

HOUSE No. 4639

House bill No. 4617, as changed by the committee on Bills in the Third Reading, and as amended and passed to be engrossed by the House. June 19, 2018.

The Commonwealth of Massachusetts

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

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 shall refer to the clerk of the house and senate any bills containing a scope of practice
10 proposal originally referred to the committee, who shall require a review and evaluation from the
11 center for health information and analysis and recommendations from the health policy
12 commission be provided to the general court 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. Said review and evaluation shall be filed with
17 the clerks of the house and senate, who shall transmit a copy upon receipt of the review and
18 evaluation to the members of the general court.

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

35 other entities as the center determines necessary in order to provide its written findings as
36 described in subsection (e) of this section.

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

42 (f) The health policy commission established in section 2 of chapter 6D shall review and
43 evaluate the scope of practice information within 90 days of receiving the written report from the
44 center for health information and analysis. The health policy commission shall hold a public
45 hearing in connection with its review and evaluation of the scope of practice proposal and shall
46 accept written testimony submitted by interested parties. The health policy commission, when
47 carrying out the duties prescribed in this section, shall review input on the scope of practice
48 proposal from the department of public health, the Betsy Lehman center for patient safety and
49 medical error reduction and such other entities as the health policy commission determines
50 necessary in order to provide its written findings as described in subsection (g). The commission
51 may take into consideration any additional data and research it deems relevant when conducting
52 the review and evaluation.

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

57 the review process. The health policy commission shall make a recommendation that the scope
58 of practice proposal is positive, negative or neutral.

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

60 SECTION 4. Said section 1 of said chapter 6D, as so appearing, is hereby further
61 amended by inserting after the definition of “Health care provider” the 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 3. Section 1 of said chapter 6D, as appearing in the 2016 Official Edition, is
70 hereby amended by inserting after the definition of “Disproportionate share hospital” the
71 following definition:-

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

74 SECTION 5. Said section 1 of said chapter 6D, as so appearing, is hereby further
75 amended by inserting after the definition of “Performance penalty” the following 3 definitions:-

76 “Pharmaceutical manufacturing company”, any entity engaged in the production,
77 preparation, propagation, compounding, conversion or processing of prescription drugs, either

78 directly or indirectly, by extraction from substances of natural origin, or independently by means
79 of chemical synthesis or by a combination of extraction and chemical synthesis, or any entity
80 engaged in the packaging, repackaging, labeling, relabeling or distribution of prescription drugs;
81 provided however, that “pharmaceutical manufacturing company” shall not include a wholesale
82 drug distributor licensed pursuant to section 36A of chapter 112 or a retail pharmacist registered
83 pursuant to section 38 of said chapter 112.

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

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

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

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

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

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

102 SECTION 8. Section 5 of said chapter 6D, as so appearing, is hereby amended by
103 striking out, in line 10, the words “and (vii)” and inserting in place thereof the following words:-
104 ; (vii) monitor the location and distribution of health care services and health care resources; and
105 (viii).

106 SECTION 9. Section 6 of said chapter 6D, as so appearing, is hereby amended by adding
107 the following paragraph:-

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

116 SECTION 10. Section 7 of said chapter 6D, as so appearing, is hereby amended by
117 striking out subsection (a) and inserting in place thereof the following subsection:-

118 (a) The commission, in consultation with the advisory council, shall administer the
119 Healthcare Payment Reform Fund, established under section 100 of chapter 194 of the acts of
120 2011. The fund shall be used for the following purposes: (1) to support the activities of the

121 commission; (2) to foster innovation in health care payment and service delivery; and (3) to
122 further the integration of physical, behavioral and oral health along the health care delivery
123 continuum.

124 SECTION 11. Said section 7 of said chapter 6D, as so appearing, is hereby further
125 amended by striking out subsection (d) and inserting in place thereof the following subsection:-

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

139 SECTION 11A. Said section 7 of said chapter 6D, as so appearing, is hereby further
140 amended by striking out, in lines 44 and 45, the words “Prevention and Wellness Trust Fund, the

141 SECTION 12. Said chapter 6D is hereby further amended by inserting after section 7 the
142 following 2 sections:-

143 Section 7A. (a) There shall be established and set upon the books of the commonwealth a
144 separate fund to be known as the Prevention and Wellness Trust Fund to be expended, without
145 further appropriation, by the commission. The commission, as trustee, shall administer the fund.
146 The commission, in consultation with the Prevention and Wellness Advisory Board established
147 pursuant to section 7B, shall make expenditures from the fund consistent with subsections (d)
148 and (e); provided, that not more than 10 per cent of the amounts held in the fund in any 1 year
149 shall be used by the commission for the combined cost of program administration, technical
150 assistance to grantees or program evaluation.

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

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

164 (d)(1) The commission shall annually award not more than 70 per cent of the Prevention
165 and Wellness Trust Fund through a statewide competitive grant process to municipalities,
166 community-based organizations, health care providers, regional-planning agencies and health
167 plans, all of whom apply for the implementation, evaluation and dissemination of evidence-based
168 community preventive health activities. To be eligible to receive a grant pursuant to this
169 subsection, a recipient shall consist of a partnership that includes at minimum: (i) a municipality
170 or a regional planning agency; (ii) a community-based health or social service provider; (iii) a
171 public health or community action agency with expertise in implementing community-wide
172 health interventions; (iv) a health care provider or a health plan; and (v) where feasible, a
173 Medicaid-certified accountable care organization or a Medicaid certified community partner
174 organization. Expenditures from the fund for such purposes shall supplement and not replace
175 existing local, state, private or federal public health-related funding. An entity that is awarded
176 funds through this program shall demonstrate the ability to: (i) utilize best practices in
177 accounting; (ii) contract with a fiscal agent who will perform the accounting functions on its
178 behalf; or (iii) be provided with technical assistance by the commission to ensure best practices
179 are followed.

180 (2) The commission shall annually award not less than 20 per cent of the Prevention and
181 Wellness Trust Fund through a special grant program and funding allocation to be distributed by
182 a regionally-based competitive bid process. The special grant program shall be targeted to
183 entities located in geographic regions of the state that: (i) demonstrate a higher than average
184 prevalence of preventable health conditions and (ii) are underrepresented in the grant program
185 established pursuant to paragraph (1). The commission, in consultation with the prevention and
186 wellness advisory board, shall work directly with municipalities or community-based

187 organizations in regions that meet the conditions in both clauses (i) and (ii) of the second
188 sentence to develop grant proposals that meet the purposes listed in subsection (c).

189 (e)(1) A grant proposal submitted pursuant to subsection (d) shall include, but not be
190 limited to: (i) a plan that defines specific goals for the reduction in preventable health conditions
191 and health care costs over a multi-year period; (ii) the evidence-based or evidence-informed
192 programs the applicant shall use to meet the goals; (iii) a budget necessary to implement the
193 plan, including a detailed description of the funding or in-kind contributions the applicant will be
194 providing in support of the proposal; (iv) any other private funding or private sector participation
195 the applicant anticipates in support of the proposal; (v) a commitment to include women, racial
196 and ethnic minorities and low-income individuals; and (vi) the anticipated number of individuals
197 that would be affected by implementation of the plan.

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

202 (f) The commission shall, annually on or before January 31, report on expenditures from
203 the Prevention and Wellness Trust Fund. The report shall include, but not be limited to: (i) the
204 revenue credited to the fund; (ii) revenue and expenditure projections and details of all
205 anticipated expenditures from the fund for the next fiscal year; (iii) the amount of fund
206 expenditures attributable to the administrative costs of the commission; (iv) an itemized list of
207 the funds expended through grants awarded pursuant to paragraphs (1) and (2) of subsection (d)
208 and a description of the grantee activities; and (v) the results of the annual evaluation of the

209 effectiveness of the activities funded through grants conducted by the center for health
210 information and analysis pursuant to section 25 of chapter 12C. The report shall be provided to
211 the secretary of health and human services, the commissioner of the department of public health,
212 the executive director of the center for health information and analysis, the executive director of
213 the health policy commission, and the chairs of the house and senate committees on ways and
214 means, the joint committee on health care financing and the joint committee on public health,
215 and shall be posted on the commission's website.

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

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

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

236 (b) The board shall consist of: the commissioner of public health or a designee, who shall
237 serve as chair; the executive director of the health policy commission or a designee; the secretary
238 of health and human services or a designee; the executive director of the center for health
239 information and analysis or a designee; the house and senate chairs of the joint committee on
240 health care financing or their designees; the house and senate chairs of the joint committee on
241 public health or their designees; and 15 persons to be appointed by the governor, 1 of whom shall
242 be a person with expertise in the field of public health economics; 1 of whom shall be a person
243 with expertise in public health research; 1 of whom shall be a person with expertise in the field
244 of health equity; 1 of whom shall be a person from a local board of health for a city or town with
245 a population greater than 50,000; 1 of whom shall be a person of a board of health for a city or
246 town with a population of fewer than 50,000; 2 of whom shall be representatives of health
247 insurance carriers; 1 of whom shall be a person from a consumer health organization; 1 of whom
248 shall be a person from a hospital association; 1 of whom shall be a person from a statewide
249 public health organization; 1 of whom shall be a representative of the interest of businesses; 1 of
250 whom shall be a public health nurse or a school nurse; 1 of whom shall be a person from an
251 association representing community health workers; 1 of whom shall represent a statewide
252 association of community-based service providers addressing public health; and 1 of whom shall

253 be a person with expertise in the design and implementation of community-wide public health
254 interventions.

255 SECTION 13. Sections 7A and 7B of said chapter 6D are hereby repealed.

256 SECTION 14. Section 8 of said chapter 6D, as so appearing, is hereby amended by
257 inserting after the word “organization” , in lines 6 and 7, the following words:- , pharmacy
258 benefit manager, pharmaceutical manufacturing company.

259 SECTION 15. Said section 8 of said chapter 6D, as so appearing, is hereby further
260 amended by inserting after the word “organizations”, in line 14, the following words:- ,
261 pharmacy benefit managers, pharmaceutical manufacturing companies.

262 SECTION 16. Said section 8 of said chapter 6D, as so appearing, is hereby further
263 amended by striking out, in lines 32 and 33 , the words “and (xi) any witness identified by the
264 attorney general or the center” and inserting in place thereof the following words:- (xi) 2
265 pharmacy benefit managers; (xii) 3 pharmaceutical manufacturing companies, 1 of which shall
266 be representative of a publically traded drug manufacturing, 1 of which shall be representative of
267 and doing business in generic drug manufacturing and 1 of which shall have been in existence
268 for fewer than 10 years; (xiii) the assistant secretary for MassHealth; and (xiv) any witness
269 identified by the attorney general or the center.

270 SECTION 17. Said section 8 of said chapter 6D, as so appearing, is hereby further
271 amended by striking out, in line 48, the first time it appears, the word “and”.

272 SECTION 18. Said section 8 of said chapter 6D, as so appearing, is hereby further
273 amended by inserting after the word “commission”, in line 59, the first time it appears, the

274 following words:- ; (iii) in the case of pharmacy benefit managers and pharmaceutical
275 manufacturing companies, testimony that is suitable for public release and that is not likely to
276 compromise the financial, competitive or proprietary nature of any information and data
277 concerning factors underlying prescription drug costs and price increases; the impact of
278 aggregate manufacturer rebates, discounts and other price concessions on net pricing; and any
279 other matters as determined by the commission; and (iv) in the case of the assistant secretary for
280 MassHealth, testimony concerning the structure, benefits, caseload and financing related
281 programs administered by the office or entered into in partnership with other state and federal
282 agencies and the agency's activities to align or redesign those programs in order to encourage the
283 development of more integrated and efficient health care delivery systems. No pharmaceutical
284 manufacturing company identified as a witness under this section, or any testimony by any such
285 company, shall be subject to the provisions of section 17 of chapter 12C.

286 SECTION 19. Subsection (g) of said section 8 of said chapter 6D, as so appearing, is
287 hereby amended by striking out the second sentence and inserting in place thereof the following
288 sentence:- The report shall be based on the commission's analysis of information provided at the
289 hearings by witnesses, providers, provider organizations, insurers, pharmaceutical manufacturing
290 companies and pharmacy benefit managers, registration data collected pursuant to section 11,
291 data collected or analyzed by the center pursuant to sections 8, 9, 10,10A and 10B of chapter
292 12C and any other available information that the commission considers necessary to fulfill its
293 duties in this section, as defined in regulations promulgated by the commission.

294 SECTION 20. Section 9 of said chapter 6D, as so appearing, is hereby amended by
295 inserting after the word "organization", in line 72, the following words:- , pharmacy benefit
296 manager, pharmaceutical manufacturing company.

297 SECTION 21. Section 10 of said chapter 6D, as so appearing, is hereby amended by
298 inserting after the figure “\$500,000”, in line 152, the following words:- the first time that a
299 determination is made, not more than \$750,000 for a second determination and not more than
300 \$1,000,000 for a third or subsequent determination; provided, however, that a civil penalty
301 assessed pursuant to 1 of the above clauses shall be a first offense if a previously assessed
302 penalty was assessed pursuant to a different clause. A civil penalty assessed pursuant to this
303 subsection shall be deposited into the Community Hospital Reinvestment Trust Fund established
304 in section 2TTTT of chapter 29.

305 SECTION 22. Said chapter 6D is hereby further amended by inserting after section 10
306 the following section:-

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

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

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

315 or

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

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

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

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

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

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

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

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

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

336 (e) If the commission declines to waive or extend the requirement for the health care
337 entity to file a performance improvement plan, the commission shall provide written notice to the

338 health care entity that its application for a waiver or extension was denied and the health care
339 entity shall file a performance improvement plan.

340 (f) A health care entity shall file a performance improvement plan: (i) within 45 days of
341 receipt of a notice under subsection (a); (ii) if the health care entity has requested a waiver or
342 extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or
343 (iii) if the health care entity is granted an extension, on the date given on such extension. The
344 performance improvement plan shall be generated by the health care entity; shall identify the
345 causes of the entity's rate of payment; and shall include, but not be limited to, specific strategies,
346 adjustments and action steps the entity proposes to implement to improve rate of payment and
347 cost performance. The performance improvement plan shall include specific identifiable and
348 measurable expected outcomes and a timetable for implementation. The timetable for a
349 performance improvement plan shall not exceed 18 months.

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

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

358 (i) Upon approval of the proposed performance improvement plan, the commission shall
359 notify the health care entity to begin immediate implementation of the performance improvement

360 plan. The commission shall provide assistance to the health care entity in the successful
361 implementation of the performance improvement plan.

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

366 (k) At the conclusion of the timetable established in the performance improvement plan,
367 the health care entity shall report to the commission regarding the outcome of the performance
368 improvement plan. If the performance improvement plan was found to be unsuccessful, the
369 commission shall either: (i) extend the implementation timetable of the existing performance
370 improvement plan; (ii) approve amendments to the performance improvement plan as proposed
371 by the health care entity; (iii) require the health care entity to submit a new performance
372 improvement plan under subsection (c); or (iv) waive or delay the requirement to file any
373 additional performance improvement plans.

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

379 (m) If the commission determines that a health care entity has: (i) willfully neglected to
380 file a performance improvement plan with the commission within the time period required under
381 subsection (f); (ii) failed to file an acceptable performance improvement plan in good faith with

382 the commission; (iii) failed to implement the performance improvement plan in good faith; or
383 (iv) knowingly failed to provide information required by this section to the commission or
384 knowingly falsified the same, the commission may assess a civil penalty to the health care entity
385 of not more than \$500,000. The first time that a determination is made, not more than \$750,000
386 for a second determination, and not more than \$1,000,000 for a third or subsequent
387 determination; provided however, that a civil penalty assessed under 1 of the above clauses shall
388 be a first offense if a previously assessed penalty was assessed pursuant to a different clause. A
389 civil penalty assessed under this subsection shall be deposited into the Community Hospital
390 Reinvestment Trust Fund established under section 2TTTT of chapter 29. The commission shall
391 seek to promote compliance with this section and shall only impose a civil penalty as a last
392 resort.

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

397 SECTION 23. Clause (10) of subsection (c) of section 15 of said chapter 6D, as so
398 appearing, is hereby amended by striking out, in lines 140 and 141, the words “adverse events
399 and unnecessary emergency room visits” and inserting in place thereof the following words:-
400 adverse events, care and unnecessary emergency room visits or extended emergency department
401 boarding.

402 SECTION 24. Clause (12) of said subsection (c) of said section 15 of said chapter 6D, as
403 so appearing, is hereby amended by striking out, in lines 149 to 151, inclusive, the words “by the

404 department of public health through the Prevention and Wellness Trust Fund established in
405 section 2G of chapter 111” and inserting in place thereof the following words:- through the
406 Prevention and Wellness Trust Fund established in section 7A.

407 SECTION 24A. Said subsection (c) of said section 15 of said chapter 6D is hereby
408 further amended by striking out clause (12), as amended by section 22, and inserting in place
409 thereof the following clause:-

410 (12) to promote community-based wellness programs and community health workers and
411 to promote other activities that integrate community public health interventions with an emphasis
412 on the social determinants of health and which have been proven to improve health;

413 SECTION 25. Said subsection (c) of said section 15 of said chapter 6D, as so appearing,
414 is hereby further amended by striking out clause (16) and inserting in place thereof the following
415 2 clauses:-

416 (16) to demonstrate evidence-based care delivery programs, which may include
417 community care transitions coaching programs led by community-based, nonprofit entities
418 designed to reduce: (i) 30-day readmission rates; (ii) avoidable emergency department use,
419 including extended emergency department boarding; provided however, that a mobile integrated
420 health care program certified pursuant to chapter 111O shall satisfy this requirement for the
421 purposes of the commission; and

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

423 SECTION 26. Said chapter 6D is hereby further amended by adding the following 3
424 sections:-

425 Section 19. (a) There is hereby established within the commission a health planning
426 council, consisting of the executive director of the health policy commission who shall serve as
427 chair, the secretary of health and human services or a designee, the commissioner of public
428 health or a designee, the director of the office of Medicaid or a designee, the commissioner of
429 mental health or a designee, the commissioner of insurance or a designee, the secretary of elder
430 affairs or a designee, the executive director of the center for health information and analysis or a
431 designee, and 3 members appointed by the governor, 1 of whom shall be a health economist, 1 of
432 whom shall have experience in health policy and planning and 1 of whom shall have experience
433 in health care market planning and service line analysis.

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

437 The state health plan developed by the council shall include the location, distribution and
438 nature of all health care resources in the commonwealth and shall identify certain categories of
439 health care resources, including: (i) acute care units; (ii) non-acute care units; (iii) specialty care
440 units, including, but not limited to, burn, coronary care, cancer care, neonatal care, post-obstetric
441 and post-operative recovery care, pulmonary care, renal dialysis and surgical, including trauma
442 and intensive care units; (iv) skilled nursing facilities; (v) assisted living facilities; (vi) long-term
443 care facilities; (vii) ambulatory surgical centers; (viii) office-based surgical centers; (ix) urgent
444 care centers; (x) home health, behavioral health and mental health services; (xi) treatment and
445 prevention services for alcohol and other drug abuse; (xii) emergency care; (xiii) ambulatory
446 care services; (xiv) primary care resources; (xv) pharmacy and pharmacological services; (xvi)
447 family planning services; (xvii) obstetrics and gynecology services; (xviii) allied health services

448 including, but not limited to, optometric care, chiropractic services, dental care and midwifery
449 services; (xix) federally qualified health centers and free clinics; (xx) numbers of technologies or
450 equipment defined as innovative services or new technologies by the department of public health
451 pursuant to section 25C of chapter 111; (xxi) hospice and palliative care service; and (xviii)
452 health screening and early intervention services.

453 The state health plan shall also make recommendations for the appropriate supply and
454 distribution of resources, programs, capacities, technologies and services identified in the second
455 paragraph of this subsection on a state-wide or regional basis based on an assessment of need for
456 the next 5 years and options for implementing such recommendations. The recommendations
457 shall reflect, at a minimum, the following goals: (i) maintain and improve the quality of health
458 care services; (ii) support the commonwealth's efforts to meet the health care cost growth
459 benchmark established pursuant to section 9; (iii) support innovative health care delivery and
460 alternative payment models as identified by the commission; (iv) reduce unnecessary
461 duplication; (v) support universal access to reduce health disparities; (vi) support efforts to
462 integrate oral health, mental health, behavioral and substance use disorder services with overall
463 medical care; (vii) reflect the latest trends in utilization and support the best standards of care;
464 and (viii) rationally distribute health care resources across geographic regions of commonwealth
465 based on the needs of the population on a statewide basis, as well as, the needs of particular
466 geographic areas of the commonwealth.

467 (c) Under the direction of the council, the department of public health, pursuant to section
468 25A of chapter 111, shall establish and maintain on a current basis an inventory of all such health
469 care resources together with all other reasonably pertinent information concerning such
470 resources. Agencies of the commonwealth that license, register, regulate or otherwise collect

471 cost, quality or other data concerning health care resources shall cooperate with the council and
472 the department in coordinating such data with information collected pursuant to this section and
473 said section 25A of said chapter 111. The inventory compiled pursuant to this section and said
474 section 25A of said chapter 111 and all related information shall be maintained in a form usable
475 by the general public in a designated office of the council and shall constitute a public record;
476 provided, however, that any item of information which is confidential or privileged in nature
477 under any other law shall not be regarded as a public record pursuant to this section.

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

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

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

493 Section 20. (a) For the purposes of this section, the following words shall, unless the
494 context clearly requires otherwise, have the following meanings:-

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

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

500 “PCORI”, patient-centered outcomes research institute

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

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

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

511 (c) The commission shall design the program after consultation with prescribers and
512 dispensers of drugs, private insurers offering prescription drug coverage, hospitals, pharmacy
513 benefit managers, consumers and the MassHealth drug utilization review board. The program, as

514 well as any affiliated organizations, shall be required to use transparent procedures for
515 development of assessments, summaries and decision-support tools that describe the methods
516 used. Such methods shall be consistent with best practices for academic detailing and systematic
517 evidence reviews. Any organization referenced or research conducted shall align with the
518 patient-centered outcomes research institute's standards for patient-centeredness in health
519 outcomes research. There shall be opportunity for input from clinical experts and patients in
520 research process and development of materials. In view of the widely recognized limitations of
521 cost-effectiveness research, the academic detailing program shall not conduct research or
522 communicate information in ways that discriminate against or otherwise disadvantage vulnerable
523 populations, including populations with health disparities, or individuals with special health
524 needs. In planning for the design of the prescription drug academic detailing program, the
525 commission shall review and evaluate use of the educational and assessment materials developed
526 by (i) the University of Massachusetts medical school, (ii) PCORI, (iii) Pennsylvania
527 PACE/Harvard University Independent Drug Information Service, and (iv) the North Carolina
528 evidence-based peer-to-peer education program outreach program.

529 (d) The program components shall include outreach and education regarding the
530 therapeutic and cost-effective use of prescription drugs as issued in peer-reviewed scientific,
531 medical and academic research publications and made available to prescribers and dispensers of
532 drugs in the commonwealth, including through written information and through personal visits
533 from program staff. To the extent possible, program components shall also include information
534 regarding clinical trials, pharmaceutical efficacy, adverse effects of drugs, evidence-based
535 treatment options and drug marketing approaches that are intended to circumvent competition
536 from generic and therapeutically equivalent drugs. Academic detailers shall observe standards of

537 conduct in their educational materials and written and oral presentations as established by rules
538 adopted by the commission that are consistent with the following federal regulations regarding
539 labeling and false and misleading advertising: (i) the Food and Drug Administration labeling
540 requirements of 21 CFR, Part 201, prescription drug advertising provisions of 21 CFR, Part 202
541 and related guidance; and (ii) the Office of the Inspector General Compliance Program Guidance
542 for Pharmaceutical Manufacturers issued in April 2003, as amended. The commission's rules
543 shall require academic detailers to disclose evidence-based information about the range and cost
544 of appropriate drug treatment options and the health benefits and risks of all appropriate drugs.

545 (e) The program shall provide outreach and education to prescribers and dispensers who
546 participate in, contract with or are reimbursed health care programs funded by the
547 commonwealth, including but not limited to, those programs for which the group insurance
548 commission purchases health insurance pursuant to section 4 of chapter 32A. The program may
549 provide outreach and education to private insurers offering prescription drug coverage, hospitals,
550 employers and other persons interested in the program on a subscription or fee-paying basis
551 pursuant to rules adopted by the commission.

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

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

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

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

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

572 (1) Pipeline drugs; and

573 (2) All biosimilar biologics license applications (BLA), upon the receipt of an action date
574 from the FDA. (c) In connection with the annual study, the applicant for a pipeline brand or
575 biosimilar shall provide the commission or the contracted third-party entity with a brief
576 description of the following for each drug, using data fields consistent with those employed by
577 the United States National Institutes of Health in clinicaltrials.gov, if applicable:

578 (1) The primary disease, health condition or therapeutic area being studied and the
579 indication;

580 (2) The routes of administration being studied;

581 (3) Clinical trial comparators, if applicable; and

582 (4) Estimated year of market entry.

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

585 (1) Orphan Drug;

586 (2) Fast Track;

587 (3) Breakthrough Therapy;

588 (4) Accelerated Approval; or

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

590 (e) The data submissions required by this section shall be submitted to the commission or
591 the contracted third-party entity no later than 60 days after receipt of the FDA action date,
592 provided, however, that for drugs in development that receive any of the FDA designations listed
593 in subsection (d) for NMEs, such submissions shall be provided as soon as practical upon receipt
594 of the relevant designation.

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

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

601 SECTION 27. Section 11N of chapter 12 of the General Laws, as so appearing, is hereby
602 amended by striking out subsection (a) and inserting in place thereof the following subsection:-

603 (a) The attorney general shall monitor trends in the health care market including, but not
604 limited to, trends in provider organization size and composition, consolidation in the provider
605 market, payer contracting trends, patient access and quality issues in the health care market and
606 prescription drug cost and price trends. The attorney general may obtain the following
607 information from a private health care payer, public health care payer, pharmacy benefit
608 manager, provider or provider organization, as any of those terms may be defined in section 1 of
609 chapter 6D: (i) any information that is required to be submitted pursuant to sections 8, 9, 10 and
610 10B of chapter 12C; (ii) filings, applications and supporting documentation related to any cost
611 and market impact review pursuant to section 13 of said chapter 6D; (iii) filings, applications and
612 supporting documentation related to a determination of need application filed pursuant to section
613 25C of chapter 111; and (iv) filings, applications and supporting documentation submitted to the
614 federal Centers for Medicare and Medicaid Services or the Office of the Inspector General for
615 any demonstration project. Pursuant to section 8 of said chapter 6D and section 17 of said
616 chapter 12C, and subject to the limitations in said sections, the attorney general may require that
617 any provider, provider organization, pharmacy benefit manager, private health care payer or
618 public health care payer produce documents, answer interrogatories and provide testimony under
619 oath related to health care costs and cost trends, the factors that contribute to cost growth within

620 the commonwealth's health care system and the relationship between provider costs and payer
621 premium rates.

622 SECTION 28. Section 1 of chapter 12C of the General Laws, as so appearing, is hereby
623 amended by inserting after the definition of “Patient-centered medical home” the following 4
624 definitions:-

625 “Pharmaceutical manufacturing company”, any entity engaged in the production,
626 preparation, propagation, compounding, conversion or processing of prescription drugs, either
627 directly or indirectly, by extraction from substances of natural origin, or independently by means
628 of chemical synthesis or by a combination of extraction and chemical synthesis, or any entity
629 engaged in the packaging, repackaging, labeling, relabeling or distribution of prescription drugs;
630 provided however, that “pharmaceutical manufacturing company” shall not include a wholesale
631 drug distributor licensed pursuant to section 36A of chapter 112 or a retail pharmacist registered
632 pursuant to section 38 of said chapter 112.

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

637 “Pharmacy benefit services” shall include, but not be limited to, formulary
638 administration; drug benefit design; pharmacy network contracting; pharmacy claims processing;
639 mail and specialty drug pharmacy services; and cost containment, clinical, safety, and adherence
640 programs for pharmacy services.

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

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

646 SECTION 29. Said section 1 of said chapter said 12C, as so appearing, is hereby further
647 amended by adding the following definition:-

648 “Wholesale acquisition cost”, the cost of a prescription drug as defined in 42 U.S.C.
649 §1395w-3a(c)(6)(B).

650 SECTION 30. Subsection (c) of section 2A of said chapter 12C, as so appearing, is
651 hereby amended by striking out clause (4) and inserting in place thereof the following clause:-

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

655 SECTION 31. Section 3 of said chapter 12C, as so appearing, is hereby amended by
656 inserting after the word “organizations”, in lines 13 and 14, the following words:- ,
657 pharmaceutical manufacturing companies, pharmacy benefit managers.

658 SECTION 32. Said section 3 of said chapter 12C, as so appearing, is hereby further
659 amended by striking out, in line 24, the words “and payer” and inserting in place thereof the
660 following words:- , payer, pharmaceutical manufacturing company and pharmacy benefit
661 manager.

662 SECTION 33. Section 5 of said chapter 12C, as so appearing, is hereby amended by
663 inserting after the word “organizations”, in line 11, the following words:- , pharmaceutical
664 manufacturing companies, pharmacy benefit managers.

665 SECTION 34. Said section 5 of said chapter 12C, as so appearing, is hereby further
666 amended by inserting after the word “providers”, in line 15, the following words:- , affected
667 pharmaceutical manufacturing companies, affected pharmacy benefit managers.

668 SECTION 35. Section 7 of said chapter 12C, as so appearing, is hereby amended by
669 striking the words “Community Hospital Reinvestment Trust Fund established in section 2TTTT
670 of chapter 29,” in lines 5 and 6, 11 and 12 and 44 to 46, inclusive, each time it appears, and
671 inserting in place thereof the following words:- Prevention and Wellness Trust Fund established
672 in section 7A of chapter 6D.

673 SECTION 35A. Said section 7 of said chapter 12C, as amended by section 33, is hereby
674 further amended by striking the words “Prevention and Wellness Trust established in section 7A
675 of chapter 6D” each time they were inserted by section 33, and inserting in place thereof the
676 following words:- Community Hospital Reinvestment Trust Fund established in section 2TTTT
677 of chapter 29.

678 SECTION 36. Said section 7 of said chapter 12C, as so appearing, is hereby further
679 amended by adding the following paragraph:-

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

684 SECTION 37. Said chapter 12C is hereby further amended by inserting after section 10
685 the following 2 sections:-

686 Section 10A. (a) On or before March 1, 2020, and annually thereafter, the center shall
687 prepare a list of not more than ten outpatient prescription drugs that the center determines
688 account for a significant share of state health care spending, considering the net cost of such
689 drugs in the immediately preceding calendar year. The list shall include outpatient prescription
690 drugs from different therapeutic classes and no more than three generic outpatient prescription
691 drugs. The center shall not list any outpatient prescription drug pursuant to this subsection
692 unless the wholesale acquisition cost of the prescription drug, less all rebates paid to the
693 commonwealth for such drug during the immediately preceding calendar year, increased by not
694 less than 25 per cent during the immediately preceding calendar year.

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

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

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

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

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

721 Section 10B. The center shall promulgate regulations necessary to ensure the uniform
722 analysis of information regarding pharmacy benefit managers that enables the center to analyze:
723 (1) year-over-year wholesale acquisition cost changes; (2) year-over-year trends in formulary,
724 maximum allowable costs list and cost-sharing design, including the establishment and
725 management of specialty product lists; (3) aggregate information regarding discounts,
726 utilizations limits, rebates, manufacturer administrative fees and other financial incentives or
727 concessions related to pharmaceutical products or formulary programs; (4) information regarding

728 the aggregate amount of payments made to pharmacies owned or controlled by the pharmacy
729 benefit managers and the aggregate amount of payments made to pharmacies that are not owned
730 or controlled by the pharmacy benefit managers; and (5) additional information deemed
731 reasonable and necessary by the center as set forth in the center's regulations.

732 SECTION 38. Section 11 of said chapter 12C, as so appearing, is hereby amended by
733 striking out the first sentence and inserting in place thereof the following sentence:-

734 The center shall ensure the timely reporting of information required pursuant to sections
735 8, 9, 10, 10A, and 10B.

736 SECTION 39. Said section 11 of said chapter 12C, as so appearing, is hereby further
737 amended by striking out, in line 11, the figure "\$1,000" and inserting in place thereof the
738 following figure:- \$5,000.

739 SECTION 40. Said section 11 of said chapter 12C, as so appearing, is hereby further
740 amended by striking out, in line 16, the figure "\$50,000" and inserting in place thereof the
741 following figure:- \$200,000.

742 SECTION 41. Section 12 of said chapter 12C, as so appearing, is hereby amended by
743 striking out, in line 2, the words "9, and 10" and inserting in place thereof the following words:-
744 9, 10, 10A and 10B.

745 SECTION 42. Said chapter 12C is hereby further amended by striking out section 14, as
746 so appearing, and inserting in place thereof the following section:-

747 Section 14. (a)(1) The center, in consultation with the statewide advisory committee
748 established pursuant to subsection (c) shall, not later than March 1 in each even-numbered year,

749 establish a standard set of measures of health care provider quality and health system
750 performance, hereinafter referred to as the “standard quality measure set”, for use in: (i) contracts
751 between payers, including the commonwealth and carriers, and health care providers, provider
752 organizations and accountable care organizations, which incorporate quality measures into
753 payment terms, including the designation of a set of core measures and a set of non-core
754 measures; (ii) assigning tiers to health care providers in the design of any health plan; (iii)
755 consumer transparency websites and other methods of providing consumer information; and (iv)
756 monitoring system-wide performance.

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

763 (3) The standard quality measure set shall designate: (i) core measures that shall be used
764 in contracts between payers, including the commonwealth and carriers, and health care
765 providers, including provider organizations and accountable care organizations, that incorporate
766 quality measures into payment terms, and shall meet the core criteria set by the Quality
767 Measurement Alignment Task Force; and (ii) a menu of non-core measures that may be used in
768 such contracts. The standard quality measure set shall allow for innovation and the development
769 of outcome measures. If the standard quality measure set established by the center differs from
770 the recommendations of the statewide advisory committee, the center shall issue a written report
771 detailing each area of disagreement and the rationale for the center’s decision.

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

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

781 (2) The statewide advisory committee shall consist of the secretary of health and human
782 services and the executive director of the health policy commission, or their designees, who shall
783 serve as co-chairs, and shall include the following members or their designees: executive director
784 of the center; the executive director of the Betsy Lehman center for patient safety and medical
785 error reduction; the executive director of the group insurance commission; the director of the
786 Massachusetts e-Health Institute; the secretary of elder affairs; the assistant secretary for
787 MassHealth; the commissioner of the department of public health; the commissioner of the
788 department of mental health; and 11 members who shall be appointed by the governor, 1 of
789 whom shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of
790 whom shall be a representative of the Massachusetts League of Community Health Centers, Inc.,
791 1 of whom shall be a representative the Massachusetts Medical Society, 1 of whom shall a
792 registered nurse licensed to practice in Massachusetts who practices in a patient care setting; 1 of
793 whom shall be a representative of a labor organizations representing health care workers; 1 of
794 whom shall be a behavioral health provider, 1 of whom shall be a long-term supports and

795 services provider, 1 of whom shall be a representative of Blue Cross and Blue Shield of
796 Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Association of
797 Health Plans, Inc., 1 of whom shall be a representative of a specialty pediatric provider and 1 of
798 whom shall be a representative for consumers. Members appointed to the statewide advisory
799 committee shall have experience with and expertise in health care quality measurement.

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

808 (4) In developing its recommendations for the standard quality measure set, the statewide
809 advisory committee shall incorporate nationally recognized quality measures including, but not
810 limited to recommendations from the executive office of health and human services performance
811 measurement alignment task force, measures used by the Centers for Medicare and Medicaid
812 Services, the group insurance commission, carriers and providers and provider organizations in
813 the commonwealth and other states, as well as other valid measures of health care provider
814 performance, outcomes, including patient-reported outcomes and functional status, patient
815 experience, disparities and population health. The statewide advisory committee shall consider
816 measures applicable to primary care providers, specialists, hospitals, provider organizations,

817 accountable care organizations, oral health providers and other types of providers and measures
818 applicable to different patient populations.

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

823 SECTION 43. Said chapter 12C is hereby further amended by striking out section 15, as
824 so appearing, and inserting in place thereof the following section:-

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

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

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

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

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

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

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

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

841 "Patient safety", freedom from accidental injury.

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

845 (b) There shall be established within the center the Betsy Lehman center for patient safety
846 and medical error reduction. The purpose of the Lehman center shall be to serve as a
847 clearinghouse for the development, evaluation and dissemination, including, but not limited to,
848 the sponsorship of training and education programs, of best practices for patient safety and
849 medical error reduction. The Lehman center shall: (i) coordinate the efforts of state agencies
850 engaged in the regulation, contracting or delivery of health care and those individuals or
851 institutions licensed by the commonwealth to provide health care to meet their responsibilities
852 for patient safety and medical error reduction; (ii) assist all such entities to work as part of a total
853 system of patient safety; and (iii) develop appropriate mechanisms for consumers to be included
854 in a statewide program for improving patient safety. The Lehman center shall coordinate state
855 participation in any appropriate state or federal reports or data collection efforts relative to
856 patient safety and medical error reduction. The Lehman center shall analyze available data,
857 research and reports for information that would improve education and training programs that
858 promote patient safety.

859 (c) Within the Lehman center, there shall be established a patient safety and medical
860 errors reduction board. The board shall consist of the secretary of health and human services, the
861 executive director of the center, the director of consumer affairs and business regulations and the
862 attorney general. The board shall appoint, in consultation with the advisory committee, the
863 director of the Lehman center by a unanimous vote and the director shall, under the general
864 supervision of the board, have general oversight of the operation of the Lehman center. The
865 director may appoint or retain and remove expert, clerical or other assistants as the work of the
866 Lehman center may require. The coalition for the prevention of medical errors shall serve as the
867 advisory committee to the board. The advisory committee shall, at the request of the director,
868 provide advice and counsel as it considers appropriate including, but not limited to, serving as a
869 resource for studies and projects undertaken or sponsored by the Lehman center. The advisory
870 committee may also review and comment on regulations and standards proposed or promulgated
871 by the Lehman center, but the review and comment shall be advisory in nature and shall not be
872 considered binding on the Lehman center.

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

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

883 (e) The Lehman center shall: (i) identify and disseminate information about evidence-
884 based best practices to reduce medical errors and enhance patient safety; (ii) develop a process
885 for determining which evidence-based best practices should be considered for adoption; (iii)
886 serve as a central clearinghouse for the collection and analysis of existing information on the
887 causes of medical errors and strategies for prevention; and (iv) increase awareness of error
888 prevention strategies through public and professional education. The information collected by the
889 Lehman center or reported to the Lehman center shall not be a public record as defined in section
890 7 of chapter 4, shall be confidential and shall not be subject to subpoena or discovery or
891 introduced into evidence in any judicial or administrative proceeding, except as otherwise
892 specifically provided by law.

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

899 (g) The Lehman center may adopt rules and regulations necessary to carry out the
900 purpose and provisions of this section. The Lehman center may contract with any federal, state
901 or municipal agency or other public institution or with any private individual, partnership, firm,

902 corporation, association or other entity to manage its affairs or carry out the purpose and
903 provisions of this section.

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

908 SECTION 44. Subsection (a) of section 16 of said chapter 12C, as so appearing, is hereby
909 amended by striking out the first sentence and inserting in place thereof the following sentence:-
910 The center shall publish an annual report based on the information submitted pursuant to sections
911 8, 9, 10, 10A and 10B concerning health care provider, provider organization, pharmaceutical
912 manufacturing company, pharmacy benefit manager and private and public health care payer
913 costs and cost and price trends, pursuant to section 13 of chapter 6D relative to market impact
914 reviews and pursuant to section 15 relative to quality data.

915 SECTION 45. Said chapter 12C is hereby further amended by striking out section 23 and
916 inserting in place thereof the following section:-

917 Section 23. Subject to appropriation, the center shall transfer annually \$10,000,000 to
918 the Prevention and Wellness Trust Fund established in section 7A of chapter 6D, not later than
919 June 30; provided, however, that such transfer shall not result in an increase in the assessment
920 calculated under section 7.

921 SECTION 45A. Section 23 of said chapter 12C, as appearing in section 43 is hereby
922 amended, by striking out the words "Prevention and Wellness Trust Fund established in section

923 7A of chapter 6D” and inserting in place thereof the following words:- Community Hospital
924 Reinvestment Trust Fund established in section 2TTTT of chapter 29.

925 SECTION 46. Said chapter 12C is hereby further amended by adding the following 2
926 sections:-

927 Section 24. (a) The center, in consultation with the division of insurance, the health
928 connector authority, the group insurance commission, the health policy commission and the
929 secretary of the executive office of health, shall develop and adopt a uniform methodology for
930 the communication of information on the assignment of tiers to health care providers and health
931 care services, including pharmacy benefits, by carriers. The methodology adopted by the center
932 shall ensure that such information educates patients, purchasers and employers on the differences
933 in the plan design and cost sharing requirements of any health plan product. The center shall also
934 ensure that such information educates patients on the role of the standard quality measure set
935 established under section 14 in a carrier’s assignment of a tier to a health care provider.

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

941 (c) The center shall issue a final report detailing the uniform methodology of
942 communication adopted by the center on or before December 31, 2019. The center shall file the
943 report with the governor, the clerks of the house of representatives and the senate, the joint

944 committee on health care financing and the house and senate committees on ways and means.
945 The report shall also be made available on the center's website.

946 Section 25. (a) The center, in consultation with the prevention and wellness advisory
947 board established in section 7B of chapter 6D, shall annually, on or before December 1, issue a
948 data report on progress toward meeting stated goals of the grant program authorized in section
949 7A of chapter 6D. The center shall issue an evaluation report at an interval to be determined by
950 the board, but not less than every 5 years from the beginning of each grant period. The report
951 shall include an analysis of all relevant data to determine the effectiveness of the program
952 including, but not limited to, an analysis of: (i) the extent to which the program impacted the
953 prevalence, severity or control of preventable health conditions and the extent to which the
954 program is projected to impact such factors in the future; (ii) the extent to which the program
955 reduced health care costs or the growth in health care cost trends and the extent to which the
956 program is projected to reduce such costs in the future; (iii) whether health care costs were
957 reduced and who benefited from the reduction; (iv) the extent that health outcomes or health
958 behaviors were positively impacted; (v) the extent that access to evidence-based community
959 services was increased; (vi) the extent that social determinants of health or other community
960 wide risk factors for poor health were reduced or mitigated; (vii) the extent that grantees
961 increased their ability to collaborate, share data and align services with other providers and
962 community-based organizations for greater impact; (viii) the extent to which health disparities
963 experienced by populations based on including but not limited to race, ethnicity, gender identity
964 and expression, disability status, sexual orientation or socio-economic status were reduced across
965 all metrics; and (ix) recommendations for whether the program should be discontinued, amended
966 or expanded and a timetable for implementation of the recommendations. (b) The center shall

967 report the results of its evaluation and its recommendations, if any, and drafts of legislation
968 necessary to carry out the recommendations to the house and senate committees on ways and
969 means, the joint committee on public health and the joint committee on health care financing and
970 shall post the report on the center's website.

971 SECTION 47. Section 10 of chapter 13 of the General Laws, as so appearing, is hereby
972 amended by striking out the last paragraph and inserting in place thereof the following
973 paragraph:-

974 The board: (i) shall adopt, amend and rescind such rules and regulations as it deems
975 necessary to carry out the this chapter; provided however, that prior to adoption, amendment or
976 rescission, any rule or regulation shall be submitted to the commissioner of public health for
977 approval; (ii) may, subject to the approval of the commissioner of public health, appoint an
978 executive director and a legal counsel; (iii) may appoint such other assistants as may be required;
979 and (iv) may make contracts and arrangements for the performance of administrative and similar
980 services required, or appropriate, in the performance of the duties of the board.

981 SECTION 48. Said chapter 13 is hereby further amended by striking out section 10A, as
982 so appearing, and inserting in place thereof the following section:-

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

987 SECTION 49. Chapter 29 of the General Laws is hereby amended by striking out section
988 2TTTT, as so appearing, and inserting in place thereof the following section:-

989 Section 2TTTT. (a) For the purposes of this section the following words shall, unless the
990 context clearly requires otherwise, have the following meanings:-

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

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

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

999 “Major service category”, a set of service categories as specified by the center for health
1000 information and analysis, including: (i) acute hospital inpatient services, by major diagnostic
1001 category; (ii) outpatient and ambulatory services, by categories as defined by the Centers for
1002 Medicare and Medicaid Services, or as specified by the center for health information and
1003 analysis, including a residual category for “all other” outpatient and ambulatory services that do
1004 not fall within a defined category; (iii) behavioral health services; (iv) professional services, by
1005 categories as defined by the Centers for Medicare and Medicaid Services, or as specified by the
1006 center for health information and analysis; and (v) sub-acute services, by major service line or
1007 clinical offering, as specified by the center for health information and analysis.

1008 “Medicaid volume”, the proportion of patients that seek care at an acute care hospital that
1009 are insured by a state medicaid program.

1010 “Primary service area”, a geographic area of the commonwealth in which consumers are
1011 likely to travel to obtain health services.

1012 “Relative price”, the contractually negotiated amounts paid to providers by each private
1013 and public carrier for health care services, including non-claims related payments and expressed
1014 in the aggregate relative to the payer’s network-wide average amount paid to providers, as
1015 calculated pursuant to section 10 of chapter 12C.

1016 (b) There shall be established and set upon the books of the commonwealth a separate
1017 fund to be known as the Community Hospital Reinvestment Trust Fund. Funds shall be
1018 expended, without further appropriation, by the secretary of health and human services. The
1019 fund shall consist of money from public and private sources, such as gifts, grants and donations,
1020 interest earned on such revenues, any other money authorized by the general court and
1021 specifically designated to be credited to the fund, and any funds provided from other sources.
1022 Money in the fund shall be used to provide annual financial support, consistent with the terms of
1023 this section, to eligible acute care hospitals. The secretary of health and human services, as
1024 trustee, shall administer the fund and shall make expenditures from the fund consistent with this
1025 section.

1026 (c) The secretary of health and human services may incur expenses and the comptroller
1027 may certify amounts for payment in anticipation of expected receipts; provided, however, that no
1028 expenditure shall be made from the fund which shall cause the fund to be deficient at the close of
1029 a fiscal year. Revenues deposited in the fund that are unexpended at the end of a fiscal year shall
1030 not revert to the general fund and shall be available for expenditure in the following fiscal year.

1031 (d) The secretary of health and human services shall annually direct payments from the
1032 fund to eligible acute care hospitals. To be eligible to receive payment from the fund, an acute
1033 care hospital shall be licensed under section 51 of chapter 111, and shall not be a hospital with
1034 relative prices that are at or above the 90th per cent of the statewide average relative price. In
1035 directing payments, the secretary of health and human services shall allocate payments to
1036 eligible acute care hospitals based on the proportion of each eligible acute care hospital's total
1037 gross patient service revenue to the combined gross patient service revenue of all eligible acute
1038 care hospitals in the prior hospital rate year; provided, however, that payments shall be adjusted
1039 to allocate proportionally greater payments to eligible acute care hospitals with relative prices
1040 that fall farthest below the 90th per cent of the statewide average relative price and shall also
1041 consider: (i) medicaid volume; (ii) commercial volume; (iii) major service categories not readily
1042 offered by providers within the same primary service areas and dispersed service areas; (iv) case
1043 mix; (v) affiliation status; and (vi) geography.

1044 (e) The secretary of health and human services shall annually direct payments from the
1045 fund to eligible acute care hospitals. To be eligible to receive payment from the fund, an acute
1046 care hospital shall be licensed under section 51 of chapter 111. In directing payments, the
1047 secretary of health and human services shall allocate payments to eligible acute care hospitals
1048 based on the proportion of each eligible acute care hospital's total gross patient service revenue
1049 to the combined gross patient service revenue of all eligible acute care hospitals in the prior
1050 hospital rate year and shall also consider: (i) medicaid volume; (ii) commercial volume; (iii)
1051 major service categories not readily offered by providers within the same primary service areas
1052 and dispersed service areas; (iv) case mix; (v) affiliation status; (vi) geography; and (vii) relative
1053 price.

1054 (f) The secretary of health and human services shall promulgate regulations necessary to
1055 carry out this section, including regulations establishing a formula to allocate payments pursuant
1056 to subsection (e).

1057 (g) Not later than 30 days after payments are allocated to eligible acute care hospitals
1058 under this section, the secretary of health and human services shall file a report with the joint
1059 committee on health care financing and the house and senate committees on ways and means
1060 detailing the allocation and recipient of each payment.

1061 (h) The secretary shall expend not less than \$15,000,000 annually to community health
1062 centers, receiving a grant under 42 USC section 254b, based on financial need. All expenditures
1063 shall have 1 or more of the following purposes: (1) to improve and enhance the ability of
1064 community health centers to serve populations efficiently and effectively through the delivery of
1065 community-based primary and preventive care, clinical support, care coordination services,
1066 disease management services, and pharmacy management services; (2) to support health
1067 disparities reduction initiatives that address the social factors that influence health inequality; (3)
1068 to support infrastructure investments necessary for the transition to alternative payment
1069 methodologies, including technology investments in data analysis functions and performance
1070 management programs, including systems to promote provider price transparency, necessary to
1071 aggregate and analyze clinical data on a population level; (4) to provide loan forgiveness or loan
1072 repayment programs for clinical staff, including but not limited to, physicians, nurses,
1073 optometrists, psychiatrists and other behavioral health clinicians, and dentists; provided, that any
1074 such program shall fund minimum loan forgiveness or repayment of \$25,000 per clinician per
1075 year, in exchange for the clinician's commitment to practice full time in 1 or more community
1076 health centers for 3 consecutive years; (5) to support efforts to expand the service area of

1077 community health centers to communities that lack adequate access to similar levels of
1078 community-based primary and preventive care; and (6) to support efforts to improve the
1079 coordination of community care delivery and encourage the partnerships and resource sharing
1080 among community health centers located in close proximity to one another.

1081 (i) The secretary may require as a condition of receiving payment from the fund that an
1082 eligible community health center agree to an independent financial and operational audit to
1083 recommend steps to increase the sustainability and efficiency of the community health center.

1084 (j) The executive office of health and human services shall promulgate regulations
1085 necessary to carry out this section.

1086 (k) Not later than 30 days after payments are allocated to eligible community health
1087 centers under this section, the secretary for health and human services shall file a report with the
1088 joint committee on health care finance and the house and senate committees on ways and means
1089 detailing the allocation and recipient of each payment.

1090 SECTION 50. Section 2TTTT of said chapter 29, as amended by section 49, is hereby
1091 further amended by striking out subsection (d).

1092 SECTION 51. Said chapter 29 is hereby further amended by inserting after section
1093 2YYYY the following section:-

1094 Section 2ZZZZ. There shall be a Mobile Integrated Health Care Trust Fund. The
1095 commissioner of public health shall administer the fund and may make expenditures from the
1096 fund to support the administration and oversight of programs certified under chapter 111O.

1097 The fund shall consist of: (i) revenue generated from fees, fines and penalties imposed
1098 under chapter 111O; (ii) revenue from appropriations or other money authorized by the general
1099 court and specifically designated to be credited to the fund; and (iii) funds from public or private
1100 sources for mobile integrated health care including, but not limited to, gifts, grants, donations,
1101 rebates and settlements received by the commonwealth that are specifically designated to be
1102 credited to the fund. The department of public health may incur expenses and the comptroller
1103 may certify for payment amounts in anticipation of expected receipts; provided however, that an
1104 expenditure shall not be made from the fund that shall cause the fund to be deficient at the close
1105 of a fiscal year. Amounts credited to the fund shall not be subject to further appropriation and
1106 money remaining in the fund at the close of a fiscal year shall not revert to the General Fund and
1107 shall be available for expenditure in the following fiscal year.

1108 The commissioner shall report annually, not later than October 1, to the house and senate
1109 committees on ways and means and the joint committee on health care financing on the fund's
1110 activity. The report shall include, but not be limited to, revenue received by the fund, revenue
1111 and expenditure projections for the next fiscal year and details of the expenditures by the fund.

1112 SECTION 51A. Chapter 32A of the General Laws, as amended by section 1 of chapter
1113 233 of the acts of 2016, is hereby amended by inserting, after section 17O, the following
1114 section:-

1115 Section 17P. Any coverage offered by the commission to an active or retired employee of
1116 the commonwealth insured under the group insurance commission shall provide coverage for
1117 genetically targeted drugs for Duchenne muscular dystrophy when (1) the drug has been
1118 prescribed for an FDA-approved use, including pursuant to the accelerated approval provisions

1119 of section 506(c) of the Federal Food, Drug, and Cosmetic Act, and as such shall not be
1120 considered experimental, investigational or unproven; and (2) the drug has been ordered or
1121 prescribed consistent with the drug’s FDA labeling and determined to be medically necessary by
1122 a licensed physician who has thoroughly evaluated the patient and either possesses expertise in
1123 Duchenne muscular dystrophy or has consulted with an expert, identified by the prescribing
1124 physician, in Duchenne muscular dystrophy who has determined the drug to be medically
1125 necessary for the patient. The prescribed drugs in this section shall not be subject to any greater
1126 deductible, coinsurance, copayments or out-of-pocket limits than any other prescribed drug
1127 provided by the commission. For purposes of this section the term “genetically targeted drug”
1128 shall mean a drug for which the approved use may result in the modulation, including
1129 suppression, up-regulation, or activation, of the function of a gene or its associated gene product
1130 and incorporates or utilizes non-replicating nucleic acid or analogous compounds to treat one or
1131 more patient subgroups, including subgroups of patients with different mutations of a gene.

1132 This section shall not apply if: (1) the price of the drug increases by a percentage greater
1133 than the corresponding percentage increase in the Consumer Price Index Urban for the 2 year
1134 period beginning on the later of (1) the date this section becomes effective or (2) the date of the
1135 drug’s approval by the FDA; provided, that for the purposes of this section, “price of the drug”
1136 shall mean the “wholesale acquisition cost” as defined in section 1847A(c)(6)(B) of the Federal
1137 Social Security Act; or (2) the manufacturer does not comply with state laws of the
1138 Commonwealth, including, but not limited to, transparency requirements related to drug pricing,
1139 if any.

1140 SECTION 52. Section 4 of chapter 32A of the General Laws, as so appearing, is hereby
1141 amended by inserting after the word “commonwealth”, in line 12, the following words:-

1142 ; provided, however, that the carrier or third-party health care administrator website shall
1143 conform with uniform methodology for the communication of information about the assignment
1144 of tiers to health care providers and health care services adopted by the center for health
1145 information and analysis pursuant to section 25 of chapter 12C.

1146 SECTION 53. Said chapter 32A is hereby further amended by adding the following 2
1147 sections:-

1148 Section 29. (a) For the purposes of this section, “telemedicine” shall mean the use of
1149 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a
1150 patient's physical, oral or mental health; provided however, that “telemedicine” shall not include
1151 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1152 (b) Coverage offered by the commission to an active or retired employee of the
1153 commonwealth insured under the group insurance commission shall provide coverage for health
1154 care services through the use of telemedicine by a contracted health care provider if (i) the health
1155 care services are covered by way of in-person consultation or delivery and (ii) the health care
1156 services may be appropriately provided through the use of telemedicine.

1157 (c) Coverage for telemedicine services may include utilization review, including
1158 preauthorization, to determine the appropriateness of telemedicine as a means of delivering a
1159 health care service; provided that, the same process is utilized as if the service was provided via
1160 in-person consultation or delivery.

1161 (d) Coverage for telemedicine services shall not be required to reimburse a health care
1162 provider for a health care service that is not a covered benefit under the plan nor reimburse a
1163 health care provider not contracted under the plan.

1164 (e) Coverage that reimburses a provider with a global payment, as defined in section 1 of
1165 chapter 6D, shall account for the provision of telemedicine services to set the global payment
1166 amount

1167 (f) Coverage for telemedicine services may include a deductible, copayment or
1168 coinsurance requirement for a health care service provided through telemedicine as long as the
1169 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance
1170 applicable to an in-person consultation or in-person delivery of services.

1171 (g) A health care provider shall not be required to document a barrier to an in-person
1172 visit, nor shall the type of setting where telemedicine is provided be limited for health care
1173 services provided through telemedicine.

1174 (h) Health care services provided by telemedicine shall conform to the standards of care
1175 applicable to the telemedicine provider's profession and specialty. Such services shall also
1176 conform to applicable federal and state health information privacy and security standards as well
1177 as standards for informed consent.

1178 Section 30. The commission shall require a carrier or a third party administrator with
1179 whom a carrier contracts to use the standard quality measure set established by the center for
1180 health information and analysis under section 14 of chapter 12C as follows: (i) the carrier or third
1181 party administrator shall use the measures designated by the center as core measures in any
1182 contract between a health care provider, provider organization or accountable care organization
1183 that incorporates quality measures into payment terms; (ii) the carrier or third party administrator
1184 may use the measures designated by the center as non-core measures in any contract with a
1185 health care provider, provider organization or accountable care organization that incorporates

1186 quality measures into payment terms and shall not use any measures not designated as non-core
1187 measures; and (iii) the carrier or third party administrator shall use the measures in the standard
1188 quality measure set established by the center to assign health care providers, provider
1189 organizations or accountable care organizations to tiers in the design of a health plan.

1190 SECTION 54. Subsection (a) of section 6D of chapter 40J of the General Laws, as so
1191 appearing, is hereby amended by inserting after the third sentence the following sentence:- The
1192 institute shall partner with the health care and technology community to accelerate the creation
1193 and adoption of digital health to drive economic growth and improve health care outcomes and
1194 efficiency.

1195 SECTION 55. Said section 6D of said chapter 40J, as so appearing, is hereby further
1196 amended by striking out, in lines 16 to 18, inclusive, the words “and (3) develop a plan to
1197 complete the implementation of electronic health records systems by all providers in the
1198 commonwealth” and inserting in place thereof the following words:- (3) develop a plan to
1199 complete the implementation of electronic health records systems by all providers in the
1200 commonwealth; and (4) advance the commonwealth’s economic competitiveness by supporting
1201 the digital health industry, including the digital health industry’s role in improving the quality of
1202 health care delivery and patient outcomes.

1203 SECTION 55A. Said section 6D of said chapter 40J, as so appearing, is hereby further
1204 amended by striking out subsection (f) and inserting in place thereof the following subsection:-

1205 (f) The institute shall identify companies and organizations that are engaged in the
1206 development of emerging new technologies associated with health information technology,
1207 including, (i) web-based and personalized care delivery or (ii) the incorporation of data on social

1208 determinants of health into digital health technology, which may include integrating individual-
1209 level determinants, community-level determinants, or both, into diverse workflows. The institute
1210 shall promote the growth and development of such companies and organizations by supporting
1211 the formation of regional health information technology clusters, coordinating the promotion and
1212 dissemination of information regarding such companies and organizations, identifying and
1213 addressing obstacles to the growth of such companies and organizations and helping to identify
1214 alternative funding sources for such companies and organizations for the implementation of their
1215 business and marketing plans.

1216 SECTION 56. Said section 6D of said chapter 40J, as so appearing, is hereby further
1217 amended by adding the following subsection:-

1218 (h) Notwithstanding any provision of this section to the contrary, if a significant portion
1219 of health care providers, as determined by the institute's director, implement and use
1220 interoperable electronic health records systems, the institute shall prioritize achieving the goal of
1221 improving the commonwealth's economic competitiveness in digital health through
1222 implementation of subsections (f) and (g).

1223 SECTION 57. Chapter 94C of the General Laws is hereby amended by inserting after
1224 section 21B the following section:-

1225 Section 21C. (a) For the purposes of this section, the following words shall, unless the
1226 context clearly requires otherwise, have the following meanings:-

1227 "Cost sharing", amounts owed by a consumer under the terms of the consumer's health
1228 benefit plan as defined in section 1 of chapter 176O or as required by a pharmacy benefit
1229 manager as defined in subsection (a) of section 226 of chapter 175.

1230 “Pharmacy retail price”, the amount an individual would pay for a prescription
1231 medication at a pharmacy if the individual purchased that prescription medication at that
1232 pharmacy without using a health benefit plan as defined in section 1 of chapter 176O or any
1233 other prescription medication benefit or discount.

1234 “Registered pharmacist”, a pharmacist who holds a valid certificate of registration issued
1235 by the board of registration in pharmacy pursuant to section 24 of chapter 112.

1236 (b) A pharmacy shall post a notice informing consumers that a consumer may request, at
1237 the point of sale, the current pharmacy retail price for each prescription medication the consumer
1238 intends to purchase. If the consumer’s cost-sharing amount for a prescription medication exceeds
1239 the current pharmacy retail price, the pharmacist, or an authorized individual at the direction of a
1240 pharmacist, shall notify the consumer that the pharmacy retail price is less than the patient’s cost-
1241 sharing amount. The pharmacist shall charge the consumer the applicable cost-sharing amount or
1242 the current pharmacy retail price for that prescription medication, as directed by the consumer.

1243 A pharmacist shall not be subject to a penalty by the board of registration in pharmacy or
1244 a third party for failure to comply with this section.

1245 (c) A contractual obligation shall not prohibit a pharmacist from complying with this
1246 section; provided however, that a pharmacist shall submit a claim to the consumer’s health
1247 benefit plan or its pharmacy benefit manager if the pharmacist has knowledge that the
1248 prescription medication is covered under the consumer’s health benefit plan.

1249 (d) Failure to post notice pursuant to subsection (b) shall be an unfair or deceptive act of
1250 practice under chapter 93A.

1251 SECTION 58. Section 14 of chapter 94G is hereby amended by striking out subsection
1252 (b), inserted by section 40 of chapter 55 of the acts of 2017, and inserting in place thereof the
1253 following subsection:-

1254 (b) Money in the fund shall be subject to appropriation. Money in the fund shall be
1255 expended for the implementation, administration and enforcement of this chapter by the
1256 commission and by the department of agricultural resources for the implementation,
1257 administration and enforcement of sections 116 to 123, inclusive, of chapter 128 and the
1258 provision of pesticide control pursuant to chapter 132B; provided, that 10 per cent of the
1259 amounts held in the fund in any 1 year shall be transferred annually to the Prevention and
1260 Wellness Trust Fund established in section 7A of chapter 6D, not later than June 30. Thereafter,
1261 money in the fund shall be expended for: (i) public and behavioral health including but not
1262 limited to, evidence-based and evidence-informed substance use prevention and treatment and
1263 substance use early intervention services in a recurring grant for school districts or community
1264 coalitions who operate on the strategic prevention framework or similar structure for youth
1265 substance use education and prevention; (ii) public safety; (iii) municipal police training; and (iv)
1266 programming for restorative justice, jail diversion, workforce development, industry specific
1267 technical assistance, and mentoring services for economically-disadvantaged persons in
1268 communities disproportionately impacted by high rates of arrest and incarceration for marijuana
1269 offenses pursuant to chapter 94C.

1270 SECTION 58A. Said section 14 of said chapter 94G, as amended by section 55, is
1271 hereby further amended by striking out the words “Prevention and Wellness Trust Fund
1272 established in section 7A of chapter 6D” and inserting in place thereof the following words:-
1273 Community Hospital Reinvestment Trust Fund established in section 2TTTT of chapter 29.

1274 SECTION 59. Section 2G of chapter 111 of the General Laws is hereby repealed.

1275 SECTION 60. Section 2H of said chapter 111 is hereby repealed.

1276 SECTION 61. Section 4N of said chapter 111 is hereby repealed.

1277 SECTION 62. Section 25A of said chapter 111, as appearing in the 2016 Official Edition,
1278 is hereby amended by striking out the first sentence and inserting in place thereof the following
1279 sentence:-

1280 Under the direction of the health planning council established under section 19 of chapter
1281 6D, the commission shall establish and maintain, on a current basis, an inventory of all health
1282 care resources together with all other reasonably pertinent information concerning such
1283 resources, in order to identify the location, distribution and nature of all such resources in the
1284 commonwealth.

1285 SECTION 63. Said section 25A of said chapter 111, as so appearing, is hereby further
1286 amended by striking out, in lines 16 and 17 , the words “in a designated office of the department”
1287 and inserting in place thereof the following words:- as determined by the health planning council
1288 established under section 19 of chapter 6D.

1289 SECTION 64. Said section 25A of said chapter 111, as so appearing, is hereby further
1290 amended by striking out the fourth paragraph.

1291 SECTION 65. Section 51H of said chapter 111, as so appearing, is hereby amended by
1292 striking out, in lines 4 and 5, the words “mothers or clinic providing ambulatory surgery as
1293 defined in section 25B” and inserting in place thereof the following words:- mothers, clinic
1294 providing ambulatory surgery as defined in section 25B, limited service clinic licensed pursuant

1295 to section 51J, office-based surgery facility licensed pursuant to section 51L, or urgent care
1296 center licensed pursuant to section 51M.

1297 SECTION 66. Said chapter 111 is hereby further amended by inserting after section
1298 51K, inserted by section 46 of chapter 47 of the acts of 2017 the following 2 sections:-

1299 Section 51L. (a) For the purposes of this section the following words shall, unless the
1300 context clearly requires otherwise, have the following meanings:-

1301 "Deep sedation", a drug-induced depression of consciousness during which: (i) the
1302 patient cannot be easily aroused but responds purposefully following repeated painful
1303 stimulation; (ii) the patient's ability to maintain independent ventilatory function may be
1304 impaired; (iii) the patient may require assistance in maintaining a patent airway and spontaneous
1305 ventilation may be inadequate; and (iv) the patient's cardiovascular function is usually
1306 maintained without assistance.

1307 "General anesthesia", a drug-induced depression of consciousness during which: (i) the
1308 patient is not arousable, even by painful stimulation; (ii) the patient's ability to maintain
1309 independent ventilatory function is often impaired; (iii) the patient, in many cases, often requires
1310 assistance in maintaining a patent airway and positive pressure ventilation may be required
1311 because of depressed spontaneous ventilation or drug-induced depression of neuromuscular
1312 function; and (iv) the patient's cardiovascular function may be impaired.

1313 "Moderate sedation", a drug-induced depression of consciousness during which: (i) the
1314 patient responds purposefully to verbal commands, either alone or accompanied by light tactile
1315 stimulation; (ii) no interventions are required to maintain a patent airway; (iii) spontaneous

1316 ventilation is adequate; and (iv) the patient's cardiovascular function is usually maintained
1317 without assistance.

1318 "Minimal sedation", a drug-induced state during which: (i) patients respond normally to
1319 verbal commands; (ii) cognitive function and coordination may be impaired; and (iii) ventilatory
1320 and cardiovascular functions are unaffected.

1321 "Minor procedures", (i) procedures that can be performed safely with a minimum of
1322 discomfort where the likelihood of complications requiring hospitalization is minimal; (ii)
1323 procedures performed with local or topical anesthesia; or (iii) liposuction with removal of less
1324 than 500 cc of fat under unsupplemented local anesthesia.

1325 "Office-based surgical services", any ambulatory surgical or other invasive procedure
1326 requiring (i) general anesthesia, (ii) moderate sedation, or (iii) deep sedation, and any liposuction
1327 procedure, excluding minor procedures and procedures requiring minimal sedation, where such
1328 surgical or other invasive procedure or liposuction is performed by a practitioner at an office-
1329 based surgical center.

1330 "Office-based surgical center", an office, group of offices, or a facility, or any portion
1331 thereof owned, leased or operated by 1 or more practitioners engaged in a solo or group practice,
1332 however organized, whether conducted for profit or not for profit, which is advertised,
1333 announced, established, or maintained for the purpose of providing office-based surgical
1334 services; provided, however, that "office-based surgical center" shall not include: (i) a hospital
1335 licensed under section 51 or by the federal government, (ii) an ambulatory surgical center as
1336 defined pursuant to section 25B and licensed under section 51, or (iii) a surgical center
1337 performing services in accordance with sections 12I to 12U, inclusive, of chapter 112.

1338 (b) The department shall establish rules, regulations, and practice standards for the
1339 licensing of office-based surgical centers licensed under this section. In determining regulations
1340 and practice standards necessary for licensure as an office-based surgical center, the department
1341 may, at its discretion determine which regulations applicable to an ambulatory surgical center, as
1342 defined by section 25B, shall apply to an office-based surgical center pursuant to this section.

1343 (c) The department shall issue for a term of 2 years, and renew for a like term, a license
1344 to maintain an office-based surgical center to an entity or organization that demonstrates to the
1345 department that it is responsible and suitable to maintain such a center. An office-based surgical
1346 center license shall list the specific locations on the premises where surgical services are
1347 provided. In the case of the transfer of ownership of an office-based surgical center, the
1348 application of the new owner for a license, when filed with the department on the date of transfer
1349 of ownership, shall have the effect of a license for a period of 3 months.

1350 (d) An office-based surgical center license shall be subject to suspension, revocation or
1351 refusal to issue or to renew for cause if, in its reasonable discretion, the department determines
1352 that the issuance of such license would be inconsistent with or opposed to the best interests of the
1353 public health, welfare or safety. Nothing in this subsection shall limit the authority of the
1354 department to require a fee, impose a fine, conduct surveys and investigations or to suspend,
1355 revoke or refuse to renew a license pursuant to subsection (c).

1356 (e) Initial application and renewal fees for the license shall be established pursuant to
1357 section 3B of chapter 7.

1358 (f) The department may impose a fine of up to \$10,000 on a person or entity that
1359 advertises, announces, establishes, maintains an office-based surgical center without a license

1360 granted by the department. The department may impose a fine of not more than \$10,000 on a
1361 licensed office-based surgical center that violates this section or any rule or regulation
1362 promulgated hereunder. Each day during which a violation continues shall constitute a separate
1363 offense. The department may conduct surveys and investigations to enforce compliance with this
1364 section.

1365 (g) Notwithstanding any general or special rule to the contrary, the department may issue
1366 a 1-time provisional license to an applicant for an office-based surgical center licensed pursuant
1367 to this section if such office-based surgical center holds a current accreditation from the
1368 Accreditation Association for Ambulatory Health Care, American Association for Accreditation
1369 of Ambulatory Surgery Facilities, Inc., or The Joint Commission, or holds a current certification
1370 for participation in either Medicare or Medicaid. The department may approve such a provisional
1371 application upon a finding of responsibility and suitability and that the center meets all other
1372 licensure requirements as determined by the department. Such provisional license issued to an
1373 office-based surgical center shall not be extended or renewed.

1374 Section 51M. (a) For the purposes of this section the following words shall, unless the
1375 context clearly requires otherwise, have the following meanings:-

1376 “Emergency services”, as defined in section 1 of chapter 6D.

1377 “Urgent care services” a model of episodic care for the diagnosis, treatment, management
1378 or monitoring of acute and chronic disease or injury that is: (i) for the treatment of illness or
1379 injury that is immediate in nature but does not require emergency services; (ii) provided on a
1380 walk-in basis without a prior appointment; (iii) available to the general public during times of the

1381 day, weekends or holidays when primary care provider offices are not customarily open; and (iv)
1382 is not intended, and should not be used for, preventative or routine services.

1383 “Urgent care center”, a clinic owned or operated by an entity that is not corporately
1384 affiliated with a hospital licensed under section 51, however organized, whether conducted for
1385 profit or not for profit, which is advertised, announced, established, or maintained for the
1386 purpose of providing urgent care services in an office or a group of offices, or any portion
1387 thereof; provided, however, that “urgent care center” shall not include: (i) a hospital licensed
1388 under section 51 or operated by the federal government or by the commonwealth, or a hospital
1389 licensed under section 51 with a public payer mix above 70 per cent as determined by the center
1390 for health information and analysis (ii) a clinic licensed under section 51, (iii) a limited service
1391 clinic licensed under section 51J or (iv) a community health center receiving a grant under 42
1392 U.S.C. 254b.

1393 (b) The department shall establish rules, regulations, and practice standards for the
1394 licensing of urgent care centers licensed under this section. In determining regulations and
1395 practice standards necessary for licensure as an urgent care center, the department may, at its
1396 discretion determine which regulations applicable to a clinic licensed under section 51, shall
1397 apply to an urgent care center pursuant to this section.

1398 (c) The department shall issue for a term of 2 years, and renew for a like term, a license
1399 to maintain an urgent care center to an entity or organization that demonstrates to the department
1400 that it is responsible and suitable to maintain such a center. In the case of the transfer of
1401 ownership of an urgent care center, the application of the new owner for a license, when filed

1402 with the department on the date of transfer of ownership, shall have the effect of a license for a
1403 period of 3 months.

1404 (d) An urgent care center license shall be subject to suspension, revocation or refusal to
1405 issue or to renew for cause if, in its reasonable discretion, the department determines that the
1406 issuance of such license would be inconsistent with or opposed to the best interests of the public
1407 health, welfare or safety. Nothing in this subsection shall limit the authority of the department to
1408 require a fee, impose a fine, conduct surveys and investigations or to suspend, revoke or refuse to
1409 renew a license pursuant to subsection (c).

1410 (e) Initial application and renewal fees for the license shall be established pursuant to
1411 section 3B of chapter 7.

1412 (f) The department may impose a fine of up to \$10,000 on a person or entity that
1413 advertises, announces, establishes, maintains an urgent care center without a license granted by
1414 the department. The department may impose a fine of not more than \$10,000 on a licensed
1415 urgent care center that violates this section or any rule or regulation promulgated hereunder.
1416 Each day during which a violation continues shall constitute a separate offense. The department
1417 may conduct surveys and investigations to enforce compliance with this section.

1418 (g) Notwithstanding any general or special rule to the contrary, the department may issue
1419 a 1-time provisional license to an applicant for an urgent care center licensed pursuant to this
1420 section if such urgent care center holds a current accreditation from the Accreditation
1421 Association for Ambulatory Health Care, Urgent Care Association of America, or The Joint
1422 Commission, or holds a current certification for participation in either Medicare or Medicaid.
1423 The department may approve such provisional application upon a finding of responsibility and

1424 suitability and that the center meets all other licensure requirements as determined by the
1425 department. Such provisional license issued to an urgent care center shall not be extended or
1426 renewed.

1427 Section 51N. The department shall designate a hospital as an acute stroke ready hospital,
1428 a primary stroke center or a comprehensive stroke center if: (i) the hospital has applied to the
1429 department for a designation; and (ii) the hospital has been certified by The Joint Commission,
1430 the American Heart Association or any other department-approved, nationally-recognized
1431 certifying body as an acute stroke ready hospital, primary stroke center or comprehensive stroke
1432 center.

1433 Section 51O. The department and regional EMS councils, as defined in section 1 of
1434 chapter 111C, shall establish prehospital care protocols related to the assessment, treatment,
1435 transport and rerouting of stroke patients by licensed emergency medical services providers to
1436 acute stroke ready hospitals, primary stroke centers and comprehensive stroke centers. The
1437 protocols shall include plans for the triage and transport of suspected stroke patients including,
1438 but not limited to, those patients who may have an emergent large vessel occlusion, to an
1439 appropriate facility within a specified timeframe of onset of symptoms. The protocols shall
1440 include any additional criteria necessary to determine the level of care that is the most
1441 appropriate for a suspected stroke patient. The protocols shall be based on nationally-recognized
1442 guidelines for the transport of acute stroke patients. The protocols shall also consider the
1443 capability of an emergency receiving facility to improve outcomes for those patients suspected,
1444 based on clinical severity, of having an emergent large vessel occlusion. Each regional EMS
1445 council shall establish a prehospital point of entry plan for stroke-related patients for their own
1446 respective region.

1447 The department shall: (i) make available the list of designated stroke centers, including
1448 the identification of hospitals with continuous neurointerventional coverage, to the medical
1449 director of each licensed emergency medical services provider; (ii) maintain a copy of the list in
1450 the office designated within the department to oversee emergency medical services; and (iii) post
1451 a list of all designated stroke centers and the level of care to the department website. The
1452 department shall update the list of designated stroke centers at least annually.

1453 Section 51P. The department shall establish and maintain a data oversight process to
1454 improve the quality of care for stroke patients. The process shall include a stroke registry
1455 database that compiles information and statistics on stroke care that align with nationally-
1456 recognized stroke measures.

1457 A hospital designated by the department as an acute stroke ready hospital, a primary
1458 stroke center or a comprehensive stroke center shall utilize a nationally-recognized data platform
1459 to collect the stroke data set that shall be required by the department. The data elements shall be
1460 collected through the data registry platform and transmitted to the department for inclusion in the
1461 stroke registry.

1462 The department shall convene a group of experts including, but not limited to, a
1463 representative from the American Stroke Association, a representative from The Massachusetts
1464 Neurologic Association, Inc., a representative from Society of Neurointerventional Surgery, a
1465 representative from Massachusetts Council of Community Hospitals, Inc., a representative from
1466 Massachusetts College of Emergency Physicians, Inc. and a representative of a regional EMS
1467 council, with input from key stroke stakeholders and professional societies, to form a stroke
1468 advisory taskforce that shall assist with data oversight, program management and advice

1469 regarding the stroke system of care. The task force shall meet not less than quarterly to review
1470 data and provide advice.

1471 SECTION 67. Said chapter 111 is hereby further amended by striking out section 52, as
1472 appearing in the 2016 Official Edition, and inserting in place thereof the following section:-

1473 Section 52. For the purposes of sections 51 to 56, inclusive, the following words shall,
1474 unless the context clearly requires otherwise, have the following meanings:-

1475 “Certified clinical specialist in psychiatric and mental health nursing”, an advanced
1476 practice registered nurse licensed and authorized by the Board of Registration in Nursing
1477 pursuant to sections 74 and 80B of chapter 112 that holds certification from a board-recognized
1478 certifying organization in the field of psychiatric mental health.

1479 “Hospital”, any institution, however named, whether conducted for charity or for profit,
1480 which is advertised, announced, established or maintained for the purpose of caring for persons
1481 admitted thereto for diagnosis, medical, surgical or restorative treatment which is rendered
1482 within said institution.

1483 “Institution for unwed mothers”, any institution or place, however named, whether
1484 conducted for charity or profit which is advertised, announced, established or maintained for the
1485 purpose of caring for 1 or more unwed mothers admitted thereto, on a resident basis, for prenatal
1486 care, supervision and short-term postnatal care.

1487 “Limited services”, diagnosis, treatment, management and monitoring of acute and
1488 chronic disease, wellness and preventative services of a nature that may be provided within the

1489 scope of practice of a nurse practitioner using available facilities and equipment, including
1490 shared toilet facilities for point-of-care testing.

1491 “Limited services clinic”, a clinic that provides limited services as defined by section 51J.

1492 “Office-based surgical center”, a clinic that is licensed to provide office-based surgical
1493 services pursuant to section 51L

1494 “Urgent care center”, a clinic that is licensed to provide urgent care services pursuant to
1495 section 51M

1496 “Clinic”, any entity, however organized, whether conducted for profit or not for profit,
1497 which is advertised, announced, established, or maintained for the purpose of providing
1498 ambulatory medical services, surgical services, dental services, limited services, office-based
1499 surgical services, physical rehabilitation services, mental health services or urgent care services;
1500 provided, however, that except for a limited service clinic licensed under section 51J, an office-
1501 based surgical center licensed under section 51L or an urgent care center licensed under section
1502 51M, “clinic” shall not include a medical office building, or 1 or more practitioners engaged in a
1503 solo or group practice, whether conducted for profit or not for profit, and however organized, so
1504 long as such practice is wholly owned and controlled by 1 or more of the practitioners so
1505 associated, or, in the case of a not for profit organization, its only members are 1 or more of the
1506 practitioners so associated or a clinic established solely to provide service to employees or
1507 students of such corporation or institution. For purposes of this section, clinic shall not include a
1508 clinic conducted by a hospital licensed under section 51 or operated by the federal government or
1509 by the commonwealth.

1510 “Original license”, a license issued to a hospital, institution for unwed mothers or clinic,
1511 not previously licensed; or a license issued to an existing hospital, institution for unwed mothers
1512 or clinic, in which there has been a change in ownership or location.

1513 “Out-of-hospital dialysis unit”, a unit, however named, maintained separately from a
1514 hospital or a license issued thereto, whether conducted for charity or for profit, for the purpose of
1515 providing dialysis treatment to persons suffering from renal disease. It shall not include a dialysis
1516 unit maintained as part of a hospital.

1517 “Practitioner”, any individual who may diagnose and treat medical, surgical, dental,
1518 physical rehabilitation, or mental health problems without limitation within the confines of his or
1519 her profession.

1520 “Rural hospital”, an acute-care hospital as defined in section 25B and licensed under this
1521 chapter, which: (1) has been designated by the department as a rural hospital based on bed size,
1522 city or town population, and population density of the city, town, service area or county as
1523 determined by the department through regulation; or (2) a hospital currently designated as a
1524 critical access hospital by the United States Department of Health and Human Services in
1525 accordance with federal regulations and state requirements.

1526 SECTION 68. Said chapter 111 is hereby further amended by striking out section 228, as
1527 so appearing, and inserting in place thereof the following 2 sections:-

1528 Section 228. (a) As used in this section and in section 228A, the following words shall,
1529 unless the context clearly requires otherwise, have the following meanings:-

1530 “Allowed amount”, the contractually agreed upon amount paid by a carrier to a health
1531 care provider for health care services provided to an insured.

1532 “Carrier”, as defined in section 1 of chapter 176O.

1533 “Emergency services”, as defined in section 1 of chapter 6D.

1534 “Facility”, as defined in section 1 of chapter 6D.

1535 “Facility fee”, a fee charged or billed by a health care provider, health care provider
1536 group or a hospital for outpatient hospital services provided in a hospital-based facility that is
1537 intended to compensate the health care provider, health care provider group or a hospital for the
1538 operational expenses and is separate and distinct from a professional fee.

1539 “Hospital”, as defined in section 1 of chapter 6D.

1540 “Hospital-based facility”, a facility that is owned or operated, in whole or in part, by a
1541 health care provider, health care provider group or a hospital where health care services are
1542 provided.

1543 “In-network cost-sharing amount”, as defined in section 1 of chapter 176O.

1544 “Insured”, as defined in section 1 of chapter 176O.

1545 “Network provider”, as defined in section 1 of chapter 176O

1546 “Network status”, as defined in section 1 of chapter 176O.

1547 “Out-of-network provider”, as defined in section 1 of chapter 176O.

1548 “Prior written consent”, a signed written consent form provided to a patient or
1549 prospective patient by an out-of-network provider at least 24 hours in advance of the out-of-
1550 network provider rendering health care services, other than for emergency services, when said
1551 services are scheduled at least 24 hours in advance of the rendering of care, to such patient or
1552 prospective patient or, if that person lacks capacity to consent, signed by the person authorized to
1553 consent for such a patient or prospective patient. A prior written consent form shall be presented
1554 in a manner and format to be determined by the commissioner of public health in consultation
1555 with the division of insurance;; provided, that such consent form shall be a document that is
1556 separate from any other document used to obtain the consent of the patient or prospective patient
1557 for any other part of the care or procedure; and provided further, that such consent form shall
1558 include: (i) a statement affirming that the out-of-network provider has disclosed its out-of-
1559 network status to the patient or prospective patient; (ii) a statement affirming that the out-of-
1560 network provider informed the patient or prospective patient that services rendered by an out-of-
1561 network provider may result in costs not covered by the patient’s or prospective patient’s carrier
1562 or specific health benefit plan; (iii) a statement affirming that the out-of-network provider
1563 informed the patient or prospective patient that services may be available from a contracted
1564 provider and that the patient or prospective patient is not required to obtain care from the out-of-
1565 network provider; (iv) a statement affirming that the out-of-network provider presented the
1566 patient or prospective patient with a written estimate of the patient or prospective patient’s total
1567 out-of-pocket cost of care for the admission, service or procedure; and (v) an affirmative
1568 declaration of the patient’s or prospective patient’s consent to receive health care services from
1569 the out-of-network provider, signed by the patient or prospective patient, or by the person
1570 authorized to consent for such a patient or prospective patient.

1571 “Professional fee”, a fee charged or billed by a hospital, provider or provider
1572 organization for professional medical services provided in a hospital-based facility.

1573 (b) At the time of scheduling an admission, procedure or service for an insured patient or
1574 prospective patient, a health care provider shall: (i) determine the provider’s own network status
1575 relative to insured’s insurance carrier and specific health benefit plan and disclose in real time
1576 such network status to the insured; (ii) notify the patient or prospective patient of their right to
1577 request and obtain from the provider, based on information available to the provider at the time
1578 of the request, additional information on the network status of any provider reasonably expected
1579 to render services in the course of such admission, procedure or service that is necessary for the
1580 patient’s or prospective patient’s use of a health benefit plan’s toll-free number and website
1581 available pursuant to section 23 of chapter 176O to obtain additional information about that
1582 provider’s network status under the patient’s or prospective patient’s health benefit plan and any
1583 applicable out-of-pocket costs for services sought from such provider; (iii) notify the patient or
1584 prospective patient of their right to request and obtain from the provider, based on information
1585 available to the provider at the time of the request, information on such admission, procedure or
1586 service that is necessary for the patient’s or prospective patient’s use of a health benefit plan’s
1587 toll-free number and website available pursuant to section 23 of chapter 176O to identify the
1588 allowed amount or charge of the admission, procedure or service, including the amount for any
1589 facility fees required; (iv) notify the patient or prospective patient that in the event a health care
1590 provider is unable to quote a specific allowed amount or charge in advance of the admission,
1591 procedure or service due to the health care provider's inability to predict the specific treatment or
1592 diagnostic code, the health care provider shall disclose to the patient or prospective patient the
1593 estimated maximum allowed amount or charge for a proposed admission, procedure or service,

1594 including the amount for any facility fees required; and (iv) inform the patient or prospective
1595 patient that the estimated costs and the actual amount the patient or prospective patient may be
1596 responsible to pay may vary due to unforeseen services that arise out of the proposed admission,
1597 procedure or service. This subsection shall not apply in cases of emergency services provided to
1598 a patient.

1599 (c) If a network provider schedules, orders or otherwise arranges for services related to
1600 an insured's admission, procedure or service and such services are performed by another health
1601 care provider, or if a network provider refers an insured to another health care provider for an
1602 admission, procedure or service, then in addition to the actions required pursuant to subsection
1603 (b) the network provider shall, based on information available to the provider at that time: (i)
1604 disclose to the insured if the provider to whom the patient is being referred is part of or
1605 represented by the same provider organization registered pursuant to section 11 of chapter 6D;
1606 (ii) disclose to the insured sufficient information about such provider for the patient to obtain
1607 information about that provider's network status under the insured's health benefit plan and
1608 identify any applicable out-of-pocket costs for services sought from such provider through the
1609 toll-free number and website of the insurance carrier available pursuant to section 23 of chapter
1610 176O; and (iii) notify the insured that if the health care provider is out-of-network under the
1611 patient's health insurance policy, that the admission, service or procedure will likely be deemed
1612 out-of-network and that any out-of-network applicable rates under such policy may apply. This
1613 subsection shall not apply in cases of emergency services provided to a patient.

1614 (d) Upon initial encounter with a patient at the time of scheduling an admission,
1615 procedure or service for an insured patient or prospective patient, an out-of-network provider
1616 shall, in addition to the actions required pursuant to subsection (b) and at least 24 hours in

1617 advance of care, when said care is scheduled at least 24 hours in advance of rendering the
1618 services: (i) disclose to the insured that the provider does not participate in the insured's health
1619 benefit plan network; (ii) provide the insured with the estimated or maximum charge that the
1620 provider will bill the insured for the admission, procedure or service if rendered as an out-of-
1621 network service, including the amount of any facility fees; (iii) inform the patient or prospective
1622 patient that additional information on applicable out-of-pocket costs for out-of-network services
1623 may be obtained through the toll-free number and website of the insurance carrier available
1624 pursuant to section 23 of chapter 176O; and (iv) obtain the prior written consent of such patient
1625 or prospective patient in advance of the out-of-network provider rendering health care services.
1626 This subsection shall not apply in cases of emergency services provided to a patient.

1627 Section 228A. (a) A hospital, hospital-based facility or a health care provider that charges
1628 or bills a facility fee for services shall provide any patient receiving such a service with written
1629 notice of the fee. The notice shall include the following: (i) a statement of disclosure informing
1630 the patient that the hospital, hospital-based facility, or provider has charged or billed a facility
1631 fee that is in addition to and separate from the professional fee charged by the provider; (ii) the
1632 amount of the facility fee charged or billed, or, if the exact type and extent of the facility fee is
1633 not known with reasonable certainty, an estimate of the facility fee; (iii) a statement that the
1634 patient's actual financial liability will depend on the professional medical services actually
1635 provided to the patient; (iv) an explanation that the patient may incur financial liability that is
1636 greater than the patient would incur if the professional medical services were not provided by a
1637 hospital-based facility; and (v) that a patient covered by a health insurance policy should contact
1638 the health insurer to receive information about alternative providers that do not charge a facility
1639 fee.

1640 (b) A hospital, hospital-based facility, or a health care provider that charges or bills a
1641 facility fee for services shall provide the notice required pursuant to subsection (a) for any
1642 admission, procedure or service occurring more than 5 working days from the date the
1643 appointment is made within a reasonable manner as determined by the commissioner. For any
1644 such admission, procedure or service occurring 5 or fewer working days from the date the
1645 appointment is made, or if the patient arrives without an appointment, then the notice required
1646 pursuant to subsection (a) shall be given orally at the time the patient makes the appointment,
1647 and written notice shall be provided to the patient prior to the service when the patient arrives at
1648 the hospital or hospital-based facility's premises.

1649 (c) If a hospital or health system designates a location as a hospital-based facility the
1650 facility shall clearly identify the facility as being hospital-based, including by stating the name of
1651 the hospital or health system in the facility's signage, marketing materials, Internet web sites and
1652 stationery.

1653 (d) If a hospital-based facility charges a facility fee, notice shall be posted informing
1654 patients that a patient may incur additional financial liability due to the hospital-based facility's
1655 status. Notice shall be prominently displayed on the website of the hospital, health system and
1656 hospital-based facility in a manner proscribed by the commissioner in designated locations
1657 accessible to and visible by patients, including in patient waiting areas.

1658 (e) The notices and statements required under this section shall be in plain language and
1659 in a form that may be reasonably understood by a patient who does not possess special
1660 knowledge regarding hospital or health system facility fee charges. All notices under this section
1661 shall be available in all languages representative of that health care provider's patient population.

1662 (f) The commissioner may promulgate regulations that are necessary to implement this
1663 section.

1664 SECTION 69. Section 1 of chapter 111O of the General Laws, as so appearing, is hereby
1665 amended by inserting after the definition of “Mobile integrated health care” the following
1666 definition:-

1667 “Mobile integrated health care provider” or “MIH provider”, a licensed health care
1668 professional delivering medical care and services to patients in an out-of-hospital environment in
1669 coordination with health care facilities or other health care providers; provided, however, that
1670 medical care and services shall include, but shall not be limited to, community paramedic
1671 provider services, chronic disease management, behavioral health, preventative care, post-
1672 discharge follow-up visits or transport or referral to facilities other than hospital emergency
1673 departments; provided further, that medical care and services shall be delivered under a mobile
1674 integrated health care program approved by the department using mobile health care resources.

1675 SECTION 70. Section 2 of said chapter 111O, as so appearing, is hereby amended by
1676 adding the following 2 subsections:-

1677 (c) The department shall issue guidance, in consultation with the advisory council, on
1678 best practices for structuring mobile integrated health care programs to obtain reimbursement for
1679 the care and services delivered to patients who are covered by public or private payers.

1680 (d) Annually, not later than March 1, the department shall report the data collected from
1681 MIH programs pursuant to subsection (b). The report shall include, but not be limited to, an
1682 analysis of the impact of MIH programs on: (i) 30-day readmission rates; (ii) siting of post-acute
1683 care treatment; (iii) incidence of emergency department presentment for behavioral health

1684 conditions; (iv) incidence of emergency department presentment for chronic conditions; and (v)
1685 the variance in each of the preceding metrics within and between Medicaid claims and
1686 commercial claims, respectively. The department may consult with the center for health
1687 information and analysis in developing the report. The report shall be made publicly available
1688 and easily searchable on the department's website.

1689 SECTION 71. Said chapter 111O is hereby further amended by adding the following
1690 section:-

1691 Section 5. (a) The department shall by regulation establish application fees that shall
1692 include, but not limited to, an initial application surcharge in addition to a general application or
1693 renewal fee, and a timeline for reviewing applications for mobile integrated health care or
1694 community EMS programs.

1695 (b) Application fees and surcharges collected pursuant to this chapter shall be deposited
1696 into the Mobile Integrated Health Care Trust Fund established in section 2ZZZZ of chapter 29.

1697 (c) The department shall prioritize the review and processing of mobile integrated health
1698 care program applicants that have been approved as MassHealth accountable care organizations
1699 or that have targeted patient populations served by MassHealth accountable care organizations.

1700 SECTION 72. Chapter 112 of the General Laws is hereby amended by inserting after
1701 section 5N the following section:-

1702 Section 5O. (a) For the purposes of this section, "telemedicine" shall mean the use of
1703 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a

1704 patient's physical, oral or mental health; provided however, that “telemedicine” shall not include
1705 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1706 (b) Notwithstanding any other provision of this chapter, the board shall allow a physician
1707 licensed by the board to obtain proxy credentialing and privileging for telemedicine services with
1708 other health care providers, as defined in section 1 of chapter 111, or facilities consistent with
1709 Medicare conditions of participation telemedicine standards.

1710 (c) The board shall promulgate regulations regarding the appropriate use of telemedicine
1711 to provide health care services. These regulations shall provide for and include, but shall not be
1712 limited to: (i) prescribing medications; (ii) services that are not appropriate to provide through
1713 telemedicine; (iii) establishing a patient-provider relationship; (iv) consumer protections; and (v)
1714 ensuring that services comply with appropriate standards of care.

1715 SECTION 72A. Chapter 118E of the General Laws, as amended by section 2 of chapter
1716 233 of the acts of 2016, is hereby amended by inserting, after section 10J, the following section:-

1717 Section 10K. The division shall provide coverage for genetically targeted drugs for
1718 Duchenne muscular dystrophy when (1) the drug has been prescribed for an FDA-approved use,
1719 including pursuant to the accelerated approval provisions of section 506(c) of the Federal Food,
1720 Drug, and Cosmetic Act, and as such shall not be considered experimental, investigational or
1721 unproven; and (2) the drug has been ordered or prescribed consistent with the drug’s FDA
1722 labeling and determined to be medically necessary by a licensed physician who has thoroughly
1723 evaluated the patient and either possesses expertise in Duchenne muscular dystrophy or has
1724 consulted with an expert, identified by the prescribing physician, in Duchenne muscular
1725 dystrophy who has determined the drug to be medically necessary using the division’s criteria,

1726 which shall comply with the obligations under Section 1927 of the Social Security Act, for the
1727 patient. The prescribed drugs in this section shall not be subject to any greater deductible,
1728 coinsurance, copayments or out-of-pocket limits than any other prescribed drugs provided by the
1729 division. For purposes of this section the term “genetically targeted drug” shall mean a drug for
1730 which the approved use may result in the modulation, including suppression, up-regulation, or
1731 activation, of the function of a gene or its associated gene product and incorporates or utilizes
1732 non-replicating nucleic acid or analogous compounds to treat one or more patient subgroups,
1733 including subgroups of patients with different mutations of a gene.

1734 This section shall not apply if: (1) the price of the drug increases by a percentage greater
1735 than the corresponding percentage increase in the Consumer Price Index Urban for the 2 year
1736 period beginning on the later of (1) the date this section becomes effective or (2) the date of the
1737 drug’s approval by the FDA; provided, that for the purposes of this section, “price of the drug”
1738 shall mean the “wholesale acquisition cost” as defined in section 1847A(c)(6)(B) of the Federal
1739 Social Security Act; or (2) the manufacturer does not comply with state laws of the
1740 Commonwealth, including, but not limited to, transparency requirements related to drug pricing,
1741 if any.

1742 SECTION 73. Chapter 118E of the General Laws is hereby amended by inserting after
1743 section 25 the following section:—

1744 Section 25A. (a) The division may, for individuals 65 years of age or older, disregard
1745 income in an amount equivalent to 15 per cent of the federal poverty level, as adjusted annually,
1746 in determining eligibility for the Qualified Medicare Beneficiary, Specified Low-Income
1747 Medicare Beneficiary and Qualified Individual programs, described in 42 U.S.C. section 1396a

1748 (a)(10)(E), known as the Medicare Savings or Medicare Buy-In Programs. Enrollment in the
1749 Qualified Individual program shall be capped if the federal allotment for the program is
1750 exhausted.

1751 (b) The division shall obtain all required federal approvals including amending its state
1752 plan and shall promulgate regulations prior to implementing subsection (a).

1753 (c) Funds may be transferred from the prescription advantage program in line item 9110-
1754 1455 and Health Safety Net Trust Fund to fund the expansion described in subsection (a), to the
1755 extent that the Secretary of the Executive Office of Health and Human Services determines that
1756 such expansion will result in a savings to those programs and funds are available as a result.

1757 SECTION 74. Section 28 of said chapter 118E, as appearing in the 2016 Official
1758 Edition, is hereby amended by adding the following paragraph:-

1759 A transfer of resources to a special needs trust that conforms to 42 U.S.C. §1396p
1760 (d)(4)(C) and established solely for the benefit of a disabled individual of any age shall not be
1761 treated as a disposal of resources for less than fair market value; provided, however, that the total
1762 value of resources transferred shall not exceed \$750,000, adjusted annually on the year-to-year
1763 increase in the Consumer Price Index.

1764 SECTION 75. Section 66 of said chapter 118E is hereby amended by striking out, in line
1765 28, as so appearing, the first time it appears, the word “and”.

1766 SECTION 76. Said section 66 of said chapter 118E is hereby further amended by
1767 inserting after the word “thereon”, in line 29, as so appearing, the following words:- ; and (v) any
1768 fines collected under section 10 of chapter 6D.

1769 SECTION 77. Said chapter 118E is hereby further amended by adding the following 3
1770 sections:-

1771 Section 79. (a) For the purposes of this section, “telemedicine” shall mean the use of
1772 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a
1773 patient's physical, oral or mental health; provided however, that “telemedicine” shall not include
1774 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1775 (b) The division and its contracted health insurers, health plans, health maintenance
1776 organizations, behavioral health management firms and third party administrators under contract
1777 to a Medicaid managed care organization or primary care clinician plan may provide coverage
1778 for health care services through the use of telemedicine by a contracted health care provider if (i)
1779 the health care services are covered by way of in-person consultation or delivery and (ii) the
1780 health care services may be appropriately provided through the use of telemedicine.

1781 (c) Coverage for telemedicine services may include utilization review, including
1782 preauthorization, to determine the appropriateness of telemedicine as a means of delivering a
1783 health care service, provided that the same process is utilized as if the service was provided via
1784 in-person consultation or delivery.

1785 (d) Coverage for telemedicine services shall not be required to reimburse a health care
1786 provider for a health care service that is not a covered benefit under the plan nor reimburse a
1787 health care provider not contracted under the plan.

1788 (e) Coverage that reimburses a provider with a global payment, as defined in section 1 of
1789 chapter 6D, shall account for the provision of telemedicine services to set the global payment
1790 amount.

1791 (f) Coverage for telemedicine services may include a deductible, copayment or
1792 coinsurance requirement for a health care service provided through telemedicine as long as the
1793 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance
1794 applicable to an in-person consultation or in-person delivery of services.

1795 (g) A health care provider shall not be required to document a barrier to an in-person
1796 visit, nor shall the type of setting where telemedicine is provided be limited for health care
1797 services provided through telemedicine.

1798 (h) Health care services provided by telemedicine shall conform to the standards of care
1799 applicable to the telemedicine provider's profession and specialty. Such services shall also
1800 conform to applicable federal and state health information privacy and security standards as well
1801 as standards for informed consent.

1802 Section 80. The division and its contracted health insurers, health plans, health
1803 maintenance organizations, behavioral health management firms and third party administrators
1804 under contract with a Medicaid managed care organization or primary care clinician plan shall
1805 use the standard quality measure set established by the center for health information and analysis
1806 under section 14 of chapter 12C as follows: (i) the measures designated by the center as core
1807 measures shall be used in any contract with a health care provider, provider organization or
1808 accountable care organization that incorporates quality measures into payment terms; (ii) the
1809 measures designated by the center as non-core measures may be used in any contract with a
1810 health care provider, provider organization or accountable care organization that incorporate
1811 quality measures into payment terms and shall not use any measures not designated as non-core
1812 measures; and (iii) measures included in the standard quality measure set shall be used to assign

1813 health care providers, provider organizations or accountable care organizations to tiers in the
1814 design of a program of medical benefits to a beneficiary under section 9A.

1815 Section 81. (a) For the purposes of this section the following words shall, unless the
1816 context clearly requires otherwise, have the following meanings:-

1817 “Assessed charges”, an assessed specialty clinic's gross patient service revenue
1818 attributable to all patients less an assessed specialty clinic's gross patient service revenue
1819 attributable to programs under Title XVIII, XIX and XXI of the Social Security Act.

1820 “Assessed specialty clinic”, a limited service clinic licensed under section 51J, an office-
1821 based surgical center licensed under section 51L or an urgent care clinic licensed under section
1822 51M.

1823 “Fiscal year”, the time period of 12 months beginning on October 1 of any calendar year
1824 and ending on September 30 of the following calendar year.

1825 “Gross patient service revenue”, the total dollar amount of an assessed specialty clinic's
1826 charges for services rendered to all patients in a fiscal year.

1827 (b) Each assessed specialty clinic shall, in each fiscal year, pay to the executive office an
1828 amount equal to 8.75 per cent of the total dollar amount of its assessed charges for commercial
1829 payers. Each assessed specialty clinic shall be exempt from contributing any percentage of the
1830 total dollar amount for its assessed charges for public payers.

1831 (c) The assessment charged pursuant to subsection (b) shall be implemented as a broad-
1832 based health care related fee as defined in 42 U.S.C. § 1396b(w)(3)(B) and shall be paid to the
1833 executive office on a yearly basis. The executive office may promulgate regulations that

1834 authorize the assessment of interest on any unpaid liability at a rate not to exceed an annual
1835 percentage rate of 18 per cent and late fees at a rate not to exceed 5 per cent per month. The
1836 receipts from the assessment, any federal financial participation received by the commonwealth
1837 as a result of expenditures funded by these assessments and interest thereon shall be deposited in
1838 the Community Hospital Reinvestment Trust Fund established in section 2TTTT of chapter 29.

1839 (d) The secretary of the executive office shall prepare a form on which each assessed
1840 specialty clinic shall report quarterly its total assessed charges and shall calculate the assessment
1841 due pursuant to subsection (b). The secretary of the executive office shall distribute the forms to
1842 each assessed specialty clinic at least annually. The failure to distribute the form or the failure to
1843 receive a copy of the form shall not stay the obligation to pay the assessment by the date
1844 specified in this section. The executive office may require additional reports as it considers
1845 necessary to monitor collections and compliance.

1846 (e) The executive office shall have the authority to inspect and copy the records of an
1847 assessed specialty clinic to audit its calculation of the assessment charged pursuant to subsection
1848 (b). In the event that the executive office determines that an assessed specialty clinic has either
1849 overpaid or underpaid the assessment, the executive office shall notify such assessed specialty
1850 clinic of the amount due or refund the overpayment. The executive office may impose per diem
1851 penalties if an assessed specialty clinic fails to produce documentation as requested by the
1852 executive office.

1853 (f) In the event that an assessed specialty clinic is aggrieved by a decision of the
1854 executive office as to the amount due, the assessed specialty clinic may file an appeal to the
1855 division of administrative law appeals within 60 days of the date of the notice of underpayment

1856 or the date the notice was received, whichever is later. The division of administrative law appeals
1857 shall conduct each appeal as an adjudicatory proceeding under chapter 30A and an assessed
1858 specialty clinic aggrieved by a decision of the division of administrative law appeals shall be
1859 entitled to judicial review under section 14 of said chapter 30A.

1860 SECTION 77A. Section 8 of chapter 118I of the General Laws, as so appearing, is hereby
1861 amended by striking out the words “2G of chapter 111” and inserting in place thereof the
1862 following words:- 7A of chapter 6D.

1863 SECTION 77B. Said section 8 of said chapter 118I, as amended by section 77A, is
1864 hereby further amended by striking out the words “Prevention and Wellness Trust Fund,
1865 established in section 7A of chapter 6D” and inserting in place thereof the following words:-
1866 Community Hospital Reinvestment Trust Fund established in section 2TTTT of chapter 29.

1867 SECTION 78. Section 47BB of chapter 175 of the General Laws is hereby repealed.

1868 SECTION 79. Said chapter 175 is hereby further amended by inserting after section 47II
1869 the following section:-

1870 Section 47JJ. (a) For the purposes of this section, “telemedicine” shall mean the use of
1871 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a
1872 patient's physical, oral or mental health; provided however, that “telemedicine” shall not include
1873 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

1874 (b) An individual policy of accident and sickness insurance issued under section 108 that
1875 provides hospital expense and surgical expense insurance and any group blanket or general
1876 policy of accident and sickness insurance issued under section 110 that provides hospital expense

1877 and surgical expense insurance which is issued or renewed within or without the commonwealth,
1878 shall not decline to provide coverage for health care services solely on the basis that those
1879 services were delivered through the use of telemedicine by a contracted health care provider if (i)
1880 the health care services are covered by way of in-person consultation or delivery and (ii) the
1881 health care services may be appropriately provided through the use of telemedicine.

1882 (c) Coverage for telemedicine services may include utilization review, including
1883 preauthorization, to determine the appropriateness of telemedicine as a means of delivering a
1884 health care service, provided that the same process is utilized as if the service was provided via
1885 in-person consultation or delivery.

1886 (d) Coverage for telemedicine services shall not be required to reimburse a health care
1887 provider for a health care service that is not a covered benefit under the plan nor reimburse a
1888 health care provider not contracted under the plan.

1889 (e) Coverage that reimburses a provider with a global payment, as defined in section 1 of
1890 chapter 6D, shall account for the provision of telemedicine services to set the global payment
1891 amount.

1892 (f) Coverage for telemedicine services may include a deductible, copayment or
1893 coinsurance requirement for a health care service provided through telemedicine as long as the
1894 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance
1895 applicable to an in-person consultation or in-person delivery of services.

1896 (g) A health care provider shall not be required to document a barrier to an in-person
1897 visit, nor shall the type of setting where telemedicine is provided be limited for health care
1898 services provided through telemedicine.

1899 (h) Health care services provided by telemedicine shall conform to the standards of care
1900 applicable to the telemedicine provider's profession. Such services shall also conform to
1901 applicable federal and state health information privacy and security standards as well as
1902 standards for informed consent.

1903 SECTION 79A. Chapter 175 of the General Laws, as amended by section 3 of chapter
1904 233 of the acts of 2016, is hereby amended by inserting the following section:-

1905 Section 47KK. Any individual policy of accident or sickness insurance issued pursuant to
1906 this chapter shall provide coverage for genetically targeted drugs for Duchenne muscular
1907 dystrophy when (1) the drug has been prescribed for an FDA-approved use, including pursuant
1908 to the accelerated approval provisions of section 506(c) of the Federal Food, Drug, and Cosmetic
1909 Act, and as such shall not be considered experimental, investigational or unproven; and (2) the
1910 drug has been ordered or prescribed consistent with the drug's FDA labeling and determined to
1911 be medically necessary by a licensed physician who has thoroughly evaluated the patient and
1912 either possesses expertise in Duchenne muscular dystrophy or has consulted with an expert,
1913 identified by the prescribing physician, in Duchenne muscular dystrophy who has determined the
1914 drug to be medically necessary for the patient. The prescribed drugs in this section shall not be
1915 subject to any greater deductible, coinsurance, copayments or out-of-pocket limits than any other
1916 prescribed drug provided by the commission. For purposes of this section the term "genetically
1917 targeted drug" shall mean a drug for which the approved use may result in the modulation,
1918 including suppression, up-regulation, or activation, of the function of a gene or its associated
1919 gene product and incorporates or utilizes non-replicating nucleic acid or analogous compounds to
1920 treat one or more patient subgroups, including subgroups of patients with different mutations of a
1921 gene.

1922 This section shall not apply if: (1) the price of the drug increases by a percentage greater
1923 than the corresponding percentage increase in the Consumer Price Index Urban for the 2 year
1924 period beginning on the later of (1) the date this section becomes effective or (2) the date of the
1925 drug's approval by the FDA; provided, that for the purposes of this section, "price of the drug"
1926 shall mean the "wholesale acquisition cost" as defined in section 1847A(c)(6)(B) of the Federal
1927 Social Security Act; or (2) the manufacturer does not comply with state laws of the
1928 Commonwealth, including, but not limited to, transparency requirements related to drug pricing,
1929 if any.

1930 SECTION 80. Said chapter 175 is hereby further amended by inserting after section
1931 108M the following 2 sections:-

1932 Section 108N. Upon request by a network provider, a carrier and, if applicable, a
1933 specialty organization subcontracted by a carrier to manage behavioral health services, shall
1934 disclose the methodology used for a provider's tier placement, including: (i) the criteria,
1935 measures, data sources and provider-specific information used in determining the provider's
1936 quality score; (ii) how the provider's quality performance compares to other in-network
1937 providers; and (iii) the data used in calculating the provider's cost-efficiency. A carrier may
1938 require a network provider to maintain information received under this section as confidential.

1939 Section 108O. An insurer licensed or otherwise authorized to transact accident or health
1940 insurance under this chapter shall use the standard quality measure set established by the center
1941 for health information and analysis under section 14 of chapter 12C as follows: (i) the insurer
1942 shall use the measures designated by the center as core measures in any contract with a health
1943 care provider, provider organization or accountable care organization that incorporates quality

1944 measures into payment terms; (ii) the insurer may use the measures designated by the center as
1945 non-core measures in any contract with a health care provider, provider organization or
1946 accountable care organization that incorporates quality measures into payment terms and shall
1947 not use any measures not designated as non-core measures; and (iii) the insurer shall only use the
1948 measures in the standard quality set established by the center to assign health care providers,
1949 provider organizations or accountable care organizations to tiers in the design of an accident or
1950 health plan.

1951 SECTION 81. Section 5 of chapter 176A of the General Laws, as so appearing, is hereby
1952 amended by striking out the eleventh paragraph and inserting in place thereof the following 2
1953 paragraphs:-

1954 Notwithstanding the other requirements of this section, the commission may approve any
1955 rate of payment to any provider or class of providers if such rate, in the opinion of the
1956 commission, contains an incentive to achieve greater efficiency and economy in the manner of
1957 providing health care services without adversely affecting the quality of such services. In making
1958 such an approval, the commission shall consider warranted factors of price variation, including
1959 but not limited to: patient acuity, high-cost outliers, and quality and research; and unwarranted
1960 factors of price variation, including but not limited to: market power, brand, geographic
1961 isolation, government payment shortfalls.

1962 If the commission finds that the payment rate under its review is influenced by
1963 unwarranted factors of price variation as outlined in this section, the commissioner shall refer the
1964 relevant health care entities to the health policy commission to file performance improvement
1965 plans, as established in section 10A of chapter 6D.

1966 SECTION 81A. Chapter 176A of the General Laws, as amended by section 4 of chapter
1967 233 of the acts of 2016, is hereby amended by inserting, after section 8KK, the following
1968 section:-

1969 Section 8LL. A contract between a subscriber and the corporation under an individual
1970 group or hospital service plan which is delivered, issued or renewed within the commonwealth
1971 shall provide coverage for genetically targeted drugs for Duchenne muscular dystrophy when (1)
1972 the drug has been prescribed for an FDA-approved use, including pursuant to the accelerated
1973 approval provisions of section 506(c) of the Federal Food, Drug, and Cosmetic Act, and as such
1974 shall not be considered experimental, investigational or unproven; and (2) the drug has been
1975 ordered or prescribed consistent with the drug’s FDA labeling and determined to be medically
1976 necessary by a licensed physician who has thoroughly evaluated the patient and either possesses
1977 expertise in Duchenne muscular dystrophy or has consulted with an expert, identified by the
1978 prescribing physician, in Duchenne muscular dystrophy who has determined the drug to be
1979 medically necessary for the patient. The prescribed drugs in this section shall not be subject to
1980 any greater deductible, coinsurance, copayments or out-of-pocket limits than any other
1981 prescribed drug provided by the commission. For purposes of this section the term “genetically
1982 targeted drug” shall mean a drug for which the approved use may result in the modulation,
1983 including suppression, up-regulation, or activation, of the function of a gene or its associated
1984 gene product and incorporates or utilizes non-replicating nucleic acid or analogous compounds to
1985 treat one or more patient subgroups, including subgroups of patients with different mutations of a
1986 gene.

1987 This section shall not apply if: (1) the price of the drug increases by a percentage greater
1988 than the corresponding percentage increase in the Consumer Price Index Urban for the 2 year

1989 period beginning on the later of (1) the date this section becomes effective or (2) the date of the
1990 drug's approval by the FDA; provided, that for the purposes of this section, "price of the drug"
1991 shall mean the "wholesale acquisition cost" as defined in section 1847A(c)(6)(B) of the Federal
1992 Social Security Act; or (2) the manufacturer does not comply with state laws of the
1993 Commonwealth, including, but not limited to, transparency requirements related to drug pricing,
1994 if any.

1995 SECTION 82. Chapter 176A of the General Laws is hereby amended by adding the
1996 following 3 sections:-

1997 Section 38. (a) For the purposes of this section, "telemedicine" shall mean the use of
1998 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a
1999 patient's physical, oral or mental health; provided however, that "telemedicine" shall not include
2000 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

2001 (b) A contract between a subscriber and a nonprofit hospital service corporation under an
2002 individual or group hospital service plan shall not decline to provide coverage for health care
2003 services solely on the basis that those services were delivered by way of telemedicine by a
2004 contracted health care provider if (i) the health care services are covered by way of in-person
2005 consultation or delivery and (ii) the health care services may be appropriately provided through
2006 the use of telemedicine.

2007 (c) Coverage for telemedicine services may include utilization review, including
2008 preauthorization, to determine the appropriateness of telemedicine as a means of delivering a
2009 health care service, provided that the same process is utilized as if the service was provided via
2010 in-person consultation or delivery.

2011 (d) Coverage for telemedicine services shall not be required to reimburse a health care
2012 provider for a health care service that is not a covered benefit under the plan nor reimburse a
2013 health care provider not contracted under the plan.

2014 (e) Coverage that reimburses a provider with a global payment, as defined in section 1 of
2015 chapter 6D, shall account for the provision of telemedicine services to set the global payment
2016 amount.

2017 (f) Coverage for telemedicine services may include a deductible, copayment or
2018 coinsurance requirement for a health care service provided through telemedicine as long as the
2019 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance
2020 applicable to an in-person consultation or in-person delivery of services.

2021 (g) A health care provider shall not be required to document a barrier to an in-person
2022 visit, nor shall the type of setting where telemedicine is provided be limited for health care
2023 services provided through telemedicine.

2024 (h) Health care services provided by telemedicine shall conform to the standards of care
2025 applicable to the telemedicine provider's profession and specialty. Such services shall also
2026 conform to applicable federal and state health information privacy and security standards as well
2027 as standards for informed consent.

2028 Section 39. Upon request by a network provider, a nonprofit hospital service corporation
2029 and, if applicable, a specialty organization subcontracted by a nonprofit hospital service
2030 corporation to manage behavioral health services, shall disclose the methodology used for a
2031 provider's tier placement, including: (i) the criteria, measures, data sources and provider-specific
2032 information used in determining the provider's quality score; (ii) how the provider's quality

2033 performance compares to other in-network providers; and (iii) the data used in calculating the
2034 provider's cost-efficiency. A carrier may require a network provider to maintain information
2035 received under this section as confidential.

2036 Section 40. A nonprofit hospital service corporation organized under this chapter shall
2037 use the standard quality measure set established by the center for health information and analysis
2038 under section 14 of chapter 12C as follows: (i) a nonprofit hospital service corporation shall use
2039 the measures designated by the center as core measures in any contract with a health care
2040 provider, provider organization or accountable care organization that incorporates quality
2041 measures into payment terms; (ii) a nonprofit hospital service corporation may use the measures
2042 designated by the center as non-core measures in any contract with a health care provider,
2043 provider organization or accountable care organization that incorporates quality measures into
2044 payment terms and shall not use any measures not designated as non-core measures; (iii) a
2045 nonprofit hospital service corporation shall only use the measures in the standard quality
2046 measure set established by the center to assign health care providers, provider organizations or
2047 accountable care organizations to tiers in the design of a group hospital service plan.

2048 SECTION 83. Section 4 of chapter 176B of the General Laws, as so appearing, is hereby
2049 amended by striking out the fifth paragraph and inserting in place thereof the following 2
2050 paragraphs:-

2051 Under such a group medical service agreement, subscription certificates and the rates
2052 charged by the corporation to the subscribers shall be filed with the commissioner within 30 days
2053 after their effective date, and shall be subject to subsequent disapproval by the commissioner if
2054 the commissioner finds that the benefits provided therein are unreasonable in relation to the rate

2055 charged, or that the rates charged are excessive, inadequate or unfairly discriminatory; and
2056 provided that group plan contracts issued and rates charged by a nonprofit medical service
2057 corporation to its subscribers providing supplemental coverage to Medicare shall be subject to
2058 the provisions of chapter 176K if the subscribers, and not their employer, employers or
2059 representatives, are billed directly for such contracts. No classification of risk may be established
2060 on the basis of age. In disapproving any rate under this section, the commissioner shall make a
2061 finding on the basis of information submitted by a medical service corporation, that such
2062 corporation employs a utilization review program and other techniques acceptable to the
2063 commissioner which have had or are expected to have a demonstrated impact on the prevention
2064 of reimbursement by such corporation for services which are not medically necessary.

2065 The commissioner may approve any rate of payment to any provider or class of providers
2066 if such rate, in the opinion of the commission, contains an incentive to achieve greater efficiency
2067 and economy in the manner of providing health care services without adversely affecting the
2068 quality of such services. In making such an approval, the commission shall consider warranted
2069 factors of price variation, including, but not limited to: patient acuity, high-cost outliers, and
2070 quality and research; and unwarranted factors of price variation, including but not limited to:
2071 market power, brand, geographic isolation, government payment shortfalls. If the commissioner
2072 finds that the payment rate under its review is influenced by unwarranted factors of price
2073 variation, the commissioner shall refer the relevant health care entities to the health policy
2074 commission to file performance improvement plans, as established in section 10A of chapter 6D.

2075 The commissioner may make and, at any time, alter or amend, reasonable rules or
2076 regulations to facilitate the operation and enforcement of this section and to govern hearings and
2077 investigations thereunder. The commissioner may issue such orders as the commissioner finds

2078 proper, expedient or necessary to enforce and administer the provisions of this section and to
2079 secure compliance with any rules and regulations made thereunder.

2080 SECTION 83A. Chapter 176B of the General Laws, as amended by section 5 of chapter
2081 233 of the acts of 2016, is hereby amended by inserting, after section 4KK, the following
2082 section:-

2083 Section 4LL. Any subscription certificate under an individual or group medical service
2084 agreement delivered, issued or renewed within the commonwealth shall provide coverage for
2085 genetically targeted drugs for Duchenne muscular dystrophy when (1) the drug has been
2086 prescribed for an FDA-approved use, including pursuant to the accelerated approval provisions
2087 of section 506(c) of the Federal Food, Drug, and Cosmetic Act, and as such shall not be
2088 considered experimental, investigational or unproven; and (2) the drug has been ordered or
2089 prescribed consistent with the drug's FDA labeling and determined to be medically necessary by
2090 a licensed physician who has thoroughly evaluated the patient and either possesses expertise in
2091 Duchenne muscular dystrophy or has consulted with an expert, identified by the prescribing
2092 physician, in Duchenne muscular dystrophy who has determined the drug to be medically
2093 necessary for the patient. The prescribed drugs in this section shall not be subject to any greater
2094 deductible, coinsurance, copayments or out-of-pocket limits than any other prescribed drug
2095 provided by the commission. For purposes of this section the term "genetically targeted drug"
2096 shall mean a drug for which the approved use may result in the modulation, including
2097 suppression, up-regulation, or activation, of the function of a gene or its associated gene product
2098 and incorporates or utilizes non-replicating nucleic acid or analogous compounds to treat one or
2099 more patient subgroups, including subgroups of patients with different mutations of a gene.

2100 This section shall not apply if: (1) the price of the drug increases by a percentage greater
2101 than the corresponding percentage increase in the Consumer Price Index Urban for the 2 year
2102 period beginning on the later of (1) the date this section becomes effective or (2) the date of the
2103 drug's approval by the FDA; provided, that for the purposes of this section, "price of the drug"
2104 shall mean the "wholesale acquisition cost" as defined in section 1847A(c)(6)(B) of the Federal
2105 Social Security Act; or (2) the manufacturer does not comply with state laws of the
2106 Commonwealth, including, but not limited to, transparency requirements related to drug pricing,
2107 if any.

2108 SECTION 84. Said chapter 176B is hereby amended by adding the following 3 sections:-

2109 Section 25. (a) For the purposes of this section, "telemedicine" shall mean the use of
2110 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a
2111 patient's physical, oral or mental health; provided, however, that "telemedicine" shall not include
2112 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

2113 (b) A contract between a subscriber and a medical service corporation shall not decline to
2114 provide coverage for health care services solely on the basis that those services were delivered
2115 by way of telemedicine by a contracted health care provider if (i) the health care services are
2116 covered by way of in-person consultation or delivery and (ii) the health care services may be
2117 appropriately provided through the use of telemedicine.

2118 (c) Coverage for telemedicine services may include utilization review, including
2119 preauthorization, to determine the appropriateness of telemedicine as a means of delivering a
2120 health care service, provided that the same process is utilized as if the service was provided via
2121 in-person consultation or delivery.

2122 (d) Coverage for telemedicine services shall not be required to reimburse a health care
2123 provider for a health care service that is not a covered benefit under the plan nor reimburse a
2124 health care provider not contracted under the plan.

2125 (e) Coverage that reimburses a provider with a global payment, as defined in section 1 of
2126 chapter 6D, shall account for the provision of telemedicine services to set the global payment
2127 amount.

2128 (f) Coverage for telemedicine services may include a deductible, copayment or
2129 coinsurance requirement for a health care service provided through telemedicine as long as the
2130 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance
2131 applicable to an in-person consultation or in-person delivery of services.

2132 (g) A health care provider shall not be required to document a barrier to an in-person
2133 visit, nor shall the type of setting where telemedicine is provided be limited for health care
2134 services provided through telemedicine.

2135 (h) Health care services provided by telemedicine shall conform to the standards of care
2136 applicable to the telemedicine provider's profession and specialty. Such services shall also
2137 conform to applicable federal and state health information privacy and security standards as well
2138 as standards for informed consent.

2139 Section 26. Upon request by a network provider, a medical service corporation and, if
2140 applicable, a specialty organization subcontracted by a medical service corporation to manage
2141 behavioral health services, shall disclose the methodology used for a provider's tier placement,
2142 including: (i) the criteria, measures, data sources and provider-specific information used in
2143 determining the provider's quality score; (ii) how the provider's quality performance compares to

2144 other in-network providers; and (iii) the data used in calculating the provider's cost-efficiency. A
2145 carrier may require a network provider to maintain information received under this section as
2146 confidential.

2147 Section 27. A medical service corporation organized under this chapter shall use the
2148 standard quality measure set established by the center for health information and analysis under
2149 section 14 of chapter 12C as follows: (i) a medical service corporation shall use the measures
2150 designated by the center as core measures in any contract with a health care provider, provider
2151 organization or accountable care organization that incorporates quality measures into payment
2152 terms; (ii) a medical service corporation may use the measures designated by the center as non-
2153 core measures in any contract with a health care provider, provider organization or accountable
2154 care organization that incorporates quality measures into payment terms and shall not use any
2155 measures not designated as non-core measures; and (iii) a medical service corporation shall only
2156 use the measures in the standard quality measure set established by the center to assign health
2157 care providers, accountable care organizations or provider organizations to tiers in the design of
2158 a group medical service plan.

2159 SECTION 84A. Chapter 176G of the General Laws, as amended by section 6 of chapter
2160 233 of the acts of 2016, is hereby amended by inserting, after section 4CC, the following
2161 section:-

2162 Section 4DD. Any individual or group health maintenance contract shall provide
2163 coverage for genetically targeted drugs for Duchenne muscular dystrophy when (1) the drug has
2164 been prescribed for an FDA-approved use, including pursuant to the accelerated approval
2165 provisions of section 506(c) of the Federal Food, Drug, and Cosmetic Act, and as such shall not

2166 be considered experimental, investigational or unproven; and (2) the drug has been ordered or
2167 prescribed consistent with the drug’s FDA labeling and determined to be medically necessary by
2168 a licensed physician who has thoroughly evaluated the patient and either possesses expertise in
2169 Duchenne muscular dystrophy or has consulted with an expert, identified by the prescribing
2170 physician, in Duchenne muscular dystrophy who has determined the drug to be medically
2171 necessary for the patient. The prescribed drugs in this section shall not be subject to any greater
2172 deductible, coinsurance, copayments or out-of-pocket limits than any other prescribed drug
2173 provided by the commission. For purposes of this section the term “genetically targeted drug”
2174 shall mean a drug for which the approved use may result in the modulation, including
2175 suppression, up-regulation, or activation, of the function of a gene or its associated gene product
2176 and incorporates or utilizes non-replicating nucleic acid or analogous compounds to treat one or
2177 more patient subgroups, including subgroups of patients with different mutations of a gene.

2178 This section shall not apply if: (1) the price of the drug increases by a percentage greater
2179 than the corresponding percentage increase in the Consumer Price Index Urban for the 2 year
2180 period beginning on the later of (1) the date this section becomes effective or (2) the date of the
2181 drug’s approval by the FDA; provided, that for the purposes of this section, “price of the drug”
2182 shall mean the “wholesale acquisition cost” as defined in section 1847A(c)(6)(B) of the Federal
2183 Social Security Act; or (2) the manufacturer does not comply with state laws of the
2184 Commonwealth, including, but not limited to, transparency requirements related to drug pricing,
2185 if any.

2186 SECTION 85. Section 5 of chapter 176G of the General Laws, as appearing in the 2016
2187 Official Edition, is hereby amended by striking out subsection (f) and inserting in place thereof
2188 the following subsection:-

2189 (f) Pursuant to sections 28 and 29 of chapter 176O, a health maintenance organization
2190 shall provide or arrange for indemnity payments to a member or provide for the cost of
2191 emergency medical services by a provider who is not normally affiliated with the health
2192 maintenance organization when the member requires services for an emergency medical
2193 condition.

2194 SECTION 86. Section 16 of said chapter 176G, as so appearing, is hereby amended by
2195 inserting after the first paragraph the following 2 paragraphs:-

2196 The commissioner may approve any rate of payment to any provider or class of providers
2197 if such rate, in the opinion of the commission, contains an incentive to achieve greater efficiency
2198 and economy in the manner of providing health care services without adversely affecting the
2199 quality of such services. In making such an approval, the commission shall consider warranted
2200 factors of price variation, including, but not limited to: patient acuity, high-cost outliers, and
2201 quality and research; and unwarranted factors of price variation, including but not limited to:
2202 market power, brand, geographic isolation, government payment shortfalls.

2203 If the commissioner finds that the payment rate under its review is influenced by
2204 unwarranted factors of price variation, the commissioner shall refer the relevant health care
2205 entities to the health policy commission to file performance improvement plans, as established in
2206 section 10A of chapter 6D.

2207 SECTION 87. Said chapter 176G is hereby further amended by adding the following 3
2208 sections:-

2209 Section 33. (a) For the purposes of this section, “telemedicine” shall mean the use of
2210 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a

2211 patient's physical, oral or mental health; provided however, that "telemedicine" shall not include
2212 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

2213 (b) A contract between a member and a health maintenance organization shall not decline
2214 to provide coverage for health care services solely on the basis that those services were delivered
2215 by way of telemedicine by a contracted health care provider if (i) the health care services are
2216 covered by way of in-person consultation or delivery and (ii) the health care services may be
2217 appropriately provided through the use of telemedicine.

2218 (c) Coverage for telemedicine services may include utilization review, including
2219 preauthorization, to determine the appropriateness of telemedicine as a means of delivering a
2220 health care service; provided that the same process is utilized as if the service was provided via
2221 in-person consultation or delivery.

2222 (d) Coverage for telemedicine services shall not be required to reimburse a health care
2223 provider for a health care service that is not a covered benefit under the plan nor reimburse a
2224 health care provider not contracted under the plan.

2225 (e) Coverage that reimburses a provider with a global payment, as defined in section 1 of
2226 chapter 6D, shall account for the provision of telemedicine services to set the global payment
2227 amount.

2228 (f) Coverage for telemedicine services may include a deductible, copayment or
2229 coinsurance requirement for a health care service provided through telemedicine as long as the
2230 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance
2231 applicable to an in-person consultation or in-person delivery of services.

2232 (g) A health care provider shall not be required to document a barrier to an in-person
2233 visit, nor shall the type of setting where telemedicine is provided be limited for health care
2234 services provided through telemedicine.

2235 (h) Health care services provided by telemedicine shall conform to the standards of care
2236 applicable to the telemedicine provider's profession and specialty. Such services shall also
2237 conform to applicable federal and state health information privacy and security standards as well
2238 as standards for informed consent.

2239 Section 34. Upon request by a network provider, a health maintenance organization and,
2240 if applicable, a specialty organization subcontracted by a health maintenance organization to
2241 manage behavioral health services, shall disclose the methodology used for a provider's tier
2242 placement, including: (i) the criteria, measures, data sources and provider-specific information
2243 used in determining the provider's quality score; (ii) how the provider's quality performance
2244 compares to other in-network providers; and (iii) the data used in calculating the provider's cost-
2245 efficiency. A carrier may require a network provider to maintain information received under this
2246 section as confidential.

2247 Section 35. A health maintenance organization organized under this chapter shall use the
2248 standard quality measure set established by the center for health information and analysis under
2249 section 14 of chapter 12C as follows: (i) a health maintenance organization shall use the
2250 measures designated by the center as core measures in any contract with a health care provider,
2251 provider organization or accountable care organization that incorporates quality measures into
2252 payment terms; (ii) a health maintenance organization may use the measures designated by the
2253 center as non-core measures in any contract with a health care provider, provider organization or

2254 accountable care organization that incorporates quality measures into payment terms and shall
2255 not use any measures not designated as non-core measures; and (iii) a health maintenance
2256 organization shall use the measures in the standard quality measure set established by the center
2257 to assign health care providers, accountable care organizations or provider organizations to tiers
2258 in the design of any health maintenance contract.

2259 SECTION 88. Section 3 of chapter 176I of the General Laws, as appearing in the 2016
2260 Official Edition, is hereby amended by striking out subsection (b) and inserting in place thereof
2261 the following subsection:-

2262 (b) If a covered person receives emergency care and cannot reasonably reach a preferred
2263 provider, payment for care related to the emergency shall be made pursuant to sections 28 and 29
2264 of chapter 176O and shall be made at the same level and in the same manner as if the covered
2265 person had been treated by a preferred provider; provided however, that every brochure, contract,
2266 policy manual and all printed materials shall clearly state that covered persons shall have the
2267 option of calling the local pre-hospital emergency medical service system by dialing the
2268 emergency telephone access number 911, or its local equivalent, whenever a covered person is
2269 confronted with a need for emergency care, and no covered person shall in any way be
2270 discouraged from using the local pre-hospital emergency medical service system, the 911
2271 telephone number, or the local equivalent, or be denied coverage for medical and transportation
2272 expenses incurred as a result of such use of emergency care;

2273 SECTION 89. Said chapter 176I is hereby further amended by adding the following 2
2274 sections:-

2275 Section 13. (a) For the purposes of this section, “telemedicine” shall mean the use of
2276 interactive audio, video or other electronic media for diagnosis, consultation and treatment of a
2277 patient's physical, oral or mental health; provided however, that “telemedicine” shall not include
2278 audio-only telephone, facsimile machine, online questionnaires, texting or text-only e-mail.

2279 (b) A preferred provider arrangement shall not decline to provide coverage for health care
2280 services solely on the basis that those services were delivered by way of telemedicine by a
2281 contracted health care provider if: (i) the health care services are covered by way of in-person
2282 consultation or delivery; and (ii) the health care services may be appropriately provided through
2283 the use of telemedicine.

2284 (c) Coverage for telemedicine services may include utilization review, including
2285 preauthorization, to determine the appropriateness of telemedicine as a means of delivering a
2286 health care service, provided that the same process is utilized as if the service was provided via
2287 in-person consultation or delivery.

2288 (d) Coverage for telemedicine services shall not be required to reimburse a health care
2289 provider for a health care service that is not a covered benefit under the plan nor reimburse a
2290 health care provider not contracted under the plan.

2291 (e) Coverage that reimburses a provider with a global payment, as defined in section 1 of
2292 chapter 6D, shall account for the provision of telemedicine services to set the global payment
2293 amount.

2294 (f) Coverage for telemedicine services may include a deductible, copayment or
2295 coinsurance requirement for a health care service provided through telemedicine as long as the

2296 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance
2297 applicable to an in-person consultation or in-person delivery of services.

2298 (g) A health care provider shall not be required to document a barrier to an in-person
2299 visit, nor shall the type of setting where telemedicine is provided be limited for health care
2300 services provided through telemedicine.

2301 (h) Health care services provided by telemedicine shall conform to the standards of care
2302 applicable to the telemedicine provider's profession and specialty. Such services shall also
2303 conform to applicable federal and state health information privacy and security standards as well
2304 as standards for informed consent.

2305 Section 14. An organization shall use the standard quality measure set established by the
2306 center for health information and analysis pursuant to section 14 of chapter 12C as follows: (i) an
2307 organization shall use the measures designated by the center as core measures in any contract
2308 with a health care provider, provider organization or accountable care organization that
2309 incorporates quality measures into payment terms; (ii) an organization may use the measures
2310 designated by the center as non-core measures in any contract with a health care provider,
2311 provider organization or accountable care organization that incorporates quality measures into
2312 payment terms and shall not use any measures not designated as non-core measures; and (iii) an
2313 organization shall use the measures in the standard quality measure set established by the center
2314 to assign health care providers, provider organizations or accountable care organizations to tiers
2315 in the design of a health benefit plan.

2316 SECTION 90. Section 6 of chapter 176J of the General Laws, as so appearing, is hereby
2317 amended by striking subsection (c) and inserting in place thereof the following subsection:-

2318 (c) Notwithstanding any general or special law to the contrary, carriers offering small
2319 group health insurance plans, including carriers licensed under chapter 175, 176A, 176B or
2320 176G, shall file small group product base rates and any changes to small group rating factors that
2321 are to be effective on January 1 of each year, on or before July 1 of the preceding year. The
2322 commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate
2323 or unreasonable in relation to the benefits charged. The commissioner shall disapprove any
2324 change to small group rating factors that is discriminatory or not actuarially sound. The
2325 commissioner may approve any rate of payment to any provider or class of providers if such rate,
2326 in the opinion of the commission, contains an incentive to achieve greater efficiency and
2327 economy in the manner of providing health care services without adversely affecting the quality
2328 of such services. In making such an approval, the commission shall consider warranted factors of
2329 price variation, including but not limited to: patient acuity, high-cost outliers, and quality and
2330 research; and unwarranted factors of price variation, including, but not limited to: market power,
2331 brand, geographic isolation, government payment shortfalls.

2332 If the commissioner finds that the payment rate under its review is influenced by
2333 unwarranted factors of price variation, the commissioner shall refer the relevant health care
2334 entities to the health policy commission to file performance improvement plans, as established in
2335 section 10A of chapter 6D.

2336 Rates of reimbursement or rating factors included in the rate filing materials submitted
2337 for review by the division shall be deemed confidential and exempt from the definition of public
2338 records in clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt
2339 regulations to carry out this section.

2340 SECTION 91. Said chapter 176J is hereby further amended by striking out section 11, as
2341 so appearing, and inserting in place thereof the following section:-

2342 Section 11. (a) For the purposes of this section, the following words shall, unless the
2343 context clearly requires otherwise, have the following meanings:-

2344 “Shoppable health care service” means a health care service for which a carrier offers a
2345 shared savings incentive payment under a program established by the carrier pursuant to this
2346 section. A shoppable health care service includes, at a minimum, health care services in the
2347 following categories:

- 2348 (i) Physical and occupational therapy services;
- 2349 (ii) Obstetrical and gynecological services;
- 2350 (iii) Radiology and imaging services;
- 2351 (iv) Laboratory services;
- 2352 (v) Infusion therapy;
- 2353 (vi) Inpatient or Outpatient Surgical procedures; and
- 2354 (vii) Outpatient non-surgical diagnostic tests or procedures.

2355 This division of insurance may expand this list.

2356 (b) A carrier that offers a health benefit plan that provides or arranges for the delivery of
2357 health care services through a closed network of health care providers and, as of the close of any
2358 preceding calendar year, has a combined total of not less than 5,000 eligible individuals, eligible

2359 employees and eligible dependents who are enrolled in health benefit plans sold, issued,
2360 delivered, made effective or renewed to eligible small businesses or eligible individuals shall
2361 offer to all eligible individuals and eligible small businesses in not less than 2 geographic areas at
2362 least 1 of the following plans:-

2363 (i) a plan with a reduced or selective network of providers;

2364 (ii) a plan in which providers are tiered and member cost-sharing is based on the tier
2365 placement of the provider that includes a base premium rate discount of not less than 20 per cent;

2366 (iii) a plan in which an enrollee's premium varies based on the primary care provider
2367 selected at the time of enrollment; or

2368 (iv) a plan in which a separate cost-sharing differential is applied to shoppable health care
2369 services among the network of providers.

2370 (c) Annually, the commissioner shall determine the base premium rate discount compared
2371 to the base premium rate of the carrier's most actuarially-similar plan with the carrier's non-
2372 selective or non-tiered network of providers under clauses (i) and (ii) of subsection (b). The
2373 savings may be achieved by means including, but not limited to: (i) the exclusion of providers
2374 with similar or lower quality based on the standard quality measure set with higher health status
2375 adjusted total medical expenses or relative prices, as determined pursuant to the methodology
2376 under section 52 of chapter 288 of the acts of 2010; or (ii) increased member cost-sharing for
2377 members who utilize providers for non-emergency services with similar or lower quality based
2378 on the standard quality measure set and with higher health status adjusted total medical expenses
2379 or relative prices, as determined pursuant to the methodology under said section 52 of said
2380 chapter 288 of the acts of 2010.

2381 The commissioner may apply waivers to the base premium rate discount determined by
2382 the commissioner under this section to carriers that receive not less than 80 per cent of their
2383 incomes from government programs or that have service areas that do not include an area within
2384 the boundaries of the abolished counties of Suffolk or Middlesex and that were first admitted to
2385 do business by the division of insurance not later than January 1, 1986 as health maintenance
2386 organizations under chapter 176G.

2387 (d) The commissioner shall require a plan under paragraph (iii) of subsection (b) to have
2388 at least 1 tier that provides the base premium rate discount.

2389 (e) A tiered network plan shall only include variations in member cost-sharing among
2390 provider tiers that are reasonable in relation to the premium charged and shall ensure adequate
2391 access to covered services. Carriers shall tier providers based on quality performance as
2392 measured by the standard quality measure set pursuant to section 24 of chapter 12C and by cost
2393 performance as measured by health status adjusted total medical expenses and relative prices. If
2394 applicable quality measures are not available, tiering may be based solely on health status
2395 adjusted total medical expenses or relative prices or both.

2396 The commissioner shall promulgate regulations requiring the uniform reporting of tiering
2397 information by carriers. The regulations shall include, but not be limited to, a requirement that a
2398 carrier that is implementing a tiered network plan or is modifying the tiering methodology for an
2399 existing tiered network plan shall report a detailed description of the methodology used for the
2400 tiering of providers to the commissioner not less than 90 days before the effective date of the
2401 plan or modification. The description shall include, but not be limited to: (i) the statistical basis
2402 for tiering; (ii) a list of providers to be tiered at each member cost-sharing level; (iii) a

2403 description of how the methodology and resulting tiers shall be communicated to each network
2404 provider, eligible individuals and small groups; (iv) a description of the appeals process a
2405 provider may pursue to challenge the assigned tier level; and (v) the utilization of a variable
2406 premium amount based on tier designation for the primary care provider selected by the member,
2407 if any.

2408 (f) The commissioner shall determine network adequacy: (i) for a tiered network plan
2409 based on the availability of sufficient network providers in the carrier's overall network of
2410 providers; and (ii) for a selective network plan based on the availability of sufficient network
2411 providers in the carrier's selective network.

2412 In determining network adequacy under this section, the commissioner may consider
2413 factors including the location of providers participating in the plan and employers or members
2414 that enroll in the plan, the range of services provided by providers in the plan and plan benefits
2415 that recognize and provide for extraordinary medical needs of members that may not be
2416 adequately dealt with by the providers within the plan network.

2417 (g) A carrier may reclassify provider tiers and determine provider participation in
2418 selective and tiered plans not more than once per calendar year; provided however, that a carrier
2419 may reclassify a provider from a higher cost tier to a lower cost tier or add a provider to a
2420 selective network at any time. If a carrier reclassifies provider tiers or providers participating in a
2421 selective plan during the course of an account year, the carrier shall provide notice to affected
2422 members of the account that shall include information regarding the plan changes not less than
2423 30 days before the changes are to take effect. A carrier shall provide information on the carrier's
2424 website about any tiered or selective plan including, but not limited to, the providers

2425 participating in the plan, the selection criteria for those providers and, where applicable, the tier
2426 in which each provider is classified.

2427 (h) The commissioner shall review plans under clauses (iii) and (iv) of subsection (b) in a
2428 manner consistent with other products offered in the commonwealth. The commissioner may
2429 disapprove a plan established pursuant to clause (iii) or (iv) of subsection (b) if the commissioner
2430 determines that the carrier-differentiated cost-sharing obligations are solely based on the
2431 provider. There shall be a rebuttable presumption that a plan has violated this subsection if the
2432 cost-sharing obligation for the services provided by a provider, including a health care facility,
2433 accountable care organization, patient-centered medical home or provider organization, is the
2434 same cost-sharing obligation without regard for the types of services provided pursuant to clause
2435 (iii) or (iv).

2436 When reviewing a plan established pursuant to clauses (iii) and (iv) of subsection (b), the
2437 commissioner shall ensure that the plan promotes: (i) the avoidance of consumer confusion; (ii)
2438 the minimization of administrative burdens on payers and providers in implementing the plan;
2439 and (iii) allowing for patients to receive services in appropriate locations.

2440 (i) The commissioner shall make publicly available on the commissioner's website: (i) a
2441 description of each plan offered under this section, including a list of providers or services by tier
2442 or a list of providers included in a selective network plan; (ii) membership trends for each plan
2443 offered under this section; (iii) the extent to which plans offered under this section have reduced
2444 health care costs for patients and employers; and (iv) the effect of plans offered under this
2445 section on provider mix and other factors impacting overall state health care costs. The
2446 commissioner shall ensure that the information is updated not less than annually and conforms to

2447 the uniform methodology for the communication of information about the assignment of tiers to
2448 health care providers and health care services adopted by the center for health information and
2449 analysis pursuant to section 24 of chapter 12C.

2450 Nothing in this section shall exempt a carrier from state and federal mental health parity
2451 and addiction equity laws, including those codified at 42 U.S.C. § 300gg-26, and regulations
2452 implemented pursuant to section 8K of chapter 26. Nothing in this section shall create a lesser
2453 standard of scrutiny for parity compliance for any reduced, tiered or discounted plan established
2454 pursuant to this section.

2455 SECTION 92. Said chapter 176J is hereby further amended by adding the following
2456 section:-

2457 Section 18. Upon request by a network provider, a carrier and, if applicable, a specialty
2458 organization subcontracted by a carrier to manage behavioral health services, shall disclose the
2459 methodology used for a provider's tier placement, including: (i) the criteria, measures, data
2460 sources and provider-specific information used in determining the provider's quality score; (ii)
2461 how the provider's quality performance compares to other in-network providers; and (iii) the data
2462 used in calculating the provider's cost-efficiency. A carrier may require a network provider to
2463 maintain information received under this section as confidential.

2464 SECTION 93. Section 1 of chapter 176O of the General Laws, as appearing in the 2016
2465 Official Edition, is hereby amended by inserting after the definition of "Emergency medical
2466 condition" the following definition:-

2467 "Emergency services", as defined under section 1 of chapter 6D.

2468 SECTION 94. Said section 1 of said chapter 176O, as so appearing, is hereby further
2469 amended by inserting after the definition of “Facility” the following definition:-

2470 “Facility fee”, a fee charged or billed by a hospital or health system for outpatient
2471 hospital services provided in a hospital-based facility that is intended to compensate the hospital
2472 or health system for the operational expenses of the hospital or health system and is separate and
2473 distinct from a professional fee.

2474 SECTION 95. Said section 1 of said chapter 176O, as so appearing, is hereby further
2475 amended by inserting after the definition of “Health care services” the following 2 definitions:-

2476 “Hospital”, a hospital as defined in section 1 of chapter 6D.

2477 “Hospital-based facility”, a facility as defined in section 228 of chapter 111.

2478 SECTION 96. Said section 1 of said chapter 176O, as so appearing, is hereby further
2479 amended by inserting after the definition of “Incentive plan” the following 2 definitions:-

2480 “In-network contracted rate”, the rate contracted between an insured's carrier and a
2481 network provider for the reimbursement of health care services delivered by that network
2482 provider to the insured.

2483 “In-network cost-sharing amount”, the cost-sharing amount that the insured is required to
2484 pay for a covered health care service received from a network provider. Cost sharing includes
2485 any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the insured
2486 other than premium or share of premium.

2487 SECTION 97. Said section 1 of said chapter 176O, as so appearing, is hereby further
2488 amended by inserting after the definition of “Network” the following 2 definitions:-

2489 “Network provider”, a participating provider who, under a contract with the carrier or
2490 with its contractor or subcontractor, has agreed to provide health care services to insureds
2491 enrolled in any or all of the carrier's network plans, policies, contracts or other arrangements.

2492 “Network status”, a designation to distinguish between a network provider and an out-of-
2493 network provider.

2494 SECTION 98. Said section 1 of said chapter 176O, as so appearing, is hereby further
2495 amended by inserting after the definition of “Office of patient protection” the following
2496 definition:-

2497 “Out-of-network provider”, a provider, other than a person licensed under Chapter 111C,
2498 that does not participate in the network of an insured’s health benefit plan because: (i) the
2499 provider contracts with a carrier to participate in the carrier’s network but does not contract as a
2500 participating provider for the specific health benefit plan to which an insured is enrolled; or (ii)
2501 the provider does not contract with a carrier to participate in any of the carrier's network plans,
2502 policies, contracts or other arrangements.

2503 SECTION 99. Said section 1 of said chapter 176O, as so appearing, is hereby further
2504 amended by inserting after the definition of “Second opinion” the following definition:-

2505 “Surprise bill”, a bill for health care services, other than for emergency services, received
2506 by an insured for the services of an out-of-network provider rendered at or by a network facility
2507 in the insured’s health benefit plan where: (i) a network provider is unavailable; (ii) the out-of-
2508 network provider renders services without the insured’s knowledge; (iii) services were referred
2509 by a network provider to an out-of-network provider without the prior written consent of the

2510 insured acknowledging the out-of-network referral or services and that such services rendered
2511 may result in costs not covered by the health benefit plan; or (iv) unforeseen medical services
2512 that require the services that are necessary to be performed by an out of network provider arise at
2513 the time the health care services are rendered; provided however, that “surprise bill” shall not
2514 mean a bill received for health care services rendered when a network provider is available and
2515 the insured affirmatively elected to receive services from an out-of-network provider.

2516 SECTION 100. Section 6 of said chapter 176O, as so appearing, is hereby amended by
2517 striking out, in lines 33 and 34, the words “has a reasonable opportunity to choose to have the
2518 service performed by a network provider” and inserting in place thereof the following words:-
2519 affirmatively chooses to receive services from an out-of-network provider pursuant to section 28
2520 and the out-of-network provider has obtained the prior written consent of the insured pursuant to
2521 section 228 of chapter 111.

2522 SECTION 101. Subsection (a) of said section 6 of said chapter 176O, as so appearing, is
2523 hereby further amended by striking out clause (8) and inserting in place thereof the following
2524 clause:-

2525 (8)(i) a clear description of the procedure, if any, by which the insured may request an
2526 out-of-network referral; (ii) a summary description of the methodology used by the insurer to
2527 determine reimbursement of out-of-network health care services; (iii) the amount that the insurer
2528 will reimburse under the methodology for out-of-network services pursuant to sections 28; and
2529 (iv) examples of anticipated out-of-pocket costs for frequently billed out-of-network health care
2530 services;

2531 SECTION 102. Section 7 of said chapter 176O, as so appearing, is hereby amended by
2532 striking out, in lines 5 and 6, the words “and summarizing on its internet website for each such
2533 provider” and inserting in place thereof the following words:-, along with a summary on its
2534 internet website for each provider that shall include.

2535 SECTION 103. Paragraph (1) of subsection (a) of said section 7 of said chapter 176O, as
2536 so appearing, is hereby further amended by striking out clause (iv) and inserting in place thereof
2537 the following clause:-

2538 (iv) current measures of the provider's quality using the measures established by the
2539 center for health information an analysis pursuant to section 14 of said chapter 12C; provided
2540 however, that if any specific provider or type of provider requested by an insured is not available
2541 in the network or is not a covered benefit, the information shall be provided in an easily
2542 obtainable manner; provided further, that the carrier shall prominently promote providers based
2543 on quality performance as measured by the measures established by the center under said section
2544 14 of said chapter 12C and cost performance as measured by health status adjusted total medical
2545 expenses and relative prices;.

2546 SECTION 104. Said chapter 176O is hereby further amended by striking out section 23,
2547 as so appearing, and inserting in place thereof the following section:-

2548 Section 23. All carriers shall establish a toll-free telephone number and website that
2549 enables consumers to request and obtain from the carrier, in real time, the network status of an
2550 identified health care provider and the estimated or maximum allowed amount or charge for a
2551 proposed admission, procedure or service, and the estimated amount the insured will be
2552 responsible to pay for a proposed admission, procedure or service that is a medically necessary

2553 covered benefit, based on the information available to the carrier at the time the request is made,
2554 including any facility fee, copayment, deductible, coinsurance or other out of pocket amount for
2555 any covered health care benefits. All carriers shall create a mechanism by which the insured can
2556 request notice of the estimated amount in writing. Upon request, the carrier shall send the
2557 consumer written notice of the estimated amount the insured will be responsible for paying.

2558 The telephone number and website shall inform the insured that the insured shall not be
2559 required to pay more than the estimated amounts disclosed in the written notice for the covered
2560 health care benefits that were actually provided; provided however, that nothing in this section
2561 shall prevent carriers from imposing cost sharing requirements disclosed in the insured's
2562 evidence of coverage document provided by the carrier for unforeseen services that arise out of
2563 the proposed admission, procedure or service; and provided further, that the carrier shall alert the
2564 insured that these are estimated costs, and that the actual amount the insured will be responsible
2565 to pay may vary due to unforeseen services that arise out of the proposed admission, procedure
2566 or service, except that the insured shall not be responsible for any additional payment caused by
2567 the carrier mistakenly identifying an out-of-network provider as in-network.

2568 The information provided on the website shall conform to the uniform methodology for
2569 the communication of information about the assignment of tiers to health care providers and
2570 health care services adopted by the center for health information and analysis pursuant to section
2571 24 of chapter 12C.

2572 SECTION 105. Said chapter 176O of the General Laws is hereby further amended by
2573 adding the following 4 sections:-

2574 Section 28. (a) When an out-of-network provider renders emergency services to an
2575 insured and such out-of-network provider is a member of an insured's carrier's network but not a
2576 network provider in the insured's health benefit plan, a carrier shall pay such out-of-network
2577 provider the in-network contracted rate for each delivered service; provided however, that such
2578 payment shall constitute payment in full and the out-of-network provider shall not bill the
2579 insured for any amount except for any in-network cost sharing amount owed for such service or
2580 services under the terms of the insured's health benefit plan.

2581 (b) When an out-of-network provider does not contract with a carrier and such out-of-
2582 network provider renders emergency services to an insured, a carrier shall pay such out-of-
2583 network provider the greater of: (i) 115 per cent of the average rate the carrier pays for that
2584 service performed by a health care provider in the same or similar specialty and provided in
2585 Massachusetts, as determined by the commissioner of the division of insurance, and in
2586 consultation with the center for health information and analysis and (ii) 125 per cent of the
2587 Medicare rate for that service; provided however, that such payment shall constitute payment in
2588 full to the out-of-network provider. The commissioner of the division of insurance shall indicate
2589 the types of claims to be excluded from the "average rate" calculation in this section, including
2590 the exclusion of public payer claims, and by excluding other claims which do not accurately
2591 reflect the valuation of provider services for commercial carrier plans. The out-of-network
2592 provider shall not bill the insured except for any applicable copayment, coinsurance or
2593 deductible that would be owed if the insured received such service or services from a network
2594 provider under the terms of the insured's health benefit plan.

2595 (c) When an out-of-network provider renders health care services, other than for
2596 emergency services, to an insured, the carrier shall pay that provider the greater of: (i) 115 per

2597 cent of the average rate the carrier pays for that service performed by a health care provider in
2598 the same or similar specialty and provided in Massachusetts, as determined by the commissioner
2599 of the division of insurance, and in consultation with the center for health information and
2600 analysis and (ii) 125 per cent of the Medicare rate for that service. Such payment shall constitute
2601 payment in full to the out-of-network provider. The commissioner of the division of insurance
2602 shall indicate the types of claims to be excluded from the “average rate” calculation in this
2603 section, including the exclusion of public payer claims, and by excluding other claims which do
2604 not accurately reflect the valuation of provider services for commercial carrier plans. The out-of-
2605 network provider shall not bill the insured except for any inpatient cost sharing under the terms
2606 of the insured’s health benefit plan, provided however, that said provider may bill or collect from
2607 the insured amounts in addition to the in-network cost-sharing amount if the out-of-network
2608 provider has obtained the prior written consent of the insured pursuant to section 228 of chapter
2609 111.

2610 (d) An insured shall not be liable for the payment of surprise bills, shall pay no more
2611 than the in-network cost-sharing amount and shall not owe an out-of-network provider more than
2612 the in-network cost-sharing amount for services subject to this section if: (i) an insured receives
2613 covered services from a network provider and as a result or in conjunction with such services
2614 receives services provided by an out-of-network provider; or (ii) where referrals or
2615 preauthorization are required under the insured’s health benefit plan, a network provider refers
2616 an insured to an out-of-network provider without the explicit written consent of the insured
2617 acknowledging that the provider is referring the insured to an out-of-network provider and that
2618 the referral may result in costs not covered by the health plan.

2619 (e) At the time of payment by a carrier to an out-of-network provider, a carrier shall
2620 inform the insured and the out-of-network provider of the in-network cost-sharing amount owed
2621 by the insured.

2622 (f) If a carrier delegates payment functions to a contracted entity, including, but not
2623 limited to, a medical group or independent practice association, the delegated entity shall comply
2624 with this section.

2625 (g) Nothing in this section shall require a carrier to pay for health care services delivered
2626 to an insured that are not covered benefits under the terms of the insured's health benefit plan.

2627

2628 Section 30. (a) The division, in consultation with the center for health information and
2629 analysis, shall establish an efficient and simple dispute resolution process by which a dispute for
2630 a bill for emergency services or a surprise bill may be resolved. The division shall have the
2631 power to grant and revoke certifications of independent dispute resolution entities to conduct the
2632 dispute resolution process. The division shall promulgate regulations establishing standards for
2633 the dispute resolution process, including a process for certifying and selecting independent
2634 dispute resolution entities.

2635 (b) In the event of a dispute between the out-of-network provider and the carrier as to the
2636 amount to be reimbursed under section 28, the parties shall use the following dispute resolution
2637 process:

2638 (i) An out-of-network provider or a carrier may submit a dispute regarding a fee or
2639 payment for emergency services for review to an independent dispute resolution entity certified
2640 by the division.

2641 (ii) The independent dispute resolution entity shall make a determination within 30 days
2642 of receipt of the dispute for review.

2643 (iii) In determining a reasonable fee for the services rendered, an independent dispute
2644 resolution entity shall select either: (A) the carrier's payment; or (B) the fee request of the out-of-
2645 network provider.

2646 (iv) the independent dispute resolution entity shall confirm or deny whether the amount
2647 applied is applied consistently with the formula set forth in section 28 of this chapter. (v) If
2648 the independent dispute resolution entity determines, based on the carrier's payment and the out-
2649 of-network provider's fee request, that a settlement between the carrier and out-of-network
2650 provider is reasonably likely, or that both the carrier's payment and the out-of-network provider's
2651 fee request represent unreasonable extremes, then the independent dispute resolution entity may
2652 direct both parties to attempt a good-faith negotiation for settlement. The carrier and the out-of-
2653 network provider may be granted up to 10 business days for this negotiation, which shall run
2654 concurrently with the 30 day period for dispute resolution.

2655 (vi) The determination of the independent dispute resolution entity shall be binding on
2656 the carrier and the out-of-network provider and shall be admissible in any court or administrative
2657 proceedings.

2658 (c) Payment to the independent dispute resolution entity shall be as follows: (i) for
2659 disputes involving a carrier and an out-of-network provider, when the independent dispute

2660 resolution entity determines that the health care plan’s payment is reasonable, payment for the
2661 dispute resolution process shall be the responsibility of the out-of-network provider; (ii) when
2662 the independent dispute resolution entity determines that the out-of-network provider’s fee
2663 request is reasonable, payment for the dispute resolution process shall be the responsibility of the
2664 health care plan; and (iii) agreed upon during course of negotiation pursuant to subsection (a)

2665 Section 31. (a) As used in this section, the term “pharmacy benefit manager” shall mean
2666 any person, business, or entity, however organized, that administers, either directly or through
2667 subsidiaries, pharmacy benefit services for prescription drugs and devices on behalf of health
2668 benefit plan sponsors, including, but not limited to, self-insured employers, insurance companies
2669 and labor unions; provided however, that “pharmacy benefit services” shall include, but not be
2670 limited to, formulary administration; drug benefit design; pharmacy network contracting;
2671 pharmacy claims processing; mail and specialty drug pharmacy services; and cost containment,
2672 clinical, safety and adherence programs for pharmacy services. A health benefit plan that does
2673 not contract with a pharmacy benefit manager shall be considered a pharmacy benefit manager
2674 for the purposes of this section.

2675 (b) A contract between a pharmacy benefit manager and a participating pharmacy or
2676 pharmacist or contracting agent shall not include any provision that prohibits, restricts, or limits a
2677 pharmacist or contracting agent or pharmacy’s right to provide an insured with information on
2678 the amount of the insured's cost share for such insured's prescription drug and the clinical
2679 efficacy of a more affordable alternative drug if one is available. Neither a pharmacy nor a
2680 pharmacist shall be penalized by a pharmacy benefits manager for disclosing such information to
2681 an insured or for selling to an insured a more affordable alternative if one is available.

2682 (c) A pharmacy benefits manager shall not charge a pharmacist or pharmacy a fee related
2683 to the adjudication of a claim, including, without limitation, a fee for: (i) the receipt and
2684 processing of a pharmacy claim; (ii) the development or management of claims processing
2685 services in a pharmacy benefits manager network; or (iii) participation in a pharmacy benefits
2686 manager network, unless such fee is set out in a contract between the pharmacy benefits manager
2687 and the pharmacist or contracting agent or pharmacy.

2688 (d) A contract between a pharmacy benefit manager and a participating pharmacy or
2689 pharmacist or contracting agent shall not include any provision that prohibits, restricts, or limits
2690 disclosure of information to the division deemed necessary by the division to ensure a pharmacy
2691 benefits manager's compliance with the requirements under this section or section 21C of chapter
2692 94C.

2693 SECTION 106. Section 304 of chapter 149 of the acts of 2004 is hereby repealed.

2694 SECTION 107. (a) Notwithstanding any special or general law to the contrary, the health
2695 policy commission established pursuant to section 2 of chapter 6D of the General Laws shall
2696 establish a one-time surcharge assessment on all acute hospitals satisfying the requirements of
2697 subsection (b) to be deposited according to the requirements of subsection (f). The surcharge
2698 amount to be paid by each acute hospital shall equal the product of: (i) the surcharge percentage;
2699 and (ii) \$90,000,000. The commission shall calculate the surcharge percentage by dividing the
2700 operating surplus in fiscal year 2016 by the total operating surplus in fiscal year 2016 of all acute
2701 hospitals paying an assessment under this section. The commission shall determine the surcharge
2702 percentage for the assessment by September 30, 2018. In the determination of the surcharge
2703 percentage, the commission shall use the best data available as determined by the commission

2704 and may consider the effect on projected surcharge payments of any modified or waived
2705 enforcement pursuant to subsection (c). The commission shall incorporate all adjustments,
2706 including, but not limited to, updates or corrections or final settlement amounts, by prospective
2707 adjustment rather than by retrospective payments or assessments.

2708 (b) Only acute hospitals or acute hospital systems with more than \$750,000,000 in total
2709 net assets in fiscal year 2017 and a public payer mix below 60 per cent in fiscal year 2016 shall
2710 be subject to the assessment.

2711 (c) The commission may provide assessment mitigation up to 50 per cent of the
2712 surcharge assessment if an assessable provider meets either of the following:

2713 (i) any acute hospital or acute hospital system that receives more than 25 per cent of its
2714 reimbursements from Title XIX of the Social Security Act; or

2715 (ii) any acute hospital or acute hospital system whose net assets do not exceed
2716 \$1,000,000,000.

2717 (d) Surcharge payors shall be assessed a surcharge to be paid to the commission in
2718 accordance with the provisions of subsection (e). The surcharge amount shall equal the product
2719 of: (i) the surcharge percentage; and (ii) up to \$247,500,000. The commission shall calculate the
2720 surcharge percentage by dividing the surcharge payor's payments for acute hospital services by
2721 the total payments for acute hospital services by all surcharge payors. The commission shall
2722 determine the surcharge percentage for the assessment by September 30, 2018. In the
2723 determination of the surcharge percentage, the commission shall use the best data available as
2724 determined by the commission and may consider the effect on projected surcharge payments of
2725 any modified or waived enforcement pursuant to subsection (c). The commission shall

2726 incorporate all adjustments, including, but not limited to, updates or corrections or final
2727 settlement amounts, by prospective adjustment rather than by retrospective payments or
2728 assessments.

2729 (e) Acute hospitals and surcharge payors shall pay the full amount of the surcharge
2730 amount as follows:

2731 (i) a single payment to be made no later than June 30, 2019; or

2732 (ii) in 3 equal annual installments to be paid on or before June 30 of each year beginning
2733 on June 30, 2019.

2734 (f) The assessment shall be deposited by the comptroller, as such assessments are
2735 collected, in the Community Hospital Reinvestment Trust Fund, established in section 2TTTT of
2736 chapter 29 of the General Laws; provided, however, that any reduced or waived assessment
2737 under subsection (b) or (c) shall reduce the amount to be deposited in the Community Hospital
2738 Reinvestment Trust Fund.

2739 (g) The commission shall specify by regulation appropriate mechanisms that provide for
2740 determination and payment of an acute hospital, or a surcharge payor's liability, including
2741 requirements for data to be submitted by acute hospitals and surcharge payors.

2742 (h) An acute hospital's liability to the fund shall in the case of a transfer of ownership be
2743 assumed by the successor in interest to the hospital.

2744 (i) A surcharge payor's liability to the fund shall in the case of a transfer of ownership be
2745 assumed by the successor in interest to the surcharge payor.

2746 (j) The commission shall establish by regulation an appropriate mechanism for enforcing
2747 an acute hospital or surcharge payor's liability to the fund if an acute hospital or surcharge payor
2748 does not make a scheduled payment to the fund; provided, however, that the commission may,
2749 for the purpose of administrative simplicity, establish threshold liability amounts below which
2750 enforcement may be modified or waived. Such enforcement mechanism may include assessment
2751 of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent
2752 and late fees or penalties at a rate not to exceed 5 per cent per month. Such enforcement
2753 mechanism may also include notification to the office of Medicaid requiring an offset of
2754 payments on the claims of the acute hospital or surcharge payor, any entity under common
2755 ownership or any successor in interest to the acute hospital or surcharge payor, from the office of
2756 Medicaid in the amount of payment owed to the fund, including any interest and penalties, and to
2757 transfer the withheld funds into said fund. If the office of Medicaid offsets claims payments as
2758 ordered by the commission, the office of Medicaid shall be considered not to be in breach of
2759 contract or any other obligation for payment of non-contracted services, and an acute hospital or
2760 surcharge payor whose payment is offset under an order of the commission shall serve all Title
2761 XIX recipients under the contract then in effect with the executive office of health and human
2762 services. In no event shall the commission direct the office of Medicaid to offset claims unless
2763 the acute hospital or surcharge payor has maintained an outstanding liability to the fund for a
2764 period longer than 45 days and has received proper notice that the commission intends to initiate
2765 enforcement actions under regulations promulgated by the commission.

2766 (k) If an acute hospital or surcharge payor fails to file any data, statistics or schedules or
2767 other information required under this chapter or by any regulation promulgated by the
2768 commission, the commission shall provide written notice to the acute hospital or surcharge

2769 payor. If an acute hospital or surcharge payor fails to provide required information within 14
2770 days after the receipt of written notice, or falsifies the same, such hospital or payor shall be
2771 subject to a civil penalty of not more than \$5,000 for each day on which the violation occurs or
2772 continues, which penalty may be assessed in an action brought on behalf of the commonwealth
2773 in any court of competent jurisdiction. The attorney general shall bring any appropriate action,
2774 including injunctive relief, necessary for the enforcement of this section.

2775 (l) Acute hospitals shall not seek an increase in rates to pay for the assessment pursuant
2776 to this section.

2777 (m) Surcharge payors shall not seek an increase in premiums to pay for the assessment
2778 pursuant to this section.

2779 (n) The commission shall not subject any surcharge payor to a performance improvement
2780 plan before the division of insurance and the health policy commission that fails to meet cost
2781 growth benchmarks as a direct result of being in accordance of any provisions of subsection (d).

2782 SECTION 108. Notwithstanding any general or special law to the contrary, the secretary
2783 of administration and finance, following a public hearing, shall increase the fee for obtaining or
2784 renewing a license, certificate, registration, permit or authority issued by the board of registration
2785 in medicine, the board of registration in nursing, the board of registration in dentistry, the board
2786 of registration in pharmacy, and the board of registration in genetic counselors by an amount
2787 equal to 25 per cent, rounded to the nearest \$1, of the fees in effect as of July 1, 2017. All new
2788 monies raised by this increase shall be deposited in the Community Hospital Reinvestment Trust
2789 Fund established under section 2TTTT of chapter 29 of the General Laws.

2790 SECTION 109. Notwithstanding any general or special law to the contrary, the secretary
2791 of administration and finance, following a public hearing, shall increase the fee for obtaining or
2792 renewing a license, certificate, registration, permit or authority issued by the board of registration
2793 in medicine, the board of registration in nursing, the board of registration in dentistry, the board
2794 of registration in pharmacy, and the board of registration in genetic counselors by an amount
2795 equal to 25 per cent, rounded to the nearest \$1, of the fees in effect as of July 1, 2019. All new
2796 monies raised by this increase shall be deposited in the Community Hospital Reinvestment Trust
2797 Fund established under section 2TTTT of chapter 29 of the General Laws.

2798 SECTION 110. Notwithstanding any general or special law to the contrary, the secretary
2799 of administration and finance, following a public hearing, shall increase the fee for obtaining or
2800 renewing a license, certificate, registration, permit or authority issued by the board of registration
2801 in podiatry and the board of registration in optometry by an amount equal to 25 per cent, rounded
2802 to the nearest \$1, of the fees in effect as of July 1, 2017. All new monies raised by this increase
2803 shall be deposited in the Community Hospital Reinvestment Trust Fund established under
2804 section 2TTTTof chapter 29 of the General Laws.

2805 SECTION 111. Notwithstanding any general or special law to the contrary, the secretary
2806 of administration and finance, following a public hearing, shall increase the fee for obtaining or
2807 renewing a license, certificate, registration, permit or authority issued by the board of registration
2808 in podiatry and the board of registration in optometry by an amount equal to 25 per cent, rounded
2809 to the nearest \$1, of the fees in effect as of July 1, 2019. All new monies raised by this increase
2810 shall be deposited in the Community Hospital Reinvestment Trust Fund established under
2811 section 2TTTT of chapter 29 of the General Laws.

2812 SECTION 112. Notwithstanding the provisions of any general or special law, or rule or
2813 regulation to the contrary, there shall be a \$75 surcharge on fees assessed for obtaining or
2814 renewing a license issued by the board of registration in medicine under section 2 of chapter 112
2815 of the General Laws. Said surcharges shall be collected by the department and deposited in the
2816 Community Hospital Reinvestment Trust Fund established under section 2TTTT of chapter 29 of
2817 the General Laws.

2818 SECTION 113. Notwithstanding the provisions of any general or special law, or rule or
2819 regulation to the contrary, there shall be a \$75 surcharge on fees assessed for obtaining or
2820 renewing a license issued by the board of registration in podiatry under section 16 of chapter 112
2821 of the General Laws, the board of registration in pharmacy under section 24 of said chapter 112,
2822 the board of registration in dentistry under section 45 of said chapter 112, the board of
2823 registration in optometry under section 68 of said chapter 112, and the board of registration of
2824 nursing under section 74 of said chapter 112. Said surcharges shall be collected by the
2825 department and deposited in the Community Hospital Reinvestment Trust Fund established
2826 under section 2TTTT of chapter 29 of the General Laws.

2827 SECTION 114. The office of Medicaid shall report on the role of long-term services and
2828 supports within MassHealth and MassHealth accountable care organizations in each year of the
2829 accountable care organization demonstration. The report shall include: (i) the baseline number of
2830 accountable care organization-attributed MassHealth members receiving long-term services and
2831 supports, disaggregated by age category, disability status, service type, and any other relevant
2832 categories; (ii) total MassHealth spending on long-term services and supports disaggregated by
2833 age category, disability status, service type and any other relevant categories; (iii) MassHealth
2834 average per member, per month long-term services and supports costs by service type; (iv) any

2835 projected changes in utilization of long-term services and supports in the coming year and the
2836 rationale for such changes; (v) any estimated shift in spending between medical and long-term
2837 services and supports or social services spending within the accountable care organization
2838 program in the prior year of the demonstration; (vi) the process for determination of long-term
2839 services and supports needs for members attributed to the accountable care organization
2840 program, disaggregated by accountable care organization if processes differ; and (vii) the appeals
2841 process for accountable care organization members denied long-term services and supports. This
2842 report shall be filed with the clerks of the house of representatives and the senate, the joint
2843 committee on health care financing and the house and senate committees on ways and means not
2844 later than April 1, 2019, and thereafter annually by April 1 for each year of the accountable care
2845 organization demonstration.

2846 SECTION 115. (a) There is hereby established a special commission to study and make
2847 recommendations on how to license foreign-trained medical professionals to expand and
2848 improve access to medical services in rural and underserved areas.

2849 (b) The commission shall consist of 16 members, as follows: the secretary of health and
2850 human services or a designee, who shall serve as chair; the commissioner of public health or a
2851 designee; 2 members appointed by the speaker of the house, 1 of whom shall be the house chair
2852 of the joint committee on public health; 2 members appointed by the senate president, 1 of whom
2853 shall be the senate chair of the joint committee on public health; 1 member appointed by the
2854 minority leader of the house; 1 member appointed by the minority leader of the senate; and 9
2855 members appointed by the governor, 1 of whom shall be a member of the governor's advisory
2856 council for refugees and immigrants, 1 of whom shall be a representative of the Massachusetts
2857 Immigrant and Refugee Advocacy Coalition, Inc., 1 of whom shall be a representative of the

2858 bureau of health professional licensure, 1 whom shall be a member of the board of registration in
2859 medicine, 1 of whom shall be a member of the board of registration in dentistry, 1 member of the
2860 board of registration in pharmacy, 1 of whom shall be a member of the board of registration in
2861 nursing, 1 of whom shall be a member of the board of registration of psychologists and 1 of
2862 whom shall be a member of the board of allied health professionals.

2863 (c) The commission shall examine and make recommendations on topics including, but
2864 not limited to: (i) ways to implement strategies to integrate foreign-trained medical professionals
2865 into rural and underserved areas that are in need of access to medical services; (ii) ways to
2866 identify state and national licensing regulations that pose barriers to practice for foreign-trained
2867 medical professionals; (iii) state licensing requirements that pose barriers to practice for foreign-
2868 trained medical professionals; (iv) alternate approaches by other states to integrate foreign-
2869 trained medical professionals into rural and underserved areas; and (v) other matters pertaining
2870 to licensing foreign-trained medical professionals. The commission may hold hearings and invite
2871 testimony from experts and the public to gather information. The report may include
2872 recommended guidelines for full licensure and conditional licensing of foreign-trained medical
2873 professionals.

2874 (d) The commission shall file its recommendations, including any drafts of legislation or
2875 regulations necessary to carry out its recommendations, with the clerks of the house of
2876 representatives and senate, the joint committee on public health and the joint committee on
2877 health care financing not later than March 1, 2019.

2878 SECTION 116. (a) There is hereby established a special legislative commission pursuant
2879 to section 2A of chapter 4 of the General Laws to examine administrative costs in the health care

2880 system. The commission shall consist of 23 members: 1 of whom shall be the senate chair of the
2881 joint committee on health care financing, who shall serve as co-chair; 1 of whom shall be the
2882 house chair of the joint committee on health care financing, who shall serve as co-chair; 1 of
2883 whom shall be appointed by the senate president; 1 of whom shall be appointed by the speaker of
2884 the house; 1 of whom shall be appointed by the minority leader of the senate; 1 of whom shall be
2885 appointed by the minority leader of the house of representatives; 1 of whom shall be the attorney
2886 general or a designee; 1 of whom shall be the secretary for administration and finance or a
2887 designee; 1 of whom shall be the secretary of health and human services or a designee; 1 of
2888 whom shall be the executive director of the group insurance commission or a designee; and 13 of
2889 whom shall be appointed by the governor, 1 of whom shall be a health economist, 1 of whom
2890 shall represent a high-Medicaid and low-income public payer disproportionate share hospital, 1
2891 of whom shall represent a hospital with 200 beds or less, 1 of whom shall represent a hospital
2892 with 800 staffed beds or more, 1 of whom shall have demonstrated expertise in representing the
2893 health care workforce as a leader in a labor organization, 1 of whom shall be a representative of
2894 an employer with less than 50 employees, 1 of whom shall be a representative of an employer
2895 with more than 50 employees, and 1 of whom shall be a representative of an ambulatory surgical
2896 center; 1 of whom shall be a representative of the Massachusetts Council of Community
2897 Hospitals; 1 of whom shall be a representative of the Massachusetts Association of Health Plans,
2898 Inc.; 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc.; 1
2899 of whom shall be a representative of the Massachusetts Hospital Association, Inc.; and 1 of
2900 whom shall be a representative of the Conference of Boston Teaching Hospitals. In making
2901 appointments, the governor shall, to the maximum extent feasible, ensure that the commission
2902 represents a broad distribution of diverse perspectives and geographic regions.

2903 (b) The commission shall conduct a rigorous, evidence-based analysis to identify the
2904 amount of administrative expense in the Massachusetts health care system. Such analysis shall
2905 include, but not be limited to, an examination of the following factors: (i) non-clinical expenses
2906 in insurance companies; (ii) administrative expense in provider offices; (iii) the impact of
2907 administrative costs on net revenues of hospitals, physicians, and other care providers; (iv) the
2908 amount of clinical time lost due to administrative expense; and (v) the costs to businesses and
2909 families of administrative expense. Such analysis shall also include a comparison of
2910 administrative practices in the commonwealth relative to other states and best practices about
2911 reducing administrative expense.

2912 (c) After identifying the factors contributing to administrative spending, the commission
2913 shall recommend steps to reduce administrative costs without experiencing offsetting increases
2914 in costs in other areas. To conduct its review and analysis, the commission may contract with an
2915 outside organization with expertise in the analysis of health care administrative practices. The
2916 center for health information and analysis and the health policy commission shall provide the
2917 commission and any contracted outside organization, to the extent possible, relevant data and
2918 analysis necessary for the evaluation; provided, however, that such data shall be confidential and
2919 shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General
2920 Laws.

2921 (d) The commission shall hold its first meeting not later than March 15, 2019, and shall
2922 thereafter meet not less frequently than monthly.

2923 (e) If the commission determines that legislation is necessary to address the
2924 administrative cost issues identified during its deliberations, the commission as part of its final

2925 report, shall file proposals for such legislation not later than September 30, 2019 with the clerks
2926 of the house of representatives and the senate, who shall forward a copy of the materials filed by
2927 the commission to the house and senate committees on ways and means and the joint committee
2928 on health care financing.

2929 SECTION 117. (a) Notwithstanding any general or special law, rule or regulation to the
2930 contrary, the secretary of health and human services shall convene an emergency task force to
2931 review the financial stability of nursing homes in the commonwealth in order to ensure the
2932 provision of quality resident care and quality jobs. The task force shall consist of the following 3
2933 members or their designees: the secretary of health and human services, who shall serve as chair;
2934 the secretary of elder affairs; the commissioner of public health; the house and senate chairs of
2935 the joint committee on health care financing; the house and senate chairs of the joint committee
2936 on elder affairs; 1 member who shall be appointed by the house minority leader; 1 member who
2937 shall be appointed by the senate minority leader; and 4 members who shall be appointed by the
2938 Governor, 1 of whom shall be a representative of the Massachusetts Senior Care Association,
2939 Inc.; 1 of whom shall be a representative of LeadingAge Massachusetts, Inc., 1 of whom shall be
2940 a representative of 1199SEIU, and 1 of whom shall be an expert on long-term care and aging
2941 policy.

2942 (b) The emergency task force shall evaluate options and make policy recommendations
2943 necessary to ensure the financial stability of the nursing homes in the commonwealth in order to
2944 provide quality nursing home resident care and quality jobs. In addition the emergency task force
2945 shall evaluate and make policy recommendations necessary to align current and future needs of
2946 nursing home care, to reform the department of public health's nursing home licensing
2947 processes, to establish an appropriate process for the closure of nursing homes, and to explore

2948 financial incentives around the closure of nursing homes. Such recommendations shall include
2949 policy options concerning the following: (i) improvements to the MassHealth reimbursement
2950 system for nursing homes to promote financial stability, including: (A) the use of an appropriate
2951 inflation update for nursing home rates, (B) the use of a base year period that reasonably reflect
2952 the costs in the actual rate year, (C) efficiency incentives that align with actual utilization, and
2953 (D) full recognition of the user fee for Medicaid residents; (ii) nursing home workforce
2954 engagement, recruitment, training, retention, rates of pay, scope of practice and other methods of
2955 ensuring that direct care and frontline staff have an opportunity to and can sustainably support
2956 themselves and their families; (iii) potential efficiencies to the commonwealth and improvements
2957 to care delivery that could be realized by a voluntary reconfiguration of the system via a
2958 reduction in the number of nursing home beds currently licensed while ensuring quality and
2959 access; (iv) potential criteria to be used to facilitate a voluntary reconfiguration program,
2960 including but not limited to occupancy, care standards and measure of regional geographic need;
2961 (v) potential incentives for nursing home operators that would help to align the need for nursing
2962 home beds with current and future demand and/or would facilitate conversion of under-utilized
2963 beds to other uses; and (vi) any additional reforms to strengthen the public process for nursing
2964 home closures and sales or other recommendations necessary to address the issues referenced
2965 above.

2966 (c) The emergency task force shall convene its first meeting within 90 days of the
2967 effective date of this act, and shall meet not less than monthly thereafter. The emergency task
2968 force shall file its report, including any drafts of legislation or regulations necessary to carry out
2969 its recommendations, with the speaker of the house of representatives, the president of the
2970 senate, the clerks of the house of representatives and senate, the house and senate committees on

2971 post audit and oversight, the house and senate chairs of the joint committee on health care
2972 financing and the joint committee on elder affairs, and the executive director of the health policy
2973 commission not later than 1 year after the effective date of this act.

2974 (d) The house and senate committees on post audit and oversight shall conduct a
2975 performance audit of the long term supports and services care delivery systems in the
2976 commonwealth as informed by the emergency task force final recommendations.

2977 SECTION 118. (a) Notwithstanding any general or special law to the contrary, the
2978 secretary of health and human services shall convene a health care trust fund working group
2979 consisting of the following members or their designees: the secretary of health and human
2980 services, who shall serve as chair; the treasurer and receiver general; the secretary for
2981 administration and finance; the comptroller; the secretary of elder affairs; the commissioner of
2982 public health; the commissioner of mental health; the commissioner of developmental services;
2983 the commissioner of the Massachusetts rehabilitation commission; the commissioner of
2984 transitional assistance; the commissioner of children and families; the executive director of the
2985 center for health information and analysis; the executive director of the health policy
2986 commission; 2 members of the senate, 1 of whom shall be appointed by the president of the
2987 senate and 1 of whom shall be appointed by the senate minority leader; 2 members of the house
2988 of representatives, 1 of whom shall be appointed by the speaker of the house and 1 of whom
2989 shall be appointed by the house minority leader.

2990 (b) The health care trust fund working group shall identify all non-budgeted special
2991 revenue funds established to support health and human service activities within the
2992 commonwealth and evaluate the effectiveness of each fund in achieving its intended purpose. In

2993 conducting its evaluation the health care trust fund working group shall consider: the original
2994 purpose for the establishment of each fund; the statutory requirements and standards governing
2995 the administration and oversight of each fund; the sources of revenues deposited into each fund;
2996 and historical expenditures from each fund.

2997 (c) The health care trust fund working group shall hold its first meeting not later than
2998 September 30, 2018 and shall issue a report making recommendations to improve the financing
2999 of health and human service programs supported by health care trust funds, including proposals
3000 to enhance transparency in the administration of funds and coordination between programs
3001 supported by fund expenditures and programs funded through other means. The health care trust
3002 fund working group shall file its report, including any drafts of legislation or regulations
3003 necessary to carry out its recommendations, with the clerks of the house of representatives and
3004 senate, the joint committee on public health and the joint committee on health care financing not
3005 later than February 1, 2019.

3006 SECTION 119. (a) The division of insurance, in consultation with the commonwealth
3007 health connector authority and the center for health information and analysis, shall issue a
3008 comprehensive report at least once every 5 years on the performance of the merged non-group
3009 and small-group health insurance market, as defined in chapter 176J of the General Laws. In the
3010 development of each 5 year report, the division may contract with an outside organization with
3011 expertise in fiscal analysis of the private insurance market. It shall be the responsibility of the
3012 division, in consultation with the commonwealth health insurance connector authority and the
3013 center for health information and analysis, to establish appropriate guidelines and assumptions
3014 regarding the health reforms authorized in this act prior to engaging an outside organization.
3015 Said organization shall study the impact of merging the non-group and small-group health

3016 insurance markets and make a report considering the impact on the uninsured, currently insured
3017 individuals, and employers in the commonwealth.

3018 (b) The study shall consider: (i) trends in premiums, cost-sharing, and actuarial value for
3019 plans in for individuals and small groups; (ii) characteristics of individuals in the merged market
3020 in contrast with characteristics of small group members, including, but not limited to, age, risk
3021 score, geography, gender, family size, industry and income; (iii) utilization and spending trends
3022 for individual and small group members, sourced from the Massachusetts All-Payer Claims
3023 Database, including differences in hospital and primary care practice utilization; (iv) status of
3024 competition between carriers in the market, including migration of insureds to new plans, the
3025 number of employers offering 1 plan to employees, and the behavior of employees whose
3026 employers offer more than 1 plan; and (v) any additional subjects the division considers relevant.
3027 In conducting its examination, the organization shall, to the extent possible, obtain and use actual
3028 health plan data; provided, however, that such data shall be confidential and shall not be a public
3029 record. The division shall publish each report on its website and file the same with the clerks of
3030 the house of representatives and senate, the joint committee on public health and the joint
3031 committee on health care financing.

3032 (c) Notwithstanding any general or special law to the contrary, at the request of the
3033 commission, all agencies, executive offices, departments, boards, commissions, bureaus,
3034 divisions and authorities of the commonwealth shall provide, to the extent possible, relevant data
3035 and analysis necessary for the study to the contracted organization; provided however, that such
3036 data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7
3037 of chapter 4 of the General Laws.

3038 SECTION 120. Notwithstanding any general or special rule to the contrary, the treasurer
3039 shall transfer a total of \$900,000 from the Board of Registration in Medicine Trust Fund
3040 established in section 35M of chapter 10 of the General Laws to the Mobile Integrated Health
3041 Care Trust Fund established in section 2ZZZZ of chapter 29 of the General Laws. SECTION
3042 120A: Subsection (n) of section 103 is hereby repealed.

3043 SECTION 120B: Subsection (e) of section 2TTTT of chapter 29 of the General Laws
3044 shall take effect on July 1, 2022.

3045

3046 SECTION 121. Sections 108 and 110 are hereby repealed.

3047 SECTION 122. Sections 112 and 113 are hereby repealed.

3048 SECTION 123. Section 107 is hereby repealed.

3049 SECTION 124. Section 13 shall take effect on July 1, 2023.

3050 SECTION 125. Section 50 shall take effect on July 1, 2022.

3051 SECTION 126. Sections 109, 111 and 121 shall take effect on September 1, 2020.

3052 SECTION 127. Section 122 shall take effect on January 1, 2022.

3053 SECTION 128. Section 123 shall take effect on June 30, 2021.

3054

3055

3056 SECTION 129. Chapter 118E of the Massachusetts General Laws is hereby amended by
3057 inserting the following at the end of Section 9D(c):

3058 “There shall be no voluntary enrollment of residents of nursing homes into the program
3059 through the use of an automatic or passive enrollment procedure. Residents of nursing homes
3060 shall be voluntarily enrolled into the program only through the use of an active enrollment
3061 procedure.

3062 SECTION 130. Chapter 32A of the General Laws, as appearing in the 20XX Official
3063 Edition, is hereby amended by inserting after section 4A the following new section: -

3064 Section 4B. (a) The commission or any entity with which the commission contracts to
3065 provide or manage health insurance benefits, including mental health services, shall not impose a
3066 retroactive claims denial, as defined in section 1 of chapter 175, for behavioral health services, as
3067 defined in section 1 of chapter 175, on a provider unless: (i) Less than twelve months have
3068 elapsed from the time of submission of the claim by the provider to the commission or other
3069 entity responsible for payment; (ii) The commission or other entity has furnished the provider
3070 with a written explanation of the reason for the retroactive claim denial, and a description of
3071 additional documentation or other corrective actions required for payment of the claim.

3072 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
3073 permitted after twelve months if: (i) The claim was submitted fraudulently; (ii) The claim
3074 payment is subject to adjustment due to expected payment from another payer and not more than
3075 12 months have elapsed since submission of the claim; or (iii) The claims, or services for which
3076 the claim has been submitted, is the subject of legal action; or (iv) The claim payment was
3077 incorrect because the provider or the insured was already paid for the health care services

3078 identified in the claim; or (v) The health care services identified in the claim were not delivered
3079 by the provider.

3080 (c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph
3081 (b), the commission or other entity shall notify a provider at least 15 days before imposing the
3082 retroactive claim denial and the provider shall have twelve months to determine whether the
3083 claim is subject to payment by a secondary insurer. Notwithstanding the contractual terms
3084 between the provider and insurer, an insurer shall allow for submission of a claim that was
3085 previously denied by another insurer due to the insured's transfer or termination of coverage.

3086 (d) For the purposes of this subsection, provider shall mean a mental health clinic or
3087 substance use disorder program licensed by the department of public health under Chapters 18,
3088 111, 111B, or 111E , a behavioral, substance use disorder, or mental health professional who is
3089 licensed under Chapter 112 of the General Laws and accredited or certified to provide services
3090 consistent with law and who has provided services under an express or implied contract or with
3091 the expectation of receiving payment, other than co- payment, deductible or co-insurance,
3092 directly or indirectly from the commission or other entity.

3093 SECTION 131. Chapter 118E of the General Laws, as so appearing, is amended by
3094 inserting after section 38 the following new section: -

3095 38A. (a) The division or any entity with which the division contracts to provide or
3096 manage health insurance benefits, including mental health services, shall not impose a retroactive
3097 claims denial, as defined in section 1 of chapter 175, for behavioral health services, as defined in
3098 section 1 of chapter 175, on a provider unless: (i) Less than twelve months have elapsed from the
3099 time of submission of the claim by the provider to the division or other entity responsible for

3100 payment; (ii) The division or other entity has furnished the provider with a written explanation of
3101 the reason for the retroactive claim denial, and a description of additional documentation or other
3102 corrective actions required for payment of the claim.

3103 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
3104 permitted after twelve months if: (i) The claim was submitted fraudulently; (ii) The claim
3105 payment is subject to adjustment due to expected payment from another payer and not more than
3106 12 months have elapsed since submission of the claim; (iii) The claims, or services for which the
3107 claim has been submitted, is the subject of legal action; (iv) The claim payment was incorrect
3108 because the provider or the insured was already paid for the health care services identified in the
3109 claim; (v) the health care services identified in the claim were not delivered by the provider.

3110 (c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph
3111 (b), the division or other entity shall notify a provider at least 15 days before imposing the
3112 retroactive claim denial and the provider shall have twelve months to determine whether the
3113 claim is subject to payment by a secondary insurer. Notwithstanding the contractual terms
3114 between the provider and insurer, an insurer shall allow for submission of a claim that was
3115 previously denied by another insurer due to the insured's transfer or termination of coverage.

3116 (d) For the purposes of this subsection, provider shall mean a mental health clinic or
3117 substance use disorder program licensed by the department of public health under Chapters 18,
3118 111, 111B, or 111E, a behavioral, substance use disorder, or mental health professional who is
3119 licensed under Chapter 112 of the General Laws and accredited or certified to provide services
3120 consistent with law and who has provided services under an express or implied contract or with

3121 the expectation of receiving payment, other than co- payment, deductible or co-insurance,
3122 directly or indirectly from the division or managed care entity.

3123 SECTION 132. Section 1 of Chapter 175 of the General Laws, as so appearing, is
3124 amended by inserting before the definition of “Commissioner” the following new definition:

3125 “Behavioral Health”, mental health and substance use disorder prevention, recovery and
3126 treatment services including but not limited to inpatient 24 hour levels of care, 24 hour and non
3127 24 hour diversionary levels of care, intermediate levels of care and outpatient services

3128 and by inserting after the definition of “Resident” the following new definition:

3129 “Retroactive Claim Denial”, an action by a) an insurer, b) an entity with which the
3130 insurer subcontracts to manage behavioral health services, c) an entity with which the Group
3131 Insurance Commission has entered into an administrative services contract or a contract to
3132 manage behavioral health services, or d) the executive office of health and human services acting
3133 as the single state agency under section 1902(a)(5) of the Social Security Act authorized to
3134 administer programs under title XIX, to deny a previously paid claim for services and to require
3135 repayment of the claim, impose a reduction in other payments, or otherwise withhold or affect
3136 future payments owed a provider in order to recoup payment for the denied claim.

3137 SECTION 133. Section 108 of chapter 175 of the General Laws, as so appearing, is
3138 hereby amended by adding the following new subsections at the end thereof: -

3139 (a) No insurer shall impose a retroactive claims denial, as defined in section 1 of chapter
3140 175, for behavioral health services, as defined in section 1 of chapter 175, on a provider unless:

3141 (i) Less than twelve months have elapsed from the time of submission of the claim by the

3142 provider to the insurer or other entity responsible for payment; (ii) The insurer or other entity has
3143 furnished the provider with a written explanation of the reason for the retroactive claim denial,
3144 and a description of additional documentation or other corrective actions required for payment of
3145 the claim.

3146 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
3147 permitted after twelve months if: (i) The claim was submitted fraudulently; (ii) The claim
3148 payment is subject to adjustment due to expected payment from another payer and not more than
3149 12 months have elapsed since submission of the claim; or (iii) The claims, or services for which
3150 the claim has been submitted, is the subject of legal action; or (iv) the claim payment was
3151 incorrect because the provider or the insured was already paid for the health care services
3152 identified in the claim; or (v) the health care services identified in the claim were not delivered
3153 by the provider.

3154 (c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph
3155 (b), the insurer shall notify a provider at least 15 days before imposing the retroactive claim
3156 denial and the provider shall have twelve months to determine whether the claim is subject to
3157 payment by a secondary insurer. Notwithstanding the contractual terms between the provider and
3158 insurer, an insurer shall allow for submission of a claim that was previously denied by another
3159 insurer due to the insured's transfer or termination of coverage.

3160 (d) For the purposes of this subsection, provider shall mean a mental health clinic or
3161 substance use disorder program licensed by the department of public health under Chapters 18,
3162 111, 111B, or 111E, a behavioral, substance use disorder, or mental health professional who is
3163 licensed under Chapter 112 of the General Laws and accredited or certified to provide services

3164 consistent with law and who has provided services under an express or implied contract or with
3165 the expectation of receiving payment, other than co- payment, deductible or co-insurance,
3166 directly or indirectly from an insurer.

3167 SECTION 134. Chapter 176A of the General Laws, as so appearing, is amended by
3168 inserting after section 8 the following new section:-

3169 Section 8A (a) The corporation shall not impose a retroactive claims denial, as defined in
3170 section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on
3171 a provider unless: (i) Less than twelve months have elapsed from the time of submission of the
3172 claim by the provider to the corporation; (ii) The corporation has furnished the provider with a
3173 written explanation of the reason for the retroactive claim denial, and a description of additional
3174 documentation or other corrective actions required for payment of the claim.

3175 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
3176 permitted after twelve months if: (i) The claim was submitted fraudulently; (ii) The claim
3177 payment is subject to adjustment due to expected payment from another payer and not more than
3178 12 months have elapsed since submission of the claim; or (iii) The claims, or services for which
3179 the claim has been submitted, is the subject of legal action; or (iv) The claim payment was
3180 incorrect because the provider or the insured was already paid for the health care services
3181 identified in the claim; or (v) the health care services identified in the claim were not delivered
3182 by the provider.

3183 (c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph
3184 (b), the corporation shall notify a provider at least 15 days before imposing the retroactive claim
3185 denial and the provider shall have twelve months to determine whether the claim is subject to

3186 payment by a secondary payer. Notwithstanding the contractual terms between the provider and
3187 secondary payer, the payer shall allow for submission of a claim that was previously denied by
3188 the corporation due to the insured's transfer or termination of coverage.

3189 (d) For the purposes of this subsection, provider shall mean a mental health clinic or
3190 substance use disorder program licensed by the department of public health under Chapters 18,
3191 111, 111B, or 111E, a behavioral, substance use disorder, or mental health professional who is
3192 licensed under Chapter 112 of the General Laws and accredited or certified to provide services
3193 consistent with law and who has provided services under an express or implied contract or with
3194 the expectation of receiving payment, other than co- payment, deductible or co-insurance,
3195 directly or indirectly from an insurer.

3196 SECTION 135. Chapter 176B of the General Laws, as so appearing is hereby amended
3197 by inserting after section 7C the following new section:-

3198 Section 7D (a) The corporation shall not impose a retroactive claims denial, as defined in
3199 section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on
3200 a provider unless: (i) Less than twelve months have elapsed from the time of submission of the
3201 claim by the provider to the corporation; (ii) The corporation has furnished the provider with a
3202 written explanation of the reason for the retroactive claim denial, and a description of additional
3203 documentation or other corrective actions required for payment of the claim.

3204 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
3205 permitted after twelve months if: (i) The claim was submitted fraudulently; (ii) The claim
3206 payment is subject to adjustment due to expected payment from another payer and not more than
3207 12 months have elapsed since submission of the claim; or (iii) The claims, or services for which

3208 the claim has been submitted, is the subject of legal action; or (iv) The claim payment was
3209 incorrect because the provider or the insured was already paid for the health care services
3210 identified in the claim; or (v) the health care services identified in the claim were not delivered
3211 by the provider.

3212 (c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph
3213 (b), the corporation shall notify a provider at least 15 days before imposing the retroactive claim
3214 denial and the provider shall have twelve months to determine whether the claim is subject to
3215 payment by a secondary payer. Notwithstanding the contractual terms between the provider and
3216 secondary payer, the payer shall allow for submission of a claim that was previously denied by
3217 the corporation due to the insured's transfer or termination of coverage.

3218 (d) For the purposes of this subsection, provider shall mean a mental health clinic or
3219 substance use disorder program licensed by the department of public health under Chapters 18,
3220 111, 111B, or 111E , a behavioral, substance use disorder, or mental health professional who is
3221 licensed under Chapter 112 of the General Laws and accredited or certified to provide services
3222 consistent with law and who has provided services under an express or implied contract or with
3223 the expectation of receiving payment, other than co- payment, deductible or co-insurance,
3224 directly or indirectly from an insurer.

3225 SECTION 136. Chapter 176G of the General Laws, as so appearing, is hereby amended
3226 by inserting after section 6A the following new section:-

3227 Section 6B. (a) No insurer shall impose a retroactive claims denial, as defined in section
3228 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on a
3229 provider unless: (i) Less than twelve months have elapsed from the time of submission of the

3230 claim by the provider to the insurer or other entity responsible for payment; (ii) The insurer or
3231 other entity has furnished the provider with a written explanation of the reason for the retroactive
3232 claim denial, and a description of additional documentation or other corrective actions required
3233 for payment of the claim.

3234 (b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be
3235 permitted after twelve months if: (i) The claim was submitted fraudulently; (ii) The claim
3236 payment is subject to adjustment due to expected payment from another payer and not more than
3237 12 months have elapsed since submission of the claim; or (iii) The claims, or services for which
3238 the claim has been submitted, is the subject of legal action; (iv) The claim payment was incorrect
3239 because the provider or the insured was already paid for the health care services identified in the
3240 claim; or (v) the health care services identified in the claim were not delivered by the provider.

3241 (c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph
3242 (b), the insurer shall notify a provider at least 15 days before imposing the retroactive claim
3243 denial and the provider shall have twelve months to determine whether the claim is subject to
3244 payment by a secondary insurer. Notwithstanding the contractual terms between the provider and
3245 insurer, an insurer shall allow for submission of a claim that was previously denied by another
3246 insurer due to the insured's transfer or termination of coverage.

3247 (d) For the purposes of this subsection, provider shall mean a mental health clinic or
3248 substance use disorder program licensed by the department of public health under Chapters 18,
3249 111, 111B, or 111E, a behavioral, substance use disorder, or mental health professional who is
3250 licensed under Chapter 112 of the General Laws and accredited or certified to provide services
3251 consistent with law and who has provided services under an express or implied contract or with

3252 the expectation of receiving payment, other than co- payment, deductible or co-insurance,
3253 directly or indirectly from an insurer.

3254 SECTION 137. The Division of Medical Assistance is hereby authorized and directed to
3255 develop an internal process for the reconciliation of claims due to retroactive eligibility changes
3256 and/or duplicate enrollments in cases that involve multiple payers for services provided to
3257 MassHealth enrollees. This process shall not require provider involvement. The division shall
3258 report to the senate and house committees on ways and means on this process no longer than five
3259 months after enactment of this legislation.

3260 SECTION 138. Chapter 176O of the General Laws is hereby amended by inserting after
3261 section 27 the following sections:-

3262 Section 28. (a) A carrier shall ensure the accuracy of the information concerning each
3263 provider listed in the carrier's provider directories for each network plan and shall review and
3264 update the entire provider directory for each network plan. In making the directory available
3265 electronically in a searchable format, the carrier shall ensure that the general public is able to
3266 view all of the current health care providers for a network plan through a clearly identifiable link
3267 or tab and without creating or accessing an account, entering a policy or contract number,
3268 providing other identifying information, or demonstrating coverage or an interest in obtaining
3269 coverage with the network plan. Thereafter, the carrier shall update each online network plan
3270 provider directory at least monthly, or more frequently, if required by state or federal law or
3271 regulations promulgated by the commissioner pursuant to Section 29(j), when informed of and
3272 upon confirmation by the plan of any of the following:

3273 (1) A contracting provider is no longer accepting new patients for that network plan, or
3274 an individual provider within a provider group is no longer accepting new patients.

3275 (2) A provider or provider group is no longer under contract for a particular network plan.

3276 (3) A provider's practice location or other information required under this section has
3277 changed.

3278 (4) Upon completion of the investigation described in paragraph (a)(4), a change is
3279 necessary based on an enrollee complaint that a provider was not accepting new patients, was
3280 otherwise not available, or whose contact information was listed incorrectly.

3281 (5) A provider has retired or otherwise has ceased to practice.

3282 (6) Any other information that affects the content or accuracy of the provider directory or
3283 directories.

3284 (b) A provider directory shall not list or include information on a provider that is not
3285 currently under contract with the network plan.

3286 (c) A carrier shall periodically audit its provider directories for accuracy and retain
3287 documentation of such an audit to be made available to the commissioner upon request.

3288 (d) A carrier shall provide a print copy, or a print copy of the requested directory
3289 information, of a current provider directory upon request of an insured or a prospective insured.
3290 The printed copy of the provider directory or directories shall be provided to the requester by
3291 mail postmarked no later than five business days following the date of the request and may be
3292 limited to the geographic region in which the requester resides or works or intends to reside or
3293 work.

3294 (e) The carrier shall include in both its electronic and print directories a dedicated
3295 customer service email address and telephone number or electronic link that insureds, providers
3296 and the general public may use to notify the carrier of inaccurate provider directory information.
3297 This information shall be disclosed prominently in the directory or directories and on the
3298 carrier's web site. The carrier shall be required to investigate reports of inaccuracies within 30
3299 days of notice and modify the directories in accordance with any findings within 30 days of such
3300 findings.

3301 (f) The provider directory or directories shall inform enrollees and potential enrollees that
3302 they are entitled to: (A) language interpreter services, at no cost to the enrollee; and (B) full and
3303 equal access to covered services as required under the federal Americans with Disabilities Act of
3304 1990 and Section 504 of the Rehabilitation Act of 1973. A provider directory, whether in
3305 electronic or print format, shall accommodate the communication needs of individuals with
3306 disabilities, and include a link to or information regarding available assistance for persons with
3307 limited English proficiency, including how to obtain interpretation and translation services.

3308 (g) The carrier shall include a disclosure in the print directory that the information
3309 included in the directory is accurate as of the date of printing and that insureds or prospective
3310 insureds should consult the carrier's electronic provider directory on its website or call a
3311 specified customer service telephone number to obtain the most current provider directory
3312 information.

3313 (h) The carrier shall update its printed provider directory or directories at least annually,
3314 or more frequently, if required by federal law or regulations promulgated by the commissioner.

3315 Section 29. (a) The division shall establish a task force to develop recommendations to
3316 ensure the current and accurate electronic posting of carrier provider directories in a searchable
3317 format for each of the carriers' network plans available for viewing by the general public.

3318 (b) The task force shall consist of the commissioner of insurance or a designee, who shall
3319 serve as chair, and 12 members: one of whom shall be a representative of the Massachusetts
3320 Association of Health Plans, one of whom shall be a representative of Blue Cross Blue Shield
3321 MA, one of whom shall be a representative of the Massachusetts Health and Hospital
3322 Association, one of whom shall be a representative of the Massachusetts Medical Society, one of
3323 whom shall be a representative of Healthcare Administrative Solutions, Inc., one of whom shall
3324 be a representative of the Children's Mental Health Campaign, one of whom shall be a
3325 representative of the Massachusetts Association for Mental Health, and five members chosen by
3326 the commissioner: one of whom shall have expertise in the treatment of individuals with
3327 substance use disorder, , one of whom shall have expertise in the treatment of individuals with a
3328 mental illness, one of whom shall be from a health consumer advocacy organization, one of
3329 whom shall be a consumer representative, and one of whom shall be a representative from an
3330 employer group. The task force shall have the ability to form workgroups to develop the
3331 recommendations defined in subsection (a).

3332 (c) The recommendations shall include measures for ensuring the accuracy of
3333 information concerning each provider listed in the carrier's provider directories for each network
3334 plan. The task force shall develop recommendations that establish substantially similar processes
3335 and time frames for health care providers included in a carrier's network to provide information
3336 to the carrier, and substantially similar processes and timeframes for carriers to include such
3337 information in their provider directories, regarding the following:

3338 (1) when a contracting provider is no longer accepting new patients for that network plan
3339 and when a contracting provider is resuming acceptance of new patients, or an individual
3340 provider within a provider group is no longer accepting new patients and when an individual
3341 provider within a provider group is resuming acceptance of new patients;

3342 (2) when a provider who is not accepting new patients is contacted by an enrollee or
3343 potential enrollee seeking to become a new patient, the provider may direct the enrollee or
3344 potential enrollee to the carrier for additional assistance in finding a provider and shall inform
3345 the carrier immediately if they have not done so already that the provider is not accepting new
3346 patients;

3347 (3) when a provider is no longer under contract for a particular network plan;

3348 (4) when a provider's practice location or other information required under this section
3349 has changed;

3350 (5) for health care professionals: (i) name; (ii) contact information; (iii) gender; (iv)
3351 participating office location(s); (v) specialty, if applicable; (vi) clinical and developmental areas
3352 of expertise; (vii) populations of interest; (viii) licensure and board certification(s); (ix) medical
3353 group affiliations, if applicable; (x) facility affiliations, if applicable; (xi) participating facility
3354 affiliations, if applicable; (xii) languages spoken other than English, if applicable; (xiii) whether
3355 accepting new patients; and (xiv) information on access for people with disabilities, including
3356 but not limited to structural accessibility and presence of accessible examination and diagnostic
3357 equipment;

3358 (6) for hospitals: (i) hospital name; (ii) hospital type; (iii) participating hospital location
3359 and telephone number; (iv) hospital accreditation status; (7) for facilities, other than hospitals, by

3360 type: (i) facility name; (ii) facility type; (iii) types of services performed; (iv) participating
3361 facility location(s) and telephone number; and

3362 (7) Any other information that affects the content or accuracy of the provider directory or
3363 directories.

3364 (d) The task force shall develop recommendations for carriers to include information in
3365 the provider directory that identifies the tier level for each specific provider, hospital or other
3366 type of facility in the network, when applicable.

3367 (e) The task force shall develop recommendations for carriers to include in the provider
3368 directories substantially similar language to assist insureds with understanding and searching for
3369 behavioral health specialty providers.

3370 (f) The task force shall consider the feasibility of carriers making updates to each online
3371 network plan provider directory in real time when health care providers included in a carrier's
3372 network provide information to the carrier pursuant to subsection (c).

3373 (g) The task force shall consider measures to address circumstances when an insured
3374 reasonably relies upon materially inaccurate information contained in a carrier's provider
3375 directory.

3376 (h) The task force shall develop recommendations for measures carriers shall take to
3377 ensure the accuracy of the information concerning each provider listed in the carrier's provider
3378 directories for each network plan based on the information provided to the carriers by network
3379 providers, as described in paragraph (c), including but not limited to periodic testing to ensure

3380 that the public interface of the directories accurately reflects the provider network, as required by
3381 state and federal laws and regulations.

3382 (i) The task force shall recommend appropriate timelines for completion of its
3383 recommendations.

3384 (j) The commissioner shall file the task force's recommendations, including any proposed
3385 regulations, with the joint committee on health care financing not later than November 15, 2018.

3386 (k) The commissioner shall promulgate regulations pursuant to section 28 and the
3387 recommendations of the task force no later than three months following the commissioner's
3388 filing under subsection (j).

3389 (l) The commissioner shall conduct quarterly implementation progress reports, which
3390 shall be available to the public, commencing on January 1, 2019 and continuing until the task
3391 force recommendations under subsection (j) are fully implemented.

3392 SECTION 139. Carriers shall ensure the accuracy of the information pursuant to the
3393 regulations issued by the commissioner of insurance pursuant to section 29 of chapter 176O of
3394 the general laws for each network plan no later than January 1, 2020.

3395 SECTION 140. Subdivision (P) of section 110 of chapter 175 of the General Laws, as
3396 appearing in the 2016 Official Edition, is hereby amended by inserting after the word "age", in
3397 line 463, the following words:- or without regard to age, so long as the dependent, who is
3398 covered under the membership of his parent as a member of a family group, is mentally or
3399 physically incapable of earning their own living due to disability.

3400 SECTION 141. Section 4T of chapter 176G of the General Laws, as appearing in the
3401 2016 Official Edition, is hereby amended by inserting after the word “age”, in line 6, the
3402 following words:- or without regard to age, so long as the dependent, who is covered under the
3403 membership of his parent as a member of a family group, is mentally or physically incapable of
3404 earning their own living due to disability.

3405 SECTION 142. Section 1 of chapter 176J of the General Laws, as appearing in the 2016
3406 Official Edition, is hereby amended by inserting after the word “age”, in line 86, the following
3407 words:- or without regard to age, so long as the dependent, who is covered under the membership
3408 of his parent as a member of a family group is mentally or physically incapable of earning their
3409 own living due to disability.

3410 SECTION 143. Section 15 of chapter 6D is hereby amended by inserting in subsection (f)
3411 in the first line after the phrase “which providers of” the following:- health care services as
3412 defined within subsection (c)(3) and

3413 SECTION 144. Section 15 of chapter 6D is hereby amended by striking in subsection (f)
3414 in the second paragraph after the phrase “approval by an ACO” the following:- as a provider of
3415 free standing ancillary services for ACO patients.

3416 SECTION 145. Section 15 of chapter 6D is hereby amended by inserting the following
3417 subsection:-

3418 (h) The commission shall annually review each certified ACO’s published standards as
3419 required pursuant to subsection (f) and shall report its findings, including any recommendations.
3420 Such review shall include, but not be limited to, if such standards ensure consideration and
3421 participation by providers of health care services and free-standing ancillary services as defined

3422 within this section sufficient to ensure the goals of subsection (c), including ensuring maximized
3423 value to patients as expressed in a reduction in price and health status adjusted total medical
3424 expenses and an increase in quality. Such findings shall be used by the commission in the
3425 examination and cross examination of witnesses at the annual cost trend hearings pursuant to
3426 Section 8 of chapter 6D. The commission shall bi-annually amend the commission's minimum
3427 standards pursuant to subsection (b) in order to ensure processes by which participants and out-
3428 of-ACO arrangements are selected and structured, including through joint venture arrangements,
3429 by certified ACOs such that said goals are sufficiently advanced.

3430 SECTION 146. Notwithstanding any other general or special law to the contrary, the
3431 health policy commission shall promulgate by March 1, 2019 regulations to establish an
3432 aggrieved provider review process pursuant to subsection (f) of Section 15 of chapter 6D.

3433 SECTION 147. To require the executive office of health and human services to submit a
3434 report to the House Committee on Ways and Means detailing: (i) the outcomes achieved by
3435 accountable care organizations and community partners including, but not limited to, financial
3436 performance, patient satisfaction and quality and aggregate and per-member reductions in
3437 spending compared to prior cost trends; (ii) the results of benchmarks on accountable care
3438 organizations' and community partners' progress toward an integrated care delivery system; and
3439 (iii) a summary of spending and activities related to traditionally non-reimbursed services to
3440 address health-related social needs including, but not limited to, housing stabilization and
3441 support, utility assistance, nonmedical transportation, physical activity, nutrition and sexual
3442 assault and domestic violence supports; provided further, that such summary shall include, to the
3443 maximum extent practicable, aggregated data on the results of health-related social needs
3444 screening, the number of referrals to human service providers to address such screening, the

3445 result of such referrals and changes in health status; provided further, that such data shall be
3446 stratified by demographic factors to support an analysis of the impact on health disparities;
3447 provided further, that where data is not available, a report on progress toward establishing
3448 necessary data systems shall be provided.

3449 SECTION 148: Section 1119A shall take effect on September 30, 2019.

3450 SECTION 149. Notwithstanding any general or special law to the contrary, until
3451 hospitals have been designated pursuant to section 51N of chapter 111 of the General Laws, the
3452 department of public health shall designate primary stroke service hospitals as acute stroke ready
3453 hospitals capable of providing care previously designated in regulations as primary stroke service
3454 care.

3455 At the time that the department begins the designation of 3 tiers of stroke facilities
3456 pursuant to said section 51N of said chapter 111, hospitals may maintain primary stroke service
3457 designation utilizing the existing processes and criteria for a 6-month period. At the time that the
3458 department begins the designation process, primary stroke service hospitals shall be recognized
3459 as acute stroke ready hospitals. After the department has begun the designation process, all
3460 primary stroke service hospitals shall be considered acute stroke ready hospitals, regardless of
3461 additional capacity, until they receive a higher designation of primary stroke center or
3462 comprehensive stroke center.

3463 SECTION 150. The department shall designate hospitals pursuant to section 51N of
3464 chapter 111 of the General Laws not later than 180 days after the effective date of this act.

3465 SECTION 151. Sections 11A, 24A, 35A, 45A and 58A, 774B shall take effect on July 1,
3466 2023.