HOUSE . . . . . No. 4470

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, May 7, 2018.

The committee on Mental Health Substance Use and Recovery to whom were referred the Message from His Excellency the Governor relative to combatting addiction, accessing treatment, reducing prescriptions, and enhancing prevention (House, No. 4033), the petition (accompanied by bill, Senate, No. 1007) of Eileen M. Donoghue, James R. Miceli, John F. Keenan, Rady Mom and other members of the General Court for legislation to raise employment and combating opioids through vocational education and rehabilitation (RECOVER), the petition (accompanied by bill, Senate, No. 1092) of Eileen M. Donoghue for legislation relative to benzodiazepines and non-benzodiazepine hypnotics, the petition (accompanied by bill, Senate, No. 1099) of John F. Keenan, James M. Cantwell, William Smitty Pignatelli and Mathew Muratore for legislation relative to patient choice to promote prescription safety, the petition (accompanied by bill, Senate, No. 1100) of John F. Keenan, William Smitty Pignatelli, Elizabeth A. Malia, Denise Provost and other members of the General Court for legislation relative to opioid prescribing practices and access to pain management, the petition (accompanied by bill, Senate, No. 1101) of John F. Keenan and Eric P. Lesser for legislation to improve access to naloxone, the petition (accompanied by bill, Senate, No. 1114) of Bruce E. Tarr, Bradley H. Jones, Jr. and Ryan C. Fattman for legislation relative to protective custody, the petition (accompanied by bill, House, No. 1066) of Kay Khan, James M. Cantwell and Leonard Mirra relative to psychiatric nurse mental health clinical specialists, the petition (accompanied by bill, House, No. 2391) of Mark J. Cusack relative to behavioral health services integration, the petition (accompanied by bill, House, No. 2396) of Bradley H. Jones, Jr., and others relative to substance abuse treatment, the joint petition (accompanied by bill, House, No. 2404) of Elizabeth A. Malia and others relative to access to behavioral health services, the petition (accompanied by bill, House, No. 3206) of Shawn Dooley, Timothy R. Whelan and Shaunna L. O'Connell relative to opiate-related overdose treatment, the petition (accompanied by resolve, House, No. 3511) of Dylan Fernandes and others for an investigation by a special commission (including

members of the General Court) of treatment options for substance misuse, the petition (accompanied by bill, House, No. 3594) of Paul McMurtry and others relative to benzodiazepines and non-benzodiazepine hypnotics, the petition (accompanied by bill, House, No. 4337) of Carole A. Fiola and others for legislation to establish a special commission to research current logistical issues related to outpatient methadone centers and to identify alternatives to the distribution of outpatient methadone treatment, the petition (accompanied by bill, House, No. 4363) of James M. Cantwell and others for legislation to establish a commission (including members of the General Court) relative to behavioral health promotion and upstream prevention, and the petition (accompanied by bill, House, No. 4380) of James J. O'Day and others relative to the treatment of substance use disorders, reports recommending that the accompanying bill (House, No. 4470) ought to pass.

For the committee,

DENISE C. GARLICK.

FILED ON: 5/3/2018

HOUSE . . . . . No. 4470

The Commonwealth of Massachusetts

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

An Act for prevention and access to appropriate care and treatment of addiction.

Whereas, The deferred operation of this act would tend to defeat its purpose, which is to continue the Commonwealth's efforts to mitigate the effects of the ongoing opioid crisis in Massachusetts, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public convenience.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 6 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by adding the following section:-

Section 219. (a) There shall be a commission on school and community-based behavioral health promotion and prevention located within, but not subject to the control of, the executive office of health and human services. The commission shall work to advance state and local policies, practices, systems and programs to promote positive mental, emotional and behavioral health and to prevent mental health and substance use disorders among residents of the commonwealth.

(b) The commission shall consist of 21 members, as follows: the secretary of health and human services and the secretary of education or their designees, who shall serve as co-chairs;

the commissioner of mental health or a designee; the commissioner of public health or a designee; the chief justice of the trial court or a designee; the house chair of the joint committee on mental health, substance use and recovery; the senate chair of the joint committee on mental health, substance use and recovery; the house chair of the joint committee on education; the senate chair of the joint committee on education; 1 person appointed by the speaker of the house personally impacted by behavioral health issues; 1 person appointed by the senate president personally impacted by behavioral health issues; and 1 representative from each of the following 10 organizations: the Association for Behavioral Healthcare; the Massachusetts Association of Community Health Workers; the Massachusetts Association of Mental Health; the Massachusetts Organization for Addiction Recovery; the Massachusetts Public Health Association; the Massachusetts Society for the Prevention of Cruelty to Children; the National Alliance on Mental Illness, Massachusetts; the Social-Emotional Learning Alliance for Massachusetts; the Freedman Center at William James College; and the Massachusetts chapter of the National Association of Social Workers.

Members of the commission shall serve for a term of 4 years, without compensation. Any member shall be eligible for reappointment. Vacancies shall be filled for the remainder of the unexpired term. Any member may be removed by the governor for cause.

(c) The commission may establish advisory committees to assist its work.

(d) The commission shall:

(1) consult with the secretary of health and human services on grants by the school and community-based behavioral health promotion and prevention trust fund established in section 35EEE of chapter 10;

(2) use, as a guide for its work, the recommendations of the report of the special commission on behavioral health promotion and upstream prevention established pursuant to section 193 of chapter 133 of the acts of 2016;

(3) promote an understanding of the science of prevention; population health; risk and protective factors; social determinants of health; evidence-based programming and policymaking; health equity; and trauma-informed care;

(4) use state and local prevalence and cost data to ensure commission recommendations are data-informed and address risks at the universal, selective and indicated levels of prevention;

(5) collaborate, as appropriate, with other active state commissions, including but not limited to the safe and supportive schools commission, the Ellen Story commission on postpartum depression and the commission on autism;

(6) make recommendations to the governor and legislature concerning: (i) promoting behavioral health and prevention issues at the universal, selective and indicated levels; (ii) strengthening community or state-level promotion and prevention systems; (iii) advancing the identification, selection and funding of evidence-based cost-beneficial programs, practices or systems designed to promote behavioral health and to prevent mental health and substance use disorders; (iv) reducing healthcare and other public costs through evidence-based promotion and prevention; (v) the regulation of substances including, but not limited to, nicotine, opiates, alcohol and marijuana in order to promote public health; and (vi) advancing sustainable funding sources for behavioral health promotion and prevention;

(7) serve, in consultation with state technical assistance providers, as a clearinghouse for the collection and dissemination of local bylaws or policies to promote behavioral health and to prevent mental health and substance use disorders and other risk-taking behaviors;

(8) hold public hearings and meetings to accept comment from the general public and to seek advice from experts, including, but not limited to, those in the fields of neuroscience, public health, behavioral health, education and prevention science; and

(9) submit an annual report to the governor and legislature as provided in subsection (e) on the state of preventing behavioral health disorders and promoting behavioral health in the commonwealth.

(e) The commission shall file an annual report, on or before March 1, with the governor, the joint committee on children, families and persons with disabilities, the joint committee on health care financing, the joint committee on public health, the joint committee on mental health, substance use and recovery and the joint committee on education on its activities and any recommendations for regulatory and legislative action. The commission shall monitor the implementation of its recommendations and update recommendations to reflect current science and evidence-based practice.

SECTION 2. Section 16R of chapter 6A of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the first paragraph the following paragraph:-

If after 14 days of a child being determined eligible for services the child cannot access the services because of disagreement about responsibility for payment among state agencies and local education agencies, the child advocate shall be notified and shall have the authority to

impose a binding temporary cost share agreement on said state agencies and local education agencies. The cost share agreement will remain in effect until the child advocate is informed in writing of a permanent cost share or payment agreement having been implemented.

SECTION 3. Said chapter 6A, as so appearing, is hereby amended by inserting after section 16Z the following two sections:-

Section 16AA. (a) Subject to appropriation, the executive office of health and human services shall develop and implement a statewide program to provide remote consultations available for at least 5 days a week to primary care practices, nurse practitioners and other health care providers for persons over the age of 17 who exhibit a possible substance use disorder. Consultation services shall include, but not be limited to, support of screening, diagnosis, treatment, other interventions and referrals for substance use disorder.

(b) Expenditures on the program by the department that are related to services provided on behalf of commercially-insured clients shall be assessed by the commissioner on surcharge payors as defined in section 64 of chapter 118E.

Section 16BB. (a) Subject to appropriation, the executive office of health and human services shall develop and implement a statewide program to provide remote consultations available for at least 5 days a week to primary care practices, nurse practitioners and other health care providers for persons over the age of 17 experiencing chronic pain. Consultation services shall include, but not be limited to, support of screening, diagnosis, pain management strategies, pharmacological and non-pharmacological treatments and referrals for chronic pain.

(b) Expenditures on the program by the department that are related to services provided on behalf of commercially-insured clients shall be assessed by the commissioner on surcharge payors as defined in section 64 of chapter 118E.

SECTION 4. Chapter 10 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after section 35DDD the following section:-

Section 35EEE. (a) There shall be established and set up on the books of the commonwealth a school and community-based behavioral health promotion and prevention trust fund. The purpose of the fund is to promote positive mental, emotional and behavioral health among children and young adults from birth through 26 years of age and to prevent mental health and substance use disorders among children and young adults from birth through 26 years of age.

(b) The fund shall be administered by the secretary of health and human services who, in consultation with the secretary of education and the school and community-based behavioral health promotion and prevention commission established in section 219 of chapter 6, shall use the fund to provide grants:

(1) to public elementary, middle and secondary schools and to public colleges and universities to support the expansion of evidence-based and evidence-informed educational and intervention programs meeting the purposes of the fund. Grants from the fund may be made to schools for the purposes specified in subsection (f) of section 1P of chapter 69 where consistent with the purposes of the fund;

(2) to community organizations to establish or support evidence-based and evidence-informed programs for children and young adults from birth through 26 years of age. The community organizations may include, but not be limited to, public and private agencies,

community organizations, community coalitions and other entities that offer resources or support to children or young adults. A community organization or coalition may include more than one community; and

(3) to the department of public health to provide technical assistance, training and guidance to support applicants in completing grant applications and to grantees to develop and evaluate programs.

(c) The secretary of health and human services shall establish application procedures and evidence-based and evidence-informed criteria upon which to base approval or disapproval of any proposal. The criteria may include, but are not limited to, the following:

(1) programs that educate children and young adults on addiction, substance misuse and other risky behaviors and that identify and support children and young adults at risk of alcohol or substance misuse;

(2) programs that use evidence-based or evidence-informed prevention programs, early detection protocols and policies, risk assessment tools or counseling in a school or community setting;

(3) support of underserved populations of children and young adults that may include, but not be limited to, young adults who are not attending a public school or college or children with multiple adverse childhood experiences;

(4) programs that offer culturally and linguistically competent services that meet the needs of the population to be served; and

(5) programs that employ the science of prevention, including, but not limited to, consideration of population health, risk and protective factors, social determinants of health, health equity, adverse childhood experiences and trauma-informed care.

(d) The secretary may use the fund for necessary and reasonable administrative and personnel costs related to administering the grants. These expenditures may not exceed, in one fiscal year, 5 per cent of the total amount deposited into the fund during that fiscal year. The fund shall consist of revenue from appropriations or other money authorized by the general court and specifically designated to be credited to the fund and revenue from private sources including, but not limited to, grants, gifts and donations received by the commonwealth that are specifically designated to be credited to the fund. Amounts credited to the fund shall not be subject to further appropriation and any money remaining in the fund at the end of a fiscal year shall not revert to the General Fund and shall be available for expenditure in subsequent fiscal years.

(e) The secretary shall file an annual report about its activities, on or before March 1, with the joint committee on children, families and persons with disabilities, the joint committee on health care financing, the joint committee on public health, the joint committee on mental health, substance use and recovery and the joint committee on education.

SECTION 5. Subsection (a) of section 13 of chapter 13 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out the last sentence and inserting in place thereof:-

The composition of the board shall be as follows: 11 registered nurses; 2 licensed practical nurses; 1 physician registered pursuant to chapter 112; 1 pharmacist registered under section 24 of chapter 112; and 2 consumers.

SECTION 6. Subsection (c) of said section 13 of said chapter 13, as so appearing, is hereby amended by striking out the first paragraph and inserting in place thereof the following paragraph:-

(1) 3 representatives with expertise in nursing education whose graduates are eligible to write nursing licensure examinations, including 1 representative from pre-licensure level, 1 representative from graduate level and 1 representative from post-graduate level. None of these 3 representatives shall be from the same institution.

SECTION 7. Said subsection (c) of said section 13 of said chapter 13, as so appearing, is hereby further amended by adding the following 3 paragraphs:-

(5) 1 registered nurse currently providing direct care to patients with substance use disorders;

(6) 1 registered nurse currently providing direct care to patients in an outpatient, community-based, behavioral health setting; and

(7) 1 registered nurse who has successfully completed the substance abuse rehabilitation program for nurses.

SECTION 8. Section 13 of chapter 17 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out, in line 2, the figure “16” and inserting in place thereof the following figure:- 18; and by striking out, in line 5, the figure “13” and inserting in place thereof the following figure:- 14.

SECTION 9. Said section 13 of said chapter 17, as so appearing, is hereby further amended by inserting, in line 5, before the word “and” the following words:- “the director of the

department of industrial accidents or a designee;", and by inserting, in line 12, after the word "pain;" the following words:- 1 representative of a Massachusetts labor organization;.

SECTION 10. Said section 13 of said chapter 17, as so appearing, is hereby further amended by inserting after the first paragraph of subsection (b) the following paragraph:-

The commission shall prepare a drug formulary of clinically appropriate opioids for use in the treatment of patients with workers' compensation claims. In establishing the formulary the commission shall consult with the department of industrial accidents established in chapter 152. The formulary shall be based on well-documented, evidence-based methodology. The commission shall include as part of the formulary a complete list of opioids that are approved for payment under chapter 152 and any specific payment, prescribing or dispensing controls associated with drugs on the list. The formulary shall include all drugs approved by the United States Food and Drug Administration for the treatment of opioid use disorder.

SECTION 11. Said chapter 17, as so appearing, is hereby further amended by inserting after section 20 the following section:-

Section 21. (a) Subject to appropriation, the department shall establish an advanced practice addiction treatment grant program. The grant shall be made to an individual in a physician training program and an individual in an advanced practice nursing program who have completed a core curriculum in general psychiatry, addiction medicine, internal medicine, family medicine or an equivalent primary specialty that will meet professional certification requirements. Said grant shall mandate integrated and interdisciplinary training and education to prepare graduates for practice in an integrated care setting, such as a medical home, accountable care organization, federally qualified health center, a department of mental health facility or

department of public health facility. The grant program shall: (i) offer training in drug courts and other diversion programs within the criminal justice system; (ii) require community-based rotations in underserved areas of the state, for each trainee, including experience working with the department's funded nurse care managers; (iii) require rotations in public sector settings such as the department of public health, the department of mental health or the department of veterans affairs.

This grant shall be provided to one individual in a physician training program and one individual in an advanced practice nursing program per year. No individual shall receive said grant for more than 1 academic year.

SECTION 12. Section 2 of chapter 18C of the General Laws, as appearing in the 2016 Offical Edition, is hereby amended by striking out, in line 14, the word "and".

SECTION 13. Said section 2 of chapter 18C, as so appearing, is hereby further amended by inserting after the word "families", in line 17, the following words:-

; and

(e) impose temporary cost share agreements, as needed, under section 16R of chapter 6A to ensure children's timely access to services.

SECTION 14. Section 19 of chapter 19 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

(a) The department shall issue for a term of 2 years, and may renew for like terms, a license, subject to revocation by it for cause, to any private, county or municipal facility or

department or unit of any such facility which offers to the public inpatient psychiatric, residential or day care services and is represented as providing treatment of persons who are mentally ill and which is deemed by it to be responsible and suitable to meet applicable licensure standards and requirements, set forth in regulations of the department, except that: (1) the department may issue a license to those facilities providing care but not treatment of persons who are mentally ill, and (2) licensing by the department is not required where such residential or day care treatment is provided within an institution or facility licensed by the department of public health pursuant to chapter 111 unless such services are provided on an involuntary basis. Whether or not a license is issued under clause (1), the department shall make regulations for the operation of such facilities. The department may issue a provisional license where a facility, department or unit has not previously operated, or is operating but is temporarily unable to meet applicable standards and requirements. No original license, as defined in subsection (i), shall be issued to establish or maintain a facility, department or unit subject to licensure under this section, unless there is determination by the department, in accordance with its regulations, that there is need for such a facility, department or unit. The department may grant the type of license that it deems suitable for the facility, department or unit. The department shall fix reasonable fees for licenses and renewal thereof. In order to be licensed by the department under this section, a facility, department or unit shall provide services to commonwealth residents with public health insurance on a non-discriminatory basis.

SECTION 15. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out, in line 20, the word "ward" and inserting in place thereof the following word:- unit.

SECTION 16. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out subsection (c) and inserting in place thereof the following subsection:-

(c) Each facility, department and unit licensed by the department shall be subject to the supervision, visitation and inspection of the department. The department shall inspect each facility, department or unit prior to granting or renewing a license pursuant to this section. The department shall establish regulations to administer licensing standards and to provide operational standards for such facilities, departments or units, including, but not limited to, the standards or criteria an applicant shall meet to demonstrate the need for an original license; provided, however, that such standards or criteria shall be reviewed by the department every 2 years and shall be limited to the health needs of persons who are mentally ill in the commonwealth, including underserved populations, and the demonstrated ability and history of a prospective licensee to meet the needs of such persons.

The regulations promulgated by the department pursuant to this section shall provide that no facility, department or unit shall discriminate against an individual, qualified within the scope of the individual’s license, when considering or acting on an application of a licensed independent clinical social worker for staff membership or clinical privileges. The regulations shall further provide that each application shall be considered solely on the basis of the applicant's education, training, current competence and experience. Each facility, department or unit shall establish, in consultation with the director of social work or, if none, a consulting licensed independent clinical social worker, the specific standards, criteria and procedures to admit an applicant for staff membership and clinical privileges. Such standards shall be available to the department upon request.

SECTION 17. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out, in line 44, the word “ward” and inserting in place thereof the following words:-

unit, including the denial or conditional issuance of an original license if an application does not meet the department’s standards or criteria for demonstrating need.

SECTION 18. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out subsections (e) through (g), inclusive, and inserting in place there of the following 5 subsections:-

(e) The department may conduct surveys and investigations to enforce compliance with this section and any rule or regulation promulgated pursuant to this section. The department may examine the books and accounts of any facility, department or unit if it deems such examination necessary for the purposes of this section. If the department finds upon inspection, or through information in its possession, that a facility, department or unit licensed by the department is not in compliance with a requirement established under this section, the department may order the facility, department or unit to correct such deficiency by providing the facility, department or unit a deficiency notice in writing of each deficiency. In such notice, the department shall specify a reasonable time, not to exceed 60 days after receipt thereof, by which time the facility, department or unit shall remedy or correct each deficiency cited therein; provided, that, in the case of any deficiency which, in the opinion of the department, is not capable of correction within 60 days, the department shall require only that the facility, department or unit submit a written plan for correction of the deficiency in a reasonable manner. The department may modify any nonconforming plan, upon notice in writing to the facility, department or unit. Within 7 days

of receipt, the affected facility, department or unit may file a written request with the department for administrative reconsideration of the order or any portion thereof.

Nothing in this section shall be construed to prohibit the department from enforcing a rule, regulation, or deficiency notice, administratively or in court, without first affording formal opportunity to make correction or to seek administrative reconsideration under this section, where, in the opinion of the department, the violation of such rule, regulation or deficiency notice jeopardizes the health or safety of patients or the public or seriously limits the capacity of the facility, department or unit to provide adequate care or where the violation of such rule, regulation or deficiency notice is the second or subsequent such violation occurring during a period of twelve full months.

Upon a failure to remedy or correct a cited deficiency by the date specified in the deficiency notice or failure to remedy or correct a cited deficiency by the date specified in a plan for correction, as accepted or modified by the department, the department may: (i) suspend, limit, restrict or (ii) impose a civil fine upon the facility, department or unit; (iii) pursue any other sanction as the department may impose administratively upon the facility, department or unit; or (iv) impose any combination of the penalties set forth in clauses (i), (ii) or (iii). A civil fine imposed pursuant to this paragraph shall not exceed $1,000 per deficiency for each day the deficiency continues to exist beyond the date prescribed for correction.

(f) No facility, department or unit, for which a license is required under subsection (a), shall provide inpatient, residential or day care services for the treatment or care of persons who are mentally ill, unless it has obtained a license under this section. The superior court sitting in equity shall have jurisdiction, upon petition of the department, to restrain any violation of this

section or to take such other action as equity and justice may require. Whoever violates this section shall be punished for the first offense by a fine of not more than $500 and for subsequent offenses by a fine of not more than $1,000 or by imprisonment for not more than 2 years.

(g) No patient shall be commercially exploited. No patient shall be photographed, interviewed or exposed to public view without the express written consent of the patient or of the patient's legal guardian.

(h) Notwithstanding subsections (a) to (g), inclusive, a child care center, family child care home, family child care system, family foster care or group care facility as defined in section 1A of chapter 15D shall not be subject to this section.

(i) As used in this section, "original license" shall mean a license, including a provisional license, issued to any facility, department or unit not previously licensed; or a license issued to an existing facility, department or unit, in which there has been a change in ownership or location or a change in class of license or specialized service as provided in regulations of the department.

SECTION 19. Chapter 32A of the General Laws, as appearing in the 2016 Offical Edition, is hereby amended by inserting after section 17O the following section:-

Section 17P. The commission shall provide, to any active or retired employee of the commonwealth who is insured under the group insurance commission, for any covered drug that is a narcotic substance contained in schedule II of section 3 of chapter 94C and that is subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, they shall not be subject to an additional payment obligation, including but not limited to co-payments, if they fill the remaining portion of the prescription.

SECTION 20. Section 1 of chapter 94C of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the definition of "Drug paraphernalia" the following definition:-

“Electronic prescription”, a lawful order from a prescriber for a drug or device for a specific patient that is generated on an electronic prescribing system that meets federal requirements for electronic prescriptions for controlled substances, and is transmitted electronically to a pharmacy designated by the patient without alteration of the prescription information, except that third-party intermediaries may act as conduits to route the prescription from the prescriber to the pharmacist; provided, however, that “electronic prescription” shall not include an order for medication which is dispensed for immediate administration to the ultimate user. The electronic prescription must be received by the pharmacy on an electronic system that meets federal requirements for electronic prescriptions. A prescription generated on an electronic system that is printed out or transmitted via facsimile is not considered an electronic prescription.

SECTION 21. Section 8 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “oral”, in line 60, the following word:- , electronic.

SECTION 22. Section 17 of said chapter 94C, as so appearing, is hereby amended by striking out, in line 2, the words “the written prescription of” and inserting in place thereof the following words:- an electronic prescription from.

SECTION 23. Said section 17 of said chapter 94C, as so appearing, is hereby further amended, by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) In emergency situations, as defined by the commissioner, a schedule II substance may be dispensed upon written prescription or oral prescription in accordance with section 20 and department regulations.

SECTION 24. Said section 17 of said chapter 94C, as so appearing, is hereby further amended, by striking out, in line 11, the words “a written or oral prescription of” and inserting in place thereof the following words:- an electronic prescription from.

SECTION 25. Section 18 of said chapter 94C, as so appearing, is hereby amended by striking out subsection (d¾), as inserted by section 21 of chapter 52 of the acts of 2016, and inserting in place thereof the following subsection:-

(d¾) A pharmacist filling a prescription for a schedule II substance shall, if requested by the patient, dispense the prescribed substance in a lesser quantity than indicated on the prescription. The remaining portion may be filled upon patient request in accordance with federal law; provided, however, that only the same pharmacy that originally dispensed the lesser quantity may dispense the remaining portion. Upon an initial partial dispensing of a prescription or a subsequent dispensing of a remaining portion, the pharmacist or the pharmacist’s designee shall make a notation in the patient's record maintained by the pharmacy, which shall be accessible to the prescribing practitioner by request, indicating that the prescription was partially filled and the quantity dispensed.

SECTION 26. Said chapter 94C, as so appearing, is hereby amended by striking out section 19B and inserting in place thereof the following section:-

Section 19B. (a) As used in this section and unless the context clearly requires otherwise, "opioid antagonist" shall mean naloxone or any other drug approved by the United States Food

and Drug Administration as a competitive narcotic antagonist used in the reversal of overdoses caused by opioids.

(b) The department shall ensure that a statewide standing order is issued to authorize the dispensing of an opioid antagonist in the commonwealth by any licensed pharmacist. The statewide standing order shall include, but shall not be limited to, written, standardized procedures or protocols for the dispensing of an opioid antagonist by a licensed pharmacist. Notwithstanding any general or special law to the contrary, the commissioner, or a physician designated by the commissioner who is registered to distribute or dispense a controlled substance in the course of professional practice pursuant to section 7, may issue a statewide standing order that may be used for a licensed pharmacist to dispense an opioid antagonist under this section.

(c) Notwithstanding any general or special law to the contrary, a licensed pharmacist may dispense an opioid antagonist in accordance with the statewide standing order issued under subsection (b). Except for an act of gross negligence or willful misconduct, a pharmacist who, acting in good faith, dispenses an opioid antagonist shall not be subject to any criminal or civil liability or any professional disciplinary action by the board of registration in pharmacy related to the use or administration of an opioid antagonist.

(d) A pharmacist dispensing an opioid antagonist shall annually report to the department the number of times the pharmacist dispenses an opioid antagonist. Reports shall not identify an individual patient, shall be confidential and shall not constitute a public record as defined in clause twenty-sixth of section 7 of chapter 4. The department shall publish an annual report that includes aggregate information about the dispensing of opioid antagonists in the commonwealth.

(e) A pharmacist or designee dispensing an opioid antagonist pursuant to this section shall, for the purposes of health insurance billing and cost-sharing, treat the transaction as the dispensing of a prescription to the person purchasing the drug regardless of the stated or potential end user. Prior to dispensing the opioid antagonist, the pharmacist or designee shall make a reasonable effort to identify the purchaser's insurance coverage and to submit a claim for the opioid antagonist to the insurance carrier at the time of purchase.

(f) Except for an act of gross negligence or willful misconduct, the commissioner or physician who issues the statewide standing order under subsection (b) and any practitioner who, acting in good faith, directly or through the standing order, prescribes or dispenses an opioid antagonist shall not be subject to any criminal or civil liability or any professional disciplinary action.

(g) A person acting in good faith may receive a prescription for an opioid antagonist, possess an opioid antagonist and administer an opioid antagonist to an individual appearing to experience an opioid-related overdose. A person who, acting in good faith, administers an opioid antagonist to an individual appearing to experience an opioid-related overdose shall not, as a result of the person's acts or omissions, be subject to any criminal or civil liability or any professional disciplinary action. The immunity in section 34A of this chapter also shall apply to a person administering an opioid antagonist pursuant to this section.

(h) The department, the board of registration in medicine and the board of registration in pharmacy shall adopt regulations to implement this section.

SECTION 27. Subsection (c) of section 20 of said chapter 94C, as so appearing, is hereby amended by striking out the first and second sentences and inserting in place thereof the following 2 sentences:-

(c) Whenever a practitioner, certified nurse practitioner, certified registered nurse anesthetist, nurse midwife, psychiatric clinical nurse specialist or physician assistant dispenses a controlled substance by oral prescription, such individual shall cause an electronic prescription for the prescribed controlled substance to be delivered to the dispensing pharmacy within 2 days; provided that if such individual has received an exception from using an electronic prescription from the commissioner pursuant to subsection (h) of section 23, they shall within a period of not more than 7 days or such shorter period that is required by federal law cause a written prescription for the prescribed controlled substance to be delivered to the dispensing pharmacy. The written prescription may be delivered to the pharmacy in person or by mail, but shall be postmarked within 7 days or such shorter period that is required by federal law.

SECTION 28. Section 22 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “written”, in line 2, the following words:- or electronic.

SECTION 29. Section 22 of chapter 94C of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking, in subsection (c), the words “recommended full quantity indicated” and inserting in place thereof the words:- full prescribed quantity.

SECTION 30. Section 23 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “written”, in lines 1 and 6, in each instance, the following words:-

or electronic.

SECTION 31. Said section 23 of said chapter 94C, as so appearing, is hereby further amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) A written or electronic prescription for a controlled substance in schedule II shall not be refilled. Written prescriptions for a controlled substance in schedule II shall be kept in a separate file.

SECTION 32. Said section 23 of said chapter 94C, as so appearing, is hereby further amended by striking out subsections (g) and (h) and inserting in place thereof the following 3 subsections:-

(g) Prescribers shall issue an electronic prescription for all controlled substances and medical devices. The department of public health shall promulgate regulations setting forth standards for electronic prescriptions.

(h) The commissioner, through regulation, shall establish exceptions to section 17 and subsection (g) authorizing the limited use of a written and oral prescription where appropriate. Said exceptions shall be limited to:

(1) prescriptions that are issued or dispensed in circumstances where electronic prescribing is not available due to temporary technological or electrical failure; and

(2) a time limited waiver process for practitioners who demonstrate technological limitations that are not reasonably within the control of the practitioner or other exceptional circumstance;

(i) All written prescriptions shall be written in ink, indelible pencil or by other means on a tamper resistant form consistent with federal requirements for Medicaid and signed by the prescriber.

SECTION 33. Subsection (c) of section 24A of said chapter 94C, as so appearing, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-

The department shall promulgate rules and regulations relative to the use of the prescription monitoring program by registered participants which shall include the requirement that prior to issuance, participants shall utilize the prescription monitoring program each time a prescription for a narcotic drug that is contained in Schedule II or III, or a prescription for a benzodiazepine, is issued. The department may require participants to utilize the prescription monitoring program prior to the issuance of any schedule IV or V prescription drug, which is commonly misused and may lead to physical or psychological dependence or which causes patients with a history of substance dependence to experience significant addictive symptoms. The regulations shall specify the circumstances under which such narcotics or benzodiazepines may be prescribed without first utilizing the prescription monitoring program. The regulations may also specify the circumstances under which support staff may use the prescription monitoring program on behalf of a registered participant. When promulgating the rules and regulations, the department shall also require that pharmacists be trained in the use of the prescription monitoring program as part of the continuing education requirements mandated for licensure by the board of registration in pharmacy, under section 24A of chapter 112. The department shall also study the feasibility and value of expanding the prescription monitoring program to include schedule VI prescription drugs.

SECTION 34. Said section 24A of said chapter 94C, as so appearing, is hereby amended by striking out subsection (g) and inserting in place thereof the following subsection:-

(g) The department may provide data from the prescription monitoring program to practitioners in accordance with this section; provided, however, that practitioners shall be able to access the data directly through a secure electronic medical record or other similar secure software or information systems. This data may be used for the purpose of providing medical or pharmaceutical care to the practitioners' patients only, unless otherwise permitted by this section. Any such secure software or information system must identify the registered participant on whose behalf the prescription monitoring program was accessed.

SECTION 35. Said section 24A of said chapter 94C, as so appearing, is hereby further amended by adding the following subsection:-

(m) The department may enter into agreements to permit health care facilities to integrate secure software or information systems into their electronic medical records for the purpose of using prescription monitoring program data to perform data analysis, compilation, or visualization, in order to provide medical or pharmaceutical care to individual patients. Any such secure software or information system shall be bound to comply with requirements established by the department to ensure the security and confidentiality of any data transferred.

SECTION 36. Chapter 111 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after section 25J the following new section:-

Section 25J ½. Every acute care hospital, as defined in section 25B, that provides emergency services in an emergency department, and every satellite emergency facility as defined and licensed by the department, shall maintain, as part of their emergency services,

protocols and capacity to provide appropriate, evidence-based interventions prior to discharge that reduce the risk of subsequent harm and fatality following an opioid-related overdose.

Such regulations shall require all hospital emergency departments and satellite emergency facilities to maintain hospital institutional protocols and capacity to possess, dispense, administer and prescribe opioid agonist treatment and offer such treatment to patients who present in an acute care hospital emergency department or a satellite emergency facility for care and treatment of an opioid-related overdose; provided, that such treatment shall occur whenever it is recommended by the treating healthcare provider and agreed to by the patient. Said regulations shall include a requirement that every hospital emergency department and satellite emergency facility shall demonstrate compliance with training and waiver requirements established by the federal drug enforcement agency and the substance abuse and mental health services administration. Prior to discharge, any patient who is administered or receives initiation of opioid agonist treatment in an emergency department or satellite emergency facility shall receive linkage to appropriate services to continue said treatment. Said regulations shall also include requirements on determining the safe and appropriate length for prescriptions issued in an emergency setting and minimum standards of care coordination for patients following the receipt of opioid agonist treatment initiated in an emergency department or satellite emergency facility.

SECTION 37. Said chapter 111, as so appearing, is hereby further amended by inserting after section 25N¾ the following new section:-

Section 25N7/8. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Human services worker", an individual who provides services that support individuals' and families' efforts to function in daily living situations, including in settings such as group homes; institutional or residential settings; correctional or community health centers; family, child and youth service agencies; and at programs that help individuals affected by alcohol or substance misuse, family violence or aging.

"Qualified education loan indebtedness", any indebtedness, including interest on such indebtedness, incurred to pay tuition or other direct expenses incurred in connection with the pursuit of a certificate, undergraduate or graduate degree related to the work of a human services worker by an applicant. It shall not include loans made by any individual related to the applicant.

(b) Subject to appropriation, there shall be a student loan repayment program for human services workers for the purpose of encouraging individuals to enter and continue in such work. The department shall administer the program in consultation with the department of higher education.

(c) To be eligible for an award under this program, an applicant shall: (i) be employed as a human services worker at a minimum of 35 hours per week; (ii) have an individual income of no more than $45,000 per year; and (iii) have been employed for 12 consecutive months as a human services worker at a minimum of 35 hours per week prior to making their application.

(d) Subject to appropriation, the department shall partially reimburse eligible individuals for payments made by the individual toward their qualified education loan indebtedness. The amount of reimbursement made by the department under the program shall be based on the total amount of qualified education loan indebtedness held by the individual. Reimbursement shall not exceed $1,800 per individual per year. Reimbursement shall be paid monthly by the department

at a rate not to exceed $150 per month. The individual shall no longer be eligible for reimbursement after 4 years from the date the individual receives his or her first reimbursement payment. An individual shall only be eligible for reimbursement payments by the department for months in which the individual acts as a human services worker in the commonwealth.

SECTION 38: Section 51½ of said chapter 111, inserted by section 32 of chapter 52 of the acts of 2016, is hereby amended by striking out, in lines 18, 35, 36, 50, 56, 73, 78, and 94, the word “abuse” and inserting in place thereof, in each instance, the following words:- use disorder.

SECTION 39: Subsection (a) of said section 51½ of said chapter 111, as so appearing, is hereby amended by striking out the definition of “Licensed mental health professional” and inserting in place thereof the following definition:-

“Licensed mental health professional”, a licensed physician who specializes in the practice of psychiatry or addiction medicine, a licensed psychologist, a licensed social worker, a licensed mental health counselor, a licensed psychiatric clinical nurse specialist, an advanced practice psychiatric nurse, a certified addictions registered nurse, a licensed alcohol and drug counselor I as defined in section 1 of chapter 111J or a healthcare provider defined in section 1 of chapter 111 whose scope of practice allows such evaluations pursuant to medical staff policies and practice as authorized by the department through regulation.

SECTION 40: Said section 51½ of said chapter 111, as so appearing, is hereby further amended by inserting after the word “program”, in line 20, the following words:- whose staff meet the criteria of a licensed mental health professional.

SECTION 41: Said section 51½ of said chapter 111, as so appearing, is hereby further amended by striking out subsection (c) and inserting in place thereof the following subsection:-

(c) After a substance use disorder evaluation has been completed pursuant to subsection (b) treatment may occur within the acute-care hospital or satellite emergency facility, if appropriate services are available, which may include induction to medication-assisted treatment. If the hospital or satellite emergency facility is unable to provide such services, the hospital or satellite emergency facility shall refer the patient to an appropriate and available hospital or treatment provider. Medical necessity for further treatment shall be determined by the treating clinician and noted in the patient's medical record.

If a patient refuses further treatment after the evaluation is complete, and is otherwise medically stable, the hospital or satellite emergency facility may initiate discharge proceedings; provided, however, if the patient is in need of and agrees to further treatment following discharge pursuant to the substance use disorder evaluation, then the hospital shall directly connect the patient with a community based program prior to discharge or within a reasonable time following discharge when the community based program is available. All patients receiving an evaluation under subsection (b) shall receive, upon discharge, information on local and statewide treatment options, providers and other relevant information as deemed appropriate by the treating clinician.

SECTION 42: Subsection (g) of said section 51½ of said chapter 111, as so appearing, is hereby amended by striking out subsection (g) and inserting in place thereof the following subsection:-

(g) Upon discharge of a patient who experienced an opiate-related overdose, the acute-care hospital, satellite emergency facility or emergency service program shall record the opiate-

related overdose and substance use disorder evaluation in the patient's electronic medical record which shall be directly accessible by other healthcare providers and facilities consistent with federal and state privacy requirements through a secure electronic medical record, health information exchange, or other similar software or information systems for the purposes of (i) improving ease of access and utilization of such data for treatment or diagnosis; (ii) supporting integration of such data within the electronic health records of a healthcare provider for purposes of treatment or diagnosis; or (iii) allowing healthcare providers and their vendors to maintain such data for the purposes of compiling and visualizing such data within the electronic health records of a healthcare provider that supports treatment or diagnosis.

SECTION 43. Subsection (i) of said section 51½ of chapter 111, as so appearing, is hereby amended by striking out, in line 97, the word "abuse" and inserting in place thereof the following words:- use and recovery.

SECTION 44. Section 237 of said chapter 111, as inserted by chapter 47 of the acts of 2017, is hereby amended by striking out the first paragraph and inserting in place thereof the following paragraph:-

The commissioner shall collect, record and analyze data, and shall assemble and maintain data systems, necessary to analyze population health trends and to prepare the annual report required pursuant to section 12C of chapter 123. The commissioner shall give priority to analyzing fatal and nonfatal opiate overdoses. The commissioner may identify and determine additional priorities for the reduction of morbidity and mortality.

SECTION 45. Section 1 of chapter 111E of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the definition of “Assignment” the following definition:-

“Commissioner”, the commissioner of public health.

SECTION 46. Said section 1 of said chapter 111E, as so appearing, is hereby further amended by inserting after the definition of “Independent physician” the following definition:-

“Original license”, a license, including a provisional license, issued to a facility not previously licensed; or a license issued to an existing facility, in which there has been a change in ownership or location.

SECTION 47. Section 7 of said chapter 111E, as so appearing, is hereby amended by striking out, in lines 1, 10, 13, 26, 27, 33, 39, 44, 50, 75, 77 and 80, each time it appears, the word “division” and inserting in place thereof, in each instance, the following word:- department.

SECTION 48. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by inserting after the word “requirements”, in line 8, the following words:- , set forth in regulations of the department.

SECTION 49. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in lines 17 and 18, the words “but such standards and requirements shall concern only” and inserting in place thereof the following words:- which shall include, but shall not be limited to.

SECTION 50. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out clauses (1) through (6), inclusive, and inserting in place thereof the following 8 clauses:-

(1) the health standards to be met by a facility;

(2) misrepresentations as to the treatment to be afforded patients at a facility;

(3) licensing fees;

(4) procedures for making and approving license applications;

(5) the services and treatment provided by programs;

(6) certification of capability of self-preservation;

(7) a requirement that the facility provide services to commonwealth residents with public health insurance on a non-discriminatory basis; and

(8) the standards or criteria a facility shall meet to demonstrate the need for an original license; provided, however, that such standards or criteria shall be reviewed by the department every 2 years and shall be limited to the health needs of drug dependent persons and persons with alcoholism, as defined in section 3 of chapter 111B, in the commonwealth, including underserved populations, and the demonstrated ability and history of a prospective licensee to meet the needs of such persons.

SECTION 51. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in lines 26 and 27, the words “from time to time, on request,”.

SECTION 52. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in lines 28 to 32, inclusive, the words “reasonably require for the purposes of this section, and any licensee or other person operating a private facility who fails to furnish any such data, statistics, schedules or information as requested, or who files fraudulent returns thereof, shall be punished by a fine of not more than five hundred dollars” and inserting in place thereof the following word:- require.

SECTION 53. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in line 42, the second time it appears, the word “or”.

SECTION 54. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in line 43, the figure “10” and inserting in place thereof the following words:- 10; or

(4) the denial or conditional issuance of an original license if an application does not meet the department’s standards or criteria for demonstrating need.

SECTION 55. Said section 7 of said chapter 111E, as so appearing, is hereby amended by striking out, in line 49, the word “director” and inserting in place thereof the following word:- commissioner.

SECTION 56. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out paragraphs 5 to 7, inclusive, and inserting in place thereof the following 5 paragraphs:-

The department may conduct surveys and investigations to enforce compliance with this section and any rule or regulation promulgated pursuant to this chapter. If the department finds

upon inspection, or through information in its possession, that a facility is not in compliance with a requirement established under this chapter, the department may order the facility to correct such violation by issuing a corrective action order, which provides the facility notice in writing of each violation. In such notice, the department shall specify a reasonable time, not to exceed 60 days after receipt thereof, by which time the facility shall remedy or correct each violation cited therein; provided, that, in the case of any violation which, in the opinion of the department, is not capable of correction within 60 days, the department shall require only that the facility submit a written plan for correction of the violation in a reasonable manner. The department may modify any nonconforming plan upon notice in writing to the facility. Within 7 days of receipt, the affected facility may file a written request with the department for administrative reconsideration of the order or any portion thereof.

Nothing in this section shall be construed to prohibit the department from enforcing a rule, regulation or corrective action order, administratively or in court, without first affording formal opportunity to make correction, or to seek administrative reconsideration under this section, where, in the opinion of the department, the violation of such rule, regulation or corrective action order jeopardizes the health or safety of patients or the public or seriously limits the capacity of the facility to provide adequate care, or where the violation of such rule, regulation or corrective action order is the second or subsequent such violation occurring during a period of twelve full months.

Upon a failure to remedy or correct a cited violation by the date specified in the corrective action order, or failure to remedy or correct a cited violation by the date specified in a plan for correction as accepted or modified by the department, the department may (i) suspend, limit, restrict or revoke the license; (ii) impose a civil fine upon the facility; (iii) pursue any other

sanction as the department may impose administratively upon the facility; or (iv) impose any combination of the penalties set forth in clauses (i), (ii) or (iii). A civil fine imposed pursuant to this paragraph shall not exceed $1,000 per violation for each day the violation continues to exist beyond the date prescribed for correction.

No person, partnership, corporation, society, association or other agency, or entity of any kind, other than a licensed general hospital, a department, agency or institution of the federal government, the commonwealth or any political subdivision thereof, shall operate a facility without a license and no department, agency or institution of the commonwealth or any political subdivision thereof shall operate a facility without approval from the department pursuant to this section. Upon petition of the department, the superior court shall have jurisdiction in equity to restrain any violation of this section and to take such other action as equity and justice may require to enforce its provisions. Whoever knowingly establishes or maintains a private facility other than a licensed general hospital without a license granted pursuant to this section shall, for a first offense, be punished by a fine of not more than $500 and for each subsequent offense by a fine of not more than $1,000 or imprisonment for not more than 2 years, or both.

Each facility shall be subject to visitation and inspection by the department to enforce compliance with this chapter and any rule or regulation issued thereunder. The department shall inspect each facility prior to granting or renewing a license or approval. The department may examine the books and accounts of any facility if it deems such examination necessary for the purposes of this section.

SECTION 57. Chapter 118E of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after section 10J the following section:-

Section 10K. The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract to a Medicaid managed care organization or primary care clinician plan shall provide, for any covered drug that is a narcotic substance contained in schedule II of section 3 of chapter 94C and that is subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, they shall not be subject to an additional payment obligation, including but not limited to co-payments, if they fill the remaining portion of the prescription.

SECTION 58: Chapter 123 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting the following three sections after section 12:-

Section 12A. (a) Any physician who is licensed pursuant to section 2 of chapter 112 or qualified psychiatric nurse mental health clinical specialist authorized to practice as such under regulations promulgated pursuant to the provisions of section 80B of said chapter 112 or a qualified psychologist licensed pursuant to sections 118 to 129, inclusive, of said chapter 112, or a licensed independent clinical social worker licensed pursuant to sections 130 to 137, inclusive, of chapter 112 who, after examining a person, has reason to believe that failure to hospitalize such person would create a likelihood of serious harm by reason of an alcohol or substance use disorder may restrain or authorize the restraint of such person and apply for the hospitalization of such person for a 72-hour period at a facility. Such person shall only be hospitalized for a 72-hour period after receiving medical clearance by the treating clinician. A person shall not be hospitalized pursuant to this section at a facility operated by the department of correction or a house of correction.

If an examination is not possible because of the emergency nature of the case and because of the refusal of the person to consent to such examination, the physician, qualified psychologist, qualified psychiatric nurse mental health clinical specialist or licensed independent clinical social worker on the basis of the facts and circumstances may determine that hospitalization is necessary and may apply therefore.

An application for hospitalization shall state the reasons for the restraint of such person and any other relevant information which may assist the admitting physician or physicians. Whenever practicable, prior to transporting such person by ambulance, the applicant shall telephone or otherwise communicate with a facility to describe the circumstances and known clinical history and to determine whether the facility is the proper facility to receive such person and also to give notice of any restraint to be used and to determine whether such restraint is necessary.

(b) Only if the application for hospitalization under the provisions of this section is made by a physician specifically designated to have the authority to admit to a facility in accordance with the regulations of the department of mental health or the department of public health shall such person be admitted to the facility immediately after the person's reception. If the application is made by someone other than a designated physician, such person shall be given an examination by a designated physician immediately after the person's reception at such facility. If the physician determines that failure to hospitalize such person would create a likelihood of serious harm by reason of an alcohol or substance use disorder the physician may admit such person to the facility for care and treatment for up to 72 hours, during which time staff of the substance use treatment facility shall attempt to engage the individual in voluntary treatment, which may include medication-assisted treatment.

Upon admission of a person under the provisions of this subsection, the facility shall inform the person that it shall, upon such person's request, notify the committee for public counsel services of the name and location of the person admitted. The committee for public counsel services shall forthwith appoint an attorney who shall meet with the person. If the appointed attorney determines that the person voluntarily and knowingly waives the right to be represented, or is presently represented or will be represented by another attorney, the appointed attorney shall so notify the committee for public counsel services, which shall withdraw the appointment.

Any person admitted under the provisions of this subsection, who has reason to believe that such admission is the result of an abuse or misuse of the provisions of this subsection, may request, or request through counsel, an emergency hearing in the juvenile court or district court in whose jurisdiction the facility is located, and unless a delay is requested by the person or through counsel, the juvenile court or district court shall hold such hearing on the day the request is filed with the court or not later than the next business day.

(c) No person shall be admitted to a facility under the provisions of this section unless the person, or the person’s parent or legal guardian on the person’s behalf, is given an opportunity to apply for voluntary admission under section 12B and unless the person, or such parent or legal guardian, has been informed (1) that the person has a right to such voluntary admission, and (2) that the period of hospitalization under the provisions of this section cannot exceed 72 hours. At any time during such period of hospitalization, the superintendent may discharge such person if the superintendent determines that such person is not in need of care and treatment.

(d) A person shall be discharged 72 hours after their reception at the treatment facility unless the person has consented to treatment under section 12B. If the person does not consent to further treatment, prior to discharge, the facility shall: (i) provide training and education regarding overdose prevention to the person; (ii) directly connect the person with a community based program that provides harm reduction services; and (iii) provide information on local and statewide treatment options, providers and other relevant information as deemed appropriate by a treating clinician.

(e) The department, in coordination with the department of public health, shall promulgate regulations to implement this section.

(f) For purposes of this section, the word "facility" shall mean a facility licensed or approved for the treatment of an alcohol or substance use disorder under this section by the department of mental health or the department of public health.

Section 12B. (a) Pursuant to departmental regulations on admission procedures, the superintendent of a facility may receive and treat on a voluntary basis any person who has been committed under section 12A; provided, that the person is in need of care and treatment for an alcohol or substance use disorder; and provided further that the admitting facility is suitable for such care and treatment. A person shall not be hospitalized at a facility operated by the department of correction or a house of correction under this section. The application for voluntary treatment may be made (1) by a person who has attained the age of sixteen, (2) by a parent or guardian of a person on behalf of a person under the age of eighteen years, and (3) by the guardian of a person on behalf of a person under his guardianship. Prior to accepting an application for a voluntary admission, the superintendent shall afford the person making the

application the opportunity for consultation with an attorney, or with a person who is working under the supervision of an attorney, concerning the legal effect of a voluntary admission. The superintendent may discharge any person admitted under this subsection at any time the superintendent deems such discharge in the best interest of such person; provided, however, that if a parent or guardian made the application for admission, 14 days' notice shall be given to such parent or guardian prior to such discharge.

(b) Pursuant to departmental regulations, the superintendent of a facility may treat persons as outpatients providing application for outpatient treatment is made in accordance with the application provisions of paragraph (a). The superintendent may, in the best interest of the person, discontinue the outpatient treatment of a person at any time.

(c) A person admitted to a facility under subsection (a) shall be free to leave such facility at any time, except that in the case of a person under the age of 18 admitted by a parent or guardian or in the case of a person under guardianship admitted by a guardian, only the parent or guardian who requested the admission of such person may withdraw such person. The parent or guardian may withdraw the person at any time, after providing written notice to the superintendent. The superintendent may restrict the right to leave or withdraw to normal working hours.

(d) The department, in coordination with the department of public health, shall promulgate regulations to implement this section.

(e) For purposes of this section, the word “facility” shall mean a facility licensed or approved for the treatment of an alcohol or substance use disorder under this section by the department of mental health or the department of public health.

Section 12C. The commissioner of public health shall prepare an annual report, pursuant to section 237 of chapter 111, in order to understand the outcomes and effectiveness of the involuntary commitment process established in section 12A of this chapter. Each report shall include a comparison of findings from the year preceding enactment of this act and all succeeding years.

The report shall examine the impact of section 12A on the behavioral health treatment system in the commonwealth, which shall include but not be limited to: (i) the number of people involuntarily committed and the number of people who voluntarily agree to further treatment after the completion of commitment under section 12A; (ii) the number of petitions filed and orders of commitment granted under section 35 of this chapter; (iii) the number of emergency hearings requested under section 12A and the disposition of such emergency hearings; and (iv) the number of individuals boarding in emergency departments with a behavioral health condition, including patients with a primary mental health, alcohol or substance use disorder diagnosis, as such individuals await admission to a 24-hour level of care.

The report shall further examine the impact of involuntary commitment on patients with alcohol and substance use disorders in the commonwealth, which shall include, but not be limited to, a comparison of individuals committed under section 12A, individuals committed under section 35 and individuals who have undergone voluntary treatment. Such examination shall, to the extent possible, control for external factors that may also impact patient outcomes in order to determine the impact of each process and treatment type on the following factors: (i) fatal and non-fatal overdoses; (ii) prevalence of opioid use disorder; (iii) any impact on care-seeking, including, but not limited to, calls to emergency services regarding a drug overdose, emergency room visits and visits for substance use treatment; (iv) other outcome measures

identified by the commissioner of public health. To the extent possible, the report shall examine the differential impact on sub-populations affected by alcohol and substance use disorder, including but not limited to: (i) individuals classified by demographic group, including race, ethnicity and gender; (ii) individuals on public or private insurance; (iii) individuals experiencing homelessness; and (iv) individuals who use opiates, alcohol, another substance or multiple substances.

The commissioner of public health shall make the report available to the public and file a copy of the report with the clerks of the house of representatives and the senate, the joint committee on mental health, substance use and recovery and the joint committee on health care financing no later than January 1, annually.

SECTION 59. Chapter 175 of the General Laws, as appearing in the 2016 Offical Edition, is hereby amended by inserting after section 47II the following section:-

Section 47JJ. Any policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth, which is considered creditable coverage under section 1 of chapter 111M, shall provide, for any covered drug that is a narcotic substance contained in schedule II of section 3 of chapter 94C and that is subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, they shall not be subject to an additional payment obligation, including but not limited to co-payments, if they fill the remaining portion of the prescription.

SECTION 60. Chapter 176A of the General Laws, as appearing in the 2016 Offical Edition, is hereby amended by inserting after section 8KK the following section:-

Section 8LL. Any contract between a subscriber and the corporation under an individual or group hospital service plan which is delivered, issued or renewed within the commonwealth shall provide, for any covered drug that is a narcotic substance contained in schedule II of section 3 of chapter 94C and that is subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, they shall not be subject to an additional payment obligation, including but not limited to co-payments, if they fill the remaining portion of the prescription.

SECTION 61. Chapter 176B of the General Laws, as appearing in the 2016 Offical Edition, 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, for any covered drug that is a narcotic substance contained in schedule II of section 3 of chapter 94C and that is subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, they shall not be subject to an additional payment obligation, including but not limited to co-payments, if they fill the remaining portion of the prescription.

SECTION 62. Chapter 176G of the General Laws of the General Laws, as appearing in the 2016 Offical Edition, is hereby amended by inserting after section 4CC the following section:-

Section 4DD. An individual or group health maintenance contract that is issued or renewed shall provide, for any covered drug that is a narcotic substance contained in schedule II of section 3 of chapter 94C and that is subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, they shall not

be subject to an additional payment obligation, including but not limited to co-payments, if they fill the remaining portion of the prescription.

SECTION 63: Chapter 52 of the acts of 2016 is hereby amended by striking out, in lines 627, 635, 639, 644, 647, 652, 655 and 659, the words “substance abuse evaluation” and inserting in place thereof, in each instance, the following words:- substance use disorder evaluation.

SECTION 64. Notwithstanding any other general or special law to the contrary, for the initial implementation of section 25J½ of Chapter 111, the commissioner of public health shall consult with a stakeholder group of provider representatives in the development of licensure regulations.

SECTION 65. (a) There shall be a commission to review and make recommendations regarding recovery coaching in the commonwealth. The commission shall review training opportunities for recovery coaches, recommend standards that should apply when credentialing a recovery coach, including whether recovery coaches should be required to register with a board, and gather all relevant data related to recovery coaches, including but not limited to: (i) the total number of recovery coaches in the commonwealth; (ii) the number of people receiving compensation as recovery coaches in the commonwealth; (iii) the average and median compensation for a recovery coach; (iv) the average and median caseload for a recovery coach; and (v) the projected need for certified recovery coach services. The commission shall develop recommendations for a streamlined process to certify recovery coaches and adequate protections to ensure unauthorized individuals are not engaging in the practice of recovery coaching.

(b) The commission shall consist of 12 members: the secretary of health and human services or the secretary’s designee, who shall serve as chair; the commissioner of the

department of public health or the commissioner's designee; the house chair of the joint committee on mental health, substance use and recovery; the senate chair of the joint committee on mental health, substance use and recovery; 1 representative from the Massachusetts Association of Health Plans; 1 representative from the Massachusetts Psychiatric Society; 1 representative from the Massachusetts Organization for Addiction Recovery; and 5 persons who shall be appointed by the secretary of health and human services: 1 of whom shall represent a community provider who employs recovery coaches, 1 of whom shall represent a hospital that employs recovery coaches, 1 of whom shall have expertise in training recovery coaches, 1 of whom shall currently be employed as a recovery coach and 1 of whom shall be a consumer of recovery coach services.

(c) The commission may hold public meetings and fact-finding hearings as it considers necessary. The commission shall file the report of its study, including recommendations for legislation, with the clerks of the house of representatives and the senate no later than 1 year after the date of the first meeting of the commission; provided, however, that the commission may, at the discretion of the chair, make a draft report available to the public for comment before filing the final version.

SECTION 66. (a) There shall be a commission to review, make recommendations and report on non-opioid and non-pharmacological pain management strategies. The commission shall: (i) develop a plan for insurers to provide adequate coverage and access to non-pharmacological pain management treatment administered by health care providers licensed by the commonwealth; and (ii) develop reasonable standards by which to assess provider networks and patient utilization of evidence-based treatment for pain management.

(b) The commission shall be comprised of 11 members: the commissioner of public health or a designee, who shall serve as chair; a representative from the Center for Health Information and Analysis; the director of Medicaid or their designee; and 1 representative from each of the following 8 organizations: the Massachusetts Association for Health Plans; Blue Cross Blue Shield Massachusetts; the Massachusetts Pain Initiative; the Acupuncture Society of Massachusetts; the American Physical Therapy Association of Massachusetts; the Massachusetts Chiropractic Society, Inc.; the Massachusetts Medical Society; and Alosa Health. The commission may hold public meetings and fact-finding hearings as it considers necessary.

(c) The commission may establish advisory committees to assist its work. The commission shall file the report of its study, including recommendations for legislation, with the clerks of the house of representatives and the senate no later than 1 year after the effective date of this act; provided, however, that the commission may, at the discretion of the chair, make a draft report available to the public for comment before filing the final version.

SECTION 67. (a) There shall be a commission to review and make recommendations about appropriate prescribing practices related to the most common oral and maxillofacial surgical procedures, which shall include the removal of wisdom teeth. The commission shall engage with drug manufacturers to create a pre-packaged product such as a blister pack or z-pack to be used in connection with common oral and maxillofacial surgical procedures that will provide patients with an appropriate, standard post-procedure dosage and quantity of commonly prescribed drugs.

(b) The commission shall be comprised of: the commissioner of public health or a designee, who shall serve as chair, a representative from the Massachusetts Dental Society, and 5

persons who shall be appointed by the commissioner of public health: 1 of whom shall be an oral surgeon; 1 of whom shall be a nurse with expertise in maxillofacial surgical procedures; 1 of whom shall represent a dental school; and 2 of whom shall have expertise in pain management.

(c) The commission shall file its recommendations, including any recommendations for legislation, with the clerks of the senate and the house of representatives 18 months from the effective date of this act.

SECTION 68. (a) There shall be an implementation committee to advise and inform the department of mental health and the department of public health on the implementation of section 12A of chapter 123 of the General Laws. The implementation committee shall address workforce capacity and facility capacity. When addressing facility capacity, the implementation committee shall establish a new level of inpatient treatment with competence to treat co-occurring mental health and substance use disorders.

(b) The implementation committee shall be comprised of 14 members: the secretary of health and human services or their designee, who shall serve as chair; the commissioner of mental health or their designee; the commissioner of public health or their designee; the director of Medicaid or their designee; the chief justice of the trial court or their designee; and 1 representative from the following 9 organizations: the committee for public counsel services; the Association for Behavioral Healthcare; the Massachusetts Health and Hospital Association; the Massachusetts Association of Behavioral Health Systems; the Massachusetts Association of Health Plans; Blue Cross Blue Shield of Massachusetts; the Massachusetts Organization for Addiction Recovery; the Massachusetts College of Emergency Physicians; and the Massachusetts chapter of the National Association of Social Workers.

(c) The implementation committee shall make its report available to the public and file a copy of its report with the clerks of the house of representatives and the senate within 180 days of the effective date of this act.

SECTION 69. (a) There shall be a commission to study and make recommendations regarding the use of medication-assisted treatment for opioid use disorder in the commonwealth, including methadone, buprenorphine and injectable long-acting naltrexone.

(b) The commission shall: (i) create aggregate demographic and geographic profiles of individuals who use medication-assisted treatment; (ii) examine the availability of and barriers to accessing medication-assisted treatment, including federal, state and local laws and regulations; (iii) determine the current utilization of, and projected need for, medication-assisted treatment in inpatient and outpatient settings, including, but limited to, inpatient and residential substance use treatment facilities, inpatient psychiatric settings, pharmacy settings, mobile settings and primary care settings; (iv) identify ways to expand access to medication-assisted treatment in both inpatient and outpatient settings; (v) identify ways to encourage practitioners to seek waivers to administer buprenorphine to treat patients with opioid use disorder; (vi) study the availability of and concurrent use of behavioral health therapy for individuals receiving medication-assisted treatment; and (vii) study other related matters.

(c) The commission shall consist of 13 members: the commissioner of public health or a designee, who shall serve as chair; the executive director of the health policy commission or a designee; the director of Medicaid or a designee; the house chair of the joint committee on mental health, substance use, and recovery; the senate chair on mental health, substance use, and recovery; and 1 representative of each of the following 7 organizations: the Massachusetts

Medical Society; the Massachusetts Health & Hospital Association; the Association for Behavioral Healthcare; the Massachusetts Association of Behavioral Health Systems, the Massachusetts Association of Health Plans; Blue Cross Blue Shield of Massachusetts; the Massachusetts Pharmacists Association; and the Massachusetts Organization for Addiction Recovery.

(d) The commission shall file a report on its findings and recommendations, together with any recommendations for legislation, with the clerks of the house of representatives and the senate no later than 1 year from the effective date of this act.

SECTION 70. (a) There shall be a commission to study best practices for programs to administer medication-assisted treatment for opioid use disorder, including methadone, buprenorphine and injectable long-acting naltrexone, to incarcerated individuals in state and county correctional facilities. The commission shall be charged with: (i) developing a definition for "informed consent" and a process for obtaining it from individuals eligible to receive medication-assisted treatment while incarcerated; (ii) creating uniform guidelines for facilities to administer medication-assisted treatment; (iii) projecting the cost of initiating and maintaining medication-assisted treatment programs in correctional facilities; (iv) establishing protocols for technical assistance that may be required by the department of public health; (v) assessing continuing access to medication-assisted treatment for individuals upon their release from incarceration; (vi) developing evaluation and reporting metrics for medication-assisted treatment programs in correctional settings, including, but not limited to: (1) relapse after release; (2) recidivism after release; (3) fatal and nonfatal overdoses; (4) rates and length of treatment retention after release; (5) diversion and disciplinary infractions within correctional facilities; (6) the number of individuals who began medication-assisted treatment while incarcerated; (7) the

number of individuals who ceased medication-assisted treatment while incarcerated; (8) the number of individuals receiving medication-assisted treatment for opioid use disorder prior to being incarcerated and who: (A) continued medication-assisted treatment upon being incarcerated; or (B) decline or voluntarily discontinue medication-assisted treatment while incarcerated; (C) a summary of changes to facility practices related to medication-assisted treatment administration; and (vii) develop standards to ensure individuals receiving medication-assisted treatment also receive behavioral health counseling.

(b) The commission shall consist of 15 members: the secretary of public safety or a designee, and the commissioner of public health or a designee, who shall serve as co-chairs; the commissioner of the department of corrections or a designee; 4 county sheriffs from geographically diverse regions of the commonwealth, appointed by the Massachusetts Sheriffs' Association; and 1 representative of each of the following 8 organizations: the Massachusetts Medical Society; the Massachusetts Health & Hospital Association; the Association for Behavioral Healthcare; the Massachusetts Association of Behavioral Health Systems; the Disability Law Center; Prisoner's Legal Services of Massachusetts; the Massachusetts Society of Addiction Medicine; and the Massachusetts Organization for Addiction Recovery.

(c) The commission shall file a report on its findings and recommendations, together with any recommendations for legislation, with the clerks of the house of representatives and the senate and the chairs of the joint committee on mental health, substance use and recovery no later than 1 year from the effective date of this act.

SECTION 71. The health policy commission, in coordination with the department of mental health, the department of public health and the center for health information and analysis,

shall prepare an annual report regarding the boarding of psychiatric patients in emergency departments as patients await admission to a 24-hour level of psychiatric care. The report shall include but not be limited to: (i) the prevalence of psychiatric emergency department boarding during the past year and compared to prior years, and (ii) an analysis of the relationship between the length of stay in the emergency department and the following factors during the past year: (1) primary and secondary diagnoses, including behavioral health and medical conditions; (2) patient characteristics, including age, race, gender, aggressive or violent behavior and involvement with state agencies; (3) when the patient arrives in the emergency department, including month, day, and time of day; (4) location; and (5) case outcome at discharge.

Notwithstanding any general or special law to the contrary, the department of mental health, the department of public health and the center for health information and analysis shall provide information to the health policy commission, upon request, to complete this report.

The health policy commission shall submit its report on psychiatric boarding to the joint committee on mental health, substance use and recovery and the joint committee on health care financing no later than January 1, annually.

SECTION 72. The department of mental health shall prepare an annual report regarding the boarding of psychiatric patients in emergency departments as patients await admission to a 24-hour level of psychiatric care. The report shall include the following: (i) efforts taken by the department and other agencies during the past year to address psychiatric emergency department boarding; (ii) an analysis of patient and unit characteristics identified by inpatient psychiatric units as factors justifying denial of admission, pursuant to 104 CMR 27.05(3); (iii) characteristics of patients referred to the department under the expedited psychiatric inpatient

admission policy that became effective February 1, 2018, including an analysis of patient characteristics and length of stay in the emergency department; (iv) steps taken to admit patients awaiting admission for over 48 hours, including but not limited to out-of-state placements, admission on specialized units and inpatient unit accommodations including higher staff to patient ratios or single rooms; (v) outcome measures for current efforts to address psychiatric emergency department boarding, including relevant information and analysis from the health policy commission report required pursuant to section 71 of this act; and (vi) legislative recommendations, if any, to address psychiatric emergency department boarding.

The department shall submit its report on psychiatric boarding to the joint committee on mental health, substance use and recovery and the joint committee on health care financing not later than March 1, annually.

SECTION 73. The department of public health, in coordination with the department of correction, shall issue a report regarding the approval of substance use treatment services at department of correction and house of correction facilities, including initial approvals and renewals, pursuant to section 7 of chapter 111E of the General Laws. The report shall include information from at least each of the past 4 years.

The report shall include, but not be limited to: (i) a description of the approval process for department of correction and house of correction facilities that provide substance use treatment services; (ii) standards and criteria for approval of department of correction and house of correction facilities that provide substance use treatment services, as well as how such standards and criteria may differ from licensing standards and criteria; (iii) standards and criteria for approval of the Massachusetts alcohol and substance abuse center at Plymouth, as well as how

such standards and criteria may differ from approval standards and criteria for facilities operated by the department of mental health or from licensing standards and criteria; (iv) the dates of approval for each department of correction or house of correction facility that provides substance use treatment services, including the Massachusetts alcohol and substance abuse center at the Massachusetts correctional institution at Bridgewater and the Massachusetts alcohol and substance abuse center at the Massachusetts correctional institution at Plymouth; (v) the number, locations and results of any on-site inspections conducted by the department of public health at department of correction or house of correction facilities; (vi) any complaints or investigations at department of correction and house of correction facilities, including investigation findings and any actions taken in response to such findings; and (vii) any revocations of approval at department of correction or house of correction facilities, including the rationale behind such revocations.

The department of public health shall file the report with the clerks of the house of representatives and the senate, the chairs of the joint committee on mental health, substance use and recovery, and the chairs of the joint committee on public safety and homeland security not later than 180 days from the effective date of this act.

SECTION 74. When developing the program pursuant to section 16AA of chapter 6A of the General Laws, the executive office of health and human services shall consider the following: (i) how to most effectively adapt the program model of the Massachusetts Child Psychiatry Access Program, established pursuant to section 16A of chapter 19 of the General Laws, for substance use disorder consultation services; (ii) program structure, including whether to use regionally based teams; (iii) the necessity of a needs assessment; (iv) outreach methods to educate and engage providers and health insurance carriers; (v) program metrics to gauge

program usage and efficacy in expanding access to appropriate substance use disorder services; and (vi) program costs.

SECTION 75. When developing the program pursuant to section 16BB of chapter 111 of the General Laws, the executive office of health and human services shall consider the following: (i) how to most effectively adapt the program model of the Massachusetts Child Psychiatry Access Program, established pursuant to section 16A of chapter 19 of the General Laws, for chronic pain consultation services; (ii) program structure, including whether to use regionally based teams; (iii) the necessity of a needs assessment; (iv) outreach methods to educate and engage providers and health insurance carriers; (v) program metrics to gauge program usage and efficacy in expanding access to appropriate pain management; and (vi) program costs.

SECTION 76. Sections 21 through 24, inclusive, and 27 through 32, inclusive, shall take effect on January 1, 2020.

SECTION 77. Sections 44 and 58 shall take effect no later than December 31, 2020.

SECTION 78. Sections 65 to 67, inclusive, 69 and 70 are hereby repealed.

SECTION 79. Sections 71 and 72 are hereby repealed.

SECTION 80. Section 78 shall take effect on January 1, 2021.

SECTION 81. Section 79 shall take effect on March 2, 2021.