benefit managers and pharmaceutical manufacturing companies, testimony concerning factors underlying prescription drug costs and price increases, the impact of manufacturer rebates, discounts and other price concessions on net

pricing, the availability of alternative drugs or treatments and any other matters as determined by the commission.

SECTION 15. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 92, the word “that” and inserting in place thereof the following words:- , including a provider organization’s rate of readmissions, that.

SECTION 16. Subsection (g) of said section 8 of said chapter 6D, as so appearing, is hereby amended by striking out the second sentence and inserting in place thereof the following sentence:- The report shall be based on the commission's analysis of information provided at the hearings by providers, provider organizations, insurers, pharmaceutical manufacturing companies and pharmacy benefit managers, registration data collected under section 11, data collected or analyzed by the center under sections 8, 9, 10 and 10A of chapter 12C and any other available information that the commission considers necessary to fulfill its duties under this section as defined in regulations promulgated by the commission.

SECTION 17. Said chapter 6D is hereby further amended by inserting after section 9 the following section:-

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

(b) Prior to establishing the annual statewide readmissions reduction benchmark pursuant to subsection (a), the commission shall hold a public hearing and hear testimony from payers, providers and other interested parties. The hearing shall examine state and national readmission rates and trends, rates and trends for different provider types, successful care delivery models and interventions to reduce readmission rates, barriers to successful implementation of such models and interventions and other information identified by the commission. Following the hearing, the commission shall provide a report to the clerks of the senate and house of

representatives and the joint committee on health care financing that summarizes the testimony received and the data and information reviewed by the commission to establish the benchmark.

SECTION 18. Section 10 of said chapter 6D, as appearing in the 2016 Official Edition, is hereby amended by inserting after the figure "$500,000", in line 152, the following words:- the first time that a determination is made and not more than $750,000 for a second or subsequent determination; provided, however, that a civil penalty assessed under 1 of the above clauses shall be a first offense if a previously assessed penalty was assessed pursuant to a different clause. A civil penalty assessed under this subsection shall be deposited into the Health Safety Net Trust Fund established in section 66 of chapter 118E.

SECTION 19. Said chapter 6D is hereby further amended by inserting after section 10 the following section:-

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

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

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

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

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

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

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

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

(f) A provider organization shall file a readmissions performance improvement plan not later than 45 days after receipt of a notice under subsection (b); provided, however, that if the provider organization has requested a waiver or extension, it shall file the plan not later than 45 days after receipt of a notice that the waiver or extension was denied or, if the provider organization is granted an extension, on the date given on the extension. The readmissions performance improvement plan shall be generated by the provider organization, identify the

causes of the provider organization's excessive readmissions rate and include, but shall not be limited to, specific strategies, adjustments and action steps that the provider organization proposes to implement to improve performance in reducing readmissions which may include coordination with a community health center. The proposed readmissions performance improvement plan shall include specific identifiable and measurable expected outcomes and a timetable for implementation. The timetable for a performance improvement plan shall not exceed 24 months.

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

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

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

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

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

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

(k) The commission may assess a civil penalty of not more than $500,000 on a provider organization if the commission determines that the provider organization: (i) willfully neglected to file a readmissions performance improvement plan with the commission as required under subsection (f); (ii) failed to file an acceptable readmissions performance improvement plan in good faith with the commission; (iii) failed to implement the readmissions performance improvement plan in good faith; or (iv) knowingly failed to provide information required under this section to the commission or knowingly falsified such information. A civil penalty assessed under this subsection shall be deposited into the Distressed Hospital Trust Fund established in section 2GGGG of chapter 29.

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

SECTION 20. Subsection (a) of section 10A of chapter 6D, as appearing in section 19, is hereby amended by adding the following paragraph:-

If the statewide readmission reduction benchmark is not met in any year, in addition to requiring a readmissions performance improvement plan pursuant to subsection (c), the

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

SECTION 21. Section 14 of said chapter 6D, as appearing in the 2016 Official Edition, is hereby amended by striking out, in lines 62 and 63, the words "the standard quality measure set established by section 14 of chapter 12C" and inserting in place thereof the following words:- the aligned quality measures recommended by the task force and established by the secretary pursuant to section 16AA of chapter 6A.

SECTION 22. Subsection (c) of section 15 of said chapter 6D, as so appearing, is hereby amended by striking out clause (10) and inserting in place thereof the following clause:-

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

SECTION 23. Said section 15 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 167, the word "and".

SECTION 24. Subsection (c) of said section 15 of said chapter 6D, as so appearing, is hereby amended by striking out clause (16) and inserting in place thereof the following 2 clauses:-

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

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

SECTION 25. Said chapter 6D is hereby further amended by inserting after section 15 the following 2 sections:-

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

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

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

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

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

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

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

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

with a third-party entity that has familiarity with the development and approval of pharmaceuticals or biologics or studies and compares the clinical effectiveness and value of prescription drugs to implement this section.

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

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

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

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

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

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

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

SECTION 26. Said chapter 6D is hereby further amended by inserting after section 16 the following section:-

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

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

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

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

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

SECTION 27. Said chapter 6D is hereby further amended by adding following section:-

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

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

social workers, other health care providers, representatives of labor organizations representing healthcare workers and consumers.

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

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

SECTION 28. Chapter 12 of the General Laws is hereby amended by striking out section 11N and inserting in place thereof the following section:-

Section 11N. (a) The attorney general shall monitor trends in the health care market including, but not limited to, trends in provider organization size and composition, consolidation in the provider market, payer contracting trends, patient access and quality issues in the health care market and prescription drug cost trends. The attorney general may obtain the following information from a private health care payer, public health care payer, pharmaceutical manufacturing company, pharmacy benefit manager, provider or provider organization as any of those terms may be defined in section 1 of chapter 6D: (i) any information that is required to be submitted under sections 8, 9 10 and 10A of chapter 12C; (ii) filings, applications and supporting documentation related to any cost and market impact review under section 13 of said chapter 6D; (iii) filings, applications and supporting documentation related to a determination of need application filed under section 25C of chapter 111; and (iv) filings, applications and supporting documentation submitted to the federal Centers for Medicare and Medicaid Services or the Office of the Inspector General for any demonstration project. Under section 17 of said chapter 12C and section 8 of said chapter 6D and subject to the limitations stated in those sections, the attorney general may require that any provider, provider organization, pharmaceutical manufacturing company, pharmacy benefit manager, private health care payer or public health care payer produce documents, answer interrogatories and provide testimony under oath related to health care costs and cost trends, pharmaceutical costs, pharmaceutical cost trends, the factors that contribute to cost growth within the commonwealth's health care system and the relationship

between provider costs and payer premium rates and the relationship between pharmaceutical drug costs and payer premium rates.

(b) The attorney general may investigate any provider organization referred to the attorney general by the health policy commission under section 13 of chapter 6D to determine whether the provider organization engaged in unfair methods of competition or anticompetitive behavior in violation of chapter 93A or any other law and, if appropriate, take action under said chapter 93A or any other law to protect consumers in the health care market.

(c) The attorney general may investigate a pharmaceutical manufacturing company or pharmacy benefit manager referred to the attorney general by the center for health information and analysis under section 11 of chapter 12C to determine whether the pharmaceutical manufacturing company or pharmacy benefit manager engaged in unfair methods of competition or anticompetitive behavior in violation of chapter 93A or any other law and, if appropriate, take action under said chapter 93A or any other law to protect consumers in the health care market.

(d) The attorney general may intervene or otherwise participate in efforts by the commonwealth to obtain exemptions or waivers from certain federal laws regarding provider market conduct, including, from the federal Office of the Inspector General, a waiver or expansion of the safe harbors' provided for under 42 U.S.C. § 1320a-7b and obtaining from the federal Office of the Inspector General a waiver of or exemption from 42 U.S.C. § 1395nn subsections (a) to (e), inclusive.

(e) Nothing in this section shall limit the authority of the attorney general to protect consumers in the health care market under any other law.

SECTION 29. Section 1 of chapter 12C of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the definition of “Patient-centered medical home” the following 2 definitions:

“Pharmaceutical manufacturing company”, an entity engaged in the production, preparation, propagation, conversion or processing of prescription drugs, directly or indirectly, by extraction from substances of natural origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis or an entity engaged in the packaging,

repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that "Pharmaceutical manufacturing company" shall not include a wholesale drug distributor licensed under section 36B of chapter 112 or a retail pharmacist registered under section 39 of said chapter 112.

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

SECTION 30. Said section 1 of said chapter 12C, as so appearing, is hereby further amended by striking out the definition of "Quality measures" and inserting in place thereof the following 2 definitions:-

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

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

SECTION 31. Section 5 of said chapter 12C, as so appearing, is hereby amended by inserting after the word "payers", in line 11, the following words:- , pharmaceutical manufacturing companies, pharmacy benefit managers.

SECTION 32. Said section 5 of said chapter 12C, as so appearing, is hereby further amended by inserting after the word "organizations", in line 15, the following words:- , affected pharmaceutical manufacturing companies, affected pharmacy benefit managers.

SECTION 33. Section 7 of said chapter 12C, as so appearing, is hereby amended by adding the following paragraph:-

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

SECTION 34. Section 10 of said chapter 12C, as so appearing, is hereby amended by striking out subsection (e) and inserting in place thereof the following 2 subsections:-

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

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

SECTION 35. Said chapter 12C is hereby further amended by inserting after section 10 the following section:-

Section 10A. (a) The center shall promulgate regulations necessary to ensure the uniform analysis of information regarding pharmaceutical manufacturing companies and pharmacy benefit managers and that enable the center to analyze: (i) year-over-year wholesale acquisition cost changes; (ii) year-over-year trends in net expenditures; (iii) net expenditures on subsets of brand and generic pharmaceuticals identified by the center; (iv) research and development costs as a percentage of revenue, costs paid with public funds and costs paid by third parties, to the extent such costs are attributable to a specific product or set of products; (v) annual marketing and advertising costs, identifying costs for direct-to-consumer advertising; (vi) annual profits over the most recent 5-year period; (vii) information regarding trends of estimated aggregate drug rebates and other price reductions paid by a pharmaceutical manufacturing company in connection with utilization of all pharmaceutical drug products offered by the pharmaceutical manufacturing company; (viii) information regarding trends of estimated aggregate drug rebates and other price reductions paid by a pharmacy benefit manager in connection with utilization of all drugs offered through the pharmacy benefit manager; (ix) information regarding pharmacy benefit manager practices in passing drug rebates or other price reductions received by the pharmacy benefit manager to a private or public health care payer or to the consumer; (x) information regarding discount or free product vouchers that a retail pharmacy provides to a consumer in connection with a pharmacy service, item or prescription transfer offer or to any discount, rebate, product voucher or other reduction in an individual's out-of-pocket expenses, including co-payments and deductibles under section 3 of chapter 175H; (xi) cost disparities between prices charged to purchasers in the commonwealth and purchasers outside of the United States and (xii) any other information deemed necessary by the center.

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

drug products as identified by the center; (iii) the price paid by the manufacturer to acquire the prescription drug product if not developed by the manufacturer; (iv) the 5-year history of any increases in the wholesale acquisition costs; (v) annual marketing and advertising expenditures apportioned by activities directed to consumers and prescribers for prescription drug products as identified by the center; and (vi) a description, suitable for public release, of factors that contributed to reported changes in wholesale acquisition costs for prescription drug products as identified by the center.

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

SECTION 36. Said chapter 12C is hereby further amended by striking out section 11, as appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

Section 11. The center shall ensure the timely reporting of information required under sections 8, 9, 10 and 10A. The center shall notify payers, providers, provider organizations, pharmacy benefit managers and pharmaceutical manufacturing companies of any applicable reporting deadlines. The center shall notify, in writing, a private health care payer, provider, provider organization, pharmacy benefit manager or pharmaceutical manufacturing company that it has failed to meet a reporting deadline and that failure to respond within 2 weeks of the receipt of the notice shall result in penalties. The center shall assess a penalty against a private health care payer, provider, provider organization, pharmacy benefit manager or pharmaceutical manufacturing company that fails, without just cause, to provide the requested information within 2 weeks following receipt of the written notice required under this paragraph of up to $5,000 per week for each week of delay after the 2-week period following receipt of the written notice; provided, however, that the maximum annual penalty against a private health care payer, provider, provider organization, pharmacy benefit manager or pharmaceutical manufacturing company under this section shall be $200,000. Amounts collected under this section shall be deposited in the Healthcare Payment Reform Fund established in section 100 of chapter 194 of the acts of 2011.

The center shall notify the attorney general of any pharmaceutical manufacturing company or pharmacy benefit manager that fails to comply with this section for further action pursuant to section 11N of chapter 12 or any other law.

For the purposes of this section, the center may promulgate regulations to define “just cause”.

SECTION 37. Section 12 of said chapter 12C, as so appearing, is hereby amended by striking out, in line 2, the words “and 10” and inserting in place thereof the following words:- , 10 and 10A.

SECTION 38. Section 12 of said chapter 12C, as so appearing, is hereby amended by striking out, in lines 11 and 12, the words “the operation of the database or its functions” and inserting in place thereof the following words:- control of the database.

SECTION 39. Said chapter 12C is hereby further amended by striking out section 14, as so appearing, and inserting in place thereof the following section:-

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

SECTION 40. Said chapter 12C is hereby further amended by striking out section 15, as so appearing, and inserting in place thereof the following section:-

Section 15. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

“Adverse event”, harm to a patient resulting from a medical intervention and not the underlying condition of the patient.

“Agency”, any agency of the executive branch of government in the commonwealth, including but not limited to any constitutional or other office, executive office, department,

division, bureau, board, commission or committee thereof; or any authority created by the general court to serve a public purpose with either statewide or local jurisdiction.

"Board", the patient safety and medical errors reduction board.

"Healthcare-associated infection", an infection that a patient acquires during the course of receiving treatment for another condition within a healthcare setting.

"Lehman center", the Betsy Lehman center for patient safety and medical error reduction.

"Incident", an incident that, if left undetected or uncorrected, might have resulted in an adverse event.

"Medical error", the failure of medical management of a planned action to be completed as intended or the use of a wrong plan to achieve an outcome.

"Patient safety", freedom from accidental injury.

"Patient safety information", data and information related to patient safety, including adverse events, incidents, medical errors or healthcare-associated infections, that are collected or maintained by agencies.

(b) There shall be established within the center the Betsy Lehman center for patient safety and medical error reduction. The Lehman center shall serve as a clearinghouse for the development, evaluation and dissemination, including, but not limited to, the sponsorship of training and education programs, of best practices for patient safety and medical error reduction. The Lehman center shall: (i) coordinate the efforts of state agencies engaged in the regulation, contracting or delivery of health care and those individuals or institutions licensed by the commonwealth to provide health care to meet their responsibilities for patient safety and medical error reduction; (ii) assist such entities to work as part of a total system of patient safety; and (iii) develop appropriate mechanisms for consumers to be included in a statewide program for improving patient safety. The Lehman center shall coordinate state participation in any appropriate state or federal reports or data collection efforts relative to patient safety and medical error reduction. The Lehman center shall analyze available data, research and reports for information that would improve education and training programs that promote patient safety.

(c) Within the Lehman center, there shall be established a patient safety and medical errors reduction board. The board shall consist of the secretary of health and human services, the executive director of the center, the director of consumer affairs and business regulations and the attorney general. The board shall appoint, in consultation with the advisory committee, the director of the Lehman center by a unanimous vote and the director shall, under the general supervision of the board, have general oversight of the operation of the Lehman center. The director may appoint or retain and remove expert, clerical or other assistants as the work of the Lehman center may require. The coalition for the prevention of medical errors shall serve as the advisory committee to the board. The advisory committee shall, at the request of the director, provide advice and counsel as it considers appropriate including, but not limited to, serving as a resource for studies and projects undertaken or sponsored by the Lehman center. The advisory committee may also review and comment on regulations and standards proposed or promulgated by the Lehman center, but the review and comment shall be advisory in nature and shall not be considered binding on the Lehman center.

(d) The Lehman center shall develop and administer a patient safety and medical error reduction education and research program to assist health care professionals, health care facilities and agencies and the general public regarding issues related to the causes and consequences of medical error and practices and procedures to promote the highest standard for patient safety in the commonwealth. The Lehman center shall annually report to the governor and the general court relative to the feasibility of developing standards for patient safety and medical error reduction programs for any state department, agency, commission or board to reduce medical errors, and the statutory responsibilities of the commonwealth, for the protection of patients and consumers of health care together with recommendations to improve coordination and effectiveness of the programs and activities.

(e) The Lehman center shall: (i) identify and disseminate information about evidence-based best practices to reduce medical errors and enhance patient safety; (ii) develop a process for determining which evidence-based best practices should be considered for adoption; (iii) serve as a central clearinghouse for the collection and analysis of existing information on the causes of medical errors and strategies for prevention; and (iv) increase awareness of error prevention strategies through public and professional education. The information collected by the

Lehman center or reported to the Lehman center shall not be a public record as defined in section 7 of chapter 4, shall be confidential and shall not be subject to subpoena or discovery or introduced into evidence in any judicial or administrative proceeding, except as otherwise specifically provided by law.

(f) Notwithstanding any general or special law to the contrary, the Lehman center and each agency that collects or maintains patient safety information may transmit such information, including personal data, as defined in section 1 of chapter 66A, to each other through an agreement, which may be an interagency service agreement, that provides for any safeguards necessary to protect the privacy and security of the information; provided, however, that the provision of the information is consistent with federal law.

(g) The Lehman center may adopt rules and regulations necessary to carry out this section. The Lehman center may contract with any federal, state or municipal agency or other public institution or with any private individual, partnership, firm, corporation, association or other entity to manage its affairs or carry out this section.

(h) The Lehman center shall report annually to the general court regarding the progress made in improving patient safety and medical error reduction. The Lehman center shall seek federal and foundation support to supplement state resources to carry out the Lehman center's patient safety and medical error reduction goals.

SECTION 41. Subsection (a) of section 16 of said chapter 12C, as so appearing, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence:- The center shall publish an annual report based on the information submitted under sections 8, 9, 10 and 10A concerning health care provider, provider organization, private and public health care payer, pharmaceutical manufacturing company and pharmacy benefit manager costs and cost trends, under section 13 of chapter 6D relative to market power reviews and under section 15 relative to quality data.

SECTION 42. Said chapter 12C is hereby further amended by striking out section 17, as so appearing, and inserting in place thereof the following section:-

Section 17. The attorney general may review and analyze any information submitted to the center under sections 8, 9, 10 and 10A and the health policy commission under section 8 of chapter 6D. The attorney general may require that any provider, provider organization, pharmaceutical manufacturing company, pharmacy benefit manager or payer produce documents, answer interrogatories and provide testimony under oath related to health care costs and cost trends, pharmaceutical cost trends, factors that contribute to cost growth within the commonwealth's health care system and the relationship between provider costs and payer premium rates. The attorney general shall keep confidential all nonpublic information and documents obtained under this section and shall not disclose the information or documents to any person without the consent of the provider, pharmaceutical manufacturing company, pharmacy benefit manager or payer that produced the information or documents except in a public hearing under said section 8 of said chapter 6D, a rate hearing before the division of insurance or in a case brought by the attorney general, if the attorney general believes that such disclosure will promote the health care cost containment goals of the commonwealth and that the disclosure shall be made in the public interest after taking into account any privacy, trade secret or anticompetitive considerations. The confidential information and documents shall not be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

SECTION 43. Section 20 of said chapter 12C, as so appearing, is hereby amended by striking out, in lines 22 and 23, the words “as determined by the center” and inserting in place thereof the following words:- consistent with the recommendations of the taskforce pursuant to section 16AA of chapter 6A.

SECTION 44. Said chapter 12C is hereby further amended by inserting after section 20 the following section:-

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

SECTION 45. Said chapter 12C is hereby further amended by adding the following section:-

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

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

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

SECTION 46. Chapter 19 of the General Laws is hereby amended by inserting after section 19 the following section:-

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

urgent care services to the public or represents itself as providing behavioral health urgent care treatment; provided, however, that a "behavioral health urgent care facility" shall not be limited to a stand-alone facility.

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

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

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

(e) The department shall set fees for licensure.

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

SECTION 47. Subsection (d) of section 2GGGG of chapter 29 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by adding the following sentence:- Monies deposited into the fund under subsection (k) of section 10A of chapter 6D may be

expended to support innovative workforce initiatives, including labor management initiatives intended to reduce 30-day readmission rates.

SECTION 48. Said section 2GGGG of said chapter 29, as so appearing, is hereby further amended by inserting after the word “commission”, in line 66, the following words:- or developed by a health care trailblazer.

SECTION 49. Said chapter 29 is hereby further amended by inserting after section 2XXXX the following 3 sections:-

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

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

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

Section 2ZZZZ. (a) There shall be a Hospital Alignment and Review Trust Fund. The hospital alignment and review council established under section 2 of chapter 176W shall

administer the fund and may make expenditures from the fund to support hospitals that meet criteria established under subsection (c).

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

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

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

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

Section 2AAAAA. There shall be a Community Health Center Transformation Fund. The fund shall consist of: (i) revenue from appropriations or other money authorized by the general court and specifically designated to be credited to the fund; (ii) funds from private sources including, but not limited to, gifts, grants and donations received by the commonwealth that are specifically designated to be credited to the fund; and (iii) interest earned on money in the fund. Amounts credited to the fund shall be subject to further appropriation and any money remaining in the fund at the close of a fiscal year shall not revert to the General Fund. Money in the fund shall be provided to distressed community health centers, based on financial need.

SECTION 50. Chapter 32A of the General Laws is hereby amended by striking out section 3, as appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

Section 3. There shall be within the executive office for administration and finance, but not under its jurisdiction, a special unpaid commission to be known as the group insurance commission. The group insurance commission shall consist of: the secretary of administration and finance; the commissioner of insurance; and 13 members to be appointed by the governor, 1 of whom shall be a representative appointed from a list of 3 representatives who shall be nominated by the president of the Retired State, County & Municipal Employees Association of Massachusetts, 1 of whom shall be a health economist and at least 3 of whom shall be full-time state employees, 1 of whom shall be a member of the Massachusetts Public Employees Council #93, AFSCME, Massachusetts State Labor Council, AFL/CIO, to be appointed from a list of 3 representatives who shall be nominated by the executive director of the Massachusetts Public Employees Council #93, 1 of whom shall be a member of the Massachusetts State Employees Association, National Association of Government Employees, to be appointed from a list of 3 representatives who shall be nominated by the president of the National Association of Government Employees, 1 labor representative to be appointed by the governor from a list of 3 representatives who shall be nominated by the president of Local 5000 SEIU/Trial Court, 1 labor representative to be appointed by the governor from a list of 3 representatives who shall be nominated by the president of the Service Employees International Union, Local 509 and 1 labor representative to be appointed by the governor from a list of 3 representatives who shall be nominated by the president of the Massachusetts Organization of State Engineers and Scientists,

1 of whom shall be a management representative who shall be appointed from a list of 3 representatives nominated by the Massachusetts Municipal Association and 1 of whom shall be a labor representative who shall be appointed from a list of 3 representatives nominated by the president of the teachers' union with the greatest amount of active and retired members enrolled in commission health plans. In addition, upon the transfer of 45,000 subscribers from municipal governmental units to the group insurance commission pursuant to section 19 of chapter 32B, there shall be an additional management representative to be appointed by the governor from a list of 3 representatives who shall be nominated by the Massachusetts Municipal Association and an additional labor representative to be appointed by the governor who shall be selected from a list of 3 representatives of municipal public safety employees nominated by the president of the Massachusetts chapter of the AFL/CIO.

Whenever an organization nominates a list of representatives for appointment by the governor under this section, the organization may nominate additional candidates if the governor declines to appoint any of those originally nominated. Not more than 55 per cent of the appointed members of the commission shall be members of the same political party. No member appointed by the governor shall be an insurance agent, broker, employee or officer of an insurance company. Upon the expiration of the term of office of an appointed member, that member’s successor shall be appointed in the same manner for a term of 3 years. The commission shall be provided with suitable offices and may, subject to appropriation, incur expenses and appoint an executive director who shall be the executive and administrative head of the commission and who shall not be subject to chapter 31. The commission may authorize the executive director to appoint such employees as may be necessary to administer this chapter. There shall be paid by the commonwealth to each appointive member of the commission the necessary expenses actually incurred in the discharge of their official duties.

The commission shall adopt such reasonable rules and regulations as may be necessary for the administration of this chapter and shall make an annual report to the governor and to the general court which shall include any modifications or amendments made to contracts executed under this chapter. The commission shall hold at least 2 public hearings annually to receive comments and feedback from interested parties prior to a board vote related to any amendment to plan design, cost sharing, deductibles or other state employee cost. The rules and regulations

shall be in a form that enables employees to understand the benefits available from the insurance program, including the costs thereof.

SECTION 51. Section 4 of chapter 32A of the General Laws, as so appearing, is hereby amended by inserting after the word “commonwealth”, in line 12, the following words:- ; provided, however, that the carrier or third-party health care administrator website shall conform to the uniform methodology for a provider’s tier designation pursuant to section 20A of chapter 12C.

SECTION 52. Said chapter 32A is hereby further amended by inserting after section 4A the following section:-

Section 4B. (a) The commission or any entity with which the commission contracts to provide or manage health insurance benefits, including mental health services, shall not impose a retroactive claims denial, as defined in section 1 of chapter 175, for behavioral health services, as defined in said section 1 of said chapter 175, on a provider unless:

(i) less than 6 months have elapsed from the time of submission of the claim by the provider to the commission or other entity responsible for payment; or

(ii) the commission or other entity has furnished the provider with a written explanation of the reason for the retroactive claim denial and a description of additional documentation or other corrective actions required for payment of the claim.

(b) Notwithstanding clause (i) of subsection (a), a retroactive claim denial may be permitted after 6 months if:

(i) the claim was submitted fraudulently;

(ii) the claim payment is subject to adjustment due to expected payment from another payer and not more than 12 months have elapsed since submission of the claim; or

(iii) the claims or services for which the claim has been submitted is the subject of legal action.

(c) If a retroactive claim denial is imposed under clause (ii) of subsection (b), the commission or other entity shall notify a provider not less than 15 days before imposing the retroactive claim denial and the provider shall have 6 months to determine whether the claim is subject to payment by a secondary insurer. Notwithstanding the contractual terms between the provider and insurer, an insurer shall allow for submission of a claim that was previously denied by another insurer due to the insured's transfer or termination of coverage.

(d) For the purposes of this section, "provider" shall mean a mental health clinic or substance use disorder program licensed by the department of public health under chapter 18, 111, 111B or 111E , a behavioral, substance use disorder or mental health professional who is licensed under chapter 112 and accredited or certified to provide services consistent with law and who has provided services under an express or implied contract or with the expectation of receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly from the commission or other entity.

SECTION 53. Said chapter 32A is hereby further amended by adding the following 3 sections:-

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 54. Subsection (a) of section 6D of chapter 40J of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the third sentence the following sentence:- The institute shall partner with the health care and technology community to accelerate the creation and adoption of digital health to drive economic growth and improve health care outcomes and efficiency.

SECTION 55. Said section 6D of said chapter 40J, as so appearing, is hereby further amended by striking out, in lines 16 to 18, inclusive, the words "and (3) develop a plan to complete the implementation of electronic health records systems by all providers in the commonwealth" and inserting in place thereof the following words:- (3) develop a plan to complete the implementation of electronic health records systems by all providers in the

commonwealth; and (4) advance the commonwealth's economic competitiveness by supporting the digital health industry, including the digital health industry's role in improving the quality of health care delivery and patient outcomes.

SECTION 56. Said section 6D of said chapter 40J, as so appearing, is hereby further amended by adding the following subsection:-

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

SECTION 57. Subsection (b) of section 7B of chapter 64C of the General Laws, as so appearing, is hereby amended by adding the following paragraph:-

In addition to the excise imposed by the first paragraph, an excise shall be imposed on fruit-flavored or other nontobacco-flavored cigars and smoking tobacco at the rate of 170 per cent of the wholesale price of such products. The excise shall be imposed on cigar distributors at the time the fruit-flavored or other nontobacco-flavored cigars or smoking tobacco are manufactured, purchased, imported, received or acquired in the commonwealth. The excise shall not be imposed on any such cigars or smoking tobacco that: (i) are exported from the commonwealth; or (ii) are not subject to taxation by the commonwealth pursuant to any federal law. The excise imposed pursuant to this paragraph shall be deposited in the Prevention and Wellness Trust Fund established under section 2G of chapter 111.

SECTION 58. Chapter 93 of the General Laws is hereby amended by striking out section 73, as so appearing, and inserting in place thereof the following section:-

Section 73. No physician shall sell hearing aids or have a direct or indirect membership, employment, co-ownership or proprietary interest in or with a business which sells hearing aids to a person to whom such physician has provided services pursuant to section 72; provided, however, that this restriction shall not apply to an otolaryngologist or a nonprofit or charitable

organization, clinic, hospital or health care facility which sells hearing aids that are dispensed by a licensed audiologist or hearing instrument specialist.

An audiologist or otolaryngologist who sells a hearing aid to a person to whom that audiologist or otolaryngologist provided services pursuant to section 72 shall disclose to the prospective purchaser before the sale of the hearing aid the fees for the services provided pursuant to section 72 and the terms of the prospective sale of the hearing aid, including a written estimate of the total purchase price, including, but not limited to, the cost of the hearing aid, the earmold, any batteries or other accessories, and any service costs, and shall inform the prospective purchaser of his right to obtain a hearing aid from a different source.

No person, directly or indirectly, shall give or offer to give, permit or cause to be given money or anything of value to a physician, otolaryngologist or audiologist as an inducement to influence the recommendation of the purchase of a hearing aid. Nothing in this section shall prevent an audiologist, physician or otolaryngologist from suggesting a specific make and model of a hearing aid.

SECTION 59. Section 1 of chapter 94C of the General Laws is hereby amended by inserting after the definition for “Marihuana”, as amended by section 14 of chapter 55 of the acts of 2017, the following definition:-

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

SECTION 60. Said section 1 of said chapter 94C is hereby further amended by striking out, in line 308, as appearing in the 2016 Official Edition, the words “and 66B” and inserting in place thereof the following words:- , 66B and 66C.

SECTION 61. The definition of “Practitioner” in said section 1 of said chapter 94C, as so appearing, is hereby amended by adding the following 3 clauses:-

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

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

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

SECTION 62. Section 7 of said chapter 94C is hereby amended by inserting after the word “nurse”, in line 80, the second time it appears, as so appearing, the following words:- , a licensed dental therapist under the supervision of a practitioner for the purposes of administering analgesics, anti-inflammatories and antibiotics.

SECTION 63. Said section 7 of said chapter 94C is hereby further amended by inserting after the word “podiatrist”, in line 122, and in lines 125 and 126, each time it appears, as so appearing, the following words:- , nurse practitioner, nurse anesthetist, psychiatric nurse mental health clinical specialist.

SECTION 64. Subsection (g) of said section 7 of said chapter 94C, as so appearing, is hereby further amended by striking out the second paragraph.

SECTION 65. Said subsection (g) of said section 7 of said chapter 94C, as so appearing, is hereby further amended by striking out the last paragraph.

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

SECTION 67. Section 9 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “podiatrist”, in line 1, the following words:- , nurse practitioner, nurse anesthetist, psychiatric nurse mental health clinical specialist.

SECTION 68. Said section 9 of said chapter 94C, as so appearing, is hereby further amended by striking out, in line 2, the words “and 66B” and inserting in place thereof the following words:- , 66B and 66C.

SECTION 69. Said section 9 of said chapter 94C, as so appearing, is hereby further amended by striking out, in lines 3 to 5, inclusive, the words “, nurse practitioner and psychiatric nurse mental health clinical specialist as limited by subsection (g) of said section 7 and section 80E of said chapter 112”.

SECTION 70. Said section 9 of said chapter 94C, as so appearing, is hereby further amended by striking out, in lines 8 and 9, the words “, nurse anesthetist, as limited by subsection (g) of said section 7 and section 80H of said chapter 112”.

SECTION 71. Subsection (a) of said section 9 of said chapter 94C, as so appearing, is hereby amended by adding the following paragraph:-

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

SECTION 72. Said section 9 of said chapter 94C, as so appearing, is hereby further amended by inserting after the word “nurse-midwifery”, in line 32, the following words:- , advanced practice nursing.

SECTION 73. Said section 9 of said chapter 94C, as so appearing, is hereby further amended by inserting after the word “podiatrist”, in lines 72 and 80, each time it appears, the following word:- , optometrist.

SECTION 74. Subsection (c) of said section 9 of said chapter 94C, as so appearing, is hereby amended by adding the following paragraph:-

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

SECTION 75. Said section 9 of said chapter 94C, as so appearing, is hereby further amended by inserting after the word “practitioner”, in lines 100 and 107, each time it appears, the following words:- , nurse anesthetist, psychiatric nurse mental health clinical specialist.

SECTION 76. Section 18 of said chapter 94C is hereby amended by striking out, in lines 10, 39 and 72, as so appearing, the words “to practice medicine” and inserting in place thereof, in each instance, the following words:- and authorized to engage in prescriptive practice.

SECTION 77. Said section 18 of said chapter 94C, as so appearing, is hereby further amended by striking out the word “physician”, in lines 25, 38, 72 and 74, and inserting in place thereof, in each instance, the following word:- practitioner.

SECTION 78. Said section 18 of said chapter 94C, as so appearing, is hereby further amended by striking out, in lines 27, 54 and 55, and in line 88, the word “medicine”.

SECTION 79. Said chapter 94C is hereby further amended by inserting after section 21B the following section:-

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

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

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

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

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

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

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

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

SECTION 80. Section 24A of said chapter 94C, as appearing in the 2016 Official Edition, is hereby amended by striking out subsection (g) and inserting in place thereof the following subsection:-

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

information that is compatible and interoperative, to the maximum feasible extent, with existing electronic medical records systems.

SECTION 81. Chapter 111 of the General Laws is hereby amended by striking out sections 2G and 2H, as so appearing, and inserting in place thereof the following 2 sections:-

Section 2G. (a) There shall be a Prevention and Wellness Trust Fund to be expended, without further appropriation, by the department of public health. The fund shall consist of revenues collected by the commonwealth, including: (i) revenue from appropriations or other money authorized by the general court and specifically designated to be credited to the fund including, but not limited to, revenue received under the second paragraph of section 7B of chapter 64C; (ii) fines and penalties allocated to the fund; (iii) funds from public and private sources, including gifts, grants, donations and settlements received by the commonwealth to further community-based prevention activities; (iv) funds provided from any other source; and (v) interest earned on revenues in the fund . The commissioner of public health, as trustee, shall administer the fund. The commissioner, in consultation with the prevention and wellness advisory board established in section 2H, shall make expenditures from the fund consistent with subsections (d) and (e); provided, however, that not more than 5 per cent of the amounts held in the fund in any 1 year shall be used by the department for the cost of program administration and not more than 10 per cent of amounts held in the fund in any 1 year shall be used for technical assistance to grantees, program evaluation and data analytics.

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

(c) Expenditures from the fund shall support the commonwealth’s efforts to meet the health care cost growth benchmark established in section 9 of chapter 6D and at least 1 of the following: (i) increase access to community-based preventive services and interventions that complement and expand the ability of MassHealth to promote coordinated care, integrate community-based services with clinical care and develop innovative ways to address social

determinants of health; (ii) reduce the impact of health conditions that are the largest drivers of poor health, health disparities, reduced quality of life and high health care costs through community-based interventions; or (iii) develop a stronger evidence-base of effective prevention interventions.

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

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

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

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

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

(g) With the advice and guidance of the prevention and wellness advisory board, the department shall report annually on its strategy for the administration and allocation of the fund, including relevant evaluation criteria. The report shall set forth the rationale for the strategy, which may include, but shall not be limited to including: (i) a list of the most prevalent preventable health conditions in the commonwealth, including health disparities experienced by populations based on race, ethnicity, gender, disability status, sexual orientation or socioeconomic status; (ii) a list of the most costly preventable health conditions in the commonwealth; and (iii) a list of evidence-based or promising community-based programs

related to the conditions identified in clauses (i) and (ii). The report shall recommend specific areas of focus for the allocation of funds. If appropriate, the report shall reference goals and best practices established by the National Prevention, Health Promotion and Public Health Council and the Centers for Disease Control and Prevention including, but not limited to, the Health Impact in 5 Years initiative, the National Prevention Strategy, the Healthy People report and the Guide to Community Preventive Services.

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

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

(b) The board shall consist of: the commissioner of public health or a designee, who shall serve as chair; the senate and house chairs of the joint committee on public health or their designees; the senate and house chairs of the joint committee on health care financing or their designees; the secretary of health and human services or a designee; the executive director of the center for health information and analysis or a designee; the executive director of the health policy commission or a designee; and 16 persons to be appointed by the governor, 1 of whom shall be a person with expertise in the field of public health economics, 1 of whom shall be a person with expertise in public health research, 1 of whom shall be a person with expertise in the field of health equity, 1 of whom shall be a person from a local board of health for a city or town with a population of not less than 50,000, 1 of whom shall be a member of a board of health for a city or town with a population of less than 50,000, 2 of whom shall be representatives of health insurance carriers, 1 of whom shall be a person from a consumer health advocacy organization, 1 of whom shall be a person from a hospital association, 1 of whom shall be a person from an independent community hospital, 1 of whom shall be a person from a statewide public health organization, 1 of whom shall be a representative of business interests, 1 of whom shall be a public health nurse or a school nurse, 1 of whom shall be a person from an association representing community health workers, 1 of whom shall represent a statewide association of community-based service providers addressing public health and 1 of whom shall be a person with expertise in the design and implementation of communitywide public health interventions.

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

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

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

SECTION 82. Section 25N½ of said chapter 111is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) Pursuant to regulations to be promulgated by the health care workforce center, there shall be established a primary care and family medicine residency grant program to finance the training of primary care providers and family physicians at teaching community health centers. Eligible applicants shall include teaching community health centers accredited through affiliations with a commonwealth-funded medical school or licensed as part of a teaching hospital with a residency program in family medicine and teaching health centers that are the independently accredited sponsoring organization for the residency program and whose residents are employed by the health center. Eligible residency programs shall be accredited by the Accreditation Council for Graduate Medical Education.

To receive funding, an applicant shall: (i) include a review of recent graduates of the community health center's residency program, including information regarding what type of practice the graduates are involved in 2 years following graduation from the residency program; and (ii) achieve a threshold of not less than 95 per cent for the percentage of graduates practicing primary care within 2 years after graduation. Graduates practicing more than 50 per cent inpatient care or more than 50 per cent specialty care as listed in the American Medical Association Masterfile shall not qualify as graduates practicing primary care.

The health care workforce center shall require applicants to include the following information and give preference to those applicants whom meet at least 1 of the following criteria: (i) have a proven record of placing graduates in areas of unmet need; (ii) have a record or written plan of attracting and admitting underrepresented minorities or economically disadvantaged groups; or (iii) host their programs or clinical training sites in areas of unmet need.

Awardees of the primary care residency grant program shall offer a 3 to 4 year residency program and maintain their teaching accreditation as an independent teaching community health center or as a teaching community health center accredited through affiliation with a commonwealth-funded medical school or licensed as part of a teaching hospital. All resident trainees shall be assigned as the primary care provider of a continuity panel of patients and see

those patients in that location not less than 40 weeks per academic year for each of the years of the residency.

The health care workforce center shall determine through regulation grant amounts per full-time resident; provided, however, that grant amounts per resident are not less than 85 per cent of the average federal Centers for Medicare and Medicaid Services annual reimbursement rate per year and funding is provided for all of the 3 or 4 year residency. Funds for such grants shall come from the Health Care Workforce Transformation Fund established under section 2FFFF of chapter 29.

SECTION 83. Said chapter 111 is hereby further amended by inserting after section 51K the following 4 sections:-

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

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

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

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

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

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

(b) A hospital, health system or hospital-based facility shall not charge, bill or collect a facility fee for services utilizing a current procedural terminology evaluation and management code if the service was provided by a hospital-based facility located off of a campus unless the facility fee was charged, billed or collected by the hospital-based facility on or before July 1, 2017. A violation of this subsection shall be an unfair trade practice under chapter 93A.

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

Section 51M. The department shall designate a hospital as an acute stroke ready hospital, a primary stroke center or a comprehensive stroke center if: (i) the hospital has applied to the department for a designation; and (ii) the hospital has been certified by The Joint Commission, the American Heart Association or any other department-approved, nationally-recognized certifying body as an acute stroke ready hospital, primary stroke center or comprehensive stroke center.

Section 51N. The department and regional EMS councils, as defined in section 1 of chapter 111C, shall establish prehospital care protocols related to the assessment, treatment, transport and rerouting of stroke patients by licensed emergency medical services providers to acute stroke ready hospitals, primary stroke centers and comprehensive stroke centers. The protocols shall include plans for the triage and transport of suspected stroke patients including, but not limited to, those patients who may have an emergent large vessel occlusion, to an appropriate facility within a specified timeframe of onset of symptoms. The protocols shall include any additional criteria necessary to determine the level of care that is the most appropriate for a suspected stroke patient. The protocols shall be based on nationally-recognized guidelines for the transport of acute stroke patients. The protocols shall also consider the capability of an emergency receiving facility to improve outcomes for those patients suspected, based on clinical severity, of having an emergent large vessel occlusion. Each regional EMS

council shall establish a prehospital point of entry plan for stroke-related patients for their own respective region.

The department shall: (i) make available the list of designated stroke centers, including the identification of hospitals with continuous neurointerventional coverage, to the medical director of each licensed emergency medical services provider; (ii) maintain a copy of the list in the office designated within the department to oversee emergency medical services; and (iii) post a list of all designated stroke centers and the level of care to the department website. The department shall update the list of designated stroke centers at least annually.

Section 51O. The department shall establish and maintain a data oversight process to improve the quality of care for stroke patients. The process shall include a stroke registry database that compiles information and statistics on stroke care that align with nationally-recognized stroke measures.

A hospital designated by the department as an acute stroke ready hospital, a primary stroke center or a comprehensive stroke center shall utilize a nationally-recognized data platform to collect the stroke data set that shall be required by the department. The data elements shall be collected through the data registry platform and transmitted to the department for inclusion in the stroke registry.

The department shall convene a group of experts including, but not limited to, a representative from the American Stroke Association, a representative from The Massachusetts Neurologic Association, Inc., a representative from Society of Neurointerventional Surgery, a representative from Massachusetts Council of Community Hospitals, Inc., a representative from Massachusetts College of Emergency Physicians, Inc. and a representative of a regional EMS council, with input from key stroke stakeholders and professional societies, to form a stroke advisory taskforce that shall assist with data oversight, program management and advice regarding the stroke system of care. The task force shall meet not less than quarterly to review data and provide advice.

SECTION 84. Said chapter 111 is hereby further amended by inserting after section 53H the following section:-

Section 53I. (a) Notwithstanding any general or special law to the contrary, a health care provider shall not knowingly or intentionally violate department rules and regulations adopted under this chapter at the direct request of a patient, authorized caregiver or other interested person. A violation shall be documented and reported by the health care provider to the department within 72 hours. The department may impose penalties including, but not limited to, a fine of not more than $10,000 per violation or complaint to the relevant board of registration. A health care provider who fails to report a violation as so provided may be subject to an additional penalty of not more than $100,000 per violation.

(b) Notwithstanding any general or special law to the contrary, a health care provider shall not knowingly or intentionally designate, mark, label or confer any special status unrelated to medical diagnosis, treatment or care to a patient due to socio-economic status or direct relationship to the health care provider. The department may impose penalties including, but not limited to, a fine of not more than $10,000 per violation or complaint to the relevant board of registration.

(c) A penalty assessed under this section shall not preclude the department from assessing fees for violations under this chapter.

(d) A health care provider reporting a violation pursuant to this section shall be afforded protection from retaliatory action in accordance with section 187 of chapter 149.

(e) All violations under this section shall be published in a clear and conspicuous manner on the department’s website.

(f) The commissioner may promulgate regulations to enforce this section.

SECTION 85. Said chapter 111 is hereby further amended by striking out section 228, as appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

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

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

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

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

SECTION 86. Said chapter 111 is hereby further amended by inserting after section 237 the following section:-

Section 238. (a) For purposes of this section, the following terms shall have the following meanings:

"Allied health professional", a person who holds and maintains a registration, certification or license to perform health care services by a state or a nationally accredited credentialing organization.

"Central service technician", any person who decontaminates, inspects, assembles, packages and sterilizes reusable medical instruments or devices in a health care facility.

"Health care practitioner", any person licensed or registered under chapter 111 or 112, including any intern, resident, fellow or medical officer, who conducts or assists with the performance of surgery.

"Health care facility", any "hospital" or any "rural hospital", as defined in section 52 of chapter 111, or surgical services that are provided in a free standing ambulatory surgery center, whether inpatient or outpatient, conducted for charity or for profit and whether or not subject to section 25C or any other facility employing or using the services of at least 1 central service technician.

(b) A health care facility shall not employ or otherwise retain the services of a central service technician unless the person:

(i) Has successfully passed a nationally accredited central service exam for central service technicians and holds and maintains a following credential administered by a nationally accredited central service technician credentialing organization: (i) the certified registered central service technician credential; (ii) the certified sterile processing and distribution technician credential; or (iii) a substantially equivalent credential; or

(ii) Provides evidence that the person was employed as a central service technician in a health care facility not later than December 31, 2017.

(c) A central service technician who does not meet the requirements of clause (ii) of subsection (b) shall have 18 months from the date of hire to obtain the certified registered central service technician credential or the certified sterile processing and distribution technician credential.

(d) A person who qualifies to function as a central service technician in a health care facility under clauses (i) and (ii) of subsection (b) shall annually complete 10 hours of continuing education credits to remain qualified to function as a central service technician. The continuing education required under this subsection shall be in area related to the functions of a central service technician.

(e) This section shall not prohibit the following persons from performing the tasks or functions of a central service technicians:

(i) A health care practitioner;

(ii) An allied health professional; and

(iii) A student or intern performing the functions of a central service technician under the direct supervision of a health care practitioner as part of the student’s or intern’s training or internship.

(f) A health care facility shall, upon the written request of a central service technician, verify, in writing, the central service technician's dates of employment or the contract period during which the central service technician provided services to the health care facility.

(g) The commissioner may adopt regulations necessary to carry out this section.

SECTION 87. Chapter 111C of the General Laws is hereby amended by striking out section 25, as appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

Section 25. (a) When a class I, II or V ambulance transports a patient receiving care at the paramedic level of advanced life support, the ambulance shall be staffed in accordance with regulations promulgated by the department; provided, however, that there shall be not less than 2 emergency medical technicians, at least 1 of whom shall be certified at the EMT-Paramedic level.

(b) When a class I, II or V ambulance transports a patient receiving care at the non-paramedic level of basic life support, the ambulance shall be staffed in accordance with

regulations promulgated by the department; provided, however, that there shall be not less than 2 emergency medical technicians.

(c)(1) For the purposes of this subsection, the following words shall have the following meanings:

"First responder", a police officer, a firefighter or an emergency reserve of a volunteer fire department or fire protection district who has been authorized and deemed qualified to staff an ambulance by the rural volunteer ambulance service's affiliate hospital medical director pursuant to the rural volunteer ambulance service's affiliation agreement and the department's regulations; provided, however, that "first responder" shall not include a police officer, firefighter or person engaged in police and fire work whose duties are primarily clerical or administrative.

"Rural volunteer ambulance service", a not-for-profit primary ambulance service staffed by volunteers operating in a service zone with a population density of less than 500 residents per square mile as designated in a department-approved service zone plan.

(2) Notwithstanding subsection (b), when a class I, II or V ambulance operated by a rural volunteer ambulance service transports a patient receiving care at the nonparamedic level of basic life support, the ambulance may be staffed in accordance with regulations promulgated by the department; provided, however, that there shall be at least 1 emergency medical technician and 1 first responder.

SECTION 88. Section 1 of chapter 111O of the General Laws, as so appearing, is hereby amended by inserting after the definition of "Mobile integrated health care" the following definition:-

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

departments; provided further, that medical care and services shall be delivered under a mobile integrated health care program approved by the department using mobile health care resources.

SECTION 89. Section 2 of said chapter 111O, as so appearing, is hereby amended by adding the following 2 subsections:-

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

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

SECTION 90. Said chapter 111O is hereby further amended by adding the following 2 sections:-

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

Section 6. (a) The department shall allow applicants for MIH programs and Community EMS programs and approved MIH and Community EMS programs to seek a waiver from transporting a patient to the closest appropriate health care facility as required by the department; provided, that any such program that obtains a waiver shall have a point-of-entry plan that fits the design and purpose of the program seeking the waiver; provided further, that the department shall only approve a waiver if it demonstrates a point-of-entry plan that provides flexibility on

the basis of the medical direction associated with a patient and does not include an explicit requirement that a patient be transported only to a health care facility owned or operated by, or affiliated with, an MIH program or Community EMS program.

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

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

SECTION 91. Section 2 of chapter 112 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by adding the following 3 paragraphs:-

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

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

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

SECTION 92. Said chapter 112 is hereby further amended by striking out section 13, as so appearing, and inserting in place thereof the following section:-

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

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

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

SECTION 93. Section 43A of said chapter 112, as so appearing, is hereby amended by inserting after the definition of “Appropriate supervision” the following 2 definitions:-

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

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

SECTION 94. Said section 43A of said chapter 112, as so appearing, is hereby further amended by inserting after the definition of “Dental supervision” the following definition:-

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

SECTION 95. Said section 43A of said chapter 112, as so appearing, is hereby further amended by adding the following definition:-

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

SECTION 96. Said chapter 112 is hereby further amended by inserting after section 51A the following section:-

Section 51B. (a) A person of good moral character shall be registered as a dental therapist and given a certificate allowing the therapist to practice in this capacity if the person: (i) has completed a dental therapist education program that meets the standards of the Commission on Dental Accreditation, has graduated from a dental therapist education program that meets the standards of the Commission on Dental Accreditation provided by a post-secondary institution accredited by the New England Association of Schools and Colleges, Inc. or is certified by the federal Indian Health Service pursuant to the Indian Health Care Improvement Act, 25 U.S.C. 1601 et seq.; (ii) passes a comprehensive, competency-based clinical examination that is approved by the board of registration in dentistry and administered independently of an institution providing registered dental therapy education; and (iii) maintains a policy of professional liability insurance and shows proof of the insurance as required by applicable regulations. A dental therapist shall also be registered as a dental hygienist and possess a certificate to practice dental hygiene pursuant to section 51. A dental therapist shall have practiced under the direct supervision of a supervising dentist for not less than 500 hours or shall have completed 1 year of residency before practicing under general supervision.

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

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

agreement and the supervising dentist is available for consultation and supervision by telephone or other means of communication.

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

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

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

A dental therapist shall, in accordance with the collaborative management agreement, refer patients to another qualified dental or health care professional to receive needed services that exceed the scope of practice of the dental therapist. The collaborating dentist shall ensure that a dentist is available to the dental therapist for timely consultation during treatment if needed

and shall either provide or arrange with another dentist or specialist to provide the necessary treatment to a patient who requires more treatment than the dental therapist is authorized to provide.

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

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

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

SECTION 97. Said chapter 112 is hereby further amended by striking out section 66, as appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

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

SECTION 98. Section 66B of said chapter 112, as so appearing, is hereby amended by striking out, in line 31, the following words:- , except glaucoma.

SECTION 99. Said chapter 112 is hereby further amended by inserting after section 66B the following section:-

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

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

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

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

SECTION 100. Said chapter 112 is hereby further amended by inserting after section 68B the following section:-

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

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

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

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

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

SECTION 101. Section 80B of said chapter 112, as appearing in the 2016 Official Edition, is hereby amended by inserting after the word "practitioners", in line 12, the following words:- , nurse anesthetists.

SECTION 102. Said section 80B of said chapter 112, as so appearing, is hereby further amended by striking out the seventh paragraph and inserting in place thereof the following paragraph:-

The board shall promulgate advanced practice nursing regulations which govern the provision of advanced practice nursing services and related care including, but not limited to, the

ordering and interpreting of tests, the ordering and evaluation of treatment and the use of therapeutics.

SECTION 103. Said section 80B of said chapter 112, as so appearing, is hereby further amended by striking out, in lines 64 and 65, the words “in the ordering of tests, therapeutics and the prescribing of medications, to” and inserting in place thereof the following word:- to.

SECTION 104. Said chapter 112 is hereby further amended by striking out section 80E, as so appearing, and inserting in place thereof the following section:-

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

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

The board may allow a nurse practitioner or psychiatric nurse mental health clinical specialist to exercise such independent practice authority upon satisfactory demonstration of not less than 2 years of alternative professional experience; provided, however, that the board determines that the nurse practitioner or psychiatric nurse mental health clinical specialist has a

demonstrated record of safe prescribing and good conduct consistent with professional licensure obligations required by each jurisdiction in which the nurse practitioner or psychiatric nurse mental health clinical specialist has been licensed.

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

SECTION 105. Said chapter 112 is hereby further amended by striking out section 80H, as so appearing, and inserting in place thereof the following section:-

Section 80H. (a) A nurse anesthetist may issue written prescriptions and medication orders and order tests and therapeutics pursuant to guidelines mutually developed and agreed upon by the nurse and either a supervising nurse anesthetist with independent practice authority or a supervising physician, in accordance with regulations promulgated by the board; provided, however, that supervision under this section by a nurse anesthetist with independent practice authority or by a physician shall be limited to written prescriptions and medication orders and the ordering of tests and therapeutics. A prescription issued by a nurse anesthetist under this subsection shall include the name of the nurse anesthetist with independent practice authority or the supervising physician with whom the nurse anesthetist developed and signed mutually agreed upon guidelines. Nothing in this section shall require a nurse anesthetist to obtain prescriptive authority to deliver anesthesia care, including the proper administration of the drugs or medicine necessary for the delivery of anesthesia care.

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

The board, in its discretion, may allow a nurse anesthetist to exercise such independent practice authority upon satisfactory demonstration of alternative professional experience if the board determines that the nurse anesthetist has a demonstrated record of safe prescribing and

good conduct consistent with professional licensure obligations required by each jurisdiction in which the nurse anesthetist has been licensed.

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

SECTION 106. Section 80I of said chapter 112, as so appearing, is hereby amended by striking out the second and third sentences.

SECTION 107. Said chapter 112 is hereby further amended by inserting after section 80I the following 2 sections:-

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

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

SECTION 108. Section 197 of said chapter 112, as appearing in the 2016 Official Edition, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

(a) Beginning July 1, 2000, a person shall not identify, present or otherwise portray himself as a hearing instrument specialist or practice hearing aid dispensing in the commonwealth unless he is licensed by the board or is an audiologist in the commonwealth, whichever registration is appropriate to the training of the individual; provided, however, that this section shall not apply to: (i) persons who only repair or manufacture hearing aids, their

accessories or both; or (ii) persons who engage in the sale of assisted listening devices or systems but not in the dispensing of hearing aids. Nothing in sections 197 to 200 shall be construed to prevent an audiologist or hearing instrument specialist from dispensing or selling hearing aids when employed by or affiliated with an otolaryngologist.

SECTION 109. Section 28 of chapter 118E of the General Laws, as so appearing, is hereby amended by adding the following paragraph:-

A transfer of resources to a special needs trust that conforms to 42 U.S.C 1396p(d)(4)(C) established solely for the benefit of a disabled individual of any age shall not be treated as a disposal of resources for less than fair market value.

SECTION 110. Said chapter 118E is hereby further amended by inserting after section 38 the following section:-

Section 38A. (a) The division or any entity with which the division contracts to provide or manage health insurance benefits, including mental health services, shall not impose a retroactive claims denial, as defined in section 1 of chapter 175, for behavioral health services, as defined in said section 1 of said chapter 175, on a provider unless:

(i) Less than 6 months have elapsed from the time of submission of the claim by the provider to the division or other entity responsible for payment; or

(ii) The division or other entity has furnished the provider with a written explanation of the reason for the retroactive claim denial and a description of additional documentation or other corrective actions required for payment of the claim.

(b) Notwithstanding clause (i) of subsection (a), a retroactive claim denial may be permitted after 6 months if:

(i) The claim was submitted fraudulently;

(ii) The claim payment is subject to adjustment due to expected payment from another payer and not more than 12 months have elapsed since submission of the claim; or

(iii) The claims or services for which the claim has been submitted is the subject of legal action.

(c) If a retroactive claim denial is imposed under clause (ii) of subsection (b), the division or other entity shall notify a provider not less than 15 days before imposing the retroactive claim denial and the provider shall have 6 months to determine whether the claim is subject to payment by a secondary insurer. Notwithstanding the contractual terms between the provider and insurer, an insurer shall allow for submission of a claim that was previously denied by another insurer due to the insured's transfer or termination of coverage.

(d) For the purposes of this section, "provider" shall mean a mental health clinic or substance use disorder program licensed by the department of public health under chapter 18, 111, 111B or 111E, a behavioral, substance use disorder or mental health professional who is licensed under chapter 112 and accredited or certified to provide services consistent with law and who has provided services under an express or implied contract or with the expectation of receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly from the division or managed care entity.

SECTION 111. Section 66 of said chapter 118E, as appearing in the 2016 Official Edition, is hereby amended by striking out, in line 28, the first time it appears, the word "and".

SECTION 112. Said section 66 of said chapter 118E, as so appearing, is hereby further amended by inserting after the word "thereon", in line 29, the following words:- ; and (v) any fines collected under section 10 of chapter 6D.

SECTION 113. Said chapter 118E is hereby further amended by adding the following 4 sections:-

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

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

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

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

(b) Information reported under subsection (a) that identifies an individual employee by name or health insurance status or that is protected health information shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66. Reported information may be exchanged among the executive office of health and human services, the commonwealth health insurance connector authority, the department of unemployment assistance, the center for health information and analysis and the department of revenue if

necessary to implement this section or section 24 of chapter 12C. An employer who knowingly falsifies or fails to file any information required by this section or by any regulation issued pursuant to this section shall be subject to a fine of not less than $1,000 not more than $5,000 for each violation.

Section 80. (a) For the purposes of this section, “telemedicine” shall mean the use of interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a patient’s physical, oral or mental health; provided, however, that “telemedicine” shall not include audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

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

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

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

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

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

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

SECTION 114. Section 1 of chapter 175 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out the definition of "commissioner" and inserting in place thereof the following 2 definitions:-

"Behavioral health", mental health and substance use disorder prevention, recovery and treatment services including, but not limited to, inpatient 24-hour levels of care, 24-hour and non-24-hour diversionary levels of care, intermediate levels of care and outpatient services.

"Commissioner", the commissioner of insurance.

SECTION 115. Said section 1 of said chapter 175, as so appearing, is hereby further amended by inserting after the definition of "Resident" the following definition:-

"Retroactive claim denial", an action by: (i) an insurer; (ii) an entity with which the insurer subcontracts to manage behavioral health services; (iii) an entity with which the group

insurance commission has entered into an administrative services contract or a contract to manage behavioral health services; or (iv) the executive office of health and human services acting as the singe state agency under section 1902(a)(5) of the federal Social Security Act authorized to administer programs under Title XIX, to deny a previously paid claim for services and to require repayment of the claim, impose a reduction in other payments or otherwise withhold or affect future payments owed a provider in order to recoup payment for the denied claim.

SECTION 116. Section 47BB of said chapter 175 is hereby repealed.

SECTION 117. Said chapter 175 is hereby further amended by inserting after section 47BB the following section:-

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

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

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

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

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

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

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

SECTION 118. Section 108 of said chapter 175, as appearing in the 2016 Official Edition, is hereby amended by adding the following subsection: -

14. (a) An insurer shall not impose a retroactive claims denial, as defined in section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on a provider unless:

(i) Less than 6 months have elapsed from the time of submission of the claim by the provider to the insurer or other entity responsible for payment; or

(ii) The insurer or other entity has furnished the provider with a written explanation of the reason for the retroactive claim denial and a description of additional documentation or other corrective actions required for payment of the claim.

(b) Notwithstanding clause (i) of paragraph (a), a retroactive claim denial may be permitted after 6 months if:

(i) The claim was submitted fraudulently;

(ii) The claim payment is subject to adjustment due to expected payment from another payer and not more than 12 months have elapsed since submission of the claim; or

(iii) The claim or services for which the claim has been submitted is the subject of legal action.

(c) If a retroactive claim denial is imposed under clause (ii) of paragraph (b), the insurer shall notify a provider not less than 15 days before imposing the retroactive claim denial and the provider shall have 6 months to determine whether the claim is subject to payment by a secondary insurer. Notwithstanding the contractual terms between the provider and insurer, an insurer shall allow for submission of a claim that was previously denied by another insurer due to the insured's transfer or termination of coverage.

(d) For the purposes of this section, "provider" shall mean a mental health clinic or substance use disorder program licensed by the department of public health under chapter 18, 111, 111B or 111E, a behavioral, substance use disorder, or mental health professional who is licensed under chapter 112 and accredited or certified to provide services consistent with law and who has provided services under an express or implied contract or with the expectation of receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly from an insurer.

SECTION 119. Said chapter 175 is hereby further amended by inserting after section 108M the following 2 sections:-

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

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

SECTION 120. Subdivision (P) of section 110 of said chapter 175, as appearing in the 2016 Official Edition, is hereby amended by inserting after the word “age”, in line 463, the following words:- or without regard to age, so long as the dependent is mentally or physically incapable of earning their own living due to disability.

SECTION 121. Chapter 176A of the General Laws is hereby amended by inserting after section 8½ the following section:-

Section 8¾. (a) A corporation shall not impose a retroactive claims denial, as defined in section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on a provider unless:

(i) Less than 6 months have elapsed from the time of submission of the claim by the provider to the corporation; or

(ii) The corporation has furnished the provider with a written explanation of the reason for the retroactive claim denial and a description of additional documentation or other corrective actions required for payment of the claim.

(b) Notwithstanding clause (i) of subsection (a), a retroactive claim denial may be permitted after 6 months if:

(i) The claim was submitted fraudulently;

(ii) The claim payment is subject to adjustment due to expected payment from another payer and not more than 12 months have elapsed since submission of the claim; or

(iii) The claims, or services for which the claim has been submitted, is the subject of legal action.

(c) If a retroactive claim denial is imposed under clause (ii) of subsection (b), the corporation shall notify a provider not less than 15 days before imposing the retroactive claim denial and the provider shall have 6 months to determine whether the claim is subject to payment by a secondary payer. Notwithstanding the contractual terms between the provider and secondary payer, the payer shall allow for submission of a claim that was previously denied by the corporation due to the insured's transfer or termination of coverage.

(d) For the purposes of this section, "provider" shall mean a mental health clinic or substance use disorder program licensed by the department of public health under chapter 18, 111, 111B or 111E or a behavioral, substance use disorder or mental health professional who is licensed under chapter 112 and accredited or certified to provide services consistent with law and who has provided services under an express or implied contract or with the expectation of receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly from an insurer.

SECTION 122. Said chapter 176A is hereby further amended by adding the following 3 sections:-

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

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

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

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

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

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

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

(e) Health care services provided by telemedicine shall conform to the standards of care applicable to the telemedicine provider’s profession. Such services shall also conform to

applicable federal and state health information privacy and security standards as well as standards for informed consent.

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

SECTION 123. Chapter 176B of the General Laws is hereby amended by inserting after section 7C the following section:-

Section 7D. (a) A corporation shall not impose a retroactive claims denial, as defined in section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on a provider unless:

(i) Less than 6 months have elapsed from the time of submission of the claim by the provider to the corporation; or

(ii) The corporation has furnished the provider with a written explanation of the reason for the retroactive claim denial and a description of additional documentation or other corrective actions required for payment of the claim.

(b) Notwithstanding clauses (i) of subsection (a), retroactive claim denials may be permitted after 6 months if:

(i) The claim was submitted fraudulently;

(ii) The claim payment is subject to adjustment due to expected payment from another payer and not more than 12 months have elapsed since submission of the claim; or

(iii) The claims or services for which the claim has been submitted is the subject of legal action.

(c) If a retroactive claim denial is imposed under clause (ii) of subsection (b), the corporation shall notify a provider not less than 15 days before imposing the retroactive claim denial and the provider shall have 6 months to determine whether the claim is subject to payment by a secondary payer. Notwithstanding the contractual terms between the provider and secondary payer, the payer shall allow for submission of a claim that was previously denied by the corporation due to the insured's transfer or termination of coverage.

(d) For the purposes of this section, "provider" shall mean a mental health clinic or substance use disorder program licensed by the department of public health under chapter 18, 111, 111B or 111E or a behavioral, substance use disorder or mental health professional who is licensed under chapter 112 and accredited or certified to provide services consistent with law and who has provided services under an express or implied contract or with the expectation of receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly from an insurer.

SECTION 124. Said chapter 176B is hereby further amended by adding the following 3 sections:-

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

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

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

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

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

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

Section 27. A nonprofit medical service corporation organized under this chapter shall use the standard quality measure set established by the secretary of health and human services

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

SECTION 125. Section 4T of chapter 176G of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the word “age”, in line 6, the following words:- or without regard to age, so long as the dependent is mentally or physically incapable of earning their own living due to disability.

SECTION 126. Said chapter 176G is hereby further amended by inserting after section 6A the following section:-

Section 6B. (a) An insurer shall not impose a retroactive claims denial, as defined in section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on a provider unless:

(i) Less than 6 months have elapsed from the time of submission of the claim by the provider to the insurer or other entity responsible for payment; or

(ii) The insurer or other entity has furnished the provider with a written explanation of the reason for the retroactive claim denial and a description of additional documentation or other corrective actions required for payment of the claim.

(b) Notwithstanding clauses (i) of subsection (a), retroactive claim denials may be permitted after 6 months if:

(i) The claim was submitted fraudulently;

(ii) The claim payment is subject to adjustment due to expected payment from another payer and not more than 12 months have elapsed since submission of the claim; or

(iii) The claims or services for which the claim has been submitted is the subject of legal action.

(c) If a retroactive claim denial is imposed under clause (ii) of subsection (b), the insurer shall notify a provider at least 15 days before imposing the retroactive claim denial and the provider shall have six months to determine whether the claim is subject to payment by a secondary insurer. Notwithstanding the contractual terms between the provider and insurer, an insurer shall allow for submission of a claim that was previously denied by another insurer due to the insured's transfer or termination of coverage.

(d) For the purposes of this section, "provider" shall mean a mental health clinic or substance use disorder program licensed by the department of public health under chapter 18, 111, 111B or 111E or a behavioral, substance use disorder or mental health professional who is licensed under chapter 112 and accredited or certified to provide services consistent with law and who has provided services under an express or implied contract or with the expectation of receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly from an insurer.

SECTION 127. Said chapter 176G is hereby further amended by adding the following 3 sections:-

Section 33. Upon request by a network provider, a health maintenance organization and, if applicable, a specialty organization subcontracted by a health maintenance organization to manage behavioral health services, shall disclose the methodology used for a provider's tier placement, including: (i) the criteria, measures, data sources and provider-specific information used in determining the provider's quality score; (ii) how the provider's quality performance compares to other in-network providers; and (iii) the data used in calculating the provider's cost-efficiency. A carrier may require a network provider to hold information received under this section confidential.

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

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

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

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

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

Section 35. A health maintenance organization organized under this chapter shall use the standard quality measure set established by the secretary of health and human services pursuant

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

SECTION 128. Chapter 176I of the General Laws is hereby amended by adding the following 2 sections:-

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

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

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

A preferred provider contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care

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

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

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

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

SECTION 129. Section 1 of chapter 176J of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the word " age", in line 86, the following words:- or without regard to age, so long as the dependent is mentally or physically incapable of earning their own living due to disability.

SECTION 130. Said chapter 176J is hereby further amended by striking out section 11, as so appearing, and inserting in place thereof the following section:-

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

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

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

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

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

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

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

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

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

(vi) a plan compatible with a health savings account authorized under federal law, a health plan design in which enrollees are directly incentivized to shop for low-cost, high-quality participating providers for comparable health care services; provided, that incentives may include, but shall not be limited to, cash payments, gift cards or credits or reductions of premiums, copayments or deductibles.

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 131. Said chapter 176J is hereby further amended by adding the following section:-

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

SECTION 132. Section 1 of chapter 176O of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the definition of “Incentive plan” the following definition:-

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

SECTION 133. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of “Network” the following 3 definitions:-

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

“Noncontracted commercial rate for nonemergency services”, the amount set pursuant to section 16A of chapter 6D and used to determine the rate of payment to a health care provider for

the provision of nonemergency health care services to an insured when the health care provider is not in the carrier’s network.

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

SECTION 134. Clause (a) of section 7 of said chapter 176O, as so appearing, is hereby amended by striking out clause (1) and inserting in place thereof the following clause:-

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

SECTION 135. Section 9A of said chapter 176O, as so appearing, is hereby amended by inserting after the word “approval”, in line 15, the following words:- unless the provider is included in a tier for a set of shoppable health care services pursuant to clause (iv) of subsection (b) of section 11 of chapter 176J.

SECTION 136. Section 23 of said chapter 176O, as so appearing, is hereby amended by inserting after the word “time”, in line 3, the following words:- , the network status of an identified health care provider.

SECTION 137. Said section 23 of said chapter 176O, as so appearing, is hereby further amended by adding the following sentence:- The information provided on the website shall conform to the uniform methodology for a provider's tier designation developed pursuant to section 20A of chapter 12C.

SECTION 138. Said chapter 176O is hereby further amended by adding the following 3 sections:-

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

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

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

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

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

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

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

(c) If a hospital or health system is required to provide a patient with notice under subsection (b) and a patient's appointment is scheduled to occur not less than 10 days after the appointment is made, the hospital or health system shall provide written notice and explanation

to the patient by first class mail, encrypted electronic means or a secure patient Internet portal not less than 3 days after the appointment is made. If an appointment is scheduled to occur less than 10 days after the appointment is made or if the patient arrives without an appointment, the notice shall be provided to the patient on the hospital-based facility's premises.

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

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

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

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

(2) If a hospital or health system designates a location as a hospital-based facility, the hospital or health system shall not collect a facility fee for a service provided at the now

designated hospital-based facility until not less than 30 days after the written notice required in paragraph (1) is mailed.

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

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

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

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

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

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

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

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

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

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

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

(2) It shall be an unfair and deceptive act or practice, in violation of section 2 of chapter 93A, for any health care provider or carrier to request payment from an enrollee, other

than the applicable coinsurance, copayment, deductible or other out-of-pocket expense, for the services described in paragraph (1).

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

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

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

SECTION 139. Chapter 176Q of the General Laws is hereby amended by striking out section 7A, as appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

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

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

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

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

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

SECTION 140. The General Laws are hereby amended by inserting after chapter 176V the following chapter:-

CHAPTER 176W.

HOSPITAL ALIGNMENT AND REVIEW COUNCIL.

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

“Carrier”, an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175, a nonprofit hospital service corporation organized under chapter 176A, a nonprofit medical service corporation organized under chapter 176B, a health maintenance organization organized under chapter 176G and an organization entering into a preferred provider arrangement under chapter 176I; provided, however, that “carrier” shall not include an employer purchasing coverage or acting on behalf of its employees or the employees of any subsidiary or affiliated corporation of the employer; provided further, that unless

specifically stated otherwise, “carrier” shall not include an entity that offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services.

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

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

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

“Division”, the division of insurance.

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

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

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

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

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

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

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

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

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

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

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

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

Section 3. (a) The council shall review the progress of carriers and hospitals towards demonstrating: (i) the target hospital rate distribution; and (ii) growth in hospital spending that does not exceed target growth in hospital spending. When conducting its review, the council shall ensure that the target hospital rate distribution and growth in hospital spending support the goals of the cost growth benchmark established in section 9 of chapter 6D and do not directly contribute to increased consumer health care costs.

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

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

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

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

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

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

(ii) assess a penalty on not less than the top 3 hospitals that contributed to hospital spending that equals in its aggregate the difference between the growth in hospital spending and the target growth in hospital spending; provided, however, that each hospital shall be responsible for a proportionate share of the penalty commensurate to its share of commercial hospital spending; provided, however, that the council may reduce the overall amount to be assessed to the identified hospitals in the aggregate or on a specific hospital basis based on the degree to which actual hospital spending that exceeded target commercial growth is predominantly attributable to hospitals that have not been identified to be assessed.

(c) In any year that the council determines that carriers and hospitals have not demonstrated the target hospital rate distribution or growth in hospital spending that does not exceed target growth in hospital spending, the council may define "target hospital rate distribution" and "target growth in hospital spending"; provided, however, that the council shall solicit input from the advisory committee, receive testimony and solicit public input and review the definition every 3 years. The council shall submit proposed definitions to the clerks of the senate and house of representatives, the joint committee on health care financing and the senate and house committees on ways and means not less than 4 months prior to their effective date. In making the definition determination, the council shall ensure that a proposed definition does not negatively impact the goals of the cost growth benchmark established in section 9 of chapter 6D and the cost of health insurance premiums.

The joint committee on health care financing may, not later than 30 days after the submission of the proposed definitions with the clerks of the senate and house of representatives, the joint committee on health care financing and the senate and house committees on ways and means, hold a public hearing on the proposed definitions. The joint committee may report its findings to the general court, together with drafts of legislation necessary to implement those findings. In the report, the joint committee may include its recommendation on whether to affirm or modify the proposed definitions. The joint committee shall issue any findings not later than 20 days after the public hearing and shall provide a copy of the findings and any proposed legislation to the board. If the general court does not enact legislation with respect to the recommendations within 65 days after the commission has submitted the recommendations to the joint committee, the proposed definitions shall be in effect until the definitions proposed take effect.

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

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

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

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

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

SECTION 141. Section 79L of chapter 233 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the word “dentist”, in line 12, the following words:- , dental therapist.

SECTION 142. Section 429 of chapter 159 of the acts of 2000 is hereby repealed.

SECTION 143. Chapter 224 of the acts of 2012 is hereby amended by inserting after section 254 the following section:-

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

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

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

"Child" a person under the age of 26.

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

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

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

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

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

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

family; (ii) the development of a treatment plan; and (iii) using established psychotherapeutic techniques, working with the family or a subset of the family to enhance problem-solving, limit-setting, communication, emotional support or other family or individual functions.

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

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

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

SECTION 144. Notwithstanding any general or special law to the contrary, until hospitals have been designated pursuant to section 51M of chapter 111 of the General Laws, the department of public health shall designate primary stroke service hospitals as acute stroke ready hospitals capable of providing care previously designated in regulations as primary stroke service care.

At the time that the department begins the designation of 3 tiers of stroke facilities pursuant to said section 51M of said chapter 111, hospitals may maintain primary stroke service designation utilizing the existing processes and criteria for a 6-month period. At the time that the department begins the designation process, primary stroke service hospitals shall be recognized

as acute stroke ready hospitals. After the department has begun the designation process, all primary stroke service hospitals shall be considered acute stroke ready hospitals, regardless of additional capacity, until they receive a higher designation of primary stroke center or comprehensive stroke center.

SECTION 145. Notwithstanding any general or special law to the contrary, the center for health information and analysis shall conduct a review of a mandated health benefit proposal to require coverage of acupuncture services rendered by licensed acupuncturists pursuant to sections 148 to 162, inclusive, of chapter 112 of the General Laws. The review shall be performed by the center consistent with section 38C of chapter 3 of the General Laws. The center shall evaluate the impact of such a mandate as a requirement for all of the health plans and policies under subsection (a) of said section 38C of said chapter 3. The center shall file its review with the clerks of the senate and house of representatives, the joint committee on health care financing, the joint committee on public health and the senate and house committees on ways and means.

SECTION 146. Notwithstanding any general or special law to the contrary, the executive office of elder affairs shall develop a plan to transfer funds from item 9110-1455 to increase eligibility for the Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary and Qualified Individual programs described in 42 U.S.C. §1396(a)(10)(E) and administered through the executive office of health and human services.

The executive office of health and human services shall develop a plan to raise or eliminate an asset test, raise the level of income eligibility or both to best expand access to the Medicare Savings Program for low-income elders if a transfer is implemented. The amount transferred from 9110-1455 shall not exceed the estimated annual cost of expanding coverage as established by the executive office of health and human services; provided, however, that no transfer shall result in reduced eligibility to the Prescription Advantage program established in the executive office of elder affairs.

Not later than September 1, 2018, the executive office shall report on whether there is planned transfer and, if so, the amount of funds expected to be transferred, the expected increased capacity in eligibility for the Medicare Savings Program and whether additional

transfers are anticipated and the executive office shall submit an additional report outlining the same criteria not less than 60 days before any subsequent transfers.

SECTION 147. Notwithstanding any general or special law to the contrary, the hospital alignment and review council established under section 2 of chapter 176W of the General Laws shall define “target hospital growth rate” to have the same meaning as “market basket percentage increase” as defined under 42 U.S.C. section 1395ww and “target hospital rate distribution” as 90 per cent of the statewide average commercial relative price in the previous calendar year unless otherwise amended under section 4 of said chapter 176W after January 1, 2022.

SECTION 148. Notwithstanding any general or special law to the contrary, the executive office of health and human services, in collaboration with the executive office of elder affairs, the office of Medicaid and the department of public health, shall develop a post-acute care referral consultation program, subject to appropriation, of regional consultation teams to: (i) assist providers and consumers in determining appropriate post-acute care settings and coordinating patient care and (ii) share best practices among providers. The program shall also ensure education and outreach on provider pre-admission counseling required under section 9 of chapter 118E of the General Laws.

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

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

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

SECTION 149. Notwithstanding any general or special law to the contrary, the department of public health and the office of consumer affairs and business regulation shall allow licensees to obtain proxy credentialing and privileging for telemedicine services with other health care providers as defined in section 1 of chapter 111 of the General Laws or facilities that comply with the Centers for Medicare & Medicaid Services' conditions of participation for telemedicine services.

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

SECTION 150. Notwithstanding any general or special law to the contrary, all commercial insurers, hospital service corporations, medical service corporations and health maintenance organizations shall:

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

(ii) not later than July 1, 2022, reimburse for health care services with alternative payment methodologies for not less than 65 per cent of its enrollees; provided, however, that 45 per cent of its enrollees shall be under alternative payment methodologies that require providers

to bear downside risk at a level not less than the amount required of a MassHealth accountable care organization; and

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

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

SECTION 151. Notwithstanding any general or special law to the contrary, the noncontracted commercial rate for nonemergency services under chapter 176O of the General Laws shall be not more than the eightieth percentile of all allowed charges for a particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database by a nonprofit organization specified by the division of insurance. Such an organization shall not be affiliated with a health carrier.

SECTION 152. Notwithstanding any general or special law to the contrary, the noncontracted commercial rate for emergency services under chapter 176O of the General Laws shall be not more than the eightieth percentile of all allowed charges for a particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database by a nonprofit organization specified by the division of insurance. Such an organization shall not be affiliated with any health carrier.

SECTION 153. Sections 151 and 152 are hereby repealed.

SECTION 154. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall apply for a federal waiver of the requirements of section 1886(q) of the federal Social Security Act.

SECTION 155. Notwithstanding any general or special law to the contrary, the readmission reduction benchmark under chapter 6D of the General Laws shall be a 20 per cent reduction of readmission rates, as measured by the health policy commission in consultation with the center for health information and analysis, between those rates observed in the year 2017 and those rates observed in the year 2020.

SECTION 156. Notwithstanding any general or special law to the contrary, the health policy commission shall identify health care trailblazers under section 19 of chapter 6D of the General Laws that have: (i) demonstrated success in patient placement in the appropriate care setting through the development of care plans that include education on appropriate use of emergency services for patients who are deemed high utilizers of emergency departments; (ii) engaged in meaningful labor-management initiatives to improve or reduce health care costs; or (iii) established an employer-sponsored insurance plan in which an employer shares an increased percentage of an employee's premium or cost sharing for employees who receive a lower salary compared to other employees.

SECTION 157. Notwithstanding any general or special law to the contrary, the office of Medicaid may establish and offer an optional expanded Medicaid plan for purchase by an individual or by an employer as an employer-sponsored insurance plan. The optional expanded plan may set alternate eligibility and cost-sharing standards beyond those established by section 9A of chapter 118E of the General Laws and may condition participation in the program; provided, however, that any optional expanded plan offered to an employer shall require the employer to pay not less than 50 per cent of the projected cost of coverage for participating employees. The office may adjust benefits offered through an optional plan under this section; provided, however, that the office shall maintain the benefit and cost-sharing standards for those individuals and employees that meet the eligibility standards established by said section 9A of said chapter 118E.

The office may establish premiums or cost-sharing requirements for an optional expanded plan that are equal to or exceed the costs of covering participating members based on the per-member-per-month expenditures or other measures. Additional revenue generated in excess of the cost to administer the expanded plan may be used to increase provider payment

rates within the optional expanded plan and the MassHealth program under said section 9A of said chapter 118E or otherwise may be applied to the sustainability of the MassHealth program.

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

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

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

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

SECTION 158. Notwithstanding any general or special law to the contrary, the office of Medicaid shall seek federal approval to amend its state plan amendment and regulations to permit member access to urgent care facilities for emergency services without requiring a referral or prior authorization. The office shall provide a progress report to the joint committee on health care financing and the senate and house committees on ways and means not later than July 1, 2018 and shall issue updated regulations not later than January 1, 2019.

SECTION 159. Notwithstanding any general or special law to the contrary, the secretary of health and human services may seek approval from Centers for Medicare & Medicaid Services to claim expenditures necessary to establish mobile integrated health care programs certified under chapter 111O of the General Laws as an allowable expenditure under the delivery system reform incentive program pursuant to requirement 57 of the Special Terms and Conditions for the MassHealth demonstration waiver under section 1115(a) of the Social Security Act.

SECTION 160. Notwithstanding any general or special law to the contrary, the office of Medicaid shall establish a plan outlining the office's method for collecting, maintaining and sharing data with providers to ensure compliance with benchmarks associated with the MassHealth accountable care program, including ways to coordinate measures of social determinants of health that provide breakdowns by special populations within and across programs.

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

SECTION 161. Notwithstanding any general or special law to the contrary, the executive office of health and human services, in consultation with the Massachusetts eHealth Institute, shall maximize information sharing, to the extent permissible under relevant privacy law, between the senior information management system operated by the executive office of elder affairs and electronic health records systems operated by health care providers.

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

SECTION 162. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall apply for a federal waiver to permit passive enrollment

of individuals eligible for Medicare into the MassHealth senior care options program. The office may apply for a federal waiver to receive Medicaid matching funds for a Medicare recipient or member of the executive office of elder affairs home care program who is not otherwise eligible for Medicaid and lacks income and assets to pay for 135 days of skilled nursing facility care. An individual passively enrolled in the MassHealth senior care options program shall be provided with notice and the ability to opt-out that is not less than that which is required under section 164.

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

At the end of each fiscal year, each SCO shall provide to MassHealth an audited statement of its medical loss ratio for the past year. If a SCO's audited medical loss ratio is below the minimum as determined by MassHealth, the SCO shall provide additional benefits or services to its enrollees in the following contract year in an amount that would raise its medical loss ratio to the minimum level as determined by MassHealth and shall submit a plan to MassHealth detailing how such benefits or services shall be provided to its plan enrollees. Not later than September 1, MassHealth shall provide a report to the senate and house committees on ways and means that provides an overview of the audited statements received and a description of: (i) any plans submitted by a SCO to reduce overhead; (ii) the percentage of each SCO’s administrative overhead expended on social determinants of health and flexible services for SCO members within the past year; (iii) the number of each SCO’s members voluntarily and involuntarily disenrolled with the level of acuity and reasons for such disenrollments; and (iv) the number of each SCO’s members who experienced an increase or decrease in payment rate.

SECTION 163. The office of Medicaid shall report on the role of long-term services and supports within MassHealth and MassHealth accountable care organizations in each year of the accountable care organization demonstration. The report shall include: (i) the baseline number of

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

SECTION 164. (a) The executive office of health and human services may establish senior care options as a default for MassHealth integrated medical and home care services and enroll MassHealth-eligible consumers enrolled in the executive office of elder affairs home care program into the MassHealth senior care options program under section 9D of chapter 118E of the General Laws.

(b) A person shall not be enrolled into the SCO program under subsection (a) if the person is 85 years of age or older, if the person has high acuity and is on the Frail Elder Waiver or if the person is a recipient of a department of developmental services home and community-based services waiver.

(c) A person shall not be enrolled into the SCO program under subsection (a) unless, prior to enrollment:

(i) the person is provided written notification, which shall include language support and provide conspicuous notice of the ability to opt-out of enrollment by mail and by telephone or, if permissible under privacy law, electronic mail, not less than 3 times, 1 of which shall be not less than 60 days prior to enrollment and 1 of which shall be not less than 30 days prior to enrollment;

(ii) the person is provided information by the senior care options provider about the details of the plan and its benefits which shall include language support, options to opt out of enrollment by mail or telephone and, if permissible under privacy law, electronic mail, and information on independent options counseling;

(iii) MassHealth has provided the person with information about options for enrolling in voluntary programming including Program of All Inclusive Care for the Elderly or PACE plans, senior care optionor SCO plans, home and community-based services waiver program for frail elders or any other voluntary, elective benefit to which they are entitled to supplement or replace their MassHealth benefits;

(iv) MassHealth has provided the person with educational materials that shall include, but not be limited to: (1) a definition of a SCO and how it functions; (2) enrollment eligibility standards; (3) the location of SCOs; (4) a complete list of their participating providers; (5) the range of available services; (6) consumer rights under Medicare and Medicaid, as applicable; and (7) an assistance worksheet for determining health care options and quality of care measurements;

(v) MassHealth and the SCO have conducted a matching process that considers the person’s most important provider in medical or home care; and

(vi) MassHealth has determined that a senior care option plan in the person’s geographic area has an adequate network and the capacity to serve the person.

(d) Within 30 days after being enrolled into a SCO from the executive office of elder affairs home care program, the SCO shall provide a member with a culturally-competent, comprehensive assessment which shall include an in-person opportunity to disenroll.

(e) The SCO shall pay for continuity of care from all out-of-network providers in compliance with federal continuity of care requirements and shall implement an individual and integrated care plan for the member; provided however, that the individual care plan shall be approved by the member.

(f) The SCO shall fund home care program services if the member so chooses in the care plan and shall contract with an ASAP unless otherwise prohibited by section 9D of chapter 118E. MassHealth may permit a risk-sharing relationship between the SCO and the ASAP in which the 2 entities share the financial risk of providing coordinated services to enrollees under a system of capitated or subcapitated rate payments. Consistent with said section 9D of said chapter 118E, ASAPs under contract with SCOs shall employ geriatric support service coordinators, who shall be members of the primary care team.

(g) (i) a SCO shall conform to the minimum medical loss ratio as established by the division of medical assistance for its category. At the end of each fiscal year, the SCO shall provide to the division an audited statement of its medical loss ratio for the past year. If an SCO's audited medical loss ratio is below the minimum as determined by the division for its category, the SCO shall provide additional benefits or services to its enrollees in the following contract year in an amount that would raise its medical loss ratio to the minimum level established by the division for its category and shall submit a plan to the division detailing how such benefits or services shall be provided to its plan enrollees.

(ii) Not later than October 1, an SCO and an ASAP shall annually issue an information statement report. The report shall detail and document expenses on overhead or administration, including the percentage spent for each item and the percentage of overhead or administration spending that is directly provided to benefit consumers, the actual and percentage of money spend on social determinants of health, the assesses acuity level of its members as compared to the previous year and the number of members who have disenrolled, with a reason for disenrollment and the level of acuity of the person who disenrolls. The report shall be provided to the clerks of the house of representatives and the senate.

(h) A member shall have the right to opt out of the SCO at any time before enrollment or the right to disenroll at any time after enrollment. Notice of disenrollment may be provided to

the division of medical assistance or the SCO and disenrollment notices received by the division or the SCO by the twentieth day of the month shall be effective on the first day of the following month.

SECTION 165. The executive office of health and human services may support the development of pilot programs of supportive housing and affordable housing providers, in coordination with health plans that service individuals eligible for Medicaid, Medicare or both including, but not limited to, the program for all-inclusive care for the elderly, senior care options and other managed care organizations and, in consultation with aging services access points, community partners and other stakeholders, to pilot any of the following: (i) establishing coordinated care protocols and staffing supports within housing sites that are funded with pooled resources to provide a critical mass of plan members necessary for care coordination and targeted investment within the housing site; (ii) creating financing models that include social impact bonds or other sources; and (iii) establishing care coordination between the housing providers and health plans.

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

SECTION 166. Notwithstanding any general or special law to the contrary, the secretary of health and human services shall develop a strategic plan outlining changes to provider funding sources, including those related to the adoption of new financing and delivery models of care as well as current supplemental payment streams to acute care hospitals. The strategic plan shall provide a breakdown of payment sources to providers, including payments authorized under the current MassHealth section 1115 demonstration waiver, by payment sources identified as: (i) time limited and as ongoing, along with expected benchmarks for providers to demonstrate sustainability due to the expiration of a time limited payment source; and (ii) included in an alternative payment model or a current supplemental payment.

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

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

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

SECTION 167. Not later than July 1, 2018, the office of Medicaid shall provide a report on the proposed eligibility changes to the MassHealth program included in the Section 1115 amendment request that was submitted on September 8, 2017, based on information received under section 79 of chapter 118E of the General Laws. The report shall include: (i) the number of members who received an offer of employer-sponsored health insurance; (ii) the number of members who received an offer of affordable employer-sponsored health insurance; (iii) details on the most frequently occurring cost-sharing arrangements for members offered affordable employer-sponsored health insurance; (iv) the number of members who would be transitioned from MassHealth to the ConnectorCare program; (v) the estimated cost savings attributed to the eligibility changes to the MassHealth program included in the amendment submitted on September 8, 2017; and (vi) the number of members who have been deemed eligible for premium assistance. The office shall submit its report to the clerks of the senate and house of representatives, the joint committee on health care financing and the senate and house committees on ways and means.

SECTION 168. Notwithstanding any general or special law to the contrary, the center for health information and analysis shall conduct a review of a mandated health benefit proposal to require coverage of services rendered by a mobile integrated health care provider pursuant to chapter 111O of the General Laws. The review shall be performed by the center consistent with section 38C of chapter 3 of the General Laws. The center shall evaluate the impact of such a

mandate as a requirement for all of the health plans and policies under subsection (a) of said section 38C of said chapter 3. The center shall file its review with the clerks of the senate and house of representatives, the joint committee on health care financing and the senate and house committees on ways and means not later July 1, 2020.

SECTION 169. Notwithstanding any general or special law to the contrary, the health policy commission, in consultation with the center for health information and analysis and with the technical assistance of an external evaluator, if available, shall review the impact of this act on: (i) reduction in hospital readmissions; (ii) emergency department utilization; (iii) reduction in post-acute institutional care; (iv) prescription drug cost trends; (v) movement of patients toward high-value provider settings; and (vi) provider price variation.

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

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

SECTION 170. Notwithstanding any general or special law to the contrary, the board of registration in dentistry, in consultation with the executive office of health and human services, shall perform an evaluation of the impact of this act on dental therapists in terms of patient safety, cost-effectiveness and access to dental services over the first 5 years of the act's implementation. The board shall report on its findings and the report shall include: (i) the number of new patients served; (ii) the impact on waiting times for needed services; (iii) the impact on travel time for patients; (iv) the impact on emergency room usage for dental care; and (v) the impact on costs to the public health care system. The report shall be submitted not later than July 1, 2023 to the joint committee on public health, the joint committee on health care financing and the senate and house committees on ways and means.

SECTION 171. There shall be a task force to investigate the impact to state agencies of joining a nonMedicaid, multistate prescription drug bulk purchase consortium. The task force shall consider: (i) the estimated costs savings related to joining a non-Medicaid, multistate consortium; (ii) the opportunity for counties, municipalities and nonprofit organizations to participate in a nonMedicaid multistate consortium; (iii) the potential administrative savings and efficiencies for participants as a result of joining a nonMedicaid, multistate consortium; (iv) other bulk purchase discounts or rebates for prescription drugs, medical supplies or other medical goods purchased by state agencies, other governmental units and nonprofit organizations; and (v) means of receiving rebates or discounts for medical supplies or medications not included under the federal 340B Drug Pricing Program for eligible entities. The task force may consider non-Medicaid, multistate consortiums that are not available to the group insurance commission.

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

SECTION 172. The office of Medicaid shall report on potential cost savings for prescription medications by the office if it joined a multistate Medicaid bulk purchasing consortium. The report shall include: (i) an analysis of increased efficiency in the receipt of discounts through participation in a multistate Medicaid bulk purchasing consortium; (ii) the

estimated cost savings related to joining a multistate Medicaid bulk purchasing consortium; (iii) the estimated administrative savings or other increased efficiencies related to joining a multistate Medicaid bulk purchasing consortium; (iv) opportunities for managed care organizations to receive rebates or discounts; and (v) a review of any identified alternative approaches to multistate Medicaid bulk purchasing consortiums that provide cost savings relative to prescription medications. The office shall file the report with the clerks of the senate and house of representatives, the joint committee on health care financing and the senate and house committees on ways and means not later than November 1, 2018.

SECTION 173. Notwithstanding any general or special law to the contrary, the Massachusetts e-Health Institute shall report projects that leverage the commonwealth's investment in electronic health record deployment and the statewide health information exchange and that are likely to have a meaningful impact on cost or quality of care. The report shall identify and support such projects and include recommended funding amounts for the projects. The institute shall file the report with the clerks of the senate and house of representatives, the joint committee on health care financing and the senate and house committees on ways and means not later than January 1, 2019.

SECTION 174. Notwithstanding any general law or special law to the contrary, the department of higher education, in conjunction with the department of public health, shall be granted the authority to establish a health corps pilot program which shall be implemented in each of the 6 executive office of health and human services geographic regions. The pilot program shall allow students of health-care related programs who have already attained a level of licensure and are currently working towards a higher level of licensure at a Massachusetts public institution of higher education or an accredited vocational institution to gain additional learning experience while providing patient care as a cost-mitigating measure. The departments shall establish guidelines which provide for creation of this pilot program, including, but not limited to, the following: (i) patient safety; (ii) the receipt of college or program credit to qualified student participants; (iii) the supervision of students over the course of their experiential learning; (iv) the forgiveness of qualified student loans; and (v) the metrics for measurements of program success and cost savings.

SECTION 175. Notwithstanding any general or special law to the contrary, the health policy commission shall issue a report on expanding the scope of practice for athletic trainers. The report shall be based on available evidence and information and shall include any legislative and regulatory recommendations on: (i) the safety, efficacy, access and cost of health care services provided by athletic trainers in workplace care settings; and (ii) improving workforce health and reducing health care costs by increasing the employment of athletic trainers in workplace care settings. The commission shall file its report with the joint committee on health care financing and the senate and house committees on ways and means not later than June 1, 2018.

SECTION 176. (a) The department of public health, hereinafter referred to as the department, shall amend the regulations governing the application and licensing procedures and suitability requirements for long-term care facilities, as described in 105 CMR 153.00, to establish new requirements that would precede approval of any application for a new license, any notice of intent for transfer of ownership or any notice of intent to sell any for-profit or non-profit skilled nursing facility.

(b) The department shall work in consultation with the executive office of elder affairs, the office of Medicaid, the office of the attorney general and all interested stakeholders to review and develop recommendations for the regulatory improvements outlined in subsection (a). Such recommendations shall include regulatory amendments that: (i) establish additional threshold requirements for applicants seeking to be deemed suitable by the department under 105 CMR 153.006(D), provided, that the additional requirements shall include, but not be limited to, mandating submission of an initial prospective annual operating budget and of an attestation concerning any anticipated changes to the facility's workforce or working conditions; (ii) establish a provisional licensure procedure where original applicants not currently doing business in the commonwealth would be issued a provisional original license that would be subject to bi-annual review and revocation procedures within the first year of operation; and (iii) provide more transparent, timely, and complete public access to information concerning skilled nursing facility licensing and suitability determination standards.

(c) Not later than 60 days after passage of this act, the department shall convene a meeting of interested stakeholders, review recommendations from those stakeholders and other state entities, and submit appropriate amendments to 105 CMR 153.00 for public review. The department shall issue the new recommendations not later than180 days after passage of this act.

SECTION 177. Notwithstanding any general or special law to the contrary, MassHealth shall recognize in the rates governing Medicaid nursing facility services the allowable costs of nurse practitioner services.

SECTION 178. Notwithstanding any general or special law to the contrary, not later than June 30, 2018 the executive office of health and human services shall report to the house and senate committees on ways and means on the availability of a waiver and, if applicable, the estimated net state cost of a waiver that would allow individuals qualifying for Medicaid and at risk of entering a nursing home to reside in a certified assisted living residence. The executive office of health and human services may request a waiver from the federal Centers for Medicare and Medicaid Services to allow individuals qualifying for Medicaid and at risk of entering a nursing home to reside in a certified assisted living residence.

SECTION 179. Notwithstanding any general or special law to the contrary, the group insurance commission shall conduct a review and submit a report on the use coverage of medically-necessary brand name prescription drugs. The report shall include, but not be limited to: (i) a description of the current group insurance policy on brand name and generic prescription drug coverage; (ii) definitions of terms that determine coverage decisions; and (iii) an outline of the appeal process when prescription drug benefits are reduced or denied, including the following information for the past 5 years, broken down by year: (1) the number of prescriptions for brand-name medications written due to a medical necessity, as stated by a practitioner, that were denied through coverage by the group insurance commission; (2) the number of people who have been denied coverage for brand name medications that have appealed or are appealing that denial; and (3) the number of appeals denied.

The commission shall report its findings to the joint committee on healthcare financing, the joint committee on public service and the senate and house committees on ways and means not later than May 1, 2018.

SECTION 180. Notwithstanding any general or special law to the contrary, the center for health information and analysis, in consultation with MassHealth, the executive office of elder affairs and the health policy commission, shall conduct an examination of cost trends and financial performance among skilled nursing facilities, as defined under 957 CMR 7.02. The information shall be analyzed on an institution-specific, provider organization and industry-wide basis and shall include, but not be limited to: (i) gross and net patient service revenues; (ii) other sources of operating and non-operating revenue; (iii) trends in relative price, payer mix, case mix, utilization and length of stay dating back to 2010; (iv) affiliations with other health care providers including, but not limited to, preferred clinical relationships and partnerships; (v) categories of costs including, but not limited to, general and administrative costs, nursing and other labor costs and salaries, building costs, capital costs and other operating costs; (vi) total spending on direct patient care as a percentage of total operating expenses; (vii) operating and total margin; (viii) occupancy rates; and (ix) other relevant measures of financial performance and service delivery. These measures shall distinguish long-term from short-stay residents, to the extent possible.

Not later than December 31, 2018, the report and any recommendations shall be filed with the clerks of the senate and house of representatives, the chairs of the house and senate committees on ways and means and the chairs of the joint committee on elder affairs.

SECTION 181. The center for health information and analysis shall report on the implementation of facility fee protections under section 28 of chapter 32A, section 51L of chapter 111 and sections 28 and 29 of chapter 176O of the General Laws. The report shall include: (i) facility fees charged or billed to provide a baseline report on facility fees that were charged or billed; and (ii) a 5-year status report.

The reports shall include: (i) the number of hospital-based facilities owned or operated by a hospital or health system that provides services for which a facility fee was charged or billed, broken down by hospital or health system; (ii) the number of patient visits provided at each hospital based facility for which a facility fee was charged or billed; (iii) the number of claims, total amount and range of allowable facility fees paid at each facility by Medicare, Medicaid and private insurance policies, including any cost sharing, as applicable; (iv) the total amount of revenue from hospital-based facility fees received by a hospital or health system, categorized by

whether a hospital-based facility is on a campus; (v) separately for on-campus and off-campus hospital-based facilities, a description of the 10 procedures or services that generated the greatest amount of facility fee revenue at hospital-based facilities and, for each such procedure or service, the total amount of revenue received by a hospital or health system from the facility fees for the services; and (vi) the top 10 procedures or services for which facility fees were charged based on volume of claims.

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

SECTION 182. There shall be a task force to investigate methods to increase efficiency in the health care system through regulatory simplification. The task force shall consist of: the secretary of health and human services or a designee, who shall serve as chair; the commissioner of public health or a designee; the assistant secretary of the office of Medicaid or a designee; the chair of the health policy commission or a designee; 1 member appointed by the senate president; 1 member appointed by the speaker of the house; and 8 members appointed by the governor, 1 of whom shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, 1 of whom shall be a representative of the Massachusetts Medical Society, 1 of whom shall be a representative of Association for Behavioral Healthcare, Inc., and one of whom shall be a representative of the American Physical Therapy Association of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Association of Behavioral Health Systems, Inc., 1 of whom shall be a representative of the Massachusetts Nurses Association and 1 of whom shall be a representative of the Home Care Alliance of Massachusetts, Inc.

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

initiatives resulting in increased access to care and cost savings; and (iv) recommendations for regulatory changes needed to support the development of global payments.

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

SECTION 183. The executive office of health and human services and the secretary of elder affairs may transfer funds between item 9110-1630 of section 2 of chapter 47 of the acts of 2017 and item 4000-0601 of said section 2 of said chapter 47 for the costs of consumers enrolled in the home care program who enroll in the MassHealth senior care options program or for the costs of senior care options enrollees who opt out of senior care options and return to the home care program; provided, however, that transfers shall account for capitation payments. The amount transferred to said item 4000-0601 of said section 2 of said chapter 47 shall not exceed the estimated annual cost of care in the home care program for participating senior care options enrollees and funds shall not be transferred in any fiscal year if the transfer results in a waiting list for services provided by said item 9110-1630 of said section 2 of said chapter 47.

SECTION 184. Notwithstanding any general or special law to the contrary, the secretary of health and human services shall study the impact of implementing section 164 and section 183. The report shall be conducted in consultation with an advisory group consisting of representatives from community advisory councils under section 9D of 118E of the General Laws, and the program of all-inclusive care for the elderly and home care providers and senior care option providers.

The report shall report on the number of MassHealth-eligible home care consumers enrolled in the senior care options program, the number of consumers planned to be enrolled, the timeline for the enrollment and the expected capacity of SCOs to accept new enrollees. The study shall include a review of: (i) methods for expanding the enrollment in home and community-based long-term care support services, including the senior care options program, the program of all-inclusive care for the elderly and the home care program; (ii) methods to maximize the availability of federal financial participation; and (iii) methods to ensure consumer choice of services, enhance care outcomes and improve the quality of services and consumer

satisfaction measures. The study shall further analyze the impact on ASAP and home care agencies if said sections 164 and 183 were implemented. The analyses shall include a study of projected finances, caseload and capacity of ASAPs and home care agencies.

If the results of the study required in the previous paragraphs determine that implementation of said sections 164 and 183 are in the best interests of the commonwealth and consumers, the secretary shall submit an implementation plan to effectuate said sections 164 and 183 to the clerks of the house of representatives and senate and the clerks shall refer the plan to an appropriate committee. The plan shall detail the results of the study and articulate the reasons why implementation is in the best interests of the commonwealth and consumers. The plan shall be designed to minimize disruption to home care agencies. The implementation plan shall ensure the robust implementation of the protections provided in said sections 164 and 183, including prior notice and clear ability to opt out and shall further detail the enrollment process, the timetable of implementation, the number of enrollees, the amount of funding associated with those enrollees, fiscal impacts to MassHealth and the executive office of elder affairs in spending and revenue, the best method to conduct a funding transfer and impacts on consumers.

Sections 164 and 183 shall not take effect unless the implementation plan has been approved by the general court.

SECTION 185. Upon the implementation of section 164 or 183, if they are so implemented, the secretary of health and human services shall report every 6 months on the impacts of senior care options as a default for MassHealth integrated medical and home care services. The report shall include the number and percentage of opt outs from enrollment, the percentage of enrollees assessed that continue to receive home care services, the amount of transferred funds associated with the enrollment and the amount of federal matching funds projected to accrue to the senior care options program.

The report shall further detail the impacts on home care agencies and ASAPs. The report shall include a fiscal analysis of the home care agencies and ASAPs, including projected finances, caseload, and capacity of ASAPs and home care agencies.

The report shall be filed with the clerks of the senate and the house of representatives and the senate and house committees on ways and means.

SECTION 186. The executive office of health and human services shall file a report with the senate and house committees on ways and means not later than March 1, 2018 detailing the projected fiscal impact, number of enrollees and administrative capacity to implement a buy-in option for individuals that surpass the income eligibility level to participate in the program for all-inclusive care for the elderly, or PACE and the senior care options program.

SECTION 187. The secretary of health and human services shall conduct a study on the advisability and feasibility of establishing a community choice counseling program that assists Medicaid-eligible individuals with home and community-based service options.

The secretary shall also report on: (i) the applicability of modeling the community choice counseling program after the Community Choice Counseling program offered by the state of New Jersey; (ii) opportunities to apply for a federal waiver to maximize federal financial participation to employ care providers to conduct mandatory preadmissions counseling services within long-term care facilities; and (iii) a proposed preadmission counseling plan that best enforces preadmissions counseling required under section 9 of chapter 118E of the General Laws which may include a process under which MassHealth may withhold payments to long-term care facilities if preadmission counseling does not occur for any individual without first receiving written documentation that the individual has received preadmission counseling on home and community-based service options pursuant to this section or that the patient has waived their right to such counseling. The secretary shall file a report of the secretary's findings not later than January 1, 2019 to the joint committee on elder affairs, the joint committee on health care financing and the chairs of the house and senate committees on ways and means.

SECTION 188. A person seeking admission to a long-term care facility paid for by MassHealth shall receive preadmission counseling for long-term care services which shall include an assessment of community-based service options. A person seeking care in a long-term care facility on a private-pay basis shall be offered preadmission counseling. The division shall report annually to the general court the number of individuals who received preadmission

counseling under this section and the number of diversions to the community generated by the preadmission counseling program.

SECTION 189. There shall be a special commission to study and make recommendations on how to license foreign-trained medical professionals and medical professionals trained or licensed in other jurisdictions to expand and improve access to medical services in rural and underserved areas.

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

The commission shall examine and make recommendations on topics including, but not limited to: (i) ways to implement strategies to integrate foreign-trained medical professionals and medical professionals trained or licensed in other jurisdictions into rural and underserved areas that are in need of access to medical services; (ii) ways to identify state and national licensing regulations that pose barriers to practice for foreign-trained medical professionals and medical professionals trained or licensed in other jurisdictions; (iii) state licensing requirements that pose barriers to practice for foreign-trained medical professionals and medical professionals trained or licensed in other jurisdictions; (iv) alternate approaches by other states to integrate foreign-trained medical professionals and medical professionals trained or licensed in other jurisdictions into rural and underserved areas; and (v) other matters pertaining to licensing foreign-trained

medical professionals and medical professionals trained or licensed in other jurisdictions. The commission may hold hearings and invite testimony from experts and the public to gather information. The report may include recommended guidelines for full licensure and conditional licensing of foreign-trained medical professionals and medical professionals trained or licensed in other jurisdictions.

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

SECTION 190. There shall be a housing security task force to investigate methods to encourage housing security as a social determinant of health. The task force shall consist of: the secretary of housing and economic development or a designee, who shall serve as co-chair; the secretary of health and human services or a designee, who shall serve as co-chair; the commissioner of public health or a designee; the executive director of the health policy commission or a designee; the undersecretary of housing and community development or a designee; the commissioner of mental health or a designee; the commissioner of developmental services or a designee; and 15 members appointed by the governor, 1 of whom shall be a representative of a public housing authority, 1 of whom shall be a provider of emergency shelter services to homeless individuals, 1 of whom shall be a representative of Massachusetts Senior Care Association, Inc., 1 of whom shall be an expert on affordable housing, 1 of whom shall be a representative of the Massachusetts Law Reform Institute, Inc., 1 of whom shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom shall be an expert in case management, 1 of whom shall be a representative of the Home Care Alliance of Massachusetts, Inc., 1 of whom shall be a representative of Arc Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Coalition for the Homeless, Inc., 1 of whom shall be a representative of the Massachusetts Housing and Shelter Alliance, Inc., 1 of whom shall be a representative of the Association for Behavioral Healthcare, Inc., 1 of whom shall be a representative of Health Care for All, Inc., 1 of whom shall be a representative of the Massachusetts Association of Behavioral Health Systems, Inc. and 1 of whom shall be a

representative of Citizens Housing And Planning Association, Inc. Members shall be selected to ensure broad geographic representation.

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

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

SECTION 191. There shall be a special commission to investigate, study and evaluate the scope of mental health peer support programs in all regions of the commonwealth to determine the scope of peer programs, classification and types of peer specialists, and appropriate training and certification requirements for such programs. The commission shall consist of the following members: the co-chairs of the joint committee on mental health, substance use, and recovery, who shall serve as co-chairs of the commission; the secretary of health and human services or a designee who is a medical professional; the commissioner of mental health or a designee who is a medical professional; the commissioner of public health or a designee; the director of Medicaid or a designee; 1 representative appointed by the commissioner of the Massachusetts rehabilitation commission or a designee; 1 representative from The Transformation Center, Inc., a statewide peer-job training organization; 1 representative from the Massachusetts Behavioral Health Partnership; 1 representative from the Association for Behavioral Healthcare, Inc.; 1 representative from the National Alliance on Mental Illness of Massachusetts, Inc.; 1 individual with lived experience as a consumer of mental health services appointed by the co-chairs of the

commission; and 1 family member of a mental health consumer appointed by the co-chairs of the commission.

The commission study shall include, but not be limited to, an examination and identification of best practices related to training and credential requirements for peer specialist programs, including: (i) types and categories of services provided by peer programs, including support, rehabilitation and clinical programs; (ii) types and categories of services that require certification; (iii) supervision required for categories of services that require certification; (iv) hours of formal work or volunteer experience related to mental health and substance use disorders conducted through such programs; (v) types of peer-support specialist exams required for such programs; (vi) codes of ethics used by such programs; (vii) required or recommended skill sets for such programs; (viii) requirements for continuing education; (ix) any other criteria necessary to develop peer specialist certification requirements; and (x) best practices from other states.

Not later than 1 year after the date of enactment of this act, the commission shall submit its findings and recommendations, together with drafts of legislation necessary to carry those recommendations into effect, by filing the same with the clerks of the senate and the house of representatives, the department of mental health and the joint committee on mental health, substance use and recovery.

SECTION 192. There shall be a food allergy task force to investigate the rising prevalence of food allergies in adults and children. The task force shall consist of the secretary of health and human services or a designee, who shall serve as chair; the commissioner of public health or a designee; the commissioner of insurance or a designee; the executive director of the Massachusetts chapter of the American Academy of Pediatrics or a designee; the executive director of the Asthma & Allergy Foundation of America, New England Chapter or a designee; a representative from the Food Allergy Science Initiative at the Broad Institute; the president of the Massachusetts Association of Health Plans, Inc. or a designee; and 2 members appointed by the governor, 1 of whom shall be a physician with experience in food allergies and 1 of whom shall be a parent of a child with food allergies.

The task force shall consider: (i) the rising prevalence of food allergies in adults and children and ways to eliminate or decrease food allergies; (ii) gaps that exist in insurance coverage for food allergy medication and services; and (iii) ways to improve insurance coverage of medically necessary food and formula.

The task force shall file its recommendations, including any drafts of legislation or regulations necessary to carry out its recommendations, to the clerks of the senate and house of representatives, the joint committee on public health and the joint committee on health care financing not later than December 31, 2019.

SECTION 193. The division of medical assistance shall develop an internal process for the reconciliation of claims due to retroactive eligibility changes or duplicate enrollments in cases that involve multiple payers for services provided to MassHealth enrollees. The process shall not require provider involvement. The division shall report to the senate and house committees on ways and means on the process not later than 5 months after the enactment of this act.

SECTION 194. Notwithstanding any general or special law to the contrary, MassHealth, in consultation with the center for health information and analysis, shall report on the costs incurred by efficiently and economically operated outpatient and diversionary behavioral health providers in providing outpatient and diversionary behavioral health services. MassHealth may contract with an independent research entity with experience in determining the costs of providing outpatient and diversionary behavioral health services.

The report shall analyze the cost of efficiently and economically operating outpatient and diversionary behavioral health providers by examining the 20 highest volume outpatient and diversionary billing codes utilized in providing services to MassHealth members, including services administered by MassHealth managed care organizations, accountable care organizations, managed behavioral health organizations with whom MassHealth may contract for management of behavioral health benefits, the managed behavioral health organization for the primary care clinician plan and MassHealth fee for service. The report’s analysis shall be based on data from not less than 15 outpatient and diversionary behavioral health providers representing the diversity of providers across the commonwealth with consideration given to, but

not limited to: (i) geographic location; (ii) whether the provider serves adults and children; (iii) providers serving racial and ethnic minority groups, including those for whom English is not a primary language; and (iv) the overall size of the outpatient and diversionary behavioral health providers in terms of annual revenues.

MassHealth, or, if contracted, the independent research entity, shall recommend an appropriate methodology for determining the true cost of providing the services identified as the 20 highest volume outpatient and diversionary billing codes; provided, however, that the methodology may be developed through on-site interviews with organizations participating in the project.

MassHealth shall submit its findings and recommendations, together with drafts of legislation necessary to carry those recommendations into effect, by filing the same with the clerks of the senate and house of representatives, the joint committee on mental health, substance use and recovery, the joint committee on health care financing and the joint committee on financial services not later than March 1, 2018.

SECTION 195. There shall be a working group to make recommendations on the licensure of behavioral health urgent care facilities under section 19A of chapter 19 of the General Laws.

The working group shall consist of: the commissioner of mental health or a designee, who shall serve as chair; a representative of the Association for Behavioral Healthcare, Inc.; a representative of the Massachusetts Psychiatric Society, Inc.; a representative of The Massachusetts Psychological Association, Inc.; a representative of the National Association of Social Workers, Inc.; a representative of the Massachusetts Health and Hospital Association, Inc.; a representative of the National Alliance on Mental Illness of Massachusetts, Inc.; a representative of M-POWER, Inc.; a representative of the Massachusetts Association of Behavioral Health Systems; and a representative of the Massachusetts Association for Mental Health, Inc.

The working group shall examine and make recommendations on topics including, but not limited to: (i) current availability and location of urgent behavioral health care services; (ii)

barriers to developing or providing urgent behavioral health care services, including rates of reimbursement for such services; (iii) adequacy of existing regulatory structure to facilitate the development and provision of urgent behavioral health care services; (iv) issues related to compliance with state and federal parity laws; and (v) criteria for licensure of behavioral health urgent care facilities, including criteria for licensure of behavioral health urgent care facilities.

The working group may hold hearings and invite testimony from experts and the public to gather information. The working group shall file a report of its recommendations with the clerks of the senate and house of representatives, the joint committee on mental health, substance use and recovery, the joint committee on health care financing and the senate and house committees on ways and means not later than January 1, 2019.

SECTION 196. (a) Notwithstanding any general or special law to the contrary, the following terms shall have the following meanings unless the context clearly requires otherwise:-

"Single payer benchmark", the estimated total costs of providing health care to all residents of the commonwealth under a single payer health care system in a given year.

"Single payer health care", a system that provides publicly financed, universal access to health care for the population through a unified public health care plan.

(b) The center for health information and analysis shall recommend a methodology to develop a single payer benchmark. The single payer health care system considered under the single payer benchmark shall offer continuous, comprehensive and affordable coverage for all residents of the commonwealth regardless of income, assets, health status or availability of other health coverage. The benchmark may consider the costs of a single-payer health care system at different actuarial values, levels of cost-sharing and levels of provider reimbursement; provided, however, that the benchmark shall include all actuarial values, levels of cost-sharing and levels of provider reimbursement considered by the center. In developing the methodology, the center shall monitor, review and evaluate reports related to single payer health care and the performance of single payer health care systems in other states and countries.

(c) The center for health information and analysis, in conjunction with the health policy commission and the division of insurance, shall provide an annual report detailing a comparison

of the actual health care expenditures in the commonwealth for 2016, 2017 and 2018 with the single payer benchmark for 2016, 2017 and 2018, respectively, indicating whether the commonwealth would have saved money while expanding access to care under a single payer health care system. The first report shall be filed with the clerks of the senate and house of representatives, the joint committee on health care financing and the senate and house committees on ways and means not later than July 1, 2018.

(d) If a report under subsection (c) determines that the single payer benchmark outperformed the actual total health care expenditures in the commonwealth in 2016, 2017 or 2018, the health policy commission shall submit a proposed single payer health care implementation plan to the clerks of the senate and house of representatives, the joint committee on health care financing and the senate and house committees on ways and means within 1 year of the date on which the report is filed. The plan may include proposed legislation to implement a single payer health care system that offers continuous, comprehensive and affordable coverage for all residents regardless of income, assets, health status or availability of other health coverage. When developing the implementation plan, the commission shall hold not less than 3 public hearings and seek stakeholder input from across the commonwealth.

SECTION 197.There shall be a task force to investigate timely updating of provider directories by health insurance carriers and determine ways to ensure that the general public is able to view all of the current health care providers for a health insurance plan.

The task force shall be consist of the commissioner of insurance or a designee, who shall serve as chair, and 8 members to be appointed by the commissioner, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of a commercial health insurer, 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of Health Care for All, Inc., 1 of whom shall be a representative of consumer rights, 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts Council of Community Hospitals, Inc. and 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, Inc.; provided, however, that the commissioner may appoint additional members to the task force. The

commissioner shall file the task force's recommendations with the joint committee on health care financing not later than May 1, 2018.

SECTION 198. (a) Within 45 days after the effective date of this act, the health policy commission shall conduct a public hearing on adherence to patient limits set forth in section 231 of chapter 111 of the General Laws. The commission shall issue a report which shall include, but shall not be limited to: (i) recommendations to measure adherence to patient limits; (ii) recommendations for methods to report potential violations of patient limits; and (iii) recommendations for measures to ensure adherence to patient limits. The commission shall issue their report to the joint committee on health care financing, the clerks of the senate and house of representatives and the commissioner of public health.

(b) The health policy commission, in consultation with the department of public health, shall adopt regulations to ensure adherence to patient limits set forth in section 231 of chapter 111 of the General Laws. The regulations shall include, but shall not be limited to: (i) a reporting process for violations of said section 231 of said chapter 111; (ii) a process for investigating reported violations; and (iii) appropriate sanctions, which shall include fines of not more than $25,000 for each separate and distinct violation of patient limits set forth in said section 231 of said chapter 111 not later than 90 days after the effective date of this act.

SECTION 199. The department of public health shall promulgate rules or regulations necessary to implement sections 59 to 61, inclusive, 63 to 70, inclusive, 72, 75, 92 and 97 to 107, inclusive, not later than January 1, 2019.

SECTION 200. The department shall designate hospitals pursuant to section 51M of chapter 111 of the General Laws not later than 180 days after the effective date of this act.

SECTION 201. The department shall establish protocols pursuant to section 51N of chapter 111 of the General Laws not later than 90 days after the effective date of this act.

SECTION 202. The department shall establish the data oversight process pursuant to section 51O of chapter 111 of the General Laws not later than 180 days after the effective date of this act.

SECTION 203. Section 66C of chapter 112 of the General Laws shall apply to registered optometrists who are qualified by an examination for practice under section 68 of said chapter 112 after January 1, 2013.

SECTION 204. An applicant for examination to permit the use and prescription of therapeutic agents pursuant to section 68C of chapter 112 of the General Laws who presents satisfactory evidence of graduation from a school or college of optometry approved by the board after January 1, 2013 shall be deemed to have satisfied sections 68 to 68B, inclusive, of said chapter 112.

SECTION 205. Subsection (d) of section 68C of chapter 112 of the General Laws shall apply to licensed optometrists who have completed a postgraduate residency program approved by the Accreditation Council on Optometric Education of the American Optometric Association after July 31, 1997.

SECTION 206. The task force established pursuant to section 16AA of chapter 6A of the General Laws shall be first convened in 2019.

SECTION 207. The regulations necessary to carry out section 238 of chapter 111 of the General Laws shall be adopted not later than 90 days after the effective date of this act.

SECTION 208. Section 30 of chapter 32A of the General Laws, section 81 of chapter 118E of the General Laws, section 108O of chapter 175 of the General Laws, section 40 of chapter 176A of the General Laws, section 27 of chapter 176B of the General Laws, section 35 of chapter 176G of the General Laws and section 14 of chapter 176I of the General Laws shall apply to contracts entered or renewed on or after January 1, 2020.

SECTION 209. Sections 26, 130 and 135 shall apply to plans submitted to the division of insurance on or after January 1, 2020.

SECTION 210. Section 2ZZZZ of chapter 29 of the General Laws and sections 4 and 5 of chapter 176W of the General Laws shall take effect on January 1, 2022.

SECTION 211. Sections 3, 6, 7, 9, 15, 17, 19, 21, 30, 39, 43, 59 to 61, inclusive, 63 to 70, inclusive, 72, 73, 75, 77, 78, 92, 97 to 107, inclusive, 116, 141 and 155, sections 29 and 30 of

chapter 32A of the General Laws and section 29 of chapter 176O of the General Laws shall take effect on January 1, 2019.

SECTION 212. Sections 10, 27 and 48 shall take effect on May 1, 2018.

SECTION 213. Sections 20 and 154 shall take effect on January 1, 2021.

SECTION 214. Sections 62, 71, 74, 91, 93 to 96, inclusive, 128, 149, 151 and 152, section 29 of chapter 32A of the General Laws, section 80 of chapter 118E of the General Laws, section 39 of chapter 176A of the General Laws, section 26 of chapter 176B of the General Laws and section 34 of 176G of the General Laws shall take effect on July 1, 2018.

SECTION 215. Section 86 shall take effect 180 days after the effective date of this act.

SECTION 216. Section 153 shall take effect on December 31, 2019.