

**HOUSE . . . . . No. 4605**

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**The Commonwealth of Massachusetts**

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**In the One Hundred and Ninetieth General Court  
(2017-2018)**  
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An Act establishing the Honorable Peter V. Kocot Act to enhance access to high quality, affordable and transparent healthcare in the Commonwealth.

*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 3 of the General Laws is hereby amended by inserting after section  
2 38C the following section:-

3           Section 38D. (a) For the purposes of this section, the term “scope of practice proposal”  
4 shall mean any general or special legislation that would change the authority of a health care  
5 provider to provide certain health services or otherwise alter the procedures, actions and  
6 processes that a healthcare practitioner is permitted to undertake in keeping with the terms of  
7 their professional license.

8           (b) Joint committees of the general court and the house and senate committees on ways  
9 and means, when reporting on a bill containing a scope of practice proposal referred to the  
10 committee, shall include a review and evaluation conducted by the center for health information  
11 and analysis and the recommendations of the health policy commission to the general court  
12 pursuant to this section.

13 (c) Upon the request of a joint standing committee of the general court having jurisdiction  
14 or the house or senate committees on ways and means, the center for health information and  
15 analysis shall conduct a review and evaluation of the scope of practice proposals in accordance  
16 with this section within 180 days of the request.

17 (d) The center for health information and analysis shall review and evaluate the scope of  
18 practice proposal. The center shall review and evaluate the scope of practice proposal and shall  
19 accept written testimony submitted by interested parties. The center may take into consideration  
20 any additional data and research it deems relevant when conducting the review and evaluation.  
21 Such review and evaluation shall include, but not be limited to: (i) an assessment of any public  
22 health and safety risks that may be associated with the request; (ii) whether the request may  
23 enhance equitable access to health care services; (iii) whether the request enhances access to  
24 affordable health care, including how the proposal will impact costs, prices and cost trends in  
25 public and private health care, with particular attention to factors that contribute to cost growth  
26 within the commonwealth's health care system; (iv) an assessment of relevant scope of practice  
27 standards and legal restrictions, both in the commonwealth and in other states, including whether  
28 the request appropriately enhances the ability of a profession to practice to the accepted level of  
29 the profession's education and training under current standards; and (v) an analysis on the  
30 potential change to the reimbursement rate due to an expanded scope of practice and certification  
31 of a medical professional. The center, when carrying out the duties prescribed in this section,  
32 shall seek input on the scope of practice proposal from the department of public health, the Betsy  
33 Lehman center for patient safety and medical error reduction and such other entities as the center  
34 determines necessary in order to provide its written findings as described in subsection (e) of this  
35 section.

36 (e) At the conclusion of its review and evaluation of the scope of practice proposal, the  
37 center for health information and analysis shall provide a written report of its findings to the  
38 health policy commission. The center for health information and analysis shall include with its  
39 written findings all materials that were presented to the committee for review and consideration  
40 during the review process.

41 (f) The health policy commission established in section 2 of chapter 6D shall review and  
42 evaluate the scope of practice information submitted by the center for health information and  
43 analysis. The health policy commission shall hold a public hearing in connection with its review  
44 and evaluation of the scope of practice proposal and shall accept written testimony submitted by  
45 interested parties. The health policy commission, when carrying out the duties prescribed in this  
46 section, shall review input on the scope of practice proposal from the department of public  
47 health, the Betsy Lehman center for patient safety and medical error reduction and such other  
48 entities as the health policy commission determines necessary in order to provide its written  
49 findings as described in subsection (g) of this section. The commission may take into  
50 consideration any additional data and research it deems relevant when conducting the review and  
51 evaluation.

52 (g) At the conclusion of its review and evaluation of the scope of practice proposal, the  
53 health policy commission shall provide a written report of its findings to the committee which  
54 initiated the request. The health policy commission shall include with its written findings all  
55 materials that were presented to the committee and center for review and consideration during  
56 the review process. The health policy commission shall make a recommendation that the scope  
57 of practice proposal is positive, negative or neutral.

58 SECTION 2. Section 16T of chapter 6A of the General Laws is hereby repealed.

59 SECTION 3. Section 1 of chapter 6D of the General Laws, as appearing in the 2016  
60 Official Edition, is hereby amended by inserting after the definition of “Health care provider” the  
61 following definition:-

62 “Health care resource”, a resource, whether personal or institutional and whether owned  
63 or operated by any person, the commonwealth or political subdivision thereof, the principal  
64 purpose of which is to provide, or facilitate the provision of, services for the prevention,  
65 detection, diagnosis or treatment of those physical and mental conditions experienced by humans  
66 which usually are the result of, or result in, disease, injury, deformity or pain; provided, that the  
67 term “treatment” shall include custodial and rehabilitative care incident to infirmity,  
68 developmental disability or old age.

69 SECTION 4. Said section 1 of said chapter 6D, as so appearing, is hereby further  
70 amended by inserting the following definitions:-

71 “Early notice”, advanced notification by a pharmaceutical manufacturing company of a  
72 new drug, device or other development coming to market.

73 “Pharmaceutical manufacturing company”, any entity engaged in the production,  
74 preparation, propagation, compounding, conversion or processing of prescription drugs, either  
75 directly or indirectly, by extraction from substances of natural origin, or independently by means  
76 of chemical synthesis or by a combination of extraction and chemical synthesis, or any entity  
77 engaged in the packaging, repackaging, labeling, relabeling or distribution of prescription drugs;  
78 provided however, that “pharmaceutical manufacturing company” shall not include a wholesale

79 drug distributor licensed pursuant to section 36A of chapter 112 or a retail pharmacist registered  
80 pursuant to section 38 of said chapter 112.

81 “Pharmacy benefit manager”, any person, business or entity, however organized, that  
82 administers, either directly or through its subsidiaries, pharmacy benefit services for prescription  
83 drugs and devices on behalf of health benefit plan sponsors, including, but not limited to, self-  
84 insured employers, insurance companies and labor unions.

85 “Pharmacy benefit services” shall include, but not be limited to: formulary  
86 administration; drug benefit design; pharmacy network contracting; pharmacy claims processing;  
87 mail and specialty drug pharmacy services; and cost containment, clinical, safety, adherence  
88 programs for pharmacy services.

89 For the purposes of the chapter, a health benefit plan that does not contract with a  
90 pharmacy benefit manager shall be a pharmacy benefit manager.

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

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

96 SECTION 6. Section 4 of said chapter 6D, as so appearing, is hereby amended by  
97 striking out, in line 7, the words “manufacturers” and inserting in place thereof the following  
98 words:- “manufacturing companies, pharmacy benefit managers.

99 SECTION 7. Section 5 of said chapter 6D, as so appearing, is hereby amended by  
100 striking out, in line 10, the words “and (vii)” and inserting in place thereof the following words:-  
101 “; (vii) monitor the location and distribution of health care services and health care resources;  
102 and (viii).

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

105 If the analysis of spending trends with respect to the pharmaceutical or biopharmaceutical  
106 products increases the expenses of the commission, the estimated increases in the commission’s  
107 expenses shall be assessed fully to pharmaceutical manufacturing companies and pharmacy  
108 benefit managers in the same manner as the assessment pursuant to section 68 of chapter 118E.  
109 A pharmacy benefit manager that is a surcharge payor subject to the preceding paragraph and  
110 administers its own prescription drug, prescription device or pharmacist services or prescription  
111 drug and device and pharmacist services portion shall not be subject to additional assessment  
112 under this paragraph.

113 SECTION 9. Section 7 of said chapter 6D, as so appearing, is hereby amended by  
114 striking out subsection (a) and inserting in place thereof the following subsection:-

115 (a) The commission, in consultation with the advisory council, shall administer the  
116 Healthcare Payment Reform Fund, established under section 100 of chapter 194 of the acts of  
117 2011. The fund shall be used for the following purposes: (1) to support the activities of the  
118 commission; (2) to foster innovation in health care payment and service delivery; and (3) to  
119 further the integration of physical, behavioral and oral health along the health care delivery  
120 continuum.

121 SECTION 10. Said section 7 of said chapter 6D, as so appearing, is hereby further  
122 amended by striking out subsection (d) and inserting in place thereof the following subsection:-

123 (d) The commission shall consider proposals that achieve 1 or more of the following  
124 goals: (i) to support safety-net provider, disproportionate share hospital and community health  
125 center participation in new payment and health care payment and service delivery models; (ii) to  
126 support the successful implementation of performance improvement plans by health care entities  
127 pursuant to subsection (c) of section 10; (iii) to support cooperative efforts between  
128 representatives of employees and management that are focused on controlling costs and  
129 improving the quality of care through workforce engagement; (iv) to support the evaluation of  
130 telemedicine, mobile integrated health, digital health and other connected health technologies to  
131 improve health outcomes among underserved patients with chronic diseases; (v) to develop the  
132 capacity to safely and effectively treat chronic, common and complex diseases in rural and  
133 underserved areas and to monitor outcomes of those treatments; (vi) to appropriately redirect  
134 inpatient and post-acute care to high value community settings; and (vii) any other goals as  
135 determined by the commission.

136 SECTION 11. Said chapter 6D is hereby further amended by inserting after section 7 the  
137 following 2 sections:-

138 Section 7A. (a) There shall be established and set upon the books of the commonwealth a  
139 separate fund to be known as the Prevention and Wellness Trust Fund to be expended, without  
140 further appropriation, by the commission. The commission, as trustee, shall administer the fund.  
141 The commission, in consultation with the Prevention and Wellness Advisory Board established  
142 pursuant to section 7B, shall make expenditures from the fund consistent with subsections (d)

143 and (e); provided, that not more than 10 per cent of the amounts held in the fund in any 1 year  
144 shall be used by the commission for the combined cost of program administration, technical  
145 assistance to grantees or program evaluation.

146 (b) The commission may incur expenses and the comptroller may certify payment of  
147 amounts in anticipation of expected receipts; provided, however, that no expenditure shall be  
148 made from the fund which shall cause the fund to be in deficit at the close of a fiscal year.  
149 Revenues deposited in the fund that are unexpended at the end of the fiscal year shall not revert  
150 to the General Fund and shall be available for expenditure in the following fiscal year.

151 (c) All expenditures from the Prevention and Wellness Trust Fund shall support 1 or  
152 more of the following purposes: (i) increasing access to community-based preventive services  
153 and interventions which complement and expand the ability of MassHealth to promote  
154 coordinated care, integrate community-based services with clinical care and develop innovative  
155 methods of addressing social determinants of health; (ii) reducing the impact of health conditions  
156 that are the largest drivers of poor health, health disparities, reduced quality of life and high  
157 health care costs through community-based interventions; or (iii) developing a stronger  
158 evidence-base of effective prevention programming.

159 (d)(1) The commission shall annually award not more than 70 per cent of the Prevention  
160 and Wellness Trust Fund through a statewide competitive grant process to municipalities,  
161 community-based organizations, health care providers, regional-planning agencies and health  
162 plans, all of whom apply for the implementation, evaluation and dissemination of evidence-based  
163 community preventive health activities. To be eligible to receive a grant pursuant to this  
164 subsection, a recipient shall consist of a partnership that includes at minimum: (i) a municipality



165 or a regional planning agency; (ii) a community-based health or social service provider; (iii) a  
166 public health or community action agency with expertise in implementing community-wide  
167 health interventions; (iv) a health care provider or a health plan; and (v) where feasible, a  
168 Medicaid-certified accountable care organization or a Medicaid certified community partner  
169 organization. Expenditures from the fund for such purposes shall supplement and not replace  
170 existing local, state, private or federal public health-related funding. An entity that is awarded  
171 funds through this program shall demonstrate the ability to: (i) utilize best practices in  
172 accounting; (ii) contract with a fiscal agent who will perform the accounting functions on its  
173 behalf; or (iii) be provided with technical assistance by the commission to ensure best practices  
174 are followed.

175 (2) The commission shall annually award not less than 20 per cent of the Prevention and  
176 Wellness Trust Fund through a special grant program and funding allocation to be distributed by  
177 a regionally-based competitive bid process. The special grant program shall be targeted to  
178 entities located in geographic regions of the state that: (i) demonstrate a higher than average  
179 prevalence of preventable health conditions and (ii) are underrepresented in the grant program  
180 established pursuant to paragraph (1). The commission, in consultation with the prevention and  
181 wellness advisory board, shall work directly with municipalities or community-based  
182 organizations in regions that meet the conditions in both clauses (i) and (ii) of the second  
183 sentence to develop grant proposals that meet the purposes listed in subsection (c).

184 (e)(1) A grant proposal submitted pursuant to subsection (d) shall include, but not be  
185 limited to: (i) a plan that defines specific goals for the reduction in preventable health conditions  
186 and health care costs over a multi-year period; (ii) the evidence-based or evidence-informed  
187 programs the applicant shall use to meet the goals; (iii) a budget necessary to implement the

188 plan, including a detailed description of the funding or in-kind contributions the applicant will be  
189 providing in support of the proposal; (iv) any other private funding or private sector participation  
190 the applicant anticipates in support of the proposal; (v) a commitment to include women, racial  
191 and ethnic minorities and low-income individuals; and (vi) the anticipated number of individuals  
192 that would be affected by implementation of the plan.

193 (2) The center for health information and analysis shall, in consultation with the  
194 commission and the prevention and wellness advisory board, develop guidelines for an annual  
195 review of the progress made by each grantee. Each grantee shall participate in any evaluation or  
196 accountability process implemented or authorized by the commission.

197 (f) The commission shall, annually on or before January 31, report on expenditures from  
198 the Prevention and Wellness Trust Fund. The report shall include, but not be limited to: (i) the  
199 revenue credited to the fund; (ii) revenue and expenditure projections and details of all  
200 anticipated expenditures from the fund for the next fiscal year; (iii) the amount of fund  
201 expenditures attributable to the administrative costs of the commission; (iv) an itemized list of  
202 the funds expended through grants awarded pursuant to paragraphs (1) and (2) of subsection (d)  
203 and a description of the grantee activities; and (v) the results of the annual evaluation of the  
204 effectiveness of the activities funded through grants conducted by the center for health  
205 information and analysis pursuant to section 25 of chapter 12C. The report shall be provided to  
206 the secretary of health and human services, the commissioner of the department of public health,  
207 the executive director of the center for health information and analysis, the executive director of  
208 the health policy commission, and the chairs of the house and senate committees on ways and  
209 means, the joint committee on health care financing and the joint committee on public health,  
210 and shall be posted on the commission's website.

211 (g) The commission shall, in consultation with the center for health information and  
212 analysis and under the advice and guidance of the prevention and wellness advisory board,  
213 annually report on its strategy for administration and allocation of the fund, including relevant  
214 evaluation criteria. The report shall set forth the rationale for such strategy, which may include:  
215 (i) a list of the most prevalent preventable health conditions in the commonwealth, including  
216 health disparities experienced by populations based on race, ethnicity, gender, disability status,  
217 sexual orientation, geography, or socio-economic status; (ii) a list of the most costly preventable  
218 health conditions in the commonwealth; and (iii) a list of evidence-based or evidence-informed  
219 community-based programs related to the conditions identified in clauses (i) and (ii). The report  
220 shall recommend specific areas of focus for allocation of funds. If appropriate, the report shall  
221 reference goals and best practices established by the National Prevention and Public Health  
222 Promotion Council and the Centers for Disease Control and Prevention, including, but not  
223 limited to the Hi-5 Initiative, the national prevention strategy, and the Healthy People report and  
224 the Guide to Community Prevention.

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

226 Section 7B. (a) There shall be a prevention and wellness advisory board to make  
227 recommendations to: (i) the commission concerning the administration and allocation of the  
228 Prevention and Wellness Trust Fund established in section 7A; and (ii) the center for health  
229 information and analysis concerning evaluation criteria for grantees awarded funds pursuant to  
230 section 7A; and (iii) perform any other functions specifically granted to it by law.

231 (b) The board shall consist of: the commissioner of public health or a designee, who shall  
232 serve as chair; the executive director of the health policy commission or a designee; the secretary

233 of health and human services or a designee; the executive director of the center for health  
234 information and analysis or a designee; the house and senate chairs of the joint committee on  
235 health care financing or their designees; the house and senate chairs of the joint committee on  
236 public health or their designees; and 15 persons to be appointed by the governor, 1 of whom shall  
237 be a person with expertise in the field of public health economics; 1 of whom shall be a person  
238 with expertise in public health research; 1 of whom shall be a person with expertise in the field  
239 of health equity; 1 of whom shall be a person from a local board of health for a city or town with  
240 a population greater than 50,000; 1 of whom shall be a person of a board of health for a city or  
241 town with a population of fewer than 50,000; 2 of whom shall be representatives of health  
242 insurance carriers; 1 of whom shall be a person from a consumer health organization; 1 of whom  
243 shall be a person from a hospital association; 1 of whom shall be a person from a statewide  
244 public health organization; 1 of whom shall be a representative of the interest of businesses; 1 of  
245 whom shall be a public health nurse or a school nurse; 1 of whom shall be a person from an  
246 association representing community health workers; 1 of whom shall represent a statewide  
247 association of community-based service providers addressing public health; and 1 of whom shall  
248 be a person with expertise in the design and implementation of community-wide public health  
249 interventions.

250 SECTION 12. Section 8 of said chapter 6D, as so appearing, is hereby amended by  
251 inserting after the word “organization” , in lines 6 and 7, the following words:-, pharmacy benefit  
252 manager, pharmaceutical manufacturing company.

253 SECTION 13. Said section 8 of said chapter 6D, as so appearing, is hereby further  
254 amended by inserting after the word “organizations”, in line 14, the following words:-, pharmacy  
255 benefit managers, pharmaceutical manufacturing companies.

256 SECTION 14. Said section 8 of said chapter 6D, as so appearing, is hereby further  
257 amended by striking out, in lines 32 and 33 , the words “and (xi) any witness identified by the  
258 attorney general or the center” and inserting in place thereof the following words:- “(xi) 2  
259 pharmacy benefit managers; (xii) 3 pharmaceutical manufacturing companies, 1 of which shall  
260 be representative of a publically traded drug manufacturing, 1 of which shall be representative  
261 of and doing business in generic drug manufacturing and 1 of which shall have been in existence  
262 for fewer than 10 years; (xiii) the assistant secretary for MassHealth; and (xiv) any witness  
263 identified by the attorney general or the center.

264 SECTION 15. Said section 8 of said chapter 6D, as so appearing, is hereby further  
265 amended by striking out, in line 48, the first time it appears, the word “and”.

266 SECTION 16. Said section 8 of said chapter 6D, as so appearing, is hereby further  
267 amended by inserting after the word “commission” , in line 59, the first time it appears, the  
268 following words:-; (iii) in the case of pharmacy benefit managers and pharmaceutical  
269 manufacturing companies, testimony that is suitable for public release and that is not likely to  
270 compromise the financial, competitive or proprietary nature of any information and data  
271 concerning factors underlying prescription drug costs and price increases; the impact of  
272 aggregate manufacturer rebates, discounts and other price concessions on net pricing; and any  
273 other matters as determined by the commission; and (iv) in the case of the assistant secretary for  
274 MassHealth, testimony concerning the structure, benefits, caseload and financing related  
275 programs administered by the office or entered into in partnership with other state and federal  
276 agencies and the agency’s activities to align or redesign those programs in order to encourage the  
277 development of more integrated and efficient health care delivery systems. No pharmaceutical

278 manufacturing company identified as a witness under this section, or any testimony by any such  
279 company, shall be subject to the provisions of section 17 of chapter 12C.

280 SECTION 17. Subsection (g) of said section 8 of said chapter 6D, as so appearing, is  
281 hereby amended by striking out the second sentence and inserting in place thereof the following  
282 sentence:- The report shall be based on the commission's analysis of information provided at the  
283 hearings by witnesses, providers, provider organizations, insurers, pharmaceutical manufacturing  
284 companies and pharmacy benefit managers, registration data collected pursuant to section 11,  
285 data collected or analyzed by the center pursuant to sections 8, 9, 10,10A and 10B of chapter  
286 12C and any other available information that the commission considers necessary to fulfill its  
287 duties in this section, as defined in regulations promulgated by the commission.

288 SECTION 18. Section 9 of said chapter 6D, as so appearing, is hereby amended by  
289 inserting after the word “organization”, in line 72, the following words:-, pharmacy benefit  
290 manager, pharmaceutical manufacturing company.

291 SECTION 19. Section 10 of said chapter 6D, as so appearing, is hereby amended by  
292 inserting after the figure “\$500,000”, in line 152, the following words:- the first time that a  
293 determination is made, not more than \$750,000 for a second determination and not more than  
294 \$1,000,000 for a third or subsequent determination; provided, however, that a civil penalty  
295 assessed pursuant to 1 of the above clauses shall be a first offense if a previously assessed  
296 penalty was assessed pursuant to a different clause. A civil penalty assessed pursuant to this  
297 subsection shall be deposited into the Community Hospital Reinvestment Trust Fund established  
298 in section 2TTTT of chapter 29.

299 SECTION 20. Said chapter 6D is hereby further amended by inserting after section 10,  
300 the following section:-

301 Section 10A. (a) If a proposed contract between two health care entities has been  
302 determined by the division of insurance to be influenced by unwarranted factors of price  
303 variation, the commission may, following a referral from and in consultation with the division,  
304 require the relevant health care entities to file a performance improvement plan. The commission  
305 shall provide written notice to such health care entities that they are each required to file a  
306 performance improvement plan.

307 (b) Within 45 days of receipt of such written notice, the health care entities shall either:

308 (1) each file a performance improvement plan with both the commission and the division;  
309 or

310 (2) each file an application with the commission to waive or extend the requirement to  
311 file a performance improvement plan.

312 (c) A health care entity may file any documentation or supporting evidence to support the  
313 health care entity's application to waive or extend the requirement to file a performance  
314 improvement plan. The commission shall require the health care entity to submit any other  
315 relevant information it deems necessary in considering the waiver or extension application.

316 (d) The commission may waive or delay the requirement for a health care entity to file a  
317 performance improvement plan in response to a waiver or extension request filed under  
318 subsection (b) in consideration of all information received from the health care entity, based on a  
319 consideration of the following factors:

320 (1) the rate of payment was a result of warranted factors or other reasonable factors for  
321 price variation;

322 (2) the costs, price and payment trends of the health care entity over time, and any  
323 demonstrated improvement to reduce total healthcare expenditures;

324 (3) any ongoing strategies or investments that the health care entity is implementing to  
325 improve future long-term efficiency and reduce cost growth;

326 (4) whether the factors that led to unwarranted price variation can reasonably be  
327 considered to be unanticipated and outside of the control of the health care entity;

328 (5) the overall financial condition of the health care entity;

329 (6) any other factors the commission considers relevant.

330 (e) If the commission declines to waive or extend the requirement for the health care  
331 entity to file a performance improvement plan, the commission shall provide written notice to the  
332 health care entity that its application for a waiver or extension was denied and the health care  
333 entity shall file a performance improvement plan.

334 (f) A health care entity shall file a performance improvement plan: (i) within 45 days of  
335 receipt of a notice under subsection (a); (ii) if the health care entity has requested a waiver or  
336 extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or  
337 (iii) if the health care entity is granted an extension, on the date given on such extension. The  
338 performance improvement plan shall be generated by the health care entity; shall identify the  
339 causes of the entity's rate of payment; and shall include, but not be limited to, specific strategies,  
340 adjustments and action steps the entity proposes to implement to improve rate of payment and



341 cost performance. The performance improvement plan shall include specific identifiable and  
342 measurable expected outcomes and a timetable for implementation. The timetable for a  
343 performance improvement plan shall not exceed 18 months.

344 (g) The commission shall approve any performance improvement plan that it determines  
345 is reasonably likely to address the underlying cause of the entity's cost growth and has a  
346 reasonable expectation for successful implementation.

347 (h) If the commission determines that the performance improvement plan is unacceptable  
348 or incomplete, the commission may provide consultation on the criteria that have not been met  
349 and may allow an additional time period of up to 30 calendar days for resubmission; provided,  
350 however, that all aspects of the performance improvement plan shall be proposed by the health  
351 care entity and the commission shall not require specific elements for approval.

352 (i) Upon approval of the proposed performance improvement plan, the commission shall  
353 notify the health care entity to begin immediate implementation of the performance improvement  
354 plan. The commission shall provide assistance to the health care entity in the successful  
355 implementation of the performance improvement plan.

356 (j) The health care entity shall, in good faith, work to implement the performance  
357 improvement plan. At any point during the implementation of the performance improvement  
358 plan the health care entity may file amendments to the performance improvement plan, subject to  
359 approval of the commission.

360 (k) At the conclusion of the timetable established in the performance improvement plan,  
361 the health care entity shall report to the commission regarding the outcome of the performance  
362 improvement plan. If the performance improvement plan was found to be unsuccessful, the

363 commission shall either: (i) extend the implementation timetable of the existing performance  
364 improvement plan; (ii) approve amendments to the performance improvement plan as proposed  
365 by the health care entity; (iii) require the health care entity to submit a new performance  
366 improvement plan under subsection (c); or (iv) waive or delay the requirement to file any  
367 additional performance improvement plans.

368 (l) The commission may submit a recommendation for proposed legislation to the joint  
369 committee on health care financing if the commission determines that further legislative  
370 authority is needed to achieve the health care cost sustainability objectives of this act, assist  
371 health care entities with the implementation of performance improvement plans or otherwise  
372 ensure compliance with the provisions of this section.

373 (n) If the commission determines that a health care entity has: (i) willfully neglected to  
374 file a performance improvement plan with the commission within the time period required under  
375 subsection (f); (ii) failed to file an acceptable performance improvement plan in good faith with  
376 the commission; (iii) failed to implement the performance improvement plan in good faith; or  
377 (iv) knowingly failed to provide information required by this section to the commission or  
378 knowingly falsified the same, the commission may assess a civil penalty to the health care entity  
379 of not more than \$500,000. The first time that a determination is made, not more than \$750,000  
380 for a second determination, and not more than \$1,000,000 for a third or subsequent  
381 determination; provided however, that a civil penalty assessed under 1 of the above clauses shall  
382 be a first offense if a previously assessed penalty was assessed pursuant to a different clause. A  
383 civil penalty assessed under this subsection shall be deposited into the Community Hospital  
384 Reinvestment Trust Fund established under section 2TTTT of chapter 29. The commission shall

385 seek to promote compliance with this section and shall only impose a civil penalty as a last  
386 resort.

387 (o) The commission shall, in consultation with the division of insurance, promulgate  
388 regulations necessary to implement this section; provided, however, that notice of any proposed  
389 regulations shall be filed with the joint committee on state administration and regulatory  
390 oversight and the joint committee on health care financing at least 180 days before adoption.

391 SECTION 21. Clause (10) of subsection (c) of section 15 of said chapter 6D, as so  
392 appearing, is hereby amended by striking out, in lines 140 and 141, the words “adverse events  
393 and unnecessary emergency room visits” and inserting in place thereof the following words:-  
394 adverse events, rates of institutional post-acute care and unnecessary emergency room visits or  
395 extended emergency department boarding.

396 SECTION 22. Clause (12) of said subsection (c) of said section 15 of said chapter 6D, as  
397 so appearing, is hereby amended by striking out, in lines 149 to 151, inclusive, the words “by the  
398 department of public health through the Prevention and Wellness Trust Fund established in  
399 section 2G of chapter 111” and inserting in place thereof the following words:- through the  
400 Prevention and Wellness Trust Fund established in section 7A.

401 SECTION 23. Said subsection (c) of said section 15 of said chapter 6D, as so appearing,  
402 is hereby further amended by striking out clause (16) and inserting in place thereof the following  
403 2 clauses:-

404 (16) to demonstrate evidence-based care delivery programs, which may include  
405 community care transitions coaching programs led by community-based, nonprofit entities  
406 designed to reduce: (i) 30-day readmission rates; (ii) avoidable emergency department use,

407 including extended emergency department boarding; or (iii) unwarranted institutional post-acute  
408 care; provided however, that a mobile integrated health care program certified pursuant to  
409 chapter 111O shall satisfy this requirement for the purposes of the commission; and

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

411 SECTION 24. Said chapter 6D is hereby further amended by adding the following 3  
412 sections:-

413 Section 19. (a) There is hereby established within the commission a health planning  
414 council, consisting of the executive director of the health policy commission who shall serve as  
415 chair, the secretary of health and human services or a designee, the commissioner of public  
416 health or a designee, the director of the office of Medicaid or a designee, the commissioner of  
417 mental health or a designee, the commissioner of insurance or a designee, the secretary of elder  
418 affairs or a designee, the executive director of the center for health information and analysis or a  
419 designee, and 3 members appointed by the governor, 1 of whom shall be a health economist, 1 of  
420 whom shall have experience in health policy and planning and 1 of whom shall have experience  
421 in health care market planning and service line analysis.

422 (b) The council shall develop a state health plan to identify: (i) the anticipated needs of  
423 the commonwealth for health care services, providers, programs and facilities; (ii) the resources  
424 available to meet those needs; and (iii) the priorities for addressing those needs.

425 The state health plan developed by the council shall include the location, distribution and  
426 nature of all health care resources in the commonwealth and shall identify certain categories of  
427 health care resources, including: (i) acute care units; (ii) non-acute care units; (iii) specialty care  
428 units, including, but not limited to, burn, coronary care, cancer care, neonatal care, post-obstetric

429 and post-operative recovery care, pulmonary care, renal dialysis and surgical, including trauma  
430 and intensive care units; (iv) skilled nursing facilities; (v) assisted living facilities; (vi) long-term  
431 care facilities; (vii) ambulatory surgical centers; (viii) office-based surgical centers; (ix) urgent  
432 care centers; (x) home health, behavioral health and mental health services; (xi) treatment and  
433 prevention services for alcohol and other drug abuse; (xii) emergency care; (xiii) ambulatory  
434 care services; (xiv) primary care resources; (xv) pharmacy and pharmacological services; (xvi)  
435 family planning services; (xvii) obstetrics and gynecology services; (xviii) allied health services  
436 including, but not limited to, optometric care, chiropractic services, dental care and midwifery  
437 services; (xix) federally qualified health centers and free clinics; (xx) numbers of technologies or  
438 equipment defined as innovative services or new technologies by the department of public health  
439 pursuant to section 25C of chapter 111; and (xxiii) health screening and early intervention  
440 services.

441         The state health plan shall also make recommendations for the appropriate supply and  
442 distribution of resources, programs, capacities, technologies and services identified in the second  
443 paragraph of this subsection on a state-wide or regional basis based on an assessment of need for  
444 the next 5 years and options for implementing such recommendations. The recommendations  
445 shall reflect, at a minimum, the following goals: (i) maintain and improve the quality of health  
446 care services; (ii) support the commonwealth's efforts to meet the health care cost growth  
447 benchmark established pursuant to section 9; (iii) support innovative health care delivery and  
448 alternative payment models as identified by the commission; (iv) reduce unnecessary  
449 duplication; (v) support universal access to reduce health disparities; (vi) support efforts to  
450 integrate oral health, mental health, behavioral and substance use disorder services with overall  
451 medical care; (vii) reflect the latest trends in utilization and support the best standards of care;

452 and (viii) rationally distribute health care resources across geographic regions of commonwealth  
453 based on the needs of the population on a statewide basis, as well as, the needs of particular  
454 geographic areas of the commonwealth.

455 (c) Under the direction of the council, the department of public health, pursuant to section  
456 25A of chapter 111, shall establish and maintain on a current basis an inventory of all such health  
457 care resources together with all other reasonably pertinent information concerning such  
458 resources. Agencies of the commonwealth that license, register, regulate or otherwise collect  
459 cost, quality or other data concerning health care resources shall cooperate with the council and  
460 the department in coordinating such data with information collected pursuant to this section and  
461 said section 25A of said chapter 111. The inventory compiled pursuant to this section and said  
462 section 25A of said chapter 111 and all related information shall be maintained in a form usable  
463 by the general public in a designated office of the council and shall constitute a public record;  
464 provided, however, that any item of information which is confidential or privileged in nature  
465 under any other law shall not be regarded as a public record pursuant to this section.

466 (d) The council shall assemble an advisory committee of not more than 15 members who  
467 shall reflect a broad distribution of diverse perspectives on the health care system, including  
468 health care providers and provider organizations, public and private third-party payers, consumer  
469 representatives and labor organizations representing health care workers. Not fewer than 2  
470 members of the advisory committee shall have expertise in rural health matters and rural health  
471 needs in the commonwealth. The advisory committee shall review drafts and provide  
472 recommendations to the council during the development of the plan.

473 (e) The council, with the commission and the department of public health, shall conduct  
474 at least 4 annual public hearings, in geographically diverse areas, during the development of the  
475 plan as proposed and shall give interested persons an opportunity to submit their views orally  
476 and in writing. In addition, the commission may create and maintain a website to allow members  
477 of the public to submit comments electronically and review comments submitted by others.

478 (f) The council shall publish analyses, reports and interpretations of information collected  
479 pursuant to this section to promote awareness of the distribution and nature of health care  
480 resources in the commonwealth.

481 Section 20. (a) For the purposes of this section, the following terms shall, unless the  
482 context clearly requires otherwise, have the following meanings:

483 “Academic detailing”, the provision of information regarding prescription drugs based on  
484 scientific and medical research, including information on therapeutic and cost-effective use of  
485 prescription drugs.

486 “Dispenser” means any person or entity licensed to dispense prescription drugs pursuant  
487 to the General Laws.

488 “PCORI”, patient-centered outcomes research institute

489 “Prescriber”, a person who is licensed, registered or otherwise authorized in the  
490 appropriate jurisdiction to prescribe and administer drugs in the course of professional practice.

491 “Program”, an academic detailing program designed and implemented pursuant to this  
492 section.

493 (b) On or before July 1, 2019, the commission shall establish a prescription drug  
494 academic detailing program to enhance the health of residents of the commonwealth, improve  
495 the quality of decisions regarding drug prescribing, encourage better communication between the  
496 commission and health care providers participating in publicly funded health programs and  
497 reduce the health complications and unnecessary costs associated with inappropriate drug  
498 prescribing.

499 (c) The commission shall design the program after consultation with prescribers and  
500 dispensers of drugs, private insurers offering prescription drug coverage, hospitals, pharmacy  
501 benefit managers, consumers and the MassHealth drug utilization review board. The program, as  
502 well as any affiliated organizations, shall be required to use transparent procedures for  
503 development of assessments, summaries and decision-support tools that describe the methods  
504 used. Such methods shall be consistent with best practices for academic detailing and systematic  
505 evidence reviews. Any organization referenced or research conducted shall align with the  
506 patient-centered outcomes research institute's standards for patient-centeredness in health  
507 outcomes research. There shall be opportunity for input from clinical experts and patients in  
508 research process and development of materials. In view of the widely recognized limitations of  
509 cost-effectiveness research, the academic detailing program shall not conduct research or  
510 communicate information in ways that discriminate against or otherwise disadvantage vulnerable  
511 populations, including populations with health disparities, or individuals with special health  
512 needs. In planning for the design of the prescription drug academic detailing program, the  
513 commission shall review and evaluate use of the educational and assessment materials developed  
514 by (i) the University of Massachusetts medical school, (ii) PCORI, (iii) Pennsylvania



515 PACE/Harvard University Independent Drug Information Service, and (iv) the North Carolina  
516 evidence-based peer-to-peer education program outreach program.

517 (d) The program components shall include outreach and education regarding the  
518 therapeutic and cost-effective use of prescription drugs as issued in peer-reviewed scientific,  
519 medical and academic research publications and made available to prescribers and dispensers of  
520 drugs in the commonwealth, including through written information and through personal visits  
521 from program staff. To the extent possible, program components shall also include information  
522 regarding clinical trials, pharmaceutical efficacy, adverse effects of drugs, evidence-based  
523 treatment options and drug marketing approaches that are intended to circumvent competition  
524 from generic and therapeutically equivalent drugs. Academic detailers shall observe standards of  
525 conduct in their educational materials and written and oral presentations as established by rules  
526 adopted by the commission that are consistent with the following federal regulations regarding  
527 labeling and false and misleading advertising: (i) the Food and Drug Administration labeling  
528 requirements of 21 CFR, Part 201, prescription drug advertising provisions of 21 CFR, Part 202  
529 and related guidance; and (ii) the Office of the Inspector General Compliance Program Guidance  
530 for Pharmaceutical Manufacturers issued in April 2003, as amended. The commission's rules  
531 shall require academic detailers to disclose evidence-based information about the range and cost  
532 of appropriate drug treatment options and the health benefits and risks of all appropriate drugs.

533 (e) The program shall provide outreach and education to prescribers and dispensers who  
534 participate in, contract with or are reimbursed health care programs funded by the  
535 commonwealth, including but not limited to, those programs for which the group insurance  
536 commission purchases health insurance pursuant to section 4 of chapter 32A. The program may  
537 provide outreach and education to private insurers offering prescription drug coverage, hospitals,

538 employers and other persons interested in the program on a subscription or fee-paying basis  
539 pursuant to rules adopted by the commission.

540 (f) On or before April 1st each year, the commission shall provide the governor with an  
541 annual report on the operation of the program. The report shall include information regarding: (i)  
542 the outreach and education components of the program; (ii) revenues, expenditures and balances;  
543 and (iii) savings attributable to the program in health care programs funded by the  
544 commonwealth. During the first 2 annual reports to the governor, the commission shall also  
545 include discussion regarding its review and evaluation of the use of the educational and  
546 assessment materials developed by educational institutions pursuant to subsection (c).

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

549 (h) The commission may seek funding from nongovernmental health access foundations  
550 and undesignated drug litigation settlement funds associated with pharmaceutical marketing and  
551 pricing practices and any unused funds collected under the annual disclosure report fee  
552 promulgated by the executive office pursuant to chapter 111N. The commission may also  
553 develop a subscription fee through which any interested party in the commonwealth may  
554 voluntarily purchase a subscription to the program.

555 Section 21. (a) In the course of its duties the commission may contract with a third-party  
556 entity, such as an accounting firm, to conduct an annual study of pharmaceutical or  
557 biopharmaceutical companies with pipeline drugs, generic drugs or biosimilar drugs that may  
558 have a significant impact on state health care expenditures.

559 (b) For purposes of this section, early notice shall be provided for the following:

- 560 (1) Pipeline drugs;
- 561 (2) All abbreviated new drug applications for generic drugs, upon submission to the  
562 federal Food and Drug Administration, hereinafter referred to as FDA; and
- 563 (3) All biosimilar therapeutic biologics applications (BLA), upon the receipt of an action  
564 date from the FDA.

565 (c) In connection with the annual study, the applicant for a pipeline brand, biosimilar or  
566 generic drug shall provide the commission or the contracted third-party entity with a brief  
567 description of the following for each drug, using data fields consistent with those employed by  
568 the United States National Institutes of Health in [clinicaltrials.gov](http://clinicaltrials.gov), if applicable:

- 569 (1) The primary disease, health condition or therapeutic area being studied and the  
570 indication;
- 571 (2) The routes of administration being studied;
- 572 (3) Clinical trial comparators, if applicable; and
- 573 (4) Estimated year of market entry.

574 (d) As part of such submission, manufacturers shall also report the receipt of any of the  
575 following designations from the FDA for each pipeline drug:

- 576 (1) Orphan Drug;
- 577 (2) Fast Track;
- 578 (3) Breakthrough Therapy;

579 (4) Accelerated Approval; or

580 (5) Priority Review for New Molecular Entities NMEs.

581 (e) The data submissions required by this section shall be submitted to the commission or  
582 the contracted third-party entity no later than 60 days after receipt of the FDA action date or after  
583 the submission of an abbreviated new drug application to the FDA, provided, however, that for  
584 drugs in development that receive any of the FDA designations listed in subsection (d) for  
585 NMEs, such submissions shall be provided as soon as practical upon receipt of the relevant  
586 designation.

587 (f) Any study conducted pursuant to this section shall be funded by annual registration  
588 fees and any other assessments that accompany the annual marketing disclosure reports required  
589 pursuant to chapter 111N.

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

593 SECTION 25. Section 11N of chapter 12 of the General Laws, as so appearing, is hereby  
594 amended by striking out subsection (a) and inserting in place thereof the following subsection:-

595 (a) The attorney general shall monitor trends in the health care market including, but not  
596 limited to, trends in provider organization size and composition, consolidation in the provider  
597 market, payer contracting trends, patient access and quality issues in the health care market and  
598 prescription drug cost and price trends. The attorney general may obtain the following  
599 information from a private health care payer, public health care payer, pharmacy benefit

600 manager, provider or provider organization, as any of those terms may be defined in section 1 of  
601 chapter 6D: (i) any information that is required to be submitted pursuant to sections 8, 9, 10 and  
602 10B of chapter 12C; (ii) filings, applications and supporting documentation related to any cost  
603 and market impact review pursuant to section 13 of said chapter 6D; (iii) filings, applications and  
604 supporting documentation related to a determination of need application filed pursuant to section  
605 25C of chapter 111; and (iv) filings, applications and supporting documentation submitted to the  
606 federal Centers for Medicare and Medicaid Services or the Office of the Inspector General for  
607 any demonstration project. Pursuant to section 8 of said chapter 6D and section 17 of said  
608 chapter 12C, and subject to the limitations in said sections, the attorney general may require that  
609 any provider, provider organization, pharmacy benefit manager, private health care payer or  
610 public health care payer produce documents, answer interrogatories and provide testimony under  
611 oath related to health care costs and cost trends, the factors that contribute to cost growth within  
612 the commonwealth's health care system and the relationship between provider costs and payer  
613 premium rates.

614 SECTION 26. Section 1 of chapter 12C of the General Laws, as so appearing, is hereby  
615 amended by inserting after the definition of "Patient-centered medical home" the following 3  
616 definitions:-

617 "Pharmaceutical manufacturing company", any entity engaged in the production,  
618 preparation, propagation, compounding, conversion or processing of prescription drugs, either  
619 directly or indirectly, by extraction from substances of natural origin, or independently by means  
620 of chemical synthesis or by a combination of extraction and chemical synthesis, or any entity  
621 engaged in the packaging, repackaging, labeling, relabeling or distribution of prescription drugs;  
622 provided however, that "pharmaceutical manufacturing company" shall not include a wholesale

623 drug distributor licensed pursuant to section 36A of chapter 112 or a retail pharmacist registered  
624 pursuant to section 38 of said chapter 112.

625 “Pharmacy benefit manager”, any person, business, or entity, however organized, that  
626 administers, either directly or through its subsidiaries, pharmacy benefit services for prescription  
627 drugs and devices on behalf of health benefit plan sponsors, including, but not limited to, self-  
628 insured employers, insurance companies and labor unions;

629 “pharmacy benefit services” shall include, but not be limited to, formulary  
630 administration; drug benefit design; pharmacy network contracting; pharmacy claims processing;  
631 mail and specialty drug pharmacy services; and cost containment, clinical, safety, and adherence  
632 programs for pharmacy services.

633 For the purposes of this section, a health benefit plan that does not contract with a  
634 pharmacy benefit manager shall be a pharmacy benefit manager, unless specifically exempted.

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

638 SECTION 27. Said section 1 of chapter 12C, as so appearing, is hereby further amended  
639 by adding the following definition:-

640 “Wholesale acquisition cost”, the cost of a prescription drug as defined in 42 U.S.C.  
641 §1395w-3a(c)(6)(B).

642 SECTION 28. Subsection (c) of section 2A of said chapter 12C is hereby amended by  
643 striking out clause (4), as so appearing, and inserting in place thereof the following clause:-

644 (4) develop annual research and analysis priorities for the center; provided however, that  
645 the council shall not require approval of the center’s actions pursuant to section 16, section 38C  
646 and 38D of chapter 3 or section 17 of chapter 176A.

647 SECTION 29. Section 3 of said chapter 12C, as so appearing, is hereby amended by  
648 inserting after the word “organizations”, in lines 13 and 14, the following words:-,  
649 pharmaceutical manufacturing companies, pharmacy benefit managers.

650 SECTION 30. Said section 3 of said chapter 12C, as so appearing, is hereby further  
651 amended by striking out the words “and payer”, in line 24, and inserting in place thereof the  
652 following words:-, payer, pharmaceutical manufacturing company and pharmacy benefit  
653 manager.

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

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

660 SECTION 33. Section 7 of said chapter 12C, as so appearing, is hereby amended by  
661 inserting after the figure “29”, in lines 6, 12 and 46, each time it appears, the following words:-  
662 or the Prevention and Wellness Trust Fund established in section 7A of chapter 6D.

663 SECTION 34. Said section 7 of said chapter 12C, as so appearing, is hereby further  
664 amended by adding the following paragraph:-

665 To the extent that the analysis and reporting activities pursuant to sections 10A or 10B  
666 increases the expenses of the center, the estimated increase in the center's expenses shall be fully  
667 assessed to pharmaceutical manufacturing companies and pharmacy benefit managers in the  
668 same manner as the assessment pursuant to section 68 of chapter 118E.

669 SECTION 35. Said chapter 12C is hereby further amended by inserting after section 10,  
670 as so appearing, the following 2 sections:-

671 Section 10A. (a) On or before March 1, 2020, and annually thereafter, the center shall  
672 prepare a list of not more than ten outpatient prescription drugs that the center determines  
673 account for a significant share of state health care spending, considering the net cost of such  
674 drugs in the immediately preceding calendar year. The list shall include outpatient prescription  
675 drugs from different therapeutic classes and 1 at least three generic outpatient prescription drugs.  
676 The center shall not list any outpatient prescription drug pursuant to this subsection unless the  
677 wholesale acquisition cost of the prescription drug, less all rebates paid to the commonwealth for  
678 such drug during the immediately preceding calendar year, increased by not less than 25 per cent  
679 during the immediately preceding calendar year.

680 (b) The pharmaceutical manufacturer of a prescription drug included on a list prepared by  
681 the center pursuant to subsection (a) shall provide to the center the following: (i) a written,  
682 narrative description, suitable for public release, of factors that caused the increase in the  
683 wholesale acquisition cost of the listed prescription drug; and (ii) aggregate, company-level  
684 research and development costs and such other capital expenditures that the center deems  
685 relevant for the most recent year for which final audited data is available.



686 (c) The quality and types of information and data that a pharmaceutical manufacturer  
687 submits to the center pursuant to this section shall be consistent with the quality and types of  
688 information and data that the pharmaceutical manufacturer includes in: (i) such pharmaceutical  
689 manufacturer's annual consolidated report on Securities and Exchange Commission Form 10-K  
690 or (ii) any other public disclosure.

691 (d) The center shall consult with pharmaceutical manufacturers to establish a single,  
692 standardized form for reporting information and data pursuant to this section. The form shall  
693 minimize the administrative burden and cost imposed on the center and pharmaceutical  
694 manufacturers.

695 (e) The center shall compile an annual report that includes all information that the center  
696 receives pursuant to subsection (b). The center shall post such report and the information  
697 described in this subsection on the center's website on or before October 1 of each year.

698 (f) Except as otherwise provided in this section, information and data submitted to the  
699 center pursuant to this section shall not be a public record and shall be exempt from disclosure  
700 pursuant to clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66. No such  
701 information and data shall be disclosed in a manner that may compromise the financial,  
702 competitive or proprietary nature of such information and data, or that would have enable a third  
703 party to identify an individual drug, therapeutic class of drugs or pharmaceutical manufacturer  
704 company the prices charged for any particular drug or therapeutic class of drugs, or the value of  
705 any rebate or discount provided for any particular drug or class of drugs.

706 Section 10B. The center shall promulgate regulations necessary to ensure the uniform  
707 analysis of information regarding pharmacy benefit managers that enables the center to analyze:

708 (1) year-over-year wholesale acquisition cost changes; (2) year-over-year trends in formulary,  
709 maximum allowable costs list and cost-sharing design, including the establishment and  
710 management of specialty product lists; (3) information regarding discounts, utilizations limits,  
711 rebates, manufacturer administrative fees and other financial incentives or concessions related to  
712 pharmaceutical products or formulary programs; (4) information regarding the aggregate amount  
713 of payments made to pharmacies owned or controlled by the pharmacy benefit managers and the  
714 aggregate amount of payments made to pharmacies that are not owned or controlled by the  
715 pharmacy benefit managers; and (5) additional information deemed reasonable and necessary by  
716 the center as set forth in the center’s regulations.

717 SECTION 36. Section 11 of said chapter 12C is hereby amended by striking out the first  
718 sentence, as so appearing, and inserting in place thereof the following sentence:-

719 The center shall ensure the timely reporting of information required pursuant to sections  
720 8, 9, 10, 10A, and 10B.

721 SECTION 37. Said section 11 of said chapter 12C, as so appearing, is hereby further  
722 amended by striking out the figure “\$1,000”, in line 11, and inserting in place thereof the  
723 following figure:- \$5,000.

724 SECTION 38. Said section 11 of said chapter 12C, as so appearing, is hereby further  
725 amended by striking out the figure “\$50,000”, in line 16, and inserting in place thereof the  
726 following figure:- \$200,000.

727 SECTION 39. Section 12 of said chapter 12C, as so appearing, is hereby amended by  
728 striking out the words “9, and 10”, in line 2, and inserting in place thereof the following words:-  
729 9, 10, 10A and 10B.

730 SECTION 40. Said chapter 12C, as so appearing, is hereby amended by striking out  
731 section 14 and inserting in place thereof the following section:-

732 Section 14. (a)(1) The center, in consultation with the statewide advisory committee  
733 established pursuant to subsection (c) shall, not later than March 1 in each even-numbered year,  
734 establish a standard set of measures of health care provider quality and health system  
735 performance, hereinafter referred to as the “standard quality measure set”, for use in: (i) contracts  
736 between payers, including the commonwealth and carriers, and health care providers, provider  
737 organizations and accountable care organizations, which incorporate quality measures into  
738 payment terms, including the designation of a set of core measures and a set of non-core  
739 measures; (ii) assigning tiers to health care providers in the design of any health plan; (iii)  
740 consumer transparency websites and other methods of providing consumer information; and (iv)  
741 monitoring system-wide performance.

742 (2) The standard quality measure set shall be used by the commonwealth and carriers in  
743 contracts with health care providers to incorporate quality measures into the payment terms  
744 pursuant to section 30 of chapter 32A, section 80 of chapter 118E, section 108O of chapter 175,  
745 section 41 of chapter 176A, section 27 of chapter 176B, section 35 of chapter 176G, section 14  
746 of chapter 176I and for assigning tiers to health care providers in tiered network plans pursuant  
747 to section 11 of chapter 176J.

748 (3) The standard quality measure set shall designate: (i) core measures that shall be used  
749 in contracts between payers, including the commonwealth and carriers, and health care  
750 providers, including provider organizations and accountable care organizations, that incorporate  
751 quality measures into payment terms; and (ii) a menu of non-core measures that may be used in

752 such contracts. If the standard quality measure set established by the center differs from the  
753 recommendations of the statewide advisory committee, the center shall issue a written report  
754 detailing each area of disagreement and the rationale for the center's decision.

755 (b) The center shall develop the uniform reporting of the standard quality measure set for  
756 each health care provider facility, medical group or provider group in the commonwealth.

757 (c)(1) The center shall convene a statewide advisory committee which shall make  
758 recommendations for the standard quality measure set to: (i) ensure consistency in the use of  
759 quality measures in contracts between payers, including the commonwealth and carriers, and  
760 health care providers in the commonwealth; (ii) ensure consistency in methods for the  
761 assignment of tiers to providers in the design of any health plan; (iii) improve quality of care;  
762 (iv) improve transparency for consumers and employers; (v) improve health system monitoring  
763 and oversight by relevant state agencies; and (vi) reduce administrative burden.

764 (2) The statewide advisory committee shall consist of the secretary of health and human  
765 services and the executive director of the health policy commission, or their designees, who shall  
766 serve as co-chairs, and shall include the following members or their designees: executive director  
767 of the center; the executive director of the Betsy Lehman center for patient safety and medical  
768 error reduction; the executive director of the group insurance commission; the director of the  
769 Massachusetts e-Health Institute; the secretary of elder affairs; the assistant secretary for  
770 MassHealth; the commissioner of the department of public health; the commissioner of the  
771 department of mental health; and 11 members who shall be appointed by the governor, 1 of  
772 whom shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of  
773 whom shall be a representative of the Massachusetts League of Community Health Centers, Inc.,

774 1 of whom shall be a representative the Massachusetts Medical Society, 1 of whom shall a  
775 registered nurse licensed to practice in Massachusetts who practices in a patient care setting; 1 of  
776 whom shall be a representative of a labor organizations representing health care workers; 1 of  
777 whom shall be a behavioral health provider, 1 of whom shall be a long-term supports and  
778 services provider, 1 of whom shall be a representative of Blue Cross and Blue Shield of  
779 Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Association of  
780 Health Plans, Inc., 1 of whom shall be a representative of a specialty pediatric provider and 1 of  
781 whom shall be a representative for consumers. Members appointed to the statewide advisory  
782 committee shall have experience with and expertise in health care quality measurement.

783 (3) The statewide advisory committee shall meet quarterly to develop recommendations  
784 for the core measure and non-core measures to be adopted in the standard quality measure set for  
785 use in: (i) contracts between payers, including the commonwealth and carriers, and health care  
786 providers, provider organizations and accountable care organizations, which incorporate quality  
787 measures into payment terms, including the designation of a set of core measures and a set of  
788 non-core measures; (ii) assigning tiers to health care providers in the design of any health plan;  
789 (iii) consumer transparency websites and other methods of providing consumer information; and  
790 (iv) monitoring system-wide performance.

791 (4) In developing its recommendations for the standard quality measure set, the statewide  
792 advisory committee shall incorporate nationally recognized quality measures including, but not  
793 limited to recommendations from the Executive Office of Health and Human Services Quality  
794 Measurement Alignment Task Force, measures used by the Centers for Medicare Medicaid  
795 Services, the group insurance commission, carriers and providers and provider organizations in  
796 the commonwealth and other states, as well as other valid measures of health care provider

797 performance, outcomes, including patient-reported outcomes and functional status, patient  
798 experience, disparities and population health. The statewide advisory committee shall consider  
799 measures applicable to primary care providers, specialists, hospitals, provider organizations,  
800 accountable care organizations, oral health providers and other types of providers and measures  
801 applicable to different patient populations.

802 (5) The statewide advisory committee shall, not later than January 1 in each even-  
803 numbered year, submit to the center its recommendations on the core measures and non-core  
804 measures to be adopted, changed or updated by the center in the standard quality measure set,  
805 along with a report in support of its recommendations.

806 SECTION 41. Said chapter 12C, as so appearing, is hereby amended by striking out  
807 section 15 and inserting in place thereof the following section:-

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

810 "Adverse event", harm to a patient resulting from a medical intervention and not to the  
811 underlying condition of the patient.

812 "Agency", any agency of the executive branch of the commonwealth, including but not  
813 limited to any constitutional or other office, executive office, department, division, bureau,  
814 board, commission or committee thereof; or any authority created by the general court to serve a  
815 public purpose, having either statewide or local jurisdiction.

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

817 "Healthcare-associated infection", an infection that a patient acquires during the course of  
818 receiving treatment for other conditions within a healthcare setting.

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

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

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

824 "Patient safety", freedom from accidental injury.

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

828 (b) There shall be established within the center the Betsy Lehman center for patient safety  
829 and medical error reduction. The purpose of the Lehman center shall be to serve as a  
830 clearinghouse for the development, evaluation and dissemination, including, but not limited to,  
831 the sponsorship of training and education programs, of best practices for patient safety and  
832 medical error reduction. The Lehman center shall: (i) coordinate the efforts of state agencies  
833 engaged in the regulation, contracting or delivery of health care and those individuals or  
834 institutions licensed by the commonwealth to provide health care to meet their responsibilities  
835 for patient safety and medical error reduction; (ii) assist all such entities to work as part of a total  
836 system of patient safety; and (iii) develop appropriate mechanisms for consumers to be included  
837 in a statewide program for improving patient safety. The Lehman center shall coordinate state

838 participation in any appropriate state or federal reports or data collection efforts relative to  
839 patient safety and medical error reduction. The Lehman center shall analyze available data,  
840 research and reports for information that would improve education and training programs that  
841 promote patient safety.

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

856 (d) The Lehman center shall develop and administer a patient safety and medical error  
857 reduction education and research program to assist health care professionals, health care facilities  
858 and agencies and the general public regarding issues related to the causes and consequences of  
859 medical error and practices and procedures to promote the highest standard for patient safety in  
860 the commonwealth. The Lehman center shall annually report to the governor and the general



861 court relative to the feasibility of developing standards for patient safety and medical error  
862 reduction programs for any state department, agency, commission or board to reduce medical  
863 errors, and the statutory responsibilities of the commonwealth, for the protection of patients and  
864 consumers of health care together with recommendations to improve coordination and  
865 effectiveness of the programs and activities.

866 (e) The Lehman center shall: (i) identify and disseminate information about evidence-  
867 based best practices to reduce medical errors and enhance patient safety; (ii) develop a process  
868 for determining which evidence-based best practices should be considered for adoption; (iii)  
869 serve as a central clearinghouse for the collection and analysis of existing information on the  
870 causes of medical errors and strategies for prevention; and (iv) increase awareness of error  
871 prevention strategies through public and professional education. The information collected by the  
872 Lehman center or reported to the Lehman center shall not be a public record as defined in section  
873 7 of chapter 4, shall be confidential and shall not be subject to subpoena or discovery or  
874 introduced into evidence in any judicial or administrative proceeding, except as otherwise  
875 specifically provided by law.

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

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

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

891 SECTION 42. Section 16 of said chapter 12C, as so appearing, is hereby amended by  
892 striking out the first sentence and inserting in place thereof the following sentence:-

893 The center shall publish an annual report based on the information submitted pursuant to  
894 sections 8, 9, 10, 10A and 10B concerning health care provider, provider organization,  
895 pharmaceutical manufacturing company, pharmacy benefit manager and private and public  
896 health care payer costs and cost and price trends, pursuant to section 13 of chapter 6D relative to  
897 market impact reviews and pursuant to section 15 relative to quality data.

898 SECTION 43. Said chapter 12C is hereby further amended by adding the following 2  
899 sections:-

900 Section 24. (a) The center, in consultation with the division of insurance, the health  
901 connector authority, the group insurance commission, the health policy commission and the  
902 secretary of the executive office of health, shall develop and adopt a uniform methodology for  
903 the communication of information on the assignment of tiers to health care providers and health

904 care services, including pharmacy benefits, by carriers. The methodology adopted by the center  
905 shall ensure that such information educates patients, purchasers and employers on the differences  
906 in the plan design and cost sharing requirements of any health plan product. The center shall also  
907 ensure that such information educates patients on the role of the standard quality measure set  
908 established under section 14 in a carrier's assignment of a tier to a health care provider.

909 (b) In the development of the uniform methodology, the center shall consult with  
910 providers, carriers and consumer representatives and hold at least 6 statewide, regional public  
911 hearings to solicit public comment on the proposed methodology. The center shall file interim  
912 reports quarterly with the joint committee on health care financing and the house and senate  
913 committees on ways and means detailing its progress in developing the uniform methodology.

914 (c) The center shall issue a final report detailing the uniform methodology of  
915 communication adopted by the center on or before December 31, 2019. The center shall file the  
916 report with the governor, the clerks of the house of representatives and the senate, the joint  
917 committee on health care financing and the house and senate committees on ways and means.  
918 The report shall also be made available on the center's website.

919 Section 25. (a) The center shall annually, on or before December 1, evaluate the grant  
920 program authorized in section 7A of chapter 6D and shall issue an evaluation report. The report  
921 shall include an analysis of all relevant data to determine the effectiveness of the program  
922 including, but not limited to, an analysis of: (i) the extent to which the program impacted the  
923 prevalence, severity or control of preventable health conditions and the extent to which the  
924 program is projected to impact such factors in the future; (ii) the extent to which the program  
925 reduced health care costs or the growth in health care cost trends and the extent to which the

926 program is projected to reduce such costs in the future; (iii) whether health care costs were  
927 reduced and who benefited from the reduction; (iv) the extent that health outcomes or health  
928 behaviors were positively impacted; (v) the extent that access to evidence-based community  
929 services was increased; (vi) the extent that social determinants of health or other community  
930 wide risk factors for poor health were reduced or mitigated; (vii) the extent that grantees  
931 increased their ability to collaborate, share data and align services with other providers and  
932 community-based organizations for greater impact; (viii) the extent to which health disparities  
933 experienced by populations based on race, ethnicity, gender, disability status, sexual orientation  
934 or socio-economic status were reduced across all metrics; and (ix) recommendations for whether  
935 the program should be discontinued, amended or expanded and a timetable for implementation of  
936 the recommendations.

937 (b) The center shall report the results of its evaluation and its recommendations, if any,  
938 and drafts of legislation necessary to carry out the recommendations to the house and senate  
939 committees on ways and means, the joint committee on public health and the joint committee on  
940 health care financing and shall post the report on the center's website.

941 SECTION 44. Section 10 of chapter 13 of the General Laws, as so appearing, is hereby  
942 amended by striking out the last paragraph and inserting in place thereof the following  
943 paragraph:-

944 The board: (i) shall adopt, amend and rescind such rules and regulations as it deems  
945 necessary to carry out the this chapter; provided however, that prior to adoption, amendment or  
946 rescission, any rule or regulation shall be submitted to the commissioner of public health for  
947 approval; (ii) may, subject to the approval of the commissioner of public health, appoint an

948 executive director and a legal counsel; (iii) may appoint such other assistants as may be required;  
949 and (iv) may make contracts and arrangements for the performance of administrative and similar  
950 services required, or appropriate, in the performance of the duties of the board.

951 SECTION 45. Said chapter 13 is hereby further amended by striking out section 10A, as  
952 so appearing, and inserting in place thereof the following section:-

953 Section 10A. The commissioner of public health shall review and approve any rule or  
954 regulation proposed by the board of registration in medicine pursuant to section 10 or any other  
955 General Law. Such rule or regulation shall be deemed disapproved unless approved within 30  
956 days of submission to the commissioner pursuant to said section 10.

957 SECTION 46. Chapter 29 of the General Laws is hereby amended by striking section  
958 2TTTT, as so appearing, and inserting in place thereof the following section:-

959 Section 2TTTT. (a) For the purposes of this section the following words shall have the  
960 following meanings:

961 “Case mix”, the description and categorization of a hospital’s patient population  
962 according to criteria determined by the center for health information and analysis including, but  
963 not limited to, primary and secondary diagnoses, primary and secondary procedures, illness  
964 severity, patient age and source of payment.

965 “Commercial volume”, the proportion of patients that seek care at an acute care hospital  
966 that are insured by private carriers.

967 “Dispersed service area,” a geographic area of the commonwealth in which a provider  
968 organization delivers health care services.

969 “Major service category”, a set of service categories as specified by the center for health  
970 information and analysis, including: (i) acute hospital inpatient services, by major diagnostic  
971 category; (ii) outpatient and ambulatory services, by categories as defined by the Centers for  
972 Medicare and Medicaid Services, or as specified by the center for health information and  
973 analysis, including a residual category for “all other” outpatient and ambulatory services that do  
974 not fall within a defined category; (iii) behavioral health services; (iv) professional services, by  
975 categories as defined by the Centers for Medicare and Medicaid Services, or as specified by the  
976 center for health information and analysis; and (v) sub-acute services, by major service line or  
977 clinical offering, as specified by the center for health information and analysis.

978 “Medicaid volume”, the proportion of patients that seek care at an acute care hospital that  
979 are insured by a state medicaid program.

980 “Primary service area”, a geographic area of the commonwealth in which consumers are  
981 likely to travel to obtain health services.

982 “Relative price”, the contractually negotiated amounts paid to providers by each private  
983 and public carrier for health care services, including non-claims related payments and expressed  
984 in the aggregate relative to the payer’s network-wide average amount paid to providers, as  
985 calculated pursuant to section 10 of chapter 12C.

986 (b) There shall be established and set upon the books of the commonwealth a separate  
987 fund to be known as the Community Hospital Reinvestment Trust Fund. Funds shall be  
988 expended, without further appropriation, by the secretary of health and human services. The  
989 fund shall consist of money from public and private sources, such as gifts, grants and donations,  
990 interest earned on such revenues, any other money authorized by the general court and

991 specifically designated to be credited to the fund, and any funds provided from other sources.  
992 Money in the fund shall be used to provide annual financial support, consistent with the terms of  
993 this section, to eligible acute care hospitals. The secretary of health and human services, as  
994 trustee, shall administer the fund and shall make expenditures from the fund consistent with this  
995 section.

996 (c) The secretary of health and human services may incur expenses and the comptroller  
997 may certify amounts for payment in anticipation of expected receipts; provided, however, that no  
998 expenditure shall be made from the fund which shall cause the fund to be deficient at the close of  
999 a fiscal year. Revenues deposited in the fund that are unexpended at the end of a fiscal year shall  
1000 not revert to the general fund and shall be available for expenditure in the following fiscal year.

1001 (d) The secretary of health and human services shall annually direct payments from the  
1002 fund to eligible acute care hospitals. To be eligible to receive payment from the fund, an acute  
1003 care hospital shall be licensed under section 51 of chapter 111, and shall not be a hospital with  
1004 relative prices that are at or above the 90th percentile of the statewide median relative price. In  
1005 directing payments, the secretary of health and human services shall allocate payments to  
1006 eligible acute care hospitals based on the proportion of each eligible acute care hospital's total  
1007 gross patient service revenue to the combined gross patient service revenue of all eligible acute  
1008 care hospitals in the prior hospital rate year; provided, however, that payments shall be adjusted  
1009 to allocate proportionally greater payments to eligible acute care hospitals with relative prices  
1010 that fall farthest below the 90th percentile of the statewide median relative price and shall also  
1011 consider: (i) medicaid volume; (ii) commercial volume; (iii) major service categories not readily  
1012 offered by providers within the same primary service areas and dispersed service areas; (iv) case  
1013 mix; (v) affiliation status; and (vi) availability of other state and federal supplemental payments.

1014 (e) The secretary of health and human services shall annually direct payments from the  
1015 fund to eligible acute care hospitals. To be eligible to receive payment from the fund, an acute  
1016 care hospital shall be licensed under section 51 of chapter 111. In directing payments, the  
1017 secretary of health and human services shall allocate payments to eligible acute care hospitals  
1018 based on the proportion of each eligible acute care hospital's total gross patient service revenue  
1019 to the combined gross patient service revenue of all eligible acute care hospitals in the prior  
1020 hospital rate year and shall also consider: (i) medicaid volume; (ii) commercial volume; (iii)  
1021 major service categories not readily offered by providers within the same primary service areas  
1022 and dispersed service areas; (iv) case mix; (v) affiliation status; (vi) availability of other state and  
1023 federal supplemental payments; and (vii) relative price.

1024 (f) The secretary of health and human services shall promulgate regulations necessary to  
1025 carry out this section, including regulations establishing a formula to allocate payments pursuant  
1026 to subsection (e).

1027 (g) Not later than 30 days after payments are allocated to eligible acute care hospitals  
1028 under this section, the secretary of health and human services shall file a report with the joint  
1029 committee on health care financing and the house and senate committees on ways and means  
1030 detailing the allocation and recipient of each payment.

1031 (h) The secretary shall expend not less than \$15,000,000 annually to community health  
1032 centers based on financial need. All expenditures shall have 1 or more of the following purposes:  
1033 (1) to improve and enhance the ability of community health centers to serve populations  
1034 efficiently and effectively through the delivery of community-based primary and preventive care,  
1035 clinical support, care coordination services, disease management services, and pharmacy



1036 management services; (2) to support health disparities reduction initiatives that address the social  
1037 factors that influence health inequality; (3) to support infrastructure investments necessary for  
1038 the transition to alternative payment methodologies, including technology investments in data  
1039 analysis functions and performance management programs, including systems to promote  
1040 provider price transparency, necessary to aggregate and analyze clinical data on a population  
1041 level; (4) to provide loan forgiveness or loan repayment programs for clinical staff, including but  
1042 not limited to, physicians, nurses, optometrists, psychiatrists and other behavioral health  
1043 clinicians, and dentists; provided, that any such program shall fund minimum loan forgiveness or  
1044 repayment of \$25,000 per clinician per year, in exchange for the clinician's commitment to  
1045 practice full time in 1 or more community health centers for 3 consecutive years; (4) to support  
1046 efforts to expand the service area of community health centers to communities that lack adequate  
1047 access to similar levels of community-based primary and preventive care; and (5) to support  
1048 efforts to improve the coordination of community care delivery and encourage the partnerships  
1049 and resource sharing among community health centers located in close proximity to one another.

1050 (i) The secretary may require as a condition of receiving payment from the fund that an  
1051 eligible community health center agree to an independent financial and operational audit to  
1052 recommend steps to increase the sustainability and efficiency of the community health center.

1053 (j) The executive office of health and human services shall promulgate regulations  
1054 necessary to carry out this section.

1055 (k) Not later than 30 days after payments are allocated to eligible community health  
1056 centers under this section, the secretary for health and human services shall file a report with the

1057 joint committee on health care finance and the house and senate committees on ways and means  
1058 detailing the allocation and recipient of each payment.

1059 SECTION 47. Chapter 29 of the General Laws is hereby further amended by inserting  
1060 after section 2YYYY the following section:-

1061 Section 2ZZZZ. There shall be a Mobile Integrated Health Care Trust Fund. The  
1062 commissioner of public health shall administer the fund and may make expenditures from the  
1063 fund to support the administration and oversight of programs certified under chapter 111O.

1064 The fund shall consist of: (i) revenue generated from fees, fines and penalties imposed  
1065 under chapter 111O; (ii) revenue from appropriations or other money authorized by the general  
1066 court and specifically designated to be credited to the fund; and (iii) funds from public or private  
1067 sources for mobile integrated health care including, but not limited to, gifts, grants, donations,  
1068 rebates and settlements received by the commonwealth that are specifically designated to be  
1069 credited to the fund. The department of public health may incur expenses and the comptroller  
1070 may certify for payment amounts in anticipation of expected receipts; provided however, that an  
1071 expenditure shall not be made from the fund that shall cause the fund to be deficient at the close  
1072 of a fiscal year. Amounts credited to the fund shall not be subject to further appropriation and  
1073 money remaining in the fund at the close of a fiscal year shall not revert to the General Fund and  
1074 shall be available for expenditure in the following fiscal year.

1075 The commissioner shall report annually, not later than October 1, to the house and senate  
1076 committees on ways and means and the joint committee on health care financing on the fund's  
1077 activity. The report shall include, but not be limited to, revenue received by the fund, revenue  
1078 and expenditure projections for the next fiscal year and details of the expenditures by the fund.

1079 SECTION 48 Section 4 of chapter 32A of the General Laws, as so appearing, is hereby  
1080 amended by inserting after the word “commonwealth”, in line 12, the following words:-

1081 ; provided, however, that the carrier or third-party health care administrator website shall  
1082 conform with uniform methodology for the communication of information about the assignment  
1083 of tiers to health care providers and health care services adopted by the center for health  
1084 information and analysis pursuant to section 25 of chapter 12C.

1085 SECTION 49. Said chapter 32A is hereby further amended by adding the following 2  
1086 sections:-

1087 Section 29. (a) For the purposes of this section, “telemedicine” shall mean the use of  
1088 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a  
1089 patient's physical, oral or mental health; provided however, that “telemedicine” shall not include  
1090 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1091 (b) Coverage offered by the commission to an active or retired employee of the  
1092 commonwealth insured under the group insurance commission shall provide coverage for health  
1093 care services through the use of telemedicine by a contracted health care provider if (i) the health  
1094 care services are covered by way of in-person consultation or delivery and (ii) the health care  
1095 services may be appropriately provided through the use of telemedicine.

1096 (c) Coverage for telemedicine services may include utilization review, including  
1097 preauthorization, to determine the appropriateness of telemedicine as a means of delivering a  
1098 health care service; provided that, the determination shall be made in the same manner as if the  
1099 service was provided via in-person consultation or delivery.

1100 (d) Coverage for telemedicine services shall not be required to reimburse a health care  
1101 provider for a health care service that is not a covered benefit under the plan nor reimburse a  
1102 health care provider not contracted under the plan.

1103 (e) Coverage that reimburses a provider with a global payment, as defined in section 1 of  
1104 chapter 6D, shall account for the provision of telemedicine services to set the global payment  
1105 amount

1106 (f) Coverage for telemedicine services may include a deductible, copayment or  
1107 coinsurance requirement for a health care service provided through telemedicine as long as the  
1108 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance  
1109 applicable to an in-person consultation or in-person delivery of services.

1110 (g) A health care provider shall not be required to document a barrier to an in-person  
1111 visit, nor shall the type of setting where telemedicine is provided be limited for health care  
1112 services provided through telemedicine.

1113 (h) Health care services provided by telemedicine shall conform to the standards of care  
1114 applicable to the telemedicine provider's profession and specialty. Such services shall also  
1115 conform to applicable federal and state health information privacy and security standards as well  
1116 as standards for informed consent.

1117 Section 30. The commission shall require a carrier or a third party administrator with  
1118 whom a carrier contracts to use the standard quality measure set established by the center for  
1119 health information and analysis under section 14 of chapter 12C as follows: (i) the carrier or third  
1120 party administrator shall use the measures designated by the center as core measures in any  
1121 contract between a health care provider, provider organization or accountable care organization

1122 that incorporates quality measures into payment terms; (ii) the carrier or third party administrator  
1123 may use the measures designated by the center as non-core measures in any contract with a  
1124 health care provider, provider organization or accountable care organization that incorporates  
1125 quality measures into payment terms and shall not use any measures not designated as non-core  
1126 measures; and (iii) the carrier or third party administrator shall use the measures in the standard  
1127 quality measure set established by the center to assign health care providers, provider  
1128 organizations or accountable care organizations to tiers in the design of a health plan.

1129 SECTION 50. Subsection (a) of section 6D of chapter 40J of the General Laws, as so  
1130 appearing, is hereby amended by inserting after the third sentence the following sentence:- The  
1131 institute shall partner with the health care and technology community to accelerate the creation  
1132 and adoption of digital health to drive economic growth and improve health care outcomes and  
1133 efficiency.

1134 SECTION 51. Said section 6D of said chapter 40J, as so appearing, is hereby further  
1135 amended by striking out, in lines 16 to 18, inclusive, the words “and (3) develop a plan to  
1136 complete the implementation of electronic health records systems by all providers in the  
1137 commonwealth” and inserting in place thereof the following words:- (3) develop a plan to  
1138 complete the implementation of electronic health records systems by all providers in the  
1139 commonwealth; and (4) advance the commonwealth’s economic competitiveness by supporting  
1140 the digital health industry, including the digital health industry’s role in improving the quality of  
1141 health care delivery and patient outcomes.

1142 SECTION 52. Said section 6D of said chapter 40J, as so appearing, is hereby further  
1143 amended by adding the following subsection:-

1144 (h) Notwithstanding any provision of this section to the contrary, if a significant portion  
1145 of health care providers, as determined by the institute’s director, implement and use  
1146 interoperable electronic health records systems, the institute shall prioritize achieving the goal of  
1147 improving the commonwealth’s economic competitiveness in digital health through  
1148 implementation of subsections (f) and (g).

1149 SECTION 53. Said chapter 94C of the General Laws is hereby amended by inserting  
1150 after section 21B the following section:-

1151 Section 21C. (a) For the purposes of this section, the following words shall, unless the  
1152 context clearly requires otherwise, have the following meanings:-

1153 “Cost sharing”, amounts owed by a consumer under the terms of the consumer’s health  
1154 benefit plan as defined in section 1 of chapter 176O or as required by a pharmacy benefit  
1155 manager as defined in subsection (a) of section 226 of chapter 175.

1156 “Pharmacy retail price”, the amount an individual would pay for a prescription  
1157 medication at a pharmacy if the individual purchased that prescription medication at that  
1158 pharmacy without using a health benefit plan as defined in section 1 of chapter 176O or any  
1159 other prescription medication benefit or discount.

1160 “Registered pharmacist”, a pharmacist who holds a valid certificate of registration issued  
1161 by the board of registration in pharmacy pursuant to section 24 of chapter 112.

1162 (b) A pharmacy shall post a notice informing consumers that a consumer may request, at  
1163 the point of sale, the current pharmacy retail price for each prescription medication the consumer  
1164 intends to purchase. If the consumer’s cost-sharing amount for a prescription medication exceeds

1165 the current pharmacy retail price, the pharmacist, or an authorized individual at the direction of a  
1166 pharmacist, shall notify the consumer that the pharmacy retail price is less than the patient's cost-  
1167 sharing amount. The pharmacist shall charge the consumer the applicable cost-sharing amount or  
1168 the current pharmacy retail price for that prescription medication, as directed by the consumer.

1169 A pharmacist shall not be subject to a penalty by the board of registration in pharmacy or  
1170 a third party for failure to comply with this section.

1171 (c) A contractual obligation shall not prohibit a pharmacist from complying with this  
1172 section; provided however, that a pharmacist shall submit a claim to the consumer's health  
1173 benefit plan or its pharmacy benefit manager if the pharmacist has knowledge that the  
1174 prescription medication is covered under the consumer's health benefit plan.

1175 (d) Failure to post notice pursuant to subsection (b) shall be an unfair or deceptive act of  
1176 practice under chapter 93A.

1177 SECTION 54. Section 2G of chapter 111 of the General Laws is hereby repealed.

1178 SECTION 55. Section 2H of said chapter 111 is hereby repealed.

1179 SECTION 56. Section 4N of said chapter 111 is hereby repealed.

1180 SECTION 57. Section 25A of said chapter 111, as appearing in the 2016 Official Edition,  
1181 is hereby amended by striking out the first sentence and inserting in place thereof the following  
1182 sentence:-

1183 Under the direction of the health planning council established under section 19 of chapter  
1184 6D, the commission shall establish and maintain, on a current basis, an inventory of all health  
1185 care resources together with all other reasonably pertinent information concerning such

1186 resources, in order to identify the location, distribution and nature of all such resources in the  
1187 commonwealth.

1188 SECTION 58. Said section 25A of said chapter 111, as so appearing, is hereby further  
1189 amended by striking out, in lines 16 and 17 , the words “in a designated office of the department”  
1190 and inserting in place thereof the following words:- as determined by the health planning council  
1191 established under section 19 of chapter 6D.

1192 SECTION 59. Said section 25A of said chapter 111, as so appearing, is hereby further  
1193 amended by striking out the fourth paragraph.

1194 SECTION 60. Section 51H of said chapter 111, as so appearing, is hereby amended by  
1195 striking out, in lines 4 and 5, the words “mothers or clinic providing ambulatory surgery as  
1196 defined in section 25B” and inserting in place thereof the following words:- mothers, clinic  
1197 providing ambulatory surgery as defined in section 25B, limited service clinic licensed pursuant  
1198 to section 51J, office-based surgery facility licensed pursuant to section 51L, or urgent care  
1199 center licensed pursuant to section 51M.

1200 SECTION 61. Said Chapter 111 is hereby further amended by inserting after section  
1201 51K, inserted by section 46 of chapter 47 of the acts of 2017 the following 2 sections:-

1202 Section 51L. (a) For the purposes of this section the following words shall, unless the  
1203 context clearly requires otherwise, have the following meanings:-

1204 "Deep sedation", a drug-induced depression of consciousness during which: (i) the  
1205 patient cannot be easily aroused but responds purposefully following repeated painful  
1206 stimulation; (ii) the patient's ability to maintain independent ventilatory function may be



1207 impaired; (iii) the patient may require assistance in maintaining a patent airway and spontaneous  
1208 ventilation may be inadequate; and (iv) the patient's cardiovascular function is usually  
1209 maintained without assistance.

1210 "General anesthesia", a drug-induced depression of consciousness during which: (i) the  
1211 patient is not arousable, even by painful stimulation; (ii) the patient's ability to maintain  
1212 independent ventilatory function is often impaired; (iii) the patient, in many cases, often requires  
1213 assistance in maintaining a patent airway and positive pressure ventilation may be required  
1214 because of depressed spontaneous ventilation or drug-induced depression of neuromuscular  
1215 function; and (iv) the patient's cardiovascular function may be impaired.

1216 "Moderate sedation", a drug-induced depression of consciousness during which: (i) the  
1217 patient responds purposefully to verbal commands, either alone or accompanied by light tactile  
1218 stimulation; (ii) no interventions are required to maintain a patent airway; (iii) spontaneous  
1219 ventilation is adequate; and (iv) the patient's cardiovascular function is usually maintained  
1220 without assistance.

1221 "Minimal sedation", a drug-induced state during which: (i) patients respond normally to  
1222 verbal commands; (ii) cognitive function and coordination may be impaired; and (iii) ventilatory  
1223 and cardiovascular functions are unaffected.

1224 "Minor procedures", (i) procedures that can be performed safely with a minimum of  
1225 discomfort where the likelihood of complications requiring hospitalization is minimal; (ii)  
1226 procedures performed with local or topical anesthesia; or (iii) liposuction with removal of less  
1227 than 500 cc of fat under unsupplemented local anesthesia.

1228 "Office-based surgical services", any ambulatory surgical or other invasive procedure  
1229 requiring (i) general anesthesia, (ii) moderate sedation, or (iii) deep sedation, and any liposuction  
1230 procedure, excluding minor procedures and procedures requiring minimal sedation, where such  
1231 surgical or other invasive procedure or liposuction is performed by a practitioner at an office-  
1232 based surgical center.

1233 "Office-based surgical center", an office, group of offices, or a facility, or any portion  
1234 thereof owned, leased or operated by 1 or more practitioners engaged in a solo or group practice,  
1235 however organized, whether conducted for profit or not for profit, which is advertised,  
1236 announced, established, or maintained for the purpose of providing office-based surgical  
1237 services; provided, however, that "office-based surgical center" shall not include: (i) a hospital  
1238 licensed under section 51 or by the federal government, (ii) an ambulatory surgical center as  
1239 defined pursuant to section 25B and licensed under section 51, or (iii) a surgical center  
1240 performing services in accordance with sections 12I to 12U, inclusive, of chapter 112.

1241 (b) The department shall establish rules, regulations, and practice standards for the  
1242 licensing of office-based surgical centers licensed under this section. In determining regulations  
1243 and practice standards necessary for licensure as an office-based surgical center, the department  
1244 may, at its discretion determine which regulations applicable to an ambulatory surgical center, as  
1245 defined by section 25B, shall apply to an office-based surgical center pursuant to this section.

1246 (c) The department shall issue for a term of 2 years, and renew for a like term, a license  
1247 to maintain an office-based surgical center to an entity or organization that demonstrates to the  
1248 department that it is responsible and suitable to maintain such a center. An office-based surgical  
1249 center license shall list the specific locations on the premises where surgical services are

1250 provided. In the case of the transfer of ownership of an office-based surgical center, the  
1251 application of the new owner for a license, when filed with the department on the date of transfer  
1252 of ownership, shall have the effect of a license for a period of 3 months.

1253 (d) An office-based surgical center license shall be subject to suspension, revocation or  
1254 refusal to issue or to renew for cause if, in its reasonable discretion, the department determines  
1255 that the issuance of such license would be inconsistent with or opposed to the best interests of the  
1256 public health, welfare or safety. Nothing in this subsection shall limit the authority of the  
1257 department to require a fee, impose a fine, conduct surveys and investigations or to suspend,  
1258 revoke or refuse to renew a license pursuant to subsection (c).

1259 (e) Initial application and renewal fees for the license shall be established pursuant to  
1260 section 3B of chapter 7.

1261 (f) The department may impose a fine of up to \$10,000 on a person or entity that  
1262 advertises, announces, establishes, maintains an office-based surgical center without a license  
1263 granted by the department. The department may impose a fine of not more than \$10,000 on a  
1264 licensed office-based surgical center that violates this section or any rule or regulation  
1265 promulgated hereunder. Each day during which a violation continues shall constitute a separate  
1266 offense. The department may conduct surveys and investigations to enforce compliance with this  
1267 section.

1268 (g) Notwithstanding any general or special rule to the contrary, the department may issue  
1269 a 1-time provisional license to an applicant for an office-based surgical center licensed pursuant  
1270 to this section if such office-based surgical center holds a current accreditation from the  
1271 Accreditation Association for Ambulatory Health Care, American Association for Accreditation

1272 of Ambulatory Surgery Facilities, Inc., or The Joint Commission, or holds a current certification  
1273 for participation in either Medicare or Medicaid. The department may approve such a provisional  
1274 application upon a finding of responsibility and suitability and that the center meets all other  
1275 licensure requirements as determined by the department. Such provisional license issued to an  
1276 office-based surgical center shall not be extended or renewed.

1277 Section 51M. (a) For the purposes of this section the following words shall, unless the  
1278 context clearly requires otherwise, have the following meanings:-

1279 “Emergency services”, as defined in section 1 of chapter 6D.

1280 “Urgent care services” a model of episodic care for the diagnosis, treatment, management  
1281 or monitoring of acute and chronic disease or injury that is: (i) for the treatment of illness or  
1282 injury that is immediate in nature but does not require emergency services; (ii) provided on a  
1283 walk-in basis without a prior appointment; (iii) available to the general public during times of the  
1284 day, weekends or holidays when primary care provider offices are not customarily open; and (iv)  
1285 is not intended, and should not be used for, preventative or routine services.

1286 “Urgent care center”, a clinic owned or operated by an entity, however organized,  
1287 whether conducted for profit or not for profit, which is advertised, announced, established, or  
1288 maintained for the purpose of providing urgent care services in an office or a group of offices, or  
1289 any portion thereof; provided, however, that “urgent care center” shall not include: (i) a hospital  
1290 licensed under section 51 or operated by the federal government or by the commonwealth, (ii) a  
1291 clinic licensed under section 51, (iii) a limited service clinic licensed under section 51J or (iv) a  
1292 community health center receiving a grant under 42 U.S.C. 254b as defined by .

1293 (b) The department shall establish rules, regulations, and practice standards for the  
1294 licensing of urgent care centers licensed under this section. In determining regulations and  
1295 practice standards necessary for licensure as an urgent care center, the department may, at its  
1296 discretion determine which regulations applicable to a clinic licensed under section 51, shall  
1297 apply to an urgent care center pursuant to this section.

1298 (c) The department shall issue for a term of 2 years, and renew for a like term, a license  
1299 to maintain an urgent care center to an entity or organization that demonstrates to the department  
1300 that it is responsible and suitable to maintain such a center. In the case of the transfer of  
1301 ownership of an urgent care center, the application of the new owner for a license, when filed  
1302 with the department on the date of transfer of ownership, shall have the effect of a license for a  
1303 period of 3 months.

1304 (d) An urgent care center license shall be subject to suspension, revocation or refusal to  
1305 issue or to renew for cause if, in its reasonable discretion, the department determines that the  
1306 issuance of such license would be inconsistent with or opposed to the best interests of the public  
1307 health, welfare or safety. Nothing in this subsection shall limit the authority of the department to  
1308 require a fee, impose a fine, conduct surveys and investigations or to suspend, revoke or refuse to  
1309 renew a license pursuant to subsection (c).

1310 (e) Initial application and renewal fees for the license shall be established pursuant to  
1311 section 3B of chapter 7.

1312 (f) The department may impose a fine of up to \$10,000 on a person or entity that  
1313 advertises, announces, establishes, maintains an urgent care center without a license granted by  
1314 the department. The department may impose a fine of not more than \$10,000 on a licensed

1315 urgent care center that violates this section or any rule or regulation promulgated hereunder.  
1316 Each day during which a violation continues shall constitute a separate offense. The department  
1317 may conduct surveys and investigations to enforce compliance with this section.

1318 (g) Notwithstanding any general or special rule to the contrary, the department may issue  
1319 a 1-time provisional license to an applicant for an urgent care center licensed pursuant to this  
1320 section if such urgent care center holds a current accreditation from the Accreditation  
1321 Association for Ambulatory Health Care, Urgent Care Association of America, or The Joint  
1322 Commission, or holds a current certification for participation in either Medicare or Medicaid.  
1323 The department may approve such provisional application upon a finding of responsibility and  
1324 suitability and that the center meets all other licensure requirements as determined by the  
1325 department. Such provisional license issued to an urgent care center shall not be extended or  
1326 renewed.

1327 SECTION 62. Chapter 111 is hereby further amended by striking out section 52, as  
1328 appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

1329 Section 52. For the purposes of sections 51 to 56, inclusive, the following words shall,  
1330 unless the context clearly requires otherwise, have the following meanings:-

1331 “Certified clinical specialist in psychiatric and mental health nursing”, a registered nurse  
1332 licensed under section 80B of chapter 112 and authorized by the board of registration in nursing  
1333 to practice as a certified clinical specialist in psychiatric and mental health nursing.

1334 “Hospital”, any institution, however named, whether conducted for charity or for profit,  
1335 which is advertised, announced, established or maintained for the purpose of caring for persons

1336 admitted thereto for diagnosis, medical, surgical or restorative treatment which is rendered  
1337 within said institution.

1338 “Institution for unwed mothers”, any institution or place, however named, whether  
1339 conducted for charity or profit which is advertised, announced, established or maintained for the  
1340 purpose of caring for 1 or more unwed mothers admitted thereto, on a resident basis, for prenatal  
1341 care, supervision and short-term postnatal care.

1342 “Limited services”, diagnosis, treatment, management and monitoring of acute and  
1343 chronic disease, wellness and preventative services of a nature that may be provided within the  
1344 scope of practice of a nurse practitioner using available facilities and equipment, including  
1345 shared toilet facilities for point-of-care testing.

1346 “Limited services clinic”, a clinic that provides limited services as defined by section 51J.

1347 “Office-based surgical center”, a clinic that is licensed to provide office-based surgical  
1348 services pursuant to section 51L

1349 “Urgent care center”, a clinic that is licensed to provide urgent care services pursuant to  
1350 section 51M

1351 “Clinic”, any entity, however organized, whether conducted for profit or not for profit,  
1352 which is advertised, announced, established, or maintained for the purpose of providing  
1353 ambulatory medical services, surgical services, dental services, limited services, office-based  
1354 surgical services, physical rehabilitation services, mental health services or urgent care services;  
1355 provided, however, that except for a limited service clinic licensed under section 51J, an office-  
1356 based surgical center licensed under section 51L or an urgent care center licensed under section

1357 51M, “clinic” shall not include a medical office building, or 1 or more practitioners engaged in a  
1358 solo or group practice, whether conducted for profit or not for profit, and however organized, so  
1359 long as such practice is wholly owned and controlled by 1 or more of the practitioners so  
1360 associated, or, in the case of a not for profit organization, its only members are 1 or more of the  
1361 practitioners so associated or a clinic established solely to provide service to employees or  
1362 students of such corporation or institution. For purposes of this section, clinic shall not include a  
1363 clinic conducted by a hospital licensed under section 51 or operated by the federal government or  
1364 by the commonwealth.

1365 “Original license”, a license issued to a hospital, institution for unwed mothers or clinic,  
1366 not previously licensed; or a license issued to an existing hospital, institution for unwed mothers  
1367 or clinic, in which there has been a change in ownership or location.

1368 “Out-of-hospital dialysis unit”, a unit, however named, maintained separately from a  
1369 hospital or a license issued thereto, whether conducted for charity or for profit, for the purpose of  
1370 providing dialysis treatment to persons suffering from renal disease. It shall not include a dialysis  
1371 unit maintained as part of a hospital.

1372 “Practitioner”, any individual who may diagnose and treat medical, surgical, dental,  
1373 physical rehabilitation, or mental health problems without limitation within the confines of his or  
1374 her profession.

1375 “Rural hospital”, an acute-care hospital as defined in section 25B and licensed under this  
1376 chapter, which: (1) has been designated by the department as a rural hospital based on bed size,  
1377 city or town population, and population density of the city, town, service area or county as  
1378 determined by the department through regulation; or (2) a hospital currently designated as a



1379 critical access hospital by the United States Department of Health and Human Services in  
1380 accordance with federal regulations and state requirements.

1381 SECTION 63. Said chapter 111 is hereby further amended by striking out section 228, as  
1382 so appearing, and inserting in place thereof the following 2 sections:-

1383 Section 228. (a) As used in this section and in section 228A, the following words shall,  
1384 unless the context clearly requires otherwise, have the following meanings:-

1385 “Allowed amount”, the contractually agreed upon amount paid by a carrier to a health  
1386 care provider for health care services provided to an insured.

1387 “Carrier”, as defined in section 1 of chapter 176O.

1388 “Emergency services”, as defined in section 1 of chapter 6D.

1389 “Facility”, as defined in section 1 of chapter 6D.

1390 “Facility fee”, a fee charged or billed by a health care provider, health care provider  
1391 group or a hospital for outpatient hospital services provided in a hospital-based facility that is  
1392 intended to compensate the health care provider, health care provider group or a hospital for the  
1393 operational expenses and is separate and distinct from a professional fee.

1394 “Hospital”, as defined in section 1 of chapter 6D.

1395 “Hospital-based facility”, a facility that is owned or operated, in whole or in part, by a  
1396 health care provider, health care provider group or a hospital where health care services are  
1397 provided.

1398 “In-network cost-sharing amount”, as defined in section 1 of chapter 176O.

1399 “Insured”, as defined in section 1 of chapter 176O.

1400 “Network provider”, as defined in section 1 of chapter 176O

1401 “Network Status”, as defined in section 1 of chapter 176O.

1402 “Out-of-network provider”, as defined in section 1 of chapter 176O.

1403 “Prior written consent”, a signed written consent form provided to a patient or  
1404 prospective patient by an out-of-network provider at least 24 hours in advance of the out-of-  
1405 network provider rendering health care services, other than for emergency services, to such  
1406 patient or prospective patient or, if that person lacks capacity to consent, signed by the person  
1407 authorized to consent for such a patient or prospective patient. A prior written consent form shall  
1408 be presented in a manner and format to be determined by the commissioner of public health in  
1409 consultation with the division of insurance;; provided, that such consent form shall be a  
1410 document that is separate from any other document used to obtain the consent of the patient or  
1411 prospective patient for any other part of the care or procedure; and provided further, that such  
1412 consent form shall include: (i) a statement affirming that the out-of-network provider has  
1413 disclosed its out-of-network status to the patient or prospective patient; (ii) a statement  
1414 affirming that the out-of-network provider informed the patient or prospective patient that  
1415 services rendered by an out-of-network provider may result in costs not covered by the patient’s  
1416 or prospective patient’s carrier or specific health benefit plan; (iii) a statement affirming that the  
1417 out-of-network provider informed the patient or prospective patient that services may be  
1418 available from a contracted provider and that the patient or prospective patient is not required to  
1419 obtain care from the out-of-network provider; (iv) a statement affirming that the out-of-network  
1420 provider presented the patient or prospective patient with a written estimate of the patient or

1421 prospective patient's total out-of-pocket cost of care for the admission, service or procedure; and  
1422 (v) an affirmative declaration of the patient's or prospective patient's consent to receive health  
1423 care services from the out-of-network provider, signed by the patient or prospective patient, or  
1424 by the person authorized to consent for such a patient or prospective patient.

1425 "Professional fee", a fee charged or billed by a hospital, provider or provider  
1426 organization for professional medical services provided in a hospital-based facility.

1427 (b) At the time of scheduling an admission, procedure or service for an insured patient or  
1428 prospective patient, a health care provider shall: (i) determine the provider's own network status  
1429 relative to insured's insurance carrier and specific health benefit plan and disclose in real time  
1430 such network status to the insured; (ii) notify the patient or prospective patient of their right to  
1431 request and obtain from the provider, based on information available to the provider at the time  
1432 of the request, additional information on the network status of any provider reasonably expected  
1433 to render services in the course of such admission, procedure or service that is necessary for the  
1434 patient's or prospective patient's use of a health benefit plan's toll-free number and website  
1435 available pursuant to section 23 of chapter 176O to obtain additional information about that  
1436 provider's network status under the patient's or prospective patient's health benefit plan and any  
1437 applicable out-of-pocket costs for services sought from such provider; (iii) notify the patient or  
1438 prospective patient of their right to request and obtain from the provider, based on information  
1439 available to the provider at the time of the request, information on such admission, procedure or  
1440 service that is necessary for the patient's or prospective patient's use of a health benefit plan's  
1441 toll-free number and website available pursuant to section 23 of chapter 176O to identify the  
1442 allowed amount or charge of the admission, procedure or service, including the amount for any  
1443 facility fees required; (iv) notify the patient or prospective patient that in the event a health care

1444 provider is unable to quote a specific allowed amount or charge in advance of the admission,  
1445 procedure or service due to the health care provider's inability to predict the specific treatment or  
1446 diagnostic code, the health care provider shall disclose to the patient or prospective patient the  
1447 estimated maximum allowed amount or charge for a proposed admission, procedure or service,  
1448 including the amount for any facility fees required; and (iv) inform the patient or prospective  
1449 patient that the estimated costs and the actual amount the patient or prospective patient may be  
1450 responsible to pay may vary due to unforeseen services that arise out of the proposed admission,  
1451 procedure or service. This subsection shall not apply in cases of emergency services provided to  
1452 a patient.

1453 (c) If a network provider schedules, orders or otherwise arranges for services related to  
1454 an insured's admission, procedure or service and such services are performed by another health  
1455 care provider, or if a network provider refers an insured to another health care provider for an  
1456 admission, procedure or service, then in addition to the actions required pursuant to subsection  
1457 (b) the network provider shall, based on information available to the provider at that time: (i)  
1458 disclose to the insured if the provider to whom the patient is being referred is part of or  
1459 represented by the same provider organization registered pursuant to section 11 of chapter 6D;  
1460 (ii) disclose to the insured sufficient information about such provider for the patient to obtain  
1461 information about that provider's network status under the insured's health benefit plan and  
1462 identify any applicable out-of-pocket costs for services sought from such provider through the  
1463 toll-free number and website of the insurance carrier available pursuant to section 23 of chapter  
1464 176O; and (iii) notify the insured that if the health care provider is out-of-network under the  
1465 patient's health insurance policy, that the admission, service or procedure will likely be deemed

1466 out-of-network and that any out-of-network applicable rates under such policy may apply. This  
1467 subsection shall not apply in cases of emergency services provided to a patient.

1468 (d) At the time of scheduling an admission, procedure or service for an insured patient or  
1469 prospective patient, an out-of-network provider shall, in addition to the actions required pursuant  
1470 to subsection (b) and at least 24 hours in advance of care: (i) disclose to the insured that the  
1471 provider does not participate in the insured's health benefit plan network; (ii) provide the insured  
1472 with the estimated or maximum charge that the provider will bill the insured for the admission,  
1473 procedure or service if rendered as an out-of-network service, including the amount of any  
1474 facility fees; (iii) inform the patient or prospective patient that additional information on  
1475 applicable out-of-pocket costs for out-of-network services may be obtained through the toll-free  
1476 number and website of the insurance carrier available pursuant to section 23 of chapter 176O;  
1477 and (iv) obtain the prior written consent of such patient or prospective patient in advance of the  
1478 out-of-network provider rendering health care services. This subsection shall not apply in cases  
1479 of emergency services provided to a patient.

1480 (e) Substantial compliance with this section shall be a condition of licensure for health  
1481 care providers licensed under chapter 111 or chapter 112.

1482 Section 228A. (a) A hospital, hospital-based facility or a health care provider that charges  
1483 or bills a facility fee for services shall provide any patient receiving such a service with written  
1484 notice of the fee. The notice shall include the following: (i) a statement of disclosure informing  
1485 the patient that the hospital, hospital-based facility, or provider has charged or billed a facility  
1486 fee that is in addition to and separate from the professional fee charged by the provider; (ii) the  
1487 amount of the facility fee charged or billed, or, if the exact type and extent of the facility fee is

1488 not known with reasonable certainty, an estimate of the facility fee; (iii) a statement that the  
1489 patient's actual financial liability will depend on the professional medical services actually  
1490 provided to the patient; (iv) an explanation that the patient may incur financial liability that is  
1491 greater than the patient would incur if the professional medical services were not provided by a  
1492 hospital-based facility; and (v) that a patient covered by a health insurance policy should contact  
1493 the health insurer to receive information about alternative providers that do not charge a facility  
1494 fee.

1495 (b) A hospital, hospital-based facility, or a health care provider that charges or bills a  
1496 facility fee for services shall provide the notice required pursuant to subsection (a) for any  
1497 admission, procedure or service occurring more than 5 working days from the date the  
1498 appointment is made within a reasonable manner as determined by the commissioner. For any  
1499 such admission, procedure or service occurring 5 or fewer working days from the date the  
1500 appointment is made, or if the patient arrives without an appointment, then the notice required  
1501 pursuant to subsection (a) shall be given orally at the time the patient makes the appointment,  
1502 and written notice shall be provided to the patient prior to the service when the patient arrives at  
1503 the hospital or hospital-based facility's premises.

1504 (c) If a hospital or health system designates a location as a hospital-based facility the  
1505 facility shall clearly identify the facility as being hospital-based, including by stating the name of  
1506 the hospital or health system in the facility's signage, marketing materials, Internet web sites and  
1507 stationery.

1508 (d) If a hospital-based facility charges a facility fee, notice shall be posted informing  
1509 patients that a patient may incur additional financial liability due to the hospital-based facility's

1510 status. Notice shall be prominently displayed on the website of the hospital, health system and  
1511 hospital-based facility in a manner proscribed by the commissioner in designated locations  
1512 accessible to and visible by patients, including in patient waiting areas.

1513 (e) The notices and statements required under this section shall be in plain language and  
1514 in a form that may be reasonably understood by a patient who does not possess special  
1515 knowledge regarding hospital or health system facility fee charges. All notices under this section  
1516 shall be available in all languages representative of that health care provider's patient population.

1517 (f) The commissioner may promulgate regulations that are necessary to implement this  
1518 section.

1519 SECTION 64. Section 1 of chapter 111O of the General Laws, as so appearing, is hereby  
1520 amended by inserting after the definition of "Mobile integrated health care" the following  
1521 definition:-

1522 "Mobile integrated health care provider" or "MIH provider", a licensed health care  
1523 professional delivering medical care and services to patients in an out-of-hospital environment in  
1524 coordination with health care facilities or other health care providers; provided, however, that  
1525 medical care and services shall include, but shall not be limited to, community paramedic  
1526 provider services, chronic disease management, behavioral health, preventative care, post-  
1527 discharge follow-up visits or transport or referral to facilities other than hospital emergency  
1528 departments; provided further, that medical care and services shall be delivered under a mobile  
1529 integrated health care program approved by the department using mobile health care resources.

1530 SECTION 65. Section 2 of said chapter 111O, as so appearing, is hereby amended by  
1531 adding the following 2 subsections:-

1532 (c) The department shall issue guidance, in consultation with the advisory council, on  
1533 best practices for structuring mobile integrated health care programs to obtain reimbursement for  
1534 the care and services delivered to patients who are covered by public or private payers.

1535 (d) Annually, not later than March 1, the department shall report the data collected from  
1536 MIH programs pursuant to subsection (b). The report shall include, but not be limited to, an  
1537 analysis of the impact of MIH programs on: (i) 30-day readmission rates; (ii) siting of post-acute  
1538 care treatment; (iii) incidence of emergency department presentment for behavioral health  
1539 conditions; (iv) incidence of emergency department presentment for chronic conditions; and (v)  
1540 the variance in each of the preceding metrics within and between Medicaid claims and  
1541 commercial claims, respectively. The department may consult with the center for health  
1542 information and analysis in developing the report. The report shall be made publicly available  
1543 and easily searchable on the department's website.

1544 SECTION 66. Said chapter 111O is hereby further amended by adding the following  
1545 section:-

1546 Section 5. (a) The department shall by regulation establish application fees that shall  
1547 include, but shall not be limited to, an initial application surcharge in addition to a general  
1548 application or renewal fee, and a timeline for reviewing applications for mobile integrated health  
1549 care or community EMS programs.

1550 (b) Application fees and surcharges collected pursuant to this chapter shall be deposited  
1551 into the Mobile Integrated Health Care Trust Fund established in section 2ZZZZ of chapter 29.



1552 (c) The department shall prioritize the review and processing of mobile integrated health  
1553 care program applicants that have been approved as MassHealth accountable care organizations  
1554 or that have targeted patient populations served by MassHealth accountable care organizations.

1555 SECTION 67. Chapter 112 of the General Laws is hereby amended by inserting after  
1556 section 5N the following section:-

1557 Section 5O. (a) For the purposes of this section, “telemedicine” shall mean the use of  
1558 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a  
1559 patient's physical, oral or mental health; provided however, that “telemedicine” shall not include  
1560 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1561 (b) Notwithstanding any other provision of this chapter, the board shall allow a physician  
1562 licensed by the board to obtain proxy credentialing and privileging for telemedicine services with  
1563 other health care providers, as defined in section 1 of chapter 111, or facilities consistent with  
1564 Medicare conditions of participation telemedicine standards.

1565 (c) The board shall promulgate regulations regarding the appropriate use of telemedicine  
1566 to provide health care services. These regulations shall provide for and include, but shall not be  
1567 limited to: (i) prescribing medications; (ii) services that are not appropriate to provide through  
1568 telemedicine; (iii) establishing a patient-provider relationship; (iv) consumer protections; and (v)  
1569 ensuring that services comply with appropriate standards of care.

1570 SECTION 68. Chapter 118E of the General Laws is hereby amended by inserting after  
1571 section 25 the following section:

1572           Section 25A. The division shall disregard income in an amount equivalent to 150 percent  
1573 of the federal poverty level, as adjusted annually, in determining eligibility for the Qualified  
1574 Medicare Beneficiary, Specified Low-Income Medicare Beneficiary and Qualified Individual  
1575 programs, described in 42 U.S.C. section 1396a(a)(10)(E) and also known as the Medicare  
1576 Savings or Medicare Buy-In Programs.

1577           (b) The division shall amend its state plan and promulgate regulations to implement  
1578 subsection (a).

1579           SECTION 69. Section 28 of said chapter 118E, as appearing in the 2016 Official  
1580 Edition, is hereby amended by adding the following paragraph:-

1581           A transfer of resources to a special needs trust that conforms to 42 U.S.C. § 1396p  
1582 (d)(4)(C) and established solely for the benefit of a disabled individual of any age shall not be  
1583 treated as a disposal of resources for less than fair market value; provided, however, that the total  
1584 value of resources transferred shall not exceed \$750,000, adjusted annually on the year-to-year  
1585 increase in the Consumer Price Index.

1586           SECTION 70. Section 66 of said chapter 118E is hereby amended by striking out, in line  
1587 28, as so appearing, the first time it appears, the word “and”.

1588           SECTION 71. Said section 66 of said chapter 118E is hereby further amended by  
1589 inserting after the word “thereon”, in line 29, as so appearing, the following words:- ; and (v) any  
1590 fines collected under section 10 of chapter 6D.

1591           SECTION 72. Said chapter 118E is hereby further amended by adding the following 3  
1592 sections:-

1593           Section 79. (a) For the purposes of this section, “telemedicine” shall mean the use of  
1594 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a  
1595 patient's physical, oral or mental health; provided however, that “telemedicine” shall not include  
1596 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1597           (b) The division and its contracted health insurers, health plans, health maintenance  
1598 organizations, behavioral health management firms and third party administrators under contract  
1599 to a Medicaid managed care organization or primary care clinician plan may provide coverage  
1600 for health care services through the use of telemedicine by a contracted health care provider if (i)  
1601 the health care services are covered by way of in-person consultation or delivery and (ii) the  
1602 health care services may be appropriately provided through the use of telemedicine.

1603           (c) Coverage for telemedicine services may include utilization review, including  
1604 preauthorization, to determine the appropriateness of telemedicine as a means of delivering a  
1605 health care service, provided that the determination shall be made in the same manner as if the  
1606 service was provided via in-person consultation or delivery.

1607           (d) Coverage for telemedicine services shall not be required to reimburse a health care  
1608 provider for a health care service that is not a covered benefit under the plan nor reimburse a  
1609 health care provider not contracted under the plan.

1610           (e) Coverage that reimburses a provider with a global payment, as defined in section 1 of  
1611 chapter 6D, shall account for the provision of telemedicine services to set the global payment  
1612 amount.

1613           (f) Coverage for telemedicine services may include a deductible, copayment or  
1614 coinsurance requirement for a health care service provided through telemedicine as long as the

1615 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance  
1616 applicable to an in-person consultation or in-person delivery of services.

1617 (g) A health care provider shall not be required to document a barrier to an in-person  
1618 visit, nor shall the type of setting where telemedicine is provided be limited for health care  
1619 services provided through telemedicine.

1620 (h) Health care services provided by telemedicine shall conform to the standards of care  
1621 applicable to the telemedicine provider's profession and specialty. Such services shall also  
1622 conform to applicable federal and state health information privacy and security standards as well  
1623 as standards for informed consent.

1624 Section 80. The division and its contracted health insurers, health plans, health  
1625 maintenance organizations, behavioral health management firms and third party administrators  
1626 under contract with a Medicaid managed care organization or primary care clinician plan shall  
1627 use the standard quality measure set established by the center for health information and analysis  
1628 under section 14 of chapter 12C as follows: (i) the measures designated by the center as core  
1629 measures shall be used in any contract with a health care provider, provider organization or  
1630 accountable care organization that incorporates quality measures into payment terms; (ii) the  
1631 measures designated by the center as non-core measures may be used in any contract with a  
1632 health care provider, provider organization or accountable care organization that incorporate  
1633 quality measures into payment terms and shall not use any measures not designated as non-core  
1634 measures; (iii) measures included in the standard quality measure set shall be used to assign  
1635 health care providers, provider organizations or accountable care organizations to tiers in the  
1636 design of a program of medical benefits to a beneficiary under section 9A.

1637 Section 81. (a) For the purposes of this section the following words shall, unless the  
1638 context clearly requires otherwise, have the following meanings:-

1639 “Assessed charges”, an assessed specialty clinic's gross patient service revenue  
1640 attributable to all patients less an assessed specialty clinic's gross patient service revenue  
1641 attributable to programs under Title XVIII, XIX and XXI of the Social Security Act.

1642 “Assessed specialty clinic”, a limited service clinic licensed under section 51J, an office-  
1643 based surgical center licensed under section 51L or an urgent care clinic licensed under section  
1644 51M.

1645 “Fiscal year”, the time period of 12 months beginning on October 1 of any calendar year  
1646 and ending on September 30 of the following calendar year.

1647 “Gross patient service revenue”, the total dollar amount of an assessed specialty clinic's  
1648 charges for services rendered to all patients in a fiscal year.

1649 (b) Each assessed specialty clinic shall, in each fiscal year, pay to the executive office an  
1650 amount equal to 8.75 per cent of the total dollar amount of its assessed charges for commercial  
1651 payers. Each assessed specialty clinic shall be exempt from contributing any percentage of the  
1652 total dollar amount for its assessed charges for public payers.

1653 (c) The assessment charged pursuant to subsection (b) shall be implemented as a broad-  
1654 based health care related fee as defined in 42 U.S.C. § 1396b(w)(3)(B) and shall be paid to the  
1655 executive office on a yearly basis. The executive office may promulgate regulations that  
1656 authorize the assessment of interest on any unpaid liability at a rate not to exceed an annual  
1657 percentage rate of 18 per cent and late fees at a rate not to exceed 5 per cent per month. The

1658 receipts from the assessment, any federal financial participation received by the commonwealth  
1659 as a result of expenditures funded by these assessments and interest thereon shall be deposited in  
1660 the Community Hospital Reinvestment Trust Fund in section 2TTTT of chapter 29.

1661 (d) The secretary of the executive office shall prepare a form on which each assessed  
1662 specialty clinic shall report quarterly its total assessed charges and shall calculate the assessment  
1663 due pursuant to subsection (b). The secretary of the executive office shall distribute the forms to  
1664 each assessed specialty clinic at least annually. The failure to distribute the form or the failure to  
1665 receive a copy of the form shall not stay the obligation to pay the assessment by the date  
1666 specified in this section. The executive office may require additional reports as it considers  
1667 necessary to monitor collections and compliance.

1668 (e) The executive office shall have the authority to inspect and copy the records of an  
1669 assessed specialty clinic to audit its calculation of the assessment charged pursuant to subsection  
1670 (b). In the event that the executive office determines that an assessed specialty clinic has either  
1671 overpaid or underpaid the assessment, the executive office shall notify such assessed specialty  
1672 clinic of the amount due or refund the overpayment. The executive office may impose per diem  
1673 penalties if an assessed specialty clinic fails to produce documentation as requested by the  
1674 executive office.

1675 (f) In the event that an assessed specialty clinic is aggrieved by a decision of the  
1676 executive office as to the amount due, the assessed specialty clinic may file an appeal to the  
1677 division of administrative law appeals within 60 days of the date of the notice of underpayment  
1678 or the date the notice was received, whichever is later. The division of administrative law appeals  
1679 shall conduct each appeal as an adjudicatory proceeding under chapter 30A and an assessed

1680 specialty clinic aggrieved by a decision of the division of administrative law appeals shall be  
1681 entitled to judicial review under section 14 of said chapter 30A.

1682 SECTION 73. Section 47BB of chapter 175 of the General Laws is hereby repealed.

1683 SECTION 74. Said chapter 175, as appearing in the Official Edition, is hereby further  
1684 amended by inserting after section 47II the following section:-

1685 Section 47JJ. (a) For the purposes of this section, “telemedicine” shall mean the use of  
1686 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a  
1687 patient's physical, oral or mental health; provided however, that “telemedicine” shall not include  
1688 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1689 (b) An individual policy of accident and sickness insurance issued under section 108 that  
1690 provides hospital expense and surgical expense insurance and any group blanket or general  
1691 policy of accident and sickness insurance issued under section 110 that provides hospital expense  
1692 and surgical expense insurance which is issued or renewed within or without the commonwealth,  
1693 shall not decline to provide coverage for health care services solely on the basis that those  
1694 services were delivered through the use of telemedicine by a contracted health care provider if (i)  
1695 the health care services are covered by way of in-person consultation or delivery and (ii) the  
1696 health care services may be appropriately provided through the use of telemedicine.

1697 (c) Coverage for telemedicine services may include utilization review, including  
1698 preauthorization, to determine the appropriateness of telemedicine as a means of delivering a  
1699 health care service, provided that the determination shall be made in the same manner as if the  
1700 service was provided via in-person consultation or delivery.

1701 (d) Coverage for telemedicine services shall not be required to reimburse a health care  
1702 provider for a health care service that is not a covered benefit under the plan nor reimburse a  
1703 health care provider not contracted under the plan.

1704 (e) Coverage that reimburses a provider with a global payment, as defined in section 1 of  
1705 chapter 6D, shall account for the provision of telemedicine services to set the global payment  
1706 amount.

1707 (f) Coverage for telemedicine services may include a deductible, copayment or  
1708 coinsurance requirement for a health care service provided through telemedicine as long as the  
1709 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance  
1710 applicable to an in-person consultation or in-person delivery of services.

1711 (g) A health care provider shall not be required to document a barrier to an in-person  
1712 visit, nor shall the type of setting where telemedicine is provided be limited for health care  
1713 services provided through telemedicine.

1714 (h) Health care services provided by telemedicine shall conform to the standards of care  
1715 applicable to the telemedicine provider's profession. Such services shall also conform to  
1716 applicable federal and state health information privacy and security standards as well as  
1717 standards for informed consent.

1718 SECTION 75. Said chapter 175, as so appearing, is hereby further amended by inserting  
1719 after section 108M the following 2 sections:-

1720 Section 108N. Upon request by a network provider, a carrier and, if applicable, a  
1721 specialty organization subcontracted by a carrier to manage behavioral health services, shall



1722 disclose the methodology used for a provider's tier placement, including: (i) the criteria,  
1723 measures, data sources and provider-specific information used in determining the provider's  
1724 quality score; (ii) how the provider's quality performance compares to other in-network  
1725 providers; and (iii) the data used in calculating the provider's cost-efficiency. A carrier may  
1726 require a network provider to maintain information received under this section as confidential.

1727           Section 108O. An insurer licensed or otherwise authorized to transact accident or health  
1728 insurance under this chapter shall use the standard quality measure set established by the center  
1729 for health information and analysis under section 14 of chapter 12C as follows: (i) the insurer  
1730 shall use the measures designated by the center as core measures in any contract with a health  
1731 care provider, provider organization or accountable care organization that incorporates quality  
1732 measures into payment terms; (ii) the insurer may use the measures designated by the center as  
1733 non-core measures in any contract with a health care provider, provider organization or  
1734 accountable care organization that incorporates quality measures into payment terms and shall  
1735 not use any measures not designated as non-core measures; and (iii) the insurer shall only use the  
1736 measures in the standard quality set established by the center to assign health care providers,  
1737 provider organizations or accountable care organizations to tiers in the design of an accident or  
1738 health plan.

1739           SECTION 76. Section 5 of chapter 176A of the General Laws, as so appearing, is hereby  
1740 amended by striking out the eleventh paragraph and inserting in place thereof the following 2  
1741 paragraphs:-

1742           Notwithstanding the other requirements of this section, the commission may approve any  
1743 rate of payment to any provider or class of providers if such rate, in the opinion of the

1744 commission, contains an incentive to achieve greater efficiency and economy in the manner of  
1745 providing health care services without adversely affecting the quality of such services. In making  
1746 such an approval, the commission shall consider warranted factors of price variation, including  
1747 but not limited to: patient acuity, high-cost outliers, and quality; and unwarranted factors of price  
1748 variation, including but not limited to: market power, brand, geographic isolation, government  
1749 payment shortfalls, and research.

1750           If the commission finds that the payment rate in a contract under its review is influenced  
1751 by unwarranted factors of price variation as outlined in this section, the commissioner shall refer  
1752 the relevant health care entities to the health policy commission to file performance improvement  
1753 plans, as established in section 10A of chapter 6D.

1754           SECTION 77. Chapter 176A of the General Laws is hereby amended by adding the  
1755 following 3 sections:-

1756           Section 38. (a) For the purposes of this section, “telemedicine” shall mean the use of  
1757 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a  
1758 patient's physical, oral or mental health; provided however, that “telemedicine” shall not include  
1759 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1760           (b) A contract between a subscriber and a nonprofit hospital service corporation under an  
1761 individual or group hospital service plan shall not decline to provide coverage for health care  
1762 services solely on the basis that those services were delivered by way of telemedicine by a  
1763 contracted health care provider if (i) the health care services are covered by way of in-person  
1764 consultation or delivery and (ii) the health care services may be appropriately provided through  
1765 the use of telemedicine.

1766 (c) Coverage for telemedicine services may include utilization review, including  
1767 preauthorization, to determine the appropriateness of telemedicine as a means of delivering a  
1768 health care service, provided that the determination shall be made in the same manner as if the  
1769 service was provided via in-person consultation or delivery.

1770 (d) Coverage for telemedicine services shall not be required to reimburse a health care  
1771 provider for a health care service that is not a covered benefit under the plan nor reimburse a  
1772 health care provider not contracted under the plan.

1773 (e) Coverage that reimburses a provider with a global payment, as defined in section 1 of  
1774 chapter 6D, shall account for the provision of telemedicine services to set the global payment  
1775 amount.

1776 (f) Coverage for telemedicine services may include a deductible, copayment or  
1777 coinsurance requirement for a health care service provided through telemedicine as long as the  
1778 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance  
1779 applicable to an in-person consultation or in-person delivery of services.

1780 (g) A health care provider shall not be required to document a barrier to an in-person  
1781 visit, nor shall the type of setting where telemedicine is provided be limited for health care  
1782 services provided through telemedicine.

1783 (h) Health care services provided by telemedicine shall conform to the standards of care  
1784 applicable to the telemedicine provider's profession and specialty. Such services shall also  
1785 conform to applicable federal and state health information privacy and security standards as well  
1786 as standards for informed consent.

1787           Section 39. Upon request by a network provider, a nonprofit hospital service corporation  
1788 and, if applicable, a specialty organization subcontracted by a nonprofit hospital service  
1789 corporation to manage behavioral health services, shall disclose the methodology used for a  
1790 provider's tier placement, including: (i) the criteria, measures, data sources and provider-specific  
1791 information used in determining the provider's quality score; (ii) how the provider's quality  
1792 performance compares to other in-network providers; and (iii) the data used in calculating the  
1793 provider's cost-efficiency. A carrier may require a network provider to maintain information  
1794 received under this section as confidential.

1795           Section 40. A nonprofit hospital service corporation organized under this chapter shall  
1796 use the standard quality measure set established by the center for health information and analysis  
1797 under section 14 of chapter 12C as follows: (i) a nonprofit hospital service corporation shall use  
1798 the measures designated by the center as core measures in any contract with a health care  
1799 provider, provider organization or accountable care organization that incorporates quality  
1800 measures into payment terms; (ii) a nonprofit hospital service corporation may use the measures  
1801 designated by the center as non-core measures in any contract with a health care provider,  
1802 provider organization or accountable care organization that incorporates quality measures into  
1803 payment terms and shall not use any measures not designated as non-core measures; (iii) a  
1804 nonprofit hospital service corporation shall only use the measures in the standard quality  
1805 measure set established by the center to assign health care providers, provider organizations or  
1806 accountable care organizations to tiers in the design of a group hospital service plan.

1807           SECTION 78. Section 4 of chapter 176B of the General Laws, as so appearing, is hereby  
1808 amended by striking out the fifth paragraph and inserting in place thereof the following 2  
1809 paragraphs:-

1810 Under such a group medical service agreement, subscription certificates and the rates  
1811 charged by the corporation to the subscribers shall be filed with the commissioner within 30 days  
1812 after their effective date, and shall be subject to subsequent disapproval by the commissioner if  
1813 the commissioner finds that the benefits provided therein are unreasonable in relation to the rate  
1814 charged, or that the rates charged are excessive, inadequate or unfairly discriminatory; and  
1815 provided that group plan contracts issued and rates charged by a nonprofit medical service  
1816 corporation to its subscribers providing supplemental coverage to Medicare shall be subject to  
1817 the provisions of chapter 176K if the subscribers, and not their employer, employers or  
1818 representatives, are billed directly for such contracts. No classification of risk may be established  
1819 on the basis of age. In disapproving any rate under this section, the commissioner shall make a  
1820 finding on the basis of information submitted by a medical service corporation, that such  
1821 corporation employs a utilization review program and other techniques acceptable to the  
1822 commissioner which have had or are expected to have a demonstrated impact on the prevention  
1823 of reimbursement by such corporation for services which are not medically necessary.

1824 The commissioner may approve any rate of payment to any provider or class of providers  
1825 if such rate, in the opinion of the commission, contains an incentive to achieve greater efficiency  
1826 and economy in the manner of providing health care services without adversely affecting the  
1827 quality of such services. In making such an approval, the commission shall consider warranted  
1828 factors of price variation, including but not limited to: patient acuity, high-cost outliers, and  
1829 quality; and unwarranted factors of price variation, including but not limited to: market power,  
1830 brand, geographic isolation, government payment shortfalls, and research. If the commissioner  
1831 finds that the payment rate in a contract under its review is influenced by unwarranted factors of

1832 price variation, the commissioner shall refer the relevant health care entities to the health policy  
1833 commission to file performance improvement plans, as established in section 10A of chapter 6D.

1834 The commissioner may make and, at any time, alter or amend, reasonable rules or  
1835 regulations to facilitate the operation and enforcement of this section and to govern hearings and  
1836 investigations thereunder. The commissioner may issue such orders as the commissioner finds  
1837 proper, expedient or necessary to enforce and administer the provisions of this section and to  
1838 secure compliance with any rules and regulations made thereunder.

1839 SECTION 79. Chapter 176B of the General Laws is hereby amended by adding the  
1840 following 3 sections:-

1841 Section 25. (a) For the purposes of this section, “telemedicine” shall mean the use of  
1842 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a  
1843 patient's physical, oral or mental health; provided however, that “telemedicine” shall not include  
1844 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1845 (b) A contract between a subscriber and a medical service corporation shall not decline to  
1846 provide coverage for health care services solely on the basis that those services were delivered  
1847 by way of telemedicine by a contracted health care provider if (i) the health care services are  
1848 covered by way of in-person consultation or delivery and (ii) the health care services may be  
1849 appropriately provided through the use of telemedicine.

1850 (c) Coverage for telemedicine services may include utilization review, including  
1851 preauthorization, to determine the appropriateness of telemedicine as a means of delivering a  
1852 health care service, provided that the determination shall be made in the same manner as if the  
1853 service was provided via in-person consultation or delivery.

1854 (d) Coverage for telemedicine services shall not be required to reimburse a health care  
1855 provider for a health care service that is not a covered benefit under the plan nor reimburse a  
1856 health care provider not contracted under the plan.

1857 (e) Coverage that reimburses a provider with a global payment, as defined in section 1 of  
1858 chapter 6D, shall account for the provision of telemedicine services to set the global payment  
1859 amount.

1860 (f) Coverage for telemedicine services may include a deductible, copayment or  
1861 coinsurance requirement for a health care service provided through telemedicine as long as the  
1862 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance  
1863 applicable to an in-person consultation or in-person delivery of services.

1864 (g) A health care provider shall not be required to document a barrier to an in-person  
1865 visit, nor shall the type of setting where telemedicine is provided be limited for health care  
1866 services provided through telemedicine.

1867 (h) Health care services provided by telemedicine shall conform to the standards of care  
1868 applicable to the telemedicine provider's profession and specialty. Such services shall also  
1869 conform to applicable federal and state health information privacy and security standards as well  
1870 as standards for informed consent.

1871 Section 26. Upon request by a network provider, a medical service corporation and, if  
1872 applicable, a specialty organization subcontracted by a medical service corporation to manage  
1873 behavioral health services, shall disclose the methodology used for a provider's tier placement,  
1874 including: (i) the criteria, measures, data sources and provider-specific information used in  
1875 determining the provider's quality score; (ii) how the provider's quality performance compares to

1876 other in-network providers; and (iii) the data used in calculating the provider's cost-efficiency. A  
1877 carrier may require a network provider to maintain information received under this section as  
1878 confidential.

1879           Section 27. A medical service corporation organized under this chapter shall use the  
1880 standard quality measure set established by the center for health information and analysis under  
1881 section 14 of chapter 12C as follows: (i) a medical service corporation shall use the measures  
1882 designated by the center as core measures in any contract with a health care provider, provider  
1883 organization or accountable care organization that incorporates quality measures into payment  
1884 terms; (ii) a medical service corporation may use the measures designated by the center as non-  
1885 core measures in any contract with a health care provider, provider organization or accountable  
1886 care organization that incorporates quality measures into payment terms and shall not use any  
1887 measures not designated as non-core measures; and (iii) a medical service corporation shall only  
1888 use the measures in the standard quality measure set established by the center to assign health  
1889 care providers, accountable care organizations or provider organizations to tiers in the design of  
1890 a group medical service plan.

1891           SECTION 80. Section 5 of chapter 176G of the General Laws, as appearing in the 2016  
1892 Official Edition, is hereby amended by striking out subsection (f) and inserting in place thereof  
1893 the following subsection:-

1894           (f) Pursuant to sections 28 and 29 of chapter 176O, a health maintenance organization  
1895 shall provide or arrange for indemnity payments to a member or provide for the cost of  
1896 emergency medical services by a provider who is not normally affiliated with the health



1897 maintenance organization when the member requires services for an emergency medical  
1898 condition.

1899 SECTION 81. Section 16 of Chapter 176G of the General Laws, as so appearing, is  
1900 hereby amended by inserting after the first paragraph, the following 2 paragraphs:-

1901 The commissioner may approve any rate of payment to any provider or class of providers  
1902 if such rate, in the opinion of the commission, contains an incentive to achieve greater efficiency  
1903 and economy in the manner of providing health care services without adversely affecting the  
1904 quality of such services. In making such an approval, the commission shall consider warranted  
1905 factors of price variation, including but not limited to: patient acuity, high-cost outliers, and  
1906 quality; and unwarranted factors of price variation, including but not limited to: market power,  
1907 brand, geographic isolation, government payment shortfalls, and research.

1908 If the commissioner finds that the payment rate in a contract under its review is  
1909 influenced by unwarranted factors of price variation, the commissioner shall refer the relevant  
1910 health care entities to the health policy commission to file performance improvement plans, as  
1911 established in section 10A of chapter 6D.

1912 SECTION 82. Said chapter 176G is hereby further amended by adding the following 3  
1913 sections:-

1914 Section 33. (a) For the purposes of this section, “telemedicine” shall mean the use of  
1915 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a  
1916 patient's physical, oral or mental health; provided however, that “telemedicine” shall not include  
1917 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1918 (b) A contract between a member and a health maintenance organization shall not decline  
1919 to provide coverage for health care services solely on the basis that those services were delivered  
1920 by way of telemedicine by a contracted health care provider if (i) the health care services are  
1921 covered by way of in-person consultation or delivery and (ii) the health care services may be  
1922 appropriately provided through the use of telemedicine.

1923 (c) Coverage for telemedicine services may include utilization review, including  
1924 preauthorization, to determine the appropriateness of telemedicine as a means of delivering a  
1925 health care service; provided that the determination shall be made in the same manner as if the  
1926 service was provided via in-person consultation or delivery.

1927 (d) Coverage for telemedicine services shall not be required to reimburse a health care  
1928 provider for a health care service that is not a covered benefit under the plan nor reimburse a  
1929 health care provider not contracted under the plan.

1930 (e) Coverage that reimburses a provider with a global payment, as defined in section 1 of  
1931 chapter 6D, shall account for the provision of telemedicine services to set the global payment  
1932 amount.

1933 (f) Coverage for telemedicine services may include a deductible, copayment or  
1934 coinsurance requirement for a health care service provided through telemedicine as long as the  
1935 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance  
1936 applicable to an in-person consultation or in-person delivery of services.

1937 (g) A health care provider shall not be required to document a barrier to an in-person  
1938 visit, nor shall the type of setting where telemedicine is provided be limited for health care  
1939 services provided through telemedicine.

1940 (h) Health care services provided by telemedicine shall conform to the standards of care  
1941 applicable to the telemedicine provider's profession and specialty. Such services shall also  
1942 conform to applicable federal and state health information privacy and security standards as well  
1943 as standards for informed consent.

1944 Section 34. Upon request by a network provider, a health maintenance organization and,  
1945 if applicable, a specialty organization subcontracted by a health maintenance organization to  
1946 manage behavioral health services, shall disclose the methodology used for a provider's tier  
1947 placement, including: (i) the criteria, measures, data sources and provider-specific information  
1948 used in determining the provider's quality score; (ii) how the provider's quality performance  
1949 compares to other in-network providers; and (iii) the data used in calculating the provider's cost-  
1950 efficiency. A carrier may require a network provider to maintain information received under this  
1951 section as confidential.

1952 Section 35. A health maintenance organization organized under this chapter shall use the  
1953 standard quality measure set established by the center for health information and analysis under  
1954 section 14 of chapter 12C as follows: (i) a health maintenance organization shall use the  
1955 measures designated by the center as core measures in any contract with a health care provider,  
1956 provider organization or accountable care organization that incorporates quality measures into  
1957 payment terms; (ii) a health maintenance organization may use the measures designated by the  
1958 center as non-core measures in any contract with a health care provider, provider organization or  
1959 accountable care organization that incorporates quality measures into payment terms and shall  
1960 not use any measures not designated as non-core measures; and (iii) a health maintenance  
1961 organization shall use the measures in the standard quality measure set established by the center

1962 to assign health care providers, accountable care organizations or provider organizations to tiers  
1963 in the design of any health maintenance contract.

1964 SECTION 83. Section 3 of chapter 176I of the General Laws, as appearing in the 2016  
1965 Official Edition, is hereby amended by striking out subsection (b) and inserting in place thereof  
1966 the following subsection:-

1967 (b) If a covered person receives emergency care and cannot reasonably reach a preferred  
1968 provider, payment for care related to the emergency shall be made pursuant to sections 28 and 29  
1969 of chapter 176O and shall be made at the same level and in the same manner as if the covered  
1970 person had been treated by a preferred provider; provided however, that every brochure, contract,  
1971 policy manual and all printed materials shall clearly state that covered persons shall have the  
1972 option of calling the local pre-hospital emergency medical service system by dialing the  
1973 emergency telephone access number 911, or its local equivalent, whenever a covered person is  
1974 confronted with a need for emergency care, and no covered person shall in any way be  
1975 discouraged from using the local pre-hospital emergency medical service system, the 911  
1976 telephone number, or the local equivalent, or be denied coverage for medical and transportation  
1977 expenses incurred as a result of such use of emergency care;

1978 SECTION 84. Said chapter 176I is hereby further amended by adding the following 2  
1979 sections:-

1980 Section 13. (a) For the purposes of this section, “telemedicine” shall mean the use of  
1981 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a  
1982 patient's physical, oral or mental health; provided however, that “telemedicine” shall not include  
1983 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1984 (b) A preferred provider arrangement shall not decline to provide coverage for health care  
1985 services solely on the basis that those services were delivered by way of telemedicine by a  
1986 contracted health care provider if: (i) the health care services are covered by way of in-person  
1987 consultation or delivery; and (ii) the health care services may be appropriately provided through  
1988 the use of telemedicine.

1989 (c) Coverage for telemedicine services may include utilization review, including  
1990 preauthorization, to determine the appropriateness of telemedicine as a means of delivering a  
1991 health care service, provided that the determination shall be made in the same manner as if the  
1992 service was provided via in-person consultation or delivery.

1993 (d) Coverage for telemedicine services shall not be required to reimburse a health care  
1994 provider for a health care service that is not a covered benefit under the plan nor reimburse a  
1995 health care provider not contracted under the plan.

1996 (e) Coverage that reimburses a provider with a global payment, as defined in section 1 of  
1997 chapter 6D, shall account for the provision of telemedicine services to set the global payment  
1998 amount.

1999 (f) Coverage for telemedicine services may include a deductible, copayment or  
2000 coinsurance requirement for a health care service provided through telemedicine as long as the  
2001 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance  
2002 applicable to an in-person consultation or in-person delivery of services.

2003 (g) A health care provider shall not be required to document a barrier to an in-person  
2004 visit, nor shall the type of setting where telemedicine is provided be limited for health care  
2005 services provided through telemedicine.

2006 (h) Health care services provided by telemedicine shall conform to the standards of care  
2007 applicable to the telemedicine provider's profession and specialty. Such services shall also  
2008 conform to applicable federal and state health information privacy and security standards as well  
2009 as standards for informed consent.

2010 Section 14. An organization shall use the standard quality measure set established by the  
2011 center for health information and analysis pursuant to section 14 of chapter 12C as follows: (i) an  
2012 organization shall use the measures designated by the center as core measures in any contract  
2013 with a health care provider, provider organization or accountable care organization that  
2014 incorporates quality measures into payment terms; (ii) an organization may use the measures  
2015 designated by the center as non-core measures in any contract with a health care provider,  
2016 provider organization or accountable care organization that incorporates quality measures into  
2017 payment terms and shall not use any measures not designated as non-core measures; and (iii) an  
2018 organization shall use the measures in the standard quality measure set established by the center  
2019 to assign health care providers, provider organizations or accountable care organizations to tiers  
2020 in the design of a health benefit plan.

2021 SECTION 85. Section 6 of Chapter 176J of the General Laws, as so appearing, is hereby  
2022 amended by striking subsection (c) and inserting in place thereof the following subsection:-

2023 (c) Notwithstanding any general or special law to the contrary, carriers offering small  
2024 group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or  
2025 176G, shall file small group product base rates and any changes to small group rating factors that  
2026 are to be effective on January 1 of each year, on or before July 1 of the preceding year. The  
2027 commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate

2028 or unreasonable in relation to the benefits charged. The commissioner shall disapprove any  
2029 change to small group rating factors that is discriminatory or not actuarially sound. The  
2030 commissioner may approve any rate of payment to any provider or class of providers if such rate,  
2031 in the opinion of the commission, contains an incentive to achieve greater efficiency and  
2032 economy in the manner of providing health care services without adversely affecting the quality  
2033 of such services. In making such an approval, the commission shall consider warranted factors of  
2034 price variation, including but not limited to: patient acuity, high-cost outliers, and quality; and  
2035 unwarranted factors of price variation, including but not limited to: market power, brand,  
2036 geographic isolation, government payment shortfalls, and research.

2037           If the commissioner finds that the payment rate in a contract under its review is  
2038 influenced by unwarranted factors of price variation, the commissioner shall refer the relevant  
2039 health care entities to the health policy commission to file performance improvement plans, as  
2040 established in section 10A of chapter 6D.

2041           Rates of reimbursement or rating factors included in the rate filing materials submitted  
2042 for review by the division shall be deemed confidential and exempt from the definition of public  
2043 records in clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt  
2044 regulations to carry out this section.

2045           SECTION 86. Chapter 176J of the General Laws is hereby amended by striking out  
2046 section 11, as appearing in the 2016 Official Edition, and inserting in place thereof the following  
2047 section:-

2048           Section 11. (a) For the purposes of this section, the following words shall, unless the  
2049 context clearly requires otherwise, have the following meanings:-

2050 “Shoppable health care service” means a health care service for which a carrier offers a  
2051 shared savings incentive payment under a program established by the carrier pursuant to this  
2052 section. A shoppable health care service includes, at a minimum, health care services in the  
2053 following categories:

- 2054 (i) Physical and occupational therapy services;
- 2055 (ii) Obstetrical and gynecological services;
- 2056 (iii) Radiology and imaging services;
- 2057 (iv) Laboratory services;
- 2058 (v) Infusion therapy;
- 2059 (vi) Inpatient or Outpatient Surgical procedures; and
- 2060 (vii) Outpatient non-surgical diagnostic tests or procedures.

2061 This division of insurance may expand this list.

2062 (b) A carrier that offers a health benefit plan that provides or arranges for the delivery of  
2063 health care services through a closed network of health care providers and, as of the close of any  
2064 preceding calendar year, has a combined total of not less than 5,000 eligible individuals, eligible  
2065 employees and eligible dependents who are enrolled in health benefit plans sold, issued,  
2066 delivered, made effective or renewed to eligible small businesses or eligible individuals shall  
2067 offer to all eligible individuals and eligible small businesses in not less than 2 geographic areas at  
2068 least 1 of the following plans:-

- 2069 (i) a plan with a reduced or selective network of providers;



2070 (ii) a plan in which providers are tiered and member cost-sharing is based on the tier  
2071 placement of the provider that includes a base premium rate discount of not less than 20 per cent;

2072 (iii) a plan in which an enrollee's premium varies based on the primary care provider  
2073 selected at the time of enrollment; or

2074 (iv) a plan in which a separate cost-sharing differential is applied to shoppable health care  
2075 services among the network of providers.

2076 (c) Annually, the commissioner shall determine the base premium rate discount compared  
2077 to the base premium rate of the carrier's most actuarially-similar plan with the carrier's non-  
2078 selective or non-tiered network of providers under clauses (i) and (ii) of subsection (b). The  
2079 savings may be achieved by means including, but not limited to: (i) the exclusion of providers  
2080 with similar or lower quality based on the standard quality measure set with higher health status  
2081 adjusted total medical expenses or relative prices, as determined pursuant to the methodology  
2082 under section 52 of chapter 288 of the acts of 2010; or (ii) increased member cost-sharing for  
2083 members who utilize providers for non-emergency services with similar or lower quality based  
2084 on the standard quality measure set and with higher health status adjusted total medical expenses  
2085 or relative prices, as determined pursuant to the methodology under said section 52 of said  
2086 chapter 288 of the acts of 2010.

2087 The commissioner may apply waivers to the base premium rate discount determined by  
2088 the commissioner under this section to carriers that receive not less than 80 per cent of their  
2089 incomes from government programs or that have service areas that do not include an area within  
2090 the boundaries of the abolished counties of Suffolk or Middlesex and that were first admitted to

2091 do business by the division of insurance not later than January 1, 1986 as health maintenance  
2092 organizations under chapter 176G.

2093 (d) The commissioner shall require a plan under paragraph (iii) of subsection (b) to have  
2094 at least 1 tier that provides the base premium rate discount.

2095 (e) A tiered network plan shall only include variations in member cost-sharing among  
2096 provider tiers that are reasonable in relation to the premium charged and shall ensure adequate  
2097 access to covered services. Carriers shall tier providers based on quality performance as  
2098 measured by the standard quality measure set pursuant to section 24 of chapter 12C and by cost  
2099 performance as measured by health status adjusted total medical expenses and relative prices. If  
2100 applicable quality measures are not available, tiering may be based solely on health status  
2101 adjusted total medical expenses or relative prices or both.

2102 The commissioner shall promulgate regulations requiring the uniform reporting of tiering  
2103 information by carriers. The regulations shall include, but not be limited to, a requirement that a  
2104 carrier that is implementing a tiered network plan or is modifying the tiering methodology for an  
2105 existing tiered network plan shall report a detailed description of the methodology used for the  
2106 tiering of providers to the commissioner not less than 90 days before the effective date of the  
2107 plan or modification. The description shall include, but not be limited to: (i) the statistical basis  
2108 for tiering; (ii) a list of providers to be tiered at each member cost-sharing level; (iii) a  
2109 description of how the methodology and resulting tiers shall be communicated to each network  
2110 provider, eligible individuals and small groups; (iv) a description of the appeals process a  
2111 provider may pursue to challenge the assigned tier level; and (v) the utilization of a variable

2112 premium amount based on tier designation for the primary care provider selected by the member,  
2113 if any.

2114 (f) The commissioner shall determine network adequacy: (i) for a tiered network plan  
2115 based on the availability of sufficient network providers in the carrier's overall network of  
2116 providers; and (ii) for a selective network plan based on the availability of sufficient network  
2117 providers in the carrier's selective network.

2118 In determining network adequacy under this section, the commissioner may consider  
2119 factors including the location of providers participating in the plan and employers or members  
2120 that enroll in the plan, the range of services provided by providers in the plan and plan benefits  
2121 that recognize and provide for extraordinary medical needs of members that may not be  
2122 adequately dealt with by the providers within the plan network.

2123 (g) A carrier may reclassify provider tiers and determine provider participation in  
2124 selective and tiered plans not more than once per calendar year; provided however, that a carrier  
2125 may reclassify a provider from a higher cost tier to a lower cost tier or add a provider to a  
2126 selective network at any time. If a carrier reclassifies provider tiers or providers participating in a  
2127 selective plan during the course of an account year, the carrier shall provide notice to affected  
2128 members of the account that shall include information regarding the plan changes not less than  
2129 30 days before the changes are to take effect. A carrier shall provide information on the carrier's  
2130 website about any tiered or selective plan including, but not limited to, the providers  
2131 participating in the plan, the selection criteria for those providers and, where applicable, the tier  
2132 in which each provider is classified.

2133 (h) The commissioner shall review plans under clauses (iii) and (iv) of subsection (b) in a  
2134 manner consistent with other products offered in the commonwealth. The commissioner may  
2135 disapprove a plan established pursuant to clause (iii) or (iv) of subsection (b) if the commissioner  
2136 determines that the carrier-differentiated cost-sharing obligations are solely based on the  
2137 provider. There shall be a rebuttable presumption that a plan has violated this subsection if the  
2138 cost-sharing obligation for the services provided by a provider, including a health care facility,  
2139 accountable care organization, patient-centered medical home or provider organization, is the  
2140 same cost-sharing obligation without regard for the types of services provided pursuant to clause  
2141 (iii) or (iv).

2142 When reviewing a plan established pursuant to clauses (iii) and (iv) of subsection (b), the  
2143 commissioner shall ensure that the plan promotes: (i) the avoidance of consumer confusion; (ii)  
2144 the minimization of administrative burdens on payers and providers in implementing the plan;  
2145 and (iii) allowing for patients to receive services in appropriate locations.

2146 (i) The commissioner shall make publicly available on the commissioner's website: (i) a  
2147 description of each plan offered under this section, including a list of providers or services by tier  
2148 or a list of providers included in a selective network plan; (ii) membership trends for each plan  
2149 offered under this section; (iii) the extent to which plans offered under this section have reduced  
2150 health care costs for patients and employers; and (iv) the effect of plans offered under this  
2151 section on provider mix and other factors impacting overall state health care costs. The  
2152 commissioner shall ensure that the information is updated not less than annually and conforms to  
2153 the uniform methodology for the communication of information about the assignment of tiers to  
2154 health care providers and health care services adopted by the center for health information and  
2155 analysis pursuant to section 24 of chapter 12C.

2156 Nothing in this section shall exempt a carrier from state and federal mental health parity  
2157 and addiction equity laws, including those codified at 42 U.S.C. § 300gg-26, and regulations  
2158 implemented pursuant to section 8K of chapter 26. Nothing in this section shall create a lesser  
2159 standard of scrutiny for parity compliance for any reduced, tiered or discounted plan established  
2160 pursuant to this section.

2161 SECTION 87. Said chapter 176J is hereby further amended by adding the following  
2162 section:-

2163 Section 18. Upon request by a network provider, a carrier and, if applicable, a specialty  
2164 organization subcontracted by a carrier to manage behavioral health services, shall disclose the  
2165 methodology used for a provider's tier placement, including: (i) the criteria, measures, data  
2166 sources and provider-specific information used in determining the provider's quality score; (ii)  
2167 how the provider's quality performance compares to other in-network providers; and (iii) the data  
2168 used in calculating the provider's cost-efficiency. A carrier may require a network provider to  
2169 maintain information received under this section as confidential.

2170 SECTION 88. Section 1 of chapter 176O of the General Laws, as appearing in the 2016  
2171 Official Edition, is hereby amended by inserting after the definition of "Emergency medical  
2172 condition" the following definition:-

2173 "Emergency services" as defined under section 1 of chapter 6D.

2174 SECTION 89. Said section 1 of said chapter 176O, as so appearing, is hereby amended  
2175 by inserting after the definition of "Facility" the following definition:-

2176 “Facility fee”, a fee charged or billed by a hospital or health system for outpatient  
2177 hospital services provided in a hospital-based facility that is intended to compensate the hospital  
2178 or health system for the operational expenses of the hospital or health system and is separate and  
2179 distinct from a professional fee.

2180 SECTION 90. Said section 1 of said chapter 176O, as so appearing, is hereby further  
2181 amended by inserting after the definition of “Health care services” the following 2 definitions:-

2182 “Hospital”, a hospital as defined in section 1 of chapter 6D.

2183 “Hospital-based facility”, a facility as defined in section 228 of chapter 111.

2184 SECTION 91. Said section 1 of said chapter 176O, as so appearing, is hereby further  
2185 amended by inserting after the definition of “Incentive plan” the following 2 definitions:-

2186 “In-network contracted rate”, the rate contracted between an insured's carrier and a  
2187 network provider for the reimbursement of health care services delivered by that network  
2188 provider to the insured.

2189 “In-network cost-sharing amount”, the cost-sharing amount that the insured is required to  
2190 pay for a covered health care service received from a network provider. Cost sharing includes  
2191 any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the insured  
2192 other than premium or share of premium.

2193 SECTION 92. Said section 1 of said chapter 176O, as so appearing, is hereby further  
2194 amended by inserting after the definition of “Network” the following 2 definitions:-

2195 “Network provider”, a participating provider who, under a contract with the carrier or  
2196 with its contractor or subcontractor, has agreed to provide health care services to insureds  
2197 enrolled in any or all of the carrier's network plans, policies, contracts or other arrangements.

2198 “Network status”, a designation to distinguish between a network provider and an out-of-  
2199 network provider.

2200 SECTION 93. Said section 1 of said chapter 176O, as so appearing, is hereby further  
2201 amended by inserting after the definition of “Office of patient protection” the following  
2202 definition:-

2203 “Out-of-network provider”, a provider that does not participate in the network of an  
2204 insured’s health benefit plan because: (i) the provider contracts with a carrier to participate in the  
2205 carrier’s network but does not contract as a participating provider for the specific health benefit  
2206 plan to which an insured is enrolled; or (ii) the provider does not contract with a carrier to  
2207 participate in any of the carrier's network plans, policies, contracts or other arrangements.

2208 SECTION 94. Said section 1 of said chapter 176O, as so appearing, is hereby further  
2209 amended by inserting after the definition of “Second opinion” the following definition:-

2210 “Surprise bill”, a bill for health care services, other than for emergency services, received  
2211 by an insured for the services of an out-of-network provider rendered at or by a network facility  
2212 in the insured’s health benefit plan where: (i) a network provider is unavailable; (ii) the out-of-  
2213 network provider renders services without the insured’s knowledge; (iii) services were referred  
2214 by a network provider to an out-of-network provider without the prior written consent of the  
2215 insured acknowledging the out-of-network referral or services and that such services rendered  
2216 may result in costs not covered by the health benefit plan; or (iv) unforeseen medical services

2217 that require the services that are necessary to be performed by an out of network provider arise at  
2218 the time the health care services are rendered; provided however, that “surprise bill” shall not  
2219 mean a bill received for health care services rendered when a network provider is available and  
2220 the insured affirmatively elected to receive services from an out-of-network provider.

2221 SECTION 95. Section 6 of said chapter 176O, as so appearing, is hereby amended by  
2222 striking out, in lines 33 and 34, the words “has a reasonable opportunity to choose to have the  
2223 service performed by a network provider” and inserting in place thereof the following words:-  
2224 affirmatively chooses to receive services from an out-of-network provider pursuant to section 28  
2225 and the out-of-network provider has obtained the prior written consent of the insured pursuant to  
2226 section 228 of chapter 111.

2227 SECTION 96. Subsection (a) of said section 6 of said chapter 176O, as so appearing, is  
2228 hereby further amended by striking out clause (8) and inserting in place thereof the following  
2229 clause:-

2230 (8)(i) a clear description of the procedure, if any, by which the insured may request an  
2231 out-of-network referral; (ii) a summary description of the methodology used by the insurer to  
2232 determine reimbursement of out-of-network health care services; (iii) the amount that the insurer  
2233 will reimburse under the methodology for out-of-network services pursuant to sections 28; and  
2234 (iv) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care  
2235 services;

2236 SECTION 97. Section 7 of said chapter 176O, as so appearing, is hereby amended by  
2237 striking out, in lines 5 and 6, the words “and summarizing on its internet website for each such



2238 provider” and inserting in place thereof the following words:-, along with a summary on its  
2239 internet website for each provider that shall include.

2240 SECTION 98. Paragraph (1) of subsection (a) of said section 7 of said chapter 176O, as  
2241 so appearing, is hereby further amended by striking out clause (iv) and inserting in place thereof  
2242 the following clause:-

2243 (iv) current measures of the provider's quality using the measures established by the  
2244 center for health information an analysis pursuant to section 14 of said chapter 12C; provided  
2245 however, that if any specific provider or type of provider requested by an insured is not available  
2246 in the network or is not a covered benefit, the information shall be provided in an easily  
2247 obtainable manner; provided further, that the carrier shall prominently promote providers based  
2248 on quality performance as measured by the measures established by the center under said section  
2249 14 of said chapter 12C and cost performance as measured by health status adjusted total medical  
2250 expenses and relative prices;.

2251 SECTION 99. Said chapter 176O is hereby further amended by striking out section 23, as  
2252 so appearing, and inserting in place thereof the following section:-

2253 Section 23. All carriers shall establish a toll-free telephone number and website that  
2254 enables consumers to request and obtain from the carrier, in real time, the network status of an  
2255 identified health care provider and the estimated or maximum allowed amount or charge for a  
2256 proposed admission, procedure or service, and the estimated amount the insured will be  
2257 responsible to pay for a proposed admission, procedure or service that is a medically necessary  
2258 covered benefit, based on the information available to the carrier at the time the request is made,  
2259 including any facility fee, copayment, deductible, coinsurance or other out of pocket amount for

2260 any covered health care benefits. All carriers shall create a mechanism by which the insured can  
2261 request notice of the estimated amount in writing. Upon request, the carrier shall send the  
2262 consumer written notice of the estimated amount the insured will be responsible for paying.

2263 The telephone number and website shall inform the insured that the insured shall not be  
2264 required to pay more than the estimated amounts disclosed in the written notice for the covered  
2265 health care benefits that were actually provided; provided however, that nothing in this section  
2266 shall prevent carriers from imposing cost sharing requirements disclosed in the insured's  
2267 evidence of coverage document provided by the carrier for unforeseen services that arise out of  
2268 the proposed admission, procedure or service; and provided further, that the carrier shall alert the  
2269 insured that these are estimated costs, and that the actual amount the insured will be responsible  
2270 to pay may vary due to unforeseen services that arise out of the proposed admission, procedure  
2271 or service, except that the insured shall not be responsible for any additional payment caused by  
2272 the carrier mistakenly identifying an out-of-network provider as in-network.

2273 The information provided on the website shall conform to the uniform methodology for  
2274 the communication of information about the assignment of tiers to health care providers and  
2275 health care services adopted by the center for health information and analysis pursuant to section  
2276 24 of chapter 12C.

2277 SECTION 100. Said chapter 176O of the General Laws is hereby further amended by  
2278 adding the following 4 sections:-

2279 Section 28. (a) When an out-of-network provider renders emergency services to an  
2280 insured and such out-of-network provider is a member of an insured's carrier's network but not a  
2281 network provider in the insured's health benefit plan, a carrier shall pay such out-of-network

2282 provider the in-network contracted rate for each delivered service; provided however, that such  
2283 payment shall constitute payment in full and the out-of-network provider shall not bill the  
2284 insured for any amount except for any in-network cost sharing amount owed for such service or  
2285 services under the terms of the insured's health benefit plan.

2286 (b) When an out-of-network provider does not contract with a carrier and such out-of-  
2287 network provider renders emergency services to an insured, a carrier shall pay such out-of-  
2288 network provider the greater of: (i) 115 per cent of the average rate the carrier pays for that  
2289 service and (ii) 125 per cent of the Medicare rate for that service; provided however, that such  
2290 payment shall constitute payment in full to the out-of-network provider. The out-of-network  
2291 provider shall not bill the insured except for any applicable copayment, coinsurance or  
2292 deductible that would be owed if the insured received such service or services from a network  
2293 provider under the terms of the insured's health benefit plan.

2294 (c) When an out-of-network provider renders health care services, other than for  
2295 emergency services, to an insured, the carrier shall pay that provider the greater of: (i) 115 per  
2296 cent of the average rate the carrier pays for that service and (ii) 125 per cent of the Medicare rate  
2297 for that service. Such payment shall constitute payment in full to the out-of-network services.  
2298 The out-of-network provider shall not bill the insured except for any inpatient cost sharing under  
2299 the terms of the insured's health benefit plan, provided however, that said provider may bill or  
2300 collect from the insured amounts in addition to the in-network cost-sharing amount if the out-of-  
2301 network provider has obtained the prior written consent of the insured pursuant to section 228 of  
2302 chapter 111.

2303 (d) An insured shall not be liable for the payment of surprise bills, shall pay no more  
2304 than the in-network cost-sharing amount and shall not owe an out-of-network provider more than  
2305 the in-network cost-sharing amount for services subject to this section if: (i) an insured receives  
2306 covered services from a network provider and as a result or in conjunction with such services  
2307 receives services provided by an out-of-network provider; or (ii) where referrals or  
2308 preauthorization are required under the insured's health benefit plan, a network provider refers  
2309 an insured to an out-of-network provider without the explicit written consent of the insured  
2310 acknowledging that the provider is referring the insured to an out-of-network provider and that  
2311 the referral may result in costs not covered by the health plan.

2312 (e) At the time of payment by a carrier to an out-of-network provider, a carrier shall  
2313 inform the insured and the out-of-network provider of the in-network cost-sharing amount owed  
2314 by the insured.

2315 (f) If a carrier delegates payment functions to a contracted entity, including, but not  
2316 limited to, a medical group or independent practice association, the delegated entity shall comply  
2317 with this section.

2318 (g) Nothing in this section shall require a carrier to pay for health care services delivered  
2319 to an insured that are not covered benefits under the terms of the insured's health benefit plan.

2320 Section 29. It shall be an unfair and deceptive act or practice, in violation of section 2 of  
2321 chapter 93A, for any health care provider or carrier to request payment from an enrollee, other  
2322 than the applicable coinsurance, copayment, deductible or other out-of-pocket expense, for the  
2323 services described in section 28.

2324           Section 30. (a) The division, in consultation with the center for health information and  
2325 analysis, shall establish an efficient and simple dispute resolution process by which a dispute for  
2326 a bill for emergency services or a surprise bill may be resolved. The division shall have the  
2327 power to grant and revoke certifications of independent dispute resolution entities to conduct the  
2328 dispute resolution process. The division shall promulgate regulations establishing standards for  
2329 the dispute resolution process, including a process for certifying and selecting independent  
2330 dispute resolution entities.

2331           (b) In the event of a dispute between the out-of-network provider and the carrier as to the  
2332 amount to be reimbursed under section 28, the parties shall use the following dispute resolution  
2333 process:

2334           (i) An out-of-network provider or a carrier may submit a dispute regarding a fee or  
2335 payment for emergency services for review to an independent dispute resolution entity certified  
2336 by the division.

2337           (ii) The independent dispute resolution entity shall make a determination within 30 days  
2338 of receipt of the dispute for review.

2339           (iii) In determining a reasonable fee for the services rendered, an independent dispute  
2340 resolution entity shall select either: (A) the carrier's payment; or (B) the fee request of the out-of-  
2341 network provider.

2342           (iv) The independent dispute resolution entity shall determine which amount to select by  
2343 considering all relevant factors, including: (A) the disparity between the fee requested by the out-  
2344 of-network provider and fees paid to the out-of-network provider for the same services by other  
2345 non-participating plans; (B) the disparity between the fee requested by the out-of-network

2346 provider and the rate the out-of-network provider is paid by participating plans; (C) the level of  
2347 training, education and experience of the out-of-network provider; (D) the circumstances and  
2348 complexity of the particular case, including the time and place of the service; and (E) the usual  
2349 and customary cost of the service.

2350 (v) If the independent dispute resolution entity determines, based on the carrier's payment  
2351 and the out-of-network provider's fee request, that a settlement between the carrier and out-of-  
2352 network provider is reasonably likely, or that both the carrier's payment and the out-of-network  
2353 provider's fee request represent unreasonable extremes, then the independent dispute resolution  
2354 entity may direct both parties to attempt a good-faith negotiation for settlement. The carrier and  
2355 the out-of-network provider may be granted up to 10 business days for this negotiation, which  
2356 shall run concurrently with the 30 day period for dispute resolution.

2357 (vi) The determination of the independent dispute resolution entity shall be binding on  
2358 the carrier and the out-of-network provider and shall be admissible in any court or administrative  
2359 proceedings.

2360 (c) Payment to the independent dispute resolution entity shall be as follows: (i) for  
2361 disputes involving a carrier and an out-of-network provider, when the independent dispute  
2362 resolution entity determines that the health care plan's payment is reasonable, payment for the  
2363 dispute resolution process shall be the responsibility of the out-of-network provider; (ii) when  
2364 the independent dispute resolution entity determines that the out-of-network provider's fee  
2365 request is reasonable, payment for the dispute resolution process shall be the responsibility of the  
2366 health care plan; and (iii) agreed upon during course of negotiation pursuant to subsection (a)

2367           Section 31. (a) As used in this section, the term “pharmacy benefit manager” shall mean  
2368 any person, business, or entity, however organized, that administers, either directly or through  
2369 subsidiaries, pharmacy benefit services for prescription drugs and devices on behalf of health  
2370 benefit plan sponsors, including, but not limited to, self-insured employers, insurance companies  
2371 and labor unions; provided however, that “pharmacy benefit services” shall include, but not be  
2372 limited to, formulary administration; drug benefit design; pharmacy network contracting;  
2373 pharmacy claims processing; mail and specialty drug pharmacy services; and cost containment,  
2374 clinical, safety and adherence programs for pharmacy services. A health benefit plan that does  
2375 not contract with a pharmacy benefit manager shall be considered a pharmacy benefit manager  
2376 for the purposes of this section.

2377           (b) A contract between a pharmacy benefit manager and a participating pharmacy or  
2378 pharmacist shall not include any provision that prohibits, restricts, or limits a pharmacist or  
2379 pharmacy’s right to provide an insured with information on the amount of the insured's cost  
2380 share for such insured's prescription drug and the clinical efficacy of a more affordable  
2381 alternative drug if one is available. Neither a pharmacy nor a pharmacist shall be penalized by a  
2382 pharmacy benefits manager for disclosing such information to an insured or for selling to an  
2383 insured a more affordable alternative if one is available.

2384           (c) A pharmacy benefits manager shall not charge a pharmacist or pharmacy a fee related  
2385 to the adjudication of a claim, including, without limitation, a fee for: (i) the receipt and  
2386 processing of a pharmacy claim; (ii) the development or management of claims processing  
2387 services in a pharmacy benefits manager network; or (iii) participation in a pharmacy benefits  
2388 manager network, unless such fee is set out in a contract between the pharmacy benefits manager  
2389 and the pharmacist or pharmacy.

2390 (d) A contract between a pharmacy benefit manager and a participating pharmacy or  
2391 pharmacist shall not include any provision that prohibits, restricts, or limits disclosure of  
2392 information to the division deemed necessary by the division to ensure a pharmacy benefits  
2393 manager's compliance with the requirements under this section or section 21C of chapter 94C.

2394 SECTION 101. (a). Notwithstanding any special or general law to the contrary, the health  
2395 policy commission established pursuant to section 2 of chapter 6D shall establish a one-time  
2396 surcharge assessment on all acute hospitals satisfying the requirements of subsection (b) to be  
2397 deposited according to the requirements of subsection (f). The surcharge amount to be paid by  
2398 each acute hospital shall equal the product of: (i) the surcharge percentage; and (ii)  
2399 \$120,000,000. The commission shall calculate the surcharge percentage by dividing the  
2400 operating surplus in fiscal year 2016 by the total operating surplus in fiscal year 2016 of all acute  
2401 hospitals paying an assessment under this section. The commission shall determine the surcharge  
2402 percentage for the assessment by December 31, 2018. In the determination of the surcharge  
2403 percentage, the commission shall use the best data available as determined by the commission  
2404 and may consider the effect on projected surcharge payments of any modified or waived  
2405 enforcement pursuant to subsection (c). The commission shall incorporate all adjustments,  
2406 including, but not limited to, updates or corrections or final settlement amounts, by prospective  
2407 adjustment rather than by retrospective payments or assessments.

2408 (b) Only acute hospitals or acute hospital systems with more than \$750,000,000 in total  
2409 net assets in fiscal year 2017 and a public payer mix below 60 per cent in fiscal year 2016 shall  
2410 be subject to the assessment. The commission may waive the assessment for certain acute  
2411 hospitals, if the commission reasonably determines the hospital or hospital system lacks access to  
2412 resources available to pay the assessment. The commission shall make a determination for



2413 waiver based on the following factors: (i) cash and investments on hand; (ii) total revenues; (iii)  
2414 total cash and investments; (iv) total reserves; (v) total profits, margins or surplus; (vi) earnings  
2415 before interest, depreciation and amortization; (vii) administrative expense ratio; and (viii) the  
2416 compensation of executive managers and board members.

2417 (c) The commission may provide assessment mitigation up to 50 per cent of the  
2418 surcharge assessment if an assessable provider meets either of the following:

2419 (i) any acute hospital or acute hospital system that receives more than 25 per cent of its  
2420 reimbursements from Title XIX of the Social Security Act; or

2421 (ii) any acute hospital or acute hospital system whose net assets do not exceed  
2422 \$1,000,000,000.

2423 (d) Surcharge payors shall be assessed a surcharge to be paid to the commission in  
2424 accordance with the provisions of subsection (e). The surcharge amount shall equal the product  
2425 of: (i) the surcharge percentage; and (ii) \$330,000,000. The commission shall calculate the  
2426 surcharge percentage by dividing the surcharge payor's payments for acute hospital services by  
2427 the total payments for acute hospital services by all surcharge payors. The commission shall  
2428 determine the surcharge percentage for the assessment by December 31, 2018. In the  
2429 determination of the surcharge percentage, the commission shall use the best data available as  
2430 determined by the commission and may consider the effect on projected surcharge payments of  
2431 any modified or waived enforcement pursuant to subsection (c). The commission shall  
2432 incorporate all adjustments, including, but not limited to, updates or corrections or final  
2433 settlement amounts, by prospective adjustment rather than by retrospective payments or  
2434 assessments.

2435 (e) Acute hospitals and surcharge payors shall pay the full amount of the surcharge  
2436 amount as follows:

2437 (i) a single payment to be made no later than June 30, 2019; or

2438 ii) in 3 equal annual installments to be paid on or before June 30 of each year beginning  
2439 on June 30, 2019.

2440 (f) The assessment shall be deposited by the comptroller, as such assessments are  
2441 collected, in the Community Hospital Reinvestment Trust Fund, established in section 2TTTT of  
2442 chapter 29 of the General Laws; provided, however, that any reduced or waived assessment  
2443 under subsections (b) or (c) shall reduce the amount to be deposited in the Community Hospital  
2444 Reinvestment Trust Fund.

2445 (g) The commission shall specify by regulation appropriate mechanisms that provide for  
2446 determination and payment of an acute hospital, or a surcharge payor's liability, including  
2447 requirements for data to be submitted by acute hospitals and surcharge payors.

2448 (h) An acute hospital's liability to the fund shall in the case of a transfer of ownership be  
2449 assumed by the successor in interest to the hospital.

2450 (i) A surcharge payor's liability to the fund shall in the case of a transfer of ownership be  
2451 assumed by the successor in interest to the surcharge payor.

2452 (j) The commission shall establish by regulation an appropriate mechanism for enforcing  
2453 an acute hospital or surcharge payor's liability to the fund if an acute hospital or surcharge payor  
2454 does not make a scheduled payment to the fund; provided, however, that the commission may,  
2455 for the purpose of administrative simplicity, establish threshold liability amounts below which

2456 enforcement may be modified or waived. Such enforcement mechanism may include assessment  
2457 of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent  
2458 and late fees or penalties at a rate not to exceed 5 per cent per month. Such enforcement  
2459 mechanism may also include notification to the office of Medicaid requiring an offset of  
2460 payments on the claims of the acute hospital or surcharge payor, any entity under common  
2461 ownership or any successor in interest to the acute hospital or surcharge payor, from the office of  
2462 Medicaid in the amount of payment owed to the fund, including any interest and penalties, and to  
2463 transfer the withheld funds into said fund. If the office of Medicaid offsets claims payments as  
2464 ordered by the commission, the office of Medicaid shall be considered not to be in breach of  
2465 contract or any other obligation for payment of non-contracted services, and an acute hospital or  
2466 surcharge payor whose payment is offset under an order of the commission shall serve all Title  
2467 XIX recipients under the contract then in effect with the executive office of health and human  
2468 services. In no event shall the commission direct the office of Medicaid to offset claims unless  
2469 the acute hospital or surcharge payor has maintained an outstanding liability to the fund for a  
2470 period longer than 45 days and has received proper notice that the commission intends to initiate  
2471 enforcement actions under regulations promulgated by the commission.

2472 (k) If an acute hospital or surcharge payor fails to file any data, statistics or schedules or  
2473 other information required under this chapter or by any regulation promulgated by the  
2474 commission, the commission shall provide written notice to the acute hospital or surcharge  
2475 payor. If an acute hospital or surcharge payor fails to provide required information within 14  
2476 days after the receipt of written notice, or falsifies the same, such hospital or payor shall be  
2477 subject to a civil penalty of not more than \$5,000 for each day on which the violation occurs or  
2478 continues, which penalty may be assessed in an action brought on behalf of the commonwealth

2479 in any court of competent jurisdiction. The attorney general shall bring any appropriate action,  
2480 including injunctive relief, necessary for the enforcement of this chapter.

2481 (l) Acute hospitals shall not seek an increase in rates to pay for the assessment pursuant  
2482 to this section.

2483 (m) Surcharge payors shall not seek an increase in premiums to pay for the assessment  
2484 pursuant to this section.

2485 SECTION 102. Notwithstanding any general or special law to the contrary, the secretary  
2486 of administration and finance, following a public hearing, shall increase the fee for obtaining or  
2487 renewing a license, certificate, registration, permit or authority issued by the board of registration  
2488 in medicine, the board of registration in nursing, the board of registration in dentistry, the board  
2489 of registration in pharmacy, and the board of registration in genetic counselors by an amount  
2490 equal to 25 per cent, rounded to the nearest \$1, of the fees in effect as of July 1, 2017. All new  
2491 monies raised by this increase shall be deposited in the Community Hospital Reinvestment Trust  
2492 Fund established under section 2TTTT of chapter 29.

2493 SECTION 103. Notwithstanding any general or special law to the contrary, the secretary  
2494 of administration and finance, following a public hearing, shall increase the fee for obtaining or  
2495 renewing a license, certificate, registration, permit or authority issued by the board of registration  
2496 in medicine, the board of registration in nursing, the board of registration in dentistry, the board  
2497 of registration in pharmacy, and the board of registration in genetic counselors by an amount  
2498 equal to 25 per cent, rounded to the nearest \$1, of the fees in effect as of July 1, 2019. All new  
2499 monies raised by this increase shall be deposited in the Community Hospital Reinvestment Trust  
2500 Fund established under section 2TTTT of chapter 29.

2501 SECTION 104. Notwithstanding any general or special law to the contrary, the secretary  
2502 of administration and finance, following a public hearing, shall increase the fee for obtaining or  
2503 renewing a license, certificate, registration, permit or authority issued by the board of registration  
2504 in podiatry and the board of registration in optometry by an amount equal to 25 per cent, rounded  
2505 to the nearest \$1, of the fees in effect as of July 1, 2017. All new monies raised by this increase  
2506 shall be deposited in the Community Hospital Reinvestment Trust Fund established under  
2507 section 2TTTTof chapter 29.

2508 SECTION 105. Notwithstanding any general or special law to the contrary, the secretary  
2509 of administration and finance, following a public hearing, shall increase the fee for obtaining or  
2510 renewing a license, certificate, registration, permit or authority issued by the board of registration  
2511 in podiatry and the board of registration in optometry by an amount equal to 25 per cent, rounded  
2512 to the nearest \$1, of the fees in effect as of July 1, 2019. All new monies raised by this increase  
2513 shall be deposited in the Community Hospital Reinvestment Trust Fund established under  
2514 section 2TTTT of chapter 29.

2515 SECTION 106. Notwithstanding the provisions of any general or special law, or rule or  
2516 regulation to the contrary, there shall be a \$75 surcharge on fees assessed for obtaining or  
2517 renewing a license issued by the board of registration in medicine under section 2 of chapter 112.  
2518 Said surcharges shall be collected by the department and deposited in the Community Hospital  
2519 Reinvestment Trust Fund established under section 2TTTT of chapter 29.

2520 SECTION 107. Notwithstanding the provisions of any general or special law, or rule or  
2521 regulation to the contrary, there shall be a \$75 surcharge on fees assessed for obtaining or  
2522 renewing a license issued by the board of registration in podiatry under section 16 of chapter

2523 112, the board of registration in pharmacy under section 24 of chapter 112, the board of  
2524 registration in dentistry under section 45 of chapter 112, the board of registration in optometry  
2525 under section 68 of chapter 112, and the board of registration of nursing under section 74 of  
2526 chapter 112. Said surcharges shall be collected by the department and deposited in the  
2527 Community Hospital Reinvestment Trust Fund established under section 2TTTT of chapter 29.

2528 SECTION 108. The office of Medicaid shall report on the role of long-term services and  
2529 supports within MassHealth and MassHealth accountable care organizations in each year of the  
2530 accountable care organization demonstration. The report shall include: (i) the baseline number of  
2531 accountable care organization-attributed MassHealth members receiving long-term services and  
2532 supports, disaggregated by age category, disability status, service type, and any other relevant  
2533 categories; (ii) total MassHealth spending on long-term services and supports disaggregated by  
2534 age category, disability status, service type and any other relevant categories; (iii) MassHealth  
2535 average per member, per month long-term services and supports costs by service type; (iv) any  
2536 projected changes in utilization of long-term services and supports in the coming year and the  
2537 rationale for such changes; (v) any estimated shift in spending between medical and long-term  
2538 services and supports or social services spending within the accountable care organization  
2539 program in the prior year of the demonstration; (vi) the process for determination of long-term  
2540 services and supports needs for members attributed to the accountable care organization  
2541 program, disaggregated by accountable care organization if processes differ; and (vii) the appeals  
2542 process for accountable care organization members denied long-term services and supports. This  
2543 report shall be filed with the clerks of the house of representatives and the senate, the joint  
2544 committee on health care financing and the house and senate committees on ways and means not

2545 later than April 1, 2019, and thereafter annually by April 1 for each year of the accountable care  
2546 organization demonstration.

2547 SECTION 109. (a) There shall be a special commission to study and make  
2548 recommendations on how to license foreign-trained medical professionals to expand and  
2549 improve access to medical services in rural and underserved areas.

2550 (b) The commission shall consist of 16 members, as follows: the secretary of health and  
2551 human services or a designee, who shall serve as chair; the commissioner of public health or a  
2552 designee; 2 members appointed by the speaker of the house, 1 of whom shall be the house chair  
2553 of the joint committee on public health; 2 members appointed by the senate president, 1 of whom  
2554 shall be the senate chair of the joint committee on public health; 1 member appointed by the  
2555 minority leader of the house; 1 member appointed by the minority leader of the senate; and 9  
2556 members appointed by the governor, 1 of whom shall be a member of the governor's advisory  
2557 council for refugees and immigrants, 1 of whom shall be a representative of the Massachusetts  
2558 Immigrant and Refugee Advocacy Coalition, Inc., 1 of whom shall be a representative of the  
2559 bureau of health professional licensure, 1 whom shall be a member of the board of registration in  
2560 medicine, 1 of whom shall be a member of the board of registration in dentistry, 1 member of the  
2561 board of registration in pharmacy, 1 of whom shall be a member of the board of registration in  
2562 nursing, 1 of whom shall be a member of the board of registration of psychologists and 1 of  
2563 whom shall be a member of the board of allied health professionals.

2564 (c) The commission shall examine and make recommendations on topics including, but  
2565 not limited to: (i) ways to implement strategies to integrate foreign-trained medical professionals  
2566 into rural and underserved areas that are in need of access to medical services; (ii) ways to

2567 identify state and national licensing regulations that pose barriers to practice for foreign-trained  
2568 medical professionals; (iii) state licensing requirements that pose barriers to practice for foreign-  
2569 trained medical professionals; (iv) alternate approaches by other states to integrate foreign-  
2570 trained medical professionals into rural and underserved areas; and (v) other matters pertaining  
2571 to licensing foreign-trained medical professionals. The commission may hold hearings and invite  
2572 testimony from experts and the public to gather information. The report may include  
2573 recommended guidelines for full licensure and conditional licensing of foreign-trained medical  
2574 professionals.

2575 (d) The commission shall file its recommendations, including any drafts of legislation or  
2576 regulations necessary to carry out its recommendations, with the clerks of the house of  
2577 representatives and senate, the joint committee on public health and the joint committee on  
2578 health care financing not later than March 1, 2019.

2579 SECTION 110. (a) There shall be a special legislative commission pursuant to section 2A  
2580 of chapter 4 to examine administrative costs in the health care system. The commission shall  
2581 consist of 23 members: 1 of whom shall be the senate chair of the joint committee on health care  
2582 financing, who shall serve as co-chair; 1 of whom shall be the house chair of the joint committee  
2583 on health care financing, who shall serve as co-chair; 1 of whom shall be appointed by the senate  
2584 president; 1 of whom shall be appointed by the speaker of the house; 1 of whom shall be  
2585 appointed by the minority leader of the senate; 1 of whom shall be appointed by the minority  
2586 leader of the house of representatives; 1 of whom shall be the attorney general or a designee; 1 of  
2587 whom shall be the secretary for administration and finance or a designee; 1 of whom shall be the  
2588 secretary of health and human services or a designee; 1 of whom shall be the executive director  
2589 of the group insurance commission or a designee; and 13 of whom shall be appointed by the



2590 governor, 1 of whom shall be a health economist, 1 of whom shall represent a high-Medicaid and  
2591 low-income public payer disproportionate share hospital, 1 of whom shall represent a hospital  
2592 with 200 beds or less, 1 of whom shall represent a hospital with 800 staffed beds or more, 1 of  
2593 whom shall have demonstrated expertise in representing the health care workforce as a leader in  
2594 a labor organization, 1 of whom shall be a representative of an employer with less than 50  
2595 employees, 1 of whom shall be a representative of an employer with more than 50 employees,  
2596 and 1 of whom shall be a representative of an ambulatory surgical center; 1 of whom shall be a  
2597 representative of the Massachusetts Council of Community Hospitals; 1 of whom shall be a  
2598 representative of the Massachusetts Association of Health Plans, Inc.; 1 of whom shall be a  
2599 representative of Blue Cross and Blue Shield of Massachusetts, Inc.; 1 of whom shall be a  
2600 representative of the Massachusetts Hospital Association, Inc.; and 1 of whom shall be a  
2601 representative of the Conference of Boston Teaching Hospitals. In making appointments, the  
2602 governor shall, to the maximum extent feasible, ensure that the commission represents a broad  
2603 distribution of diverse perspectives and geographic regions.

2604 (b) The commission shall conduct a rigorous, evidence-based analysis to identify the  
2605 amount of administrative expense in the Massachusetts health care system. Such analysis shall  
2606 include, but not be limited to, an examination of the following factors: (i) non-clinical expenses  
2607 in insurance companies; (ii) administrative expense in provider offices; (iii) the impact of  
2608 administrative costs on net revenues of hospitals, physicians, and other care providers; (iv) the  
2609 amount of clinical time lost due to administrative expense; and (v) the costs to businesses and  
2610 families of administrative expense. Such analysis shall also include a comparison of  
2611 administrative practices in the commonwealth relative to other states and best practices about  
2612 reducing administrative expense.

2613 (c) After identifying the factors contributing to administrative spending, the commission  
2614 shall recommend steps to reduce administrative costs without experiencing offsetting increases  
2615 in costs in other areas. To conduct its review and analysis, the commission may contract with an  
2616 outside organization with expertise in the analysis of health care administrative practices. The  
2617 center for health information and analysis and the health policy commission shall provide the  
2618 commission and any contracted outside organization, to the extent possible, relevant data and  
2619 analysis necessary for the evaluation; provided, however, that such data shall be confidential and  
2620 shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General  
2621 Laws.

2622 (d) The commission shall hold its first meeting not later than March 15, 2019, and shall  
2623 thereafter meet not less frequently than monthly.

2624 (e) If the commission determines that legislation is necessary to address the  
2625 administrative cost issues identified during its deliberations, the commission as part of its final  
2626 report, shall file proposals for such legislation not later than September 30, 2019 with the clerks  
2627 of the house of representatives and the senate, who shall forward a copy of the materials filed by  
2628 the commission to the house and senate committees on ways and means and the joint committee  
2629 on health care financing.

2630 SECTION 111. (a) Notwithstanding any general or special law, rule or regulation to the  
2631 contrary, the secretary of health and human services shall convene an emergency task force to  
2632 review the financial stability of nursing homes in the commonwealth in order to ensure the  
2633 provision of quality resident care and quality jobs. The task force shall consist of the following 3  
2634 members or their designees: the secretary of health and human services, who shall serve as chair;

2635 the secretary of elder affairs; the commissioner of public health; the house and senate chairs of  
2636 the joint committee on health care financing; the house and senate chairs of the joint committee  
2637 on elder affairs; 1 member who shall be appointed by the house minority leader; 1 member who  
2638 shall be appointed by the senate minority leader; and 4 members who shall be appointed by the  
2639 Governor, 1 of whom shall be a representative of the Massachusetts Senior Care Association,  
2640 Inc.; 1 of whom shall be a representative of LeadingAge Massachusetts, Inc., 1 of whom shall be  
2641 a representative of 1199SEIU, and 1 of whom shall be an expert on long-term care and aging  
2642 policy.

2643 (b) The emergency task force shall evaluate options and make policy recommendations  
2644 necessary to ensure the financial stability of the nursing homes in the commonwealth in order to  
2645 provide quality nursing home resident care and quality jobs. In addition the emergency task force  
2646 shall evaluate and make policy recommendations necessary to align current and future needs of  
2647 nursing home care, to reform the department of public health's nursing home licensing  
2648 processes, to establish an appropriate process for the closure of nursing homes, and to explore  
2649 financial incentives around the closure of nursing homes. Such recommendations shall include  
2650 policy options concerning the following: (i) improvements to the MassHealth reimbursement  
2651 system for nursing homes to promote financial stability, including: (A) the use of an appropriate  
2652 inflation update for nursing home rates, (B) the use of a base year period that reasonably reflect  
2653 the costs in the actual rate year, (C) efficiency incentives that align with actual utilization, and  
2654 (D) full recognition of the user fee for Medicaid residents; (ii) nursing home workforce  
2655 engagement, recruitment, training, retention, rates of pay, scope of practice and other methods of  
2656 ensuring that direct care and frontline staff have an opportunity to and can sustainably support  
2657 themselves and their families; (iii) potential efficiencies to the commonwealth and improvements

2658 to care delivery that could be realized by a voluntary reconfiguration of the system via a  
2659 reduction in the number of nursing home beds currently licensed while ensuring quality and  
2660 access; (iv) potential criteria to be used to facilitate a voluntary reconfiguration program,  
2661 including but not limited to occupancy, care standards and measure of regional geographic need;  
2662 (v) potential incentives for nursing home operators that would help to align the need for nursing  
2663 home beds with current and future demand and/or would facilitate conversion of under-utilized  
2664 beds to other uses; and (vi) any additional reforms to strengthen the public process for nursing  
2665 home closures and sales or other recommendations necessary to address the issues referenced  
2666 above.

2667 (c) The emergency task force shall convene its first meeting within 90 days of the  
2668 effective date of this act, and shall meet not less than monthly thereafter. The emergency task  
2669 force shall file its report, including any drafts of legislation or regulations necessary to carry out  
2670 its recommendations, with the speaker of the house of representatives, the president of the  
2671 senate, the clerks of the house of representatives and senate, the house and senate committees on  
2672 post audit and oversight, the house and senate chairs of the joint committee on health care  
2673 financing and the joint committee on elder affairs, and the executive director of the health policy  
2674 commission not later than 1 year after the effective date of this act.

2675 (d) The house and senate committees on post audit and oversight shall conduct a  
2676 performance audit of the long term supports and services care delivery systems in the  
2677 commonwealth as informed by the emergency task force final recommendations.

2678 SECTION 112. (a) Notwithstanding any general or special law to the contrary, the  
2679 secretary of health and human services shall convene a health care trust fund working group

2680 consisting of the following members or their designees: the secretary of health and human  
2681 services, who shall serve as chair; the treasurer and receiver general; the secretary for  
2682 administration and finance; the comptroller; the secretary of elder affairs; the commissioner of  
2683 public health; the commissioner of mental health; the commissioner of developmental services;  
2684 the commissioner of the Massachusetts rehabilitation commission; the commissioner of  
2685 transitional assistance; the commissioner of children and families; the executive director of the  
2686 center for health information and analysis; the executive director of the health policy  
2687 commission; 2 members of the senate, 1 of whom shall be appointed by the president of the  
2688 senate and 1 of whom shall be appointed by the senate minority leader; 2 members of the house  
2689 of representatives, 1 of whom shall be appointed by the speaker of the house and 1 of whom  
2690 shall be appointed by the house minority leader.

2691 (b) The health care trust fund working group shall identify all non-budgeted special  
2692 revenue funds established to support health and human service activities within the  
2693 commonwealth and evaluate the effectiveness of each fund in achieving its intended purpose. In  
2694 conducting its evaluation the health care trust fund working group shall consider: the original  
2695 purpose for the establishment of each fund; the statutory requirements and standards governing  
2696 the administration and oversight of each fund; the sources of revenues deposited into each fund;  
2697 and historical expenditures from each fund.

2698 (c) The health care trust fund working group shall hold its first meeting not later than  
2699 September 30, 2018 and shall issue a report making recommendations to improve the financing  
2700 of health and human service programs supported by health care trust funds, including proposals  
2701 to enhance transparency in the administration of funds and coordination between programs  
2702 supported by fund expenditures and programs funded through other means. The health care trust

2703 fund working group shall file its report, including any drafts of legislation or regulations  
2704 necessary to carry out its recommendations, with the clerks of the house of representatives and  
2705 senate, the joint committee on public health and the joint committee on health care financing not  
2706 later than February 1, 2019.

2707 SECTION 113. (a) The division of insurance, in consultation with the commonwealth  
2708 health connector authority and the center for health information and analysis, shall issue a  
2709 comprehensive report at least once every 5 years on the performance of the merged non-group  
2710 and small-group health insurance market, as defined in chapter 176J of the General Laws. In the  
2711 development of each 5 year report, the division may contract with an outside organization with  
2712 expertise in fiscal analysis of the private insurance market. It shall be the responsibility of the  
2713 division, in consultation with the commonwealth health insurance connector authority and the  
2714 center for health information and analysis, to establish appropriate guidelines and assumptions  
2715 regarding the health reforms authorized in this act prior to engaging an outside organization.  
2716 Said organization shall study the impact of merging the non-group and small-group health  
2717 insurance markets and make a report considering the impact on the uninsured, currently insured  
2718 individuals, and employers in the commonwealth.

2719 (b) The study shall consider: (i) trends in premiums, cost-sharing, and actuarial value for  
2720 plans in for individuals and small groups; (ii) characteristics of individuals in the merged market  
2721 in contrast with characteristics of small group members, including, but not limited to, age, risk  
2722 score, geography, gender, family size, industry and income; (iii) utilization and spending trends  
2723 for individual and small group members, sourced from the Massachusetts All-Payer Claims  
2724 Database, including differences in hospital and primary care practice utilization; (iv) status of  
2725 competition between carriers in the market, including migration of insureds to new plans, the

2726 number of employers offering 1 plan to employees, and the behavior of employees whose  
2727 employers offer more than 1 plan; (v) and any additional subjects the division considers relevant.  
2728 In conducting its examination, the organization shall, to the extent possible, obtain and use actual  
2729 health plan data; provided, however, that such data shall be confidential and shall not be a public  
2730 record. The division shall publish each report on its website and file the same with the clerks of  
2731 the house of representatives and senate, the joint committee on public health and the joint  
2732 committee on health care financing.

2733 (c) Notwithstanding any general or special law to the contrary, at the request of the  
2734 commission, all agencies, executive offices, departments, boards, commissions, bureaus,  
2735 divisions and authorities of the commonwealth shall provide, to the extent possible, relevant data  
2736 and analysis necessary for the study to the contracted organization; provided however, that such  
2737 data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7  
2738 of chapter 4 of the General Laws.

2739 SECTION 114. Notwithstanding any general or special rule to the contrary, the treasurer  
2740 shall transfer a total of \$900,000 from the Board of Registration in Medicine Trust Fund  
2741 established in section 35M of chapter 10 of the General Laws to the Mobile Integrated Health  
2742 Care Trust Fund established in section 2ZZZZ of chapter 29 of the General Laws.

2743 SECTION 115. Subsection (d) of section 2TTTT of chapter 29 of the General Laws is  
2744 hereby repealed.

2745 SECTION 116. Section 304 of chapter 149 of the acts of 2004 is hereby repealed.

2746 SECTION 117. Sections 102 and 104 are hereby repealed.

- 2747 SECTION 118. Sections 106 and 107 are hereby repealed.
- 2748 SECTION 119. Section 46 is hereby repealed.
- 2749 SECTION 120. Sections 103, 105 and 117 shall take effect on September 1, 2020.
- 2750 SECTION 121. Section 118 shall take effect on January 1, 2022.
- 2751 SECTION 122. Section 119 shall take effect on June 30, 2021.
- 2752 SECTION 123. Section 115 shall take effect on July 1, 2022.