The Commonwealth of Massachusetts

JOURNAL OF THE HOUSE.

TUESDAY, JUNE 19, 2018.

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Tuesday, June 19, 2018.

Met according to adjournment at eleven o'clock A.M., with Mr. Kafka of Stoughton in the Chair (having been appointed by the Speaker, under authority conferred by Rule 5, to perform the duties of the Chair).

Pledge of allegiance.

At the request of the Chair (Mr. Kafka), the members, guests and employees joined with him in reciting the pledge of allegiance to the flag.

Appointments to a Special Commission.

Pay disparity commission.

The Speaker announced that he had appointed Representatives Haddad of Somerset and Tyler of Boston to the special commission established (under Section 5 of Chapter 177 of the Acts of 2016) to investigate, analyze and study the factors, causes and impact of pay disparity based on race, color, religious creed, national origin, gender identity, sexual orientation, genetic information as defined in section 1 of chapter 151B, ancestry, disability, and military status.

Statement of Representative Rogers of Cambridge.

A statement of Mr. Rogers of Cambridge was spread upon the records of the House, as follows:

Statement of Mr. Rogers of Cambridge.

MR. SPEAKER: I would like to call to the attention of the House the fact that I was unable to be present in the House Chamber for the sitting of Wednesday, June 13. Had I been present for the taking of Yea and Nay Nos. 370, 371 and 372, I would have voted, in each instance, in the affirmative.

Resolutions.

Herbert Levine.

Resolutions (filed with the Clerk by Messrs. Speliotis of Danvers and Walsh of Peabody) congratulating Dr. Herbert W. Levine on his retirement, were referred, under Rule 85, to the committee on Rules.

Mr. Galvin of Canton, for said committee, reported that the resolutions ought to be adopted. Under suspension of the rules, on motion of the same member, the resolutions (reported by the committee on Bills in the Third Reading to be correctly drawn) were considered forthwith; and they were adopted.

Petition.

Sharon,—land.

Mr. Kafka of Stoughton presented a petition (accompanied by bill, House, No. 4633) of Louis L. Kafka, Paul R. Feeney and Walter F. Timilty (by vote of the town) that the town of Sharon be authorized to use a certain parcel of land for general municipal purposes; and the same was referred to the committee on

Municipalities and Regional Government. Sent to the Senate for concurrence.

Paper from the Senate.

A petition (accompanied by bill, Senate, No. 2563) of Michael O. Moore and Paul K. Frost (by vote of the town) for legislation relative to marijuana-related revenue in the town of Millbury, was referred, in concurrence, to the committee on Municipalities and Regional Government. Millbury,— revenue.

Reports of Committees.

By Mr. Galvin of Canton, for the committee on Rules and the committees on Rules of the two branches, acting concurrently, that Joint Rule 12 be suspended on the following petitions:

Joint petition (accompanied by bill) of David K. Muradian, Jr., and Michael O. Moore that James J. Malloy be authorized to buy back creditable service time from the Worcester Regional Retirement System. To the committee on Public Service. James Malloy,— creditable service.

Petition (accompanied by bill) of David K. Muradian, Jr., for legislation to promote adoption of certain of dogs or cats from animal shelters by establishing tax credits for certain costs associated with said adoptions and by the creation of a motor vehicle registration plate. To the committee on Revenue. Pets,— adoption.

Under suspension of the rules, on motion of Mr. Galvin of Canton, the reports were considered forthwith. Joint Rule 12 then was suspended, in each instance. Severally sent to the Senate for concurrence.

By Mr. Murphy of Weymouth, for the committee on Steering, Policy and Scheduling, that the following Senate bills be scheduled for consideration by the House:

Relative to protecting biometric information under the security breach law (Senate, No. 95); Biometric information.

Relative to the powers and duties of a regional school district (Senate, No. 264); and Regional schools.

Relative to solar drying of laundry (Senate, No. 1117); Laundry.

Under suspension of Rule 7A, in each instance, on motion of Mr. Galvin of Canton, the bills severally were read a second time forthwith; and they were ordered to a third reading.

Mr. Galvin of Canton, for the committee on Rules, on the Order relative to authorizing the committee on Revenue to make an investigation and study of certain House documents concerning revenue (House, No. 4244), reported, in part, asking to be discharged from further consideration Revenue,— study.

Of the petition (accompanied by bill, House, No. 1544) of Bradley H. Jones, Jr., and others for legislation to establish an annual sales tax holiday; and Sales tax holiday.

Of the petition (accompanied by bill, House, No. 1595) of James M. Murphy and Paul McMurtry for legislation to declare a sales tax holiday for the dates of August 18, 2018 and August 19, 2018; Id.

And recommending that the same severally be referred to the committee on Ways and Means.

Under Rule 42, the reports severally were considered forthwith; and they were accepted.

By Mr. Brodeur of Melrose, for the committee on Labor and Workforce Development, asking to be discharged from further consideration

Of the petition (accompanied by bill, Senate, No. 1004) of Kenneth J. Donnelly, James R. Miceli, Jack Lewis, Sal N. DiDomenico and other members of the General Court for legislation to improve the Commonwealth's economy with a strong minimum wage and a strong tipped minimum wage; — Minimum wage.

Of the petition (accompanied by bill, Senate, No. 1040) of Marc R. Pacheco, Jonathan Hecht, Sal N. DiDomenico, Michael S. Day and others for legislation to establish a living wage for employees of big box retailers; — Retail workers,— wages.

Of the petition (accompanied by bill, Senate, No. 1048) of Karen E. Spilka, Jack Lewis, Sal N. DiDomenico, Michael J. Barrett and other members of the General Court for legislation to establish a family and medical leave insurance program; — Family and medical leave,— insurance.

Of the petition (accompanied by bill, House, No. 1015) of Bradley H. Jones, Jr., and others relative to a study of the economic impact of the increased minimum wage; — Minimum wage,— study.

Of the petition (accompanied by bill, House, No. 1021) of Kevin J. Kuros and others relative to wages paid to persons under eighteen years of age; — Wages,— minors.

Of the petition (accompanied by bill, House, No. 2172) of Kenneth I. Gordon and others relative to establishing a paid family and medical leave insurance program; — Family and medical leave,— insurance.

Of the petition (accompanied by bill, House, No. 2365) of Daniel M. Donahue and others relative to the tipped minimum wage; — Tipped minimum wage.

Of the petition (accompanied by bill, House, No. 3134) of Antonio F. D. Cabral and others for legislation to further regulate paid family leave; — Paid family leave.

Of the petition (accompanied by bill, House, No. 3152) of John J. Mahoney and others relative to increasing the minimum wage for private sector human service workers; and — Human service workers,— minimum wage.

Of the petition (accompanied by bill, House, No. 3154) of Elizabeth A. Malia, Sean Garballey and others for legislation to ensure the payment of at least a living wage to all employees; — Living wage.

And recommending that the same severally be referred to the committee on Ways and Means.

Under Rule 42, the reports severally were considered forthwith; and they were accepted. Severally sent to the Senate for concurrence, insomuch as relates to the discharge of the committee.

By Ms. Peisch of Wellesley, for the committee on Education, on House, Nos. 228, 233, 234, 236, 242, 243, 260, 272, 281, 287, 293, 296, 301, 303, 2014, 2033, 2034, 2041, 2844, 2850, 2851, 2860, 2861 and 2875, an Order relative to authorizing the committee on Education to make an investigation and study of certain House documents concerning education (House, No. 4632). Referred, under Joint Rule 29, to the committees on Rules of the two branches, acting concurrently. — Underperforming schools,— study.

Subsequently, Mr. Galvin of Canton, for said committees, reported asking to be discharged from further consideration of the order; and recommending that the same be referred to the House committee on Rules.

Under Rule 42, the report was considered forthwith; and it was accepted.

By Mr. Galvin of Canton, for the committee on Rules, that the Bill improving real property tax abatements, application deadlines, and deferrals (Senate, No. — Tax abatements.

2135), ought to pass. Referred, under Rule 33, to the committee on Ways and Means.

Salem,— land.

By Ms. Benson of Lunenburg, for the committee on State Administration and Regulatory Oversight, on Senate, No. 2533 and House, No. 4524, a Bill authorizing the commissioner of Capital Asset Management and Maintenance to convey a certain parcel of land to the Salem Redevelopment Authority (House, No. 4635). Read; and referred, under Rule 33, to the committee on Ways and Means.

Marlborough,— liquor licenses.

By Mr. Chan of Quincy, for the committee on Consumer Protection and Professional Licensure, on House, No. 4442, a Bill authorizing the city of Marlborough to grant additional licenses for the sale of alcoholic beverages not to be drunk on the premises (House, No. 4621) [Local Approval Received].

Otis,— liquor license.

By the same member, for the same committee, on House, No. 4443, a Bill relative to the sale of alcoholic beverages in the town of Otis (House, No. 4622) [Local Approval Received].

Keri Volk,— sick leave.

By Mr. Parisella of Beverly, for the committee on Public Service, on a petition, a Bill establishing a sick leave bank for Keri Volk, an employee of the Department of Correction (House, No. 4616).

Severally read; and referred, under Rule 7A, to the committee on Steering, Policy and Scheduling.

Emergency Measure.

Maria Benitez,— sick leave.

The engrossed Bill establishing a sick leave bank for Maria Benitez, an employee of the Department of Children and Families (see House, No. 4474, amended) having been certified by the Clerk to be rightly and truly prepared for final passage, was considered, the question being on adopting the emergency preamble.

A separate vote was taken, as required by the provisions of Article XLVIII (as amended by Article LXVII) of the Amendments to the Constitution; and the preamble was adopted, by a vote of 3 to 0. Sent to the Senate for concurrence.

Bill enacted.

Subsequently, the Senate having concurred in adoption of the emergency preamble, the bill (which originated in the House) was passed to be enacted; and it was signed by the Speaker and sent to the Senate.

Engrossed Bill.

Bill enacted.

The engrossed Bill establishing a sick leave bank for Gloria Phillips, an employee of the Department of Industrial Accidents (see House, No. 4336, amended) (which originated in the House), in respect to which the Senate had concurred in adoption of the emergency preamble, was passed to be enacted; and it was signed by the acting Speaker and sent to the Senate.

Recess.

Recess.

At eleven minutes after eleven o'clock A.M., on motion of Mr. D'Emilia of Bridgewater (Mr. Kafka of Stoughton being in the Chair), the House recessed until a half past one o'clock P.M.; and at eighteen minutes before two o'clock the House was called to order with the Speaker in the Chair.

Reports of Committees.

Mr. Donato of Medford being in the Chair,—

Foxborough,— land.

By Mr. Galvin of Canton, for the committee on Rules and the committees on Rules of the two branches, acting concurrently, that Joint Rule 12 be suspended on the joint petition of F. Jay Barrows and Paul R. Feeney (by vote of the town) that the commissioner of Capital Asset Management and Maintenance be authorized to convey a certain parcel of land to the town of Foxborough for use by the fire department of said town. Under suspension of the rules, on motion of Mr. Garballey of Arlington, the report was considered forthwith. Joint Rule 12 was suspended; and the petition (accompanied by bill) was referred to the committee on State Administration and Regulatory Oversight. Sent to the Senate for concurrence.

Motions to Discharge Certain Matters in the Orders of the Day.

Mr. Kafka of Stoughton being in the Chair,—

Robert Dunphy,— sick leave.

The House Bill establishing a sick leave bank for Robert F. Dunphy Jr., an employee of the Executive Office [sic] of the Trial Court (House, No. 4583), reported by the committee on Bills in the Third Reading to be correctly drawn, was discharged from its position in the Orders of the Day, and read a third time forthwith, under suspension of Rule 47, on motion of Mr. Brodeur of Melrose; and it was passed to be engrossed. Sent to the Senate for concurrence.

Healthcare,— access.

Prior to the noon recess, the House Bill establishing the Honorable Peter V. Kocot Act to enhance access to high quality, affordable and transparent healthcare in the Commonwealth (House, No. 4605), was discharged from its position in the Orders of the Day, and read a second time forthwith, under suspension of Rule 47, on motion of Mr. Mariano of Quincy.

The amendment previously recommended by the committee on Way and Means,— that the bill be amended by substitution of a bill with the same title (House, No. 4617),— was adopted; and the substituted bill was ordered to a third reading.

Subsequently, the noon recess having terminated, under suspension of the rules (the Speaker being in the Chair), on motion of Mr. Sánchez of Boston, the bill (having been reported by the committee on Bills in the Third Reading to be correctly drawn) was read a third time.

Point of order.

Mr. Jones of North Reading thereupon raised a point of order that the bill was improperly before the House because it did not contain a fiscal note as required under House Rule 33.

The Speaker ruled that the point of order was not well taken because it was not raised at the appropriate time.

Appeal from decision of Chair.

Mr. Hill of Ipswich thereupon appealed from the decision of the Chair; and the appeal was seconded by Mr. McKenna of Webster.

The question was then put “Shall the decision of the Chair stand as the judgment of the House?”.

Decision of Chair sustained,— yea and nay No. 373.

After remarks on the appeal from the decision of the Chair, the sense of the House was taken by yeas and nays, at the request of Mr. Jones of North Reading; and on the roll call 115 members voted in the affirmative and 34 in the negative.

[See Yea and Nay No. 373 in Supplement.]

Therefore the decision of the Chair was sustained.

After debate on the question on passing the bill to be engrossed (Mr. Donato of Medford being in the Chair), Mr. Golden of Lowell moved to amend it by adding the following section:

"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.'.".

The amendment was adopted.

The same member then moved to amend it in section 10 (as published), in line 134, by striking out the words "and post-acute"; in section 21 (as published), in line 394, by striking out words "rates of institutional post-acute care"; and in section 23 (as published), in lines 407 and 408, by striking out the following: "or (iii) unwarranted institutional post-acute care;". The amendments were adopted.

Mr. Galvin of Canton then moved to amend the bill in section 102 (as published), in lines 2368 to 2375, inclusive, by striking out the paragraph contained in those lines and inserting in place thereof the following paragraph:

"(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.".

The amendment was adopted.

Ms. Hogan of Stow then moved to amend the bill in section 24 (as published), in line 439, by inserting after the figures: "111" the following: "; (xxi) hospice and palliative care services "; and the amendment was adopted.

Mr. McMurtry of Dedham and other members of the House then moved to amend the bill in section 102 (as published), in line 2404, by inserting after the word "pharmacist", in each instance, the words "or contracting agent", and in lines 2415 and 2417, by inserting after the word "pharmacist", in each instance, the words "or contracting agent". The amendments were adopted.

Messrs. O'Day of West Boylston and Michlewitz of Boston then moved to amend the bill by adding the following eight sections:

"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.”.

The amendment was adopted.

Ms. Atkins of Concord then moved to amend the bill by adding the following six sections:

“SECTION 138. Section 70E of chapter 111 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the first paragraph the following paragraph:—

As used in this section, the terms ‘Attending physician’, ‘Concurrent surgical procedure’, ‘Elective surgical procedure’, ‘Emergency surgical procedure’, and ‘Secondary emergency surgical procedure’ shall have the same meanings as defined in section 70i.

SECTION 139. Said section 70E of said chapter 111, as so appearing, is hereby further amended by striking out, in line 105, the word “and”.

SECTION 140. The fifth paragraph of said section 70E of said chapter 111, as so appearing, is hereby amended by striking out clause(o) and inserting in place thereof the following 2 clauses:—

(o) if the patient is a female rape victim of childbearing age, to receive medically and factually accurate written information prepared by the commissioner of public health about emergency contraception; to be promptly offered emergency contraception; and to be provided with emergency contraception upon request; and

(p) to refuse to undergo a concurrent surgical procedure, except in cases of an emergency surgical procedure.

SECTION 141. The sixth paragraph of said section 70E of said chapter 111, as so appearing, is hereby amended by striking out clause (h) and inserting in place thereof the following 3 clauses:—

(h) in the case of a patient suffering from any form of breast cancer, to complete information on all alternative treatments which are medically viable;

(i) in the case of a patient scheduled for an elective concurrent surgical procedure, to written notice and informed consent of such concurrent scheduling, and a detailed account of the attending physician’s participation in the surgical procedure, at least 14 days prior to the surgical procedure pursuant to section 70i; and

(j) in the case of a patient scheduled for a secondary emergency concurrent surgical procedure, to written notice and informed consent of such concurrent scheduling, and a detailed account of the attending physician’s participation in the surgical procedure, at least 48 hours prior to the surgical procedure pursuant to section 70i.

SECTION 142. Said chapter 111 is hereby further amended by inserting after section 70H the following section:—

Section 70I. (a) As used in this section, the following words shall have the following meanings:

‘Attending physician’, the physician licensed under sections 2 through 9B of chapter 112, who has been credentialed by the facility to independently perform the patient’s procedure and to supervise physician trainees or physician extenders.

‘Concurrent surgical procedure’, any surgical procedure during which the attending physician is scheduled to leave the operating room at any point between incision and skin closure of the procedure to participate in the performance or supervision of a different surgical procedure on a different patient in a different operating room, where critical portions of the operations are performed

concurrently.

'Elective surgical procedure', a surgical procedure that is scheduled at least 14 days in advance, that is not urgent in nature and is not an emergency procedure.

'Emergency surgical procedure', an urgent surgical procedure that must be performed immediately upon the patient's arrival at the facility, and is not scheduled in advance.

'Facility', any hospital, institution for the care of unwed mothers, clinic, infirmary maintained in a town, convalescent or nursing home, rest home, or charitable home for the aged, licensed or subject to licensing by the department; any state hospital operated by the department; any 'facility' as defined in section 3 of chapter 111B; any private, county or municipal facility, department or ward which is licensed or subject to licensing by the department of mental health pursuant to section 19 of chapter 19; or by the department of developmental services pursuant to section 15 of chapter 19B; any 'facility' as defined in section 1 of chapter 123; the Soldiers Home in Holyoke, the Soldiers' Home in Massachusetts; and any facility set forth in section 1 of chapter 19 or section 1 of chapter 19B.

'Overlapping surgical procedure', a surgical procedure during which the attending physician is scheduled to leave the operating room at any point between incision and skin closure of the procedure to participate in the performance or supervision of a different surgical procedure on a different patient in a different operating room at the same time, where critical portions of the operations are not performed concurrently.

'Physician', a person licensed to practice medicine under sections 2 through 9B of chapter 112.

'Physician Extender', a person who is participating in the patient's procedure who is under the direct supervision of the attending physician. A physician extender may be a resident, a fellow, a physician assistant, an advanced practice registered nurse or other person authorized by the facility to participate in the procedure, and who is directly supervised by the attending physician.

'Secondary emergency surgical procedure', a surgical procedure that is scheduled at least 48 hours in advance, but is still more urgent in nature than an elective surgical procedure.

'Staggered surgical procedure', a surgical procedure during which the attending physician performs different surgical procedures on different patients in different operating rooms, one procedure directly after another, where no portions of the operations are performed concurrently.

(b) At least 14 days before the attending physician operates on a patient scheduled for an elective concurrent surgical procedure, and at least 48 hours before the attending physician operates on a patient scheduled for a secondary emergency concurrent surgical procedure, the attending physician shall inform the patient, in writing, of the concurrent scheduling and the involvement of the attending physician in the patient's procedure, and shall obtain written informed consent from the patient prior to performing such procedure; provided, that the attending physician shall provide to the patient, in writing, a detailed description of what specific steps of the surgery said physician will and will not be performing, including, but not limited to critical surgical steps. The department shall develop a standardized written summary and consent form for use in obtaining informed consent for concurrent surgical procedures. This summary and consent form shall be written in a manner designed to permit a person unfamiliar with medical terminology to understand its purpose and content and shall inform the patient that they are scheduled to undergo a concurrent surgical procedure. The department shall update

the form as necessary, and distribute such forms to each facility in the commonwealth in which the department knows or has reason to know concurrent surgical procedures are performed.

(c) The attending physician shall include in the patient's medical record written documentation of the attending physician's presence or absence during the surgical procedure. If the attending physician was absent for any part of the surgical procedure, the medical record shall accurately reflect the time of the absence or absences and who was the attending physician during the absence, if any.

(d) Any facility that performs concurrent surgical procedures shall publish, on their website, notice that said facility performs concurrent surgical procedures, and shall publish such notice on the individual webpages of each physician who performs concurrent surgeries at said facility.

SECTION 143. The department of public health shall promulgate rules and regulations necessary to implement sections 138 through 142, inclusive.".

Amendment rejected,—yea and nay No. 374.

After debate on the question on adoption of the amendment, the sense of the House was taken by yeas and nays at the request of the same member; and on the roll call 49 members voted in the affirmative and 100 in the negative.

[See Yea and Nay No. 374 in Supplement.]

Therefore the amendment was rejected.

Ms. Barber of Somerville and other members of the House then moved to amend the bill by adding the following two sections:

"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.".

The amendment was adopted.

Ms. Barber and other members of the House then moved to amend the bill by adding the following three sections:

"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.".

The amendment was adopted.

Mr. Jones of North Reading and other members of the House then moved to amend the bill in section 1, in lines 42 and 43, by striking out the words "submitted by" and inserting in place thereof the following: "within 90 days of receiving the written report from the center for health information and analysis.". The amendment was adopted.

Mr. Livingstone of Boston then moved to amend the bill in section 78 (as published), in line 1773, in section 80 (as published), in line 1885, in section 83 (as

published), in line 1932, and in section 87 (as published), in line 2060, by inserting after the word "quality", in each instance, the words "and research"; and in section 78 (as published), in line 1775, in section 80 (as published), in line 1856, in section 83 (as published), in line 1933, and in section 87 (as published), in line 2062, by striking out the words ", and research", in each instance.

The amendments were adopted.

Mr. Cahill of Lynn then moved to amend the bill by adding the following four sections:

"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.". The amendment was adopted.

Mr. Jones of North Reading and other members of the House then moved to amend the bill in section 1, in line 18, by striking out the following: "proposal. The center shall review and evaluate the scope of practice".

The amendment was adopted.

Ms. Tyler of Boston and other members of the House then moved to amend the bill by adding the following section:

"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.".

The amendment was adopted.

The same member then moved to amend the bill by inserting after section 52 (as published) the following section:

"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.".

The amendment was adopted.

Mr. Petrolati of Ludlow being in the Chair,—

Mr. Jones of North Reading and other members of the House then moved to amend the bill in section 1, in lines 8 to 12, inclusive, by striking out the paragraph contained in those lines and inserting in place thereof the following paragraph:

"(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."; and

In line 16 by inserting after the word "request." the following sentence: "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.".

The amendments were adopted.

Ms. Garlick of Needham then moved to amend the bill in section 40 (as published), in line 750, by inserting after the word "terms" the words ", and shall meet the core criteria set by the Quality Measurement Alignment Task Force"; and the amendment was adopted.

Mr. Nangle of Lowell then moved to amend the bill in section 103 (as published), in line 2425, by striking out the figures: "120,000,000" and inserting in place thereof the figures: "90,000,000", in line 2445, by striking out the figures: "$330,000,000" and inserting in place thereof the following: "up to $247,500,000"; and by adding at the end thereof the following paragraph:

"(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).";

By inserting after section 119 (as published) the following section:

"SECTION 120A: Subsection (n) of section 103 is hereby repealed."; and

By adding the following section:

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

The amendments were adopted.

Mr. Lawn of Watertown then moved to amend the bill by inserting after section 48 (as published) the following section:

"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.";

By inserting after section 69 (as published) the following section:

"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.";

By inserting after section 76 (as published) the following section:

"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.";

By inserting after section 78 (as published) the following section:

"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.";

By inserting after section 80 (as published) the following section:

"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."; and

By inserting after section 81 (as published) the following section:

"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.".

The amendments were adopted.

Mr. Cassidy of Brockton then moved to amend the bill in section 102 (as published), in line 2315, the first time it appears, and also in line 2322, by inserting after the word "service", the words "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",

In line 2316 by inserting after the word "provider." the following sentence: "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."; and

In line 2323 by striking out the word "services." and inserting in place thereof the word "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 amendments were adopted.

The same member then moved to amend the bill in section 65 (as published), in line 1431, by inserting after the word "services" the following: "when said services are scheduled at least 24 hours in advance of the rendering of care,"; and

In lines 1494 to1505, inclusive, by striking out the paragraph contained in those lines and inserting in place thereof the following:

"(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.".

The amendments were adopted.

Mr. Cassidy then moved to amend the bill in section 65 (as published), in lines 1506 and 1507, and also in section 102, in lines 2346 to 2349, inclusive, by striking out the paragraphs contained in those lines; and the amendments were adopted.

Mr. Fernandes of Falmouth then moved to amend the bill in section 11 (as published), in line 216, by inserting after the word "gender" the following: ", gender identity and expression"; and

In section 44 (as published), in lines 925 to 942, inclusive, by striking out the paragraph contained in those lines and inserting in place thereof the following

paragraph:

"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.".

The amendments were adopted.

Mr. Madaro of Boston then moved to amend the bill in section 47 (as published), in line 1038, by striking out the words "as defined" and inserting in place thereof the words "receiving a grant"; and the amendment was adopted.

Mr. Donato of Medford being in the Chair,—

Mr. Diehl of Whitman and other members of the House then move to amend the bill by adding the following section:

"SECTION 149. Section 6 of chapter 64H of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by adding the following paragraph:—

(yy) Sales of nonprescription drugs or medicines available for purchase for use in or on the body, including: vitamin or mineral concentrates; dietary supplements; natural or herbal drugs or medicines; products intended to be taken for coughs, cold, asthma or allergies or antihistamines; laxatives; antidiarrheal medicines; analgesics; antibiotic, antibacterial, antiviral and antifungal medicines; antiseptics; astringents; anesthetics; steroidal medicines; anthelmintics; emetics and antiemetics; antacids; and any medication prepared to be used in the eyes, ears or nose; provided, however, that nonprescription drugs or medicines shall not include cosmetics, dentrifrices, mouthwash, shaving and hair care products, soaps or deodorants.".

After remarks the amendment was rejected.

Mr. Murphy of Weymouth then moved to amend the bill in section 63 (as published), in line 1312, by inserting after the word "entity" the following: "that is not corporately affiliated with a hospital licensed under section 51"; and the amendment was adopted.

Representatives O'Connell of Taunton, Diehl of Whitman and Lyons of Andover then moved to amend the bill by adding the following section:

"SECTION 149. The executive office of health and human services and the

office of Medicaid shall coordinate and develop an application for a waiver and demonstration project request for submission to the federal Centers for Medicare and Medicaid Services pursuant to section 1115 of the Social Security Act by January 1, 2020.".

The amendment was rejected.

Mr. Cusack of Braintree and other members of the House then moved to amend the bill in section 63 (as published), in line 1352, by inserting at the end thereof the following six paragraphs:

"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."; and

By adding the following two sections:

"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.".

The amendments were adopted.

Rule 1A.

The Chair (Mr. Donato of Medford) then placed before the House the question on suspension of Rule 1A in order that the House might continue to meet beyond the hour of nine o'clock P.M.

Rule 1A suspended,—yea and nay No. 375.

On the question on suspension of Rule 1A, the sense of the House was taken by yeas and nays, as required under the provisions of said rule; and on the roll 115 members voted in the affirmative and 34 in the negative.

[See Yea and Nay No. 375 in Supplement.]

Therefore Rule 1A was suspended.

Mrs. Haddad of Somerset then moved to amend the bill in section 63 (as published), in line 1316, by inserting after the word "commonwealth," the following: "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"; and the amendment was adopted.

Mr. Sánchez of Boston then moved to amend the bill by inserting after section 10 (as published) the following section:

"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'.";

By inserting after section 22 (as published) the following section:

"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.";

In section 24 (as published), in line 561 and 562, by striking out the sentence

contained in those lines and inserting in place thereof the following sentence: “All biosimilar biologics license applications (BLA), upon the receipt of an action date from the FDA.”;

By inserting after section 33 (as published) the following section:

“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.”;

In section 35 (as published), in line 709, by inserting after the following: “(3)” the word “aggregate”;

By inserting after section 43 (as published) the following section:

“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.”;

In section 47 (as published), in lines 1010 and also in 1016, by striking out the word “percentile”, in each instance, and inserting in place thereof the words “per cent”;

In section 64 (as published), in lines 1357, 1358 and 1359 by striking out the following: “a registered nurse licensed under section 80B of chapter 112 and authorized by the board of registration in nursing to practice as a certified clinical specialist in psychiatric and mental health nursing” and inserting in place thereof the following: “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.”;

By inserting after section 55 (as published) the following section:

“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.”;

By striking out section 70 (as published) and inserting in place thereof the following section:

“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'.";

By inserting after section 74 (as published) the following two sections:

"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 74A, 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.";

In section 95 (as published), in line 2229, by inserting after the word "provider" the following: ", other than a person licensed under Chapter 111C,";

By inserting after section 120A (as inserted by amendment) the following section:

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

By adding the following section:

"SECTION 151. Sections 11A, 24A, 35A, 45A and 58A, 77B shall take effect on July 1, 2023.".

The amendments were adopted.

Bill passed to be engrossed,— yea and nay No. 376.

On the question on passing the bill, as amended, to be engrossed, the sense of the House taken by yeas and nays, at the request of Mr. Mariano of Quincy; and on the roll call 117 members voted in the affirmative and 32 in the negative.

[See Yea and Nay No. 376 in Supplement.]

Therefore the bill (House, No. 4639, published as amended) was passed to be engrossed. Sent to the Senate for concurrence.

Order.

On motion of Mr. DeLeo of Winthrop,—

Next sitting.

Ordered, That when the House adjourns today, it adjourn to meet tomorrow at eleven o'clock A.M.

Mr. D'Emilia of Bridgewater then moved that the House adjourn; and the motion prevailed. Accordingly, without proceeding to consideration of the matters in the Orders of the Day, at seven minutes after eleven o'clock P.M. (Mr. Donato of Medford being in the Chair), the House adjourned, to meet the following day at eleven o'clock A.M.