Massachusetts Taxpayers Foundation

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Section by Section Summary of Senate HEALTH Act

Section 1: Allows the Health Planning Council (MGL 6A:16T) to create 5 regional health planning councils created to:

- ID innovations/best practices within the region
- ID interventions that improve population health
- ID shortages of HC resources in the region
- Facilitate implementation of best practices, etc.

The Health Planning Council is required to produce an annual summary of the reports put out by each regional council.

Section 2: Creates a 13 member task force to better align performance and quality measures across the health care system (i.e. for providers and carriers). The task force will produce an annual report. Task force recommendations shall focus on aligning quality measures (including core and non-core measures), assigning tiers to HC providers in the design of health plans, improving consumer transparency and monitoring system wide performance.

The EHS secretary is directed to establish an annual set of aligned measures to be used by the commonwealth and carriers in contracts with HC providers. The measures shall differentiate between core and non-core measures.

Sections 3 - 5: Adds the following definitions to MGL 6A:1.:

- Pharmaceutical manufacturing company
- Pharmacy benefit manager
- Pipeline drugs
- Quality measures
- Rate of readmissions
- Readmissions performance improvement plan
- Readmission reduction benchmark

Section 6: Adds newly created section of MGL 6D (related to hospital readmission) to the list of reporting requirements not subject to prohibitions on disclosing patient information (MGL 6D:2A)

Section 7. Allows HPC to assess pharmaceutical and biopharmaceutical companies for any costs associated with analyzing pharmaceutical cost trends. (MGL 6D:6)

Section 8: Adds "fostering innovations in reducing readmissions, including social determinants of health and improving behavioral health integration" to the mission of the HPC. (MGL 6D:7)

Section 9. Adds "health care trailblazers to the list of entities the HPC shall solicit innovative ideas from prior to releasing RFPs.

Section 10. Adds three pharma representatives and one pharmacy benefit manager to the list of those providing testimony at the annual HC cost benchmark trend.

Section 11: Adds an organization's rate of readmission to the list of things they need to provide information to the HPC on if called to testify on the state exceeding its HC cost benchmark. (MGL 6D:8)

Section 12. Adds pharmaceutical cost information to the list of topics covered in the HPC's annual cost trend report. (MGL 6D:8)

Section 13. Creates a new section (9A) within MGL 6D. The new section directs HPC to create an annual statewide readmission reduction benchmark. The benchmark shall consider available data and other relevant information. The commission must hold a public hearing prior to releasing the benchmark. (MGL 6D:9A)

Section 14. Increases the fine for an HC entity that failed to file or implement a Performance Improvement Plan for second and subsequent offenses to $750,000. Currently the fine is $500,000. All fines will be deposited into the Health Safety Net (MGL 6D:10)

Section 15. Creates a new section (10A) within MGL 6D. The new section directs HPC to ID providers that have rates of readmission that are excessive and threaten the readmission benchmark. Any provider identification shall consider elements specific to that provider and will rely on CHIA information and information submitted by the provider.

If warranted, HPC can require providers to file a PIP to reduce readmissions. The PIP needs to be filed within 45 days and approved by HPC. If a provider fails to file or implement a proper PIP it can be assessed up to $500,000. These funds will be go to the Distressed Hospital Trust Fund. (MGL 6D: 10A)

Section 16. Starting in 2021, HPC can fine a provider for an excess readmission rate irrespective of the PIP process. The funds will go to the Healthcare Payment Reform Fund. (MGL 6D:10A)

Section 17. Ensures that standards used by HPC to certify patient centered medical homes are consistent with the newly created aligned quality measures. (MGL 6D:14)

Section 18. Amends the goals that the HPC can use to create additional ACO standards by adding demonstrated commitment to reducing avoidable hospitalizations, adverse events, rates of institutional post-acute care and unnecessary ER visits and ED boarding. (MGL 6D:15)

Sections 19 & 20. Adds a new ACO goal of demonstrating evidence based care delivery programs to reduce 30 day readmission rates, avoidable ER use and unwarranted institutional post-acute care. Mobile integrated HC programs satisfy this goal. (MGL 6D:15)

Section 21. Adds two new sections (15A and 15B) to MGL 6D.

- Section 15A allows HPC create an academic detailing education program. The program is targeted to physicians who participate in MassHealth. The HPC is empowered to contract with private health care payers to participate in the program.
- Section 15B directs the HPC to conduct an annual study of pharma companies with pipeline, generic or biosimilar drugs that may have a significant impact on HC expenditures.
    - Pharma companies are directed to provide early notice to the HPC of pipeline, generic or biosimilar drugs within 60 days of receipt of an action date from the FDA. The HPC will provide this early notice to MassHealth.
    - HPC shall assess pharma companies for the implementation of this section. (MGL 6D 15A &B)

Section 22. Adds a new section (16A) to MGL 6D. The new section empowers HPC to recommend a non-contracted commercial rate for emergency and non-emergency services for the purpose of out of network billing. The rates shall be in effect for 5 years. The recommendations are to be approved by the HPC board and then submitted to DOI who will hold a public hearing. The HPC is also required to hold a public hearing prior to recommending rates. (MGL 6D:16A)

Section 23. Adds a new section (19) to MGL 6D. The new section directs HPC, in conjunction with other relevant state entities, to develop standards for creating a "health care trailblazer" certification to recognize innovative practices that can be translated across the HC system. (MGL6D:19)

Sections 24 & 25. Adds the following new definitions to MGL 12C (CHIA):

- Pharmaceutical manufacturing company
- Pharmacy benefit manager
- Quality measures
- Readmission reduction benchmark

(MGL 12C:1)

Sections 26 & 27. Adds pharma manufacturing companies and pharmacy benefit managers to the list of entities to be notified/consulted with prior to new CHIA regulations (MGL 12C:5).

Section 28. Empowers CHIA to assess pharma companies for costs related to analyzing pharma cost trends.

Section 29. Directs CHIA, with EOHHS, to develop a process for reporting provider health care price and related information for use by consumers. The info shall include a list of most common procedures (and behavioral health procedures). Public and private payers will be required to submit payment rates for procedures to determine the procedure rate for every provider.

Section 30. Adds a new section (10A) to MGL 12C. The new section directs CHIA to provide uniform analysis of pharmaceutical cost trends. Pharma companies are required to submit data on changes in wholesale acquisition costs, R&D and other relevant capital expenditures and a description of factors leading to changes in wholesale acquisition costs. (MGL 12C:10A)

Sections 31 & 32. Adds pharma information to CHIA sections defining information reporting and data storing requirements. (MGL 12C:11 & 12)

Section 33. Amends language governing what database functions CHIA can contract out for. (MGL 12C:12)

Section 34. Eliminates current language directing CHIA to develop HC quality measures and directs CHIA to create a system of uniform reporting based on the aligned measure set that is part of the legislation. (MGL 12C14)

Section 35. Adds pharma analysis to the scope of CHIA's annual report. (MGL 12C:35).

Section 36. Amends language governing the CHIA health consumer website so that it is aligned with the new aligned quality measure system. (MGL 12C: 20)

Section 37. Adds a new section (20A) to MGL 12C. The new section directs CHIA to (in collaboration with carriers) develop a process for communicating provider tier information to be used by patients. (MGL 12C:20A)

Section 38. Adds a new section (24) to MGL 12C. The new section directs CHIA to file an annual report identifying the 50 employers with the highest number of employees receiving publicly subsidized health insurance. (MGL12C:24).

Section 39. Adds a new section (19A) to MGL 19 (DMH). The new section allows DMH to license "behavioral health urgent care facilities." Qualifying facilities – either stand alone or wards of larger facilities – will offer behavioral health urgent care to the public. Licenses will be for 2 years. DMH can set fees for licensure.

Section 40. Allows innovative approaches ID'd by HC trailblazers to count toward an application for a grant from the Distressed Hospital Trust Fund. (MGL 29:2GGGG)

Section 41. Creates two new trust funds.

- The new Mobile Integrated Health Care Trust Fund is to be administered by DPH. The fund will receive revenue from MIH fees and fines. (MGL 29:2YYYY)
- The new Hospital Alignment and Review Trust Fund is to be administered by the (newly created) Hospital Alignment and Review Council and will receive fees/fines imposed by the council. The fund will be used to support quality hospitals that receive rates below the statewide commercial relative price. (GL 29:2ZZZZ)

Section 42. Requires the websites of GIC purchased plans to conform with the (newly created) uniform methodology for a provider's tier designation. (MGL 32A:4)

Section 43. Adds three new sections to MGL 32A:

- Section 28 prohibits GIC plans from imposing a separate copay or make a separate payment to a provider for a facility fee for services using current procedural terminology evaluation and management code or which is other limited under MGL 111:51L. No provider can charge an insured member a facility fee greater than the reimbursement rate agreed to with the carrier
- Section 29 Allows GIC coverage to include telemedicine services (including utilization review, preauthorization, etc.)
- Section 30 directs GIC to require its plans to use EHS designated core and non-core aligned measures and plans can only use aligned measures to organize providers into tiers

Section 44. Directs the e-Health Institute to partner with the HC and tech communities to accelerate the creation and adoption of digital health. (MGL 40J:6D))

Section 45. Adds to the e-Health institute's mission the goal of advancing the commonwealth's economic competitiveness by supporting the digital health industry. (MGL 40J:6D)

Section 46. Directs the e-Health institute to prioritize improving the state's economic competitiveness in the area of digital health once a "significant portion" of providers use digital records. (MGL 40J;6D)

Sections 47 – 64. Makes changes to MGL 94C (controlled substances) to reflect greater scope of practice/controlled substance distribution powers for optometrists, nurse practitioners, nurse anesthetists, dental therapists and psychiatric nurse mental health clinicians.

Section 65. Adds a new section (21C) to MGL 94C. The new section requires pharmacies to post a notice to consumers giving them the right to ask for the retail price of medications being purchased. Pharmacists are required to notify the consumer if the retail price is less than the relevant copay. The consumer can pay the less amount if they choose. (MGL 94C:21C)

Section 66. Requires DPH to make prescription monitoring info available to providers through a secure electronic medical record. (MGL 94C:24A).

Section 67. Strikes and replaces MGL 111:2G (Prevention and Wellness Trust Fund) and 111:2H (Prevention and Wellness Advisory Board).

Most notable changes to the Trust Fund are:

- Expansion of allowable revenue sources (to include an – as yet unspecified – dedicated revenue sources)
- Reducing the percentage of the fund available for administration from 15% to 10%
- Increasing the amount of the fund to be used for grants from 75% to 90%
- Eliminating 10% set aside to encourage workplace wellness goals

Changes to the Board:

- Increases membership from 21 to 23 (adds HPC Commissioner, person representing a statewide association of community based service providers, person with expertise in the design/implementation of public health interventions) removes representation of someone administering an employee assistance program
- Directs the Board to report on evaluation of the fund at least once every 5 years

Section 68. Adds a new section (51L) to MGL 111 which prohibits providers from charging a facility for "services utilizing a current procedural terminology code as determined by…"…DPH.

Section 69. Amends MGL 111:228 to require network providers to provide relevant procedure and cost information at the time of schedule a procedure (currently the patient has to ask). The provider must also inform the patient if the provider to whom the patient is referred is part of the same network. (MGL 111:228)

Sections 70-72. Amends the MIH chapter (111O) to:

- Define MIH provider
- Require DPH to issue guidance on best practices for structuring MIH programs to obtain reimbursement.
- Require DPH to report annually on program data including impact on things like readmission rate, incidence of ED presentment, etc.
- Require DPH to establish fees for MIH licensure
- Allow MIH and Community EMS programs to seek waivers from requirement to transport patient to closest appropriate health care facility. In order to receive a waiver, programs must demonstrate appropriate "point-of-entry" plans

(MGL 111O)

Section 73. Defines telemedicine for the purpose of medical licensure and allows physicians to obtain proxy credentials for providers participating in telemedicine programs. The board of professional licensure is directed to promulgate telemedicine regulations (MGL 112:2)

Sections 74 – 89. Makes a number of changes in MGL 112 associated with expanded scope of practice for optometrists, nurse practitioners, nurse anesthetists, dental therapists and psychiatric nurse mental health clinicians. (MGL 112)

Sections 90 – 91. Allows the HSN to receive certain PIP fines. (MGL 118E:66)

Section 92. Adds four new sections to MGL 118E (MassHealth). The first two sections (MGL 118E 78&79) create the HIRD form.

- MGL 118E:80 allows MassHealth and its plans to contract with telemedicine services and may undertake a utilization review to determine the appropriateness to telemedicine services
- MGL 118E:81 requires MassHealth and its plans to use the aligned quality measures now created annually.

Section 93. Eliminates MGL 175:47BB which deals with insurance coverage requirements related to children with cleft lip/palate.

Section 94. Creates a new section (47CC) in chapter 175 allowing commercial insurance plans to cover telemedicine. (MGL 175:47CC)

Section 95. Adds two new sections to chapter 175.

- Section 108N requires insurance carriers to disclose to providers (if requested) the methodology used to determine a provider's tier placement.
- Section 108O requires carriers to use aligned measures established by EHS for core and non-core measures. Only those measures can be used to assign providers to tiers.

Section 96. Adds three new sections to chapter 176A

- Section 38 requires nonprofit hospital service corporations to provide to providers (if requested) the methodology used to determine a provider's tier placement.
- Section 39. allows non-profit hospital service corporations to cover telemedicine.
- Section 40 requires non-profit hospital service corporations to use aligned measures established by EHS for core and non-core measures. Only those measures can be used to assign providers to tiers.

Section 97. Adds three new sections to chapter 176B

- Section 25 requires medical service corporations to provide to providers (if requested) the methodology used to determine a provider's tier placement.
- Section 26 allows medical service corporations to cover telemedicine.
- Section 27 requires medical service corporations to use aligned measures established by EHS for core and non-core measures. Only those measures can be used to assign providers to tiers.

Section 98. Makes changes to ambulance billing requirements (MGL 176D:3C)

Section 99. Adds three new sections to chapter 176G

- Section 33 requires HMOs to provide to providers (if requested) the methodology used to determine a provider's tier placement.
- Section 34 allows HMOs to cover telemedicine.
- Section 35 requires HMOs to use aligned measures established by EHS for core and non-core measures. Only those measures can be used to assign providers to tiers.

Section 100. Adds two new sections chapter 176I

- Section 13 allows PPOs to cover telemedicine
- Section 14 requires PPOs to use aligned measures established by EHS for core and non-core measures. Only those measures can be used to assign providers to tiers.

Section 101. Strikes and replaces MGL 176J:11 (reduced/selective/tiered plans for small group health insurance) making a number of changes, including:

- Adding definitions for:
  - "High value health care services" – services designed to manage chronic conditions or reduce occurrence of high cost episodes
  - "Shoppable health care services" – services that are substitutable and for which sufficient cost info exists to provide a choice as to where to purchase the service
- Requires closed network plans to be offered in at least 2 geographic regions (up from 1)
- Eliminates the "smart tiering" offering option
- Specifies that tiered plans have to include a premium discount of at least 19%
- Adds three new plan options:
  - Plans where enrollee premium varies based on PCP chosen at time of enrollment
  - Plans with separate cost sharing differentials for shoppable services
  - Plans with separate reduced or eliminated cost sharing differentials for high value services
- Amends reporting requirements to reflect amended plan options
- Applies many of the same controls that had previous applied to the "smart tiering" option to the plans with different cost sharing provisions for shoppable or high value services
- Requires the Commissioner of DOI to make publicly available a description of each plan offered under this section as well as supplemental information related to membership trends, impact on cost for both consumers and the state system at large

(MGL 176J:11)

Section 102. Adds a new section (18) to MGL 176J. The new section requires carriers to disclose tier placement methodology, if requested, to impacted providers.

Sections 103 and 104. Add the following new definitions to MGL 176O (Health Insurance Consumer Protections):

- In network contracted rate
- Non-contracted commercial rate for emergency services (consistent with earlier out of network billing sections)
- Non-contracted commercial rate for non-emergency services (also consistent)
- Non-emergency services

Section 105. Amends language governing information carriers must provide to consumers to ensure that quality measures provided are consistent with the aligned method set forth in the bill and requiring the carrier to prominently present aligned quality measure info on their website. (MGL 176O:7)

Section 106. Amends language prohibiting certain types of agreements between carriers and providers to ensure that the newly created shoppable plans are allowed. (MGL 176O:9A)

Section 107. Requires carriers to provide consumers, when requested, with the network status of a given provider. (MGL 176O:23)

Section 108. Ensures that information provided on a carrier's website conforms with the new uniform methodology for tier designation. (MGL 176O:23)

Section 109. Adds 4 sections to MGL 176O:

- Section 28 creates new notice and disclosure requirements for hospitals related to facility fee charges (patients to be provided with written notice of a facility fee to be charged). In addition, hospitals based facilities (defined in the section) are required to clearly identify themselves as such on websites/other materials as well as post notice that patients may be subject to facilities fees. If a location is to be designated a hospital based facility, the operating system must provide advance notice of the change and cannot charge facilities fees for 30 days following written notice.
- Section 29 (similar to earlier language) prohibits carriers from imposing separate copayments or providing reimbursements to hospitals for facilities fees "utilizing a current procedural terminology evaluation and management code or otherwise prohibited (under MGL 111:51K)
- Section 30 lays out the rules governing carrier payments to providers in the following situations:
    - Emergency services where provider is a member of the carrier's network, but not in a members plan
    - Emergency services where provider is not a member of the carrier's network
    - Non-emergency services where provider is a member of the carrier's network, but not in a members plan
    - Non-emergency services where provider is not a member of the carrier's network

- Section 31 creates a nine member "ambulance service advisory council" to advise EHS on the pricing schedule for out of network ambulance billing. In consultation with this council, the EHS secretary will establish a price schedule every 3 years. EHS will have a waiver process for municipal ambulance services.

Section 110. Eliminates the Small Group Wellness Incentive Program and replaces it with a "Small Group Incentive Program." Unlike the old pilot, which sought to expand employee wellness initiatives, this new pilot is designed to encourage small employers to offer small group plans available on the Connector. The pilot will provide technical assistance subsidies. The Connector is directed to provide an annual subsidy of up to 50% of eligible employer health care costs for participating employers. (MGL 176Q:7A)

Section 111. Creates MGL 176W – Hospital Alignment and Review Council. The chapter:

- Creates the three member council to consist of DOI (Chair), CHIA and HPC
- Empowers the council to review growth in hospital spending and to review progress of carriers and providers toward:
    - Demonstrating target hospital rate distribution (reducing price variation)
    - Meeting cost growth targets for the system
- Carriers must certify that all rates filed meet with the target rate distribution and that if any provider receives a rate increase all providers need to receive a rate increase (though not necessarily the same rate of increase)
    - If the carrier does not meet these standards, DOI shall presumptively disapprove the rates
- In any year that the council determines that the target hospital rate distribution or hospital spending has exceed the target, the Council shall:
    - Assess carriers that have not met the distribution. The assessment is equal to the percentage rates would have to be changed at the fewest number of providers to meet the target multiplied by expected utilization at those providers
- In any year that provider spending exceeds the cap, the council will assess the top three hospitals contributing to hospital spending for the difference between actual growth and the target
- The council is responsible for defining distribution and cost targets, but must solicit input on those definitions at least every three years
- Assessment amounts are to be deposited into the newly created Hospital Alignment and Review Trust Fund
    - Amounts distributed to hospitals from the fund are not to be counted toward hospital spending for that year

Section 112. Adds a new section (254A) to chapter 224 of the acts of 2012. The new section requires carriers to include as part of the certification already required by section 254 of chapter

224 certification that coverage includes a number of elements related to mental health home/community based supports for children

Section 113. Defines hospital rate distribution and system wide target growth rate through 2021:

- Target hospital rate distribution is a minimum of 90% of the statewide commercial relative price in the previous calendar year
- Target hospital growth rate is the "market basket percentage increase" as defined under 42 USC section 1395ww

Section 114. Directs EHS with ELD and DPH to develop a post-acute referral consultation program or regional consulting teams, subject to appropriation, to assist providers and consumers in determining appropriate care settings. EHS is directed to report on the possible structure and cost of this program by March of 2018.

Section 115. Directs DPH and OCABR to allow licensed entities to obtain proxy credentialing for telemedicine services.

Section 116. Requires all insurance plans to use alternative payment methods for not less than 50% of enrollees by the start of FY 2020, 65% for FY 2023 and 85% for FY 2026. The schedule also requires a growing percentage of enrollees to be covered by payment methods that require providers to take on at least the same level of downside risk as MassHealth ACOs

Sections 117 -119. Caps the non-contracted commercial rate for nonemergency and emergency services at the 80th percentile of all allowed changes for the same service provided in the same area. These specific caps are repealed on 12/31/2019

Section 120. Directs EHS to file for a waiver from the federal hospital readmission payment rule (section 1886(q)).

Section 121. Sets the states readmission benchmark at a 20% reduction between 2017 and 2020.

Section 122. Directs HPC to identify as healthcare trailblazers entities that have seen success in improving patient placement through education and access to appropriate use of emergency services.

Section 123. Allows EHS to establish and offer a Medicaid buy in program for individuals or employers. The plan will have its own eligibility and cost sharing standards. Employers must pay at least 50% of the cost of coverage. If revenues from the program exceed administration costs, the excess will go to higher MH provider rates.

Section 124. Directs EHS to seek a federal waiver to amend its state plan to allow members to access urgent or emergency care without requiring a referral or prior authorization.

Section 125. Allows EHS to seek a federal approval to claim MIH expenditures for FFP.

Section 126. Directs EHS to establish a plan for sharing MassHealth ACO benchmark data with providers.

Section 127. Directs EHS to work with the e-Health institute to maximize information sharing between ELD and medical providers.

Section 128. Directs EHS to apply for a federal waiver to allow for passive enrollment into the MassHealth SCO program. EHS may also include in the waiver the option of prospective SCO enrollment for those not yet income eligible, but likely to be so.

Section 129. Directs EHS to report on the role of long-term services and supports within MassHealth and MassHealth ACOs. The section requirements include information on per-member cost by service type, expected change in utilization over time and the process for determining the long-term service needs of members in the ACO program.

Section 130. Directs MassHealth to enroll MassHealth home care members into the SCO program. The section allows for an associated budget transfer and requires EHS to report on how many home care members moved to the SCO program.

Section 131. Allows EHS to create a pilot program to certify supportive affordable housing that services MassHealth/Medicare eligible clients and to provide coordinated care teams to support those hosing sites. If allowed authorized by the federal government, eligible residents could be passively enrolled into SCO or other appropriate globally budgeted plans.

Section 132. Directs EHS to develop a strategic plan for changing provider funding sources (i.e. new financing and delivery models). The report must breakdown current payment sources including those authorized by the state's waiver. The plan will define metrics for aligning financing and delivery models, ID regional disparities in funding, etc. The plan would be analyzed and evaluated by an independent third party.

Section 133. Directs EHS to report on the MassHealth eligible changes included in the state's waiver amendment request from September of 2017. The report shall detail the number of members who received offers of ESI due to the waiver, cost sharing arrangements, number of members expected to transition from MassHealth to the Connector, cost savings associated with the changes, etc.

Section 134. Directs CHIA to conduct a review of a mandated health benefit proposal to require coverage of MIH services.

Section 135. Directs HPC, along with CHIA, to review the impact of the legislation on:

- ED utilization
- Reduction in hospital readmission
- Reduction in post-acute institutional care
- Prescription drug cost trends

- Movement of patients towards high value provider settings
- Provider price variation

The report will provide system wide aggregate estimates as well as estimates broken down by provider, payer and consumer. The first report is due no later than 7/1/2025 and the final report no later than the start of 7/1/2030.

Section 136. Directs the Board of Registration in Dentistry to report on the impact of the dental therapist change on safety, cost and access. The report is due on 7/1/2023.

Section 137. Creates a 15 member task force to investigate the impact of state agencies joining a non-Medicaid, multistate prescription drug bulk purchasing consortium. The task force report is due 11/1/2018.

Section 138. Directs EHS to report on potential cost savings of joining a multistate Medicaid bulk purchasing consortium.

Section 139. Directs the e-Health institute to report on projects that leverage the state's investment in e-Health record deployment and HIX that are likely to have a meaningful impact on cost or quality of care.

Section 140. Directs CHIA to report on the implementation of the facility fee protections included in the legislation. The report, first version due 12/31/2018, will provide baseline and change information on the use of facility fees in the system.

Section 141. Creates a 13 member task force to investigate regulatory reform in health care. The report is due 10/1/2019.

Section 142. Creates a 16 member special commission to study and make recommendations on how to license foreign trained medical professionals. The report is due 3/1/2019.

Section 143. Creates a 19 member task force to investigate methods of improving housing security as a social determinant of health. The report is due 11/1/2018.

Sections 144-146. Requires DPH to promulgate scope of practice and facility fee regulations by 1/1/2019. Hospitals licensed as of 1/1/2019 will not be subject to the new facility fee regulations until their license is next renewed.

Section 147. Clarifies that existing insurance rate agreements are not impacted by the facility fee changes until those rates are next up for approval.

Sections 148 - 150. Clarifies what licensing/graduation standards optometrists must meet in order to expand their scope of practice.

Section 151. Requires the aligned quality metric task force to first meet in 2019.

Section 152. Requires aligned quality metrics to be used by contracts between insurers (etc.) and providers starting with contracts entered into or renewed at the start of 2020.

Section 153. Requires plans submitted to DOI to meet non-contracted rate and new low-cost plan offering requirements starting in 2020.

Section 154. Delays the creation of the Hospital Alignment and Review Fund, as well as the certification and assessment provisions until 2022.

Section 155. Delays the effective date on a number of provisions of the bill (44 or so out of 150 policy sections) until 1/1/2019.

Section 156. Delays implementation of health care trail blazer sections until 5/1/2018.

Section 157. Delays readmission penalties and the requirement to apply for a waiver from related federal rules until 1/1/2021.

Section 158. Delays implementation of dental therapist and telemedicine provisions until 7/1/2018.

Section 159. Repeals initial non-contracted rate cap for emergency and non-emergency services effective 12/31/2019.

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