HOUSE . . . . . No. 4725

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, July 10, 2018.

The committee on Ways and Means, to whom was referred the Bill for prevention and access to appropriate care and treatment of addiction (House, No. 4470), reports recommending that the same ought to pass with an amendment substituting therefor the accompanying bill (House, No. 4725).

For the committee,

JEFFREY SÁNCHEZ.

FILED ON: 7/10/2018

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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 bolster forthwith 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 is hereby amended by adding the following section:-

Section 219. (a) There shall be a commission on 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 promote positive mental, emotional and behavioral health and to prevent mental health and substance use disorders among residents of the commonwealth.

(b) (1) The commission shall consist of 17 members, as follows: the secretary of health and human services or a designee, who shall serve as the chair; 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; 1 person appointed by the speaker of the house; 1 person appointed by the senate president; and 1 representative from each of the following 9 organizations: the Association for Behavioral Healthcare, Inc.; the Massachusetts Association of Community Health Workers, Inc.; the Massachusetts Association for Mental Health, Inc.; the Massachusetts Organization for Addiction Recovery, Inc.; the Massachusetts Public Health Association; the Massachusetts Society for the Prevention of Cruelty to Children; the National Alliance on Mental Illness of Massachusetts, Inc.; the Social-Emotional Learning Alliance for Massachusetts, Inc.; and the Freedman Center at William James College.

(2) 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 in accordance with paragraph (1) for the remainder of the unexpired term. Any member who is appointed by the governor may be removed by the governor for cause.

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

(d) The commission shall:

(1) promote an understanding of: (i) the science of prevention; (ii) population health; (iii) risk and protective factors; (iv) social determinants of health; (v) evidence-based programming and policymaking; (vi) health equity; and (vii) trauma-informed care; provided that the commission may 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;

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

(3) 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;

(4) make recommendations to the legislature that: (i) promote behavioral health and prevention issues at the universal, selective and indicated levels; (ii) strengthen community or state-level promotion and prevention systems; and (iii) reduce healthcare and other public costs through evidence-based promotion and prevention; provided that the commission may 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) 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

(6) submit an annual report to the 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 joint committee on health care financing and the joint committee on mental health, substance use and recovery on its activities and any recommendations. 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 the team determining which services a child is eligible for, the team is unable to reach a consensus on the responsibility of payment, and the child is unable to access said 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 shall remain in effect until the child advocate is informed in writing of a permanent cost share or payment agreement having been implemented or until the child no longer qualifies for said services.

SECTION 3. Said chapter 6A is hereby further 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 symptoms of a 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 executive office of health and human services 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 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 community-based behavioral health promotion and prevention trust fund. The purpose of the fund shall be to promote positive mental, emotional and behavioral health among children and young adults and to prevent mental health and substance use disorders among children and young adults.

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

(1) community organizations to establish or support evidence-based and evidence-informed programs for children and young adults. The community organizations may include, but not be limited to, public and private agencies, 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

(2) 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 for a grant under this section. 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 for 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 community setting;

(3) support for underserved populations of children and young adults including, but not limited to, 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. Expenditures made pursuant to this subsection may not exceed, in 1 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 on its activities, on or before March 1, with the joint committee on health care financing and the joint committee on mental health, substance use and recovery.

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 following sentence:- 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 clause (1) and inserting in place thereof the following paragraph:-

(1) three 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 2 clauses:-

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

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

SECTION 8. Said section 13 of said chapter 13, as so appearing, is hereby amended by striking out subsection (d) and inserting in place thereof the following subsection:-

(d) Licensed practical nurse board members shall include representatives from at least 2 of the following 3 settings: long-term care, acute care, and community health settings.

SECTION 9. Section 13 of chapter 17 of the General Laws, as so appearing, is hereby amended by striking out, in line 2, the figure “16” and inserting in place thereof the following figure:- 18.

SECTION 10. Said section 13 of said chapter 17, as so appearing, is hereby further amended by striking out, in line 5, the figure “13” and inserting in place thereof the following figure:- 14.

SECTION 11. Said section 13 of said chapter 17, as so appearing, is hereby further amended by inserting after the word “designee”, in line 5, the second time it appears, the following words:- ; the director of the department of industrial accidents or a designee.

SECTION 12. Said section 13 of said chapter 17, as so appearing, is hereby further amended by inserting after the word “pain”, in line 12, the following words:- ; 1 representative of a Massachusetts labor organization.

SECTION 13. 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 14. Section 2 of chapter 18C of the General Laws, as so appearing, is hereby amended by striking out, in line 14, the word “and”.

SECTION 15. Said section 2 of said 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 necessary pursuant to section 16R of chapter 6A to ensure children’s timely access to services.

SECTION 16. Section 19 of chapter 19 of the General Laws, as so appearing, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

(a) The 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 17. 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 18. 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 19. 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 20. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out subsections (e) to (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 a 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 12 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 the facility, department or unit; (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 clause (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 21. Section 17M of chapter 32A of the General Laws, as so appearing, is hereby amended by striking out, in line 3, the word "abuse" and inserting in place thereof the following words:- use disorder.

SECTION 22. Section 17N of said chapter 32A, as so appearing, is hereby amended by striking out, in line 31, the word "abuse" and inserting in place thereof the following words:- use disorder.

SECTION 23. Said chapter 32A is hereby further 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 pursuant to chapter 94C and subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C,said person shall not be subject to an additional payment obligation, including but not limited to co-payments, if said person fills the remaining portion of the prescription.

SECTION 24. Section 1 of chapter 94C of the General Laws is hereby amended by inserting after the definition of "Drug paraphernalia", as so appearing, the following definition:-

“Electronic prescription”, a lawful order from a practitioner 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; provided further, the electronic prescription shall be received by the pharmacy on an electronic system that meets federal requirements for electronic prescriptions. For the purposes of this chapter, a prescription generated on an electronic system that is printed out or transmitted via facsimile is not considered an electronic prescription.

SECTION 25. 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 26. 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 27. 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, III, IV, V, or VI substance may be dispensed upon written prescription or oral prescription in accordance with section 20 and department regulations.

SECTION 28. 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 29. Said section 17 of chapter 94C, as so appearing, is hereby further amended by striking subsection (d).

SECTION 30. Section 18 of said chapter 94C, as so appearing, is hereby amended by striking out subsection (d¾) 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. The initial partial dispensing of a prescription filled pursuant to subsection

(d) or (d1/2) shall be filled within 5 days of the prescription issue date. The remaining portion pursuant to this subsection must be filled within 30 days of the prescription issue date.

SECTION 31. Said chapter 94C is hereby amended by striking out section 19B, as so appearing, 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) 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.

(f) 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 established under section 34A shall also apply to a person administering an opioid antagonist pursuant to this section.

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

SECTION 32. 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:- Whenever a practitioner 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 33. 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 34. Said section 22 of chapter 94C of the General Laws, as so appearing , is hereby further amended by striking out, in line 21, the words “recommended full quantity indicated” and inserting in place thereof the words:- full prescribed quantity.

SECTION 35. 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 36. 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 37. 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 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 by veterinarians;

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

(3) a time limited waiver process for practitioners who demonstrate economic hardship, technological limitations that are not reasonably within the control of the practitioner, or other exceptional circumstances;

(4) prescriptions that are issued or dispensed in emergency situations;

(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 38. 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 39. Said section 24A of said chapter 94C, as so appearing, is hereby further 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 shall identify the registered participant on whose behalf the prescription monitoring program was accessed.

SECTION 40. 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 41. Chapter 111 of the General Laws is hereby amended by inserting after section 25J the following 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 in section 51½, 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.

Every acute care hospital that provides emergency services in an emergency department or satellite emergency facility shall maintain hospital institutional protocols and the 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. Every hospital emergency department and satellite emergency facility shall demonstrate compliance with applicable training and waiver requirements established by the federal drug enforcement agency and the substance abuse and mental health services administration relative to prescribing opioid agonist treatment, and compliance with federal enforcement agency regulations relative to administering or dispensing of narcotic drugs.

Prior to discharge, any patient who is administered or prescribed opioid agonist treatment in an emergency department or satellite emergency facility shall be directly connected to an appropriate treatment site to continue said treatment.

SECTION 42: Section 51½ of said chapter 111, as appearing in the 2016 Official Edition, 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 43: 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 independent

clinical social worker, a licensed mental health counselor, a licensed psychiatric clinical nurse specialist, a licensed alcohol and drug counselor I as defined in section 1 of chapter 111J or any other professional with appropriate privileges at the facility to diagnose a substance use disorder.

SECTION 44: 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:- , by a licensed mental health professional.

SECTION 45: 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), a patient may consent to treatment, which may occur within the acute-care hospital or satellite emergency facility, if appropriate services are available, and 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, 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 46: Said section 51½ of said chapter 111, as so appearing, is hereby further 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 47. Said section 51½ of chapter 111, as so appearing, is hereby amended by striking out, in line 97, the words "and substance abuse" and inserting in place thereof the following words:- , substance use and recovery.

SECTION 48. Section 1 of chapter 111E of the General Laws is hereby amended by inserting after the definition of "Assignment", as so appearing, the following definition:-

"Commissioner", the commissioner of public health.

SECTION 49. Said section 1 of said chapter 111E is hereby further amended by inserting after the definition of “Independent addiction specialist”, as appearing in section 63 of chapter 69 of the acts of 2018, 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 50. Section 7 of said chapter 111E, as appearing in the 2016 Official Edition, 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 51. 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 52. 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 53. The fourth sentence of the first paragraph of said section 7 of said chapter 111E, as so appearing, is hereby amended by striking out clauses (1) to (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 54. 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 55. 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 56 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 57. 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) an application for an original license fails to meet the department’s standards or criteria for demonstrating need.

SECTION 58. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in line 49, the word “director” and inserting in place thereof the following word:- commissioner.

SECTION 59. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out the fifth, sixth and seventh paragraphs 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 shall provide 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 12 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, except 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, except 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 60. Section 10H of chapter 118E of the General Laws, as added by section 19 of chapter 258 of the acts of 2014, is hereby amended by striking out, in line 55, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 61. Said chapter 118E is hereby further amended by inserting after section 10K, inserted by section 2 of chapter 120 of the acts of 2017, the following section:-

Section 10L. 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 pursuant to chapter 94C and subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, said person shall not be subject to an additional payment obligation, including, but not limited, to co-payments, if said person fills the remaining portion of the prescription.

SECTION 62. Section 47FF of chapter 175 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out, in line 3, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 63. Section 47GG of said chapter 175, as so appearing, is hereby amended by striking out, in line 33, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 64. Said chapter 175is hereby further 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 pursuant to chapter 94C and subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, said person shall not be subject to an additional payment obligation, including but not limited to co-payments, if said person fills the remaining portion of the prescription.

SECTION 65. Section 8HH of chapter 176A of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out, in line 3, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 66. Section 8II of said chapter 176A, as so appearing, is hereby amended by striking out, in line 32, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 67. Said chapter 176A of the General Laws is hereby further 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 pursuant to chapter 94C and subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, said person shall not be subject to an additional payment obligation, including but not limited to co-payments, if said person fills the remaining portion of the prescription.

SECTION 68. Section 4HH of chapter 176B of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out, in line 3, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 69. Section 4II of said chapter 176B, as so appearing, is hereby amended by striking out, in line 31, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 70. Said chapter 176B is hereby further 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 pursuant to chapter 94C and subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, said person shall not be subject to an additional payment obligation, including but not limited to co-payments, if said person fills the remaining portion of the prescription.

SECTION 71. Section 4Z of chapter 176G of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out, in line 3, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 72. Section 4AA of said chapter 176G, as so appearing, is hereby amended by striking out, in line 30, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 73. Said chapter 176G is hereby further 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 pursuant to chapter 94C and subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, said person shall not be subject to

an additional payment obligation, including but not limited to co-payments, if said person fills the remaining portion of the prescription.

SECTION 74. Notwithstanding any other general or special law to the contrary, for the initial implementation of section 25J½ of chapter 111 of the General Laws, the commissioner of public health shall consult with a stakeholder group of provider representatives in the development of licensure regulations.

SECTION 75. (a) There shall be a special commission established pursuant to section 2A of chapter 4 of the General Laws 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 11 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 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 76. (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 77. (a) There shall be a special commission established pursuant to section 2A of chapter 4 of the General Laws 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 8 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 78. (a) For the purposes of this section, the following words shall have the following meanings:-

"Informed consent," consent to treatment that is: (a) voluntarily given by the patient; (b) recorded on a consent form signed by the patient; and (c) given after a written and verbal explanation of the following information: (i) the nature of federal Food and Drug Administration-approved medication used in substance use disorder treatment, including benefits

and risks, and the benefits and risks of not receiving treatment; (ii) the distinction between detoxification and maintenance, and the availability of short-term detoxification treatment; (iii) the approximate length of each type of treatment; (iv) a clear statement of the goals of each type of treatment, and the tasks necessary to reach those goals; (v) the need for the patient to inform the prescribing physician or advanced practice nurse of medical conditions and medications that the patient is currently taking; (vi) acknowledgement that the patient may withdraw voluntarily from treatment and discontinue use of medications; (vii) the options available to both the patient and the program as a result of either a voluntary or involuntary termination, including medically supervised withdrawal; and (viii) for women of child-bearing age, acknowledgement of the benefits and risks of treatment during pregnancy, and the importance of informing the prescribing physician or advanced practice nurse if she is or becomes pregnant. No incentives, rewards, or punishments shall be used to encourage, or discourage, a patient's decision to receive treatment, other than the information provided in this definition.

"Medication-assisted treatment," treatment for substance use disorder provided to a prisoner that (a) is provided with informed consent; (b) is determined to be medically necessary by a physician or advanced practice nurse; (c) involves the use of medication that is approved by the federal Food and Drug Administration for treatment of substance use disorder and is included in the MassHealth drug list; (d) includes counseling and behavioral therapy; and (e) is offered in accordance with a treatment plan that is reviewed every 90 days by a physician or advanced practice nurse.

(b) The commissioner of the department of correction, in consultation with the commissioner of the department of public health, shall establish a 2 year pilot program to provide medication-assisted treatment for the treatment of substance use disorder in correctional

facilities. The commissioner, in consultation with the commissioner of the department of public health, shall develop criteria for the selection of state prisons to participate in a pilot program and shall select two state prisons for participation in the pilot program.

Selected facilities shall maintain or provide for the capacity to possess, dispense and administer all drugs approved by the federal Food and Drug Administration for use in medication-assisted treatment for substance use disorder, and shall make such treatment available to any inmate who was receiving medication for opioid addiction immediately preceding incarceration; provided however, that facilities selected shall not be required to maintain or provide an opioid substitution therapy that is not included in the MassHealth drug list and is not a MassHealth covered benefit.

Selected facilities shall ensure that each inmate who is receiving medication-assisted treatment for opioid addiction continues the treatment unless the inmate voluntarily discontinues the treatment or unless the inmate's treating provider determines that treatment is no longer medically necessary.

Selected facilities shall ensure access to a qualified addiction specialist who is a licensed DATA-waiver practitioner under the federal Comprehensive Addiction and Recovery Act of 2016, Public Law 114-198.

Treatment established under this section shall include behavioral health counseling for individuals diagnosed with substance use disorder, and said counseling services shall be consistent with current therapeutic standards for these therapies in a community setting.

Not later than March 1, 2019, and by March 1 of each subsequent year that the pilot program is in place, selected facilities shall report to the commissioner of correction the

following information: (i) the cost of the pilot program to the facility; (ii) the type and prevalence of medication-assisted treatments provided through the pilot program; (iii) the number of inmates who continued to receive the same medication as they received prior to incarceration; (iv) the number of inmates who voluntarily discontinued medication that they received prior to incarceration; (v) the number of inmates who discontinued the medication that they received prior to incarceration due to a determination by an addiction specialist; (vi) a review of the facility's practices related to medication-assisted treatment prior to inclusion in the pilot program; and (vii) any other information determined necessary by the department of correction, in consultation with the department of public health, related to the administration of the pilot program.

The department of correction, in consultation with the department of public health, shall provide a report of the findings collected from selected facilities to the chairs of the joint committee on mental health, substance use and recovery and the house and senate committees on ways and means not later than December 31 of each year that the pilot program is in place detailing: (i) the cost of the pilot program in the prior year; (ii) the type and prevalence of medication assisted-treatments provided through the pilot program; (iii) a summary of changes to facility practices concerning medication-assisted treatment related to the pilot program; and (iv) the aggregated results of: (A) the number of inmates who continued to receive the same medication as they received prior to incarceration; (B) the number of inmates who voluntarily discontinued the medication that they received prior to incarceration; and (C) the number of inmates who discontinued medication that they received prior to incarceration based on a determination that it was no longer medically necessary.

At the completion of the pilot program, the department of correction and the department of public health shall provide a final report that includes a plan for the initiation and maintenance of medication-assisted treatment programs in all state and county correctional facilities, the types of protocols for technical assistance that may be required by the department of public health the estimated costs to the chairs of the joint committee on mental health, substance use and recovery and the house and senate committees on ways and means not later than April 30 of the following year. The report shall also include (a) rates of relapse after release for individuals who received medication-assisted treatment through the pilot program; (b) rates of recidivism for individuals who received medication-assisted treatment through the pilot program; (c) rates of overdose death for individuals who received medication-assisted treatment through the pilot program; (g) the cost of the pilot program; and (h) the projected cost associated with expanding the pilot program to additional state and county correctional institutions.

SECTION 79. 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 80. Sections 24 through 29, inclusive, 32, 33, and 35 through 37, inclusive, shall take effect on January 1, 2020.

SECTION 81. Sections 75 to 77, inclusive, are hereby repealed.

SECTION 82. Section 81 shall take effect on January 1, 2021.