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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:

SECTION 1. Chapter 3 of the General Laws is hereby amended by inserting after section 38C the following section:-

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

(b) Joint committees of the general court and the house and senate committees on ways and means shall refer to the clerk of the house and senate any bills containing a scope of practice proposal originally referred to the committee, who shall require a review and evaluation from the center for health information and analysis and recommendations from the health policy commission be provided to the general court pursuant to this section.

(c) Upon the request of a joint standing committee of the general court having jurisdiction or the house or senate committees on ways and means, the center for health information and analysis shall conduct a review and evaluation of the scope of practice proposals in accordance with this section within 180 days of the request. Said review and evaluation shall be filed with the clerks of the house and senate, who shall transmit a copy upon receipt of the review and evaluation to the members of the general court.

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

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

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

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

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

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

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

SECTION 4. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Health care provider" the following definition:-

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

SECTION 3. Section 1 of said chapter 6D, as appearing in the 2016 Official Edition, is hereby amended by inserting after the definition of "Disproportionate share hospital" the following definition:-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) any other factors the commission considers relevant.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Academic detailing", the provision of information regarding prescription drugs based on scientific and medical research, including information on therapeutic and cost-effective use of prescription drugs.

"Dispenser" means any person or entity licensed to dispense prescription drugs pursuant to the General Laws.

"PCORI", patient-centered outcomes research institute

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

"Program", an academic detailing program designed and implemented pursuant to this section.

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

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

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

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

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

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

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

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

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

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

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

(1) Pipeline drugs; and

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

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

(2) The routes of administration being studied;

(3) Clinical trial comparators, if applicable; and

(4) Estimated year of market entry.

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

(1) Orphan Drug;

(2) Fast Track;

(3) Breakthrough Therapy;

(4) Accelerated Approval; or

(5) Priority Review for New Molecular Entities NMEs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 14. (a)(1) The center, in consultation with the statewide advisory committee 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 rational for the center’s decision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Patient safety", freedom from accidental injury.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Dispersed service area," a geographic area of the commonwealth in which a provider organization delivers health care services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Limited services clinic", a clinic that provides limited services as defined by section 51J.

"Office-based surgical center", a clinic that is licensed to provide office-based surgical services pursuant to section 51L

"Urgent care center", a clinic that is licensed to provide urgent care services pursuant to section 51M

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

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

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

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

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

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

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

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

"Carrier", as defined in section 1 of chapter 176O.

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

"Facility", as defined in section 1 of chapter 6D.

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

"Hospital", as defined in section 1 of chapter 6D.

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

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

"Insured", as defined in section 1 of chapter 176O.

"Network provider", as defined in section 1 of chapter 176O

"Network status", as defined in section 1 of chapter 176O.

"Out-of-network provider", as defined in section 1 of chapter 176O.

"Prior written consent", a signed written consent form provided to a patient or prospective patient by an out-of-network provider at least 24 hours in advance of the out-of-network provider rendering health care services, other than for emergency services, when said services are scheduled at least 24 hours in advance of the rendering of care, to such patient or prospective patient or, if that person lacks capacity to consent, signed by the person authorized to consent for such a patient or prospective patient. A prior written consent form shall be presented in a manner and format to be determined by the commissioner of public health in consultation with the division of insurance;; provided, that such consent form shall be a document that is separate from any other document used to obtain the consent of the patient or prospective patient for any other part of the care or procedure; and provided further, that such consent form shall include: (i) a statement affirming that the out-of-network provider has disclosed its out-of-network¬ status to the patient or prospective patient; (ii) a statement affirming that the out-of-network provider informed the patient or prospective patient that services rendered by an out-of-network provider may result in costs not covered by the patient's or prospective patient's carrier or specific health benefit plan; (iii) a statement affirming that the out-of-network provider informed the patient or prospective patient that services may be available from a contracted provider and that the patient or prospective patient is not required to obtain care from the out-of-network provider; (iv) a statement affirming that the out-of-network provider presented the patient or prospective patient with a written estimate of the patient or prospective patient's total out-of-pocket cost of care for the admission, service or procedure; and (v) an affirmative declaration of the patient's or prospective patient's consent to receive health care services from the out-of-network provider, signed by the patient or prospective patient, or by the person authorized to consent for such a patient or prospective patient.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Physical and occupational therapy services;

(ii) Obstetrical and gynecological services;

(iii) Radiology and imaging services;

(iv) Laboratory services;

(v) Infusion therapy;

(vi) Inpatient or Outpatient Surgical procedures; and

(vii) Outpatient non-surgical diagnostic tests or procedures.

This division of insurance may expand this list.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Network status", a designation to distinguish between a network provider and an out-of-network provider.

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

"Out-of-network provider", a provider, other than a person licensed under Chapter 111C,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 121. Sections 108 and 110 are hereby repealed.

SECTION 122. Sections 112 and 113 are hereby repealed.

SECTION 123. Section 107 is hereby repealed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and by inserting after the definition of "Resident" the following new definition:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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