

**SENATE . . . . . No. 735**

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**The Commonwealth of Massachusetts**

PRESENTED BY:

*James T. Welch*

*To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:*

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act relative to structural health care oversight and reform.

PETITION OF:

NAME:

*James T. Welch*

DISTRICT/ADDRESS:

*Hampden*

**SENATE . . . . . No. 735**

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By Mr. Welch, a petition (accompanied by bill, Senate, No. 735) of James T. Welch for legislation relative to structural health care oversight and reform. Health Care Financing.

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**The Commonwealth of Massachusetts**

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**In the One Hundred and Ninety-First General Court  
(2019-2020)**  
\_\_\_\_\_

An Act relative to structural health care oversight and reform.

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

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

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

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

13 shortages of health care resources in the region; and (iii) facilitate implementation of  
14 innovations, best practices and interventions throughout the region.

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

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

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

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

33 The task force shall be convened by the secretary of health and human services and the  
34 executive director of the health policy commission, or their designees, who shall serve as co-

35 chairs, and shall include the following members or their designees: the commissioner of public  
36 health; the executive director of the center for health information and analysis; the executive  
37 director of the group insurance commission; the assistant secretary for MassHealth; the  
38 commissioner of insurance; and 10 members who shall be appointed by the governor, 1 of whom  
39 shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom  
40 shall be a representative the Massachusetts Medical Society, 1 of whom shall be a behavioral  
41 health provider, 1 of whom shall be a long-term supports and services provider, 1 of whom shall  
42 be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a  
43 representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a  
44 representative of a Medicaid managed care organization, 1 of whom shall be a represent for  
45 persons with disabilities, 1 of whom shall be a representative for consumers and 1 of whom shall  
46 be an expert in establishing health system performance measures. Members appointed to the task  
47 force shall have experience with and expertise in health care quality measurement.

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

53         The task force shall make recommendations on aligned quality measures for use in: (i)  
54 contracts between payers, including the commonwealth and carriers, and health care providers,  
55 provider organizations and accountable care organizations, which incorporate quality measures  
56 into payment terms, including the designation of a set of core measures and a set of non-core  
57 measures; (ii) assigning tiers to health care providers in the design of any health plan; (iii)

58 consumer transparency websites and other methods of providing consumer information; and (iv)  
59 monitoring system-wide performance.

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

69 (b) Annually, not later than July 1, the secretary of health and human services shall  
70 establish an aligned measure set to be used by the commonwealth and carriers in contracts with  
71 health care providers that incorporate quality measures into the payment terms pursuant to  
72 section 28 of chapter 32A, section 78 of chapter 118E, section 108O of chapter 175, section 39  
73 of chapter 176A, section 26 of chapter 176B, section 34 of chapter 176G, section 14 of chapter  
74 176I and for assigning tiers to health care providers in tiered network plans pursuant to section  
75 11 of chapter 176J. The aligned measure set shall designate: (i) core measures that shall be used  
76 in contracts between payers, including the commonwealth and carriers, and health care  
77 providers, including provider organizations and accountable care organizations, that incorporate  
78 quality measures into payment terms; and (ii) non-core measures that may be used in such  
79 contracts.

80 SECTION 3. Chapter 6D of the General Laws, as appearing in the 2016 Official Edition,  
81 is hereby amended by striking out the definition of “Quality measures” and inserting in place  
82 thereof the following 4 definitions:-

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

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

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

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

91 SECTION 4. Section 2A of said chapter 6D, as so appearing, is hereby amended by  
92 inserting after the figure “10”, in lines 5 and 9, each time it appears, the following figure:- , 10A.

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

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

102 SECTION 7. Said section 8 of said chapter 6D, as so appearing, is hereby further  
103 amended by striking out, in line 92, the word “that” and inserting in place thereof the following  
104 words:- , including a provider organization’s rate of readmissions, that.

105 SECTION 8. Said chapter 6D is hereby further amended by inserting after section 9 the  
106 following section:-

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

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

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

122 SECTION 9. Section 10 of said chapter 6D, as appearing in the 2016 Official Edition, is  
123 hereby amended by inserting after the figure “\$500,000”, in line 152, the following words:- the  
124 first time that a determination is made and not more than \$750,000 for a second or subsequent  
125 determination; provided, however, that a civil penalty assessed under 1 of the above clauses shall  
126 be a first offense if a previously assessed penalty was assessed pursuant to a different clause. A  
127 civil penalty assessed under this subsection shall be deposited into the Health Safety Net Trust  
128 Fund established in section 66 of chapter 118E.

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

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

137 (b) The commission shall review the performance of the provider organizations identified  
138 pursuant to subsection (a) and consider: (i) the trends of the provider organization’s readmission  
139 rates; (ii) the payer mix of the provider organization; (iii) the demographics and health status of  
140 the provider organization’s patient population; (iv) the status of the provider organization as an  
141 accountable care organization or a participant in an accountable care organization; (v) the

142 percentage of the provider organization’s revenue and patient population subject to alternative  
143 payment arrangements; (vi) the provider organization’s ongoing strategies or investments  
144 designed to reduce readmissions; and (vii) any other factor that the commission considers  
145 relevant.

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

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

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

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

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

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

172 (f) A provider organization shall file a readmissions performance improvement plan not  
173 later than 45 days after receipt of a notice under subsection (b); provided, however, that if the  
174 provider organization has requested a waiver or extension, it shall file the plan not later than 45  
175 days after receipt of a notice that the waiver or extension was denied or, if the provider  
176 organization is granted an extension, on the date given on the extension. The readmissions  
177 performance improvement plan shall be generated by the provider organization, identify the  
178 causes of the provider organization's excessive readmissions rate and include, but shall not be  
179 limited to, specific strategies, adjustments and action steps that the provider organization  
180 proposes to implement to improve performance in reducing readmissions which may include  
181 coordination with a community health center. The proposed readmissions performance  
182 improvement plan shall include specific identifiable and measurable expected outcomes and a  
183 timetable for implementation. The timetable for a performance improvement plan shall not  
184 exceed 24 months.

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

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

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

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

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

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

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

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

232 SECTION 11. Subsection (a) of section 10A of chapter 6D, as appearing in section 19, is  
233 hereby amended by adding the following paragraph:-

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

246 SECTION 12. Section 14 of said chapter 6D, as appearing in the 2016 Official Edition, is  
247 hereby amended by striking out, in lines 62 and 63, the words "the standard quality measure set  
248 established by section 14 of chapter 12C" and inserting in place thereof the following words:- the

249 aligned quality measures recommended by the task force and established by the secretary  
250 pursuant to section 16AA of chapter 6A.

251 SECTION 13. Subsection (c) of section 15 of said chapter 6D, as so appearing, is hereby  
252 amended by striking out clause (10) and inserting in place thereof the following clause:-

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

261 SECTION 14. Said section 15 of said chapter 6D, as so appearing, is hereby further  
262 amended by striking out, in line 167, the word “and”.

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

266 (16) to demonstrate evidence-based care delivery programs, which may include  
267 community care transitions coaching programs led by community-based, nonprofit entities,  
268 designed to reduce: (i) 30-day readmission rates; (ii) avoidable emergency department use,  
269 including extended emergency department boarding; or (iii) unwarranted institutional post-acute

270 care; provided, however, that a mobile integrated health care program certified under chapter  
271 1110 shall satisfy this requirement for the purposes of the commission; and

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

273 SECTION 16 . Said chapter 6D is hereby further amended by adding following section:-

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

284 When developing standards, the commission shall consult with national and local  
285 organizations working on health care cost containment, relevant state agencies, health plans,  
286 physicians, nurse practitioners, behavioral health providers, hospitals, community health centers,  
287 social workers, other health care providers, representatives of labor organizations representing  
288 healthcare workers and consumers.

289 (b) Certification as a health care trailblazer organization shall be voluntary. An  
290 organization may use its certification in advertising or promotional materials. An organization

291 certified by the commission as a health care trailblazer organization shall renew its certification  
292 every 2 years under like terms.

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

295 SECTION 17. Section 1 of said chapter 12C, as appearing in the 2016 Official Edition, is  
296 hereby amended by striking out the definition of “Quality measures” and inserting in place  
297 thereof the following 2 definitions:-

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

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

302 SECTION 18. Said chapter 12C is hereby further amended by striking out section 14, as  
303 so appearing, and inserting in place thereof the following section:-

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

308 SECTION 19. Section 20 of said chapter 12C, as so appearing, is hereby amended by  
309 striking out, in lines 22 and 23, the words “as determined by the center” and inserting in place  
310 thereof the following words:- consistent with the recommendations of the taskforce pursuant to  
311 section 16AA of chapter 6A.

312 SECTION 20. Said chapter 12C is hereby further amended by adding the following  
313 section:-

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

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

329 The report shall not include the names of any individual public health access program  
330 beneficiaries and shall be subject to privacy standards pursuant to Public Law 104-191 and the  
331 Health Insurance Portability and Accountability Act of 1996. The center may establish  
332 interagency agreements to collect information to fulfill the requirements of this section  
333 including, but not limited to, an interagency agreement to access and utilize information

334 collected through the health insurance responsibility disclosure form established under section 79  
335 of chapter 118E.

336 SECTION 21. Chapter 19 of the General Laws is hereby amended by inserting after  
337 section 19 the following section:-

338 Section 19A. (a) For the purposes of this section and unless the context clearly indicates  
339 otherwise, the words “behavioral health urgent care facility” shall mean a private, county or  
340 municipal facility or any department or ward of such a facility that offers behavioral health  
341 urgent care services to the public or represents itself as providing behavioral health urgent care  
342 treatment; provided, however, that a “behavioral health urgent care facility” shall not be limited  
343 to a stand-alone facility.

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

353 (c) A facility, department or ward shall not provide behavioral health urgent care services  
354 unless it has obtained a license under this section. The superior court shall have jurisdiction,  
355 upon petition of the department, to restrain a violation of this section or to take such other action

356 as equity and justice may require. A violation of this section shall be punished for a first offense  
357 by a fine of not more than \$1,000 and for a second or subsequent offense by a fine of not more  
358 than \$2,000 or by imprisonment for not more than 2 years.

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

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

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

365 SECTION 22. Section 2GGGG of chapter 29 of the General Laws, as appearing in the  
366 2016 Official Edition, is hereby amended by inserting after the word “commission”, in line 66,  
367 the following words:- or developed by a health care trailblazer.

368 SECTION 23. Chapter 29 is hereby further amended by inserting after section 2VVVV  
369 the following 3 sections:-

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

373 The fund shall consist of: (i) revenue generated from fees, fines and penalties imposed  
374 under chapter 111O; (ii) revenue from appropriations or other money authorized by the general  
375 court and specifically designated to be credited to the fund; and (iii) funds public or private  
376 sources for mobile integrated health care including, but not limited to, gifts, grants, donations,

377 rebates and settlements received by the commonwealth that are specifically designated to be  
378 credited to the fund. The department may incur expenses and the comptroller may certify for  
379 payment amounts in anticipation of expected receipts; provided, however, that an expenditure  
380 shall not be made from the fund that shall cause the fund to be deficient at the close of a fiscal  
381 year. Amounts credited to the fund shall not be subject to further appropriation and money  
382 remaining in the fund at the close of a fiscal year shall not revert to the General Fund and shall  
383 be available for expenditure in the following fiscal year.

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

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

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

399 the fund to be deficient at the close of a fiscal year. Amounts credited to the fund shall not be  
400 subject to further appropriation and money remaining in the fund at the close of a fiscal year  
401 shall not revert to the General Fund and shall be available for expenditure in the following fiscal  
402 year.

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

411 (d) The council may expend funds collected under clause (ii) of subsection (b) of section  
412 4 of chapter 176W to defray premium costs for individuals and employers through a competitive  
413 grant program established by the council.

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

418 Section 2YYYY. There shall be a Community Health Center Transformation Fund. The  
419 fund shall consist of: (i) revenue from appropriations or other money authorized by the general  
420 court and specifically designated to be credited to the fund; (ii) funds from private sources

421 including, but not limited to, gifts, grants and donations received by the commonwealth that are  
422 specifically designated to be credited to the fund; and (iii) interest earned on money in the fund.  
423 Amounts credited to the fund shall be subject to further appropriation and any money remaining  
424 in the fund at the close of a fiscal year shall not revert to the General Fund. Money in the fund  
425 shall be provided to distressed community health centers, based on financial need.

426 SECTION 24. Chapter 32A of the General Laws, as appearing in the 2016 Official  
427 Edition, is hereby amended by adding the following section:-

428 Section 28. The commission shall require a carrier or a third party administrator with  
429 whom a carrier contracts to use the aligned measure set established by the secretary pursuant to  
430 section 16AA of chapter 6A as follows: (i) the carrier or third party administrator shall use the  
431 measures designated by the secretary as core measures in any contract between a health care  
432 provider, provider organization or accountable care organization that incorporates quality  
433 measures into payment terms; (ii) the carrier or third party administrator may use the measures  
434 designated by the secretary as non-core measures in any contract with a health care provider,  
435 provider organization or accountable care organizations that incorporates quality measures into  
436 payment terms and shall not use any measures not designated as non-core measures; (iii) the  
437 carrier or third party administrator shall only use the measures in the aligned measure set  
438 established by the secretary to assign health care providers, provider organization or accountable  
439 care organization to tiers in the design of a health plan.

440 SECTION 25. Subsection (a) of section 6D of chapter 40J of the General Laws, as  
441 appearing in the 2016 Official Edition, is hereby amended by inserting after the third sentence  
442 the following sentence:- The institute shall partner with the health care and technology

443 community to accelerate the creation and adoption of digital health to drive economic growth  
444 and improve health care outcomes and efficiency.

445 SECTION 26. Said section 6D of said chapter 40J, as so appearing, is hereby further  
446 amended by striking out, in lines 16 to 18, inclusive, the words “and (3) develop a plan to  
447 complete the implementation of electronic health records systems by all providers in the  
448 commonwealth” and inserting in place thereof the following words:- (3) develop a plan to  
449 complete the implementation of electronic health records systems by all providers in the  
450 commonwealth; and (4) advance the commonwealth’s economic competitiveness by supporting  
451 the digital health industry, including the digital health industry’s role in improving the quality of  
452 health care delivery and patient outcomes.

453 SECTION 27. Said section 6D of said chapter 40J, as so appearing, is hereby further  
454 amended by adding the following subsection:-

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

460 SECTION 28. Section 1 of chapter 111O of the General Laws, as appearing in the 2016  
461 Official Edition, is hereby amended by inserting after the definition of “Mobile integrated health  
462 care” the following definition:-

463 “Mobile integrated health care provider” or “MIH provider”, a licensed health care  
464 professional delivering medical care and services to patients in an out-of-hospital environment in

465 coordination with health care facilities or other health care providers; provided, however, that  
466 medical care and services shall include, but shall not be limited to, community paramedic  
467 provider services, chronic disease management, behavioral health, preventative care, post-  
468 discharge follow-up visits or transport or referral to facilities other than hospital emergency  
469 departments; provided further, that medical care and services shall be delivered under a mobile  
470 integrated health care program approved by the department using mobile health care resources.

471 SECTION 29. Section 2 of said chapter 111O, as so appearing, is hereby amended by  
472 adding the following 2 subsections:-

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

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

485 SECTION 30. Said chapter 111O is hereby further amended by adding the following 2  
486 sections:-

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

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

500           (b) Application fees and surcharges collected pursuant to this section shall be deposited  
501 into the Mobile Integrated Health Care Trust Fund established in section 2WWW of chapter  
502 29.

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

506           SECTION 31. Chapter 118E of the General Laws, as appearing in the 2016 Official  
507 Edition, is hereby amended by adding the following section:-

508           Section 78. The division and its contracted health insurers, health plans, health  
509 maintenance organizations, behavioral health management firms and third party administrators  
510 under contract with a Medicaid managed care organization or primary care clinician plan shall  
511 use the aligned measure set established by the secretary pursuant to section 16AA of chapter 6A  
512 as follows: (i) the measures designated by the secretary as core measures shall be used in any  
513 contract with a health care provider, provider organization or accountable care organization that  
514 incorporates quality measures into payment terms; (ii) the measures designated by the secretary  
515 as non-core measures may be used in any contract with a health care provider, provider  
516 organization or accountable care organization that incorporate quality measures into payment  
517 terms and shall not use any measures not designated as non-core measures; (iii) only measures  
518 included in the aligned measure set shall be used to assign health care providers, provider  
519 organizations or accountable care organizations to tiers in the design of a program of medical  
520 benefits to a beneficiary under section 9A.

521           SECTION 32. Chapter 175 of the General Laws, as appearing in the 2016 Official  
522 Edition, is hereby amended by inserting after section 108M the following 2 sections:-

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

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

542           SECTION 33. Chapter 176A of the General Laws, as appearing in the 2016 Official  
543 Edition, is hereby amended by adding the following 2 sections:-

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

552 Section 39. A nonprofit hospital service corporation organized under this chapter shall  
553 use the standard quality measure set established by the secretary of health and human services  
554 pursuant to section 16AA of chapter 6A as follows: (i) a nonprofit hospital service corporation  
555 shall use the measures designated by the secretary as core measures in any contract with a health  
556 care provider, provider organization or accountable care organization that incorporates quality  
557 measures into payment terms; (ii) a nonprofit hospital service corporation may use the measures  
558 designated by the secretary as non-core measures in any contract with a health care provider,  
559 provider organization or accountable care organization that incorporates quality measures into  
560 payment terms and shall not use any measures not designated as non-core measures; (iii) a  
561 nonprofit hospital service corporation shall only use the measures in the aligned measure set  
562 established by the secretary to assign health care providers, provider organizations or  
563 accountable care organizations to tiers in the design of a group hospital service plan.

564 SECTION 34. Chapter 176B of the General Laws, as appearing in the 2016 Official  
565 Edition, is hereby amended by adding the following 2 sections:-

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

574 Section 26. A nonprofit medical service corporation organized under this chapter shall  
575 use the standard quality measure set established by the secretary of health and human services  
576 pursuant to section 16AA of chapter 6A as follows: (i) a nonprofit medical service corporation  
577 shall use the measures designated by the secretary as core measures in any contract with a health  
578 care provider, provider organization or accountable care organization that incorporates quality  
579 measures into payment terms; (ii) a nonprofit medical service corporation may use the measures  
580 designated by the secretary as non-core measures in any contract with a health care provider,  
581 provider organization or accountable care organization that incorporates quality measures into  
582 payment terms and shall not use any measures not designated as non-core measures; (iii) a  
583 nonprofit medical service corporation shall only use the measures in the aligned measure set  
584 established by the secretary to assign health care providers, accountable care organizations or  
585 provider organizations to tiers in the design of a group medical service plan.

586 SECTION 35. Chapter 176G of the General Laws, as appearing in the 2016 Official  
587 Edition, is hereby amended by adding the following 2 sections:-

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

596 Section 34. A health maintenance organization organized under this chapter shall use the  
597 standard quality measure set established by the secretary of health and human services pursuant  
598 to section 16AA of chapter 6A as follows: (i) a health maintenance organization shall use the  
599 measures designated by the secretary as core measures in any contract with a health care  
600 provider, provider organization or accountable care organization that incorporates quality  
601 measures into payment terms; (ii) a health maintenance organization may use the measures  
602 designated by the secretary as non-core measures in any contract with a health care provider,  
603 provider organization or accountable care organization that incorporates quality measures into  
604 payment terms and shall not use any measures not designated as non-core measures; (iii) a health  
605 maintenance organization shall only use the measures in the aligned measure set established by  
606 the secretary to assign health care providers, accountable care organizations or provider  
607 organizations to tiers in the design of any health maintenance contract.

608 SECTION 36. Chapter 176I of the General Laws, as appearing in the 2016 Official  
609 Edition, is hereby amended by adding the following section:-

610 Section 14. An organization shall use the standard quality measure set established by the  
611 secretary of health and human services pursuant to section 16AA of chapter 6A as follows: (i) an  
612 organization shall use the measures designated by the secretary as core measures in any contract  
613 with a health care provider, provider organization or accountable care organization that  
614 incorporates quality measures into payment terms; (ii) an organization may use the measures  
615 designated by the secretary as non-core measures in any contract with a health care provider,  
616 provider organization or accountable care organization that incorporates quality measures into  
617 payment terms and shall not use any measures not designated as non-core measures; (iii) an  
618 organization shall only use the measures in the aligned measure set established by the secretary

619 to assign health care providers, accountable care organizations or provider organizations to tiers  
620 in the design of a health benefit plan.

621 SECTION 37. Chapter 176J of the General Laws, as appearing in the 2016 Official  
622 Edition, is hereby amended by striking out section 11, as appearing in the 2016 Official Edition,  
623 and inserting in place thereof the following section:-

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

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

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

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

641 offer to all eligible individuals and small businesses in not less than 2 geographic areas at least 1  
642 of the following plans:

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

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

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

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

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

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

661 prices, as determined pursuant to the methodology under said section 52 of chapter 288 of the  
662 Acts of 2010.

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

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

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

680 The commissioner shall promulgate regulations requiring the uniform reporting of tiering  
681 information by carriers. The regulations shall include, but not be limited to, a requirement that a  
682 carrier that is implementing a tiered network plan or is modifying the tiering methodology for an

683 existing tiered network plan shall report a detailed description of the methodology used for the  
684 tiering of providers to the commissioner not less than 90 days before the effective date of the  
685 plan or modification. The description shall include, but not be limited to: (i) the statistical basis  
686 for tiering; (ii) a list of providers to be tiered at each member cost-sharing level; (iii) a  
687 description of how the methodology and resulting tiers shall be communicated to each network  
688 provider, eligible individuals and small groups; (iv) a description of the appeals process a  
689 provider may pursue to challenge the assigned tier level; and (v) the utilization of a variable  
690 premium amount based on tier designation for the primary care provider selected by the member,  
691 if any.

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

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

701 (g) A carrier may reclassify provider tiers and determine provider participation in  
702 selective and tiered plans not more than once per calendar year; provided, however, that a carrier  
703 may reclassify a provider from a higher cost tier to a lower cost tier or add a provider to a  
704 selective network at any time. If a carrier reclassifies provider tiers or providers participating in a

705 selective plan during the course of an account year, the carrier shall provide notice to affected  
706 members of the account that shall include information regarding the plan changes not less than  
707 30 days before the changes are to take effect. A carrier shall provide information on the carrier's  
708 website about any tiered or selective plan including, but not limited to, the providers  
709 participating in the plan, the selection criteria for those providers and, where applicable, the tier  
710 in which each provider is classified.

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

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

723 (i) The commissioner shall make publicly available on the commissioner's website: (i) a  
724 description of each plan offered under this section, including a list of providers or services by tier  
725 or a list of providers included in a selective network plan; (ii) membership trends for each plan  
726 offered under this section; (iii) the extent to which plans offered under this section have reduced

727 health care costs for patients and employers; and (iv) the effect of plans offered under this  
728 section on provider mix and other factors impacting overall state health care costs. The  
729 commissioner shall ensure that the information is updated not less than annually.

730 Nothing in this section shall exempt an insurance carrier or product from state and federal  
731 mental health parity and addiction equity laws, including those codified at 42 U.S. Code §  
732 300gg-26, and regulations implemented pursuant to section 8K of chapter 26. Nothing in this  
733 section shall create a lesser standard of scrutiny for parity compliance for any reduced, tiered or  
734 discounted plan established pursuant to this section.

735 SECTION 38. Said chapter 176J is hereby further amended by adding the following  
736 section:-

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

744 SECTION 39. Clause (a) of section 7 of chapter 176O of the General Laws, as appearing  
745 in the 2016 Official Edition, is hereby amended by striking out clause (1) and inserting in place  
746 thereof the following clause:-

747 (1) a list of health care providers in the carrier's network, organized by specialty and by  
748 location, along with a summary on its internet website for each provider that shall include: (i) the

749 method used to compensate or reimburse the provider, including details of measures and  
750 compensation percentages tied to any incentive plan or pay for performance provision; (ii) the  
751 provider price relativity, as reported under section 10 of chapter 12C ; (iii) the provider's health  
752 status adjusted total medical expenses, as defined in and reported under said section 10 of said  
753 chapter 12C; and (iv) current measures of the provider's quality using the measures established  
754 by the secretary of health and human services pursuant to section 16AA of chapter 6A; provided,  
755 however, that if any specific provider or type of provider requested by an insured is not available  
756 in the network or is not a covered benefit, the information shall be provided in an easily  
757 obtainable manner; provided further, that the carrier shall prominently promote providers based  
758 on quality performance as measured by the measures established by the secretary of health and  
759 human services pursuant to said section 16AA of said chapter 6A and cost performance as  
760 measured by health status adjusted total medical expenses and relative prices.

761 SECTION 40. Section 9A of said chapter 176O, as so appearing, is hereby amended by  
762 inserting after the word “approval”, in line 15, the following words:- unless the provider is  
763 included in a tier for a set of shoppable health care services pursuant to clause (iv) of subsection  
764 (b) of section 11 of chapter 176J.

765 SECTION 41. Chapter 176Q of the General Laws is hereby amended by striking out  
766 section 7A, as appearing in the 2016 Official Edition, and inserting in place thereof the following  
767 section:-

768 Section 7A. (a) There shall be a small group incentive program to expand the prevalence  
769 of employee health plans offered by small businesses that shall be administered by the board, in  
770 consultation with the department of public health. The program shall provide subsidies and

771 technical assistance for eligible small groups that offer health plans to employees. A small group  
772 shall be eligible to participate in the program if the small group purchases group coverage  
773 through the connector and meets certain criteria determined by the board. In determining such  
774 criteria, the board may consider, but not be limited to considering, the following factors: (i) the  
775 size of the employer group; (ii) the amount of an employer's subsidy for the cost of employee  
776 coverage; (iii) the average salary of employees in the group; (iv) enrollment in a high-value plan  
777 that promotes employee wellness; and (v) participation in a plan-administered or employer-  
778 administered wellness program.

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

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

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

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

793 SECTION 42. The General Laws are hereby amended by inserting after chapter 176V the  
794 following chapter:-

795 CHAPTER 176W.

796 HOSPITAL ALIGNMENT AND REVIEW COUNCIL.

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

799 “Carrier”, an insurer licensed or otherwise authorized to transact accident or health  
800 insurance under chapter 175, a nonprofit hospital service corporation organized under chapter  
801 176A, a nonprofit medical service corporation organized under chapter 176B, a health  
802 maintenance organization organized under chapter 176G and an organization entering into a  
803 preferred provider arrangement under chapter 176I; provided, however, that “carrier” shall not  
804 include an employer purchasing coverage or acting on behalf of its employees or the employees  
805 of any subsidiary or affiliated corporation of the employer; provided further, that unless  
806 specifically stated otherwise, “carrier” shall not include an entity that offers a policy, certificate  
807 or contract that provides coverage solely for dental care services or vision care services.

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

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

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

811 “Division”, the division of insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

858 (c) Annually, the center, in consultation with the commission, shall submit a report to the  
859 council on the statewide commercial relative price distribution and growth in hospital spending  
860 not later than October 1. The council shall review the report and certify, not later than December  
861 1, whether the conditions established under subsection (a) were satisfied for the previous year.

862 Section 4. (a) Carriers shall annually certify to the division that all rates filed align with  
863 the target hospital rate distribution.

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

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

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

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

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

895 The joint committee on health care financing may, not later than 30 days after the  
896 submission of the proposed definitions with the clerks of the senate and house of representatives,  
897 the joint committee on health care financing and the senate and house committees on ways and  
898 means, hold a public hearing on the proposed definitions. The joint committee may report its

899 findings to the general court, together with drafts of legislation necessary to implement those  
900 findings. In the report, the joint committee may include its recommendation on whether to affirm  
901 or modify the proposed definitions. The joint committee shall issue any findings not later than  
902 20 days after the public hearing and shall provide a copy of the findings and any proposed  
903 legislation to the board. If the general court does not enact legislation with respect to the  
904 recommendations within 65 days after the commission has submitted the recommendations to the  
905 joint committee, the proposed definitions shall be in effect until the definitions proposed take  
906 effect.

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

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

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

919 Section 5. There shall be an advisory committee to the council. The committee shall  
920 support its responsibilities under this section. The committee shall be chosen by the council and

921 shall ensure broad representation of carriers and hospitals across regions, of different sizes and, if  
922 a hospital, payer mix and other stakeholders.

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

924 SECTION 43. Notwithstanding any general or special law to the contrary, the hospital  
925 alignment and review council established under section 2 of chapter 176W of the General Laws  
926 shall define “target hospital growth rate” to have the same meaning as “market basket percentage  
927 increase” as defined under 42 U.S.C. section 1395ww , unless this definition is otherwise  
928 amended under section 4 of said chapter 176W after January 1, 2022.

929 SECTION 44. Notwithstanding any general or special law to the contrary, the hospital  
930 alignment and review council established under section 2 of chapter 176W of the General Laws  
931 shall define “target hospital rate distribution” as .85 per cent of the statewide commercial relative  
932 price in the previous calendar year for each acute care hospital, provided however that if that  
933 acute care hospital is a member of a provider organization, as defined in section 1 of chapter 6D,  
934 that contains one or more acute care hospitals licensed under section 51 of chapter 111, that  
935 acute care hospital shall not be eligible unless the commercial volume weighted statewide  
936 average relative price of all acute care hospitals in that provider organization is less than or equal  
937 to .95; provided further that a disproportionate share hospital, as defined in section 1 of chapter  
938 6D, shall receive .90 percent of the statewide average commercial relative price in the previous  
939 calendar year, provided however that if that disproportionate share hospital is a member of a  
940 provider organization, as defined in section 1 of chapter 6D, that contains one or more acute care  
941 hospitals licensed under section 51 of chapter 111, that disproportionate share hospital shall not  
942 be eligible unless the commercial volume weighted statewide average relative price of all acute

943 care hospitals in that provider organization is less than or equal to .95, unless this definition is  
944 otherwise amended under section 4 of said chapter 176W after January 1, 2022 .

945 SECTION 45. Notwithstanding any general or special law to the contrary, the executive  
946 office of health and human services, in collaboration with the executive office of elder affairs,  
947 the office of Medicaid and the department of public health, shall develop a post-acute care  
948 referral consultation program, subject to appropriation, of regional consultation teams to: (i)  
949 assist providers and consumers in determining appropriate post-acute care settings and  
950 coordinating patient care and (ii) share best practices among providers. The program shall also  
951 ensure education and outreach on provider pre-admission counseling required under section 9 of  
952 chapter 118E of the General Laws.

953 SECTION 46. Notwithstanding any general or special law to the contrary, all commercial  
954 insurers, hospital service corporations, medical service corporations and health maintenance  
955 organizations shall:

956 (i) not later than July 1, 2020, reimburse for health care services with alternative payment  
957 methodologies for not less than 50 per cent of its enrollees; provided, however, that 25 per cent  
958 of its enrollees shall be under alternative payment methodologies that require providers to bear  
959 downside risk at a level not less than the amount required of a MassHealth accountable care  
960 organization;

961 (ii) not later than July 1, 2023, reimburse for health care services with alternative  
962 payment methodologies for not less than 65 per cent of its enrollees; provided, however, that 45  
963 per cent of its enrollees shall be under alternative payment methodologies that require providers

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

966 (iii) not later than July 1, 2026, reimburse for health care services with alternative  
967 payment methodologies for not less than 85 per cent of its enrollees; provided, however, that 65  
968 per cent of its enrollees shall be under alternative payment methodologies that require providers  
969 to bear downside risk at a level not less than the amount required of a MassHealth accountable  
970 care organization.

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

974 SECTION 47. Notwithstanding any general or special law to the contrary, the executive  
975 office of health and human services shall apply for a federal waiver of the requirements of  
976 section 1886(q) of the federal Social Security Act.

977 SECTION 48. Notwithstanding any general or special law to the contrary, the  
978 readmission reduction benchmark under chapter 6D of the General Laws shall be not less than a  
979 5 per cent reduction of readmissions and no more than a 20 per cent reduction of readmission  
980 rates, as measured by the health policy commission in consultation with the center for health  
981 information and analysis, between those rates observed in the year 2019 and those rates observed  
982 in the year 2022.

983 SECTION 49 . Notwithstanding any general or special law to the contrary, the health  
984 policy commission shall identify health care trailblazers under section 19 of chapter 6D of the  
985 General Laws that have either: (i) demonstrated success in patient placement in the appropriate

986 care setting through the development of care plans that include education on appropriate use of  
987 emergency services for patients who are deemed high utilizers of emergency departments; or (ii)  
988 established an employer-sponsored insurance plan in which an employer shares an increased  
989 percentage of an employee's premium or cost sharing for employees who receive a lower salary  
990 compared to other employees.

991 SECTION 50 . Notwithstanding any general or special law to the contrary, the office of  
992 Medicaid may establish and offer an optional expanded Medicaid plan for purchase by an  
993 individual or by an employer as an employer-sponsored insurance plan. The optional expanded  
994 plan may set alternate eligibility and cost-sharing standards beyond those established by section  
995 9A of chapter 118E of the General Laws and may condition participation in the program;  
996 provided, however, that any optional expanded plan offered to an employer shall require the  
997 employer to pay not less than 50 per cent of the projected cost of coverage for participating  
998 employees. The office may adjust benefits offered through an optional plan under this section;  
999 provided, however, that the office shall maintain the benefit and cost-sharing standards for those  
1000 individuals and employees that meet the eligibility standards established by said section 9A of  
1001 said chapter 118E.

1002 The office may establish premiums or cost-sharing requirements for an optional  
1003 expanded plan that are equal to or exceed the costs of covering participating members based on  
1004 the per-member-per-month expenditures or other measures. Additional revenue generated in  
1005 excess of the cost to administer the expanded plan may be used to increase provider payment  
1006 rates within the optional expanded plan and the MassHealth program under said section 9A of  
1007 said chapter 118E or otherwise may be applied to the sustainability of the MassHealth program.

1008           An individual eligible for MassHealth under said section 9A of said chapter 118E shall  
1009 receive commensurate cost sharing, coverage and benefits as they would receive under said  
1010 section 9A of said chapter 118E, regardless of participation in the optional expanded plan  
1011 through their employer. Nothing in this section shall preclude the office from requiring an  
1012 employee to participate in the premium assistance program or a commensurate program.

1013           The office may, in addition to premiums or cost sharing required from employers for  
1014 employees on the optional expanded plan, require contributions from an employer that  
1015 participates in the optional expanded plan as employer-sponsored insurance, for an employee  
1016 that meets the eligibility standards under said section 9A of said chapter 118E.

1017           The office may apply for federal authorization to permit the application of available  
1018 subsidies for participation in the optional expanded plan including, but not limited to, advance  
1019 premium tax credits, cost-sharing reductions or state wrap funds applicable to the purchase of  
1020 MassHealth coverage through the commonwealth health insurance connector authority.

1021           Not later than October 1, 2020, the office shall file a plan outlining: (i) whether the office  
1022 plans to implement an optional expanded plan; (ii) recommended statutory language, if any; (iii)  
1023 expected benefits and cost sharing to be offered through the optional expanded plan; (iv)  
1024 expected start-up costs to implement the optional expanded plan; (v) expected revenue from the  
1025 optional expanded plan to support the full MassHealth program; and (vi) expected savings to the  
1026 MassHealth program related to the implementation of an optional expanded plan.

1027           SECTION 51. Notwithstanding any general or special law to the contrary, the office of  
1028 Medicaid shall seek federal approval to amend its state plan amendment and regulations to  
1029 permit member access to urgent care facilities for emergency services without requiring a

1030 referral or prior authorization. The office shall provide a progress report to the joint committee  
1031 on health care financing and the senate and house committees on ways and means not later than  
1032 January 1, 2020 and shall issue updated regulations not later than July 1, 2020.

1033 SECTION 52. Notwithstanding any general or special law to the contrary, the executive  
1034 office of health and human services, in consultation with the Massachusetts eHealth Institute,  
1035 shall maximize information sharing, to the extent permissible under relevant privacy law,  
1036 between the senior information management system operated by the executive office of elder  
1037 affairs and electronic health records systems operated by health care providers.

1038 Not later than January 1, 2020, the executive office of health and human services shall  
1039 provide a report on electronic information sharing efforts between the senior information  
1040 management system and other electronic health records systems, any existing barriers to  
1041 electronic information sharing and planned efforts to reduce such barriers to the clerks of the  
1042 senate and house of representatives, the joint committee on elder affairs, the joint committee on  
1043 health care financing and the senate and house committees on ways and means.

1044 SECTION 53. The office of Medicaid shall report on the role of long-term services and  
1045 supports within MassHealth and MassHealth accountable care organizations in each year of the  
1046 accountable care organization demonstration. The report shall include: (i) the baseline number of  
1047 accountable care organization-attributed MassHealth members receiving long-term services and  
1048 supports, disaggregated by age category, disability status, service type, and any other relevant  
1049 categories; (ii) total MassHealth spending on long-term services and supports and number of  
1050 members receiving long-term services and supports disaggregated by age category, disability  
1051 status, service type, and any other relevant categories; (iii) MassHealth average per member, per

1052 month long-term services and supports costs by service type; (iv) any projected changes in  
1053 utilization of long-term services and supports in the coming year and the rationale for such  
1054 changes; (v) any estimated shift in spending between medical and long-term services and  
1055 supports or social services spending within the accountable care organization program in the  
1056 prior year of the demonstration; (vi) the process for determination of long-term services and  
1057 supports needs for members attributed to the accountable care organization program,  
1058 disaggregated by accountable care organization if processes differ; and (vii) the appeals process  
1059 for accountable care organization members denied long-term services and supports. This report  
1060 shall be filed with the clerks of the senate and house of representatives, the joint committee on  
1061 health care financing and the senate and house committees on ways and means not later than  
1062 April 1, 2020, and thereafter annually by April 1 for each year of the accountable care  
1063 organization demonstration.

1064 SECTION 54. The executive office of health and human services may support the  
1065 development of pilot programs of supportive housing and affordable housing providers, in  
1066 coordination with health plans that service individuals eligible for Medicaid, Medicare or both  
1067 including, but not limited to, the program for all-inclusive care for the elderly, senior care  
1068 options and other managed care organizations and, in consultation with aging services access  
1069 points, community partners and other stakeholders, to pilot any of the following: (i) establishing  
1070 coordinated care protocols and staffing supports within housing sites that are funded with pooled  
1071 resources to provide a critical mass of plan members necessary for care coordination and targeted  
1072 investment within the housing site; (ii) creating financing models that include social impact  
1073 bonds or other sources; and (iii) establishing care coordination between the housing providers  
1074 and health plans.

1075           The executive office of health and human services may engage the technical assistance  
1076 and program design expertise of an external evaluator, if available, and share relevant data with  
1077 the evaluator to implement this section in accordance with a rigorous evaluation of program  
1078 impact and cost-effectiveness. Any completed evaluation shall be filed with the clerks of the  
1079 senate and house of representatives, the joint committee on health care financing and the senate  
1080 and house committees on ways and means.

1081           SECTION 55. Notwithstanding any general or special law to the contrary, the secretary  
1082 of health and human services shall develop a strategic plan outlining changes to provider funding  
1083 sources, including those related to the adoption of new financing and delivery models of care as  
1084 well as current supplemental payment streams to acute care hospitals. The strategic plan shall  
1085 provide a breakdown of payment sources to providers, including payments authorized under the  
1086 current MassHealth section 1115 demonstration waiver, by payment sources identified as: (i)  
1087 time limited and as ongoing, along with expected benchmarks for providers to demonstrate  
1088 sustainability due to the expiration of a time limited payment source; and (ii) included in an  
1089 alternative payment model or a current supplemental payment.

1090           In developing the strategic plan, the secretary shall consult with a diverse set of providers  
1091 that represent differing regional perspectives, patient volume and acuity and payment structures.

1092           The strategic plan shall identify: (i) regional disparities in funding; (ii) metrics for  
1093 allocating funds that align with new health care financing and delivery models; (iii) opportunities  
1094 to maximize federal financial participation; and (iv) any other factor pertinent to the evaluation  
1095 of different approaches to the allocation of these funds.

1096           The secretary may identify an independent third-party to analyze and evaluate the  
1097 allocation of the funds described in this section. The strategic plan and any underlying analysis  
1098 by the independent third-party shall be filed with the senate and house committees on ways and  
1099 means and the joint committee on health care financing not later than October 1, 2020.

1100           SECTION 56. Notwithstanding any general or special law to the contrary, the center for  
1101 health information and analysis shall conduct a review of a mandated health benefit proposal to  
1102 require coverage of services rendered by a mobile integrated health care provider pursuant to  
1103 chapter 111O of the General Laws. The review shall be performed by the center consistent with  
1104 section 38C of chapter 3 of the General Laws. The center shall evaluate the impact of such a  
1105 mandate as a requirement for all of the health plans and policies under subsection (a) of said  
1106 section 38C of said chapter 3. The center shall file its review with the clerks of the senate and  
1107 house of representatives, the joint committee on health care financing and the senate and house  
1108 committees on ways and means, and the mobile integrated health advisory council established  
1109 pursuant to section 4 of chapter 111O, not later January 1, 2021.

1110           SECTION 57. Notwithstanding any general or special law to the contrary, the health  
1111 policy commission, in consultation with the center for health information and analysis and with  
1112 the technical assistance of an external evaluator, if available, shall review the impact of this act  
1113 on: (i) reduction in hospital readmissions; (ii) emergency department utilization; (iii) reduction in  
1114 post-acute institutional care; (iv) movement of patients toward high-value provider settings; and  
1115 (vi) provider price variation.

1116           SECTION 58. Notwithstanding any general or special law to the contrary, the  
1117 Massachusetts e-Health Institute shall report projects that leverage the commonwealth's

1118 investment in electronic health record deployment and the statewide health information exchange  
1119 and that are likely to have a meaningful impact on cost or quality of care. The report shall  
1120 identify and support such projects and include recommended funding amounts for the projects.  
1121 The institute shall file the report with the clerks of the senate and house of representatives, the  
1122 joint committee on health care financing and the senate and house committees on ways and  
1123 means not later than January 1, 2020.

1124 SECTION 59. There shall be a task force to investigate methods to increase efficiency in  
1125 the health care system through regulatory simplification. The task force shall consist of: the  
1126 secretary of health and human services or a designee, who shall serve as chair; the commissioner  
1127 of public health or a designee; the assistant secretary of the office of Medicaid or a designee; the  
1128 chair of the health policy commission or a designee; 1 member appointed by the senate  
1129 president; 1 member appointed by the speaker of the house; and 8 members appointed by the  
1130 governor, 1 of whom shall be a representative of the Massachusetts Health and Hospital  
1131 Association, Inc., 1 of whom shall be a representative of the Massachusetts League of  
1132 Community Health Centers, 1 of whom shall be a representative of the Massachusetts Medical  
1133 Society, 1 of whom shall be a representative of Association for Behavioral Healthcare, Inc., and  
1134 one of whom shall be a representative of the American Physical Therapy Association of  
1135 Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Association of  
1136 Behavioral Health Systems, Inc., 1 of whom shall be a representative of the Massachusetts  
1137 Nurses Association and 1 of whom shall be a representative of the Home Care Alliance of  
1138 Massachusetts, Inc.

1139 SECTION 60. There shall be a housing security task force to investigate methods to  
1140 encourage housing security as a social determinant of health. The task force shall consist of: the

1141 secretary of housing and economic development or a designee, who shall serve as co-chair; the  
1142 secretary of health and human services or a designee, who shall serve as co-chair; the  
1143 commissioner of public health or a designee; the executive director of the health policy  
1144 commission or a designee; the undersecretary of housing and community development or a  
1145 designee; the commissioner of mental health or a designee; the commissioner of developmental  
1146 services or a designee; and 15 members appointed by the governor, 1 of whom shall be a  
1147 representative of a public housing authority, 1 of whom shall be a provider of emergency shelter  
1148 services to homeless individuals, 1 of whom shall be a representative of Massachusetts Senior  
1149 Care Association, Inc., 1 of whom shall be an expert on affordable housing, 1 of whom shall be a  
1150 representative of the Massachusetts Law Reform Institute, Inc., 1 of whom shall be a  
1151 representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom shall be an  
1152 expert in case management, 1 of whom shall be a representative of the Home Care Alliance of  
1153 Massachusetts, Inc., 1 of whom shall be a representative of Arc Massachusetts, Inc., 1 of whom  
1154 shall be a representative of the Massachusetts Coalition for the Homeless, Inc., 1 of whom shall  
1155 be a representative of the Massachusetts Housing and Shelter Alliance, Inc., 1 of whom shall be  
1156 a representative of the Association for Behavioral Healthcare, Inc., 1 of whom shall be a  
1157 representative of Health Care for All, Inc., 1 of whom shall be a representative of the  
1158 Massachusetts Association of Behavioral Health Systems, Inc. and 1 of whom shall be a  
1159 representative of Citizens Housing And Planning Association, Inc. Members shall be selected to  
1160 ensure broad geographic representation.

1161 The task force shall consider: (i) ways to develop priority designation for shelter beds for  
1162 individuals eligible for discharge from an emergency department or inpatient setting; (ii) ways to  
1163 locate affordable housing for individuals who are homeless or at risk of homelessness; (iii)

1164 recommended policies to increase the amount of affordable housing; (iv) gaps that exist in  
1165 providing post-acute care to individuals residing in shelter beds; and (v) opportunities to  
1166 integrate care coordination or other health services into housing authorities or other housing  
1167 models.

1168           The task force shall hold its first meeting not later than April 1, 2020 and shall meet not  
1169 less than 4 times. The task force may consult with the interagency council on housing and  
1170 homelessness and solicit stakeholder feedback or public testimony. The task force shall file its  
1171 report not later than January 1, 2021 with the clerks of the senate and house of representatives,  
1172 the joint committee on housing, the joint committee on health care financing; the joint committee  
1173 on public health and the senate and house committees on ways and means.

1174           SECTION 61. There shall be a working group to make recommendations on the licensure  
1175 of behavioral health urgent care facilities under section 19A of chapter 19 of the General Laws.

1176           The working group shall consist of: the commissioner of mental health or a designee,  
1177 who shall serve as chair; a representative of the Association for Behavioral Healthcare, Inc.; a  
1178 representative of the Massachusetts Psychiatric Society, Inc.; a representative of The  
1179 Massachusetts Psychological Association, Inc.; a representative of the National Association of  
1180 Social Workers, Inc.; a representative of the Massachusetts Health and Hospital Association,  
1181 Inc.; a representative of the National Alliance on Mental Illness of Massachusetts, Inc.; a  
1182 representative of M-POWER, Inc.; a representative of the Massachusetts Association of  
1183 Behavioral Health Systems; and a representative of the Massachusetts Association for Mental  
1184 Health, Inc.

1185           The working group shall examine and make recommendations on topics including, but  
1186 not limited to: (i) current availability and location of urgent behavioral health care services; (ii)  
1187 barriers to developing or providing urgent behavioral health care services, including rates of  
1188 reimbursement for such services; (iii) adequacy of existing regulatory structure to facilitate the  
1189 development and provision of urgent behavioral health care services; (iv) issues related to  
1190 compliance with state and federal parity laws; and (v) criteria for licensure of behavioral health  
1191 urgent care facilities, including criteria for licensure of behavioral health urgent care facilities.

1192           The working group may hold hearings and invite testimony from experts and the public  
1193 to gather information. The working group shall file a report of its recommendations with the  
1194 clerks of the senate and house of representatives, the joint committee on mental health, substance  
1195 use and recovery, the joint committee on health care financing and the senate and house  
1196 committees on ways and means not later than January 1, 2021.

1197           SECTION 62. (a) Notwithstanding any general or special law to the contrary, the  
1198 following terms shall have the following meanings unless the context clearly requires otherwise:-

1199           “Single payer benchmark”, the estimated total costs of providing health care to all  
1200 residents of the commonwealth under a single payer health care system in a given year.

1201           “Single payer health care”, a system that provides publicly financed, universal access to  
1202 health care for the population through a unified public health care plan.

1203           (b) The center for health information and analysis shall recommend a methodology to  
1204 develop a single payer benchmark. The single payer health care system considered under the  
1205 single payer benchmark shall offer continuous, comprehensive and affordable coverage for all  
1206 residents of the commonwealth regardless of income, assets, health status or availability of other

1207 health coverage. The benchmark may consider the costs of a single-payer health care system at  
1208 different actuarial values, levels of cost-sharing and levels of provider reimbursement; provided,  
1209 however, that the benchmark shall include all actuarial values, levels of cost-sharing and levels  
1210 of provider reimbursement considered by the center. In developing the methodology, the center  
1211 shall monitor, review and evaluate reports related to single payer health care and the  
1212 performance of single payer health care systems in other states and countries.

1213 (c) The center for health information and analysis, in conjunction with the health policy  
1214 commission and the division of insurance, shall provide an annual report detailing a comparison  
1215 of the actual health care expenditures in the commonwealth for 2016, 2017 and 2018 with the  
1216 single payer benchmark for 2016, 2017 and 2018, respectively, indicating whether the  
1217 commonwealth would have saved money while expanding access to care under a single payer  
1218 health care system. The first report shall be filed with the clerks of the senate and house of  
1219 representatives, the joint committee on health care financing and the senate and house  
1220 committees on ways and means not later than January 1, 2020.

1221 (d) If a report under subsection (c) determines that the single payer benchmark  
1222 outperformed the actual total health care expenditures in the commonwealth in 2016, 2017 or  
1223 2018, the health policy commission shall submit a proposed single payer health care  
1224 implementation plan to the clerks of the senate and house of representatives, the joint committee  
1225 on health care financing and the senate and house committees on ways and means within 1 year  
1226 of the date on which the report is filed. The plan may include proposed legislation to implement  
1227 a single payer health care system that offers continuous, comprehensive and affordable coverage  
1228 for all residents regardless of income, assets, health status or availability of other health

1229 coverage. When developing the implementation plan, the commission shall hold not less than 3  
1230 public hearings and seek stakeholder input from across the commonwealth.

1231 SECTION 63. Sections 37 and 40 shall apply to plans submitted to the division of  
1232 insurance on or after January 1, 2021.

1233 SECTION 64. Section 2XXXX of chapter 29 of the General Laws and sections 4 and 5 of  
1234 chapter 176W of the General Laws shall take effect on January 1, 2022.

1235 SECTION 65. Section 30 of chapter 32A of the General Laws, section 81 of chapter  
1236 118E of the General Laws, section 108O of chapter 175 of the General Laws, section 40 of  
1237 chapter 176A of the General Laws, section 27 of chapter 176B of the General Laws, section 35  
1238 of chapter 176G of the General Laws and section 14 of chapter 176I of the General Laws shall  
1239 apply to contracts entered or renewed on or after January 1, 2021.

1240 SECTION 66. Sections 3, 4, 5, 7, 8, 10, 12, 17, 18, 19, and 24 shall take effect on January  
1241 1, 2019.

1242 SECTION 67. The task force established pursuant to section 16AA of chapter 6A of the  
1243 General Laws shall be first convened no later than 120 days after the passage of this act.

1244 SECTION 68. Sections 6, 16, 22, and 49 shall take effect on January 1, 2020.

1245 SECTION 69. Sections 11 and 47 shall take effect on January 1, 2023.