

SENATE No. 2211

Senate, November 9, 2017, – Text of the Senate Bill furthering health empowerment and affordability by leveraging transformative health care (being the text of Senate document number 2202, printed as amended)

The Commonwealth of Massachusetts

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

An Act furthering health empowerment and affordability by leveraging transformative health care.

Whereas, The deferred operation of this act would tend to defeat its purpose, which is to further health empowerment and affordability while leveraging transformative health care, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public health.

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

1 SECTION 1. Chapter 6 of the General Laws is hereby amended by inserting after section
2 15DDDDDD, inserted by chapter 53 of the acts of 2017, the following section:-

3 Section 15EEEEEE. The governor shall annually issue a proclamation setting apart May
4 6th as Moyamoya Awareness Day, to raise awareness of the occurrence of this rare
5 neurovascular condition seen in children and adults in which the walls of the internal carotid
6 arteries become thickened and narrowed resulting in reduced blood flow and an increased risk of
7 transient ischemic attacks and strokes, and recommending that the day be observed in an
8 appropriate manner by the people.

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

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

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

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

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

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

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

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

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

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

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

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

77 (b) Annually, not later than July 1, the secretary of health and human services shall
78 establish an aligned measure set to be used by the commonwealth and carriers in contracts with
79 health care providers that incorporate quality measures into the payment terms pursuant to
80 section 28 of chapter 32A, section 81 of chapter 118E, section 108N of chapter 175, section 40
81 of chapter 176A, section 26 of chapter 176B, section 35 of chapter 176G, section 14 of chapter
82 176I and for assigning tiers to health care providers in tiered network plans pursuant to section
83 11 of chapter 176J. The aligned measure set shall designate: (i) core measures that shall be used
84 in contracts between payers, including the commonwealth and carriers, and health care
85 providers, including provider organizations and accountable care organizations, that incorporate
86 quality measures into payment terms; and (ii) non-core measures that may be used in such
87 contracts.

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

91 "Pharmaceutical manufacturing company", an entity engaged in the production,
92 preparation, propagation, conversion or processing of prescription drugs, directly or indirectly,
93 by extraction from substances of natural origin or independently by means of chemical synthesis
94 or by a combination of extraction and chemical synthesis or an entity engaged in the packaging,
95 repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that
96 "Pharmaceutical manufacturing company" shall not include a wholesale drug distributor licensed

97 under section 36B of chapter 112 or a retail pharmacist registered under section 39 of said
98 chapter 112.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

148 SECTION 12. Said section 8 of said chapter 6D, as so appearing, is hereby further
149 amended by inserting after the word “system”, in line 46, the following words:- , information on
150 ongoing provider efforts and initiatives that demonstrate planning and investment in worker

151 readiness, including maintaining the engagement of the workforce and any significant workforce
152 changes implemented during the reporting year.

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

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

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

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

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

175 Section 9A. (a) The commission shall establish an annual statewide readmissions
176 reduction benchmark. In establishing the benchmark, the commission shall consider: (i) the data
177 collected by the center on hospital and provider organization readmission rates from the 3 most
178 recent years for which the center has data; (ii) the distribution of readmissions volume among

179 provider types; (iii) available evidence on feasible interventions to reduce readmissions rates;
180 and (iv) any other relevant information identified by the commission.

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

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

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

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

205 (b) The commission shall review the performance of the provider organizations identified
206 pursuant to subsection (a) and consider: (i) the trends of the provider organization’s readmission
207 rates; (ii) the payer mix of the provider organization; (iii) the demographics and health status of

208 the provider organization's patient population; (iv) the status of the provider organization as an
209 accountable care organization or a participant in an accountable care organization; (v) the
210 percentage of the provider organization's revenue and patient population subject to alternative
211 payment arrangements; (vi) the provider organization's ongoing strategies or investments
212 designed to reduce readmissions; and (vii) any other factor that the commission considers
213 relevant.

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

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

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

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

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

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

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

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

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

263 (3) Upon approval of the proposed readmissions performance improvement plan,
264 the commission shall notify the provider organization to begin immediate implementation of the

265 readmissions performance improvement plan. Public notice shall be provided by the commission
266 on its website, identifying that the provider organization is implementing a readmissions
267 performance improvement plan. A provider organization implementing an approved performance
268 improvement plan shall be subject to additional reporting requirements and compliance
269 monitoring, as determined by the commission. The commission shall provide assistance to the
270 provider organization in order to implement the performance improvement plan successfully.

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

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

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

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

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

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

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

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

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

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

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

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

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

334 (16) to demonstrate evidence-based care delivery programs, which may include
335 community care transitions coaching programs led by community-based, nonprofit entities,
336 designed to reduce: (i) 30-day readmission rates; (ii) avoidable emergency department use,
337 including extended emergency department boarding; or (iii) unwarranted institutional post-acute
338 care; provided, however, that a mobile integrated health care program certified under chapter
339 111O shall satisfy this requirement for the purposes of the commission; and

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

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

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

349 University of Massachusetts medical school and researchers and organizations that are engaged
350 in the development, training and deployment of health practitioner education outreach programs.

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

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

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

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

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

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

383 Section 15B. (a) The commission shall conduct an annual study of pharmaceutical
384 manufacturing companies with pipeline drugs, generic drugs or biosimilar drug products that
385 may have a significant impact on statewide health care expenditures; provided, however, that the
386 commission may issue interim studies if it deems it necessary. The commission may contract
387 with a third-party entity that has familiarity with the development and approval of
388 pharmaceuticals or biologics or studies and compares the clinical effectiveness and value of
389 prescription drugs to implement this section.

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

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

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

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

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

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

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

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

420 Section 16A. (a) The commission shall, upon consideration of advice or any other
421 pertinent evidence, recommend the noncontracted commercial rate for emergency services and
422 the noncontracted commercial rate for nonemergency services, as defined in section 1 of chapter
423 176O. The noncontracted commercial rate for emergency services and the noncontracted
424 commercial rate for nonemergency services shall be in effect for a term of 5 years and shall
425 apply to payments under clauses (ii) and (iv) of section 28 of said chapter 176O.

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

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

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

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

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

458 Section 19. (a) The commission, in consultation with the office of Medicaid, the
459 department of public health, the department of mental health and the department of
460 developmental services, shall develop and implement standards of certification for health care
461 trailblazer organizations for innovative practices that can be translated to similar organizations or

462 impact the health care delivery system. The standards developed by the commission shall be
463 based on the following: (i) demonstrated cost savings to the organization or the health care
464 delivery system; (ii) evidence of quality care improvement at a sustained or lower relative cost;
465 (iii) the actual and scalable impact of the innovative practices on the health care delivery system;
466 (iv) documented feedback from the individuals or patients targeted by the innovation; and (v)
467 such other criteria as determined by the commission.

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

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

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

479 SECTION 28. Chapter 12 of the General Laws is hereby amended by striking out section
480 11N and inserting in place thereof the following section:-

481 Section 11N. (a) The attorney general shall monitor trends in the health care market
482 including, but not limited to, trends in provider organization size and composition, consolidation
483 in the provider market, payer contracting trends, patient access and quality issues in the health
484 care market and prescription drug cost trends. The attorney general may obtain the following
485 information from a private health care payer, public health care payer, pharmaceutical
486 manufacturing company, pharmacy benefit manager, provider or provider organization as any of
487 those terms may be defined in section 1 of chapter 6D: (i) any information that is required to be
488 submitted under sections 8, 9 10 and 10A of chapter 12C; (ii) filings, applications and supporting
489 documentation related to any cost and market impact review under section 13 of said chapter 6D;
490 (iii) filings, applications and supporting documentation related to a determination of need

491 application filed under section 25C of chapter 111; and (iv) filings, applications and supporting
492 documentation submitted to the federal Centers for Medicare and Medicaid Services or the
493 Office of the Inspector General for any demonstration project. Under section 17 of said chapter
494 12C and section 8 of said chapter 6D and subject to the limitations stated in those sections, the
495 attorney general may require that any provider, provider organization, pharmaceutical
496 manufacturing company, pharmacy benefit manager, private health care payer or public health
497 care payer produce documents, answer interrogatories and provide testimony under oath related
498 to health care costs and cost trends, pharmaceutical costs, pharmaceutical cost trends, the factors
499 that contribute to cost growth within the commonwealth's health care system and the relationship
500 between provider costs and payer premium rates and the relationship between pharmaceutical
501 drug costs and payer premium rates.

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

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

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

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

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

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

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

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

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

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

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

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

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

555 To the extent that the analysis of pharmaceutical manufacturing companies and pharmacy
556 benefit managers pursuant to section 10A increases the expenses of the center, the estimated
557 increase in the center’s expenses shall be fully assessed to pharmaceutical manufacturing
558 companies and pharmacy benefit managers in the same manner as the assessment under section
559 68 of chapter 118E. A pharmacy benefit manager that is a surcharge payor subject to the
560 preceding paragraph and administers either its own: (i) prescription drug, prescription device or
561 pharmacist services; or (ii) prescription drug and device and pharmacist services portion shall not
562 be subject to additional assessment under this paragraph.

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

565 (e) The center, in consultation with the executive office of health and human services,
566 shall develop a process for reporting health care prices and related information from providers
567 for use by consumers, employers and other stakeholders. The center shall develop and
568 periodically update a list of the most common procedures and services and a list of the most
569 common behavioral health services, including outpatient and diversionary mental health and
570 substance use disorder services, based on data collected pursuant to this section and sections 8
571 and 9. The center shall require private and public health care payers to submit the payment rates
572 for procedures and services and other information necessary for the center to determine the rate
573 for every provider with which the payer has contracted or has a compensation arrangement. The
574 center shall make the prices and related information publicly available on the consumer health
575 information website required by section 20. The center shall keep confidential all nonpublic data

576 obtained pursuant to this subsection and shall not disclose such data to any person without the
577 consent of the provider or payer that produced the data; provided, however, that the center may
578 disclose such data in an aggregated format. The center shall promulgate regulations necessary to
579 implement this subsection.

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

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

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

605 between prices charged to purchasers in the commonwealth and purchasers outside of the United
606 States and (xii) any other information deemed necessary by the center.

607 (b) The center shall require the submission of available data and other information
608 from pharmaceutical manufacturing companies and pharmacy benefit managers including, but
609 not limited to: (i) changes in wholesale acquisition costs for prescription drug products as
610 identified by the center; (ii) aggregate, company-level and product-specific research and
611 development to the extent attributable to a specific product or products and other relevant capital
612 expenditures for the most recent year for which final audited data are available for prescription
613 drug products as identified by the center; (iii) the price paid by the manufacturer to acquire the
614 prescription drug product if not developed by the manufacturer; (iv) the 5-year history of any
615 increases in the wholesale acquisition costs; (v) annual marketing and advertising expenditures
616 apportioned by activities directed to consumers and prescribers for prescription drug products as
617 identified by the center; and (vi) a description, suitable for public release, of factors that
618 contributed to reported changes in wholesale acquisition costs for prescription drug products as
619 identified by the center.

620 (c) Except as specifically provided otherwise by the center or under this chapter, data
621 collected by the center pursuant to this section from pharmaceutical manufacturing companies
622 and pharmacy benefit managers shall not be a public record under clause Twenty-sixth of section
623 7 of chapter 4 or under chapter 66.

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

626 Section 11. The center shall ensure the timely reporting of information required under
627 sections 8, 9, 10 and 10A. The center shall notify payers, providers, provider organizations,
628 pharmacy benefit managers and pharmaceutical manufacturing companies of any applicable
629 reporting deadlines. The center shall notify, in writing, a private health care payer, provider,
630 provider organization, pharmacy benefit manager or pharmaceutical manufacturing company that
631 it has failed to meet a reporting deadline and that failure to respond within 2 weeks of the receipt
632 of the notice shall result in penalties. The center shall assess a penalty against a private health
633 care payer, provider, provider organization, pharmacy benefit manager or pharmaceutical

634 manufacturing company that fails, without just cause, to provide the requested information
635 within 2 weeks following receipt of the written notice required under this paragraph of up to
636 \$5,000 per week for each week of delay after the 2-week period following receipt of the written
637 notice; provided, however, that the maximum annual penalty against a private health care payer,
638 provider, provider organization, pharmacy benefit manager or pharmaceutical manufacturing
639 company under this section shall be \$200,000. Amounts collected under this section shall be
640 deposited in the Healthcare Payment Reform Fund established in section 100 of chapter 194 of
641 the acts of 2011.

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

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

647 SECTION 37. Section 12 of said chapter 12C, as so appearing, is hereby amended by
648 striking out, in line 2, the words “and 10” and inserting in place thereof the following words:- ,
649 10 and 10A.

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

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

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

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

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

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

665 “Agency”, any agency of the executive branch of government in the commonwealth,
666 including but not limited to any constitutional or other office, executive office, department,
667 division, bureau, board, commission or committee thereof; or any authority created by the
668 general court to serve a public purpose with either statewide or local jurisdiction.

669 “Board”, the patient safety and medical errors reduction board.

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

672 “Lehman center”, the Betsy Lehman center for patient safety and medical error reduction.

673 “Incident”, an incident that, if left undetected or uncorrected, might have resulted in an
674 adverse event.

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

677 “Patient safety”, freedom from accidental injury.

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

681 (b) There shall be established within the center the Betsy Lehman center for patient safety
682 and medical error reduction. The Lehman center shall serve as a clearinghouse for the
683 development, evaluation and dissemination, including, but not limited to, the sponsorship of
684 training and education programs, of best practices for patient safety and medical error reduction.
685 The Lehman center shall: (i) coordinate the efforts of state agencies engaged in the regulation,

686 contracting or delivery of health care and those individuals or institutions licensed by the
687 commonwealth to provide health care to meet their responsibilities for patient safety and medical
688 error reduction; (ii) assist such entities to work as part of a total system of patient safety; and (iii)
689 develop appropriate mechanisms for consumers to be included in a statewide program for
690 improving patient safety. The Lehman center shall coordinate state participation in any
691 appropriate state or federal reports or data collection efforts relative to patient safety and medical
692 error reduction. The Lehman center shall analyze available data, research and reports for
693 information that would improve education and training programs that promote patient safety.

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

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

716 consumers of health care together with recommendations to improve coordination and
717 effectiveness of the programs and activities.

718 (e) The Lehman center shall: (i) identify and disseminate information about evidence-
719 based best practices to reduce medical errors and enhance patient safety; (ii) develop a process
720 for determining which evidence-based best practices should be considered for adoption; (iii)
721 serve as a central clearinghouse for the collection and analysis of existing information on the
722 causes of medical errors and strategies for prevention; and (iv) increase awareness of error
723 prevention strategies through public and professional education. The information collected by the
724 Lehman center or reported to the Lehman center shall not be a public record as defined in section
725 7 of chapter 4, shall be confidential and shall not be subject to subpoena or discovery or
726 introduced into evidence in any judicial or administrative proceeding, except as otherwise
727 specifically provided by law.

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

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

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

742 SECTION 41. Subsection (a) of section 16 of said chapter 12C, as so appearing, is hereby
743 amended by striking out the first sentence and inserting in place thereof the following sentence:-

744 The center shall publish an annual report based on the information submitted under sections 8, 9,
745 10 and 10A concerning health care provider, provider organization, private and public health
746 care payer, pharmaceutical manufacturing company and pharmacy benefit manager costs and
747 cost trends, under section 13 of chapter 6D relative to market power reviews and under section
748 15 relative to quality data.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

833 SECTION 47. Subsection (d) of section 2GGGG of chapter 29 of the General Laws, as
834 appearing in the 2016 Official Edition, is hereby amended by adding the following sentence:-
835 Monies deposited into the fund under subsection (k) of section 10A of chapter 6D may be
836 expended to support innovative workforce initiatives, including labor management initiatives
837 intended to reduce 30-day readmission rates.

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

841 SECTION 49. Said chapter 29 is hereby further amended by inserting after section
842 2XXXX the following 3 sections:-

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

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

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

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

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

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

884 (d) The council may expend funds collected under clause (ii) of subsection (b) of section
885 4 of chapter 176W to defray premium costs for individuals and employers through a competitive
886 grant program established by the council.

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

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

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

902 Section 3. There shall be within the executive office for administration and finance, but
903 not under its jurisdiction, a special unpaid commission to be known as the group insurance
904 commission. The group insurance commission shall consist of: the secretary of administration
905 and finance; the commissioner of insurance; and 13 members to be appointed by the governor, 1
906 of whom shall be a representative appointed from a list of 3 representatives who shall be
907 nominated by the president of the Retired State, County & Municipal Employees Association of
908 Massachusetts, 1 of whom shall be a health economist and at least 3 of whom shall be full-time
909 state employees, 1 of whom shall be a member of the Massachusetts Public Employees Council
910 #93, AFSCME, Massachusetts State Labor Council, AFL/CIO, to be appointed from a list of 3
911 representatives who shall be nominated by the executive director of the Massachusetts Public
912 Employees Council #93, 1 of whom shall be a member of the Massachusetts State Employees

913 Association, National Association of Government Employees, to be appointed from a list of 3
914 representatives who shall be nominated by the president of the National Association of
915 Government Employees, 1 labor representative to be appointed by the governor from a list of 3
916 representatives who shall be nominated by the president of Local 5000 SEIU/Trial Court, 1 labor
917 representative to be appointed by the governor from a list of 3 representatives who shall be
918 nominated by the president of the Service Employees International Union, Local 509 and 1 labor
919 representative to be appointed by the governor from a list of 3 representatives who shall be
920 nominated by the president of the Massachusetts Organization of State Engineers and Scientists,
921 1 of whom shall be a management representative who shall be appointed from a list of 3
922 representatives nominated by the Massachusetts Municipal Association and 1 of whom shall be a
923 labor representative who shall be appointed from a list of 3 representatives nominated by the
924 president of the teachers' union with the greatest amount of active and retired members enrolled
925 in commission health plans. In addition, upon the transfer of 45,000 subscribers from municipal
926 governmental units to the group insurance commission pursuant to section 19 of chapter 32B,
927 there shall be an additional management representative to be appointed by the governor from a
928 list of 3 representatives who shall be nominated by the Massachusetts Municipal Association and
929 an additional labor representative to be appointed by the governor who shall be selected from a
930 list of 3 representatives of municipal public safety employees nominated by the president of the
931 Massachusetts chapter of the AFL/CIO.

932 Whenever an organization nominates a list of representatives for appointment by the
933 governor under this section, the organization may nominate additional candidates if the governor
934 declines to appoint any of those originally nominated. Not more than 55 per cent of the
935 appointed members of the commission shall be members of the same political party. No member
936 appointed by the governor shall be an insurance agent, broker, employee or officer of an
937 insurance company. Upon the expiration of the term of office of an appointed member, that
938 member's successor shall be appointed in the same manner for a term of 3 years. The
939 commission shall be provided with suitable offices and may, subject to appropriation, incur
940 expenses and appoint an executive director who shall be the executive and administrative head of
941 the commission and who shall not be subject to chapter 31. The commission may authorize the
942 executive director to appoint such employees as may be necessary to administer this chapter.

943 There shall be paid by the commonwealth to each appointive member of the commission the
944 necessary expenses actually incurred in the discharge of their official duties.

945 The commission shall adopt such reasonable rules and regulations as may be necessary
946 for the administration of this chapter and shall make an annual report to the governor and to the
947 general court which shall include any modifications or amendments made to contracts executed
948 under this chapter. The commission shall hold at least 2 public hearings annually to receive
949 comments and feedback from interested parties prior to a board vote related to any amendment to
950 plan design, cost sharing, deductibles or other state employee cost. The rules and regulations
951 shall be in a form that enables employees to understand the benefits available from the insurance
952 program, including the costs thereof.

953 SECTION 51. Section 4 of chapter 32A of the General Laws, as so appearing, is hereby
954 amended by inserting after the word “commonwealth”, in line 12, the following words:- ;
955 provided, however, that the carrier or third-party health care administrator website shall conform
956 to the uniform methodology for a provider’s tier designation pursuant to section 20A of chapter
957 12C.

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

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

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

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

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

971 (i) the claim was submitted fraudulently;

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

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

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

982 (d) For the purposes of this section, "provider" shall mean a mental health clinic or
983 substance use disorder program licensed by the department of public health under chapter 18,
984 111, 111B or 111E , a behavioral, substance use disorder or mental health professional who is
985 licensed under chapter 112 and accredited or certified to provide services consistent with law and
986 who has provided services under an express or implied contract or with the expectation of
987 receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly
988 from the commission or other entity.

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

991 Section 28. (a) As used in this section, "facility fee", "health system", "hospital" and
992 "hospital-based facility" shall have the same meanings as provided in section 28 of chapter
993 176O.

994 (b) Coverage offered by the commission to an active or retired employee of the
995 commonwealth insured under the group insurance commission shall not impose a separate

996 copayment on an insured or provide reimbursement to a hospital, health system or hospital-based
997 facility for services provided at a hospital, health system or hospital-based facility or for
998 reimbursement to any such hospital, health system or hospital-based facility for a facility fee for
999 services utilizing a current procedural terminology evaluation and management code or which is
1000 otherwise limited pursuant to section 51L of chapter 111.

1001 A hospital, health system or hospital-based facility shall not charge, bill or collect from
1002 an insured a facility fee greater than the facility fee reimbursement rate agreed to by the carrier
1003 pursuant to an insured's policy.

1004 (c) Nothing in this section shall prohibit the commission from offering coverage that
1005 restricts the reimbursement of facility fees beyond the limitations set forth in section 51L of
1006 chapter 111.

1007 Section 29. (a) For the purposes of this section, "telemedicine" shall mean the use of
1008 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
1009 patient's physical, oral or mental health; provided, however, that "telemedicine" shall not include
1010 audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

1011 (b) Coverage offered by the commission to an active or retired employee of the
1012 commonwealth insured under the group insurance commission shall provide coverage for health
1013 care services through the use of telemedicine by a contracted health care provider if the health
1014 care services are covered by way of in-person consultation or delivery. Health care services
1015 delivered by way of telemedicine shall be covered to the same extent as if they were provided via
1016 in-person consultation or delivery.

1017 (c) Coverage may include utilization review, including preauthorization, to determine the
1018 appropriateness of telemedicine as a means of delivering a health care service, provided that the
1019 determination shall be made in the same manner as if the service was delivered in person. A
1020 carrier shall not be required to reimburse a health care provider for a health care service that is
1021 not a covered benefit under the plan nor reimburse a health care provider not contracted under
1022 the plan.

1023 A health care provider shall not be required to document a barrier to an in-person visit,
1024 nor shall the type of setting where telemedicine is provided be limited for health care services
1025 provided through telemedicine.

1026 Coverage for telemedicine services may include a deductible, copayment or coinsurance
1027 requirement for a health care service provided through telemedicine as long as the deductible,
1028 copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable
1029 to an in-person consultation or in-person delivery of services.

1030 (d) Coverage that reimburses a provider with a global payment, as defined in section 1 of
1031 chapter 6D, shall account for the provision of telemedicine services to set the global payment
1032 amount.

1033 (e) Health care services provided by telemedicine shall conform to the standards of care
1034 applicable to the telemedicine provider's profession. Such services shall also conform to
1035 applicable federal and state health information privacy and security standards as well as
1036 standards for informed consent.

1037 Section 30. The commission shall require a carrier or a third party administrator with
1038 whom a carrier contracts to use the aligned measure set established by the secretary pursuant to
1039 section 16AA of chapter 6A as follows: (i) the carrier or third party administrator shall use the
1040 measures designated by the secretary as core measures in any contract between a health care
1041 provider, provider organization or accountable care organization that incorporates quality
1042 measures into payment terms; (ii) the carrier or third party administrator may use the measures
1043 designated by the secretary as non-core measures in any contract with a health care provider,
1044 provider organization or accountable care organizations that incorporates quality measures into
1045 payment terms and shall not use any measures not designated as non-core measures; (iii) the
1046 carrier or third party administrator shall only use the measures in the aligned measure set
1047 established by the secretary to assign health care providers, provider organization or accountable
1048 care organization to tiers in the design of a health plan.

1049 SECTION 54. Subsection (a) of section 6D of chapter 40J of the General Laws, as
1050 appearing in the 2016 Official Edition, is hereby amended by inserting after the third sentence
1051 the following sentence:- The institute shall partner with the health care and technology

1052 community to accelerate the creation and adoption of digital health to drive economic growth
1053 and improve health care outcomes and efficiency.

1054 SECTION 55. Said section 6D of said chapter 40J, as so appearing, is hereby further
1055 amended by striking out, in lines 16 to 18, inclusive, the words “and (3) develop a plan to
1056 complete the implementation of electronic health records systems by all providers in the
1057 commonwealth” and inserting in place thereof the following words:- (3) develop a plan to
1058 complete the implementation of electronic health records systems by all providers in the
1059 commonwealth; and (4) advance the commonwealth’s economic competitiveness by supporting
1060 the digital health industry, including the digital health industry’s role in improving the quality of
1061 health care delivery and patient outcomes.

1062 SECTION 56. Said section 6D of said chapter 40J, as so appearing, is hereby further
1063 amended by adding the following subsection:-

1064 (h) Notwithstanding any provision of this section to the contrary, if a significant portion
1065 of health care providers, as determined by the institute’s director, implement and use
1066 interoperable electronic health records systems, the institute shall prioritize achieving the goal of
1067 improving the commonwealth’s economic competitiveness in digital health through
1068 implementation of subsections (f) and (g).

1069 SECTION 57. Subsection (b) of section 7B of chapter 64C of the General Laws, as so
1070 appearing, is hereby amended by adding the following paragraph:-

1071 In addition to the excise imposed by the first paragraph, an excise shall be imposed on
1072 fruit-flavored or other nontobacco-flavored cigars and smoking tobacco at the rate of 170 per
1073 cent of the wholesale price of such products. The excise shall be imposed on cigar distributors at
1074 the time the fruit-flavored or other nontobacco-flavored cigars or smoking tobacco are
1075 manufactured, purchased, imported, received or acquired in the commonwealth. The excise shall
1076 not be imposed on any such cigars or smoking tobacco that: (i) are exported from the
1077 commonwealth; or (ii) are not subject to taxation by the commonwealth pursuant to any federal
1078 law. The excise imposed pursuant to this paragraph shall be deposited in the Prevention and
1079 Wellness Trust Fund established under section 2G of chapter 111.

1080 SECTION 58. Chapter 93 of the General Laws is hereby amended by striking out section
1081 73, as so appearing, and inserting in place thereof the following section:-

1082 Section 73. No physician shall sell hearing aids or have a direct or indirect membership,
1083 employment, co-ownership or proprietary interest in or with a business which sells hearing aids
1084 to a person to whom such physician has provided services pursuant to section 72; provided,
1085 however, that this restriction shall not apply to an otolaryngologist or a nonprofit or charitable
1086 organization, clinic, hospital or health care facility which sells hearing aids that are dispensed by
1087 a licensed audiologist or hearing instrument specialist.

1088 An audiologist or otolaryngologist who sells a hearing aid to a person to whom that
1089 audiologist or otolaryngologist provided services pursuant to section 72 shall disclose to the
1090 prospective purchaser before the sale of the hearing aid the fees for the services provided
1091 pursuant to section 72 and the terms of the prospective sale of the hearing aid, including a written
1092 estimate of the total purchase price, including, but not limited to, the cost of the hearing aid, the
1093 earmold, any batteries or other accessories, and any service costs, and shall inform the
1094 prospective purchaser of his right to obtain a hearing aid from a different source.

1095 No person, directly or indirectly, shall give or offer to give, permit or cause to be given
1096 money or anything of value to a physician, otolaryngologist or audiologist as an inducement to
1097 influence the recommendation of the purchase of a hearing aid. Nothing in this section shall
1098 prevent an audiologist, physician or otolaryngologist from suggesting a specific make and model
1099 of a hearing aid.

1100 SECTION 59. Section 1 of chapter 94C of the General Laws is hereby amended by
1101 inserting after the definition for “Marihuana”, as amended by section 14 of chapter 55 of the acts
1102 of 2017, the following definition:-

1103 “Medication Order”, an order for medication entered on a patient's medical record
1104 maintained at a hospital, other health facility or ambulatory health care setting registered under
1105 this chapter; provided, however, that the order is dispensed only for immediate administration at
1106 the facility to the ultimate user by an individual who administers such medication under this
1107 chapter.

1108 SECTION 60. Said section 1 of said chapter 94C is hereby further amended by striking
1109 out, in line 308, as appearing in the 2016 Official Edition, the words “and 66B” and inserting in
1110 place thereof the following words:- , 66B and 66C.

1111 SECTION 61. The definition of “Practitioner” in said section 1 of said chapter 94C, as so
1112 appearing, is hereby amended by adding the following 3 clauses:-

1113 (d) a nurse practitioner registered pursuant to subsection (f) of section 7 and authorized
1114 by section 80E of chapter 112 to distribute, dispense, conduct research with respect to or use in
1115 teaching or chemical analysis a controlled substance in the course of professional practice or
1116 research in the commonwealth.

1117 (e) a nurse anesthetist registered pursuant to subsection (f) of section 7 and authorized by
1118 section 80H of chapter 112 to distribute, dispense, conduct research with respect to or use in
1119 teaching or chemical analysis a controlled substance in the course of professional practice or
1120 research in the commonwealth.

1121 (f) a psychiatric nurse mental health clinical specialist registered pursuant to subsection
1122 (f) of section 7 and authorized by section 80J of chapter 112 to distribute, dispense, conduct
1123 research with respect to or use in teaching or chemical analysis a controlled substance in the
1124 course of professional practice or research in the commonwealth.

1125 SECTION 62. Section 7 of said chapter 94C is hereby amended by inserting after the
1126 word “nurse”, in line 80, the second time it appears, as so appearing, the following words:- , a
1127 licensed dental therapist under the supervision of a practitioner for the purposes of administering
1128 analgesics, anti-inflammatories and antibiotics.

1129 SECTION 63. Said section 7 of said chapter 94C is hereby further amended by inserting
1130 after the word “podiatrist”, in line 122, and in lines 125 and 126, each time it appears, as so
1131 appearing, the following words:- , nurse practitioner, nurse anesthetist, psychiatric nurse mental
1132 health clinical specialist.

1133 SECTION 64. Subsection (g) of said section 7 of said chapter 94C, as so appearing, is
1134 hereby further amended by striking out the second paragraph.

1135 SECTION 65. Said subsection (g) of said section 7 of said chapter 94C, as so appearing,
1136 is hereby further amended by striking out the last paragraph.

1137 SECTION 66. Said section 7 of said chapter 94C is hereby further amended by striking
1138 out, in line 213, as so appearing, the words “and 66B” and inserting in place thereof the
1139 following words:- , 66B and 66C.

1140 SECTION 67. Section 9 of said chapter 94C, as so appearing, is hereby amended by
1141 inserting after the word “podiatrist”, in line 1, the following words:- , nurse practitioner, nurse
1142 anesthetist, psychiatric nurse mental health clinical specialist.

1143 SECTION 68. Said section 9 of said chapter 94C, as so appearing, is hereby further
1144 amended by striking out, in line 2, the words “and 66B” and inserting in place thereof the
1145 following words:- , 66B and 66C.

1146 SECTION 69. Said section 9 of said chapter 94C, as so appearing, is hereby further
1147 amended by striking out, in lines 3 to 5, inclusive, the words “, nurse practitioner and psychiatric
1148 nurse mental health clinical specialist as limited by subsection (g) of said section 7 and section
1149 80E of said chapter 112”.

1150 SECTION 70. Said section 9 of said chapter 94C, as so appearing, is hereby further
1151 amended by striking out, in lines 8 and 9, the words “, nurse anesthetist, as limited by subsection
1152 (g) of said section 7 and section 80H of said chapter 112”.

1153 SECTION 71. Subsection (a) of said section 9 of said chapter 94C, as so appearing, is
1154 hereby amended by adding the following paragraph:-

1155 A practitioner may cause controlled substances to be administered under the
1156 practitioner’s direction by a licensed dental therapist, for the purposes of administering
1157 analgesics, anti-inflammatories and antibiotics.

1158 SECTION 72. Said section 9 of said chapter 94C, as so appearing, is hereby further
1159 amended by inserting after the word “nurse-midwifery”, in line 32, the following words:- ,
1160 advanced practice nursing.

1161 SECTION 73. Said section 9 of said chapter 94C, as so appearing, is hereby further
1162 amended by inserting after the word “podiatrist”, in lines 72 and 80, each time it appears, the
1163 following word:- , optometrist.

1164 SECTION 74. Subsection (c) of said section 9 of said chapter 94C, as so appearing, is
1165 hereby amended by adding the following paragraph:-

1166 A licensed dental therapist who has obtained a controlled substance from a practitioner
1167 for dispensing to an ultimate user under subsection (a) shall return any unused portion of the
1168 substance that is no longer required by the patient to the practitioner.

1169 SECTION 75. Said section 9 of said chapter 94C, as so appearing, is hereby further
1170 amended by inserting after the word “practitioner”, in lines 100 and 107, each time it appears,
1171 the following words:- , nurse anesthetist, psychiatric nurse mental health clinical specialist.

1172 SECTION 76. Section 18 of said chapter 94C is hereby amended by striking out, in lines
1173 10, 39 and 72, as so appearing, the words “to practice medicine” and inserting in place thereof, in
1174 each instance, the following words:- and authorized to engage in prescriptive practice.

1175 SECTION 77. Said section 18 of said chapter 94C, as so appearing, is hereby further
1176 amended by striking out the word “physician”, in lines 25, 38, 72 and 74, and inserting in place
1177 thereof, in each instance, the following word:- practitioner.

1178 SECTION 78. Said section 18 of said chapter 94C, as so appearing, is hereby further
1179 amended by striking out, in lines 27, 54 and 55, and in line 88, the word “medicine”.

1180 SECTION 79. Said chapter 94C is hereby further amended by inserting after section 21B
1181 the following section:-

1182 Section 21C. (a) For the purposes of this section, the following words shall have the
1183 following meanings unless the context clearly requires otherwise:

1184 “Cost sharing”, amounts owed by a consumer under the terms of the consumer’s health
1185 benefit plan as defined in section 1 of chapter 176O or as required by a pharmacy benefit
1186 manager as defined in subsection (a) of section 226 of chapter 175.

1187 “Pharmacy retail price”, the amount an individual would pay for a prescription
1188 medication at a pharmacy if the individual purchased that prescription medication at that
1189 pharmacy without using a health benefit plan as defined in section 1 of chapter 176O or any
1190 other prescription medication benefit or discount.

1191 “Registered pharmacist”, a pharmacist who holds a valid certificate of registration issued
1192 by the board of registration in pharmacy pursuant to section 24 of chapter 112.

1193 (b) A pharmacy shall post a notice informing consumers that a consumer may request, at
1194 the point of sale, the current pharmacy retail price for each prescription medication the consumer
1195 intends to purchase. If the consumer’s cost-sharing amount for a prescription medication exceeds
1196 the current pharmacy retail price, the pharmacist, or an authorized individual at the direction of a
1197 pharmacist, shall notify the consumer that the pharmacy retail price is less than the patient’s cost-
1198 sharing amount. The pharmacist shall charge the consumer the applicable cost-sharing amount
1199 or the current pharmacy retail price for that prescription medication, as directed by the consumer.

1200 A pharmacist shall not be subject to a penalty by the board of registration in pharmacy or
1201 a third party for failure to comply with this section.

1202 (c) A contractual obligation shall not prohibit a pharmacist from complying with this
1203 section; provided, however, that a pharmacist shall submit a claim to the consumer’s health
1204 benefit plan or its pharmacy benefit manager if the pharmacist has knowledge that the
1205 prescription medication is covered under the consumer’s health benefit plan.

1206 (d) A violation of this section shall be an unfair or deceptive act or practice under chapter
1207 93A.

1208 SECTION 80. Section 24A of said chapter 94C, as appearing in the 2016 Official
1209 Edition, is hereby amended by striking out subsection (g) and inserting in place thereof the
1210 following subsection:-

1211 (g) The department may provide data from the prescription monitoring program to
1212 practitioners in accordance with section 24; provided, however, that health care providers, as
1213 defined in section 1 of chapter 111, shall be able to access the data directly through a secure
1214 electronic medical record, health information exchange or other similar software or information

1215 systems connected to the prescription monitoring program to: (i) improve ease of access and
1216 utilization of such data for treatment, diagnosis or health care operations; (ii) support integration
1217 of such data within the electronic health records of a health care provider for treatment, diagnosis
1218 or health care operations; or (iii) allow health care providers and their vendors to maintain such
1219 data for the purposes of compiling and visualizing such data within the electronic health records
1220 of a health care provider that supports treatment, diagnosis or health care operations. The
1221 department may establish protocols or other processes to ensure the secure sharing of patient
1222 information that is compatible and interoperative, to the maximum feasible extent, with existing
1223 electronic medical records systems.

1224 SECTION 81. Chapter 111 of the General Laws is hereby amended by striking out
1225 sections 2G and 2H, as so appearing, and inserting in place thereof the following 2 sections:-

1226 Section 2G. (a) There shall be a Prevention and Wellness Trust Fund to be expended,
1227 without further appropriation, by the department of public health. The fund shall consist of
1228 revenues collected by the commonwealth, including: (i) revenue from appropriations or other
1229 money authorized by the general court and specifically designated to be credited to the fund
1230 including, but not limited to, revenue received under the second paragraph of section 7B of
1231 chapter 64C; (ii) fines and penalties allocated to the fund; (iii) funds from public and private
1232 sources, including gifts, grants, donations and settlements received by the commonwealth to
1233 further community-based prevention activities; (iv) funds provided from any other source; and
1234 (v) interest earned on revenues in the fund . The commissioner of public health, as trustee, shall
1235 administer the fund. The commissioner, in consultation with the prevention and wellness
1236 advisory board established in section 2H, shall make expenditures from the fund consistent with
1237 subsections (d) and (e); provided, however, that not more than 5 per cent of the amounts held in
1238 the fund in any 1 year shall be used by the department for the cost of program administration and
1239 not more than 10 per cent of amounts held in the fund in any 1 year shall be used for technical
1240 assistance to grantees, program evaluation and data analytics.

1241 (b) The department may incur expenses and the comptroller may certify for payment
1242 amounts in anticipation of expected receipts; provided, however, that an expenditure shall not be
1243 made from the fund if it would cause the fund to be in deficit at the close of a fiscal year.

1244 Revenues deposited in the fund that are unexpended at the end of a fiscal year shall not revert to
1245 the General Fund and shall be available for expenditure in the following fiscal year.

1246 (c) Expenditures from the fund shall support the commonwealth's efforts to meet the
1247 health care cost growth benchmark established in section 9 of chapter 6D and at least 1 of the
1248 following: (i) increase access to community-based preventive services and interventions that
1249 complement and expand the ability of MassHealth to promote coordinated care, integrate
1250 community-based services with clinical care and develop innovative ways to address social
1251 determinants of health; (ii) reduce the impact of health conditions that are the largest drivers of
1252 poor health, health disparities, reduced quality of life and high health care costs through
1253 community-based interventions; or (iii) develop a stronger evidence-base of effective prevention
1254 interventions.

1255 (d) Using a competitive grant process, the commissioner shall annually award not less
1256 than 85 per cent of the money in the fund to municipalities, community-based organizations,
1257 health care providers, including, but not limited to, independent community hospitals regional
1258 planning agencies and health plans that apply for the implementation, evaluation and
1259 dissemination of evidence-based community preventive health activities. To be eligible to
1260 receive a grant under this subsection, a recipient shall be a partnership that includes, at a
1261 minimum: (i) a municipality or regional planning agency; (ii) a community-based health or
1262 social service provider; (iii) a public health or community action agency with expertise in
1263 implementing community-wide health interventions; (iv) a health care provider, independent
1264 community hospital or a health plan; and (v) where feasible, a Medicaid-certified accountable
1265 care organization or a Medicaid-certified community partner organization. Expenditures from the
1266 fund pursuant to this subsection shall supplement and not replace existing local, state, private or
1267 federal public health-related funding. An entity that is awarded funds through this program shall
1268 demonstrate the ability to: (A) utilize best practices in accounting; (B) contract with a fiscal
1269 agent who shall perform accounting functions on its behalf; or (C) be provided with technical
1270 assistance by the department to ensure that best practices are followed.

1271 (e) (1) A grant proposal submitted under subsection (d) shall include, but shall not be
1272 limited to: (i) a plan that defines specific goals for the reduction in preventable health conditions
1273 and health care costs over a multi-year period; (ii) the evidence-based or evidence-informed

1274 programs the applicant shall use to meet the goals; (iii) a budget necessary to implement the
1275 plan, including a detailed description of the funding or in-kind contributions the applicant will be
1276 providing in support of the proposal; (iv) any other private funding or private sector participation
1277 that the applicant anticipates in support of the proposal; (v) a commitment to include women,
1278 racial and ethnic minorities and low-income individuals; and (vi) the anticipated number of
1279 individuals that would be affected by the implementation of the plan.

1280 (2) Priority may be given to proposals in a geographic region of the
1281 commonwealth with a higher than average prevalence of preventable health conditions as
1282 determined by the commissioner of public health, in consultation with the prevention and
1283 wellness advisory board. If no proposals from an area of the commonwealth with particular need
1284 are offered, the department shall ask for a specific request for proposals for that specific region.
1285 If the commissioner determines that a suitable proposal has not been received and the particular
1286 need remains unmet, the department may work directly with municipalities or community-based
1287 organizations to develop grant proposals to address particular needs in the geographic region.

1288 (3) The department of public health, in consultation with the prevention and
1289 wellness advisory board, shall develop guidelines for an annual review of the progress being
1290 made by each grantee. Each grantee shall participate in an evaluation or accountability process
1291 implemented or authorized by the department.

1292 (f) Annually, not later than November 1, the department shall report on expenditures
1293 from the fund from the previous fiscal year and anticipated revenues for the next fiscal year. The
1294 report shall include, but not be limited to: (i) the revenue credited to the fund; (ii) revenue and
1295 expenditure projections and details of the anticipated expenditures from the fund for the next
1296 fiscal year; (iii) the amount of fund expenditures attributable to the administrative costs of the
1297 department of public health; (iv) an itemized list of the funds expended through the competitive
1298 grant process and a description of the grantee activities; and (v) the results of the evaluation of
1299 the effectiveness of the activities funded through the grants. The report shall be provided to the
1300 senate and house committees on ways and means, the joint committee on public health and the
1301 joint committee on health care financing and shall be posted on the department's website.

1302 (g) With the advice and guidance of the prevention and wellness advisory board, the
1303 department shall report annually on its strategy for the administration and allocation of the fund,
1304 including relevant evaluation criteria. The report shall set forth the rationale for the strategy,
1305 which may include, but shall not be limited to including: (i) a list of the most prevalent
1306 preventable health conditions in the commonwealth, including health disparities experienced by
1307 populations based on race, ethnicity, gender, disability status, sexual orientation or
1308 socioeconomic status; (ii) a list of the most costly preventable health conditions in the
1309 commonwealth; and (iii) a list of evidence-based or promising community-based programs
1310 related to the conditions identified in clauses (i) and (ii). The report shall recommend specific
1311 areas of focus for the allocation of funds. If appropriate, the report shall reference goals and best
1312 practices established by the National Prevention, Health Promotion and Public Health Council
1313 and the Centers for Disease Control and Prevention including, but not limited to, the Health
1314 Impact in 5 Years initiative, the National Prevention Strategy, the Healthy People report and the
1315 Guide to Community Preventive Services.

1316 (h) The department shall promulgate regulations necessary to carry out this section.

1317 Section 2H. (a) There shall be a prevention and wellness advisory board. The board shall:
1318 (i) make recommendations to the commissioner concerning the administration and allocation of
1319 the Prevention and Wellness Trust Fund established in section 2G; (ii) establish evaluation
1320 criteria; and (iii) perform any other functions specifically granted to it by law.

1321 (b) The board shall consist of: the commissioner of public health or a designee, who shall
1322 serve as chair; the senate and house chairs of the joint committee on public health or their
1323 designees; the senate and house chairs of the joint committee on health care financing or their
1324 designees; the secretary of health and human services or a designee; the executive director of the
1325 center for health information and analysis or a designee; the executive director of the health
1326 policy commission or a designee; and 16 persons to be appointed by the governor, 1 of whom
1327 shall be a person with expertise in the field of public health economics, 1 of whom shall be a
1328 person with expertise in public health research, 1 of whom shall be a person with expertise in the
1329 field of health equity, 1 of whom shall be a person from a local board of health for a city or town
1330 with a population of not less than 50,000, 1 of whom shall be a member of a board of health for a
1331 city or town with a population of less than 50,000, 2 of whom shall be representatives of health

1332 insurance carriers, 1 of whom shall be a person from a consumer health advocacy organization, 1
1333 of whom shall be a person from a hospital association, 1 of whom shall be a person from an
1334 independent community hospital, 1 of whom shall be a person from a statewide public health
1335 organization, 1 of whom shall be a representative of business interests, 1 of whom shall be a
1336 public health nurse or a school nurse, 1 of whom shall be a person from an association
1337 representing community health workers, 1 of whom shall represent a statewide association of
1338 community-based service providers addressing public health and 1 of whom shall be a person
1339 with expertise in the design and implementation of communitywide public health interventions.

1340 (c) (1) The board shall evaluate the grant program under section 2G and shall issue a
1341 report at intervals to be determined by the board but not less than every 5 years from the
1342 beginning of each grant period. The report shall include an analysis of all relevant data to
1343 determine the effectiveness of the program including, but not limited to: (i) the extent to which
1344 the program impacted the prevalence, severity or control of preventable health conditions and the
1345 extent to which the program is projected to impact those factors in the future; (ii) the extent to
1346 which the program reduced health care costs or the growth in health care cost trends and the
1347 extent to which the program is projected to reduce those costs in the future; (iii) whether health
1348 care costs were reduced and who benefited from the reduction; (iv) the extent to which health
1349 outcomes or health behaviors were positively impacted; (v) the extent to which access to
1350 evidence-based community services was increased; (vi) the extent to which social determinants
1351 of health or other community-wide risk factors for poor health were reduced or mitigated; (vii)
1352 the extent to which grantees increased their ability to collaborate, share data and align services
1353 with other providers and community-based organizations for greater impact; (viii) the extent to
1354 which health disparities experienced by populations based on race, ethnicity, gender, disability
1355 status, sexual orientation or socioeconomic status were reduced across all metrics; and (ix)
1356 recommendations for whether the program should be discontinued, amended or expanded and a
1357 timetable for implementation of those recommendations.

1358 (2) The department of public health shall coordinate with grantees to contract with
1359 an outside organization that has expertise in the analysis of public health and health care
1360 financing to assist the board in conducting its evaluation. The outside organization shall be
1361 provided with access to actual health plan data from the all-payer claims database administered

1362 by the center for health information and analysis and to data from MassHealth, to the extent
1363 permitted by law; provided, however, that such data shall be confidential and shall not be a
1364 public record under clause Twenty-sixth of section 7 of chapter 4.

1365 (3) The board shall report the results of its evaluation and its recommendations, if
1366 any, and submit drafts of legislation necessary to carry out the recommendations to the senate
1367 and house committees on ways and means, the joint committee on public health and the joint
1368 committee on health care financing and shall post the board's report on the department's website.

1369 SECTION 82. Section 25N½ of said chapter 111 is hereby amended by striking out
1370 subsection (b) and inserting in place thereof the following subsection:-

1371 (b) Pursuant to regulations to be promulgated by the health care workforce center, there
1372 shall be established a primary care and family medicine residency grant program to finance the
1373 training of primary care providers and family physicians at teaching community health centers.
1374 Eligible applicants shall include teaching community health centers accredited through
1375 affiliations with a commonwealth-funded medical school or licensed as part of a teaching
1376 hospital with a residency program in family medicine and teaching health centers that are the
1377 independently accredited sponsoring organization for the residency program and whose residents
1378 are employed by the health center. Eligible residency programs shall be accredited by the
1379 Accreditation Council for Graduate Medical Education.

1380 To receive funding, an applicant shall: (i) include a review of recent graduates of the
1381 community health center's residency program, including information regarding what type of
1382 practice the graduates are involved in 2 years following graduation from the residency program;
1383 and (ii) achieve a threshold of not less than 95 per cent for the percentage of graduates practicing
1384 primary care within 2 years after graduation. Graduates practicing more than 50 per cent
1385 inpatient care or more than 50 per cent specialty care as listed in the American Medical
1386 Association Masterfile shall not qualify as graduates practicing primary care.

1387 The health care workforce center shall require applicants to include the following
1388 information and give preference to those applicants whom meet at least 1 of the following
1389 criteria: (i) have a proven record of placing graduates in areas of unmet need; (ii) have a record

1390 or written plan of attracting and admitting underrepresented minorities or economically
1391 disadvantaged groups; or (iii) host their programs or clinical training sites in areas of unmet
1392 need.

1393 Awardees of the primary care residency grant program shall offer a 3 to 4 year residency
1394 program and maintain their teaching accreditation as an independent teaching community health
1395 center or as a teaching community health center accredited through affiliation with a
1396 commonwealth-funded medical school or licensed as part of a teaching hospital. All resident
1397 trainees shall be assigned as the primary care provider of a continuity panel of patients and see
1398 those patients in that location not less than 40 weeks per academic year for each of the years of
1399 the residency.

1400 The health care workforce center shall determine through regulation grant amounts per
1401 full-time resident; provided, however, that grant amounts per resident are not less than 85 per
1402 cent of the average federal Centers for Medicare and Medicaid Services annual reimbursement
1403 rate per year and funding is provided for all of the 3 or 4 year residency. Funds for such grants
1404 shall come from the Health Care Workforce Transformation Fund established under section
1405 2FFFF of chapter 29.

1406 SECTION 83. Said chapter 111 is hereby further amended by inserting after section 51K
1407 the following 4 sections:-

1408 Section 51L. (a) For the purposes of this section, the following terms shall have the
1409 following meanings unless the context clearly indicates otherwise:

1410 “Campus”, the physical area immediately adjacent to a hospital's main buildings and
1411 other areas and structures that are not strictly contiguous to the main buildings but are located not
1412 more than 250 yards from the main buildings or any other area that has been determined on an
1413 individual case basis by the Centers for Medicare & Medicaid Services to be part of a hospital's
1414 campus.

1415 “Carrier”, shall have the same meaning as provided in section 1 of chapter 176O.

1416 “Facility fee”, shall have the same meaning as provided in section 28 of chapter 176O.

1417 “Health system”, shall have the same meaning as provided in section 28 of chapter 176O.

1418 “Hospital-based facility”, shall have the same meaning as provided in section 28 of
1419 chapter 176O.

1420 (b) A hospital, health system or hospital-based facility shall not charge, bill or collect a
1421 facility fee for services utilizing a current procedural terminology evaluation and management
1422 code if the service was provided by a hospital-based facility located off of a campus unless the
1423 facility fee was charged, billed or collected by the hospital-based facility on or before July 1,
1424 2017. A violation of this subsection shall be an unfair trade practice under chapter 93A.

1425 (c) The department may identify additional conditions or factors that would prohibit a
1426 hospital, health system or hospital-based facility from charging, billing or collecting a facility fee
1427 for health care services. Additional conditions or factors may include, but shall not be limited to:
1428 (i) additional current procedural terminology codes for which a hospital, health system or
1429 hospital-based facility shall not charge, bill or collect a facility fee; (ii) health care services for
1430 which a hospital, health system or hospital-based facility shall not charge, bill or collect a facility
1431 fee; (iii) limitations on physical locations, including whether on a campus or not, for which a
1432 hospital, health system or hospital-based facility shall not charge, bill or collect a facility fee; and
1433 (iv) other conditions or factors. The department shall forward any recommendations under this
1434 subsection to the joint committee on health care financing and the house and senate committees
1435 on ways and means.

1436 Section 51M. The department shall designate a hospital as an acute stroke ready hospital,
1437 a primary stroke center or a comprehensive stroke center if: (i) the hospital has applied to the
1438 department for a designation; and (ii) the hospital has been certified by The Joint Commission,
1439 the American Heart Association or any other department-approved, nationally-recognized
1440 certifying body as an acute stroke ready hospital, primary stroke center or comprehensive stroke
1441 center.

1442 Section 51N. The department and regional EMS councils, as defined in section 1 of
1443 chapter 111C, shall establish prehospital care protocols related to the assessment, treatment,
1444 transport and rerouting of stroke patients by licensed emergency medical services providers to
1445 acute stroke ready hospitals, primary stroke centers and comprehensive stroke centers. The

1446 protocols shall include plans for the triage and transport of suspected stroke patients including,
1447 but not limited to, those patients who may have an emergent large vessel occlusion, to an
1448 appropriate facility within a specified timeframe of onset of symptoms. The protocols shall
1449 include any additional criteria necessary to determine the level of care that is the most
1450 appropriate for a suspected stroke patient. The protocols shall be based on nationally-recognized
1451 guidelines for the transport of acute stroke patients. The protocols shall also consider the
1452 capability of an emergency receiving facility to improve outcomes for those patients suspected,
1453 based on clinical severity, of having an emergent large vessel occlusion. Each regional EMS
1454 council shall establish a prehospital point of entry plan for stroke-related patients for their own
1455 respective region.

1456 The department shall: (i) make available the list of designated stroke centers, including
1457 the identification of hospitals with continuous neurointerventional coverage, to the medical
1458 director of each licensed emergency medical services provider; (ii) maintain a copy of the list in
1459 the office designated within the department to oversee emergency medical services; and (iii) post
1460 a list of all designated stroke centers and the level of care to the department website. The
1461 department shall update the list of designated stroke centers at least annually.

1462 Section 51O. The department shall establish and maintain a data oversight process to
1463 improve the quality of care for stroke patients. The process shall include a stroke registry
1464 database that compiles information and statistics on stroke care that align with nationally-
1465 recognized stroke measures.

1466 A hospital designated by the department as an acute stroke ready hospital, a primary
1467 stroke center or a comprehensive stroke center shall utilize a nationally-recognized data platform
1468 to collect the stroke data set that shall be required by the department. The data elements shall be
1469 collected through the data registry platform and transmitted to the department for inclusion in the
1470 stroke registry.

1471 The department shall convene a group of experts including, but not limited to, a
1472 representative from the American Stroke Association, a representative from The Massachusetts
1473 Neurologic Association, Inc., a representative from Society of Neurointerventional Surgery, a
1474 representative from Massachusetts Council of Community Hospitals, Inc., a representative from

1475 Massachusetts College of Emergency Physicians, Inc. and a representative of a regional EMS
1476 council, with input from key stroke stakeholders and professional societies, to form a stroke
1477 advisory taskforce that shall assist with data oversight, program management and advice
1478 regarding the stroke system of care. The task force shall meet not less than quarterly to review
1479 data and provide advice.

1480 SECTION 84. Said chapter 111 is hereby further amended by inserting after section 53H
1481 the following section:-

1482 Section 53I. (a) Notwithstanding any general or special law to the contrary, a health care
1483 provider shall not knowingly or intentionally violate department rules and regulations adopted
1484 under this chapter at the direct request of a patient, authorized caregiver or other interested
1485 person. A violation shall be documented and reported by the health care provider to the
1486 department within 72 hours. The department may impose penalties including, but not limited to,
1487 a fine of not more than \$10,000 per violation or complaint to the relevant board of registration. A
1488 health care provider who fails to report a violation as so provided may be subject to an additional
1489 penalty of not more than \$100,000 per violation.

1490 (b) Notwithstanding any general or special law to the contrary, a health care provider
1491 shall not knowingly or intentionally designate, mark, label or confer any special status unrelated
1492 to medical diagnosis, treatment or care to a patient due to socio-economic status or direct
1493 relationship to the health care provider. The department may impose penalties including, but not
1494 limited to, a fine of not more than \$10,000 per violation or complaint to the relevant board of
1495 registration.

1496 (c) A penalty assessed under this section shall not preclude the department from assessing
1497 fees for violations under this chapter.

1498 (d) A health care provider reporting a violation pursuant to this section shall be afforded
1499 protection from retaliatory action in accordance with section 187 of chapter 149.

1500 (e) All violations under this section shall be published in a clear and conspicuous manner
1501 on the department's website.

1502 (f) The commissioner may promulgate regulations to enforce this section.

1503 SECTION 85. Said chapter 111 is hereby further amended by striking out section 228, as
1504 appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

1505 Section 228. (a) For the purposes of this section, “allowed amount” shall mean the
1506 contractually agreed-upon amount paid by a carrier to a health care provider for health care
1507 services provided to an insured.

1508 (b) Prior to an admission, procedure or service, and upon request by a patient or
1509 prospective patient, a health care provider shall, not later than 2 working days after receipt of the
1510 request, disclose the allowed amount or charge for the admission, procedure or service, including
1511 the amount of any facility fees. If a health care provider is unable to quote a specific amount in
1512 advance due to the health care provider's inability to predict the specific treatment or diagnostic
1513 code, the health care provider shall disclose the estimated maximum allowed amount or charge
1514 for a proposed admission, procedure or service, including the amount of any facility fees.

1515 (c) If a patient or prospective patient is covered by a health plan, a health care provider
1516 who participates as a network provider shall, at the time of scheduling a procedure or service: (i)
1517 provide sufficient information regarding the proposed admission, procedure or service for the
1518 patient or prospective patient to make an informed decision about the costs associated with that
1519 admission, procedure or service based on information available to the provider at that time,
1520 including the amount of any facility fees; and (ii) inform the patient or prospective patient that
1521 the patient or prospective patient may obtain additional information about any applicable out-of-
1522 pocket costs, pursuant to section 23 of chapter 176O. A health care provider may assist a patient
1523 or prospective patient in using the health plan’s toll-free number and website pursuant to said
1524 section 23 of said chapter 176O.

1525 (d) A health care provider referring a patient to another provider shall disclose: (i) if the
1526 provider to whom the patient is being referred is part of or represented by the same provider
1527 organization, as used in section 11 of chapter 6D; (ii) the network status of the referred provider
1528 under the patient’s health plan based on information available to the provider at the time of the
1529 referral; and (iii) sufficient information about the referred provider for the patient to obtain
1530 additional information about that provider’s network status under the patient’s health plan and

1531 any applicable out-of-pocket costs for services sought from the referred provider pursuant to
1532 section 23 of chapter 176O, based on information available to the provider at that time.

1533 SECTION 86. Said chapter 111 is hereby further amended by inserting after section 237
1534 the following section:-

1535 Section 238. (a) For purposes of this section, the following terms shall have the following
1536 meanings:

1537 “Allied health professional”, a person who holds and maintains a registration,
1538 certification or license to perform health care services by a state or a nationally accredited
1539 credentialing organization.

1540 “Central service technician”, any person who decontaminates, inspects, assembles,
1541 packages and sterilizes reusable medical instruments or devices in a health care facility.

1542 “Health care practitioner”, any person licensed or registered under chapter 111 or 112,
1543 including any intern, resident, fellow or medical officer, who conducts or assists with the
1544 performance of surgery.

1545 “Health care facility”, any “hospital” or any “rural hospital”, as defined in section 52 of
1546 chapter 111, or surgical services that are provided in a free standing ambulatory surgery center,
1547 whether inpatient or outpatient, conducted for charity or for profit and whether or not subject to
1548 section 25C or any other facility employing or using the services of at least 1 central service
1549 technician.

1550 (b) A health care facility shall not employ or otherwise retain the services of a central
1551 service technician unless the person:

1552 (i) Has successfully passed a nationally accredited central service exam for central
1553 service technicians and holds and maintains a following credential administered by a nationally
1554 accredited central service technician credentialing organization: (i) the certified registered central
1555 service technician credential; (ii) the certified sterile processing and distribution technician
1556 credential; or (iii) a substantially equivalent credential; or

1557 (ii) Provides evidence that the person was employed as a central service technician in a
1558 health care facility not later than December 31, 2017.

1559 (c) A central service technician who does not meet the requirements of clause (ii) of
1560 subsection (b) shall have 18 months from the date of hire to obtain the certified registered central
1561 service technician credential or the certified sterile processing and distribution technician
1562 credential.

1563 (d) A person who qualifies to function as a central service technician in a health care
1564 facility under clauses (i) and (ii) of subsection (b) shall annually complete 10 hours of continuing
1565 education credits to remain qualified to function as a central service technician. The continuing
1566 education required under this subsection shall be in area related to the functions of a central
1567 service technician.

1568 (e) This section shall not prohibit the following persons from performing the tasks or
1569 functions of a central service technicians:

1570 (i) A health care practitioner;

1571 (ii) An allied health professional; and

1572 (iii) A student or intern performing the functions of a central service technician under the
1573 direct supervision of a health care practitioner as part of the student's or intern's training or
1574 internship.

1575 (f) A health care facility shall, upon the written request of a central service technician,
1576 verify, in writing, the central service technician's dates of employment or the contract period
1577 during which the central service technician provided services to the health care facility.

1578 (g) The commissioner may adopt regulations necessary to carry out this section.

1579 SECTION 87. Chapter 111C of the General Laws is hereby amended by striking out
1580 section 25, as appearing in the 2016 Official Edition, and inserting in place thereof the following
1581 section:-

1582 Section 25. (a) When a class I, II or V ambulance transports a patient receiving care at the
1583 paramedic level of advanced life support, the ambulance shall be staffed in accordance with
1584 regulations promulgated by the department; provided, however, that there shall be not less than 2
1585 emergency medical technicians, at least 1 of whom shall be certified at the EMT-Paramedic
1586 level.

1587 (b) When a class I, II or V ambulance transports a patient receiving care at the non-
1588 paramedic level of basic life support, the ambulance shall be staffed in accordance with
1589 regulations promulgated by the department; provided, however, that there shall be not less than 2
1590 emergency medical technicians.

1591 (c)(1) For the purposes of this subsection, the following words shall have the following
1592 meanings:

1593 “First responder”, a police officer, a firefighter or an emergency reserve of a volunteer
1594 fire department or fire protection district who has been authorized and deemed qualified to staff
1595 an ambulance by the rural volunteer ambulance service’s affiliate hospital medical director
1596 pursuant to the rural volunteer ambulance service’s affiliation agreement and the department’s
1597 regulations; provided, however, that “first responder” shall not include a police officer,
1598 firefighter or person engaged in police and fire work whose duties are primarily clerical or
1599 administrative.

1600 “Rural volunteer ambulance service”, a not-for-profit primary ambulance service staffed
1601 by volunteers operating in a service zone with a population density of less than 500 residents per
1602 square mile as designated in a department-approved service zone plan.

1603 (2) Notwithstanding subsection (b), when a class I, II or V ambulance operated by a rural
1604 volunteer ambulance service transports a patient receiving care at the nonparamedic level of
1605 basic life support, the ambulance may be staffed in accordance with regulations promulgated by
1606 the department; provided, however, that there shall be at least 1 emergency medical technician
1607 and 1 first responder.

1608 SECTION 88. Section 1 of chapter 111O of the General Laws, as so appearing, is hereby
1609 amended by inserting after the definition of “Mobile integrated health care” the following
1610 definition:-

1611 “Mobile integrated health care provider” or “MIH provider”, a licensed health care
1612 professional delivering medical care and services to patients in an out-of-hospital environment in
1613 coordination with health care facilities or other health care providers; provided, however, that
1614 medical care and services shall include, but shall not be limited to, community paramedic
1615 provider services, chronic disease management, behavioral health, preventative care, post-
1616 discharge follow-up visits or transport or referral to facilities other than hospital emergency
1617 departments; provided further, that medical care and services shall be delivered under a mobile
1618 integrated health care program approved by the department using mobile health care resources.

1619 SECTION 89. Section 2 of said chapter 111O, as so appearing, is hereby amended by
1620 adding the following 2 subsections:-

1621 (c) The department shall issue guidance, in consultation with the advisory council, on
1622 best practices for structuring mobile integrated health care programs to obtain reimbursement for
1623 the care and services delivered to patients who are covered by public or private payers.

1624 (d) Annually, not later than March 1, the department shall report the data collected from
1625 MIH programs pursuant to subsection (b). The report shall include, but not be limited to, an
1626 analysis of the impact of MIH programs on: (i) 30-day readmission rates; (ii) siting of post-acute
1627 care treatment; (iii) incidence of emergency department presentment for behavioral health
1628 conditions; (iv) incidence of emergency department presentment for chronic conditions; and (v)
1629 the variance in each of the preceding metrics within and between Medicaid claims and
1630 commercial claims, respectively. The department may consult with the center for health
1631 information and analysis in developing the report. The report shall be made publicly available
1632 and easily searchable on the department’s website.

1633 SECTION 90. Said chapter 111O is hereby further amended by adding the following 2
1634 sections:-

1635 Section 5. (a) The department shall by regulation establish application fees that shall
1636 include, but shall not limited to, an initial application surcharge in addition to a general
1637 application or renewal fee, and a timeline for reviewing applications for mobile integrated health
1638 care or community EMS programs.

1639 Section 6. (a) The department shall allow applicants for MIH programs and Community
1640 EMS programs and approved MIH and Community EMS programs to seek a waiver from
1641 transporting a patient to the closest appropriate health care facility as required by the department;
1642 provided, that any such program that obtains a waiver shall have a point-of-entry plan that fits
1643 the design and purpose of the program seeking the waiver; provided further, that the department
1644 shall only approve a waiver if it demonstrates a point-of-entry plan that provides flexibility on
1645 the basis of the medical direction associated with a patient and does not include an explicit
1646 requirement that a patient be transported only to a health care facility owned or operated by, or
1647 affiliated with, an MIH program or Community EMS program.

1648 (b) Application fees and surcharges collected pursuant to this section shall be deposited
1649 into the Mobile Integrated Health Care Trust Fund established in section 2YYYYY of chapter 29.

1650 (c) The department shall prioritize the review and processing of mobile integrated health
1651 care program applicants who have been approved as a MassHealth accountable care organization
1652 or targeted patient populations served by MassHealth accountable care organizations.

1653 SECTION 91. Section 2 of chapter 112 of the General Laws, as appearing in the 2016
1654 Official Edition, is hereby amended by adding the following 3 paragraphs:-

1655 For the purposes of this section, “telemedicine” shall mean the use of audio, video or
1656 other electronic media for a diagnosis, consultation or treatment of a patient's physical, oral or
1657 mental health; provided, however, that ”telemedicine” shall not include audio-only telephone,
1658 facsimile machine, online questionnaire, texting or text-only e-mail.

1659 Notwithstanding any other provision of this chapter, the board shall allow a physician to
1660 obtain proxy credentialing and privileging for telemedicine services with other health care
1661 providers, as defined in section 1 of chapter 111, or facilities consistent with Medicare conditions
1662 of participation telemedicine standards.

1663 The board shall promulgate regulations regarding the appropriate use of telemedicine to
1664 provide health care services. These regulations shall provide for and include, but shall not be
1665 limited to: (i) prescribing medications; (ii) services that are not appropriate to provide through
1666 telemedicine; (iii) establishing a patient-provider relationship; (iv) consumer protections; and (v)
1667 ensuring that services comply with appropriate standards of care.

1668 SECTION 92. Said chapter 112 is hereby further amended by striking out section 13, as
1669 so appearing, and inserting in place thereof the following section:-

1670 Section 13. (a) As used in this chapter, “podiatry” shall mean the diagnosis and treatment,
1671 by medical, mechanical, electrical or surgical means, of ailments of the human foot and lower
1672 leg.

1673 (b) As used in sections 12B, 12G and 80B, “physician” shall include a podiatrist
1674 registered under section 16.

1675 (c) Sections 13 to 18, inclusive, shall not apply to surgeons of the United States army,
1676 United States navy or of the United States Public Health Service or to physicians registered in
1677 the commonwealth.

1678 SECTION 93. Section 43A of said chapter 112, as so appearing, is hereby amended by
1679 inserting after the definition of “Appropriate supervision” the following 2 definitions:-

1680 “Board”, the board of registration in dentistry established pursuant to section 19 of
1681 chapter 13 or a committee or subcommittee of the board.

1682 “Collaborative management agreement”, a written agreement between a local, state or
1683 federal government agency or institution or a licensed dentist and a dental therapist outlining the
1684 procedures, services, responsibilities and limitations of the therapist.

1685 SECTION 94. Said section 43A of said chapter 112, as so appearing, is hereby further
1686 amended by inserting after the definition of “Dental supervision” the following definition:-

1687 “Dental therapist”, a person who: (i) is registered by the board to practice as a dental
1688 therapist pursuant to section 51B and as a dental hygienist pursuant to section 51; and (ii)
1689 provides oral health care services pursuant to said section 51B.

1690 SECTION 95. Said section 43A of said chapter 112, as so appearing, is hereby further
1691 amended by adding the following definition:-

1692 “Supervising dentist”, a licensed dentist who enters into a collaborative management
1693 agreement with a dental therapist.

1694 SECTION 96. Said chapter 112 is hereby further amended by inserting after section 51A
1695 the following section:-

1696 Section 51B. (a) A person of good moral character shall be registered as a dental therapist
1697 and given a certificate allowing the therapist to practice in this capacity if the person: (i) has
1698 completed a dental therapist education program that meets the standards of the Commission on
1699 Dental Accreditation, has graduated from a dental therapist education program that meets the
1700 standards of the Commission on Dental Accreditation provided by a post-secondary institution
1701 accredited by the New England Association of Schools and Colleges, Inc. or is certified by the
1702 federal Indian Health Service pursuant to the Indian Health Care Improvement Act, 25 U.S.C.
1703 1601 et seq.; (ii) passes a comprehensive, competency-based clinical examination that is
1704 approved by the board of registration in dentistry and administered independently of an
1705 institution providing registered dental therapy education; and (iii) maintains a policy of
1706 professional liability insurance and shows proof of the insurance as required by applicable
1707 regulations. A dental therapist shall also be registered as a dental hygienist and possess a
1708 certificate to practice dental hygiene pursuant to section 51. A dental therapist shall have
1709 practiced under the direct supervision of a supervising dentist for not less than 500 hours or shall
1710 have completed 1 year of residency before practicing under general supervision.

1711 (b) The educational curriculum for a dental therapist shall include training on how to
1712 serve certain patients including, but not limited to: (i) people with developmental disabilities,
1713 including autism spectrum disorders, mental illness, cognitive impairment, complex medical
1714 problems or significant physical limitations; and (ii) the elderly.

1715 (c) A dental therapist shall enter into a collaborative management agreement with a
1716 licensed dentist before performing a procedure or providing a service under this paragraph. The
1717 agreement shall address: (i) practice settings; (ii) limitations on services established by the
1718 supervising dentist; (iii) the level of supervision required for various services or treatment

1719 settings; (iv) patient populations that may be served by the dental therapist; (v) practice
1720 protocols; (vi) record keeping; (vii) management of medical emergencies; (viii) quality
1721 assurance; (ix) administration and dispensing of medications; and (x) supervision of dental
1722 assistants and dental hygienists. A dental therapist may provide services authorized in practice
1723 settings where the supervising dentist is not on-site and has not previously examined the patient
1724 if such a service is authorized by the supervising dentist in the collaborative management
1725 agreement and the supervising dentist is available for consultation and supervision by telephone
1726 or other means of communication.

1727 The collaborative management agreement shall include specific protocols to govern
1728 situations in which the dental therapist encounters a patient who requires treatment that exceeds
1729 the authorized scope of practice of the dental therapist. A collaborative management agreement
1730 shall be signed and maintained by the supervising dentist and the dental therapist and shall be
1731 submitted to the board upon request. The board shall establish appropriate guidelines for a
1732 collaborative management agreement. The collaborative management agreement may be updated
1733 from time to time. A supervising dentist may have a collaborative management agreement with
1734 not more than 4 dental therapists at the same time.

1735 A dental therapist may perform: (i) acts of a public health dental hygienist under section
1736 51; (ii) acts provided for in the Commission on Dental Accreditation's dental therapy standards;
1737 and (iii) the following services and procedures pursuant to the collaborative management
1738 agreement without the supervision or direction of a dentist: (1) interpretation of radiographs; (2)
1739 placement of space maintainers; (3) pulpotomy on primary teeth; (4) oral evaluation and
1740 assessment of dental disease and the formulation of an individualized treatment plan authorized
1741 by the collaborating dentist; and (5) nonsurgical extraction of permanent teeth except as limited
1742 under this section.

1743 A dental therapist shall not perform a service or procedure described in this section
1744 except as authorized by the collaborating dentist. A dental therapist may perform nonsurgical
1745 extractions of periodontally-diseased permanent teeth with tooth mobility of +3 under general
1746 supervision if authorized in advance by the collaborating dentist. A dental therapist shall not
1747 extract a tooth for a patient if the tooth is unerupted, impacted or needs to be sectioned for

1748 removal. The collaborating dentist shall be responsible for directly providing or arranging for
1749 another dentist or specialist to provide necessary advanced services needed by the patient.

1750 A dental therapist shall, in accordance with the collaborative management agreement,
1751 refer patients to another qualified dental or health care professional to receive needed services
1752 that exceed the scope of practice of the dental therapist. The collaborating dentist shall ensure
1753 that a dentist is available to the dental therapist for timely consultation during treatment if needed
1754 and shall either provide or arrange with another dentist or specialist to provide the necessary
1755 treatment to a patient who requires more treatment than the dental therapist is authorized to
1756 provide.

1757 A dental therapist may dispense and administer analgesics, anti-inflammatories and
1758 antibiotics within the scope of the dental therapist's practice and the collaborative management
1759 agreement and with the authorization of the collaborating dentist. The authority to dispense
1760 under this paragraph shall include the authority to dispense sample drugs within the categories
1761 identified in this paragraph if permitted by the collaborative management agreement. A dental
1762 therapist shall not dispense or administer a narcotic drug.

1763 (d) A dental therapist shall be reimbursed for services covered by Medicaid and other
1764 third-party payers. A dental therapist shall not operate independently of a dentist unless the
1765 dental therapist works for a local, state or federal government agency or a non-profit institution
1766 or practices in a mobile or portable prevention program licensed or certified by the department of
1767 public health.

1768 (e) A dental therapist may supervise dental assistants to the extent permitted in the
1769 collaborative management agreement and in accordance with section 51½.

1770 SECTION 97. Said chapter 112 is hereby further amended by striking out section 66, as
1771 appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

1772 Section 66. As used in this chapter, "practice of optometry" shall mean the diagnosis,
1773 prevention, correction, management or treatment of optical deficiencies, optical deformities,
1774 visual anomalies, muscular anomalies, ocular diseases and ocular abnormalities of the human eye
1775 and adjacent tissue, including removal of superficial foreign bodies and misaligned eyelashes, by

1776 utilization of pharmaceutical agents, by the prescription, adaptation and application of
1777 ophthalmic lenses, devices containing lenses, prisms, contact lenses, orthoptics, vision therapy,
1778 prosthetic devices and other optical aids and the utilization of corrective procedures to preserve,
1779 restore or improve vision, consistent with sections 66A, 66B and 66C.

1780 SECTION 98. Section 66B of said chapter 112, as so appearing, is hereby amended by
1781 striking out, in line 31, the following words:- , except glaucoma.

1782 SECTION 99. Said chapter 112 is hereby further amended by inserting after section 66B
1783 the following section:-

1784 Section 66C. (a) A registered optometrist who is qualified by an examination for practice
1785 under section 68, certified under section 68C and registered to issue written prescriptions
1786 pursuant to subsection (h) of section 7 of chapter 94C, may: (i) use and prescribe topical and oral
1787 therapeutic pharmaceutical agents, as defined in section 66B, that are used in the practice of
1788 optometry, including those placed in schedules III, IV, V and VI pursuant to section 2 of said
1789 chapter 94C, for the purpose of diagnosing, preventing, correcting, managing or treating
1790 glaucoma and other ocular abnormalities of the human eye and adjacent tissue; and (ii) prescribe
1791 all necessary eye-related medications, including oral anti-infective medications; provided,
1792 however, that a registered optometrist shall not use or prescribe: (1) therapeutic pharmaceutical
1793 agents for the treatment of systemic diseases; (2) invasive surgical procedures; (3)
1794 pharmaceutical agents administered by subdermal injection, intramuscular injection, intravenous
1795 injection, subcutaneous injection, intraocular injection or retrobulbar injection; or (4) an opioid
1796 substance or drug product.

1797 (b) If an optometrist, while examining or treating a patient with the aid of a diagnostic or
1798 therapeutic pharmaceutical agent and exercising professional judgment and the degree of
1799 expertise, care and knowledge ordinarily possessed and exercised by optometrists under like
1800 circumstances, encounters a sign of a previously unevaluated disease that would require
1801 treatment not included in the scope of the practice of optometry, the optometrist shall refer the
1802 patient to a licensed physician or other qualified health care practitioner.

1803 (c) If an optometrist diagnoses a patient with congenital glaucoma or if, during the course
1804 of examining, managing or treating a patient with glaucoma, the optometrist determines that

1805 surgical treatment is indicated, the optometrist shall refer the patient to a qualified health care
1806 provider for treatment.

1807 (d) An optometrist licensed under this chapter shall participate in any relevant state or
1808 federal report or data collection effort relative to patient safety and medical error reduction
1809 coordinated by the Betsy Lehman center for patient safety and medical error reduction
1810 established in section 15 of chapter 12C.

1811 SECTION 100. Said chapter 112 is hereby further amended by inserting after section
1812 68B the following section:-

1813 Section 68C. (a) The board of registration in optometry shall administer an examination
1814 to permit the use and prescription of therapeutic pharmaceutical agents as authorized in section
1815 66C. The examination shall: (i) be held in conjunction with examinations provided for in
1816 sections 68, 68A and 68B; and (ii) include any portion of the examination administered by the
1817 National Board of Examiners in Optometry or other appropriate examination covering the
1818 subject matter of therapeutic pharmaceutical agents as authorized in said section 66C. The board
1819 may administer a single examination to measure the qualifications necessary under said sections
1820 68, 68A, 68B and this section. The board shall qualify optometrists to use and prescribe
1821 therapeutic pharmaceutical agents in accordance with said sections 68, 68A, 68B and this
1822 section.

1823 (b) Examination for the use and prescription of therapeutic pharmaceutical agents placed
1824 in schedules III, IV, V and VI under section 2 of chapter 94C and defined in section 66C shall,
1825 upon application, be open to an optometrist registered under section 68, 68A or 68B and to any
1826 person who meets the qualifications for examination under said sections 68, 68A and 68B. An
1827 applicant registered as an optometrist under said section 68, 68A or 68B shall: (i) be registered
1828 pursuant to paragraph (h) of section 7 to use or prescribe pharmaceutical agents for the purpose
1829 of diagnosing or treating glaucoma and other ocular abnormalities of the human eye and adjacent
1830 tissue; and (ii) furnish to the board of registration in optometry evidence of the satisfactory
1831 completion of 40 hours of didactic education and 20 hours of supervised clinical education
1832 relating to the use and prescription of therapeutic pharmaceutical agents under section 66C;
1833 provided, however, that such education shall: (1) be administered by the Massachusetts Society

1834 of Optometrists, Inc.; (2) be accredited by a college of optometry or medicine; and (3) meet the
1835 guidelines and requirements of the board of registration in optometry. The board of registration
1836 in optometry shall provide to each successful applicant a certificate of qualification in the use
1837 and prescription of all therapeutic pharmaceutical agents as authorized under said section 66C
1838 and shall forward to the department of public health notice of such certification for each
1839 successful applicant.

1840 (c) An optometrist licensed in another jurisdiction shall be deemed an applicant under
1841 this section by the board of registration in optometry. An optometrist licensed in another
1842 jurisdiction may submit evidence to the board of registration in optometry of practice equivalent
1843 to that required in section 68, 68A or 68B and the board, in its discretion, may accept the
1844 evidence in order to satisfy any of the requirements of this section. An optometrist in another
1845 jurisdiction licensed to utilize and prescribe therapeutic pharmaceutical agents for treating
1846 glaucoma and other ocular abnormalities of the human eye and adjacent tissue may submit
1847 evidence to the board of registration in optometry of equivalent didactic and supervised clinical
1848 education, and the board, in its discretion, may accept the evidence in order to satisfy any of the
1849 requirements of this section.

1850 (d) A licensed optometrist who has completed a postgraduate residency program
1851 approved by the Accreditation Council on Optometric Education of the American Optometric
1852 Association may submit an affidavit to the board of registration in optometry from the licensed
1853 optometrist's residency supervisor or the director of residencies at the affiliated college of
1854 optometry attesting that the optometrist has completed an equivalent level of instruction and
1855 supervision and the board, in its discretion, may accept the evidence in order to satisfy any of the
1856 requirements of this section.

1857 (e) As a condition of license renewal, an optometrist licensed under this section shall
1858 submit to the board of registration in optometry evidence attesting to the completion of 3 hours
1859 of continuing education specific to glaucoma and the board, in its discretion, may accept the
1860 evidence to satisfy this condition for license renewal.

1861 SECTION 101. Section 80B of said chapter 112, as appearing in the 2016 Official
1862 Edition, is hereby amended by inserting after the word “practitioners”, in line 12, the following
1863 words:- , nurse anesthetists.

1864 SECTION 102. Said section 80B of said chapter 112, as so appearing, is hereby further
1865 amended by striking out the seventh paragraph and inserting in place thereof the following
1866 paragraph:-

1867 The board shall promulgate advanced practice nursing regulations which govern the
1868 provision of advanced practice nursing services and related care including, but not limited to, the
1869 ordering and interpreting of tests, the ordering and evaluation of treatment and the use of
1870 therapeutics.

1871 SECTION 103. Said section 80B of said chapter 112, as so appearing, is hereby further
1872 amended by striking out, in lines 64 and 65, the words “in the ordering of tests, therapeutics and
1873 the prescribing of medications, to” and inserting in place thereof the following word:- to.

1874 SECTION 104. Said chapter 112 is hereby further amended by striking out section 80E,
1875 as so appearing, and inserting in place thereof the following section:-

1876 Section 80E. (a) A nurse practitioner or psychiatric nurse mental health clinical specialist
1877 may issue written prescriptions and medication orders and order tests and therapeutics pursuant
1878 to guidelines mutually developed and agreed upon by the nurse and either a supervising nurse
1879 practitioner or psychiatric nurse mental health clinical specialist who has independent practice
1880 authority or a supervising physician, in accordance with regulations promulgated by the board. A
1881 prescription issued by a nurse practitioner or psychiatric nurse mental health clinical specialist
1882 under this subsection shall include the name of the nurse practitioner or the psychiatric nurse
1883 mental health clinical specialist who has independent practice authority or the supervising
1884 physician with whom the nurse practitioner or psychiatric nurse mental health clinical specialist
1885 developed and signed mutually agreed upon guidelines.

1886 A nurse practitioner or psychiatric nurse mental health clinical specialist shall have
1887 independent practice authority to issue written prescriptions and medication orders and order
1888 tests and therapeutics without the supervision described in this subsection if the nurse

1889 practitioner or psychiatric nurse mental health clinical specialist has completed not less than 2
1890 years of supervised practice following certification from a board-recognized certifying body;
1891 provided, however, that supervision of clinical practice shall be conducted by a health care
1892 professional who meets minimum qualification criteria promulgated by the board, which shall
1893 include a minimum number of years of independent practice authority.

1894 The board may allow a nurse practitioner or psychiatric nurse mental health clinical
1895 specialist to exercise such independent practice authority upon satisfactory demonstration of not
1896 less than 2 years of alternative professional experience; provided, however, that the board
1897 determines that the nurse practitioner or psychiatric nurse mental health clinical specialist has a
1898 demonstrated record of safe prescribing and good conduct consistent with professional licensure
1899 obligations required by each jurisdiction in which the nurse practitioner or psychiatric nurse
1900 mental health clinical specialist has been licensed.

1901 (b) The board shall promulgate regulations to implement this section.

1902 SECTION 105. Said chapter 112 is hereby further amended by striking out section 80H,
1903 as so appearing, and inserting in place thereof the following section:-

1904 Section 80H. (a) A nurse anesthetist may issue written prescriptions and medication
1905 orders and order tests and therapeutics pursuant to guidelines mutually developed and agreed
1906 upon by the nurse and either a supervising nurse anesthetist with independent practice authority
1907 or a supervising physician, in accordance with regulations promulgated by the board; provided,
1908 however, that supervision under this section by a nurse anesthetist with independent practice
1909 authority or by a physician shall be limited to written prescriptions and medication orders and the
1910 ordering of tests and therapeutics. A prescription issued by a nurse anesthetist under this
1911 subsection shall include the name of the nurse anesthetist with independent practice authority or
1912 the supervising physician with whom the nurse anesthetist developed and signed mutually agreed
1913 upon guidelines. Nothing in this section shall require a nurse anesthetist to obtain prescriptive
1914 authority to deliver anesthesia care, including the proper administration of the drugs or medicine
1915 necessary for the delivery of anesthesia care.

1916 A nurse anesthetist shall have independent practice authority to issue written
1917 prescriptions and medication orders and order tests and therapeutics without the supervision

1918 described in this subsection if the nurse anesthetist has completed not less than 2 years of
1919 supervised practice following certification from a board-recognized certifying body; provided,
1920 however, that supervision of practice shall be conducted by a health care professional who meets
1921 minimum qualification criteria promulgated by the board which shall include a minimum number
1922 of years of independent practice experience.

1923 The board, in its discretion, may allow a nurse anesthetist to exercise such independent
1924 practice authority upon satisfactory demonstration of alternative professional experience if the
1925 board determines that the nurse anesthetist has a demonstrated record of safe prescribing and
1926 good conduct consistent with professional licensure obligations required by each jurisdiction in
1927 which the nurse anesthetist has been licensed.

1928 (b) The board shall promulgate regulations to implement this section.

1929 SECTION 106. Section 80I of said chapter 112, as so appearing, is hereby amended by
1930 striking out the second and third sentences.

1931 SECTION 107. Said chapter 112 is hereby further amended by inserting after section 80I
1932 the following 2 sections:-

1933 Section 80J. A nurse authorized to practice as a psychiatric nurse mental health clinical
1934 specialist pursuant to section 80B, may order and interpret tests, therapeutics and prescribe
1935 medications in accordance with regulations promulgated by the board and subject to the
1936 provisions of subsection (g) of section 7 of chapter 94C.

1937 Section 80K. The board shall promulgate regulations, which shall be subject to approval
1938 by the commissioner, to ensure that nurse practitioners, nurse anesthetists and psychiatric nurse
1939 mental health clinical specialists under the board of registration in nursing are subject to
1940 requirements commensurate to those that physicians are subject to under the board of registration
1941 in medicine pursuant to the sixth and seventh paragraphs of section 5 and sections 5A to 5M,
1942 inclusive, as they apply to the creation and public dissemination of individual profiles and
1943 licensure restrictions, disciplinary actions and reports, claims or reports of malpractice,
1944 communication with professional organizations, physical and mental examinations, investigation
1945 of complaints and other aspects of professional conduct and discipline

1946 SECTION 108. Section 197 of said chapter 112, as appearing in the 2016 Official
1947 Edition, is hereby amended by striking out subsection (a) and inserting in place thereof the
1948 following subsection:-

1949 (a) Beginning July 1, 2000, a person shall not identify, present or otherwise portray
1950 himself as a hearing instrument specialist or practice hearing aid dispensing in the
1951 commonwealth unless he is licensed by the board or is an audiologist in the commonwealth,
1952 whichever registration is appropriate to the training of the individual; provided, however, that
1953 this section shall not apply to: (i) persons who only repair or manufacture hearing aids, their
1954 accessories or both; or (ii) persons who engage in the sale of assisted listening devices or systems
1955 but not in the dispensing of hearing aids. Nothing in sections 197 to 200 shall be construed to
1956 prevent an audiologist or hearing instrument specialist from dispensing or selling hearing aids
1957 when employed by or affiliated with an otolaryngologist.

1958 SECTION 109. Section 28 of chapter 118E of the General Laws, as so appearing, is
1959 hereby amended by adding the following paragraph:-

1960 A transfer of resources to a special needs trust that conforms to 42 U.S.C 1396p(d)(4)(C)
1961 established solely for the benefit of a disabled individual of any age shall not be treated as a
1962 disposal of resources for less than fair market value.

1963 SECTION 110. Said chapter 118E is hereby further amended by inserting after section 38
1964 the following section:-

1965 Section 38A. (a) The division or any entity with which the division contracts to provide
1966 or manage health insurance benefits, including mental health services, shall not impose a
1967 retroactive claims denial, as defined in section 1 of chapter 175, for behavioral health services, as
1968 defined in said section 1 of said chapter 175, on a provider unless:

1969 (i) Less than 6 months have elapsed from the time of submission of the claim by the
1970 provider to the division or other entity responsible for payment; or

1971 (ii) The division or other entity has furnished the provider with a written explanation
1972 of the reason for the retroactive claim denial and a description of additional documentation or
1973 other corrective actions required for payment of the claim.

1974 (b) Notwithstanding clause (i) of subsection (a), a retroactive claim denial may be
1975 permitted after 6 months if:

1976 (i) The claim was submitted fraudulently;

1977 (ii) The claim payment is subject to adjustment due to expected payment from
1978 another payer and not more than 12 months have elapsed since submission of the claim; or

1979 (iii) The claims or services for which the claim has been submitted is the subject of
1980 legal action.

1981 (c) If a retroactive claim denial is imposed under clause (ii) of subsection (b), the division
1982 or other entity shall notify a provider not less than 15 days before imposing the retroactive claim
1983 denial and the provider shall have 6 months to determine whether the claim is subject to payment
1984 by a secondary insurer. Notwithstanding the contractual terms between the provider and insurer,
1985 an insurer shall allow for submission of a claim that was previously denied by another insurer
1986 due to the insured's transfer or termination of coverage.

1987 (d) For the purposes of this section, "provider" shall mean a mental health clinic or
1988 substance use disorder program licensed by the department of public health under chapter 18,
1989 111, 111B or 111E, a behavioral, substance use disorder or mental health professional who is
1990 licensed under chapter 112 and accredited or certified to provide services consistent with law and
1991 who has provided services under an express or implied contract or with the expectation of
1992 receiving payment, other than co-payment, deductible or co-insurance, directly or indirectly
1993 from the division or managed care entity.

1994 SECTION 111. Section 66 of said chapter 118E, as appearing in the 2016 Official
1995 Edition, is hereby amended by striking out, in line 28, the first time it appears, the word "and".

1996 SECTION 112. Said section 66 of said chapter 118E, as so appearing, is hereby further
1997 amended by inserting after the word “thereon”, in line 29, the following words:- ; and (v) any
1998 fines collected under section 10 of chapter 6D.

1999 SECTION 113. Said chapter 118E is hereby further amended by adding the following 4
2000 sections:-

2001 Section 78. (a) Upon request from the division, an employer shall provide, under oath,
2002 health insurance information about an employee who has applied for benefits from a state
2003 subsidized health insurance program. An employer receiving information that identifies or may
2004 be used to identify a MassHealth member or recipient of subsidized health insurance shall not
2005 use or disclose such information except as authorized by the division.

2006 (b) Information reported under this section that identifies an individual employee by
2007 name or health insurance status or is health information protected under state and federal privacy
2008 laws shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under
2009 chapter 66. Reported information may be exchanged among the executive office of health and
2010 human services, the commonwealth health insurance connector authority, the department of
2011 unemployment assistance, the center for health information and analysis and the department of
2012 revenue for the exclusive purpose of determining an individual’s eligibility for benefits from a
2013 state subsidized health insurance program. An employer who knowingly falsifies or fails to file
2014 any information required by this section or by any regulation issued pursuant to this section shall
2015 be subject to a fine of not more than \$5,000 for each violation

2016 Section 79. (a) The division shall create a health insurance responsibility disclosure form.
2017 An employer with 6 or more employees and doing business in the commonwealth shall annually
2018 complete and submit the form under oath. The form shall indicate whether the employer has
2019 offered to pay for or arrange for the purchase of health care insurance and information about
2020 such health care insurance including, but not limited to: (i) the premium cost; (ii) benefits
2021 offered; (iii) cost sharing details; (iv) eligibility criteria; and (v) any other information deemed
2022 necessary by the division.

2023 The division may make arrangements with other agencies, including the department of
2024 revenue and the department of unemployment assistance, to assist with the administration of this

2025 section. Employers shall provide supplemental information that is deemed necessary by the
2026 division or its designee upon request by the division. An employer receiving information that
2027 identifies or may be used to identify a MassHealth member or recipient of subsidized health
2028 insurance shall not use or disclose such information except as authorized by the division to
2029 implement this section.

2030 (b) Information reported under subsection (a) that identifies an individual employee by
2031 name or health insurance status or that is protected health information shall not be a public
2032 record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66. Reported
2033 information may be exchanged among the executive office of health and human services, the
2034 commonwealth health insurance connector authority, the department of unemployment
2035 assistance, the center for health information and analysis and the department of revenue if
2036 necessary to implement this section or section 24 of chapter 12C. An employer who knowingly
2037 falsifies or fails to file any information required by this section or by any regulation issued
2038 pursuant to this section shall be subject to a fine of not less than \$1,000 not more than \$5,000 for
2039 each violation.

2040 Section 80. (a) For the purposes of this section, “telemedicine” shall mean the use of
2041 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
2042 patient’s physical, oral or mental health; provided, however, that “telemedicine” shall not include
2043 audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

2044 (b) The division and its contracted health insurers, health plans, health maintenance
2045 organizations, behavioral health management firms and third party administrators under contract
2046 to a Medicaid managed care organization or primary care clinician plan may provide coverage
2047 for health care services appropriately provided through telemedicine by a contracted provider.

2048 (c) The division may undertake utilization review, including preauthorization, to
2049 determine the appropriateness of telemedicine as a means of delivering a health care service;
2050 provided, however, that determinations shall be made in the same manner as if service was
2051 delivered in person. The division, a contracted health insurer, health plan, health maintenance
2052 organization, behavioral health management firm or third party administrators under contract to a
2053 Medicaid managed care organization or primary care clinician plan shall not be required to

2054 reimburse a health care provider for a health care service that is not a covered benefit under the
2055 plan nor reimburse a health care provider not contracted under the plan.

2056 A health care provider shall not be required to document a barrier to an in-person visit,
2057 nor shall the type of setting where telemedicine is provided be limited for health care services
2058 provided through telemedicine.

2059 (d) A contract that provides coverage for telemedicine services may include a deductible,
2060 copayment or coinsurance requirement for a health care service provided through telemedicine as
2061 long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or
2062 coinsurance applicable to an in-person consultation or in-person delivery of services. Coverage
2063 that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall
2064 account for the provision of telemedicine services in setting that global payment amount.

2065 (e) Health care services provided by telemedicine shall conform to the standards of care
2066 applicable to the telemedicine provider's profession. Such services shall also conform to
2067 applicable federal and state health information privacy and security standards as well as
2068 standards for informed consent.

2069 Section 81. The division and its contracted health insurers, health plans, health
2070 maintenance organizations, behavioral health management firms and third party administrators
2071 under contract with a Medicaid managed care organization or primary care clinician plan shall
2072 use the aligned measure set established by the secretary pursuant to section 16AA of chapter 6A
2073 as follows: (i) the measures designated by the secretary as core measures shall be used in any
2074 contract with a health care provider, provider organization or accountable care organization that
2075 incorporates quality measures into payment terms; (ii) the measures designated by the secretary
2076 as non-core measures may be used in any contract with a health care provider, provider
2077 organization or accountable care organization that incorporate quality measures into payment
2078 terms and shall not use any measures not designated as non-core measures; (iii) only measures
2079 included in the aligned measure set shall be used to assign health care providers, provider
2080 organizations or accountable care organizations to tiers in the design of a program of medical
2081 benefits to a beneficiary under section 9A.

2082 SECTION 114. Section 1 of chapter 175 of the General Laws, as appearing in the 2016
2083 Official Edition, is hereby amended by striking out the definition of “commissioner” and
2084 inserting in place thereof the following 2 definitions:-

2085 “Behavioral health”, mental health and substance use disorder prevention, recovery and
2086 treatment services including, but not limited to, inpatient 24-hour levels of care, 24-hour and
2087 non-24-hour diversionary levels of care, intermediate levels of care and outpatient services.

2088 “Commissioner”, the commissioner of insurance.

2089 SECTION 115. Said section 1 of said chapter 175, as so appearing, is hereby further
2090 amended by inserting after the definition of “Resident” the following definition:-

2091 “Retroactive claim denial”, an action by: (i) an insurer; (ii) an entity with which the
2092 insurer subcontracts to manage behavioral health services; (iii) an entity with which the group
2093 insurance commission has entered into an administrative services contract or a contract to
2094 manage behavioral health services; or (iv) the executive office of health and human services
2095 acting as the single state agency under section 1902(a)(5) of the federal Social Security Act
2096 authorized to administer programs under Title XIX, to deny a previously paid claim for services
2097 and to require repayment of the claim, impose a reduction in other payments or otherwise
2098 withhold or affect future payments owed a provider in order to recoup payment for the denied
2099 claim.

2100 SECTION 116. Section 47BB of said chapter 175 is hereby repealed.

2101 SECTION 117. Said chapter 175 is hereby further amended by inserting after section
2102 47BB the following section:-

2103 Section 47CC. (a) For the purposes of this section, “telemedicine” shall mean the use of
2104 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
2105 patient's physical, oral or mental health; provided, however, that “telemedicine” shall not include
2106 audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

2107 (b) An individual policy of accident and sickness insurance issued under section 108 that
2108 provides hospital expense and surgical expense insurance and any group blanket or general

2109 policy of accident and sickness insurance issued under section 110 that provides hospital expense
2110 and surgical expense insurance which is issued or renewed within or without the commonwealth,
2111 shall not decline to provide coverage for health care services solely on the basis that those
2112 services were delivered through the use of telemedicine by a contracted health care provider.
2113 Health care services delivered by way of telemedicine shall be covered to the same extent as if
2114 they were provided by way of in-person consultation or in-person delivery.

2115 (c) Coverage may include utilization review, including preauthorization, to determine the
2116 appropriateness of telemedicine as a means of delivering a health care service; provided,
2117 however, that the determinations shall be made in the same manner as if the service was
2118 delivered in person. A policy, contract, agreement, plan or certificate of insurance issued,
2119 delivered or renewed within the commonwealth, shall not be required to reimburse a health care
2120 provider for a health care service that is not a covered benefit under the plan nor reimburse a
2121 health care provider not contracted under the plan.

2122 A health care provider shall not be required to document a barrier to an in-person visit,
2123 nor shall the type of setting where telemedicine is provided be limited for health care services
2124 provided through telemedicine.

2125 A contract that provides coverage for telemedicine services may include a deductible,
2126 copayment or coinsurance requirement for a health care service provided through telemedicine as
2127 long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or
2128 coinsurance applicable to an in-person consultation or in-person delivery of services.

2129 (d) Coverage that reimburses a provider with a global payment, as defined in section 1 of
2130 chapter 6D, shall account for the provision of telemedicine services in setting that global
2131 payment amount.

2132 (e) Health care services provided by telemedicine shall conform to the standards of care
2133 applicable to the telemedicine provider's profession. Such services shall also conform to
2134 applicable federal and state health information privacy and security standards as well as
2135 standards for informed consent.

2136 SECTION 118. Section 108 of said chapter 175, as appearing in the 2016 Official
2137 Edition, is hereby amended by adding the following subsection: -

2138 14. (a) An insurer shall not impose a retroactive claims denial, as defined in section 1 of
2139 chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on a provider
2140 unless:

2141 (i) Less than 6 months have elapsed from the time of submission of the claim by the
2142 provider to the insurer or other entity responsible for payment; or

2143 (ii) The insurer or other entity has furnished the provider with a written explanation
2144 of the reason for the retroactive claim denial and a description of additional documentation or
2145 other corrective actions required for payment of the claim.

2146 (b) Notwithstanding clause (i) of paragraph (a), a retroactive claim denial may be
2147 permitted after 6 months if:

2148 (i) The claim was submitted fraudulently;

2149 (ii) The claim payment is subject to adjustment due to expected payment from
2150 another payer and not more than 12 months have elapsed since submission of the claim; or

2151 (iii) The claim or services for which the claim has been submitted is the subject of
2152 legal action.

2153 (c) If a retroactive claim denial is imposed under clause (ii) of paragraph (b), the insurer
2154 shall notify a provider not less than 15 days before imposing the retroactive claim denial and the
2155 provider shall have 6 months to determine whether the claim is subject to payment by a
2156 secondary insurer. Notwithstanding the contractual terms between the provider and insurer, an
2157 insurer shall allow for submission of a claim that was previously denied by another insurer due to
2158 the insured's transfer or termination of coverage.

2159 (d) For the purposes of this section, "provider" shall mean a mental health clinic or
2160 substance use disorder program licensed by the department of public health under chapter 18,
2161 111, 111B or 111E, a behavioral, substance use disorder, or mental health professional who is

2162 licensed under chapter 112 and accredited or certified to provide services consistent with law and
2163 who has provided services under an express or implied contract or with the expectation of
2164 receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly
2165 from an insurer.

2166 SECTION 119. Said chapter 175 is hereby further amended by inserting after section
2167 108M the following 2 sections:-

2168 Section 108N. Upon request by a network provider, a carrier and, if applicable, a
2169 specialty organization subcontracted by a carrier to manage behavioral health services, shall
2170 disclose the methodology used for a provider's tier placement, including: (i) the criteria,
2171 measures, data sources and provider-specific information used in determining the provider's
2172 quality score; (ii) how the provider's quality performance compares to other in-network
2173 providers; and (iii) the data used in calculating the provider's cost-efficiency. A carrier may
2174 require a network provider to hold information received under this section confidential.

2175 Section 108O. An insurer licensed or otherwise authorized to transact accident or health
2176 insurance under this chapter shall use the aligned measure set established by the secretary of
2177 health and human services pursuant to section 16AA of chapter 6A as follows: (i) the insurer
2178 shall use the measures designated by the secretary as core measures in any contract with a health
2179 care provider, provider organization or accountable care organization that incorporates quality
2180 measures into payment terms; (ii) the insurer may use the measures designated by the secretary
2181 as non-core measures in any contract with a health care provider, provider organization or
2182 accountable care organization that incorporates quality measures into payment terms and shall
2183 not use any measures not designated as non-core measures; (iii) the insurer shall only use the
2184 measures in the aligned measure set established by the secretary to assign health care providers,
2185 provider organizations or accountable care organizations to tiers in the design of an accident or
2186 health plan.

2187 SECTION 120. Subdivision (P) of section 110 of said chapter 175, as appearing in the
2188 2016 Official Edition, is hereby amended by inserting after the word “age”, in line 463, the
2189 following words:- or without regard to age, so long as the dependent is mentally or physically
2190 incapable of earning their own living due to disability.

2191 SECTION 121. Chapter 176A of the General Laws is hereby amended by inserting after
2192 section 8½ the following section:-

2193 Section 8¾. (a) A corporation shall not impose a retroactive claims denial, as defined in
2194 section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on
2195 a provider unless:

2196 (i) Less than 6 months have elapsed from the time of submission of the claim by the
2197 provider to the corporation; or

2198 (ii) The corporation has furnished the provider with a written explanation of the
2199 reason for the retroactive claim denial and a description of additional documentation or other
2200 corrective actions required for payment of the claim.

2201 (b) Notwithstanding clause (i) of subsection (a), a retroactive claim denial may be
2202 permitted after 6 months if:

2203 (i) The claim was submitted fraudulently;

2204 (ii) The claim payment is subject to adjustment due to expected payment from
2205 another payer and not more than 12 months have elapsed since submission of the claim; or

2206 (iii) The claims, or services for which the claim has been submitted, is the subject of
2207 legal action.

2208 (c) If a retroactive claim denial is imposed under clause (ii) of subsection (b), the
2209 corporation shall notify a provider not less than 15 days before imposing the retroactive claim
2210 denial and the provider shall have 6 months to determine whether the claim is subject to payment
2211 by a secondary payer. Notwithstanding the contractual terms between the provider and secondary
2212 payer, the payer shall allow for submission of a claim that was previously denied by the
2213 corporation due to the insured's transfer or termination of coverage.

2214 (d) For the purposes of this section, "provider" shall mean a mental health clinic or
2215 substance use disorder program licensed by the department of public health under chapter 18,
2216 111, 111B or 111E or a behavioral, substance use disorder or mental health professional who is

2217 licensed under chapter 112 and accredited or certified to provide services consistent with law and
2218 who has provided services under an express or implied contract or with the expectation of
2219 receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly
2220 from an insurer.

2221 SECTION 122. Said chapter 176A is hereby further amended by adding the following 3
2222 sections:-

2223 Section 38. Upon request by a network provider, a nonprofit hospital service corporation
2224 and, if applicable, a specialty organization subcontracted by a nonprofit hospital service
2225 corporation to manage behavioral health services, shall disclose the methodology used for a
2226 provider's tier placement, including: (i) the criteria, measures, data sources and provider-specific
2227 information used in determining the provider's quality score; (ii) how the provider's quality
2228 performance compares to other in-network providers; and (iii) the data used in calculating the
2229 provider's cost-efficiency. A carrier may require a network provider to hold information received
2230 under this section confidential.

2231 Section 39. (a) For purposes of this section, “telemedicine” shall mean the use of
2232 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
2233 patient's physical, oral or mental health; provided, however, that “telemedicine” shall not include
2234 audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

2235 (b) A contract between a subscriber and a nonprofit hospital service corporation under an
2236 individual or group hospital service plan shall not decline to provide coverage for health care
2237 services solely on the basis that those services were delivered by way of telemedicine by a
2238 contracted health care provider. Health care services delivered by way of telemedicine shall be
2239 covered to the same extent as if they were provided by way of in-person consultation or in-
2240 person delivery.

2241 (c) Coverage may include utilization review, including preauthorization, to determine the
2242 appropriateness of telemedicine as a means of delivering a health care service, provided that the
2243 determinations shall be made as if the service was delivered in person. A carrier shall not be
2244 required to reimburse a health care provider for a health care service that is not a covered benefit
2245 under the plan nor reimburse a health care provider not contracted under the plan.

2246 Coverage for telemedicine services may include a provision for a deductible, copayment
2247 or coinsurance requirement for a health care service provided through telemedicine as long as the
2248 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance
2249 applicable to an in-person consultation or in-person delivery of services.

2250 Coverage that reimburses a provider with a global payment, as defined in section 1 of
2251 chapter 6D, shall account for the provision of telemedicine services in setting that global
2252 payment amount.

2253 (d) A health care provider shall not be required to document a barrier to an in-person
2254 visit, nor shall the type of setting where telemedicine is provided be limited for health care
2255 services provided through telemedicine.

2256 (e) Health care services provided by telemedicine shall conform to the standards of care
2257 applicable to the telemedicine provider's profession. Such services shall also conform to
2258 applicable federal and state health information privacy and security standards as well as
2259 standards for informed consent.

2260 Section 40. A nonprofit hospital service corporation organized under this chapter shall
2261 use the standard quality measure set established by the secretary of health and human services
2262 pursuant to section 16AA of chapter 6A as follows: (i) a nonprofit hospital service corporation
2263 shall use the measures designated by the secretary as core measures in any contract with a health
2264 care provider, provider organization or accountable care organization that incorporates quality
2265 measures into payment terms; (ii) a nonprofit hospital service corporation may use the measures
2266 designated by the secretary as non-core measures in any contract with a health care provider,
2267 provider organization or accountable care organization that incorporates quality measures into
2268 payment terms and shall not use any measures not designated as non-core measures; (iii) a
2269 nonprofit hospital service corporation shall only use the measures in the aligned measure set
2270 established by the secretary to assign health care providers, provider organizations or
2271 accountable care organizations to tiers in the design of a group hospital service plan.

2272 SECTION 123. Chapter 176B of the General Laws is hereby amended by inserting after
2273 section 7C the following section:-

2274 Section 7D. (a) A corporation shall not impose a retroactive claims denial, as defined in
2275 section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on
2276 a provider unless:

2277 (i) Less than 6 months have elapsed from the time of submission of the claim by the
2278 provider to the corporation; or

2279 (ii) The corporation has furnished the provider with a written explanation of the
2280 reason for the retroactive claim denial and a description of additional documentation or other
2281 corrective actions required for payment of the claim.

2282 (b) Notwithstanding clauses (i) of subsection (a), retroactive claim denials may be
2283 permitted after 6 months if:

2284 (i) The claim was submitted fraudulently;

2285 (ii) The claim payment is subject to adjustment due to expected payment from
2286 another payer and not more than 12 months have elapsed since submission of the claim; or

2287 (iii) The claims or services for which the claim has been submitted is the subject of
2288 legal action.

2289 (c) If a retroactive claim denial is imposed under clause (ii) of subsection (b), the
2290 corporation shall notify a provider not less than 15 days before imposing the retroactive claim
2291 denial and the provider shall have 6 months to determine whether the claim is subject to payment
2292 by a secondary payer. Notwithstanding the contractual terms between the provider and secondary
2293 payer, the payer shall allow for submission of a claim that was previously denied by the
2294 corporation due to the insured's transfer or termination of coverage.

2295 (d) For the purposes of this section, "provider" shall mean a mental health clinic or
2296 substance use disorder program licensed by the department of public health under chapter 18,
2297 111, 111B or 111E or a behavioral, substance use disorder or mental health professional who is
2298 licensed under chapter 112 and accredited or certified to provide services consistent with law and
2299 who has provided services under an express or implied contract or with the expectation of

2300 receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly
2301 from an insurer.

2302 SECTION 124. Said chapter 176B is hereby further amended by adding the following 3
2303 sections:-

2304 Section 25. Upon request by a network provider, a medical service corporation and, if
2305 applicable, a specialty organization subcontracted by a medical service corporation to manage
2306 behavioral health services, shall disclose the methodology used for a provider's tier placement,
2307 including: (i) the criteria, measures, data sources and provider-specific information used in
2308 determining the provider's quality score; (ii) how the provider's quality performance compares to
2309 other in-network providers; and (iii) the data used in calculating the provider's cost-efficiency. A
2310 carrier may require a network provider to hold information received under this section
2311 confidential.

2312 Section 26. (a) For the purposes of this section, “telemedicine” shall mean the use of
2313 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
2314 patient's physical, oral or mental health; provided, however, that “telemedicine” shall not include
2315 audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

2316 (b) A contract between a subscriber and a medical service corporation shall not decline to
2317 provide coverage for health care services solely on the basis that those services were delivered
2318 by way e of telemedicine by a contracted health care provider. Health care services delivered by
2319 way of telemedicine shall be covered to the same extent as if they were provided by way of in-
2320 person consultation or in-person delivery.

2321 (c) Coverage may include utilization review, including preauthorization, to determine the
2322 appropriateness of telemedicine as a means of delivering a health care service, provided that the
2323 determinations shall be made as if the service was delivered in person. A carrier is not required
2324 to reimburse a health care provider for a health care service that is not a covered benefit under
2325 the plan nor reimburse a health care provider not contracted under the plan. Coverage that
2326 reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall account
2327 for the provision of telemedicine services in setting that global payment amount. A contract that
2328 provides coverage for telemedicine services may contain a provision for a deductible, copayment

2329 or coinsurance requirement for a health care service provided through telemedicine as long as the
2330 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance
2331 applicable to an in-person consultation or in-person delivery of services.

2332 (d) A health care provider shall not be required to document a barrier to an in-person
2333 visit, nor shall the type of setting where telemedicine is provided be limited for health care
2334 services provided through telemedicine.

2335 (e) Health care services provided by telemedicine shall conform to the standards of care
2336 applicable to the telemedicine provider's profession. Such services shall also conform to
2337 applicable federal and state health information privacy and security standards as well as
2338 standards for informed consent.

2339 Section 27. A nonprofit medical service corporation organized under this chapter shall
2340 use the standard quality measure set established by the secretary of health and human services
2341 pursuant to section 16AA of chapter 6A as follows: (i) a nonprofit medical service corporation
2342 shall use the measures designated by the secretary as core measures in any contract with a health
2343 care provider, provider organization or accountable care organization that incorporates quality
2344 measures into payment terms; (ii) a nonprofit medical service corporation may use the measures
2345 designated by the secretary as non-core measures in any contract with a health care provider,
2346 provider organization or accountable care organization that incorporates quality measures into
2347 payment terms and shall not use any measures not designated as non-core measures; (iii) a
2348 nonprofit medical service corporation shall only use the measures in the aligned measure set
2349 established by the secretary to assign health care providers, accountable care organizations or
2350 provider organizations to tiers in the design of a group medical service plan.

2351 SECTION 125. Section 4T of chapter 176G of the General Laws, as appearing in the
2352 2016 Official Edition, is hereby amended by inserting after the word "age", in line 6, the
2353 following words:- or without regard to age, so long as the dependent is mentally or physically
2354 incapable of earning their own living due to disability.

2355 SECTION 126. Said chapter 176G is hereby further amended by inserting after section
2356 6A the following section:-

2357 Section 6B. (a) An insurer shall not impose a retroactive claims denial, as defined in
2358 section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on
2359 a provider unless:

2360 (i) Less than 6 months have elapsed from the time of submission of the claim by the
2361 provider to the insurer or other entity responsible for payment; or

2362 (ii) The insurer or other entity has furnished the provider with a written explanation
2363 of the reason for the retroactive claim denial and a description of additional documentation or
2364 other corrective actions required for payment of the claim.

2365 (b) Notwithstanding clauses (i) of subsection (a), retroactive claim denials may be
2366 permitted after 6 months if:

2367 (i) The claim was submitted fraudulently;

2368 (ii) The claim payment is subject to adjustment due to expected payment from
2369 another payer and not more than 12 months have elapsed since submission of the claim; or

2370 (iii) The claims or services for which the claim has been submitted is the subject of
2371 legal action.

2372 (c) If a retroactive claim denial is imposed under clause (ii) of subsection (b), the insurer
2373 shall notify a provider at least 15 days before imposing the retroactive claim denial and the
2374 provider shall have six months to determine whether the claim is subject to payment by a
2375 secondary insurer. Notwithstanding the contractual terms between the provider and insurer, an
2376 insurer shall allow for submission of a claim that was previously denied by another insurer due to
2377 the insured's transfer or termination of coverage.

2378 (d) For the purposes of this section, "provider" shall mean a mental health clinic or
2379 substance use disorder program licensed by the department of public health under chapter 18,
2380 111, 111B or 111E or a behavioral, substance use disorder or mental health professional who is
2381 licensed under chapter 112 and accredited or certified to provide services consistent with law and
2382 who has provided services under an express or implied contract or with the expectation of

2383 receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly
2384 from an insurer.

2385 SECTION 127. Said chapter 176G is hereby further amended by adding the following 3
2386 sections:-

2387 Section 33. Upon request by a network provider, a health maintenance organization and,
2388 if applicable, a specialty organization subcontracted by a health maintenance organization to
2389 manage behavioral health services, shall disclose the methodology used for a provider's tier
2390 placement, including: (i) the criteria, measures, data sources and provider-specific information
2391 used in determining the provider's quality score; (ii) how the provider's quality performance
2392 compares to other in-network providers; and (iii) the data used in calculating the provider's cost-
2393 efficiency. A carrier may require a network provider to hold information received under this
2394 section confidential.

2395 Section 34. (a) For the purposes of this section, “telemedicine” shall mean the use of
2396 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
2397 patient's physical, oral or mental health; provided, however, that “telemedicine” shall not include
2398 audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

2399 (b) A contract between a member and a health maintenance organization shall not decline
2400 to provide coverage for health care services solely on the basis that those services were delivered
2401 by way of telemedicine by a contracted health care provider. Health care services delivered by
2402 way of telemedicine shall be covered to the same extent as if they were provided by way of in-
2403 person consultation or in-person delivery.

2404 (c) A carrier may undertake utilization review, including preauthorization, to determine
2405 the appropriateness of telemedicine as a means of delivering a health care service, provided that
2406 the determinations shall be made as if the service was delivered in person. A carrier is not
2407 required to reimburse a health care provider for a health care service that is not a covered benefit
2408 under the plan nor reimburse a health care provider not contracted under the plan. A contract
2409 that provides coverage for telemedicine services may contain a provision for a deductible,
2410 copayment or coinsurance requirement for a health care service provided through telemedicine as
2411 long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or

2412 coinsurance applicable to an in-person consultation or in-person delivery of services. Coverage
2413 that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall
2414 account for the provision of telemedicine services in setting that global payment amount.

2415 (d) A health care provider shall not be required to document a barrier to an in-person
2416 visit, nor shall the type of setting where telemedicine is provided be limited for health care
2417 services provided through telemedicine.

2418 (e) Health care services provided by telemedicine shall conform to the standards of care
2419 applicable to the telemedicine provider's profession. Such services shall also conform to
2420 applicable federal and state health information privacy and security standards as well as
2421 standards for informed consent.

2422 Section 35. A health maintenance organization organized under this chapter shall use the
2423 standard quality measure set established by the secretary of health and human services pursuant
2424 to section 16AA of chapter 6A as follows: (i) a health maintenance organization shall use the
2425 measures designated by the secretary as core measures in any contract with a health care
2426 provider, provider organization or accountable care organization that incorporates quality
2427 measures into payment terms; (ii) a health maintenance organization may use the measures
2428 designated by the secretary as non-core measures in any contract with a health care provider,
2429 provider organization or accountable care organization that incorporates quality measures into
2430 payment terms and shall not use any measures not designated as non-core measures; (iii) a health
2431 maintenance organization shall only use the measures in the aligned measure set established by
2432 the secretary to assign health care providers, accountable care organizations or provider
2433 organizations to tiers in the design of any health maintenance contract.

2434 SECTION 128. Chapter 176I of the General Laws is hereby amended by adding the
2435 following 2 sections:-

2436 Section 13. (a) For the purposes of this section, "telemedicine" shall mean the use of
2437 interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a
2438 patient's physical, oral or mental health; provided, however, that "telemedicine" shall not include
2439 audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

2440 (b) A preferred provider contract between a covered person and an organization shall not
2441 decline to provide coverage for health care services solely on the basis that those services were
2442 delivered by way of telemedicine by a contracted health care provider. Health care services
2443 delivered by way of telemedicine shall be covered to the same extent as if they were provided by
2444 way of in-person consultation or in-person delivery.

2445 (c) An organization may undertake utilization review, including preauthorization, to
2446 determine the appropriateness of telemedicine as a means of delivering a health care service,
2447 provided that the determinations shall be made in the same manner as those regarding the same
2448 service when it is delivered in person. An organization is not required to reimburse a health care
2449 provider for a health care service that is not a covered benefit under the plan nor reimburse a
2450 health care provider not contracted under the plan.

2451 A preferred provider contract that provides coverage for telemedicine services may
2452 contain a provision for a deductible, copayment or coinsurance requirement for a health care
2453 service provided through telemedicine as long as the deductible, copayment or coinsurance does
2454 not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or
2455 in-person delivery of services. Coverage that reimburses a provider with a global payment, as
2456 defined in section 1 of chapter 6D, shall account for the provision of telemedicine services in
2457 setting that global payment amount.

2458 (d) A health care provider shall not be required to document a barrier to an in-person
2459 visit, nor shall the type of setting where telemedicine is provided be limited for health care
2460 services provided through telemedicine.

2461 (e) Health care services provided by telemedicine shall conform to the standards of care
2462 applicable to the telemedicine provider's profession. Such services shall also conform to
2463 applicable federal and state health information privacy and security standards as well as
2464 standards for informed consent.

2465 Section 14. An organization shall use the standard quality measure set established by the
2466 secretary of health and human services pursuant to section 16AA of chapter 6A as follows: (i) an
2467 organization shall use the measures designated by the secretary as core measures in any contract
2468 with a health care provider, provider organization or accountable care organization that

2469 incorporates quality measures into payment terms; (ii) an organization may use the measures
2470 designated by the secretary as non-core measures in any contract with a health care provider,
2471 provider organization or accountable care organization that incorporates quality measures into
2472 payment terms and shall not use any measures not designated as non-core measures; (iii) an
2473 organization shall only use the measures in the aligned measure set established by the secretary
2474 to assign health care providers, accountable care organizations or provider organizations to tiers
2475 in the design of a health benefit plan.

2476 SECTION 129. Section 1 of chapter 176J of the General Laws, as appearing in the 2016
2477 Official Edition, is hereby amended by inserting after the word “ age”, in line 86, the following
2478 words:- or without regard to age, so long as the dependent is mentally or physically incapable of
2479 earning their own living due to disability.

2480 SECTION 130. Said chapter 176J is hereby further amended by striking out section 11,
2481 as so appearing, and inserting in place thereof the following section:-

2482 Section 11. (a) For the purposes of this section, the following words shall have the
2483 following meanings unless the context clearly requires otherwise:

2484 “High-value health care services”, a set of services that yield improved management of
2485 chronic conditions or meaningfully reduce the occurrence of high-cost care episodes related to
2486 the underlying condition that the service is meant to treat, as identified by the division of
2487 insurance, in consultation with the health policy commission and the center for health
2488 information and analysis;

2489 “Shoppable health care services”, a set of services deemed sufficiently substitutable
2490 across providers for which there is adequate information on cost and quality to inform a patient’s
2491 decision on where to obtain those health care services as identified by the division of insurance
2492 in consultation with the health policy commission and the center for health information and
2493 analysis.

2494 (b) A carrier that offers a health benefit plan that provides or arranges for the delivery of
2495 health care services through a closed network of health care providers and, as of the close of any
2496 preceding calendar year, has a combined total of not less than 5,000 eligible individuals, eligible

2497 employees and eligible dependents who are enrolled in health benefit plans sold, issued,
2498 delivered, made effective or renewed to qualified small businesses or eligible individuals shall
2499 offer to all eligible individuals and small businesses in not less than 2 geographic areas at least 1
2500 of the following plans:

2501 (i) a plan with a reduced or selective network of providers;

2502 (ii) a plan in which providers are tiered and member cost-sharing is based on the tier
2503 placement of the provider that includes a base premium discount of not less than 19 per cent;

2504 (iii) a plan in which an enrollee's premium varies based on the primary care provider
2505 selected at the time of enrollment;

2506 (iv) a plan in which a separate cost-sharing differential is applied to shoppable health care
2507 services among the network of providers;

2508 (v) a plan in which there is a separate reduced or eliminated cost-sharing differential for
2509 high value health care services relative to other services covered by the plan; or

2510 (vi) a plan compatible with a health savings account authorized under federal law, a
2511 health plan design in which enrollees are directly incentivized to shop for low-cost, high-quality
2512 participating providers for comparable health care services; provided, that incentives may
2513 include, but shall not be limited to, cash payments, gift cards or credits or reductions of
2514 premiums, copayments or deductibles.

2515 (c) Annually, the commissioner shall determine the base premium rate discount compared
2516 to the base premium of the carrier's most actuarially-similar plan with the carrier's non-selective
2517 or non-tiered network of providers under clauses (i) and (ii) of subsection (b). The savings may
2518 be achieved by means including, but not limited to: (i) the exclusion of providers with similar or
2519 lower quality based on the standard quality measure set with higher health status adjusted total
2520 medical expenses or relative prices, as determined pursuant to the methodology under section 52
2521 of chapter 288 of the Acts of 2010; or (ii) increased member cost-sharing for members who
2522 utilize providers for non-emergency services with similar or lower quality based on the standard
2523 quality measure set and with higher health status adjusted total medical expenses or relative

2524 prices, as determined pursuant to the methodology under said section 52 of chapter 288 of the
2525 Acts of 2010.

2526 The commissioner may apply waivers to the base premium rate discount determined by
2527 the commissioner under this section to carriers that receive not less than 80 per cent of their
2528 incomes from government programs or that have service areas that do not include an area within
2529 the boundaries of the abolished counties of Suffolk or Middlesex and that were first admitted to
2530 do business by the division of insurance not later than January 1, 1986 as health maintenance
2531 organizations under chapter 176G.

2532 (d) The commissioner shall require a plan under paragraph (iii) of subsection (b) to have
2533 at least 1 tier that provides the base premium rate discount. A carrier may include any of its
2534 participating providers in a plan under paragraph (iii) of subsection (b) only if a provider
2535 receives reasonable information on plan performance from the carrier pursuant to the plan.

2536 (e) A tiered network plan shall only include variations in member cost-sharing among
2537 provider tiers that are reasonable in relation to the premium charged and shall ensure adequate
2538 access to covered services. Carriers shall tier providers based on quality performance as
2539 measured by the standard quality measure set and by cost performance as measured by health
2540 status adjusted total medical expenses and relative prices. If applicable quality measures are not
2541 available, tiering may be based solely on health status adjusted total medical expenses or relative
2542 prices or both.

2543 The commissioner shall promulgate regulations requiring the uniform reporting of tiering
2544 information by carriers. The regulations shall include, but not be limited to, a requirement that a
2545 carrier that is implementing a tiered network plan or is modifying the tiering methodology for an
2546 existing tiered network plan shall report a detailed description of the methodology used for the
2547 tiering of providers to the commissioner not less than 90 days before the effective date of the
2548 plan or modification. The description shall include, but not be limited to: (i) the statistical basis
2549 for tiering; (ii) a list of providers to be tiered at each member cost-sharing level; (iii) a
2550 description of how the methodology and resulting tiers shall be communicated to each network
2551 provider, eligible individuals and small groups; (iv) a description of the appeals process a
2552 provider may pursue to challenge the assigned tier level; and (v) the utilization of a variable

2553 premium amount based on tier designation for the primary care provider selected by the member,
2554 if any.

2555 (f) The commissioner shall determine network adequacy: (i) for a tiered network plan
2556 based on the availability of sufficient network providers in the carrier's overall network of
2557 providers; and (ii) for a selective network plan based on the availability of sufficient network
2558 providers in the carrier's selective network.

2559 In determining network adequacy under this section, the commissioner may consider
2560 factors including the location of providers participating in the plan and employers or members
2561 that enroll in the plan, the range of services provided by providers in the plan and plan benefits
2562 that recognize and provide for extraordinary medical needs of members that may not be
2563 adequately dealt with by the providers within the plan network.

2564 (g) A carrier may reclassify provider tiers and determine provider participation in
2565 selective and tiered plans not more than once per calendar year; provided, however, that a carrier
2566 may reclassify a provider from a higher cost tier to a lower cost tier or add a provider to a
2567 selective network at any time. If a carrier reclassifies provider tiers or providers participating in a
2568 selective plan during the course of an account year, the carrier shall provide notice to affected
2569 members of the account that shall include information regarding the plan changes not less than
2570 30 days before the changes are to take effect. A carrier shall provide information on the carrier's
2571 website about any tiered or selective plan including, but not limited to, the providers
2572 participating in the plan, the selection criteria for those providers and, where applicable, the tier
2573 in which each provider is classified.

2574 (h) The commissioner shall review plans under clauses (iv) and (v) of subsection (b) in a
2575 manner consistent with other products offered in the commonwealth. The commissioner may
2576 disapprove a plan established pursuant to clause (iv) or (v) of subsection (b) if it determines that
2577 the carrier-differentiated cost-sharing obligations are solely based on the provider. There shall be
2578 a rebuttable presumption that a plan has violated this subsection if the cost-sharing obligation for
2579 the services provided by a provider, including a health care facility, accountable care
2580 organization, patient-centered medical home or provider organization, is the same cost-sharing
2581 obligation without regard for the types of services provided pursuant to clause (iv) or (v).

2582 When reviewing a plan established pursuant to clauses (iv) and (v) of subsection (b), the
2583 commissioner shall ensure that the plan promotes: (i) the avoidance of consumer confusion; (ii)
2584 the minimization of administrative burdens on payers and providers in implementing the plan;
2585 and (iii) allowing for patients to receive services in appropriate locations.

2586 (i) The commissioner shall make publicly available on the commissioner’s website: (i) a
2587 description of each plan offered under this section, including a list of providers or services by tier
2588 or a list of providers included in a selective network plan; (ii) membership trends for each plan
2589 offered under this section; (iii) the extent to which plans offered under this section have reduced
2590 health care costs for patients and employers; and (iv) the effect of plans offered under this
2591 section on provider mix and other factors impacting overall state health care costs. The
2592 commissioner shall ensure that the information is updated not less than annually.

2593 Nothing in this section shall exempt an insurance carrier or product from state and federal
2594 mental health parity and addiction equity laws, including those codified at 42 U.S. Code §
2595 300gg-26, and regulations implemented pursuant to section 8K of chapter 26. Nothing in this
2596 section shall create a lesser standard of scrutiny for parity compliance for any reduced, tiered or
2597 discounted plan established pursuant to this section.

2598 SECTION 131. Said chapter 176J is hereby further amended by adding the following
2599 section:-

2600 Section 18. Upon request by a network provider, a carrier and, if applicable, a specialty
2601 organization subcontracted by a carrier to manage behavioral health services, shall disclose the
2602 methodology used for a provider's tier placement, including: (i) the criteria, measures, data
2603 sources and provider-specific information used in determining the provider's quality score; (ii)
2604 how the provider's quality performance compares to other in-network providers; and (iii) the data
2605 used in calculating the provider's cost-efficiency. A carrier may require a network provider to
2606 hold information received under this section confidential.

2607 SECTION 132. Section 1 of chapter 176O of the General Laws, as appearing in the 2016
2608 Official Edition, is hereby amended by inserting after the definition of “Incentive plan” the
2609 following definition:-

2610 “In-network contracted rate”, the rate contracted between an insured's carrier and a
2611 network health care provider for the reimbursement of health care services delivered by that
2612 health care provider to the insured.

2613 SECTION 133. Said section 1 of said chapter 176O, as so appearing, is hereby further
2614 amended by inserting after the definition of “Network” the following 3 definitions:-

2615 “Noncontracted commercial rate for emergency services”, the amount set pursuant to
2616 section 16A of chapter 6D and used to determine the rate of payment to a health care provider for
2617 the provision of emergency health care services to an insured when the health care provider is
2618 not in the carrier’s network.

2619 “Noncontracted commercial rate for nonemergency services”, the amount set pursuant to
2620 section 16A of chapter 6D and used to determine the rate of payment to a health care provider for
2621 the provision of nonemergency health care services to an insured when the health care provider
2622 is not in the carrier’s network.

2623 “Nonemergency services”, health care services rendered to an insured experiencing a
2624 condition other than an emergency medical condition.

2625 SECTION 134. Clause (a) of section 7 of said chapter 176O, as so appearing, is hereby
2626 amended by striking out clause (1) and inserting in place thereof the following clause:-

2627 (1) a list of health care providers in the carrier's network, organized by specialty and by
2628 location, along with a summary on its internet website for each provider that shall include: (i) the
2629 method used to compensate or reimburse the provider, including details of measures and
2630 compensation percentages tied to any incentive plan or pay for performance provision; (ii) the
2631 provider price relativity, as reported under section 10 of chapter 12C ; (iii) the provider's health
2632 status adjusted total medical expenses, as defined in and reported under said section 10 of said
2633 chapter 12C; and (iv) current measures of the provider's quality using the measures established
2634 by the secretary of health and human services pursuant to section 16AA of chapter 6A; provided,
2635 however, that if any specific provider or type of provider requested by an insured is not available
2636 in the network or is not a covered benefit, the information shall be provided in an easily
2637 obtainable manner; provided further, that the carrier shall prominently promote providers based

2638 on quality performance as measured by the measures established by the secretary of health and
2639 human services pursuant to said section 16AA of said chapter 6A and cost performance as
2640 measured by health status adjusted total medical expenses and relative prices.

2641 SECTION 135. Section 9A of said chapter 176O, as so appearing, is hereby amended by
2642 inserting after the word “approval”, in line 15, the following words:- unless the provider is
2643 included in a tier for a set of shoppable health care services pursuant to clause (iv) of subsection
2644 (b) of section 11 of chapter 176J.

2645 SECTION 136. Section 23 of said chapter 176O, as so appearing, is hereby amended by
2646 inserting after the word “time”, in line 3, the following words:- , the network status of an
2647 identified health care provider.

2648 SECTION 137. Said section 23 of said chapter 176O, as so appearing, is hereby further
2649 amended by adding the following sentence:- The information provided on the website shall
2650 conform to the uniform methodology for a provider’s tier designation developed pursuant to
2651 section 20A of chapter 12C.

2652 SECTION 138. Said chapter 176O is hereby further amended by adding the following 3
2653 sections:-

2654 Section 28. (a) As used in this section, the following words shall have the following
2655 meanings unless the context clearly requires otherwise:

2656 “Facility fee”, a fee charged or billed by a hospital or health system for outpatient
2657 hospital services provided in a hospital-based facility that is intended to compensate the hospital
2658 or health system for the operational expenses of the hospital or health system and is separate and
2659 distinct from a professional fee.

2660 “Health system”, shall have the same meaning as “Provider Organization or Health
2661 System or System”, as provided by the health policy commission.

2662 “Hospital”, a hospital licensed pursuant to section 51 of chapter 111.

2663 “Hospital-based facility”, a facility that is owned or operated, in whole or in part, by a
2664 hospital or health system where hospital or professional medical services are provided.

2665 “Professional fee”, a fee charged or billed by a provider, hospital or health system for
2666 professional medical services provided in a hospital-based facility.

2667 (b) If a hospital or health system charges a facility fee for services that are not subject to
2668 the limitations of section 51L of chapter 111, the hospital or health system shall provide any
2669 patient receiving such a service with written notice of the fee. The notice shall include a
2670 statement that the patient may be billed separately for that facility fee and the expected amount
2671 of the facility fee.

2672 (c) If a hospital or health system is required to provide a patient with notice under
2673 subsection (b) and a patient's appointment is scheduled to occur not less than 10 days after the
2674 appointment is made, the hospital or health system shall provide written notice and explanation
2675 to the patient by first class mail, encrypted electronic means or a secure patient Internet portal
2676 not less than 3 days after the appointment is made. If an appointment is scheduled to occur less
2677 than 10 days after the appointment is made or if the patient arrives without an appointment, the
2678 notice shall be provided to the patient on the hospital-based facility’s premises.

2679 For emergency care, a hospital or health system shall provide written notice and
2680 explanation to the patient prior to the care if practicable, or if notice is not practicable, the
2681 hospital or health system shall provide an explanation of the fee to the patient within a
2682 reasonable period of time; provided, however, that the explanation of the fee shall be provided
2683 before the patient leaves the hospital-based facility. If the patient is incapacitated or otherwise
2684 unable to read, understand and act on the patient’s rights, the notice and explanation of the fee
2685 shall be provided to the patient's representative within a reasonable period of time.

2686 (d) A hospital-based facility shall clearly identify itself as being hospital-based, including
2687 by stating the name of the hospital or health system in its signage, marketing materials, Internet
2688 web sites and stationery.

2689 (e) If a hospital-based facility charges a facility fee, notice shall be posted informing
2690 patients that a patient may incur additional financial liability due to the hospital-based facility’s
2691 status. Notice shall be prominently displayed in locations accessible to and visible by patients,
2692 including in patient waiting areas.

2693 (f) (1) If a hospital or health system designates a location as a hospital-based facility,
2694 the hospital or health system shall provide written notice of the designation to all patients who
2695 received services at the now designated hospital-based facility during the previous calendar year.
2696 The written notice shall be provided not later than 30 days after the designation and shall state
2697 that: (i) the location is now considered to be a hospital-based facility; (ii) certain health care
2698 services delivered at the facility may result in separate bills for services from the hospital and the
2699 provider; and (iii) patients seeking care at the facility may incur additional financial liability at
2700 that location due its hospital-based facility status.

2701 (2) If a hospital or health system designates a location as a hospital-based facility,
2702 the hospital or health system shall not collect a facility fee for a service provided at the now
2703 designated hospital-based facility until not less than 30 days after the written notice required in
2704 paragraph (1) is mailed.

2705 (3) A notice required or provided under paragraph (1) or (2) shall be filed with the
2706 health policy commission established under section 2 of chapter 6D not later than 30 days after
2707 its issuance.

2708 (g) A violation of this section shall be an unfair trade practice under chapter 93A.

2709 (h) The commissioner may promulgate regulations that are necessary to implement this
2710 section subject to the limitations of section 16A of chapter 6D.

2711 Section 29. (a) As used in this section, “facility fee”, “health system”, “hospital” and
2712 “hospital-based facility” shall have the meanings as provided in section 28.

2713 (b) A carrier shall not impose a separate copayment on an insured or provide
2714 reimbursement to a hospital, health system or hospital-based facility for services provided at a
2715 hospital, health system or a hospital-based facility or for reimbursement to such a hospital, health
2716 system or hospital-based facility for a facility fee for services utilizing a current procedural
2717 terminology evaluation and management code or otherwise prohibited pursuant to section 51L of
2718 chapter 111.

2719 (c) Nothing in this section shall prohibit a carrier from restricting the reimbursement of
2720 facility fees beyond the limitations set forth in section 51K of chapter 111.

2721 Section 30. (a)(1) A carrier shall reimburse a health care provider as follows:

2722 (i) where the health care provider is a member of an insured's carrier's
2723 network but not a participating provider in the insured's health benefit plan and the health care
2724 provider has delivered health care services to the insured to treat an emergency medical
2725 condition, the carrier shall pay that provider the in-network contracted rate for each delivered
2726 service; provided, however, that such payment shall constitute payment in full to that health care
2727 provider and the provider shall not bill the insured except for any applicable copayment,
2728 coinsurance or deductible that would be owed if the insured received such service or services
2729 from a participating health care provider under the terms of the insured's health benefit plan;

2730 (ii) where the health care provider is not a member of an insured's
2731 carrier's network and the health care provider has delivered health care services to the insured to
2732 treat an emergency medical condition, the carrier shall pay that provider the noncontracted
2733 commercial rate for emergency services for each delivered service; provided, however, that such
2734 payment shall constitute payment in full to the health care provider and the provider shall not bill
2735 the insured except for any applicable copayment, coinsurance or deductible that would be owed
2736 if the insured received such service or services from a participating health care provider under
2737 the terms of the insured's health benefit plan;

2738 (iii) where the health care provider is a member of an insured's carrier's
2739 network but not a participating provider in the insured's health benefit plan and the health care
2740 provider has delivered nonemergency health care services to the insured and a participating
2741 provider in the insured's health benefit plan is unavailable or the health care provider renders
2742 those nonemergency health care services without the insured's knowledge, the carrier shall pay
2743 that provider the in-network contracted rate for each delivered service; provided, however, that
2744 such payment shall constitute payment in full to the health care provider and the provider shall
2745 not bill the insured except for any applicable copayment, coinsurance or deductible that would be
2746 owed if the insured received such service from a participating health care provider under the
2747 terms of the insured's health benefit plan; and

2748 (iv) where the health care provider is not a member of an insured's
2749 carrier's network and the health care provider has delivered nonemergency services to the

2750 insured and a participating provider in the insured's health benefit plan is unavailable or the
2751 health care provider renders those nonemergency health care services without the insured's
2752 knowledge, the carrier shall pay the provider the noncontracted commercial rate for
2753 nonemergency services for each delivered service; provided, however, that such payment shall
2754 constitute payment in full to the health care provider and the provider shall not bill the insured
2755 except for any applicable copayment, coinsurance or deductible that would be owed if the
2756 insured received such service or services from a participating health care provider under the
2757 terms of the insured's health benefit plan.

2758 (2) It shall be an unfair and deceptive act or practice, in violation of section 2 of
2759 chapter 93A, for any health care provider or carrier to request payment from an enrollee, other
2760 than the applicable coinsurance, copayment, deductible or other out-of-pocket expense, for the
2761 services described in paragraph (1).

2762 (b) Nothing in this section shall require a carrier to pay for health care services delivered
2763 to an insured that are not covered benefits under the terms of the insured's health benefit plan.

2764 (c) Nothing in this section shall require a carrier to pay for nonemergency health care
2765 services delivered to an insured if the insured had a reasonable opportunity to choose to have the
2766 service performed by a network provider participating in the insured's health benefit plan.
2767 Evidence that an insured had a reasonable opportunity to choose to have the service performed
2768 by a network provider may include, but not be limited to, a written acknowledgement submitted
2769 with any claim for reimbursement from the carrier that: (i) is signed by the insured; and (ii) was
2770 provided by the health care provider to the insured before the delivery of nonemergency health
2771 care services and provided the insured a reasonable amount of time to seek health care services
2772 from a participating provider in the insured's health benefit plan.

2773 (d) The commissioner shall promulgate regulations that are necessary to implement this
2774 section.

2775 SECTION 139. Chapter 176Q of the General Laws is hereby amended by striking out
2776 section 7A, as appearing in the 2016 Official Edition, and inserting in place thereof the following
2777 section:-

2778 Section 7A. (a) There shall be a small group incentive program to expand the prevalence
2779 of employee health plans offered by small businesses that shall be administered by the board, in
2780 consultation with the department of public health. The program shall provide subsidies and
2781 technical assistance for eligible small groups that offer health plans to employees. A small group
2782 shall be eligible to participate in the program if the small group purchases group coverage
2783 through the connector and meets certain criteria determined by the board. In determining such
2784 criteria, the board may consider, but not be limited to considering, the following factors: (i) the
2785 size of the employer group; (ii) the amount of an employer's subsidy for the cost of employee
2786 coverage; (iii) the average salary of employees in the group; (iv) enrollment in a high-value plan
2787 that promotes employee wellness; and (v) participation in a plan-administered or employer-
2788 administered wellness program.

2789 (b) The connector shall provide an annual subsidy of up to 50 per cent of eligible
2790 employer health care costs, calculated by the board, for eligible small groups participating in the
2791 program. The connector may seek a state innovation waiver under 42 U.S.C. 18052 to fund this
2792 program.

2793 (c) If the director determines that available funds are insufficient to meet the projected
2794 costs of enrolling new eligible employers, the director may impose a cap on enrollment in the
2795 program or on the subsidy amounts available to eligible small groups.

2796 (d) The connector shall provide a report on the enrollment in the small group incentive
2797 program and an evaluation of the impact of the program on expanding health plan participation
2798 for small groups annually, not later than March 1, to the clerks of the senate and house of
2799 representatives, the chairs of the joint committee on community development and small
2800 businesses, the chairs of the joint committee on health care financing and the chairs of the house
2801 and senate committees on ways and means.

2802 (e) The connector shall promulgate regulations necessary to implement this section.

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

CHAPTER 176W.

HOSPITAL ALIGNMENT AND REVIEW COUNCIL.

2803 Section 1. For the purposes of this chapter, the following words shall have the following
2804 meanings unless the context clearly requires otherwise:

2805 “Carrier”, an insurer licensed or otherwise authorized to transact accident or health
2806 insurance under chapter 175, a nonprofit hospital service corporation organized under chapter
2807 176A, a nonprofit medical service corporation organized under chapter 176B, a health
2808 maintenance organization organized under chapter 176G and an organization entering into a
2809 preferred provider arrangement under chapter 176I; provided, however, that “carrier” shall not
2810 include an employer purchasing coverage or acting on behalf of its employees or the employees
2811 of any subsidiary or affiliated corporation of the employer; provided further, that unless
2812 specifically stated otherwise, “carrier” shall not include an entity that offers a policy, certificate
2813 or contract that provides coverage solely for dental care services or vision care services.

2814 “Center”, the center for health information and analysis established in chapter 12C.

2815 “Commission”, the health policy commission established in chapter 6D.

2816 “Council”, the hospital alignment and review council established in section 2.

2817 “Division”, the division of insurance.

2818 “Growth in hospital spending”, the annual growth in total commercial hospital inpatient
2819 and outpatient spending as reported by the center.

2820 “Hospital”, the teaching hospital of the University of Massachusetts medical school and
2821 any hospital licensed under section 51 of chapter 111 that contains a majority of medical-
2822 surgical, pediatric, obstetric and maternity beds, as defined by the department of public health.

2823 “Hospital spending”, total commercial spending on hospital inpatient and outpatient
2824 services.

2825 “Relative price”, the contractually negotiated amounts paid to providers by each private
2826 and public carrier for health care services, including nonclaims-related payments, and expressed

2827 in the aggregate relative to the payer's networkwide average amount paid to providers, as
2828 determined pursuant to the methodology under section 52 of chapter 288 of the acts of 2010.

2829 “Target growth in hospital spending”, the percentage of growth in hospital spending
2830 determined by the council.

2831 “Target hospital rate distribution”, the minimum rate of a carrier’s reimbursement for
2832 services provided by a hospital as determined by the council.

2833 Section 2. (a) There shall be a hospital alignment and review council. The council shall
2834 consist of the following members or their designee: (i) the commissioner of insurance, who shall
2835 serve as chair; (ii) the executive director of the center for health information and analysis; and
2836 (iii) the executive director of the health policy commission.

2837 The council shall review growth in hospital spending and receive information from the
2838 center, commission and division for its overall consideration.

2839 (b) The council may: (i) make, amend and repeal rules and regulations for the
2840 management of its affairs; (ii) make contracts and execute all instruments necessary or
2841 convenient for the carrying on of its business; (iii) enter into agreements or transactions with any
2842 federal, state or municipal agency or other public institution or with any private individual,
2843 partnership, firm, corporation, association or other entity; and (iv) enter into interdepartmental
2844 agreements with any other state agencies the council considers necessary to implement this
2845 chapter.

2846 (c) Information received by the council from the center, commission and division shall be
2847 confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4
2848 or chapter 66 unless the information received by the council is otherwise made publicly
2849 available.

2850 (d) The council shall be subject to chapter 30A.

2851 The center, commission and division shall enter into a memorandum of understanding
2852 that outlines the information authorized to be shared between each agency for use pursuant to

2853 this chapter and ensures that any information received by an agency that it would not otherwise
2854 receive shall be used solely for the purposes of this chapter.

2855 Section 3. (a) The council shall review the progress of carriers and hospitals towards
2856 demonstrating: (i) the target hospital rate distribution; and (ii) growth in hospital spending that
2857 does not exceed target growth in hospital spending. When conducting its review, the council
2858 shall ensure that the target hospital rate distribution and growth in hospital spending support the
2859 goals of the cost growth benchmark established in section 9 of chapter 6D and do not directly
2860 contribute to increased consumer health care costs.

2861 (b) The council shall review the growth in hospital spending and the statewide
2862 commercial relative price distribution for the previous year to determine whether the carriers and
2863 hospitals have met the goals established under subsection (a).

2864 (c) Annually, the center, in consultation with the commission, shall submit a report to the
2865 council on the statewide commercial relative price distribution and growth in hospital spending
2866 not later than October 1. The council shall review the report and certify, not later than December
2867 1, whether the conditions established under subsection (a) were satisfied for the previous year.

2868 Section 4. (a) Carriers shall annually certify to the division that: (i) all rates filed align
2869 with the target hospital rate distribution; and (ii) if any hospital has received an increase in its
2870 rate of reimbursement, all hospitals contracting with the carrier have received an increase greater
2871 than 0 per cent.

2872 If the division determines that a carrier does not meet the certification requirements, the
2873 division shall notify the carrier and presumptively disapprove the rates filed by the carrier.

2874 (b) In any year that the council determines that either carriers have not demonstrated the
2875 target hospital rate distribution or the growth in hospital spending exceeded the target growth in
2876 hospital spending, the council shall:

2877 (i) assess a carrier referred to the council by the division that did not meet the
2878 certification requirements of subsection (a) in an amount equal to the product of: (i) the total
2879 change in rates for the fewest number of contracted hospitals necessary for the carrier to achieve
2880 alignment with the target hospital rate distribution; and (ii) the projected utilization of those same

2881 hospitals provided, however, that a carrier shall not be assessed unless the division certifies that
2882 the carrier was notified that the carrier's rates did not meet the certification requirements of said
2883 subsection (a) and did not refile compliant rates; or

2884 (ii) assess a penalty on not less than the top 3 hospitals that contributed to hospital
2885 spending that equals in its aggregate the difference between the growth in hospital spending and
2886 the target growth in hospital spending; provided, however, that each hospital shall be responsible
2887 for a proportionate share of the penalty commensurate to its share of commercial hospital
2888 spending; provided, however, that the council may reduce the overall amount to be assessed to
2889 the identified hospitals in the aggregate or on a specific hospital basis based on the degree to
2890 which actual hospital spending that exceeded target commercial growth is predominantly
2891 attributable to hospitals that have not been identified to be assessed.

2892 (c) In any year that the council determines that carriers and hospitals have not
2893 demonstrated the target hospital rate distribution or growth in hospital spending that does not
2894 exceed target growth in hospital spending, the council may define "target hospital rate
2895 distribution" and "target growth in hospital spending"; provided, however, that the council shall
2896 solicit input from the advisory committee, receive testimony and solicit public input and review
2897 the definition every 3 years. The council shall submit proposed definitions to the clerks of the
2898 senate and house of representatives, the joint committee on health care financing and the senate
2899 and house committees on ways and means not less than 4 months prior to their effective date. In
2900 making the definition determination, the council shall ensure that a proposed definition does not
2901 negatively impact the goals of the cost growth benchmark established in section 9 of chapter 6D
2902 and the cost of health insurance premiums.

2903 The joint committee on health care financing may, not later than 30 days after the
2904 submission of the proposed definitions with the clerks of the senate and house of representatives,
2905 the joint committee on health care financing and the senate and house committees on ways and
2906 means, hold a public hearing on the proposed definitions. The joint committee may report its
2907 findings to the general court, together with drafts of legislation necessary to implement those
2908 findings. In the report, the joint committee may include its recommendation on whether to affirm
2909 or modify the proposed definitions. The joint committee shall issue any findings not later than
2910 20 days after the public hearing and shall provide a copy of the findings and any proposed

2911 legislation to the board. If the general court does not enact legislation with respect to the
2912 recommendations within 65 days after the commission has submitted the recommendations to the
2913 joint committee, the proposed definitions shall be in effect until the definitions proposed take
2914 effect.

2915 (d) If the council amends the definition of “target hospital rate distribution” or “target
2916 growth in hospital spending”, the council shall consider: (i) factors resulting in a hospital’s
2917 relative price and any weighting assigned by the council to those factors; (ii) alternative payment
2918 methodologies in place between a hospital and carrier; (iii) the volume and mix of services
2919 provided; (iv) a hospital’s patient population and payer mix; (v) hospital inpatient and outpatient
2920 rates as compared to the commercial relative price levels; and (vi) any other information deemed
2921 necessary by the council.

2922 (e) Amounts assessed by the council under this section shall be deposited into the
2923 Hospital Alignment and Review Trust Fund established in section 2ZZZZ of chapter 29.

2924 (f) Any amounts assessed by the council and then distributed through the Hospital
2925 Alignment and Review Trust Fund shall be excluded from the calculation of growth in hospital
2926 spending for a year in which the funds are distributed.

2927 Section 5. There shall be an advisory committee to the council. The committee shall
2928 support its responsibilities under this section. The committee shall be chosen by the council and
2929 shall ensure broad representation of carriers and hospitals across regions, of different sizes and, if
2930 a hospital, payer mix and other stakeholders.

2931 Section 6. The council may establish regulations or guidance to implement this chapter.

2932 SECTION 141. Section 79L of chapter 233 of the General Laws, as appearing in the
2933 2016 Official Edition, is hereby amended by inserting after the word “dentist”, in line 12, the
2934 following words:- , dental therapist.

2935 SECTION 142. Section 429 of chapter 159 of the acts of 2000 is hereby repealed.

2936 SECTION 143. Chapter 224 of the acts of 2012 is hereby amended by inserting after
2937 section 254 the following section:-

2938 Section 254A. (a) For the purposes of this section, the following words shall have the
2939 following meanings unless the context clearly requires otherwise:

2940 “Behavior management monitoring”, monitoring that shall include the monitoring of a
2941 child’s behavior, the implementation a behavior plan and reinforcing implementation of the plan
2942 by the child’s parent or other caregiver.

2943 “Behavior management therapy”, therapy that addresses challenging behaviors that
2944 interfere with a child’s successful functioning; provided, however, that “behavior management
2945 therapy” may include short-term counseling and assistance; provided further, that “behavior
2946 management therapy” shall include assessment, development of a behavior plan and supervision
2947 and coordination of interventions to address specific behavioral objectives or performance,
2948 including the development of a crisis-response strategy.

2949 “Child” a person under the age of 26.

2950 “Family support and training”, a service provided to a parent or caretaker of a child to
2951 improve the capacity of the parent or caretaker to ameliorate or resolve the child’s emotional or
2952 behavioral needs and to parent; provided, however, that such a service shall be provided where
2953 the child resides, including the child’s home, including a foster home and therapeutic foster
2954 home, or another community setting.

2955 “In-home behavioral services”, a combination of behavior management therapy and
2956 behavior management monitoring; provided, however, that such a service shall be provided
2957 where the child resides, including the child’s home, including a foster home and therapeutic
2958 foster home or another community setting.

2959 “In-home therapy”, therapeutic clinical intervention or ongoing training and therapeutic
2960 support; provided however, that the intervention or support shall be provided where the child
2961 resides, including the child’s home, including a foster home and therapeutic foster home, or
2962 another community setting.

2963 “Mobile crisis intervention”, a short-term, mobile, on-site, face-to-face therapeutic
2964 response service that is available 24 hours a day, 7 days a week to a child experiencing a
2965 behavioral health crisis to identify, assess, treat and stabilize a situation and reduce the

2966 immediate risk of danger to the child or others; provided, however, that the intervention shall be
2967 consistent with the child’s risk management or safety plan, if any.

2968 “Ongoing therapeutic training and support”, services that support implementation of a
2969 treatment plan pursuant to therapeutic clinical intervention that shall include, but shall not
2970 limited to, teaching the child to understand, direct, interpret, manage and control feelings and
2971 emotional responses to situations and assistance to the family in supporting the child and
2972 addressing the child’s emotional and mental health needs.

2973 “Therapeutic clinical intervention”, intervention that shall include: (i) a structured and
2974 consistent therapeutic relationship between a licensed clinician and a child and the child’s family
2975 to treat the child’s mental health needs, including improvement of the family’s ability to provide
2976 effective support for the child and promotion of healthy functioning of the child within the
2977 family; (ii) the development of a treatment plan; and (iii) using established psychotherapeutic
2978 techniques, working with the family or a subset of the family to enhance problem-solving, limit-
2979 setting, communication, emotional support or other family or individual functions.

2980 “Therapeutic mentoring services”, services provided to a child designed to support age-
2981 appropriate social functioning or ameliorate deficits in the child’s age-appropriate social
2982 functioning; provided, however, that such a service may include supporting, coaching and
2983 training the child in age-appropriate behaviors, interpersonal communication, problem-solving,
2984 conflict resolution and relating appropriately to other children and adolescents and adults in
2985 recreational and social activities; provided further, that such a service shall be provided where
2986 the child resides including the child’s home, including a foster home and therapeutic foster
2987 home, or another community setting.

2988 (b) The annual report submitted by carriers and contractor pursuant to section 254 shall
2989 include a certification whether their coverage includes the following mental health home-based
2990 and community-based services for a child: (i) intensive care coordination for child with serious
2991 emotional disturbance; (ii) mobile crisis intervention; (iii) family support and training; (iv) in-
2992 home therapy; (v) therapeutic mentoring services; and (vi) in-home behavioral services. The
2993 certification shall substantiate that networks for provided services, if offered, are active and
2994 adequate to ensure access.

2995 (c) The commissioner may promulgate regulations or guidelines to implement this
2996 section.

2997 SECTION 144. Notwithstanding any general or special law to the contrary, until
2998 hospitals have been designated pursuant to section 51M of chapter 111 of the General Laws, the
2999 department of public health shall designate primary stroke service hospitals as acute stroke ready
3000 hospitals capable of providing care previously designated in regulations as primary stroke service
3001 care.

3002 At the time that the department begins the designation of 3 tiers of stroke facilities
3003 pursuant to said section 51M of said chapter 111, hospitals may maintain primary stroke service
3004 designation utilizing the existing processes and criteria for a 6-month period. At the time that the
3005 department begins the designation process, primary stroke service hospitals shall be recognized
3006 as acute stroke ready hospitals. After the department has begun the designation process, all
3007 primary stroke service hospitals shall be considered acute stroke ready hospitals, regardless of
3008 additional capacity, until they receive a higher designation of primary stroke center or
3009 comprehensive stroke center.

3010 SECTION 145. Notwithstanding any general or special law to the contrary, the center for
3011 health information and analysis shall conduct a review of a mandated health benefit proposal to
3012 require coverage of acupuncture services rendered by licensed acupuncturists pursuant to
3013 sections 148 to 162, inclusive, of chapter 112 of the General Laws. The review shall be
3014 performed by the center consistent with section 38C of chapter 3 of the General Laws. The
3015 center shall evaluate the impact of such a mandate as a requirement for all of the health plans and
3016 policies under subsection (a) of said section 38C of said chapter 3. The center shall file its review
3017 with the clerks of the senate and house of representatives, the joint committee on health care
3018 financing, the joint committee on public health and the senate and house committees on ways
3019 and means.

3020 SECTION 146. Notwithstanding any general or special law to the contrary, the executive
3021 office of elder affairs shall develop a plan to transfer funds from item 9110-1455 to increase
3022 eligibility for the Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary

3023 and Qualified Individual programs described in 42 U.S.C. §1396(a)(10)(E) and administered
3024 through the executive office of health and human services.

3025 The executive office of health and human services shall develop a plan to raise or
3026 eliminate an asset test, raise the level of income eligibility or both to best expand access to the
3027 Medicare Savings Program for low-income elders if a transfer is implemented. The amount
3028 transferred from 9110-1455 shall not exceed the estimated annual cost of expanding coverage as
3029 established by the executive office of health and human services; provided, however, that no
3030 transfer shall result in reduced eligibility to the Prescription Advantage program established in
3031 the executive office of elder affairs.

3032 Not later than September 1, 2018, the executive office shall report on whether there is
3033 planned transfer and, if so, the amount of funds expected to be transferred, the expected
3034 increased capacity in eligibility for the Medicare Savings Program and whether additional
3035 transfers are anticipated and the executive office shall submit an additional report outlining the
3036 same criteria not less than 60 days before any subsequent transfers.

3037 SECTION 147. Notwithstanding any general or special law to the contrary, the hospital
3038 alignment and review council established under section 2 of chapter 176W of the General Laws
3039 shall define “target hospital growth rate” to have the same meaning as “market basket percentage
3040 increase” as defined under 42 U.S.C. section 1395ww and “target hospital rate distribution” as
3041 90 per cent of the statewide average commercial relative price in the previous calendar year
3042 unless otherwise amended under section 4 of said chapter 176W after January 1, 2022.

3043 SECTION 148. Notwithstanding any general or special law to the contrary, the executive
3044 office of health and human services, in collaboration with the executive office of elder affairs,
3045 the office of Medicaid and the department of public health, shall develop a post-acute care
3046 referral consultation program, subject to appropriation, of regional consultation teams to: (i)
3047 assist providers and consumers in determining appropriate post-acute care settings and
3048 coordinating patient care and (ii) share best practices among providers. The program shall also
3049 ensure education and outreach on provider pre-admission counseling required under section 9 of
3050 chapter 118E of the General Laws.

3051 A regional consultation team shall include regional representation from: (i) aging service
3052 access points; (ii) senior care organization members of the MassHealth Senior Care Options
3053 program; (iii) Program of All-inclusive Care for the Elderly plans; (iv) One Care plans; (v) the
3054 Massachusetts council on aging; (vi) the Massachusetts Healthy Aging Collaborative; (vii)
3055 skilled nursing facilities; (viii) and other entities or individuals deemed appropriate by the
3056 executive office of health and human services. A regional consultation team may be based within
3057 an aging service access point.

3058 The executive office of health and human services shall submit an initial report to the
3059 joint committee on health care financing, the joint committee on elder affairs and the senate and
3060 house committees on ways and means not later than March 15, 2018, that details: (i) the
3061 anticipated structure for the program; (ii) estimated cost estimates for the implementation and
3062 maintenance of the program; (iii) a breakdown of the state investment and anticipated alternate
3063 funding sources; and (iv) a timeline for program implementation.

3064 Beginning in 2019, the executive office of health and human services shall submit an
3065 annual report not later than March 15 to the joint committee on health care financing, the joint
3066 committee on elder affairs and the senate and house committees on ways and means that shall
3067 include, but not be limited to: (i) education and outreach efforts on preadmission counseling; (ii)
3068 the number of providers accessing the program; (iii) the estimated cost estimates for the
3069 implementation and maintenance of the program; and (iv) a breakdown of referrals based on the
3070 site of post-acute care.

3071 SECTION 149. Notwithstanding any general or special law to the contrary, the
3072 department of public health and the office of consumer affairs and business regulation shall
3073 allow licensees to obtain proxy credentialing and privileging for telemedicine services with other
3074 health care providers as defined in section 1 of chapter 111 of the General Laws or facilities that
3075 comply with the Centers for Medicare & Medicaid Services' conditions of participation for
3076 telemedicine services.

3077 For the purposes of this section, "telemedicine" shall mean the use of interactive audio,
3078 video or other electronic media for the purposes of a diagnosis, consultation or treatment of a

3079 patient's physical, oral or mental health; provided, however, that “telemedicine” shall not include
3080 an audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

3081 SECTION 150. Notwithstanding any general or special law to the contrary, all
3082 commercial insurers, hospital service corporations, medical service corporations and health
3083 maintenance organizations shall:

3084 (i) not later than July 1, 2019, reimburse for health care services with alternative payment
3085 methodologies for not less than 50 per cent of its enrollees; provided, however, that 25 per cent
3086 of its enrollees shall be under alternative payment methodologies that require providers to bear
3087 downside risk at a level not less than the amount required of a MassHealth accountable care
3088 organization;

3089 (ii) not later than July 1, 2022, reimburse for health care services with alternative
3090 payment methodologies for not less than 65 per cent of its enrollees; provided, however, that 45
3091 per cent of its enrollees shall be under alternative payment methodologies that require providers
3092 to bear downside risk at a level not less than the amount required of a MassHealth accountable
3093 care organization; and

3094 (iii) not later than July 1, 2025, reimburse for health care services with alternative
3095 payment methodologies for not less than 85 per cent of its enrollees; provided, however, that 65
3096 per cent of its enrollees shall be under alternative payment methodologies that require providers
3097 to bear downside risk at a level not less than the amount required of a MassHealth accountable
3098 care organization.

3099 All providers shall work with commercial insurers, hospital service corporations, medical
3100 service corporations and health maintenance organizations to meet the goals described in this
3101 section.

3102 SECTION 151. Notwithstanding any general or special law to the contrary, the
3103 noncontracted commercial rate for nonemergency services under chapter 176O of the General
3104 Laws shall be not more than the eightieth percentile of all allowed charges for a particular health
3105 care service performed by a health care provider in the same or similar specialty and provided in
3106 the same geographical area, as reported in a benchmarking database by a nonprofit organization

3107 specified by the division of insurance. Such an organization shall not be affiliated with a health
3108 carrier.

3109 SECTION 152. Notwithstanding any general or special law to the contrary, the
3110 noncontracted commercial rate for emergency services under chapter 176O of the General Laws
3111 shall be not more than the eightieth percentile of all allowed charges for a particular health care
3112 service performed by a health care provider in the same or similar specialty and provided in the
3113 same geographical area, as reported in a benchmarking database by a nonprofit organization
3114 specified by the division of insurance. Such an organization shall not be affiliated with any
3115 health carrier.

3116 SECTION 153. Sections 151 and 152 are hereby repealed.

3117 SECTION 154. Notwithstanding any general or special law to the contrary, the executive
3118 office of health and human services shall apply for a federal waiver of the requirements of
3119 section 1886(q) of the federal Social Security Act.

3120 SECTION 155. Notwithstanding any general or special law to the contrary, the
3121 readmission reduction benchmark under chapter 6D of the General Laws shall be a 20 per cent
3122 reduction of readmission rates, as measured by the health policy commission in consultation with
3123 the center for health information and analysis, between those rates observed in the year 2017 and
3124 those rates observed in the year 2020.

3125 SECTION 156. Notwithstanding any general or special law to the contrary, the health
3126 policy commission shall identify health care trailblazers under section 19 of chapter 6D of the
3127 General Laws that have: (i) demonstrated success in patient placement in the appropriate care
3128 setting through the development of care plans that include education on appropriate use of
3129 emergency services for patients who are deemed high utilizers of emergency departments; (ii)
3130 engaged in meaningful labor-management initiatives to improve or reduce health care costs; or
3131 (iii) established an employer-sponsored insurance plan in which an employer shares an increased
3132 percentage of an employee's premium or cost sharing for employees who receive a lower salary
3133 compared to other employees.

3134 SECTION 157. Notwithstanding any general or special law to the contrary, the office of
3135 Medicaid may establish and offer an optional expanded Medicaid plan for purchase by an
3136 individual or by an employer as an employer-sponsored insurance plan. The optional expanded
3137 plan may set alternate eligibility and cost-sharing standards beyond those established by section
3138 9A of chapter 118E of the General Laws and may condition participation in the program;
3139 provided, however, that any optional expanded plan offered to an employer shall require the
3140 employer to pay not less than 50 per cent of the projected cost of coverage for participating
3141 employees. The office may adjust benefits offered through an optional plan under this section;
3142 provided, however, that the office shall maintain the benefit and cost-sharing standards for those
3143 individuals and employees that meet the eligibility standards established by said section 9A of
3144 said chapter 118E.

3145 The office may establish premiums or cost-sharing requirements for an optional
3146 expanded plan that are equal to or exceed the costs of covering participating members based on
3147 the per-member-per-month expenditures or other measures. Additional revenue generated in
3148 excess of the cost to administer the expanded plan may be used to increase provider payment
3149 rates within the optional expanded plan and the MassHealth program under said section 9A of
3150 said chapter 118E or otherwise may be applied to the sustainability of the MassHealth program.

3151 An individual eligible for MassHealth under said section 9A of said chapter 118E shall
3152 receive commensurate cost sharing, coverage and benefits as they would receive under said
3153 section 9A of said chapter 118E, regardless of participation in the optional expanded plan
3154 through their employer. Nothing in this section shall preclude the office from requiring an
3155 employee to participate in the premium assistance program or a commensurate program.

3156 The office may, in addition to premiums or cost sharing required from employers for
3157 employees on the optional expanded plan, require contributions from an employer that
3158 participates in the optional expanded plan as employer-sponsored insurance, for an employee
3159 that meets the eligibility standards under said section 9A of said chapter 118E.

3160 The office may apply for federal authorization to permit the application of available
3161 subsidies for participation in the optional expanded plan including, but not limited to, advance

3162 premium tax credits, cost-sharing reductions or state wrap funds applicable to the purchase of
3163 MassHealth coverage through the commonwealth health insurance connector authority.

3164 Not later than October 1, 2018, the office shall file a plan outlining: (i) whether the office
3165 plans to implement an optional expanded plan; (ii) recommended statutory language, if any; (iii)
3166 expected benefits and cost sharing to be offered through the optional expanded plan; (iv)
3167 expected start-up costs to implement the optional expanded plan; (v) expected revenue from the
3168 optional expanded plan to support the full MassHealth program; and (vi) expected savings to the
3169 MassHealth program related to the implementation of an optional expanded plan.

3170 SECTION 158. Notwithstanding any general or special law to the contrary, the office of
3171 Medicaid shall seek federal approval to amend its state plan amendment and regulations to
3172 permit member access to urgent care facilities for emergency services without requiring a
3173 referral or prior authorization. The office shall provide a progress report to the joint committee
3174 on health care financing and the senate and house committees on ways and means not later than
3175 July 1, 2018 and shall issue updated regulations not later than January 1, 2019.

3176 SECTION 159. Notwithstanding any general or special law to the contrary, the secretary
3177 of health and human services may seek approval from Centers for Medicare & Medicaid
3178 Services to claim expenditures necessary to establish mobile integrated health care programs
3179 certified under chapter 111O of the General Laws as an allowable expenditure under the delivery
3180 system reform incentive program pursuant to requirement 57 of the Special Terms and
3181 Conditions for the MassHealth demonstration waiver under section 1115(a) of the Social
3182 Security Act.

3183 SECTION 160. Notwithstanding any general or special law to the contrary, the office of
3184 Medicaid shall establish a plan outlining the office's method for collecting, maintaining and
3185 sharing data with providers to ensure compliance with benchmarks associated with the
3186 MassHealth accountable care program, including ways to coordinate measures of social
3187 determinants of health that provide breakdowns by special populations within and across
3188 programs.

3189 The plan shall be filed with the clerks of the senate and house of representatives, the joint
3190 committee on health care financing and the senate and house committees on ways and means not
3191 later than August 1, 2018.

3192 SECTION 161. Notwithstanding any general or special law to the contrary, the executive
3193 office of health and human services, in consultation with the Massachusetts eHealth Institute,
3194 shall maximize information sharing, to the extent permissible under relevant privacy law,
3195 between the senior information management system operated by the executive office of elder
3196 affairs and electronic health records systems operated by health care providers.

3197 Not later than October 1, 2018, the executive office of health and human services shall
3198 provide a report on electronic information sharing efforts between the senior information
3199 management system and other electronic health records systems, any existing barriers to
3200 electronic information sharing and planned efforts to reduce such barriers to the clerks of the
3201 senate and house of representatives, the joint committee on elder affairs, the joint committee on
3202 health care financing and the senate and house committees on ways and means.

3203 SECTION 162. Notwithstanding any general or special law to the contrary, the executive
3204 office of health and human services shall apply for a federal waiver to permit passive enrollment
3205 of individuals eligible for Medicare into the MassHealth senior care options program. The office
3206 may apply for a federal waiver to receive Medicaid matching funds for a Medicare recipient or
3207 member of the executive office of elder affairs home care program who is not otherwise eligible
3208 for Medicaid and lacks income and assets to pay for 135 days of skilled nursing facility care. An
3209 individual passively enrolled in the MassHealth senior care options program shall be provided
3210 with notice and the ability to opt-out that is not less than that which is required under section
3211 164.

3212 The executive office of health and human services may engage the technical assistance
3213 and program design expertise of an external evaluator, if available, and share relevant data with
3214 the evaluator in order to implement this section in accordance with rigorous evaluation for
3215 program impact and cost-effectiveness. Any completed evaluation shall be filed with the clerks
3216 of the senate and house of representatives, the joint committee on health care financing and the
3217 senate and house committees on ways and means.

3218 At the end of each fiscal year, each SCO shall provide to MassHealth an audited
3219 statement of its medical loss ratio for the past year. If a SCO's audited medical loss ratio is below
3220 the minimum as determined by MassHealth, the SCO shall provide additional benefits or
3221 services to its enrollees in the following contract year in an amount that would raise its medical
3222 loss ratio to the minimum level as determined by MassHealth and shall submit a plan to
3223 MassHealth detailing how such benefits or services shall be provided to its plan enrollees. Not
3224 later than September 1, MassHealth shall provide a report to the senate and house committees on
3225 ways and means that provides an overview of the audited statements received and a description
3226 of: (i) any plans submitted by a SCO to reduce overhead; (ii) the percentage of each SCO's
3227 administrative overhead expended on social determinants of health and flexible services for SCO
3228 members within the past year; (iii) the number of each SCO's members voluntarily and
3229 involuntarily disenrolled with the level of acuity and reasons for such disenrollments; and (iv)
3230 the number of each SCO's members who experienced an increase or decrease in payment rate.

3231 SECTION 163. The office of Medicaid shall report on the role of long-term services and
3232 supports within MassHealth and MassHealth accountable care organizations in each year of the
3233 accountable care organization demonstration. The report shall include: (i) the baseline number of
3234 accountable care organization-attributed MassHealth members receiving long-term services and
3235 supports, disaggregated by age category, disability status, service type, and any other relevant
3236 categories; (ii) total MassHealth spending on long-term services and supports and number of
3237 members receiving long-term services and supports disaggregated by age category, disability
3238 status, service type, and any other relevant categories; (iii) MassHealth average per member, per
3239 month long-term services and supports costs by service type; (iv) any projected changes in
3240 utilization of long-term services and supports in the coming year and the rationale for such
3241 changes; (v) any estimated shift in spending between medical and long-term services and
3242 supports or social services spending within the accountable care organization program in the
3243 prior year of the demonstration; (vi) the process for determination of long-term services and
3244 supports needs for members attributed to the accountable care organization program,
3245 disaggregated by accountable care organization if processes differ; and (vii) the appeals process
3246 for accountable care organization members denied long-term services and supports. This report
3247 shall be filed with the clerks of the senate and house of representatives, the joint committee on
3248 health care financing and the senate and house committees on ways and means not later than

3249 April 1, 2018, and thereafter annually by April 1 for each year of the accountable care
3250 organization demonstration.

3251 SECTION 164. (a) The executive office of health and human services may establish
3252 senior care options as a default for MassHealth integrated medical and home care services and
3253 enroll MassHealth-eligible consumers enrolled in the executive office of elder affairs home care
3254 program into the MassHealth senior care options program under section 9D of chapter 118E of
3255 the General Laws.

3256 (b) A person shall not be enrolled into the SCO program under subsection (a) if the
3257 person is 85 years of age or older, if the person has high acuity and is on the Frail Elder Waiver
3258 or if the person is a recipient of a department of developmental services home and community-
3259 based services waiver.

3260 (c) A person shall not be enrolled into the SCO program under subsection (a) unless,
3261 prior to enrollment:

3262 (i) the person is provided written notification, which shall include language support and
3263 provide conspicuous notice of the ability to opt-out of enrollment by mail and by telephone or, if
3264 permissible under privacy law, electronic mail, not less than 3 times, 1 of which shall be not less
3265 than 60 days prior to enrollment and 1 of which shall be not less than 30 days prior to
3266 enrollment;

3267 (ii) the person is provided information by the senior care options provider about the
3268 details of the plan and its benefits which shall include language support, options to opt out of
3269 enrollment by mail or telephone and, if permissible under privacy law, electronic mail, and
3270 information on independent options counseling;

3271 (iii) MassHealth has provided the person with information about options for enrolling in
3272 voluntary programming including Program of All Inclusive Care for the Elderly or PACE plans,
3273 senior care option or SCO plans, home and community-based services waiver program for frail
3274 elders or any other voluntary, elective benefit to which they are entitled to supplement or replace
3275 their MassHealth benefits;

3276 (iv) MassHealth has provided the person with educational materials that shall include, but
3277 not be limited to: (1) a definition of a SCO and how it functions; (2) enrollment eligibility
3278 standards; (3) the location of SCOs; (4) a complete list of their participating providers; (5) the
3279 range of available services; (6) consumer rights under Medicare and Medicaid, as applicable; and
3280 (7) an assistance worksheet for determining health care options and quality of care
3281 measurements;

3282 (v) MassHealth and the SCO have conducted a matching process that considers the
3283 person's most important provider in medical or home care; and

3284 (vi) MassHealth has determined that a senior care option plan in the person's geographic
3285 area has an adequate network and the capacity to serve the person.

3286 (d) Within 30 days after being enrolled into a SCO from the executive office of elder
3287 affairs home care program, the SCO shall provide a member with a culturally-competent,
3288 comprehensive assessment which shall include an in-person opportunity to disenroll.

3289 (e) The SCO shall pay for continuity of care from all out-of-network providers in
3290 compliance with federal continuity of care requirements and shall implement an individual and
3291 integrated care plan for the member; provided however, that the individual care plan shall be
3292 approved by the member.

3293 (f) The SCO shall fund home care program services if the member so chooses in the care
3294 plan and shall contract with an ASAP unless otherwise prohibited by section 9D of chapter 118E.
3295 MassHealth may permit a risk-sharing relationship between the SCO and the ASAP in which the
3296 2 entities share the financial risk of providing coordinated services to enrollees under a system of
3297 capitated or subcapitated rate payments. Consistent with said section 9D of said chapter 118E,
3298 ASAPs under contract with SCOs shall employ geriatric support service coordinators, who shall
3299 be members of the primary care team.

3300 (g) (i) a SCO shall conform to the minimum medical loss ratio as established by the
3301 division of medical assistance for its category. At the end of each fiscal year, the SCO shall
3302 provide to the division an audited statement of its medical loss ratio for the past year. If an SCO's
3303 audited medical loss ratio is below the minimum as determined by the division for its category,

3304 the SCO shall provide additional benefits or services to its enrollees in the following contract
3305 year in an amount that would raise its medical loss ratio to the minimum level established by the
3306 division for its category and shall submit a plan to the division detailing how such benefits or
3307 services shall be provided to its plan enrollees.

3308 (ii) Not later than October 1, an SCO and an ASAP shall annually issue an information
3309 statement report. The report shall detail and document expenses on overhead or administration,
3310 including the percentage spent for each item and the percentage of overhead or administration
3311 spending that is directly provided to benefit consumers, the actual and percentage of money
3312 spend on social determinants of health, the assesses acuity level of its members as compared to
3313 the previous year and the number of members who have disenrolled, with a reason for
3314 disenrollment and the level of acuity of the person who disenrolls. The report shall be provided
3315 to the clerks of the house of representatives and the senate.

3316 (h) A member shall have the right to opt out of the SCO at any time before enrollment or
3317 the right to disenroll at any time after enrollment. Notice of disenrollment may be provided to
3318 the division of medical assistance or the SCO and disenrollment notices received by the division
3319 or the SCO by the twentieth day of the month shall be effective on the first day of the following
3320 month.

3321 SECTION 165. The executive office of health and human services may support the
3322 development of pilot programs of supportive housing and affordable housing providers, in
3323 coordination with health plans that service individuals eligible for Medicaid, Medicare or both
3324 including, but not limited to, the program for all-inclusive care for the elderly, senior care
3325 options and other managed care organizations and, in consultation with aging services access
3326 points, community partners and other stakeholders, to pilot any of the following: (i) establishing
3327 coordinated care protocols and staffing supports within housing sites that are funded with pooled
3328 resources to provide a critical mass of plan members necessary for care coordination and targeted
3329 investment within the housing site; (ii) creating financing models that include social impact
3330 bonds or other sources; and (iii) establishing care coordination between the housing providers
3331 and health plans.

3332 The executive office of health and human services may engage the technical assistance
3333 and program design expertise of an external evaluator, if available, and share relevant data with
3334 the evaluator to implement this section in accordance with a rigorous evaluation of program
3335 impact and cost-effectiveness. Any completed evaluation shall be filed with the clerks of the
3336 senate and house of representatives, the joint committee on health care financing and the senate
3337 and house committees on ways and means.

3338 SECTION 166. Notwithstanding any general or special law to the contrary, the secretary
3339 of health and human services shall develop a strategic plan outlining changes to provider funding
3340 sources, including those related to the adoption of new financing and delivery models of care as
3341 well as current supplemental payment streams to acute care hospitals. The strategic plan shall
3342 provide a breakdown of payment sources to providers, including payments authorized under the
3343 current MassHealth section 1115 demonstration waiver, by payment sources identified as: (i)
3344 time limited and as ongoing, along with expected benchmarks for providers to demonstrate
3345 sustainability due to the expiration of a time limited payment source; and (ii) included in an
3346 alternative payment model or a current supplemental payment.

3347 In developing the strategic plan, the secretary shall consult with a diverse set of providers
3348 that represent differing regional perspectives, patient volume and acuity and payment structures.

3349 The strategic plan shall identify: (i) regional disparities in funding; (ii) metrics for
3350 allocating funds that align with new health care financing and delivery models; (iii) opportunities
3351 to maximize federal financial participation; and (iv) any other factor pertinent to the evaluation
3352 of different approaches to the allocation of these funds.

3353 The secretary may identify an independent third-party to analyze and evaluate the
3354 allocation of the funds described in this section. The strategic plan and any underlying analysis
3355 by the independent third-party shall be filed with the senate and house committees on ways and
3356 means and the joint committee on health care financing not later than January 1, 2020.

3357 SECTION 167. Not later than July 1, 2018, the office of Medicaid shall provide a report
3358 on the proposed eligibility changes to the MassHealth program included in the Section 1115
3359 amendment request that was submitted on September 8, 2017, based on information received
3360 under section 79 of chapter 118E of the General Laws. The report shall include: (i) the number of

3361 members who received an offer of employer-sponsored health insurance; (ii) the number of
3362 members who received an offer of affordable employer-sponsored health insurance; (iii) details
3363 on the most frequently occurring cost-sharing arrangements for members offered affordable
3364 employer-sponsored health insurance; (iv) the number of members who would be transitioned
3365 from MassHealth to the ConnectorCare program; (v) the estimated cost savings attributed to the
3366 eligibility changes to the MassHealth program included in the amendment submitted on
3367 September 8, 2017; and (vi) the number of members who have been deemed eligible for
3368 premium assistance. The office shall submit its report to the clerks of the senate and house of
3369 representatives, the joint committee on health care financing and the senate and house
3370 committees on ways and means.

3371 SECTION 168. Notwithstanding any general or special law to the contrary, the center for
3372 health information and analysis shall conduct a review of a mandated health benefit proposal to
3373 require coverage of services rendered by a mobile integrated health care provider pursuant to
3374 chapter 111O of the General Laws. The review shall be performed by the center consistent with
3375 section 38C of chapter 3 of the General Laws. The center shall evaluate the impact of such a
3376 mandate as a requirement for all of the health plans and policies under subsection (a) of said
3377 section 38C of said chapter 3. The center shall file its review with the clerks of the senate and
3378 house of representatives, the joint committee on health care financing and the senate and house
3379 committees on ways and means not later July 1, 2020.

3380 SECTION 169. Notwithstanding any general or special law to the contrary, the health
3381 policy commission, in consultation with the center for health information and analysis and with
3382 the technical assistance of an external evaluator, if available, shall review the impact of this act
3383 on: (i) reduction in hospital readmissions; (ii) emergency department utilization; (iii) reduction in
3384 post-acute institutional care; (iv) prescription drug cost trends; (v) movement of patients toward
3385 high-value provider settings; and (vi) provider price variation.

3386 The commission's review shall be made in 2 parts and include, but not be limited to: (i)
3387 system wide aggregate savings; (ii) cost savings broken down by provider, payer, consumer and
3388 the commonwealth; and (iii) impact on consumer choice of providers that are lower-cost, high
3389 quality or both lower-cost and high quality.

3390 The commission shall issue its first report not later than July 1, 2025 and its final report
3391 not later than July 1, 2030 and file the report with the clerks of the senate and house of
3392 representatives, the joint committee on health care financing, the joint committee on public
3393 health and the senate and house committees on ways and means.

3394 SECTION 170. Notwithstanding any general or special law to the contrary, the board of
3395 registration in dentistry, in consultation with the executive office of health and human services,
3396 shall perform an evaluation of the impact of this act on dental therapists in terms of patient
3397 safety, cost-effectiveness and access to dental services over the first 5 years of the act's
3398 implementation. The board shall report on its findings and the report shall include: (i) the number
3399 of new patients served; (ii) the impact on waiting times for needed services; (iii) the impact on
3400 travel time for patients; (iv) the impact on emergency room usage for dental care; and (v) the
3401 impact on costs to the public health care system. The report shall be submitted not later than July
3402 1, 2023 to the joint committee on public health, the joint committee on health care financing and
3403 the senate and house committees on ways and means.

3404 SECTION 171. There shall be a task force to investigate the impact to state agencies of
3405 joining a non-Medicaid, multistate prescription drug bulk purchase consortium. The task force
3406 shall consider: (i) the estimated costs savings related to joining a non-Medicaid, multistate
3407 consortium; (ii) the opportunity for counties, municipalities and nonprofit organizations to
3408 participate in a non-Medicaid multistate consortium; (iii) the potential administrative savings and
3409 efficiencies for participants as a result of joining a non-Medicaid, multistate consortium; (iv)
3410 other bulk purchase discounts or rebates for prescription drugs, medical supplies or other medical
3411 goods purchased by state agencies, other governmental units and nonprofit organizations; and (v)
3412 means of receiving rebates or discounts for medical supplies or medications not included under
3413 the federal 340B Drug Pricing Program for eligible entities. The task force may consider non-
3414 Medicaid, multistate consortiums that are not available to the group insurance commission.

3415 The task force shall consist of: (i) the commissioner of public health or a designee, who
3416 shall serve as chair; (ii) the chief of pharmacy or a designee; (iii) the commissioner of mental
3417 health or a designee; (iv) the commissioner of developmental services or a designee; (v) the
3418 secretary of veterans' services or a designee; (vi) the commissioner of correction or a designee;
3419 (vii) the president of the Massachusetts Sheriffs Association or a designee; (viii) the president of

3420 the Massachusetts Biotechnology Council, Inc. or a designee; (ix) the chairperson of the
3421 Massachusetts Chamber of Commerce Inc. or a designee; (x) the executive director of the group
3422 insurance commission or a designee; and (xi) 5 persons to be appointed by the governor, 1 of
3423 whom shall be a health care economist, 1 of whom shall be a pharmacist registered by the board
3424 of registration in pharmacy, 1 of whom shall be a county or municipal representative, 1 of whom
3425 shall be a representative of a nonprofit community health center and 1 of whom shall have
3426 experience with multistate bulk purchasing consortiums for prescription drugs. The task force
3427 shall file its report, including drafts of any proposed legislation, with the clerks of the senate and
3428 the house of representatives, the joint committee on health care financing and the senate and
3429 house committees on ways and means not later than November 1, 2018.

3430 SECTION 172. The office of Medicaid shall report on potential cost savings for
3431 prescription medications by the office if it joined a multistate Medicaid bulk purchasing
3432 consortium. The report shall include: (i) an analysis of increased efficiency in the receipt of
3433 discounts through participation in a multistate Medicaid bulk purchasing consortium; (ii) the
3434 estimated cost savings related to joining a multistate Medicaid bulk purchasing consortium; (iii)
3435 the estimated administrative savings or other increased efficiencies related to joining a multistate
3436 Medicaid bulk purchasing consortium; (iv) opportunities for managed care organizations to
3437 receive rebates or discounts; and (v) a review of any identified alternative approaches to
3438 multistate Medicaid bulk purchasing consortiums that provide cost savings relative to
3439 prescription medications. The office shall file the report with the clerks of the senate and house
3440 of representatives, the joint committee on health care financing and the senate and house
3441 committees on ways and means not later than November 1, 2018.

3442 SECTION 173. Notwithstanding any general or special law to the contrary, the
3443 Massachusetts e-Health Institute shall report projects that leverage the commonwealth's
3444 investment in electronic health record deployment and the statewide health information exchange
3445 and that are likely to have a meaningful impact on cost or quality of care. The report shall
3446 identify and support such projects and include recommended funding amounts for the projects.
3447 The institute shall file the report with the clerks of the senate and house of representatives, the
3448 joint committee on health care financing and the senate and house committees on ways and
3449 means not later than January 1, 2019.

3450 SECTION 174. Notwithstanding any general law or special law to the contrary, the
3451 department of higher education, in conjunction with the department of public health, shall be
3452 granted the authority to establish a health corps pilot program which shall be implemented in
3453 each of the 6 executive office of health and human services geographic regions. The pilot
3454 program shall allow students of health-care related programs who have already attained a level of
3455 licensure and are currently working towards a higher level of licensure at a Massachusetts public
3456 institution of higher education or an accredited vocational institution to gain additional learning
3457 experience while providing patient care as a cost-mitigating measure. The departments shall
3458 establish guidelines which provide for creation of this pilot program, including, but not limited
3459 to, the following: (i) patient safety; (ii) the receipt of college or program credit to qualified
3460 student participants; (iii) the supervision of students over the course of their experiential
3461 learning; (iv) the forgiveness of qualified student loans; and (v) the metrics for measurements of
3462 program success and cost savings.

3463 SECTION 175. Notwithstanding any general or special law to the contrary, the health
3464 policy commission shall issue a report on expanding the scope of practice for athletic trainers.
3465 The report shall be based on available evidence and information and shall include any legislative
3466 and regulatory recommendations on: (i) the safety, efficacy, access and cost of health care
3467 services provided by athletic trainers in workplace care settings; and (ii) improving workforce
3468 health and reducing health care costs by increasing the employment of athletic trainers in
3469 workplace care settings. The commission shall file its report with the joint committee on health
3470 care financing and the senate and house committees on ways and means not later than June 1,
3471 2018.

3472 SECTION 176. (a) The department of public health, hereinafter referred to as the
3473 department, shall amend the regulations governing the application and licensing procedures and
3474 suitability requirements for long-term care facilities, as described in 105 CMR 153.00, to
3475 establish new requirements that would precede approval of any application for a new license, any
3476 notice of intent for transfer of ownership or any notice of intent to sell any for-profit or non-
3477 profit skilled nursing facility.

3478 (b) The department shall work in consultation with the executive office of elder affairs,
3479 the office of Medicaid, the office of the attorney general and all interested stakeholders to review

3480 and develop recommendations for the regulatory improvements outlined in subsection (a). Such
3481 recommendations shall include regulatory amendments that: (i) establish additional threshold
3482 requirements for applicants seeking to be deemed suitable by the department under 105 CMR
3483 153.006(D), provided, that the additional requirements shall include, but not be limited to,
3484 mandating submission of an initial prospective annual operating budget and of an attestation
3485 concerning any anticipated changes to the facility's workforce or working conditions; (ii)
3486 establish a provisional licensure procedure where original applicants not currently doing business
3487 in the commonwealth would be issued a provisional original license that would be subject to bi-
3488 annual review and revocation procedures within the first year of operation; and (iii) provide more
3489 transparent, timely, and complete public access to information concerning skilled nursing facility
3490 licensing and suitability determination standards.

3491 (c) Not later than 60 days after passage of this act, the department shall convene a
3492 meeting of interested stakeholders, review recommendations from those stakeholders and other
3493 state entities, and submit appropriate amendments to 105 CMR 153.00 for public review. The
3494 department shall issue the new recommendations not later than 180 days after passage of this act.

3495 SECTION 177. Notwithstanding any general or special law to the contrary, MassHealth
3496 shall recognize in the rates governing Medicaid nursing facility services the allowable costs of
3497 nurse practitioner services.

3498 SECTION 178. Notwithstanding any general or special law to the contrary, not later than
3499 June 30, 2018 the executive office of health and human services shall report to the house and
3500 senate committees on ways and means on the availability of a waiver and, if applicable, the
3501 estimated net state cost of a waiver that would allow individuals qualifying for Medicaid and at
3502 risk of entering a nursing home to reside in a certified assisted living residence. The executive
3503 office of health and human services may request a waiver from the federal Centers for Medicare
3504 and Medicaid Services to allow individuals qualifying for Medicaid and at risk of entering a
3505 nursing home to reside in a certified assisted living residence.

3506 SECTION 179. Notwithstanding any general or special law to the contrary, the group
3507 insurance commission shall conduct a review and submit a report on the use coverage of
3508 medically-necessary brand name prescription drugs. The report shall include, but not be limited

3509 to: (i) a description of the current group insurance policy on brand name and generic prescription
3510 drug coverage; (ii) definitions of terms that determine coverage decisions; and (iii) an outline of
3511 the appeal process when prescription drug benefits are reduced or denied, including the
3512 following information for the past 5 years, broken down by year: (1) the number of prescriptions
3513 for brand-name medications written due to a medical necessity, as stated by a practitioner, that
3514 were denied through coverage by the group insurance commission; (2) the number of people who
3515 have been denied coverage for brand name medications that have appealed or are appealing that
3516 denial; and (3) the number of appeals denied.

3517 The commission shall report its findings to the joint committee on healthcare financing,
3518 the joint committee on public service and the senate and house committees on ways and means
3519 not later than May 1, 2018.

3520 SECTION 180. Notwithstanding any general or special law to the contrary, the center for
3521 health information and analysis, in consultation with MassHealth, the executive office of elder
3522 affairs and the health policy commission, shall conduct an examination of cost trends and
3523 financial performance among skilled nursing facilities, as defined under 957 CMR 7.02. The
3524 information shall be analyzed on an institution-specific, provider organization and industry-wide
3525 basis and shall include, but not be limited to: (i) gross and net patient service revenues; (ii) other
3526 sources of operating and non-operating revenue; (iii) trends in relative price, payer mix, case
3527 mix, utilization and length of stay dating back to 2010; (iv) affiliations with other health care
3528 providers including, but not limited to, preferred clinical relationships and partnerships; (v)
3529 categories of costs including, but not limited to, general and administrative costs, nursing and
3530 other labor costs and salaries, building costs, capital costs and other operating costs; (vi) total
3531 spending on direct patient care as a percentage of total operating expenses; (vii) operating and
3532 total margin; (viii) occupancy rates; and (ix) other relevant measures of financial performance
3533 and service delivery. These measures shall distinguish long-term from short-stay residents, to the
3534 extent possible.

3535 Not later than December 31, 2018, the report and any recommendations shall be filed
3536 with the clerks of the senate and house of representatives, the chairs of the house and senate
3537 committees on ways and means and the chairs of the joint committee on elder affairs.

3538 SECTION 181. The center for health information and analysis shall report on the
3539 implementation of facility fee protections under section 28 of chapter 32A, section 51L of
3540 chapter 111 and sections 28 and 29 of chapter 176O of the General Laws. The report shall
3541 include: (i) facility fees charged or billed to provide a baseline report on facility fees that were
3542 charged or billed; and (ii) a 5-year status report.

3543 The reports shall include: (i) the number of hospital-based facilities owned or operated by
3544 a hospital or health system that provides services for which a facility fee was charged or billed,
3545 broken down by hospital or health system; (ii) the number of patient visits provided at each
3546 hospital based facility for which a facility fee was charged or billed; (iii) the number of claims,
3547 total amount and range of allowable facility fees paid at each facility by Medicare, Medicaid and
3548 private insurance policies, including any cost sharing, as applicable; (iv) the total amount of
3549 revenue from hospital-based facility fees received by a hospital or health system, categorized by
3550 whether a hospital-based facility is on a campus; (v) separately for on-campus and off-campus
3551 hospital-based facilities, a description of the 10 procedures or services that generated the greatest
3552 amount of facility fee revenue at hospital-based facilities and, for each such procedure or service,
3553 the total amount of revenue received by a hospital or health system from the facility fees for the
3554 services; and (vi) the top 10 procedures or services for which facility fees were charged based on
3555 volume of claims.

3556 The center for health information and analysis shall make the information publicly
3557 available on its website. The baseline report shall be made available on December 31, 2018 and
3558 the 5-year status report shall be made available on January 1, 2024.

3559 SECTION 182. There shall be a task force to investigate methods to increase efficiency
3560 in the health care system through regulatory simplification. The task force shall consist of: the
3561 secretary of health and human services or a designee, who shall serve as chair; the commissioner
3562 of public health or a designee; the assistant secretary of the office of Medicaid or a designee; the
3563 chair of the health policy commission or a designee; 1 member appointed by the senate
3564 president; 1 member appointed by the speaker of the house; and 8 members appointed by the
3565 governor, 1 of whom shall be a representative of the Massachusetts Health and Hospital
3566 Association, Inc., 1 of whom shall be a representative of the Massachusetts League of
3567 Community Health Centers, 1 of whom shall be a representative of the Massachusetts Medical

3568 Society, 1 of whom shall be a representative of Association for Behavioral Healthcare, Inc., and
3569 one of whom shall be a representative of the American Physical Therapy Association of
3570 Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Association of
3571 Behavioral Health Systems, Inc., 1 of whom shall be a representative of the Massachusetts
3572 Nurses Association and 1 of whom shall be a representative of the Home Care Alliance of
3573 Massachusetts, Inc.

3574 The task force shall consider: (i) the cost and benefit of establishing an office of care
3575 coordination to provide cross-agency coordination for providers to improve patient access to
3576 needed services; (ii) the feasibility of a regulatory waiver process within the office of Medicaid
3577 for payers and providers seeking flexibility to implement innovative initiatives resulting in
3578 increased access to care and cost savings; (iii) the feasibility of a regulatory waiver process
3579 within the department of public health for providers seeking flexibility to implement innovative
3580 initiatives resulting in increased access to care and cost savings; and (iv) recommendations for
3581 regulatory changes needed to support the development of global payments.

3582 The task force shall file its report not later than October 1, 2019 with the clerks of the
3583 senate and house of representatives, the joint committee on health care financing, the joint
3584 committee on public health and the senate and house committee on ways and means.

3585 SECTION 183. The executive office of health and human services and the secretary of
3586 elder affairs may transfer funds between item 9110-1630 of section 2 of chapter 47 of the acts of
3587 2017 and item 4000-0601 of said section 2 of said chapter 47 for the costs of consumers enrolled
3588 in the home care program who enroll in the MassHealth senior care options program or for the
3589 costs of senior care options enrollees who opt out of senior care options and return to the home
3590 care program; provided, however, that transfers shall account for capitation payments. The
3591 amount transferred to said item 4000-0601 of said section 2 of said chapter 47 shall not exceed
3592 the estimated annual cost of care in the home care program for participating senior care options
3593 enrollees and funds shall not be transferred in any fiscal year if the transfer results in a waiting
3594 list for services provided by said item 9110-1630 of said section 2 of said chapter 47.

3595 SECTION 184. Notwithstanding any general or special law to the contrary, the secretary
3596 of health and human services shall study the impact of implementing section 164 and section

3597 183. The report shall be conducted in consultation with an advisory group consisting of
3598 representatives from community advisory councils under section 9D of 118E of the General
3599 Laws, and the program of all-inclusive care for the elderly and home care providers and senior
3600 care option providers.

3601 The report shall report on the number of MassHealth-eligible home care consumers
3602 enrolled in the senior care options program, the number of consumers planned to be enrolled, the
3603 timeline for the enrollment and the expected capacity of SCOs to accept new enrollees. The
3604 study shall include a review of: (i) methods for expanding the enrollment in home and
3605 community-based long-term care support services, including the senior care options program, the
3606 program of all-inclusive care for the elderly and the home care program; (ii) methods to
3607 maximize the availability of federal financial participation; and (iii) methods to ensure consumer
3608 choice of services, enhance care outcomes and improve the quality of services and consumer
3609 satisfaction measures. The study shall further analyze the impact on ASAP and home care
3610 agencies if said sections 164 and 183 were implemented. The analyses shall include a study of
3611 projected finances, caseload and capacity of ASAPs and home care agencies.

3612 If the results of the study required in the previous paragraphs determine that
3613 implementation of said sections 164 and 183 are in the best interests of the commonwealth and
3614 consumers, the secretary shall submit an implementation plan to effectuate said sections 164 and
3615 183 to the clerks of the house of representatives and senate and the clerks shall refer the plan to
3616 an appropriate committee. The plan shall detail the results of the study and articulate the reasons
3617 why implementation is in the best interests of the commonwealth and consumers. The plan shall
3618 be designed to minimize disruption to home care agencies. The implementation plan shall
3619 ensure the robust implementation of the protections provided in said sections 164 and 183,
3620 including prior notice and clear ability to opt out and shall further detail the enrollment process,
3621 the timetable of implementation, the number of enrollees, the amount of funding associated with
3622 those enrollees, fiscal impacts to MassHealth and the executive office of elder affairs in spending
3623 and revenue, the best method to conduct a funding transfer and impacts on consumers.

3624 Sections 164 and 183 shall not take effect unless the implementation plan has been
3625 approved by the general court.

3626 SECTION 185. Upon the implementation of section 164 or 183, if they are so
3627 implemented, the secretary of health and human services shall report every 6 months on the
3628 impacts of senior care options as a default for MassHealth integrated medical and home care
3629 services. The report shall include the number and percentage of opt outs from enrollment, the
3630 percentage of enrollees assessed that continue to receive home care services, the amount of
3631 transferred funds associated with the enrollment and the amount of federal matching funds
3632 projected to accrue to the senior care options program.

3633 The report shall further detail the impacts on home care agencies and ASAPs. The report
3634 shall include a fiscal analysis of the home care agencies and ASAPs, including projected
3635 finances, caseload, and capacity of ASAPs and home care agencies.

3636 The report shall be filed with the clerks of the senate and the house of representatives and
3637 the senate and house committees on ways and means.

3638 SECTION 186. The executive office of health and human services shall file a report with
3639 the senate and house committees on ways and means not later than March 1, 2018 detailing the
3640 projected fiscal impact, number of enrollees and administrative capacity to implement a buy-in
3641 option for individuals that surpass the income eligibility level to participate in the program for
3642 all-inclusive care for the elderly, or PACE and the senior care options program.

3643 SECTION 187. The secretary of health and human services shall conduct a study on the
3644 advisability and feasibility of establishing a community choice counseling program that assists
3645 Medicaid-eligible individuals with home and community-based service options.

3646 The secretary shall also report on: (i) the applicability of modeling the community choice
3647 counseling program after the Community Choice Counseling program offered by the state of
3648 New Jersey; (ii) opportunities to apply for a federal waiver to maximize federal financial
3649 participation to employ care providers to conduct mandatory preadmissions counseling services
3650 within long-term care facilities; and (iii) a proposed preadmission counseling plan that best
3651 enforces preadmissions counseling required under section 9 of chapter 118E of the General Laws
3652 which may include a process under which MassHealth may withhold payments to long-term care
3653 facilities if preadmission counseling does not occur for any individual without first receiving

3654 written documentation that the individual has received preadmission counseling on home and
3655 community-based service options pursuant to this section or that the patient has waived their
3656 right to such counseling. The secretary shall file a report of the secretary's findings not later than
3657 January 1, 2019 to the joint committee on elder affairs, the joint committee on health care
3658 financing and the chairs of the house and senate committees on ways and means.

3659 SECTION 188. A person seeking admission to a long-term care facility paid for by
3660 MassHealth shall receive preadmission counseling for long-term care services which shall
3661 include an assessment of community-based service options. A person seeking care in a long-term
3662 care facility on a private-pay basis shall be offered preadmission counseling. The division shall
3663 report annually to the general court the number of individuals who received preadmission
3664 counseling under this section and the number of diversions to the community generated by the
3665 preadmission counseling program.

3666 SECTION 189. There shall be a special commission to study and make recommendations
3667 on how to license foreign-trained medical professionals and medical professionals trained or
3668 licensed in other jurisdictions to expand and improve access to medical services in rural and
3669 underserved areas.

3670 The commission shall consist of: (i) the secretary of health and human services or a
3671 designee, who shall serve as chair; (ii) the commissioner of public health or a designee; (iii) 1
3672 member appointed by the senate president; (iv) 1 member appointed by the speaker of the house;
3673 (v) 1 member appointed by the minority leader of the senate; (vi) 1 member appointed by the
3674 minority leader of the house; (vii) the house and senate chairs of the joint committee on public
3675 health; and (viii) 9 members appointed by the governor, 1 of whom shall be a member of the
3676 governor's advisory council for refugees and immigrants, 1 of whom shall be a representative of
3677 the Massachusetts Immigrant and Refugee Advocacy Coalition, Inc., 1 of whom shall be a
3678 representative of the division of health professional licensure, 1 whom shall be a member of the
3679 board of registration in medicine, 1 of whom shall be a member of the board of registration in
3680 dentistry, 1 member of the board of registration in pharmacy, 1 of whom shall be a member of
3681 the board of registration in nursing, 1 of whom shall be a member of the board of registration of
3682 psychologists and 1 of whom shall be a member of the board of allied health professionals

3683 The commission shall examine and make recommendations on topics including, but not
3684 limited to: (i) ways to implement strategies to integrate foreign-trained medical professionals and
3685 medical professionals trained or licensed in other jurisdictions into rural and underserved areas
3686 that are in need of access to medical services; (ii) ways to identify state and national licensing
3687 regulations that pose barriers to practice for foreign-trained medical professionals and medical
3688 professionals trained or licensed in other jurisdictions; (iii) state licensing requirements that pose
3689 barriers to practice for foreign-trained medical professionals and medical professionals trained or
3690 licensed in other jurisdictions; (iv) alternate approaches by other states to integrate foreign-
3691 trained medical professionals and medical professionals trained or licensed in other jurisdictions
3692 into rural and underserved areas; and (v) other matters pertaining to licensing foreign-trained
3693 medical professionals and medical professionals trained or licensed in other jurisdictions. The
3694 commission may hold hearings and invite testimony from experts and the public to gather
3695 information. The report may include recommended guidelines for full licensure and conditional
3696 licensing of foreign-trained medical professionals and medical professionals trained or licensed
3697 in other jurisdictions.

3698 Not later than March 1, 2019, the commission shall file its recommendations, including any
3699 drafts of legislation or regulations necessary to carry out its recommendations, with the clerks of
3700 the senate and house of representatives, the joint committee on public health and the joint
3701 committee on health care financing.

3702 SECTION 190. There shall be a housing security task force to investigate methods to
3703 encourage housing security as a social determinant of health. The task force shall consist of: the
3704 secretary of housing and economic development or a designee, who shall serve as co-chair; the
3705 secretary of health and human services or a designee, who shall serve as co-chair; the
3706 commissioner of public health or a designee; the executive director of the health policy
3707 commission or a designee; the undersecretary of housing and community development or a
3708 designee; the commissioner of mental health or a designee; the commissioner of developmental
3709 services or a designee; and 15 members appointed by the governor, 1 of whom shall be a
3710 representative of a public housing authority, 1 of whom shall be a provider of emergency shelter
3711 services to homeless individuals, 1 of whom shall be a representative of Massachusetts Senior
3712 Care Association, Inc., 1 of whom shall be an expert on affordable housing, 1 of whom shall be a

3713 representative of the Massachusetts Law Reform Institute, Inc., 1 of whom shall be a
3714 representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom shall be an
3715 expert in case management, 1 of whom shall be a representative of the Home Care Alliance of
3716 Massachusetts, Inc., 1 of whom shall be a representative of Arc Massachusetts, Inc., 1 of whom
3717 shall be a representative of the Massachusetts Coalition for the Homeless, Inc., 1 of whom shall
3718 be a representative of the Massachusetts Housing and Shelter Alliance, Inc., 1 of whom shall be
3719 a representative of the Association for Behavioral Healthcare, Inc., 1 of whom shall be a
3720 representative of Health Care for All, Inc., 1 of whom shall be a representative of the
3721 Massachusetts Association of Behavioral Health Systems, Inc. and 1 of whom shall be a
3722 representative of Citizens Housing And Planning Association, Inc. Members shall be selected to
3723 ensure broad geographic representation.

3724 The task force shall consider: (i) ways to develop priority designation for shelter beds for
3725 individuals eligible for discharge from an emergency department or inpatient setting; (ii) ways to
3726 locate affordable housing for individuals who are homeless or at risk of homelessness; (iii)
3727 recommended policies to increase the amount of affordable housing; (iv) gaps that exist in
3728 providing post-acute care to individuals residing in shelter beds; and (v) opportunities to
3729 integrate care coordination or other health services into housing authorities or other housing
3730 models.

3731 The task force shall hold its first meeting not later than April 1, 2018 and shall meet not
3732 less than 4 times. The task force may consult with the interagency council on housing and
3733 homelessness and solicit stakeholder feedback or public testimony. The task force shall file its
3734 report not later than November 1, 2018 with the clerks of the senate and house of representatives,
3735 the joint committee on housing, the joint committee on health care financing; the joint committee
3736 on public health and the senate and house committees on ways and means.

3737 SECTION 191. There shall be a special commission to investigate, study and evaluate the
3738 scope of mental health peer support programs in all regions of the commonwealth to determine
3739 the scope of peer programs, classification and types of peer specialists, and appropriate training
3740 and certification requirements for such programs. The commission shall consist of the following
3741 members: the co-chairs of the joint committee on mental health, substance use, and recovery,
3742 who shall serve as co-chairs of the commission; the secretary of health and human services or a

3743 designee who is a medical professional; the commissioner of mental health or a designee who is
3744 a medical professional; the commissioner of public health or a designee; the director of Medicaid
3745 or a designee; 1 representative appointed by the commissioner of the Massachusetts
3746 rehabilitation commission or a designee; 1 representative from The Transformation Center, Inc.,
3747 a statewide peer-job training organization; 1 representative from the Massachusetts Behavioral
3748 Health Partnership; 1 representative from the Association for Behavioral Healthcare, Inc.; 1
3749 representative from the National Alliance on Mental Illness of Massachusetts, Inc.; 1 individual
3750 with lived experience as a consumer of mental health services appointed by the co-chairs of the
3751 commission; and 1 family member of a mental health consumer appointed by the co-chairs of the
3752 commission.

3753 The commission study shall include, but not be limited to, an examination and
3754 identification of best practices related to training and credential requirements for peer specialist
3755 programs, including: (i) types and categories of services provided by peer programs, including
3756 support, rehabilitation and clinical programs; (ii) types and categories of services that require
3757 certification; (iii) supervision required for categories of services that require certification; (iv)
3758 hours of formal work or volunteer experience related to mental health and substance use
3759 disorders conducted through such programs; (v) types of peer-support specialist exams required
3760 for such programs; (vi) codes of ethics used by such programs; (vii) required or recommended
3761 skill sets for such programs; (viii) requirements for continuing education; (ix) any other criteria
3762 necessary to develop peer specialist certification requirements; and (x) best practices from other
3763 states.

3764 Not later than 1 year after the date of enactment of this act, the commission shall submit
3765 its findings and recommendations, together with drafts of legislation necessary to carry those
3766 recommendations into effect, by filing the same with the clerks of the senate and the house of
3767 representatives, the department of mental health and the joint committee on mental health,
3768 substance use and recovery.

3769 SECTION 192. There shall be a food allergy task force to investigate the rising
3770 prevalence of food allergies in adults and children. The task force shall consist of the secretary
3771 of health and human services or a designee, who shall serve as chair; the commissioner of public

3772 health or a designee; the commissioner of insurance or a designee; the executive director of the
3773 Massachusetts chapter of the American Academy of Pediatrics or a designee; the executive
3774 director of the Asthma & Allergy Foundation of America, New England Chapter or a designee; a
3775 representative from the Food Allergy Science Initiative at the Broad Institute; the president of the
3776 Massachusetts Association of Health Plans, Inc. or a designee; and 2 members appointed by the
3777 governor, 1 of whom shall be a physician with experience in food allergies and 1 of whom shall
3778 be a parent of a child with food allergies.

3779 The task force shall consider: (i) the rising prevalence of food allergies in adults and
3780 children and ways to eliminate or decrease food allergies; (ii) gaps that exist in insurance
3781 coverage for food allergy medication and services; and (iii) ways to improve insurance coverage
3782 of medically necessary food and formula.

3783 The task force shall file its recommendations, including any drafts of legislation or
3784 regulations necessary to carry out its recommendations, to the clerks of the senate and house of
3785 representatives, the joint committee on public health and the joint committee on health care
3786 financing not later than December 31, 2019.

3787 SECTION 193. The division of medical assistance shall develop an internal process for
3788 the reconciliation of claims due to retroactive eligibility changes or duplicate enrollments in
3789 cases that involve multiple payers for services provided to MassHealth enrollees. The process
3790 shall not require provider involvement. The division shall report to the senate and house
3791 committees on ways and means on the process not later than 5 months after the enactment of this
3792 act.

3793 SECTION 194. Notwithstanding any general or special law to the contrary, MassHealth,
3794 in consultation with the center for health information and analysis, shall report on the costs
3795 incurred by efficiently and economically operated outpatient and diversionary behavioral health
3796 providers in providing outpatient and diversionary behavioral health services. MassHealth may
3797 contract with an independent research entity with experience in determining the costs of
3798 providing outpatient and diversionary behavioral health services.

3799 The report shall analyze the cost of efficiently and economically operating outpatient and
3800 diversionary behavioral health providers by examining the 20 highest volume outpatient and
3801 diversionary billing codes utilized in providing services to MassHealth members, including
3802 services administered by MassHealth managed care organizations, accountable care
3803 organizations, managed behavioral health organizations with whom MassHealth may contract for
3804 management of behavioral health benefits, the managed behavioral health organization for the
3805 primary care clinician plan and MassHealth fee for service. The report’s analysis shall be based
3806 on data from not less than 15 outpatient and diversionary behavioral health providers
3807 representing the diversity of providers across the commonwealth with consideration given to, but
3808 not limited to: (i) geographic location; (ii) whether the provider serves adults and children; (iii)
3809 providers serving racial and ethnic minority groups, including those for whom English is not a
3810 primary language; and (iv) the overall size of the outpatient and diversionary behavioral health
3811 providers in terms of annual revenues.

3812 MassHealth, or, if contracted, the independent research entity, shall recommend an
3813 appropriate methodology for determining the true cost of providing the services identified as the
3814 20 highest volume outpatient and diversionary billing codes; provided, however, that the
3815 methodology may be developed through on-site interviews with organizations participating in
3816 the project.

3817 MassHealth shall submit its findings and recommendations, together with drafts of
3818 legislation necessary to carry those recommendations into effect, by filing the same with the
3819 clerks of the senate and house of representatives, the joint committee on mental health, substance
3820 use and recovery, the joint committee on health care financing and the joint committee on
3821 financial services not later than March 1, 2018.

3822 SECTION 195. There shall be a working group to make recommendations on the
3823 licensure of behavioral health urgent care facilities under section 19A of chapter 19 of the
3824 General Laws.

3825 The working group shall consist of: the commissioner of mental health or a designee,
3826 who shall serve as chair; a representative of the Association for Behavioral Healthcare, Inc.; a
3827 representative of the Massachusetts Psychiatric Society, Inc.; a representative of The

3828 Massachusetts Psychological Association, Inc.; a representative of the National Association of
3829 Social Workers, Inc.; a representative of the Massachusetts Health and Hospital Association,
3830 Inc.; a representative of the National Alliance on Mental Illness of Massachusetts, Inc.; a
3831 representative of M-POWER, Inc.; a representative of the Massachusetts Association of
3832 Behavioral Health Systems; and a representative of the Massachusetts Association for Mental
3833 Health, Inc.

3834 The working group shall examine and make recommendations on topics including, but
3835 not limited to: (i) current availability and location of urgent behavioral health care services; (ii)
3836 barriers to developing or providing urgent behavioral health care services, including rates of
3837 reimbursement for such services; (iii) adequacy of existing regulatory structure to facilitate the
3838 development and provision of urgent behavioral health care services; (iv) issues related to
3839 compliance with state and federal parity laws; and (v) criteria for licensure of behavioral health
3840 urgent care facilities, including criteria for licensure of behavioral health urgent care facilities.

3841 The working group may hold hearings and invite testimony from experts and the public
3842 to gather information. The working group shall file a report of its recommendations with the
3843 clerks of the senate and house of representatives, the joint committee on mental health, substance
3844 use and recovery, the joint committee on health care financing and the senate and house
3845 committees on ways and means not later than January 1, 2019.

3846 SECTION 196. (a) Notwithstanding any general or special law to the contrary, the
3847 following terms shall have the following meanings unless the context clearly requires otherwise:-

3848 “Single payer benchmark”, the estimated total costs of providing health care to all
3849 residents of the commonwealth under a single payer health care system in a given year.

3850 “Single payer health care”, a system that provides publicly financed, universal access to
3851 health care for the population through a unified public health care plan.

3852 (b) The center for health information and analysis shall recommend a methodology to
3853 develop a single payer benchmark. The single payer health care system considered under the
3854 single payer benchmark shall offer continuous, comprehensive and affordable coverage for all
3855 residents of the commonwealth regardless of income, assets, health status or availability of other

3856 health coverage. The benchmark may consider the costs of a single-payer health care system at
3857 different actuarial values, levels of cost-sharing and levels of provider reimbursement; provided,
3858 however, that the benchmark shall include all actuarial values, levels of cost-sharing and levels
3859 of provider reimbursement considered by the center. In developing the methodology, the center
3860 shall monitor, review and evaluate reports related to single payer health care and the
3861 performance of single payer health care systems in other states and countries.

3862 (c) The center for health information and analysis, in conjunction with the health policy
3863 commission and the division of insurance, shall provide an annual report detailing a comparison
3864 of the actual health care expenditures in the commonwealth for 2016, 2017 and 2018 with the
3865 single payer benchmark for 2016, 2017 and 2018, respectively, indicating whether the
3866 commonwealth would have saved money while expanding access to care under a single payer
3867 health care system. The first report shall be filed with the clerks of the senate and house of
3868 representatives, the joint committee on health care financing and the senate and house
3869 committees on ways and means not later than July 1, 2018.

3870 (d) If a report under subsection (c) determines that the single payer benchmark
3871 outperformed the actual total health care expenditures in the commonwealth in 2016, 2017 or
3872 2018, the health policy commission shall submit a proposed single payer health care
3873 implementation plan to the clerks of the senate and house of representatives, the joint committee
3874 on health care financing and the senate and house committees on ways and means within 1 year
3875 of the date on which the report is filed. The plan may include proposed legislation to implement
3876 a single payer health care system that offers continuous, comprehensive and affordable coverage
3877 for all residents regardless of income, assets, health status or availability of other health
3878 coverage. When developing the implementation plan, the commission shall hold not less than 3
3879 public hearings and seek stakeholder input from across the commonwealth.

3880 SECTION 197. There shall be a task force to investigate timely updating of provider
3881 directories by health insurance carriers and determine ways to ensure that the general public is
3882 able to view all of the current health care providers for a health insurance plan.

3883 The task force shall be consist of the commissioner of insurance or a designee, who shall
3884 serve as chair, and 8 members to be appointed by the commissioner, 1 of whom shall be a

3885 representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a
3886 representative of a commercial health insurer, 1 of whom shall be a representative of Blue Cross
3887 and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of Health Care for
3888 All, Inc., 1 of whom shall be a representative of consumer rights, 1 of whom shall be a
3889 representative of the Massachusetts Hospital Association, Inc., 1 of whom shall be a
3890 representative of the Massachusetts Council of Community Hospitals, Inc. and 1 of whom shall
3891 be a representative of the Massachusetts League of Community Health Centers, Inc.; provided,
3892 however, that the commissioner may appoint additional members to the task force. The
3893 commissioner shall file the task force's recommendations with the joint committee on health care
3894 financing not later than May 1, 2018.

3895 SECTION 198. (a) Within 45 days after the effective date of this act, the health policy
3896 commission shall conduct a public hearing on adherence to patient limits set forth in section 231
3897 of chapter 111 of the General Laws. The commission shall issue a report which shall include, but
3898 shall not be limited to: (i) recommendations to measure adherence to patient limits; (ii)
3899 recommendations for methods to report potential violations of patient limits; and (iii)
3900 recommendations for measures to ensure adherence to patient limits. The commission shall issue
3901 their report to the joint committee on health care financing, the clerks of the senate and house of
3902 representatives and the commissioner of public health.

3903 (b) The health policy commission, in consultation with the department of public health,
3904 shall adopt regulations to ensure adherence to patient limits set forth in section 231 of chapter
3905 111 of the General Laws. The regulations shall include, but shall not be limited to: (i) a reporting
3906 process for violations of said section 231 of said chapter 111; (ii) a process for investigating
3907 reported violations; and (iii) appropriate sanctions, which shall include fines of not more than
3908 \$25,000 for each separate and distinct violation of patient limits set forth in said section 231 of
3909 said chapter 111 not later than 90 days after the effective date of this act.

3910 SECTION 199. The department of public health shall promulgate rules or regulations
3911 necessary to implement sections 59 to 61, inclusive, 63 to 70, inclusive, 72, 75, 92 and 97 to 107,
3912 inclusive, not later than January 1, 2019.

3913 SECTION 200. The department shall designate hospitals pursuant to section 51M of
3914 chapter 111 of the General Laws not later than 180 days after the effective date of this act.

3915 SECTION 201. The department shall establish protocols pursuant to section 51N of
3916 chapter 111 of the General Laws not later than 90 days after the effective date of this act.

3917 SECTION 202. The department shall establish the data oversight process pursuant to
3918 section 51O of chapter 111 of the General Laws not later than 180 days after the effective date of
3919 this act.

3920 SECTION 203. Section 66C of chapter 112 of the General Laws shall apply to registered
3921 optometrists who are qualified by an examination for practice under section 68 of said chapter
3922 112 after January 1, 2013.

3923 SECTION 204. An applicant for examination to permit the use and prescription of
3924 therapeutic agents pursuant to section 68C of chapter 112 of the General Laws who presents
3925 satisfactory evidence of graduation from a school or college of optometry approved by the board
3926 after January 1, 2013 shall be deemed to have satisfied sections 68 to 68B, inclusive, of said
3927 chapter 112.

3928 SECTION 205. Subsection (d) of section 68C of chapter 112 of the General Laws shall
3929 apply to licensed optometrists who have completed a postgraduate residency program approved
3930 by the Accreditation Council on Optometric Education of the American Optometric Association
3931 after July 31, 1997.

3932 SECTION 206. The task force established pursuant to section 16AA of chapter 6A of the
3933 General Laws shall be first convened in 2019.

3934 SECTION 207. The regulations necessary to carry out section 238 of chapter 111 of the
3935 General Laws shall be adopted not later than 90 days after the effective date of this act.

3936 SECTION 208. Section 30 of chapter 32A of the General Laws, section 81 of chapter
3937 118E of the General Laws, section 108O of chapter 175 of the General Laws, section 40 of
3938 chapter 176A of the General Laws, section 27 of chapter 176B of the General Laws, section 35

3939 of chapter 176G of the General Laws and section 14 of chapter 176I of the General Laws shall
3940 apply to contracts entered or renewed on or after January 1, 2020.

3941 SECTION 209. Sections 26, 130 and 135 shall apply to plans submitted to the division of
3942 insurance on or after January 1, 2020.

3943 SECTION 210. Section 2ZZZZ of chapter 29 of the General Laws and sections 4 and 5
3944 of chapter 176W of the General Laws shall take effect on January 1, 2022.

3945 SECTION 211. Sections 3, 6, 7, 9, 15, 17, 19, 21, 30, 39, 43, 59 to 61, inclusive, 63 to
3946 70, inclusive, 72, 73, 75, 77, 78, 92, 97 to 107, inclusive, 116, 141 and 155, sections 29 and 30 of
3947 chapter 32A of the General Laws and section 29 of chapter 176O of the General Laws shall take
3948 effect on January 1, 2019.

3949 SECTION 212. Sections 10, 27 and 48 shall take effect on May 1, 2018.

3950 SECTION 213. Sections 20 and 154 shall take effect on January 1, 2021.

3951 SECTION 214. Sections 62, 71, 74, 91, 93 to 96, inclusive, 128, 149, 151 and 152,
3952 section 29 of chapter 32A of the General Laws, section 80 of chapter 118E of the General Laws,
3953 section 39 of chapter 176A of the General Laws, section 26 of chapter 176B of the General Laws
3954 and section 34 of 176G of the General Laws shall take effect on July 1, 2018.

3955 SECTION 215. Section 86 shall take effect 180 days after the effective date of this act.

3956 SECTION 216. Section 153 shall take effect on December 31, 2019.