SENATE . . . . . No. 2623

Senate July 19, 2018, – Text of the Senate amendment to the House Bill for prevention and access to appropriate care and treatment of addiction (House, No. 4742) (being the text of Senate document numbered 2609, printed as amended)

The Commonwealth of Massachusetts

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

SECTION 1. Chapter 6A of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after section 16Z the following section:-

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 not less than 5 days a week to primary care practices, nurse practitioners and other health care providers who are providing care for persons who are over the age of 17 and are experiencing chronic pain; provided, however, that the remote consultations shall include, but not be limited to, support for screening, diagnosis, pain management strategies, pharmacological and non-pharmacological treatments and referrals for chronic pain.

(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 of medical assistance on surcharge payors, as defined in section 64 of chapter 118E.

SECTION 2. Section 15 of chapter 6D of the General Laws, as so appearing, is hereby amended by inserting after the word “abuse”, in line 65, the following words:- ; pain management, including non-opioid and non-pharmaceutical pain management.

SECTION 3. Said section 15 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word “illnesses”, in line 91, the following words:- , including chronic pain,.

SECTION 4. Chapter 10 of the General Laws is hereby amended by inserting after section 35EEE the following section:-

Section 35FFF. (a) There shall be established and set up on the books of the commonwealth a Substance Use Prevention, Education and Screening Trust Fund for the purpose of supporting school-based programs that (i) educate children and young persons on alcohol and substance misuse and (ii) identify and support children and young persons at risk of alcohol or substance misuse and related risky behaviors. The fund shall be administered by the secretary of education, in consultation with the secretary of health and human services and the advisory commission established under subsection (b). The fund shall be used: (i) to provide grants to public elementary, middle and secondary, including vocational schools, schools and to public institutions of higher education to support the expansion of educational and intervention programs meeting the purposes of the fund; and (ii) for the department of public health to support public schools in implementing evidence-based alcohol and substance use prevention programs, early detection protocols and policies, risk assessment tools or counseling in the school setting. Grants from the fund may be made for the implementation of the safe and supportive schools framework specified in subsection (f) of section 1P of chapter 69 or for the purposes specified in sections 96 or 97 of chapter 71. The secretary may use the fund for necessary and reasonable administrative and personnel costs related to administering the grants; provided, however that such expenditures shall not exceed, in any fiscal year, 5 per cent of the total amount present in the fund during that fiscal year.

The fund shall consist of: (i) money appropriated or otherwise authorized by the general court and specifically designated to be credited to the fund and (ii) money from private sources including, but not limited to, grants, gifts and donations received by the commonwealth and 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.

(b) There shall be a Substance Use Prevention, Education, and Screening Trust Fund Advisory Commission who shall be appointed by the secretary of education in consultation with the secretary of health and human services. The advisory commission shall consist of experts in children's behavioral health, adolescent substance use prevention and treatment, public health, school nursing and education. The advisory commission shall develop a set of standards and criteria for programs to meet in order to be eligible for funding under subsection (a); provided, however, that the set of standards and criteria shall include documented evidence of effectiveness as determined by the National Registry of Effective and Promising Practices. The advisory commission shall identify and may recommend to the secretary of education funding for evidence-informed practices and programs that identify and eliminate disparities related to substance use disorders and its effects among different population groups, including youth of color and lesbian, gay, bisexual, transgender, queer and questioning youth.

(c) Annually, not later than December 31, the secretary of education shall report to the house and senate committees on ways and means and the joint committee on mental health, substance use and recovery on: (i) the status of grants awarded under this section, including a list and description of all practices and programs that received grant funds; (ii) the amount of awarded grants; and (iii) a breakdown of the number of youth receiving services through each grant.

SECTION 5. Section 21A of chapter 12C of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the words “mental health”, in line 2, the following words:- , chronic pain.

SECTION 6. Said section 21A of said chapter 12C, as so appearing, is hereby further amended by adding the following sentence:- The program may include, but not be limited to, assisting the division of insurance in its assessment of provider networks and utilization of services for mental health, substance use disorder and pain management under the division’s network adequacy review process established under section 2A of chapter 176O .

SECTION 7. Section 13 of chapter 13 of the General Laws, as so appearing, is hereby amended by striking out, in line 6, the words “9 registered nurses; 4” and inserting in place thereof the following words:- 11 registered nurses; 2.

SECTION 8. 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 clause:-

(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; provided, however, that none of these 3 representatives shall be from the same institution;

SECTION 9. Said subsection (c) of said section 13 of said chapter 13, as so appearing, is hereby further amended by striking out clause (4) and inserting in place thereof the following 4 clauses:-

(4) 2 registered nurses not authorized in advanced nursing practice and who provide direct patient care;

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

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

(7) 1 registered nurse currently providing direct care to patients living with chronic pain.

SECTION 10. 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 11. 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 that: (i) offers to the public inpatient psychiatric, residential or day care services; (ii) is represented as providing treatment of persons with a mental illness; and (iii) meets the department's applicable licensure standards and requirements; provided, however, that the department may issue a license to those facilities, departments or units providing care but not treatment of persons with a mental illness; and provided further, that licensing by the department

shall not be required if 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. The department shall regulate the operation of facilities, departments or units that provide care but not treatment of persons with a mental illness and such facilities and such facilities, departments or units shall be subject to such regulations as the department shall promulgate whether they obtain a license or not. The department may issue a provisional license to a facility, department or unit that has not previously operated, or is operating but is temporarily unable to meet applicable standards and requirements. No original license 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, as described in subsection (c). 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 12. 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 13. 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 or unit licensed by the department shall be subject to supervision, visitation and inspection by 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 that an applicant shall meet to demonstrate the need for an original license. Such standards or criteria shall be reviewed by the department every 2 years and shall consider: (i) the health needs of persons who have a mental illness, including but not limited to persons with a co-occurring substance use disorder and underserved populations, or both; and (ii) 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 14. 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; provided, however, that the department may deny or condition the issuance of an original license if an application does not meet the department's standards or criteria for demonstrating need, as described in subsection (c).

SECTION 15. 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 under 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 upon inspection, or through information in its possession, the department finds 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. The notice shall specify a reasonable time, not more than 60 days after receipt of the notice, by which time the facility, department or unit shall remedy or correct each deficiency cited in the notice; provided, however, 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 that the facility, department or unit submit a written plan for correction of the deficiency in a reasonable manner. The department may modify any written plan for correction, upon notice in writing to the facility, department or unit. Not more than 7 days after the receipt of notice of such a modification of a written plan for correction, the affected facility, department or unit may file a written request with the department for administrative reconsideration of the modified plan for correction or any portion thereof.

Nothing in this section shall be construed to prohibit the department from enforcing a rule, regulation, deficiency notice or plan for correction, 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, deficiency notice or plan for correction jeopardizes the health or safety of patients or the public or seriously limits the capacity of a facility, department or unit to provide adequate care, or where the violation of such rule, regulation, deficiency notice or plan for correction is the second or subsequent such violation occurring during a period of 12 months.

If a facility, department or unit fails to remedy or correct a cited deficiency by the date specified in the written deficiency notice or fails 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 revoke the license of 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 clauses (i) to (iii), inclusive, of this paragraph. A civil fine imposed pursuant to this subsection shall be not more than $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 psychiatric, residential or day care services for the treatment or care of persons with a mental illness, 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, or both.

(g) No patient at a facility, department or unit subject to licensure under this section shall be commercially exploited. No patient shall be photographed, interviewed or exposed to public view without the express written consent of the patient or 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 a 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 16. Subsection (a) of section 2RRRR of chapter 29 of the General Laws, as so appearing, is hereby amended by inserting after the second sentence the following sentence:- A sheriff of a house of correction that contracts with the department of public health may also participate in the program; provided, however, that such participation shall be pursuant to any terms that the department may establish for such a contract.

SECTION 17. 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 18. 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 19. Said chapter 32A is hereby amended by inserting after section 17O the following 2 sections:-

Section 17P. (a) The commission shall develop a plan to provide active or retired employees adequate coverage and access to a broad spectrum of pain management services, including, but not limited to, those that serve as alternatives to opioid prescribing, in accordance with guidelines developed by the division of insurance.

(b) The plan shall be subject to review by the division of insurance. In its review, the division shall consider the adequacy of access to a broad spectrum of pain management services and any carrier policies which may create unduly preferential coverage to prescribing opiates without other pain management modalities.

(c) The commission shall distribute educational materials to providers within their networks about the pain management access plan and make information about its plan publicly available on its website.

Section 17Q. Any coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission 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, a schedule that allows for adjustments and reductions in the cost sharing if a person requests a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C.

SECTION 20. Section 97 of chapter 71 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out, in line 25, the words “, parent or guardian”.

SECTION 21. Section 1 of chapter 94C of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Drug paraphernalia” the following definition:-

“Electronic prescription”, a lawful order from a practitioner registered under section 7 for a drug or device for a specific patient that is: (i) generated on an electronic prescribing system that meets federal requirements for electronic prescriptions for controlled substances; (ii) received by the pharmacy on an electronic system that meets federal requirements for electronic prescriptions for controlled substances; and (iii) is transmitted electronically to a pharmacy designated by the patient without alteration of the prescription information; provided, however, that a third-party intermediary may act as a conduit to route the prescription from the practitioner to the pharmacist; provided further, that “electronic prescription” shall not include: (i) an order for medication which is dispensed for immediate administration to the ultimate user; or (ii) a prescription generated on an electronic system that is printed out or transmitted via facsimile.

SECTION 22. 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 23. 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 24. 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 related regulations.

SECTION 25. 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 26. 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 shall 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 27. Section 18B of said chapter 94C, as so appearing, is hereby amended by striking out, in lines 15 and 16, the words “and in the prescription drug monitoring program established in section 24A”.

SECTION 28. Said chapter 94C is hereby further amended by striking out section 19B, as so appearing, and inserting in place thereof the following 2 sections:-

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 federal 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 who is designated by the commissioner and is registered under 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 who dispenses an opioid antagonist shall annually report to the department the number of times the pharmacist dispensed 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 who dispenses 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 opioid antagonist regardless of the ultimate user of the opioid antagonist. 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 a physician who issues the statewide standing order under subsection (a) 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 established under section 34A shall also 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 19B½. Notwithstanding any special or general law to the contrary, a municipality or non-municipal public agency that is duly registered pursuant to subsection (g) of section 7 may

convey or exchange Naloxone or another opioid antagonist approved by the department of public health to or with another duly registered entity to ensure the availability and use of unexpired Naloxone or other approved opioid antagonist; provided, however, that such an exchange shall be recorded in a memorandum between the registered entities in a manner prescribed by the department.

SECTION 29. 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 registered under section 7 prescribes a controlled substance by oral prescription, such individual shall, within a period of not more than 7 days or such shorter period if required by federal law, cause an electronic or written prescription for the prescribed controlled substance to be delivered to the dispensing pharmacy; provided, however, that the written prescription may be delivered to the pharmacy in person or by mail, but shall be postmarked within a period of not more than 7 days or such shorter period if required by federal law.

SECTION 30. Section 21 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “written”, in line 1, the following word:-, electronic.

SECTION 31. Said section 21 of said chapter 94C, as so appearing, is hereby further amended by inserting after the word “oral”, in line 28, the following word:-, electronic.

SECTION 32. 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 33. Said section 22 of said chapter 94C, 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 following words:- full prescribed quantity.

SECTION 34. 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 35. 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 36. 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 include, but shall not be limited to: (i) prescriptions issued by veterinarians; (ii) prescriptions issued or dispensed in circumstances where electronic prescribing is not available

due to temporary technological or electrical failure; (iii) 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 circumstance; and (iv) instances where it would be impractical for the patient to obtain controlled substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the patient's medical condition.

(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 prescribing practitioner.

SECTION 37. Section 24A of said chapter 94C, as so appearing, is hereby amended by striking out clause (4) of subsection (f) and inserting in place thereof the following clause:-

(4) local, state and federal law enforcement or prosecutorial officials working with the executive office of public safety engaged in the administration, investigation or enforcement of the laws governing prescription drugs; provided, however, that the data request is in connection with a bona fide specific controlled substance or additional drug-related investigation and accompanied by a probable cause warrant issued pursuant to chapter 276;

SECTION 38. Said section 24A of said chapter 94C, as so appearing, is hereby further amended by striking out clause (6) of subsection (f) and inserting in place thereof the following clause:-

(6) personnel of the United States attorney, office of the attorney general or a district attorney; provided, however, that the data request is in connection with a bona fide specific

controlled substance or additional drug related investigation and accompanied by a probable cause warrant issued pursuant to chapter 276.

SECTION 39. 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 system that enables automated query and retrieval of prescription monitoring program data to a practitioner. This data may be used only for the purpose of diagnosis, treatment and coordinating care of the practitioners' patients, 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. The department may enter into data use agreements to allow summary prescription monitoring program data to be securely retained in the patient's medical record as a clinical note associated with a clinical encounter; provided, however, that prescription monitoring program data shall not be retained separately from said clinical note; and provided further, that no such agreement shall allow for prescription monitoring program data to be used for purposes inconsistent with this section.

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,

for purposes of diagnosis, treatment and coordinating care of the practitioner's patient. 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. Section 34A of said chapter 94C, as so appearing, is hereby amended by adding the following subsection:-

(f) A person acting in good faith may provide, administer or utilize a narcotic testing product to assist another person in determining whether a narcotic or substance contains chemicals, toxic substances or hazardous compounds. A person who, in good faith, provides, administers or utilizes a narcotic testing product to assist another person in determining whether a narcotic or substance contains chemicals, toxic substances or hazardous compounds shall not be charged or prosecuted for possession of a controlled substance under sections 34 or 35 if the evidence for the charge of possession of a controlled substance was gained as a result of providing, administering or utilizing a narcotic testing product to provide assistance to another person. Narcotic testing products shall include, but not be limited to, fentanyl test strips.

SECTION 42. Section 3 of chapter 94H of the General Laws, as so appearing, is hereby amended by striking out, in lines 15 to 18, inclusive, the words "(D) in-home disposal methods that render a product safe from misuse and that comply with applicable controlled substance regulations and environmental safety regulations; or (E)" and inserting in place thereof the following words:- or (D).

SECTION 43. Section 4 of said chapter 94H, as so appearing, is hereby amended by striking out, in line 20, the word "may" and inserting in place thereof the following word:- shall.

SECTION 44. Said chapter 94H is hereby amended by adding the following section:-

Section 7. Annually, not later than April 1, the department shall file a report with the clerks of the senate and the house of representatives and the chairs of the joint committee on mental health, substance use and recovery regarding the status of the drug stewardship program, including, but not limited to information regarding: (i) the regulations established under chapter 94H; (ii) any new applications for drug stewardship programs; (iii) the status of existing drug stewardship programs operating in the commonwealth; and (iv) a list of noncompliance notices issued pursuant to section 4, including the reason for the noncompliance notice, the recipient of the noncompliance notice and any subsequent department action taken to address noncompliance.

SECTION 45. Chapter 111 of the General Laws is hereby amended by inserting after section 25J the following section:-

Section 25J½. An 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 its 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 including, but not limited to, 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, however, that such treatment shall occur when it is recommended by the treating healthcare provider and is voluntarily agreed to by the patient. An acute care hospital that provides emergency services in an emergency department, and every 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. Prior to discharge, any patient who is administered or prescribed an opioid agonist treatment in an acute care hospital emergency department or satellite emergency facility shall be directly connected to an appropriate provider or treatment site to voluntarily continue said treatment.

SECTION 46. Said chapter 111, as appearing in the 2016 Official Edition, is hereby further amended by inserting after section 25N¾ the following section:-

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

"Human services worker", an individual who provides services that support an individual's and family's efforts to function in daily living situations, including such settings including but not limited to group homes; institutional or residential settings; correctional facilities; community health centers; family, child and youth service agencies; and programs that help individuals affected by alcohol or substance use disorder, 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 at an institution of higher education as accepted by the department related to the work of a human services worker by an applicant; provided, however, that "qualified education loan indebtedness" shall not include a loan made by an 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 into and continue in such

professional positions. 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; (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; and (iv) has qualified education loan indebtedness.

(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 47. Subsection (a) of 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”, (i) a licensed physician who specializes in the practice of psychiatry or addiction medicine; (ii) a licensed psychologist; (iii) a licensed independent clinical social worker; (iv) a licensed certified social worker; (v) a licensed mental

health counselor; (vi) a licensed psychiatric clinical nurse specialist; (vii) a certified addictions registered nurse; (viii) a licensed alcohol and drug counselor I as defined in section 1 of chapter 111J; (ix) a healthcare provider defined in section 1 of chapter 111 whose scope of practice allows such evaluations pursuant to medical staff policies and practice; or (x) another professional authorized by the department through regulation.

SECTION 48. Said section 51½ of said chapter 111, as so appearing, is hereby further 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 49. 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 staff member who is a licensed mental health professional.

SECTION 50. Said section 51½ of said chapter 111, as so appearing, is hereby further amended by striking out, in lines 33, 79, 82 and 84 and 85, the word “opiate-related” and inserting in place thereof the following word:- “opioid-related.”

SECTION 51. 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) During or after a substance use disorder evaluation conducted pursuant to subsection (b), treatment may occur within the acute care hospital or satellite emergency facility, if available, that may include induction to medication assisted treatment. If the acute care hospital or satellite emergency facility is unable to provide such services, the acute care hospital or satellite emergency facility shall refer the patient to an appropriate and available hospital or treatment provider; provided, however, that nothing in this section shall relieve an acute care hospital or satellite

emergency facility from the requirements of section 25J½. 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 acute care hospital or satellite emergency facility may initiate discharge proceedings; provided, however, that if the patient is in need of and agrees to further treatment following discharge pursuant to the substance use disorder evaluation, then the acute care hospital or satellite emergency facility 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.

SECTION 52. 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 opioid-related overdose, the acute-care hospital, satellite emergency facility or emergency service program shall record the opioid-related overdose and substance use disorder evaluation in the patient's electronic medical record and shall make the evaluation 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 system for the purposes of: (i) improving the ease of access and utilization of such data for treatment or diagnosis; (ii) supporting the 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 in a manner that supports treatment or diagnosis.

SECTION 53. Subsection (i) of section 51½ of said chapter 111, as so appearing, is hereby repealed.

SECTION 54. 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 55. Said section 1 of said chapter 111E is hereby amended by inserting after the definition of "Independent addiction specialist", inserted by 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 56. 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, the word "division" and inserting in place thereof, in each instance, the following word:- department.

SECTION 57. 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 58. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out the fourth and fifth sentences and inserting in place thereof the following 2 sentences:- The commissioner shall promulgate rules and regulations establishing licensure and approval standards and requirements which shall include, but not be limited to: (i) the health

standards to be met by a facility; (ii) misrepresentations regarding the treatment that would be provided to patients at a facility; (iii) licensing fees; (iv) procedures for making and approving license applications; (v) services and treatment provided by programs at a facility; (vi) certification of capability of self-preservation; (vii) a requirement that the facility provide services to commonwealth residents with public health insurance on a non-discriminatory basis; and (viii) the standards or criteria that 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 consider the health needs of persons who have a substance use disorder with a co-occurring mental illness, including underserved populations, and the demonstrated ability and history of a prospective licensee to meet the needs of such persons. Each facility shall file with the division such data, statistics, schedules or information as the division may require.

SECTION 59. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by inserting after the number "10", in line 43, the following words:- ; provided, however, that the department may, in its discretion, deny or condition the issuance of an original license if an application does not meet the department's standards or criteria for demonstrating the need for an original license.

SECTION 60. 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 61. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out the fifth through seventh paragraphs, inclusive, and inserting in place thereof the following 7 paragraphs:-

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.

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 deficiency by providing the facility written notice of each deficiency. The notice shall specify a reasonable time, but not more than 60 days after receipt of the notice, by which time the facility shall remedy or correct each deficiency cited in the notice; provided, however, 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 that the facility submit a written plan for correction of the deficiency in a reasonable manner. The department may modify a written plan for correction upon written notice to the facility. Within 7 days of receipt of such notice of modification of a written plan for correction, the affected facility may file a written request with the department for administrative reconsideration of the modified plan for correction or any portion thereof.

Nothing in this section shall be construed to prohibit the department from enforcing a rule, regulation, deficiency notice or plan for correction, 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,

deficiency notice or plan for correction jeopardizes the health or safety of patients or the public or seriously limits the capacity of a facility to provide adequate care, or where the violation of such rule, regulation, deficiency notice or plan for correction is the second or subsequent such violation occurring during a period of 12 months.

Upon a failure to remedy or correct a cited deficiency by the date specified in the written 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 revoke the facility's 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) to (iii), inclusive, of this paragraph. A civil fine imposed pursuant to this section shall not exceed $1,000 per deficiency for each day the deficiency continues to exist beyond the date prescribed for correction.

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 the department's 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.

A 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.

No patient at a facility subject to licensure under this section shall be commercially exploited. No patient shall be photographed, interviewed or exposed to public view without the express written consent of the patient or the patient's legal guardian.

SECTION 62. Section 10H of chapter 118E of the General Laws, as inserted by section 19 of chapter 258 of the acts of 2014, is hereby amended by striking out, in line 55, as appearing in the 2016 Official Edition, the word "abuse" and inserting in place thereof the following words:- use disorder.

SECTION 63. Section 35 of chapter 123 of the General Laws is hereby amended by inserting after the word "guardian", in line 18, as so appearing, the following words:- , medical professional as defined by the department in regulation.

SECTION 64. Said section 35 of said chapter 123 is hereby further amended by inserting after the word "harm" in line 59, as so appearing, the following words:- ; provided, however, that the superintendent has provided notification to the committing court and the petitioner.

SECTION 65. Said Section 35 of said chapter 123 is hereby further amended by inserting after the word "court", in line 67, as so appearing, the following words:- and the petitioner.

SECTION 66. Said section 35 of said chapter 123 is hereby further amended by inserting after the third paragraph, as so appearing, the following paragraph:-

When the court is closed for business, upon filing of a petition by a person authorized to do so under the second paragraph, a justice of the court may order a person to be committed to a

facility designated by the department of public health if the court finds that the person is an individual with a substance use disorder and finds that there is a grave likelihood of serious harm as a result of the person's substance use disorder; provided, however, that at the next available opportunity, or at the next business day, whichever is sooner, the person shall receive a hearing in accordance with the preceding paragraph; and provided further, that an order issued pursuant to this paragraph shall expire not more than 72 hours after the issuance of the order, at which point the person committed shall be immediately released from commitment or transported to the court for a hearing. The court may adopt rules and procedures to implement this paragraph.

SECTION 67. Said section 35 of said chapter 123 is hereby further amended by inserting after the seventh paragraph, as so appearing, the following paragraph:-

A facility used for commitment under this section for a person found to be a person with a substance use disorder 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 opioid agonist treatment and opioid antagonist treatment for addiction and shall make such treatment available to any person for whom such treatment is medically appropriate.

SECTION 68. Section 1 of chapter 127 of the General Laws, as so appearing, is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following 2 definitions:-

“Behavioral health counseling”, a non-pharmacological intervention carried out by a qualified behavioral health professional in a therapeutic context at an individual, family or group level; provided, however, that such an intervention may include a structured, professionally

administered intervention delivered in person or an intervention delivered remotely via telemedicine.

"Commissioner", the commissioner of correction.

SECTION 69. Said section 1 of said chapter 127 is hereby further amended by inserting after the definition of "Placement review", inserted by section 86 of chapter 69 of the acts of 2018, the following definition:-

"Qualified addiction specialist", a treatment provider who is: (i) a physician licensed by the board of registration of medicine, a licensed advanced practice registered nurse or a licensed physician assistant; and (ii) a licensed a qualifying practitioner or qualifying other practitioner, as defined in section 303(g) of the federal Controlled Substances Act, 21 U.S.C. 823(g), who has been issued an identification number by the United States Drug Enforcement Administration pursuant to section 303(g)(2)(D)(ii) or (iii) of said federal Controlled Substances Act, 21 U.S.C. 823(g)(2)(D)(ii) or (iii).

SECTION 70. Section 16 of said chapter 127 is hereby amended by inserting after the word "more", in line 6, as appearing in the 2016 Official Edition, the following words:- ; provided, however, that if an inmate is diagnosed with substance use disorder, the report of such examination shall include a determination of whether or not opioid agonist treatment for opioid use disorder is appropriate for the inmate; provided further, that this requirement may be satisfied by relying on the report of an examination made pursuant to section 10 of chapter 111E if the report includes a determination of whether or not opioid agonist treatment for opioid use disorder is appropriate for the inmate.

SECTION 71. Said chapter 127 is hereby further amended by inserting after section 17A the following 4 sections:-

Section 17B. Each county correctional facility 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 opioid agonist treatment and opioid antagonist treatment for addiction; provided, however, that a facility shall not be required to maintain or provide an opioid agonist treatment or opioid antagonist treatment that is not also included as a MassHealth covered benefit.

If a person in the custody of a county correctional facility, in any status, was receiving opioid agonist treatment or opioid antagonist treatment for opioid addiction through any legally authorized medical program or by a valid prescription immediately preceding incarceration, the treatment shall not be involuntarily changed or discontinued except upon a determination by a qualified addiction specialist that the treatment is no longer appropriate. The qualified addiction specialist who makes a determination to change or discontinue treatment shall provide the reason for the change or discontinuance in the person's medical record. The person shall be provided, both orally and in writing, with a specific explanation of the decision to change or discontinue the treatment and with notice of the right to have the person's community-based prescriber notified of the decision. If the person provides signed authorization, the superintendent or sheriff shall notify the community-based prescriber in writing of the decision to change or discontinue the treatment.

Treatment established under this section shall be subject to section 7 of chapter 111E and facilities shall report not less than biannually to the commissioner of public health in a manner to be determined by the commissioner of public health for the evaluation of such treatment.

A county correctional facility shall also make treatment under this section available not less than 30 days prior to release to any person in the custody of a county correctional facility for whom such treatment is determined to be medically appropriate by a qualified addiction specialist. Treatment established under this section shall include behavioral health counseling for individuals diagnosed with substance use disorder and such counseling services shall be consistent with current therapeutic standards for these therapies in a community setting.

Section 17C. The commissioner, in consultation with the commissioner of public health, shall provide medication-assisted treatment for opioid use disorder to a detainee or prisoner at the Massachusetts Alcohol and Substance Abuse Center, the Massachusetts Correctional Institution at Framingham or South Middlesex Correctional Center, upon the recommendation of a qualified addiction specialist. The medication-assisted treatment program shall not be required to be administered in any other state correctional facility; provided, however, that for the first 90 days during which a prisoner is serving a sentence to the state prison, the commissioner shall provide medication-assisted treatment for such prisoner at the Massachusetts Correctional Institution at Cedar Junction upon the recommendation of a qualified addiction specialist.

Such 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 opioid use disorder; provided however, that such facilities shall not be required to maintain or provide a drug that is not is not a MassHealth covered benefit.

Such facilities shall ensure that each detainee or prisoner who is receiving medication-assisted treatment for opioid use disorder continues the treatment unless such person voluntarily

discontinues the treatment or unless a qualified addiction specialist determines that treatment is no longer medically necessary.

Such facilities shall ensure access to a qualified addiction specialist by a detainee or prisoner.

Treatment established under this section shall include, but not be limited to, behavioral health counseling for individuals diagnosed with opioid use disorder; provided, however, that counseling services shall be consistent with current therapeutic standards for these therapies in a community setting.

Section 17D. The commissioner shall ensure that, not later than 120 days prior to the expected discharge date of a prisoner serving a sentence to the state prison, a prisoner shall have access to a qualified addiction specialist who shall conduct an assessment of the prisoner. Upon a determination by the qualified addiction specialist that the prisoner requires treatment for opioid use disorder, the qualified addiction specialist shall establish a medically appropriate treatment plan for the prisoner, which may include, but shall not be limited to, medication-assisted treatment during the final 90 days of incarceration. A treatment plan may include any treatment upon discharge that the qualified addiction specialist shall recommend and deem appropriate, which may include, but shall not be limited to, all drugs approved by the federal Food and Drug Administration for use in medication-assisted treatment for opioid use disorder; provided, however, that the treatment plan shall not be required to include a drug that is not a MassHealth covered benefit.

The treatment plant shall be forwarded to the parole board and shall be incorporated into any treatment plan included within the terms and conditions of parole.

Section 17E. Not later than February 1, each state and county correctional facility shall report to the commissioner and the commissioner of public health the following information for the prior calendar year: (i) the cost to the facility of providing opioid agonist treatment and opioid antagonist treatment for addiction; (ii) the type and prevalence of opioid agonist treatment and opioid antagonist treatment for addiction provided; (iii) the number of persons in the custody of the facility, in any status, who continued to receive the same opioid agonist treatment or opioid antagonist treatment for addiction as they received prior to incarceration; (iv) the number of persons in the custody of the facility, in any status, who voluntarily changed or discontinued the opioid agonist treatment or opioid antagonist treatment for addiction that they received prior to incarceration; (v) the number of persons in the custody of the facility, in any status, who changed or discontinued opioid agonist treatment and opioid antagonist treatment for addiction that they received prior to incarceration due to a determination by a physician or addiction specialist; (vi) the number of persons in the custody of the facility, in any status, who received opioid agonist treatment or opioid antagonist treatment for addiction not less than 30 days prior to release; (vii) the number of persons in the custody of the facility, in any status, who received opioid agonist treatment or opioid antagonist treatment for addiction who did not receive such treatment prior to incarceration; and (viii) any other information requested by the commissioner related to the provision of opioid agonist treatment and opioid antagonist treatment for addiction.

Annually, not later than March 1, the department of correction, in consultation with the department of public health, shall submit a report on the findings collected from facilities under this section to the joint committee on mental health, substance use and recovery and the house and senate committees on ways and means.

The report shall include, but not be limited to: (a) the cost of providing opioid agonist treatment and opioid antagonist treatment for addiction for all persons in the custody of state and correctional facilities, regardless of status; (b) the type and prevalence of opioid agonist treatment and opioid antagonist treatment for addiction provided at state and correctional facilities in the commonwealth; (c) a summary of facility practices and any changes to those practices related to opioid agonist treatment or opioid antagonist treatment for addiction; and (d) the aggregated results of the information collected pursuant to clauses (iii) to (vii), inclusive, of the first paragraph.

SECTION 72. 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 73. 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 74. Said chapter 175 is hereby further amended by inserting after section 47II the following 2 sections:-

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, a schedule that allows for adjustments and reductions in the cost sharing if a person requests a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C.

Section 47KK. (a) 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 develop a plan to provide adequate coverage and access to a broad spectrum of pain management services, including, but not limited to, those that serve as alternatives to opioid prescribing, in accordance with guidelines developed by the division of insurance.

(b) The plan shall be subject to approval and shall be a component of carrier accreditation by the division of insurance pursuant to section 2 of chapter 176O. In its review, the division shall consider the adequacy of access to a broad spectrum of pain management services and any carrier policies that may create unduly preferential coverage to prescribing opiates, as defined in section 1 of chapter 94C, without other pain management modalities.

(c) Carriers shall distribute educational materials to providers within their networks about the pain management access plan and make information about its plan publicly available on its website.

SECTION 75. Section 3 of chapter 175H of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the word “Administration”, in line 38, the following words:- or for any prescription drug that is an opiate, as defined in section 1 of chapter 94C, placed by the commissioner of public health on schedule II pursuant to subsection (a) of section 2 of said chapter 94C.

SECTION 76. Section 8HH of chapter 176A 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 77. 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 78. Said chapter 176A is hereby amended by inserting after section 8KK the following 2 sections:-

Section 8LL. Any contract between a subscriber and the corporation under an individual or group hospital service plan that 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, a schedule that allows for adjustments and reductions in the cost sharing if a person requests a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C.

Section 8MM. (a) Any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall develop a plan to provide adequate coverage and access to a broad spectrum of pain management services, including, but not limited to, those that serve as alternatives to opioid prescribing, in accordance with guidelines developed by the division of insurance.

(b) The plan shall be subject to approval and shall be a component of carrier accreditation by the division of insurance pursuant to section 2 of chapter 176O. In its review, the division shall consider the adequacy of access to a broad spectrum of pain management services and any carrier policies that may create unduly preferential coverage to prescribing opiates, as defined in section 1 of chapter 94C, without other pain management modalities.

(c) Carriers shall distribute educational materials to providers within their networks about the pain management access plan and make information about its plan publicly available on its website.

SECTION 79. 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 80. 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 81. Said chapter 176B is hereby amended by inserting after section 4KK the following 2 sections:-

Section 4LL. Any subscription certificate under an individual or group medical service agreement that 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, a schedule that allows for adjustments and reductions in the cost sharing if a person requests a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C.

Section 4MM. (a) Any subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall develop a plan to provide adequate coverage and access to a broad spectrum of pain management services, including, but not limited to, those that serve as alternatives to opioid prescribing, in accordance with guidelines developed by the division of insurance.

(b) The plan shall be subject to approval and shall be a component of carrier accreditation by the division of insurance pursuant to section 2 of chapter 176O. In its review, the division shall consider the adequacy of access to a broad spectrum of pain management services and any carrier policies that may create unduly preferential coverage to prescribing opiates, as defined in section 1 of chapter 94C, without other pain management modalities.

(c) Carriers shall distribute educational materials to providers within their networks about the pain management access plan and make information about its plan publicly available on its website.

SECTION 82. 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 83. 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 84. Said chapter 176G is hereby amended by inserting after section 4CC the following 2 sections:-

Section 4DD. Any 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, a schedule that allows for adjustments and reductions in the cost sharing if a person requests a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C.

Section 4EE. (a) Any individual or group health maintenance contract that is issued or renewed shall develop a plan to provide adequate coverage and access to a broad spectrum of pain management services, including, but not limited to, those that serve as alternatives to opioid prescribing, in accordance with guidelines developed by the division of insurance.

(b) The plan shall be subject to approval and shall be a component of carrier accreditation by the division of insurance pursuant to section 2 of chapter 176O. In its review, the division shall consider the adequacy of access to a broad spectrum of pain management services and any carrier policies that may create unduly preferential coverage to prescribing opiates, as defined in section 1 of chapter 94C, without other pain management modalities.

(c) Carriers shall distribute educational materials to providers within their networks about the pain management access plan and make information about its plan publicly available on its website.

SECTION 85. Subsection (a) of section 2 of chapter 176O of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out clauses (4) and (5) and inserting in place thereof the following 3 clauses:-

(4) preventive health services;

(5) access to pain management services, including non-opioid and non-pharmaceutical service options; and

(6) compliance with sections 2 to 12, inclusive.

SECTION 86. Said section 2 of said chapter 176O, as so appearing, is hereby further amended by striking out, in line 24, the words “of health care finance and policy” and inserting in place thereof the following words:- for health information and analysis.

SECTION 87. Subsection (b) of said section 2 of said chapter 176O, as so appearing, is hereby amended by adding the following paragraph:-

For the purposes of accreditation review in the area of pain management, the division shall consult with the health policy commission, established under chapter 6D, for assistance in determining appropriate standards for evidence-based pain management, including non-opioid pain management products and services, and shall publish guidelines to assist and evaluate carriers’ development and submission of pain management access plans as required under clause (5) of subsection (a).

SECTION 88. Said chapter 176O is hereby amended by inserting after section 2 the following section:-

Section 2A. The division may require the submission of plan provider network documents by carriers to assess network adequacy of provider networks and utilization of services for mental health, substance use disorder and pain management based on standards and procedures established by the division and may be in consultation with the center for health information and analysis. The division may share documents received under this section pursuant to an interagency agreement with the center. The center may compare the documents to actual claims paid by the carrier to assist the division in determining whether a carrier’s provider network documents accurately reflect actual service access and utilization by the carrier’s covered members.

SECTION 89. Section 55 of chapter 52 of the acts of 2016 is hereby repealed.

SECTION 90. Section 77 of said chapter 52 is hereby repealed.

SECTION 91. Notwithstanding any general or special law to the contrary, the secretary of health and human services shall convene an advisory board to advise the secretary on the implementation of the program established in section 16AA of chapter 6A of the General Laws. The advisory board shall consist of: the secretary of health and human services or a designee, who shall serve as chair; and 10 persons who shall be appointed by the secretary, 1 of whom shall have substantial knowledge of or experience with the Massachusetts Child Psychiatry Access Program, established in section 16A of chapter 19 of the General Laws, 2 of whom shall be representatives from the Massachusetts Pain Initiative, 1 of whom shall be a representative from the Massachusetts Medical Society, 1 of whom shall be a representative of the Massachusetts Associations of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross Blue Shield of Massachusetts, Inc., 1 of whom shall be a patient living with chronic pain, 1 of whom shall be a pain management doctor specializing in the care of people living with chronic pain, 1 of whom shall be a primary care physician with experience treating patients with chronic pain and 1 of whom shall be an integrative care physician with expertise in treating patients with chronic pain with a combination of traditional and complementary therapies.

The advisory board shall study and make recommendations on: (i) how to most effectively adapt the Massachusetts Child Psychiatry Access Program model for chronic pain remote consultation services; (ii) program design and structure, including whether to use regionally based teams; (iii) whether to conduct a needs assessment of key stakeholders; (iv) outreach methods to educate and engage providers, chronic pain patients and health insurance carriers; (v) program metrics to gauge program usage and efficacy in expanding access to appropriate pain management; and (vi) estimated program costs. The advisory board shall submit its recommendations to the

clerks of the house of representatives and senate, the joint committee on mental health substance use and recovery and the senate and house committees on ways and means not later than 6 months after the effective date of this act.

SECTION 92. Notwithstanding any general or special law to the contrary, not later than January 1, 2019, and annually thereafter for the next 5 years, the center for health information and analysis shall submit to the department of public health, the joint committee on mental health, substance use and recovery, the joint committee on public health, the joint committee on health care financing and the house and senate committees on ways and means a report regarding the frequency and location of substance use disorder evaluations ordered pursuant to section 51½ of chapter 111 of the General Laws utilizing the center for health information and analysis' merged case-mix discharge database.

SECTION 93. There shall be a commission to review and make recommendations regarding the feasibility of operating harm reduction sites in which: (i) a person with a substance use disorder may consume pre-obtained controlled substances; (ii) medical assistance by health care professionals is made immediately available to a person with a substance use disorder as necessary to prevent fatal overdose; and (iii) counseling, referrals to treatment and other appropriate services are available on a voluntary basis.

The commission shall consist of: the secretary of health and human services or a designee, who shall serve as chair; the commissioner of public health; the house and senate chairs of the joint committee on mental health, substance use and recovery or their designees, the mayor of the city of Boston or a designee; the mayor of the city of Cambridge or a designee; a representative from the Massachusetts Medical Society; a representative from the Massachusetts Health and

Hospital Association, Inc.; and 7 members appointed by the secretary, 2 of whom shall be persons with a substance use disorder, 1 of whom shall be a clinician with experience providing direct care to individuals with a co-occurring mental health and substance use disorder, 1 of whom shall be a person working in an established harm reduction program providing direct support to persons with substance use disorders, 1 of whom shall be a representative of the Massachusetts Chiefs of Police Association Incorporated, 1 of whom shall have expertise in relevant state and federal law and regulation and 1 of whom shall be a representative of local municipal boards of health. In making appointments, the secretary shall, to the maximum extent feasible, ensure that the commission represents a broad distribution of diverse perspectives and geographic regions.

As part of its review, the commission shall consider: (i) the potential public health and public safety benefits and risks; (ii) the potential federal, state and local legal issues involved with establishing harm reduction sites; (iii) appropriate guidance that would be necessary and required for professional licensure boards and any necessary changes to the regulations of such boards; (iv) existing harm reduction efforts in the commonwealth and whether there is potential for collaboration with existing public health harm reduction organizations; (v) opportunities to maximize public health benefits, including educating persons utilizing the sites of the risks of contracting HIV and viral hepatitis and proper disposal of hypodermic needles and syringes; (vi) ways to support persons utilizing the sites who express an interest in seeking substance use disorder treatment, including providing information on evidence-based treatment options and direct referral to treatment providers; and (vii) other matters deemed appropriate by the commission. In developing its report, the commission shall review the experiences and results of other states and countries that have established supervised drug consumption sites and report on the impact of those harm reduction sites.

The commission shall submit its findings and recommendations to the clerks of the senate and the house of representatives, the joint committee on mental health, substance use and recovery, the joint committee on public health, the joint committee on the judiciary and the senate and house committees on ways and means not later than February 1, 2019. The secretary shall also make the report publicly available on the executive office of health and human services' website.

SECTION 94. There shall be a commission to review and make recommendations regarding the standards for credentialing a recovery coach, including whether recovery coaches should be subject to a board of registration through the department of public health.

The commission shall consist of: the secretary of health and human services or a designee, who shall serve as chair; the commissioner of public health or a designee; the director of Medicaid or a designee; and 8 persons who shall be appointed by the secretary of health and human services, 1 of whom shall have expertise in training recovery coaches, 1 of whom shall be a community provider who employs recovery coaches, 1 of whom shall represent a hospital who employs recovery coaches, 1 of whom shall be a family member to an individual with a substance use disorder, 1 of whom shall have lived experience with addiction, 1 of whom shall represent payers, 1 of whom shall currently be employed as a recovery coach and 1 of whom shall be a psychiatrist specializing in addiction.

The commission shall submit its findings and recommendations, together with drafts of legislation, in any, necessary to carry those recommendations into effect, with the clerks of the senate and the house of representatives and the joint committee on mental health, substance use and recovery not later than 1 year from the effective date of this act.

SECTION 95. There shall be a commission to review and make recommendations regarding the standards that should apply when credentialing a peer specialist or peer specialist program, including whether peer specialists should be required to register with a board.

The commission shall consist of: the secretary of health and human services or a designee, who shall serve as chair; the commissioner of mental health or a designee; the director of Medicaid or a designee; a representative from the Association for Behavioral Healthcare, Inc.; and 5 persons who shall be appointed by the secretary, 1 of whom shall have expertise in training peer specialists, 1 of whom shall be a family member to an individual with a mental illness, 1 of whom shall have lived experience with a mental illness, 1 of whom shall represent payers and 1 of whom shall currently be employed as a peer specialist.

The commission shall submit its findings and recommendations, together with drafts of legislation necessary to carry those recommendations into effect, to the clerks of the senate and the house of representatives and the joint committee on mental health, substance use and recovery not later than 1 year after the effective date of this act.

SECTION 96. There shall be a commission to review evidence based treatment for individuals with a substance use disorder, mental illness or co-occurring substance use disorder and mental illness. The commission shall recommend a taxonomy of licensed behavioral health clinician specialties. Notwithstanding any general or special law to the contrary, the taxonomy of licensed behavioral health clinician specialties may be used by insurance carriers to develop a provider network. The commission shall recommend a process that may be used by carriers to validate a licensed behavioral health clinician’s specialty.

The commission shall be comprised of: the secretary of health and human services or a designee, who shall serve as chair; the commissioner of insurance or a designee; the executive director of the group insurance commission or a designee; and 8 persons who shall be appointed by the secretary of health and human services, 1 of whom shall have expertise in the treatment of individuals with a substance use disorder, 1 of whom shall have expertise in the treatment of adults with a mental illness, 1 of whom shall have expertise in children's behavioral health, 1 of whom shall be an emergency medicine expert with expertise in the treatment of addiction, 1 of whom shall be a hospital medicine expert with expertise in the treatment of addiction, 1 of whom shall represent payers, 1 of whom shall be a licensed behavioral health clinician and 1 of whom shall be a family member to an individual with a substance use disorder or mental illness. The secretary may appoint additional members who have expertise that will aid the commission in producing its recommendations.

The commission shall file a report of its findings and recommendations, together with drafts of legislation necessary to carry those recommendations into effect, with the clerks of the senate and the house of representatives 180 days after the effective date of this act.

SECTION 97. The executive office of health and human services, in coordination with the trial court of the commonwealth, shall convene an advisory committee of healthcare providers and provider associations that shall evaluate and develop a consistent statewide standard for the medical review of individuals who are involuntarily committed due to an alcohol or substance use disorder pursuant to section 35 of chapter 123 of the General Laws, including, but not limited to, developing: (i) a standardized form and criteria for releasing medical information for use in a commitment hearing under said section 35 of said chapter 123 that is in compliance with federal

and state privacy requirements; and (ii) criteria and guidance to medical staff about filing a petition under said section 35 of said chapter 123.

SECTION 98. For the purposes of this section, the following terms shall have the following meanings unless the context clearly requires otherwise:

"Mental health acute treatment", 24-hour medically supervised mental health services provided in an inpatient facility, licensed by the department of mental health, that provides psychiatric evaluation, management, treatment and discharge planning in a structured treatment milieu.

"Mental health crisis stabilization services", 24-hour clinically managed mental health diversionary or step-down services for adults or adolescents, as defined by MassHealth, usually provided as an alternative to mental health acute treatment or following mental health acute treatment, which may include intensive crisis stabilization counseling, outreach to families and significant others and aftercare planning.

"Community-based acute treatment (CBAT)", 24-hour clinically managed mental health diversionary or step-down services for children and adolescents, as defined by the department of early education and care, usually provided as an alternative to mental health acute treatment.

"Intensive community-based acute treatment (ICBAT)", intensive 24-hour clinically managed mental health diversionary or step-down services for children and adolescents, as defined by the department of early education and care, usually provided as an alternative to mental health acute treatment.

Notwithstanding any general or special law to the contrary, the center for health information and analysis shall conduct a review of a mandated health benefit proposal to require coverage for: (i) medically necessary mental health acute treatment that does not require preauthorization prior to obtaining treatment and medical necessity shall be determined by the treating clinician in consultation with the patient and noted in the patient's medical record; (ii) medically necessary mental health crisis stabilization services for not more than 14 days that does not require preauthorization prior to obtaining such services; provided, however, that a facility shall provide the carrier both notification of admission and the initial treatment plan within 48 hours of admission, utilization review procedures may be initiated on day 7 and medical necessity shall be determined by the treating clinician in consultation with the patient and noted in the patient's medical record; and (iii) medically necessary intensive community based acute treatment services for not more than 14 days; provided, however, that a facility shall provide the carrier both notification of admission and the initial treatment plan within 48 hours of admission, utilization review procedures may be initiated on day 7 and medical necessity shall be determined by the treating clinician in consultation with the patient and noted in the patient's medical record.

The review shall be performed by the center consistent with section 38C of chapter 3 of the General Laws. The center shall evaluate the impact of such a mandate as a requirement for all of the health plans and policies under subsection (a) of said section 38C of said chapter 3. The center shall file its review with the clerks of the senate and house of representatives, the joint committee on mental health, substance use and recovery, the joint committee on health care financing and the senate and house committees on ways and means not later July 1, 2019.

SECTION 99. There shall be a special commission to review the prevalence and barriers to the provision of medication assisted treatment for substance use disorders by primary care

providers. The commission shall review current practices, identify barriers to accessing medication assisted treatment through primary care, including whether certain primary care settings are more difficult than others, and recommend ways to increase access to medication assisted treatment through primary care providers and other related wrap around services.

The commission shall consist of the following members or a designee: the secretary of health and human services, who shall serve as chair; the director of the bureau of substance addiction services; and 11 members appointed by the governor, 1 of whom shall be a representative of the Massachusetts Medical Society, 1 of whom shall be a representative of the Massachusetts chapter of the National Alliance on Mental Illness, 1 of whom shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom shall be a representative of the Association for Behavioral Healthcare, Inc., 1 of whom shall be a representative of the Massachusetts Association of Behavioral Health Systems, Inc., 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Organization for Addiction Recovery, Inc.,1 of whom shall be a representative of community health centers, 1 of whom shall be a primary care provider with experience providing medication assisted treatment and 1 of whom shall be an expert in substance use disorder treatment.

The commission shall file its report with the clerks of the senate and house of representatives, the joint committee on mental health, substance use and recovery and the house and senate committees on ways and means not later than July 1, 2019.

SECTION 100. The division of insurance and the office of Medicaid shall jointly develop and issue bulletins identifying the Healthcare Common Procedure Coding System codes that are

used by carriers, as defined in section 1 of chapter 176O of the General Laws, behavioral health management firms and third party administrators under contract to a carrier, Medicaid managed care organization, accountable care organization or the MassHealth primary care clinician plan for initiation and continuation of opioid agonist treatment of opioid use disorders provided in: (i) acute care hospital emergency departments or satellite emergency facilities; (ii) community-based treatment facilities, outpatient clinics, primary care practices or office based treatment clinics; (iii) inpatient facilities providing treatment for substance use disorders; and (iv) any facility used for commitment pursuant to section 35 of chapter 123 of the General Laws for persons with a substance use disorder; provided, however, that the procedures identified in the bulletins shall be based on medical necessity, pursuant to said chapter 176O, and shall not require a prior authorization for access to opioid agonist treatment unless such prior authorization is to promote the use of generic medication or for patient safety purposes. Prior to the issuance of the bulletins, the division and the office of Medicaid shall convene and consult with a group of carriers and providers regarding opioid agonist treatment in each of the treatment settings described in clauses (i) to (iv), inclusive. The division and the office of Medicaid shall publish the bulletins on their respective websites not later than January 1, 2019.

SECTION 101. There shall be a special commission to study the ways consumer protection laws in the commonwealth can be strengthened to hold corporate entities responsible for their role in furthering the opioid epidemic. The commission shall issue a report that shall include, but not be limited to, a review of and recommendations regarding: (i) the personal liability standard for executives of pharmaceutical companies; (ii) the use of deceptive or misleading marketing practices by pharmaceutical companies; (iii) the need to strengthen existing penalties against pharmaceutical companies engaged in unfair or deceptive acts or practices related to the opioid

epidemic; and (iv) remedial action pharmaceutical companies can take to mitigate the harmful effects of the opioid epidemic.

The commission shall consist of the following members or a designee: the governor; the attorney general; the commissioner of public health; the senate president, who shall serve as co-chair; the senate minority leader; the speaker of the house, who shall serve as co-chair; the house minority leader; and 6 members appointed by the attorney general, 1 of whom shall be a legal expert in consumer protection and liability, 1 of whom shall be an expert in the field of pain medication and management, 1 of whom shall be a medical expert in the area of substance use disorders and treatment, 1 of whom shall be a provider with extensive experience in the field of pain medication prescription and 2 of whom shall be persons who have struggled with a substance use disorder.

The commission shall file a report, including any recommendations, with the clerks of the senate and house of representatives, the joint committee on mental health, substance use and recovery, the joint committee on consumer protection and professional licensure, the joint committee on the judiciary and the house and senate committees on ways and means annually not later than January 1, 2019.

SECTION 102. There shall be a county correctional facility working group to provide recommendations on the feasibility of offering of medication-assisted treatment to all persons, regardless of status, in the custody of a county correctional facility.

The working group shall consist of: the commissioner of public health or a designee; 5 county sheriffs from geographically diverse regions of the commonwealth appointed by the Massachusetts Sheriffs' Association; and 1 representative of each of the following 7 organizations:

the Massachusetts Medical Society; the Massachusetts Health and Hospital Association, Inc.; the Association for Behavioral Healthcare, Inc.; the Disability Law Center, Inc.; Prisoners' Legal Services of Massachusetts; the Massachusetts Society of Addiction Medicine, Inc.; and the Massachusetts Organization for Addiction Recovery, Inc.. The chair shall be selected by a majority of members.

The working group shall file its recommendations with the clerks of the senate and house of representatives, the joint committee on mental health, substance abuse and recovery and the senate and house committees on ways and means not later than July 1, 2019.

SECTION 103. Sections 19 to 23, inclusive, 27, 28, and 30 to 32, inclusive, shall take effect on January 1, 2020.

SECTION 104. Section 17B of chapter 127 of the General Laws shall take effect on July 1, 2019.

SECTION 105. Sections 17C to 17E, inclusive, of chapter 127 of the General Laws shall take effect on April 1, 2019.