SENATE DOCKET, NO. 1706 FILED ON: 1/18/2019

SENATE . . . . . No. 735

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:	DISTRICT/ADDRESS:
James T. Welch	*Hampden*

SENATE DOCKET, NO. 1706 FILED ON: 1/18/2019

SENATE . . . . . No. 735

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.

The Commonwealth of Massachusetts

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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

care; provided, however, that a mobile integrated health care program certified under chapter 111O shall satisfy this requirement for the purposes of the commission; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) The department shall set fees for licensure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 176W.

HOSPITAL ALIGNMENT AND REVIEW COUNCIL.

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

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

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

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

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

"Division", the division of insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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