Massachusetts Taxpayers Foundation

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June 13, 2018

Section by Section Summary of House Health Care Bill (Peter V. Kocot Act)

Section 1. Creates new section (38D) within MGL 3 which establishes a review process for legislative proposals to expand scope of practice. Under the system:

- Committees reporting on a scope of practice bill refer the bill to CHIA for review.
- CHIA's review must consider:
    - Public health risks
    - Impacts on access
    - Impacts on affordability
    - Comparison to practices in other jurisdiction
    - Impact on "reimbursement rate" changes

  CHIA then provides its review to the HPC

- HPC, after holding a public hearing on the proposal and soliciting feedback from interested parties (including DPH and the Betsy Lehman Center), provides a written report of its findings to the committee that requested to the review. The report must include a recommendation as to whether the proposed change is "positive, negative, or neutral."

MGL 3:38D

Section 2. Eliminates the Health Planning Council within EOHHS by striking MGL 6A:16T. This council is later reestablished under HPC (section 24 of the bill).

MGL 6A:16T

Sections 3 through 5. Adds 6 definitions to MGL 6D (Health Policy Commission). Definitions added:

- Health care resource – a resource which (regardless of ownership) is designed to prevent, detect, diagnose or treat medical conditions
- Early Notice – advance notification by a pharma company of a drug/device coming to market
- Pharmaceutical manufacturing company
- Pharmacy benefit manager
- Pharmacy benefit services
- Pipeline drugs – a prescription drug containing a new molecular entity that has been submitted for a new drug/biologics license application

MGL 6D:1

Section 6. Adds representatives of pharmacy benefits managers to the HPC advisory council.

MGL 6D:4

Section 7. Adds monitoring the location and distribution of health care services and health care resources to the charge of the HPC.

MGL 6D: 5

Section 8. Allows the HPC to assess pharma manufacturers/benefits managers for any costs related to the analysis of health care spending trends related to pharmaceuticals. Pharmacy benefits managers subject to a surcharge assessment (provided it administers its own prescription/pharmacist services) will not be subject to an additional assessment under this section.

MGL 6D:6

Section 9. Adds the "further integration of physical, behavioral and oral health along the health care delivery continuum" as an allowable use of the Healthcare Payment Reform Fund.

MGL 6D:7

Section 10. Adds proposals that appropriately redirect inpatient/post-acute care to community settings to the list of proposals that HPC can consider for use of Healthcare Payment Reform Funds

MGL 6D:7

Section 11. Adds two new section (7A) to MGL 6D that:

- Moves the Prevention & Wellness Trust Fund under HPC.
    - HPC is named as the fund administrator in consultation with the Prevention & Wellness Trust Fund Advisory Board.
    - Allowable expenditures for the fund are amended. The current 5 are reduced to 3:
        - Increase access to community-based preventive care which complement/expand MassHealth's efforts to coordinate care and address social determinants of health
        - Reduce impact of conditions that drive poor health, health disparities, health care cost
        - Develop stronger evidence-based prevention programming
    - Up to 70 percent of funds are to be awarded as competitive grants to municipalities in which the municipality or regional planning agency partners with an eligible entity (provider, community health/social service org, etc.).
    - At least 20 percent of the funds are to be distributed through a regionally based competitive grant. The program is to be targeted to areas that have a higher than

average prevalence of preventable health conditions and are underrepresented in awards from the other grant program
    - CHIA is to annually review each grant for progress in achieving goals
    - HPC is to report annually on:
        - Expenditures from the fund
        - Strategy used to allocate funds and evaluation criteria used
- Reestablishes the Prevention & Wellness Advisory Board under the HPC
    - The board is increased from 19 to 23 members. A representative of an employee assistance program is removed, Those added:
        - HPC Commissioner
        - Joint Committee on Public Health chairs
        - Representative of a statewide association of community based service providers
        - Person with expertise in the design/implementation of community wide public health interventions.

MGL 6D:7A & 7B

Sections 12 through 17. Add pharma manufacturers and benefit managers and the MassHealth director to the list of entities included within the scope of the HPC Health Care Cost Benchmark hearing and reporting (MGL 6A:8). Specifically, the sections:

- Include pharma manufacturers/benefit managers within the list of costs to be examined at the hearings
- Adds pharma manufacturers/benefit managers to the list of witnesses at the hearings. Including:
    - 3 pharma manufacturing companies (1 of which is publically traded, 1 of which involved in generic manufacturing, one less than 10 years old)
- Adds the EOHHS MassHealth director to the list of witnesses at the hearings
- Adds criteria to the testimony provided:
    - For pharma manufacturing companies' testimony is to be suitable for public release concerning the factors underlying prescription drug costs, the impact of rebates and other price concessions. Pharma witnesses are not subject to MGL 12C:17 (AG power to compel provision of information)
    - For the MassHealth director testimony concerning the structure, benefits, caseload and financing as well as efforts to redesign programs to improve program integration and efficiency.
- Amends the requirements for the HPC's cost trend report to include:
    - Analysis of pharma manufacturers/benefit managers
    - Data collected under two new sections (6D:10A & 10B) which relate to DOI referral of HC contracts that have unwarranted price factors (10A) and pharma benefit manager cost trends (10B)

MGL 6D:8

Section 18. Adds pharma manufacturers/benefit manager cost trends to the list of topics to be examined at the hearing prior to establishing the health care cost benchmark.

MGL 6D:9

Section 19. Creates a tiered penalty structure for failure to file appropriated/failure to implement a performance improvement plan to:

- $500K for first violation
- $750K for second violation
- $1M thereafter

The section also directs any penalties to the Community Hospital Reinvestment Fund.

MGL 6D:10

Section 20. Creates a new section (10A) within MGL 6D which empowers HPC to require performance improvement plans for health care entities referred by DOI. DOI would make referrals if they determine that a proposed contract has been "influenced by unwarranted factors of price variation." Under this section:

- Impacted entities must file the PIP (or request an extension/waiver) within 45 days
- HPC can waive the requirement if:
    - Proposed rates of payment are warranted or due to other reasonable factors
    - Ongoing efforts of impacted entities to improve efficiency or reduce costs
    - Pricing factors are outside of the control of the health care entity
    - Warranted by the overall financial condition of the health care entity
- The PIP must:
    - Identify the causes of the entity's rate of payment
    - Action steps to improve rate of payment
    - Specific identifiable and measurable outcomes and a timetable for implementation
        - Timetable cannot exceed 18 months
- If the HPC determines a PIP is not acceptable, it must allow 30 days for resubmission
- At the conclusion of the timetable the entity must report to the HPC on relevant outcomes in implementing the plan.
- If the plan is unsuccessful, HPC can:
    - Extend the timetable
    - Approve amendments to the plan proposed by the entity
    - Require a new PIP
    - Waive or delay the PIP
- HPC can submit proposed legislation necessary to achieve the goals of this section
- HPC can levy penalties (identical to those set forth in section 19 of the bill) for failure to appropriately file/implement PIPs under this section. The penalties would go to the Community Hospital Reinvestment Trust

MGL 6D:10

Sections 21 through 23. Makes three changes to the ACO certification section (MGL 6D:15):

- Amends the care coordination standard by replacing reference to success in reducing "adverse events and unnecessary emergency room visits" with "adverse events, rates of

institutional post-acute care and unnecessary emergency room visits or extended emergency department boarding."

- Amends references to the Prevention & Wellness Trust Fund to reflect the move under HPC
- Adds a new standard for certification of demonstrating evidence-based care delivery programs and makes certification as a mobile integrated health program under 111O sufficient to satisfy this requirement.

MGL 6D:15

Section 24. Adds three new sections to MGL 6D:

- Section 19:
    - Establishes the Health Planning Council within the HPC (6D:19). The Commissioner of HPC is named chair and the DOI is added to the membership. The Council is charged with coming up with a state health plan. The goals and criteria for the plan appear to be largely the same as the current Council within EOHHS (struck by section 2 of the bill)
    - Creates an HPC academic detailing program (6D:20). The program, which must begin by 7/1/2019, must be designed to improve drug prescribing practices, improve communication with MassHealth providers and reduce costs related to unnecessary prescriptions.
        - The program is to be developed in conjunction with impacted prescribers, dispensers, benefit managers and the MassHealth drug utilization review board. The program is to be consistent with best practices.
        - The program will include outreach and education regarding cost effective prescribing practices including new information regarding peer reviewed research and clinical trials on treatment options
        - The program is to include a public education component
        - The Commission is to report on the program annually (by April 1)
        - The HCP can seek funding from foundations, undesignated drug litigation settlements, pharma annual disclosure fees and program subscription fees
    - Empowers HPC to contract with an accounting firm or other outside entity to annually study pharma companies with pipeline, generic or biosimilar drugs that may impact healthcare costs in the commonwealth. The section:
        - Requires applicants of pipeline brand, biosimilar or generic drugs to provide specific information for each drug
        - Requires "early notice" for pipeline drugs, abbreviated new drug applications for generics and biosimilars
        - Requires pharma manufacturers to report on certain FDA designations for each pipeline drug, including:
            - Orphan drugs
            - Breakthrough therapy
            - Fast Track
            - Accelerated approval
            - Priority review for new molecular NMEs

- Data submissions (when possible) must occur within 60 days of FDA action
- The study is to be supported by pharmaceutical company assessments/fees required under MGL 111N

MGL 6D: 19-21

Section 25. Adds review of pharmaceutical costs to the AG's annual health care market trends report and adds pharma benefit managers to the list of entities the AG can require to provide information.

MGL 12:11N

Sections 26 and 27. Adds 4 new definitions to the CHIA statute:

- Pharmaceutical manufacturing company
- Pharmacy benefit manager (with additional language specifying what is included in the term "pharmacy benefit services)
- Pipeline drug
- Wholesale acquisition cost (related to the cost of prescription drugs)

MGL 12C:1

Section 28. Adds the bill's new scope of practice provisions (section 1 of the bill) to the list of statutes CHIA does not need council approval for prior to action.

MGL 12C:2A

Sections 29 and 30. Updates section to reflect CHIA's new duties related to pharma manufacturer/benefit manager information collection and analysis.

MGL 12C:3

Sections 31 and 32. Adds pharma manufacturer/benefit managers to the list of entities that must be consulted/notified prior to promulgation of CHIA regulations.

MGL 12C:5

Sections 33 and 34. Adds the Prevention & Wellness Trust Fund as an eligible source of CHIA assessment funds (currently, the assessment also goes in part of the Community Hospital Reinvestment Trust Fund). Language is also added directing pharma manufacturers/benefit managers to be assessed for the cost of CHIA's new responsibilities related to those industries.

MGL 12C:7

Section 35. Creates two new sections in the CHIA statute (12C):

- Requires CHIA to annually report a list of up to ten outpatient prescriptions that account for a significant share of health care spending (section 10A). Under this section:

    - The list is to include drugs from different therapeutic classes and at least three generic outpatient prescriptions. Only drugs whose wholesale cost increased by at least 25 percent over the previous year
    - Manufacturers on the list must provide a description of the factors that contributed to cost increase and aggregate R&D cost and other capital spending information they deem relevant. This information will be published annually by CHIA (October 1)
    - Information provided not included in the CHIA report is not to be a public record
- Requires CHIA to develop and undertake a standard method for analyzing pharmacy benefit manager cost information (section 10B). Types of information required include:
    - Year over year wholesale acquisition cost changes
    - Year over year trends in other formulary, product design, maximum cost changes
    - Rebate and other discount information
    - Payments made to pharmacies that are/are not owned by the benefit manager

MGL 12C:10A &10B

Sections 36 through 38. Amends requirements and penalties related to information disclosures to CHIA:

- Updates section ensuring timely reporting of information due to CHIA to reflect new sections 10A and 10B.
- Increases weekly penalties for failure to comply to $5K (currently $1K)
- Increases maximum penalty to $200K (currently $50K)

MGL 12C:11

Section 39. Updates section related to proper data storage to reflect new sections 10A and 10B.

MGL 12C: 12

Section 40. Strikes and replaces section empowering CHIA to develop a standard quality measure set. Under the new language:

- The standard quality measure set (SQMS), developed in consultation with statewide advisory committee, is to be updated every 2 years
- The SQMS is to be used in:
    - Contracts between payors (including the Commonwealth) which incorporate quality measures under the following statutes:
        - MGL 32A:30
        - MGL 118:80
        - MGL 175:108O
        - MGL 176A:41
        - MGL 176B: 27
        - MGL 176G:35
        - MGL 176I:14
        - MGL 176J:11
    - Assigning tiers to health care providers in the design of a health plan

    - Consumer transparency websites
    - Monitoring system performance
- The SQMS shall designate core and non-core measures to be used in relative contracts
- CHIA is required to develop a uniform SQMS reporting requirement for all providers
- The Advisory committee is increased from 10 to 19 members. Members added include:
    - ED of the Betsy Lehman Center
    - Director of the e-Health Institute
    - Commissioners/Secretaries of Elder Affairs, DMH, DPH
    - Various health care organizations/associations are now named members of the Committee
- The Advisory Committee will meet quarterly to develop core/non-core measures to be included within SQMS
- The Advisory Committee will annually (January 1) submit recommendations to CHIA

MGL 12C:14.

Section 41. Strikes and replaces the Betsy Lehman statute (MGL 12C:15). The new language:

- Empowers the Lehman Center and other agencies that collect patient safety information to share that information
- Directs the Lehman Center to adopt rules and regulations necessary to perform its functions and to contract with public or private entities to "manage its affairs or carry out the purpose" of the section.

MGL 12C:15.

Section 42. Updates CHIA reporting language to include information related to new duties (12C:10A and 10B).

MGL 12C: 16

Section 43. Creates two new sections within the CHIA statute:

- Section 24: Directs CHIA to develop a methodology to communicate information on the assignment of tiers to health care providers, health care services, pharmacy benefit managers and carriers. Under this section:
    - CHIA is to develop this methodology in conjunction with HPC, EOHHS, DOI, GIC, Connector
    - The goal of the methodology is to educate patients, purchasers and employers on the differences in health plan products
    - In developing the methodology, CHIA must consult with impacted entities and hold at least 6 statewide hearings
    - The uniform methodology is due by 12/31/2019
- Section 25: Directs CHIA to annually (December 1) evaluate and report on the Prevention & Wellness trust fund. The evaluation must focus on impact, cost reduction, collaboration and recommendations for changes to the program (including elimination or expansion).

MGL 12C:24 and 25

Section 44. Requires any rule or regulation changes proposed by the Board of Registration in Medicine to be approved by DPH.

MGL 13:10

Section 45. Amends section that currently allows DPH to approve rule or regulation changes proposed by the Board of Registration in Medicine to require that approval. Rules or regulations not approved by DPH within 30 days are to be deemed disapproved.

MGL 13:10A

Section 46. Strikes and replaces the Community Hospital Reinvestment Fund. Under the new language:

- Limits the relative price eligibility standard for payment to the 90th percentile (currently the 120th percentile). Under subsection (d) payments to eligible acute care hospitals will be made to prioritize hospitals with relative prices farthest below the 90th percentile standards. Other considerations for payment include Medicaid/commercial volume, service categories offered not available nearby, affiliation status and availability of state & federal supplemental rates
- Adds a new subsection (e) which also directs payments to eligible acute care hospitals. Unlike subsection (d), this subsection does not include a relative price standard for payment; it appears that this section is intended to go into effect 6/1/2022, but that's after this whole section is repealed according to sections 119 and 122. Under subsection (e) payments would be allocated based on each hospital's proportion of gross patient service revenue compared to the gross patient service revenue of all acute care hospitals in the prior hospital rate year. The same other considerations as specified in subsection (d) may also be used, as well as consideration of relative price.
- Requires an annual expenditure of at least $15M from the fund to community health centers. Those funds would be distributed based on 5 eligible uses to improve service, reduce health disparities, support infrastructure investment, provide loan forgiveness, or improve coordination or scope of care.

MGL 29:2TTTT

Section 47. Creates a new Mobile Integrated Health Care Trust Fund. The fund is:

- Administered by DPH to support administration and oversight of the mobile integrated health program created in MGL 111O
- Supported by fees and fines generated by MGL 111O and other donations and appropriations
- Subject to an annual report (October 1) which summarizes expenditures from the fund.

MGL 29:2ZZZZ

Section 48. Amends GIC statute to ensure that the website of any third party administrator hired by GIC conforms to CHIA's standards for communicating health provider tier information and the academic detailing public information campaign.

MGL 32A:4.

Section 49. Adds two new sections to the GIC statute. The sections:

- Section 29: Requires GIC plans to cover telemedicine services (section 29).
    - Telemedicine coverage may include preauthorization or utilization review, but all determinations must be made in the same way as in-person services.
    - Telemedicine shall not be reimbursed for non-covered benefits
    - Telemedicine services may include a deductible, copayment or coinsurance
- Section 30: Requires GIC ensure that carriers or third party administrators use the SQMS established by CHIA.

MGL 32A:29 and 30

Sections 50 through 52. Makes several changes regarding the mission of the e-Health Institute

- Directs the e-Health Institute to partner with the health care and technology community to accelerate the adoption of digital health.
- Adds the advancement of the commonwealth's economic competitiveness by support of the digital health industry to the e-Health Institute's mission
- Directs the Institute to prioritize improving the commonwealth's digital health economic competitiveness if sufficient progress is made in ensuring that providers use interoperable e-health records.

MGL 40J:6D.

Section 53. Adds a new section to MGL 94C (controlled substances). The new section requires pharmacies to inform customers that they may request the retail price for any pharmaceuticals they plan to purchase. If the retail process is less than the cost-sharing amount, the customer can choose to pay the retail price. Pharmacists must comply with this section regardless of contractual obligations. The pharmacist can submit a claim to the consumer's health plan if the medication is covered.

MGL 94C:21C

Sections 54 through 56. Repeals sections from MGL 111 related to the Prevention & Wellness Trust and Academic Detailing (the bill moves both programs to the HPC).

MGL 111:2G, 2H & 4N

Sections 57 through 59. Makes several changes related to the oversight of the inventory of healthcare resources in the state:

- Eliminates DPH as the entity that oversees the inventory of all health care resources and related information and replaces DPH with the Health Planning Council.
- Eliminates requirement that DPH publish analyses or reports related to the inventory

MGL 111:25A

Section 60. Expands the definition of "facility" for the purposes reporting requirements related to healthcare infections.

MGL 111:51H

Section 61. Adds two new sections to MGL 111 (public health):

- Section 51L: Directs DPH to establish rules, regulations and standards for the licensing of office-based surgical centers. Under the section:
    - Licenses are issued/renewed for 2 year terms
    - DPH can suspend or revoke licenses at its own discretion in the best interests of health, safety or public welfare
    - Licensure violations are subject to fines of up to $10K per day
    - DPH may issue provisional licenses to office-based surgical centers meeting certain accreditation/certification requirements
- Section 51M: Directs DPH to establish rules, regulations and standards for the licensing of urgent care centers. Under the section:
    - Licenses are issued/renewed for 2 year terms
    - DPH can suspend or revoke licenses at its own discretion in the best interests of health, safety or public welfare
    - Licensure violations are subject to fines of up to $10K per day
    - DPH may issue provisional licenses to urgent care centers meeting certain accreditation/certification requirements

MGL 111:51L and 51M

Section 62. Amends the definition section applying to MGL 111:51 through 56 to:

- Add a definition of "office based surgical center"
- Add a definition of "urgent care center"
- Amend the definition of "clinic"
    - The new definition adds references to the two new definitions and appears to eliminate language applying the clinic definition to a range of entities not otherwise named.

MGL 111:52

Section 63. Strikes MGL 111:228 (related to advance disclosure of charges for admission, procedure or service) and adds two sections in its place. The first section (228) relates to advanced notification of billing and includes the following provisions:

- Providers are required to:
    - Determine and disclose network status to the patient
    - Notify patients at the time of admission/procedure/service of their rights to obtain cost information including network information of providers reasonably expected to render services for the patient's use of their health plan's toll free number/website to obtain information about likely costs including copays and facility fees

    - Notify the patient of estimated maximum cost if specific cost information is not available
    - Notify the insured if they order services to be provided by another health provider and provide sufficient information for the insured to determine network status of the other provider or notify the insured if the other provider is likely out of network
- Out of network providers are required to:
    - Disclose that they are out of network at least 24 hours in advance of care
    - Provide an estimated maximum charge
    - Inform the patient of the availability of additional information through their insurance carrier
    - Obtain written consent from the patient to perform services

The other section (228) relates to facility fees and includes the following provisions:

- Hospitals, hospital-based facilities, providers that charges facility fees must:
    - Provide patients with written notice of applicable facilities
        - Notification must detail the amount of the fee or (if unknown) estimate the fee
    - Notify the patient that the charge may be greater than if the same service were not provided by a hospital-based facility
    - Direct the patient to contact their carrier for information about facilities that may not charge facility fees
- Written notice must be provided in advance for all admissions/procedures/services scheduled more than 5 working days in advance
- Hospitals must identify locations as hospital based facilities in signage, marketing materials, etc.
- Hospital-based facilities charging facility fees must prominently display that fact

MGL 111:228 and 228A

Section 64. Adds a definition for "mobile integrated health care provider" to the Mobile Integrated Health Care chapter.

MGL 111O:1

Section 65. Adds two subsections to the Mobile Integrated Health Care chapter which direct DPH to issue guidance on best practices for MIH programs to obtain reimbursement for services provided and requires DPH to annually report on the impact of MIH programs.

MGL 111O:2

Section 66. Adds a new section to the MIH chapter requiring DPH to establish application fees, including an initial application surcharge, for MIH and community EMS programs. In reviewing applications, DPH is to prioritize programs that have been approved as MassHealth ACOs or target populations served by MassHealth ACOs.

MGL 11O:5

Section 67. Adds a new section to MGL 112 (professional licensure). The new section directs the Board of Registration in Medicine to develop regulations regarding the appropriate use of telemedicine. The regulations must address prescribing medication, services not appropriate for telemedicine, consumer protection and appropriate standards of care. The board may allow a licensed physician to obtain proxy credentialing/privileging for telemedicine with other health care providers or facilities.

MGL 112:5O

Section 68. Adds a new section to MGL 118E (Medicaid) which requires MassHealth to disregard income up to 150% of FPL for the purpose of determining eligibility for Medicare Savings or Medicare Buy-in Programs. MassHealth is directed to amend its state plan to effectuate this change.

MGL 118E:25A

Section 69. Amends MGL 118E:28, which relates to the disposal of resources for institutionalized individuals seeking MassHealth. The new language would disregard transfers of up to $750K to a special needs trust from determinations as to whether resources were disposed of at less than fair market value.

MGL 118E:28

Sections 70 and 71. Directs fines collected related to PIPs to the Health Safety Net Trust Fund.

MGL 118E:66

Section 72. Adds three new sections to MGL 118. The sections:

- Section 79: Allows MassHealth to provide coverage for appropriate telemedicine services.
    - Coverage may require utilization review or preauthorization
    - Coverage may include a deductible, copayment or coinsurance payment
    - Telemedicine services must conform to relevant standards of care
- Section 80: Requires entities under contract with a MassHealth MCO or PCC plan to use SQMS.
    - Core measures must be used in contracts; non-core measures may be used.
    - SQMS must be used to assign providers/organizations to tiers in the design of medical benefit programs
- Section 81: Levies an assessment on limited service clinics (licensed under section 51J), office-based surgical centers (licensed under section 51L) or urgent care clinics (licensed under section 51M).
    - The assessment is 8.75 percent of charges for commercial payers
    - Late fees cannot exceed 18 percent per year or 5 percent per month

- All assessments and related FFP generated through expenditures are to be deposited into the Community Hospital Reinvestment Fund
- Assessed clinics can appeal notices of underpayment within 60 days

MGL 118E:79 though 81

Section 73. Eliminates the existing section of MGL 175 (DOI) related to telemedicine coverage.

MGL 175:47BB

Section 74. Adds a new section to MGL 175 (DOI) for telemedicine. The language:

- Prohibits individual insurance policies under section 108 or 110 from declining coverage for services solely due to the fact that the services were delivered by telemedicine, provided that the service is covered for in-person consultation and that the services are appropriately provided through telemedicine.
- Telemedicine coverage may include utilization review, preauthorization, deductibles, copayment or coinsurance payments.
- Telemedicine services must conform to relevant standards of care

MGL 175:47JJ

Section 75. Adds two new sections to MGL 175 (DOI):

- Section 108N: Requires behavioral health specialty organizations contracting with carrier to disclose their method for tiering providers if requested by a network provider.
- Section 108O: Requires insurers licensed under MGL 175 to use the SQMS developed by CHIA.
    - Core measures must be used in any contract that incorporates quality measures
    - Non-core measures may be used
    - SQMS must be used to assign providers to tiers in plan design

MGL 175:108N and 108O.

Section 76. Amends MGL 176A (non-profit hospitals) in section 5. The amended paragraph allows DOI to approve any rate of payment to any provider or class of providers if the payments incentivize greater efficiency without sacrificing quality. The amended language directs the commission to consider warranted price variation factors in approving such rates. If DOI determines the payment rate is influenced by unwarranted price variation factors it's directed to refer the contract to HPC for the filing of a Performance Improvement Plan.

MGL 176A:5

Section 77. Adds 3 sections to MGL 176A:

- Section 38: Prohibits contracts between carriers and non-profit hospitals from denying coverage solely because the service was provided through telemedicine.
    - Telemedicine coverage may include utilization review, preauthorization, deductibles, copayment or coinsurance payments.
    - Telemedicine services must conform to relevant standards of care

- Section 39: Requires non-profit hospital service corporations (or the behavioral health specialty organizations the contract with) contracting with carrier to disclose their method for tiering providers if requested by a network provider.
- Section 40: Requires non-profit hospital service corporations to use the SQMS developed by CHIA.
    - Core measures must be used in any contract that incorporates quality measures
    - Non-core measures may be used
    - SQMS must be used to assign providers to tiers in plan design

Section 78. Amends MGL 176B (medical service corporations) by adding language mirroring the language added under section 76. DOI is empowered to approve any rates that incentivize efficiency without sacrificing quality and in approving rates is directed to consider warranted price variation factors. If DOI finds a contract is influenced by unwarranted price variation factors, it is to refer the entities to HPC for a Performance Improvement Plan.

MGL 176B 78.

Section 79. Adds 3 sections to MGL 176B (medical service corporations):

- Section 25: Prohibits contracts between carriers and medical service corporations from denying coverage solely because the service was provided through telemedicine.
    - Telemedicine coverage may include utilization review, preauthorization, deductibles, copayment or coinsurance payments.
    - Telemedicine services must conform to relevant standards of care
- Section 26: Requires medical service corporations (or the behavioral health specialty organizations the contract with) contracting with carrier to disclose their method for tiering providers if requested by a network provider.
- Section 27: Requires medical service corporations to use the SQMS developed by CHIA.
    - Core measures must be used in any contract that incorporates quality measures
    - Non-core measures may be used
    - SQMS must be used to assign providers to tiers in plan design

MGL 176B:25 through 27

Section 80. Amends language related to out of network charges for HMOs (MGL 176G:5). It eliminates existing language specifying that the payment be a "reasonable amount" and that the payments are not subject to the commonwealth's insurance laws and requires payments to be consistent with sections 28 and 29 of MGL 176O (section 100 of this bill)

MGL 176G:5

Section 81. Amends MGL 176G (health maintenance organizations) by adding language mirroring the language added under sections 76 and 78. DOI is empowered to approve any rates that incentivize efficiency without sacrificing quality and in approving rates is directed to consider warranted price variation factors. If DOI finds a contract is influenced by unwarranted price variation factors, it is to refer the entities to HPC for a Performance Improvement Plan.

Section 82. Adds 3 sections to MGL 176G (health maintenance organizations):

- Section 33: Prohibits contracts between HMOs and members from denying coverage solely because the service was provided through telemedicine.
    - Telemedicine coverage may include utilization review, preauthorization, deductibles, copayment or coinsurance payments.
    - Telemedicine services must conform to relevant standards of care
- Section 34: Requires HMOs (or the behavioral health specialty organizations the contract with) contracting with carrier to disclose their method for tiering providers if requested by a network provider.
- Section 35: Requires HMOs to use the SQMS developed by CHIA.
    - Core measures must be used in any contract that incorporates quality measures
    - Non-core measures may be used
    - SQMS must be used to assign providers to tiers in plan design

MGL 176G:33 through 35

Section 83. Ensures that out of network payments made through preferred provider arrangements are consistent with sections 28 and 29 of MGL 176O (section 100 of this bill).

MGL 176I:3

Section 84. Adds 2 sections to MGL 176I (preferred provider arrangements):

- Section 13: Prohibits preferred provider arrangements from denying coverage solely because the service was provided through telemedicine.
    - Telemedicine coverage may include utilization review, preauthorization, deductibles, copayment or coinsurance payments.
    - Telemedicine services must conform to relevant standards of care
- Section 14: Requires preferred provider arrangements to use the SQMS developed by CHIA.
    - Core measures must be used in any contract that incorporates quality measures
    - Non-core measures may be used
    - SQMS must be used to assign providers to tiers in plan design

MGL 176I:13 and 14

Section 85. Amends MGL 176J (small group health insurance) by adding language mirroring the language added under sections 76, 78 and 81. DOI is empowered to approve any rates that incentivize efficiency without sacrificing quality and in approving rates is directed to consider warranted price variation factors. If DOI finds a contract is influenced by unwarranted price variation factors, it is to refer the entities to HPC for a Performance Improvement Plan.

MGL 176J:6

Section 86. Strikes and replaces section governing reduced, selective or tiered plans for small group insurance. Notable changes include:

- Inclusion of a definition for "shoppable health care services"
- Requires impacted carriers to offer applicable plans = in at least 2 geographic areas (up from 1)

- Requires tiered plans to have a base premium discount rate of least 20 percent (up from 14)
- Adds two new possible plan offerings:
    - Plans where premiums vary based on primary care physician
        - At least 1 plan offered under this option must have a base premium discount rate
    - Plans with a separate cost sharing differential is applied to shoppable services among network providers
    - These two plan types are:
        - Subject to DOI disapproval if it is determined that carrier differentiated cost sharing obligations are solely based on the provider
        - To be reviewed to ensure that the plans avoid confusion, minimize administrative burdens and provide access to care at appropriate locations
- Eliminates smart tiering plans as an option
- Requires carriers to report on the utilization of a variable premium amount based on tier designation for the primary care provider, if any
- Directs DOI to provide information on each plan offered on its website
- Requires that any plans offered under the section meet state and federal mental health parity and addiction equity laws.

MGL 176J:11

Section 87. Adds a new section to MGL 176J (small group health insurance) requiring behavioral health specialty organizations contracting with carriers governed by the chapter to disclose their method for tiering providers if requested by a network provider.

MGL 176J:18

Sections 88 through 94. Adds 10 definitions to MGL 176O (health insurance consumer protections). Definitions added:

- Emergency services
- Facility fee
- Hospital
- Hospital-based facility
- In-network contracted rate
- In-network cost-sharing amount
- Network provider
- Network status
- Out-of-network provider
- Surprise bill

MGL 176O:1

Sections 95 and 96. Amends standard for when an insured member can be billed for services provided by an out of network provider provided in a network location. Currently the standard is if the insured "has a reasonable opportunity" to have the service performed by a network

provider. Under the new standard, the insured must affirmatively choose an out of network provider and provides prior written consent to that effect.

Also, expands the information that carriers must provide to insureds related to the process, billing methodology and out of pocket costs likely for an out of network referral.

MGL 176O:6

Sections 97 and 98. Makes a technical language change related to the bill's provisions for CHIA's development of SQMS as well as clarifications as to the network information each carrier must provide on its website.

MGL 176O:7

Section 99. Amends requirement that all carriers must operate a toll free number and website that allows insureds to get information related to the likely cost and insured share of procedures/admissions. Under the new language:

- Insureds can request the network status of providers
- Carriers must create an option for insureds can request notice of estimated amounts in writing
- The information on the website must conform to the uniform methodology of communicating health care tier information developed by CHIA.

MGL 176O:23

Section 100. Adds four new sections to MGL 176O:

- Section 28: Establishes standards for out-of-network billing:
    - When an out of network provider renders emergency services and the provider is a member of the carrier's network but not the insured member's plan, the carrier shall pay the in-network contracted rate. The provider can only bill the insured for in-network cost sharing.
    - When an out of network provider does not contract with carrier and provides emergency services, the carrier shall pay the greater of 115 percent of the average rate the carrier pays for the service and 125 percent of the Medicare rate. The provider can only bill the insured for copayment/coinsurance/deductible that would have been owed if provided by a network provider.
    - When an out of network provider renders non-emergency services, thee carrier shall pay the greater of 115 percent of the average rate the carrier pays for the service and 125 percent of the Medicare rate. The provider can only bill the insured for copayment/coinsurance/deductible that would have been owed if provided by a network provider (unless they have prior written consent of the insured).
    - The insured:
        - Is not liable for payment of surprise bills
        - Shall not pay more than the in-network cost sharing amount (unless they provide prior written consent)

    - When a payment is made to an out of network provider, the carrier shall inform the insured and the out of network provider of the in-network cost sharing amount
- Section 29: Defines as an unfair and deceptive business practice for any provider or carrier to request payment from an enrollee other than applicable coinsurance, copayment, deductible or other out-of-pocket expenses for services covered by section 28
- Section 30: Directs DOI, in consultation with CHIA, to establish a fair and efficient dispute resolution process for emergency or surprise bills. The dispute resolution process will work as follows for cases involving out-of-network providers and carriers:
    - Either the provider or carrier can submit a dispute to an independent dispute resolution entity
    - A determination will be made within 30 days
    - The dispute resolution entity can choose either the carrier's payment or the fee request of the out of network provider or direct both parties to attempt good faith negotiation for settlement
    - Factors to be considered when making a decision include:
        - Disparity in the fee requested by the out of network provider and fees paid to the out of network provider by other non-participating plans
        - Disparity in the fee requested by the out of network provider and fees paid to the out of network provider by other participating plans
        - The out of network provider's level of training, education and experience
        - The circumstances of the case
        - The usual and customary cost of service
    - The decision of the dispute resolution entity is binding
- Section 31: Prohibits contracts between pharmacy benefits managers and pharmacies from:
    - Prohibiting/restricting the right of the pharmacist to provide an insured with information about their cost share for a prescription or a more affordable alternative.
    - Allowing the pharmacy benefits manager from charging a fee related to the adjudication of a claim
    - Prohibiting or limiting the provision of relevant information to DOI related to section 53 of this bill

MGL 176O:28 through 31

Section 101. Creates a $450 million assessment on some acute care hospitals and insurers (surcharge payors). The assessment works as follows:

- Directs HPC to establish a one-time surcharge $120M assessment on acute hospitals with:
    - More than $700M in total net assets in FY 2017
    - A public payer mix below 60 percent in FY 2016
    - The assessment shall be $120M and will be levied in proportion to an acute hospital's operating surplus in FY 2016 as a share of total operating surpluses for all hospitals subject to the assessment.

    - A hospital's assessment may be reduced by up to 50 percent if the following criteria are met:
        - The hospital receives more than 25 percent of its reimbursement for Medicaid
        - The hospital's net assets don't exceed $1 billion
- Creates a $330 million assessment on insurers (surcharge payors).
    - This surcharge shall be paid based on an entity's total payments for acute hospital services as a share of all such payments by surcharge payors.
- All assessments can either be paid in one lump sum or paid over a 3 year period (beginning on June 30, 2019).
- The assessment is to be deposited in the Community Hospital Reinvestment Trust Fund.
- Assessments for late payment cannot exceed 18 percent annually or 5 percent per month
- Acute hospitals are prohibited from seeking rate increases to pay for the assessment
- Surcharge payors are prohibited from seeking premium increases to pay for the assessment

Section 102. Directs ANF to increase registration and license renewal fees for the nurses, physicians, dentistry and pharmacist by 25 percent effective 7/1/2017. Increased revenue is to be deposited into the Community Hospital Reinvestment Trust Fund.

Section 103. Directs ANF to increase registration and license renewal fees for the nurses, physicians, dentistry and pharmacist by a further 25 percent effective 7/1/2019. Increased revenue is to be deposited into the Community Hospital Reinvestment Trust Fund.

Section 104. Directs ANF to increase registration and license renewal fees for podiatrists and optometrists by 25 percent effective 7/1/2017. Increased revenue is to be deposited into the Community Hospital Reinvestment Trust Fund.

Section 105. Directs ANF to increase registration and license renewal fees for podiatrists and optometrists by a further 25 percent effective 7/1/2019. Increased revenue is to be deposited into the Community Hospital Reinvestment Trust Fund.

Section 106. Creates a $75 surcharge on fees assessed for obtaining or renewing licenses issued by the Board of Registration in Medicine. Increased revenue is to be deposited into the Community Hospital Reinvestment Trust Fund.

Section 107. Creates a $75 surcharge on fees assessed for obtaining or renewing licenses issued by the Board of Registration in Podiatry, Pharmacy, Dentistry, Optometry, and Nursing. Increased revenue is to be deposited into the Community Hospital Reinvestment Trust Fund.

Section 108. Directs MassHealth to report on the role of long-term services and supports within MassHealth in each year for the ACO demonstration.

Section 109. Creates a special commission to study and make recommendations on how to license foreign-trained medical professionals.

Section 110. Creates a special legislative commission to examine administrative costs in the health care system.

Section 111. Creates an emergency taskforce to review the financial stability of nursing homes in Massachusetts in order to ensure the provision of quality resident care and quality jobs.

Section 112. Creates a health care trust fund working group.

Section 113. Directs DOI to issue a comprehensive report at least once every 5 years on the performance of the merged non-group and small-group health insurance market.

Section 114. Directs the treasurer to transfer $900K from the Board of Registration in Medicine Trust Fund to the Mobile Integrated Health Care Trust Fund.

Section 115 and 123. Strikes the allocation method of the Community Hospital Reinvestment Trust Fund related to relative price effective 7/1/2022.

Section 116. Eliminates the requirement that EOHHS annually prepare a public health access program beneficiary employer report.

Sections 117 and 120. Eliminates the first 25 percent increase on registration fees (sections 102 and 104) effective 9/1/2020

Sections 118 and 121. Eliminates the $75 registration surcharges effective 7/1/2022.

Sections 119 and 122. Eliminates section 46 (Community Hospital Reinvestment Trust Fund Language) effective 6/30/2021

Section 120. Makes additional 25 percent registration fee increases effective 9/1/2020.