

HOUSE No. 4134

The Commonwealth of Massachusetts



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To the Honorable Senate and House of Representatives,

For the past 50 years, the US health care system has been focused primarily on promoting and supporting the technological advancement of medicine. That focus has cured disease, enhanced therapies, and saved lives. But as that focus, and the success it has achieved, has dominated what and how we pay for health care, we have failed to appreciate the changing nature of illness, and the systemic gaps in care delivery that have been created by this approach.

One need look no further than the opioid epidemic to understand what we have missed. The overprescribing of addictive and potentially deadly pain medication, brought on by a system in which it is more financially beneficial to write a prescription than it is to provide supportive and sustained therapy, created an addiction epidemic of gargantuan proportions.

While many people would argue that the fundamental problems with our health care system are rooted in some provider organizations being paid too much, and others being paid too little, we would argue the problem is more fundamental than that. Our health care system rewards those providers that invest in technology and transactional specialty services, at the expense of those that choose to invest in primary care, geriatrics, addiction services and behavioral health care.

This is problematic for three reasons. First, the nature of illness is changing. Chronic illnesses are far more prevalent than they used to be, in part because of the success of modern medicine in solving many kinds of acute illness over the past five decades. Second, we are an aging population. Many of us who live to the age of 60 will make it into our 80s and 90s, where

brain diseases are far more common than they used to be, again in part because of our success in treating heart disease and many forms of cancer. Third, for a variety of clinical and sociological reasons, mental health, addiction and behavioral health issues are far more challenging than they were in the past, and we increasingly recognize how they are intertwined with physical illnesses.

And the primary care shortage that was identified over 30 years ago has gotten worse over the past three decades.

Simply put, the care delivery and financing system we have today is not designed to take care of the people and the patients we have become. We pay for a system that is built on transactions and technological advances, not on collaborative care delivery, therapeutic support, or a combination of both. While technological advances remain a critical component of delivering effective health care, a 21st century health system should presume that collaboration and time are at least as important as technology, and that for many people, physical and mental health are related. It should reward providers and provider organizations that invest in a comprehensive set of physical and behavioral health services, and understand that population based health management requires time and connection.

Solving this problem at the state level is complicated by the overarching role played by public and private national payors in health care in this country. For the most part, national payors, including Medicare, use payment policies that favor technology and transactional medicine at the expense of primary care, mental and behavioral health and addiction services, and ironically, geriatrics. Almost all providers and payors build their financial models and their operations using the Medicare fee schedule as their baseline. This makes any decision to deviate from that model – for example, to offer more mental health services – extremely hard to do.

Federal policy and research funding also drive provider organizations to focus on specialty services and care, instead of on addiction, mental or behavioral health, primary care or geriatrics. This makes it financially difficult for any care delivery organization to double down in the areas where the greatest gaps in the existing care delivery system exist.

The bill I am filing today, “An Act to Improve Health Care by Investing in VALUE,” is designed to create positive financial incentives for health care providers and payors to rethink their service delivery and investment decisions. This bill encourages providers and payors to invest in the behavioral health, addiction and recovery, and primary care and geriatric services that are underfunded by today’s payment models and incorporate these services more directly into their care delivery strategies.

The legislation targets those challenges by requiring investments in behavioral and primary care and establishing a statewide spending target.

- Providers and insurers, including MassHealth, will be required to increase spending on behavioral health and primary care by 30% over three years.

- Calendar year 2019 spending will serve as the baseline, and providers and insurers will be measured on their performance beginning in calendar year 2023.
- The legislation does not suggest a standard pathway for providers and insurers to achieve the target.
- Providers and insurers will be required to report their progress on an annual basis through the Center for Health Information Analysis' (CHIA) and Health Policy Commission's (HPC) existing processes.
- If the target is not achieved, providers and insurers will be referred by CHIA to the HPC and may be subject to a performance improvement plan which may require them to identify strategies and opportunities to increase investments in primary care and behavioral health.

The legislation proposes these increased investments in primary care and behavioral health while requiring overall spending to stay within the parameters of the state's overall health care cost growth benchmark.

This will be a break from the trajectory of the past several decades and may cause some modest disruptions. But even a cursory review of the literature makes clear that this is the right direction for our payment systems and our health care providers to move in if we want to create a payment and care delivery model that properly and cost effectively serves the people of the Commonwealth.

Our bill also builds upon the foundation put forth by prior health care legislation, including Chapter 224, the 2012 cost containment legislation. Recent efforts have yielded moderate success in bending the cost growth curve. However, increasing health care costs disproportionately fall to individuals and employers, as increases in premiums and cost-sharing continue to outpace overall expenditures.

This legislation seeks to address excess costs and spending through a multi-faceted approach that both targets systemic cost drivers and promotes consumer access to high-value, affordable coverage. The bill strengthens the process by which the Health Policy Commission (HPC) evaluates, and holds accountable, entities that exceed the cost growth benchmark.

To address year-over-year increases in pharmacy spend, we seek to:

- hold high-cost drug manufacturers accountable through a similar framework used for payors and providers that exceed the benchmark;
- penalize manufacturers for excessive price increases; and
- establish new oversight authority of pharmacy benefit managers (PBMs).

The bill also includes several consumer protections and measures to reduce consumers' out-of-pocket costs, including prohibitions on surprise billing practices and facility fees, and reforms promoting access to more affordable, innovative health plans for individuals and employers, alike.

Further, a stable and affordable insurance market is key to maintaining our near-universal coverage levels and a well-functioning health care system. To address many of the emerging federal policy changes and dynamics that may impact the Massachusetts merged market, I will be issuing an executive order in parallel, to establish an advisory council to conduct an independent actuarial analysis of the merged market and provide recommendations, including any regulatory or statutory reforms, for improved market functioning no later than April 30, 2020.

Finally, this legislation promotes access to quality, coordinated care and modernizes policies to bring Massachusetts in line with other states in areas where we have lagged behind. These measures include: removing outdated practice restrictions for mid-level clinicians, creating a new mid-level dental therapist, standardizing urgent care services and advancing telemedicine through aligned regulatory and coverage policies.

Managing excess costs in the system and promoting increased access to vital services will support the Commonwealth in recalibrating its health care financing and delivery system towards a model that values time and positive outcomes, and stands prepared to meet the evolving needs of our changing patient populations. Many of the reforms we have proposed will also reduce costs – including to patients and small businesses – while maintaining the quality of care the people of Massachusetts deserve.

We can't afford to wait. I look forward to working with the Legislature to enact comprehensive health care legislation that delivers a more cost-effective, nimble and patient-centric health care system for the 21st century.

Respectfully submitted,

Charles D. Baker,
Governor

The Commonwealth of Massachusetts

**In the One Hundred and Ninety-First General Court
(2019-2020)**

An Act to improve health care by investing in VALUE.

Whereas, The deferred operation of this act would tend to defeat its purpose, which is to improve the delivery of health care and reduce health care costs, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public convenience.

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

1 SECTION 1. Chapter 6A of the General Laws is hereby amended by inserting after
2 section 16BB the following section:-

3 Section 16CC. (a) There shall be a task force to make recommendations on aligned
4 measures of health care provider quality and health system performance to ensure consistency in
5 the use of quality measures in contracts between payers, including the commonwealth and
6 carriers, and health care providers in the commonwealth, ensure consistency in methods for
7 evaluating providers for tiered network products, reduce administrative burden, improve
8 transparency for consumers, improve health system monitoring and oversight by relevant state
9 agencies and improve quality of care. Through May 2021, the members of the task force shall be
10 the members of the existing Executive Office of Health and Human Services Quality
11 Measurement Taskforce. After May 2021, the task force shall include the following members or
12 their designees: the secretary of health and human services, who shall serve as chair; the

13 commissioner of public health; the commissioner of mental health; the executive director of the
14 center for health information and analysis; the executive director of the health policy
15 commission; the executive director of the group insurance commission; the assistant secretary for
16 MassHealth; the commissioner of insurance; and at a minimum, 12 members who shall be
17 appointed by the governor, 1 of whom shall be a representative of a provider trade association; 1
18 of whom shall be a representative of a medical society; 1 of whom shall be a behavioral health
19 provider; 1 of whom shall be a long-term supports and services provider; 1 of whom shall be a
20 representative of a community health center serving the Medicaid population; 1 of whom shall be
21 a representative of a Medicaid managed care organization; 1 of whom shall be a representative of
22 a statewide ACO; 1 of whom shall be a representative of a commercial managed care
23 organization; 1 of whom shall be a representative for persons with complex health conditions; 1
24 of whom shall be a representative for consumers; 1 of whom shall be a representative of a
25 hospital; at least 1 of whom shall be an academic with expertise in health care quality
26 measurement and 1 of whom shall be a representative of an employer with experience in health
27 care quality measurement. Members appointed to the task force shall have experience with and
28 expertise in health care quality measurement. The task force shall convene annually, with its first
29 meeting occurring not later than January 15, and shall meet not less than monthly or as
30 determined necessary by the chair of the task force. The task force shall submit an annual report
31 with its recommendations, including any changes or updates to aligned measures of health care
32 provider quality and health system performance, to the secretary of health and human services
33 and the joint committee on health care financing not later than January 31 of each year with the
34 first report due in the year following the effective date of this section.

35 (b) The task force shall make recommendations on aligned measures of health care
36 provider quality and health system performance for use in: (i) contracts between payers,
37 including the commonwealth and carriers, and health care providers, provider organizations and
38 accountable care organizations, which incorporate quality measures into payment terms,
39 including the designation of a set of core measures and a set of non-core measures; (ii) assigning
40 tiers to health care providers in the design of any health plan; (iii) consumer transparency
41 websites and other methods of providing consumer information and (iv) monitoring system-wide
42 performance. The task force shall regularly review its recommended aligned measures of health
43 care provider quality and health system performance, and shall update its recommendations each
44 year.

45 (c) In developing its recommendations, the task force shall consider evidence-based,
46 scientifically acceptable, nationally-endorsed quality measures, including, but not limited to,
47 measures endorsed by the National Committee for Quality Assurance or the National Quality
48 Forum. Such quality measures shall include, but not be limited to, measures used by the
49 commonwealth, the Centers for Medicare and Medicaid Services, the group insurance
50 commission, carriers, and provider organizations in the commonwealth and other states, as well
51 as other valid measures of health care provider performance, outcomes, including patient-
52 reported outcomes and functional status, patient experience, disparities, and population health.
53 The task force shall consider measures applicable to primary care providers, specialists,
54 hospitals, provider organizations, accountable care organizations, oral health providers and other
55 types of providers and measures applicable to different patient populations.

56 (d) No later than March 31 of each year, the secretary of health and human services in
57 consultation with the commissioner of insurance, may establish an aligned measure set to be

58 used by the commonwealth and carriers in contracts with health care providers that incorporate
59 quality measures into the payment terms pursuant to sections 4 and 4A of chapter 32A, section
60 10K of chapter 118E, section 108N of chapter 175, section 8W of chapter 176A, section 4W of
61 chapter 176B, section 4O of chapter 176G, and for assigning tiers to health care providers in
62 tiered network plans pursuant to section 11 of chapter 176J. The aligned measure set shall
63 designate: (i) core measures that shall be used in contracts between payers, including the
64 commonwealth and carriers, and health care providers, including provider organizations and
65 accountable care organizations, which incorporate quality measures into payment terms; and (ii)
66 non-core measures that may be used in such contracts. In establishing the aligned measure set,
67 the secretary of health and human services may consider factors including but not limited to
68 quality improvement priorities for the Commonwealth, quality measurement innovation, data
69 collection methodology, and measure feasibility.

70 SECTION 2. Section 1 of chapter 6D of the General Laws, as appearing in the 2018
71 Official Edition, is hereby amended by inserting after the definition of “After-hours care” the
72 following 2 definitions:-

73 “Aggregate baseline expenditures”, the sum of all primary care and behavioral health
74 expenditures, as defined by the center, in the commonwealth in the calendar year preceding the
75 three year period to which the aggregate target applies; provided, however, that aggregate
76 baseline expenditures shall initially be calculated using calendar year 2019.

77 “Aggregate primary care and behavioral health expenditure target”, hereinafter “the
78 aggregate target”, the targeted percentage change in total expenditures on primary care and
79 behavioral health in the commonwealth from aggregate baseline expenditures.

80 SECTION 3. Said section 1 of said chapter 6D, as so appearing, is hereby further
81 amended by inserting after the definition of “Alternative payment methodologies or methods”
82 the following definition:-

83 “Baseline expenditures”, the sum of all primary care and behavioral health expenditures,
84 as defined by the center, by or attributed to an individual health care entity in the calendar year
85 preceding the three year period to which the target applies; provided, however, that baseline
86 expenditures shall initially be calculated using as calendar year 2019.

87 SECTION 4. Said section 1 of said chapter 6D, as so appearing, is hereby further
88 amended by inserting after the definition of “Physician” the following definition:-

89 “Primary care and behavioral health expenditure target”, hereinafter “the target”, the
90 targeted percentage change in expenditures on primary care and behavioral health by or
91 attributed to an individual health care entity compared to the entity’s baseline expenditures.

92 SECTION 5. Section 8 of said chapter 6D, as so appearing, is hereby further amended by
93 striking out subsection (a), and inserting in place thereof the following subsection:-

94 (a) Not later than October 1 of every year, the commission shall hold public hearings
95 based on the report submitted by the center under section 16 of chapter 12C comparing the
96 growth in total health care expenditures to the health care cost growth benchmark for the
97 previous calendar year and comparing actual aggregate primary care and behavioral health
98 expenditures for the previous calendar year to the aggregate primary care and behavioral health
99 expenditure target. The hearings shall examine health care provider, provider organization and
100 private and public health care payer costs, prices and cost trends, with particular attention to
101 factors that contribute to cost growth within the commonwealth’s health care system and

102 challenge the ability of the commonwealth’s health care system to meet the benchmark or the
103 aggregate primary care and behavioral health expenditure target established under section 9A.

104 SECTION 6. Subsection (d) of said section 8 of said chapter 6D, as so appearing, is
105 hereby further amended by striking out, in line 32, the words “and (xi)” and inserting in place
106 thereof the following words:- (xi) at least 3 representatives of pharmaceutical or
107 biopharmaceutical companies doing business in the commonwealth, including 1 publicly-traded
108 company, 1 company that primarily manufactures generic drugs and 1 company that has been in
109 existence for less than 10 years; and (xii).

110 SECTION 7. Said chapter 6D is hereby further amended by inserting after section 8A, as
111 inserted by section 6 of chapter 41 of the acts of 2019, the following section:-

112 Section 8B. (a) As used in this section, the following words shall, unless the context
113 clearly requires otherwise, have the following meaning:

114 “Manufacturer”, an entity that manufactures a pharmaceutical drug.

115 (b) The commission may require a manufacturer specified in subsection (c) to disclose to
116 the commission within a reasonable time information relating to the manufacturer’s pricing of
117 that drug, on a standard reporting form developed by the commission with the input of the
118 manufacturers, which includes but shall not be limited to, the following:

119 (1) A schedule of the drug’s wholesale acquisition cost increases over the previous five
120 calendar years;

121 (2) The manufacturer's aggregate, company-level research and development and other
122 relevant capital expenditures, including facility construction, for the most recent year for which
123 final audited data are available;

124 (3) A written, narrative description, suitable for public release, of factors that contributed
125 to reported changes in wholesale acquisition cost during the previous five calendar years; and

126 (4) Any other information that the manufacturer wishes to provide to the commission.

127 Based on the records furnished, the commission may identify a proposed value for a
128 prescribed drug specified in subsection (c). The commission may request additional relevant
129 information that it deems necessary to identify a proposed value of the drug.

130 (c) A manufacturer of a drug for which the commission has received a referral from the
131 center under subsection (b) of section 24 of chapter 12C shall comply with the requirements set
132 forth in this section; provided that the commission may select or prioritize a subset of the
133 referred drugs for the commission's review.

134 (d) Records disclosed by a manufacturer under this section shall: (i) be accompanied by
135 an attestation that all information provided is true and correct; (ii) not be public records under
136 section 7 of chapter 4 or chapter 66; and (iii) remain confidential; provided, however, that the
137 commission may produce reports summarizing any findings; provided that any such report shall
138 not be in a form that identifies specific prices charged for or rebate amounts associated with
139 drugs by a manufacturer, or in a manner that is likely to compromise the financial, competitive or
140 proprietary nature of the information.

141 (e) If, after review of any records furnished to the commission under subsection (b), the
142 commission determines that the manufacturer's pricing of the drug is potentially unreasonable or
143 excessive in relation to the commission's proposed value under subsection (b), the commission
144 shall, with 30 days' advance notice to the manufacturer, request that the manufacturer provide
145 further information related to the pricing of the prescribed drug and the manufacturer's
146 justification for the pricing. In addition to the manufacturer, the commission may identify other
147 relevant parties including but not limited to patients, providers, provider organizations and
148 payers who may provide information to the commission.

149 (f) Any information, analyses or reports regarding a particular drug reviewed or used in
150 assessing the proposed value of the drug shall be provided to the manufacturer for review and
151 input. The commission shall consider any clarifications or data provided by the manufacturer
152 with respect to its drug. The commission may not base its determination regarding the proposed
153 value or the reasonableness of the drug pricing solely on the analysis or research of an outside
154 third party.

155 (g) If the commission relies upon a third party to provide cost-effectiveness analysis or
156 research related to the proposed value, such analysis or research shall also provide, but not be
157 limited in scope to, (i) a description of the methodologies and models used in its analysis; (ii) any
158 assumptions and potential limitations of research findings in the context of the results; and (iii)
159 outcomes for affected subpopulations that utilize the drug.

160 (h) Not later than 60 days after receiving information from the manufacturer, as required
161 under subsection (b) or (e), the commission shall issue a determination on whether the

162 manufacturer's pricing of a drug is unreasonable or excessive in relation to the commission's
163 proposed value of the drug.

164 (i) If the manufacturer fails to timely comply with the commission's request for records
165 under subsections (b) or (e), or otherwise knowingly obstructs the commission's ability to issue
166 its determination under subsection (h), including, but not limited to, providing incomplete, false
167 or misleading information, the commission may impose appropriate sanctions against the
168 manufacturer, including reasonable monetary penalties not to exceed \$500,000, in each instance.
169 The commission shall seek to promote compliance with this section and shall only impose a civil
170 penalty on the manufacturer as a last resort.

171 (j) The commission shall adopt any written policies, procedures or regulations that the
172 commission determines necessary to implement this section.

173 SECTION 8. Said chapter 6D is hereby further amended by inserting after section 9 the
174 following section:-

175 Section 9A. (a) The board shall establish an aggregate primary care and behavioral health
176 expenditure target for the commonwealth, which the commission shall prominently publish on its
177 website.

178 (b) The commission shall establish the aggregate primary care and behavioral health
179 expenditure target as follows:

180 (1) For the three year period ending with calendar year 2022, the aggregate target shall be
181 equal to a 30 per cent increase above aggregate baseline expenditures and the target shall be
182 equal to a 30 per cent increase above baseline expenditures.

183 (2) For calendar years 2023 and beyond, the commission may modify the target and
184 aggregate target, to be effective for a three year period provided that the target and aggregate
185 target shall be approved by a two thirds vote of the board not later than December 31 of the final
186 calendar year of the preceding three year period. If the commission does not act to establish an
187 updated target and aggregate target pursuant to this subsection, the target shall be equal to a 30
188 per cent increase above baseline expenditures, and the aggregate target shall be equal to a 30 per
189 cent increase above aggregate baseline expenditures until such time as the commission acts to
190 modify the target and aggregate target. If the commission modifies the target and aggregate
191 target, the modification shall not take effect until the three year period beginning with the next
192 full calendar year.

193 (c) Prior to establishing the target and aggregate target, the commission shall hold a
194 public hearing. The public hearing shall be based on the report submitted by the center under
195 section 16 of chapter 12C, comparing the actual aggregate expenditures on primary care and
196 behavioral health services to the aggregate target, any other data submitted by the center and
197 such other pertinent information or data as may be available to the board. The hearings shall
198 examine the performance of health care entities in meeting the target and the commonwealth's
199 health care system in meeting the aggregate target. The commission shall provide public notice
200 of the hearing at least 45 days prior to the date of the hearing, including notice to the joint
201 committee on health care financing. The joint committee on health care financing may
202 participate in the hearing. The commission shall identify as witnesses for the public hearing a
203 representative sample of providers, provider organizations, payers and such other interested
204 parties as the commission may determine. Any other interested parties may testify at the hearing.

205 SECTION 9. Chapter 6D of the General Laws is hereby further amended by striking out
206 section 10, as appearing in the 2018 Official Edition, and inserting in place thereof the following
207 2 sections:-

208 Section 10. (a) For the purposes of this section, “health care entity” shall mean any entity
209 identified by the center under section 18 of chapter 12C.

210 (b) The commission shall provide notice to all health care entities that have been
211 identified by the center under section 18 of chapter 12C. Such notice shall state that the
212 commission may analyze the spending growth of individual health care entities and the
213 commission may require certain actions, as established in this section, from health care entities
214 so identified.

215 (c) In addition to the notice provided under subsection (b), the commission may require
216 any health care entity that is identified by the center under section 18 of chapter 12C to file a
217 performance improvement plan with the commission. The commission shall provide written
218 notice to such health care entity that they are required to file a performance improvement plan.
219 Within 45 days of receipt of such written notice, the health care entity shall either:

220 (1) file a performance improvement plan with the commission; or

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

223 (d) The health care entity may file any documentation or supporting evidence with the
224 commission to support the health care entity’s application to waive or extend the requirement to
225 file a performance improvement plan. The commission shall require the health care entity to

226 submit any other relevant information it deems necessary in considering the waiver or extension
227 application; provided, however, that such information shall be made public at the discretion of
228 the commission.

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

233 (1) the costs, price and utilization trends of the health care entity over time, and any
234 demonstrated improvement to reduce health status total medical expenses;

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

237 (3) whether the factors that led to increased spending for the health care entity can
238 reasonably be considered to be unanticipated and outside of the control of the entity. Such factors
239 may include, but shall not be limited to, age and other health status adjusted factors and other
240 cost inputs such as pharmaceutical expenses and medical device expenses;

241 (4) the overall financial condition of the health care entity;

242 (5) a significant difference between the growth rate of potential gross state product and
243 the growth rate of actual gross state product, as determined under section 7H 1/2 of chapter 29;
244 and

245 (6) any other factors the commission considers relevant.

246 (f) If the commission declines to waive or extend the requirement for the health care
247 entity to file a performance improvement plan, the commission shall provide written notice to the
248 health care entity that its application for a waiver or extension was denied and the health care
249 entity shall file a performance improvement plan.

250 (g) A health care entity shall file a performance improvement plan: (1) within 45 days of
251 receipt of a notice under subsection (c); (2) if the health care entity has requested a waiver or
252 extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or
253 (3) if the health care entity is granted an extension, on the date given on such extension. The
254 performance improvement plan shall identify the causes of the entity's spending growth and shall
255 include, but not be limited to, specific strategies, adjustments and action steps the entity proposes
256 to implement to improve spending performance. The proposed performance improvement plan
257 shall include specific identifiable and measurable expected outcomes and a timetable for
258 implementation. The timetable for a performance improvement plan shall not exceed 18 months.

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

262 (i) If the board determines that the performance improvement plan is unacceptable or
263 incomplete, the commission may provide consultation on the criteria that have not been met and
264 may allow an additional time period, up to 30 calendar days, for resubmission.

265 (j) Upon approval of the proposed performance improvement plan, the commission shall
266 notify the health care entity to begin immediate implementation of the performance improvement
267 plan. Public notice shall be provided by the commission on its website, identifying that the health

268 care entity is implementing a performance improvement plan. All health care entities
269 implementing an approved performance improvement plan shall be subject to additional
270 reporting requirements and compliance monitoring, as determined by the commission. The
271 commission shall provide assistance to the health care entity in the successful implementation of
272 the performance improvement plan.

273 (k) All health care entities shall, in good faith, work to implement the performance
274 improvement plan. At any point during the implementation of the performance improvement
275 plan the health care entity may file amendments to the performance improvement plan, subject to
276 approval of the commission.

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

285 (m) Upon the successful completion of the performance improvement plan, the identity
286 of the health care entity shall be removed from the commission's website.

287 (n) The commission may submit a recommendation for proposed legislation to the joint
288 committee on health care financing if the commission determines that further legislative
289 authority is needed to achieve the health care quality and spending sustainability objectives of

290 this act, assist health care entities with the implementation of performance improvement plans, or
291 otherwise ensure compliance with the provisions of this section.

292 (o) (1) If the commission determines that a health care entity has: (i) willfully neglected
293 to file a performance improvement plan with the commission within 45 days as required under
294 subsection (c); (ii) failed to file an acceptable performance improvement plan in good faith with
295 the commission; (iii) failed to implement the performance improvement plan in good faith; or
296 (iv) knowingly failed to provide information required by this section to the commission or that
297 knowingly falsifies the same, the commission may assess a civil penalty to the health care entity
298 of not more than \$500,000 the first time that a determination is made, not more than \$750,000
299 for a second determination and not more than \$1,000,000 for a third or subsequent
300 determination; provided, however, that a civil penalty assessed pursuant to 1 of the above clauses
301 shall be a first offense if a previously assessed penalty was assessed pursuant to a different
302 clause. A civil penalty assessed under this subsection shall be deposited into the Community
303 Hospital and Health Center Investment Trust Fund established under section 2TTTT of chapter
304 29. The commission shall seek to promote compliance with this section and shall only impose a
305 civil penalty as a last resort.

306 (2) In lieu of requiring a performance improvement plan pursuant to this section, the
307 commission may assess a civil penalty on a health care entity identified by the center pursuant to
308 section 18 of chapter 12C if the commission determines that a performance improvement plan is
309 not an appropriate remedial measure. The civil penalty may be an amount up to the total cost
310 attributable to the health care entity's spending in excess of the health care cost growth
311 benchmark in the most recent year for which data is available and shall be deposited into the

312 Community Hospital and Health Center Investment Trust Fund established under section 2TTTT
313 of chapter 29.

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

318 Section 10A. (a) For the purposes of this section, “health care entity” shall mean any
319 entity identified by the center under section 18 of chapter 12C.

320 (b) The commission shall provide notice to all health care entities that have been
321 identified by the center under section 18 of chapter 12C for failure to meet the target. Such notice
322 shall state that the center may analyze the performance of individual health care entities in
323 meeting the target and, beginning in calendar year 2023, the commission may require certain
324 actions, as established in this section, from health care entities so identified.

325 (c) In addition to the notice provided under subsection (b), the commission may require
326 any health care entity that is identified by the center under section 18 of chapter 12C for failure
327 to meet the primary care and behavioral health expenditure target to file and implement a
328 performance improvement plan. The commission shall provide written notice to such health care
329 entity that they are required to file a performance improvement plan. Within 45 days of receipt of
330 such written notice, the health care entity shall either:

331 (1) file a performance improvement plan with the commission; or

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

334 (d) The health care entity may file any documentation or supporting evidence with the
335 commission to support the health care entity's application to waive or extend the requirement to
336 file a performance improvement plan. The commission shall require the health care entity to
337 submit any other relevant information it deems necessary in considering the waiver or extension
338 application; provided, however, that such information shall be made public at the discretion of
339 the commission.

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

344 (1) the baseline expenditures, costs, price and utilization trends of the health care entity
345 over time, and any demonstrated improvement to increase the proportion of primary care and
346 behavioral health expenditures;

347 (2) any ongoing strategies or investments that the health care entity is implementing to
348 invest in or expand access to primary care and behavioral health services;

349 (3) whether the factors that led to the inability of the health care entity to meet the target
350 can reasonably be considered to be unanticipated and outside of the control of the entity. Such
351 factors may include, but shall not be limited to market dynamics, technological changes and
352 other drivers of non-primary care and non-behavioral health spending such as pharmaceutical
353 and medical devices expenses.

354 (4) the overall financial condition of the health care entity;

355 (5) any other factors the commission considers relevant.

356 (f) If the commission declines to waive or extend the requirement for the health care
357 entity to file a performance improvement plan, the commission shall provide written notice to the
358 health care entity that its application for a waiver or extension was denied and the health care
359 entity shall file a performance improvement plan.

360 (g) The commission shall provide the department of public health any notice requiring a
361 health care entity to file and implement a performance improvement plan pursuant to this
362 section. In the event a health care entity required to file a performance improvement plan under
363 this section submits an application for a notice of determination of need under section 25C or 51
364 of chapter 111, the notice of the commission requiring the health care entity to file and
365 implement a performance improvement plan pursuant to this section shall be considered part of
366 the written record pursuant to said section 25C of chapter 111.

367 (h) A health care entity shall file a performance improvement plan: (1) within 45 days of
368 receipt of a notice under subsection (c); (2) if the health care entity has requested a waiver or
369 extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or
370 (3) if the health care entity is granted an extension, on the date given on such extension. The
371 performance improvement plan shall identify specific strategies, adjustments and action steps the
372 entity proposes to implement to increase the proportion of primary care and behavioral health
373 expenditures. The proposed performance improvement plan shall include specific identifiable
374 and measurable expected outcomes and a timetable for implementation.

375 (i) The commission shall approve any performance improvement plan that it determines
376 is reasonably likely to address the underlying cause of the entity's inability to meet the target and
377 has a reasonable expectation for successful implementation.

378 (j) If the board determines that the performance improvement plan is unacceptable or
379 incomplete, the commission may provide consultation on the criteria that have not been met and
380 may allow an additional time period, up to 30 calendar days, for resubmission.

381 (k) Upon approval of the proposed performance improvement plan, the commission shall
382 notify the health care entity to begin immediate implementation of the performance improvement
383 plan. Public notice shall be provided by the commission on its website, identifying that the health
384 care entity is implementing a performance improvement plan. All health care entities
385 implementing an approved performance improvement plan shall be subject to additional
386 reporting requirements and compliance monitoring, as determined by the commission. The
387 commission shall provide assistance to the health care entity in the successful implementation of
388 the performance improvement plan.

389 (l) All health care entities shall, in good faith, work to implement the performance
390 improvement plan. At any point during the implementation of the performance improvement
391 plan the health care entity may file amendments to the performance improvement plan, subject to
392 approval of the commission.

393 (m) At the conclusion of the timetable established in the performance improvement plan,
394 the health care entity shall report to the commission regarding the outcome of the performance
395 improvement plan. If the performance improvement plan was found to be unsuccessful, the
396 commission shall either: (i) extend the implementation timetable of the existing performance

397 improvement plan; (ii) approve amendments to the performance improvement plan as proposed
398 by the health care entity; (iii) require the health care entity to submit a new performance
399 improvement plan under subsection (c) or (iv) waive or delay the requirement to file any
400 additional performance improvement plans.

401 (n) Upon the successful completion of the performance improvement plan, the identity of
402 the health care entity shall be removed from the commission's website.

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

408 (p) If the commission determines that a health care entity has: (i) willfully neglected to
409 file a performance improvement plan with the commission by the time required in subsection (h);
410 (ii) failed to file an acceptable performance improvement plan in good faith with the
411 commission; (iii) failed to implement the performance improvement plan in good faith; or (iv)
412 knowingly failed to provide information required by this section to the commission or that
413 knowingly falsifies the same, the commission may assess a civil penalty to the health care entity
414 of not more than \$500,000 the first time that a determination is made, not more than \$750,000
415 for a second determination and not more than \$1,000,000 for a third or subsequent
416 determination; provided, however, that a civil penalty assessed pursuant to 1 of the above clauses
417 shall be a first offense if a previously assessed penalty was assessed pursuant to a different
418 clause. A civil penalty assessed under this subsection shall be deposited into the Community

419 Hospital and Health Center Investment Trust Fund established under section 2TTTT of chapter
420 29. The commission shall seek to promote compliance with this section and shall only impose a
421 civil penalty as a last resort.

422 (q) The commission shall promulgate regulations necessary to implement this section.

423 (r) Nothing in this section shall be construed as affecting or limiting the applicability of
424 the health care cost growth benchmark established under section 9 of chapter 6D, and the
425 obligations of a health care entity thereto.

426 SECTION 10. Section 11 of said chapter 6D of the General Laws, as appearing in the
427 2018 Official Edition, is hereby amended by inserting, in lines 20 to 21, after the words “the
428 name and address of licensed facilities”, the following words:- , including whether any such
429 facilities charge a facility fee as defined in section 51L of chapter 111.

430 SECTION 11. Section 13 of said chapter 6D, as so appearing, is hereby amended by
431 striking out subsection (b) and inserting in place thereof the following subsection:-

432 (b) In addition to the grounds for a cost and market impact review set forth in subsection
433 (a), if the commission finds, based on the center’s annual report, that the percentage change in
434 total health care expenditures exceeded the health care cost growth benchmark in the previous
435 calendar year, the commission may conduct a cost and market impact review of any provider or
436 provider organization identified by the center under section 18 of chapter 12C.

437 SECTION 12. Said chapter 6D of the General Laws is hereby further amended by adding
438 the following section:-

439 Section 20. (a) The commission shall annually identify services subject to the limitations
440 on facility fees provided in subsection (c) of section 51L of chapter 111.

441 (b) Services identified by the commission under this section shall include evaluation and
442 management services, diagnostics and imaging services, and other outpatient services that the
443 commission determines may reliably be provided safely and effectively in settings other than
444 hospitals.

445 SECTION 13. Section 7 of chapter 12C of the General Laws, as appearing in the 2018
446 Official Edition, is hereby amended by striking out each time they appear, in lines 5 and 11, the
447 words “Community Hospital Reinvestment Trust Fund” and inserting in place thereof the
448 following words:-

449 Community Hospital and Health Center Investment Trust Fund.

450 SECTION 14. Said section 7 of said chapter 12C, as so appearing, is hereby further
451 amended by striking out each time they appear, in lines 15 to 16 and 49 to 50, the words “or
452 received retroactively for expenses of predecessor agencies” and inserting in place thereof the
453 following words:-

454 excluding those made from the Community Hospital and Health Center Investment Trust
455 Fund.

456 SECTION 15. Said chapter 12C is hereby amended by inserting after section 10 the
457 following section:-

458 Section 10A. (a) The center shall promulgate regulations necessary to ensure the uniform
459 annual reporting of information from pharmacy benefit managers certified under chapter 175N,

460 including but not limited to information on (1) payments received by pharmacy benefit managers
461 by payers related to drugs provided to Massachusetts residents; (2) payments made by pharmacy
462 benefit managers to pharmacies related to drugs provided to Massachusetts residents; (3) rebates
463 received by pharmacy benefit managers from drug manufacturers related to drugs provided to
464 Massachusetts residents; (4) rebates paid by pharmacy benefit managers to payers related to
465 drugs provided to Massachusetts residents; (5) other payments made or received by pharmacy
466 benefit managers by payers or pharmacies, including but not limited to administrative or
467 performance-based payments, related to doing business in Massachusetts; (6) other rebates paid
468 to or received by pharmacy benefit managers by drug manufacturers or payers related to doing
469 business in Massachusetts; and (7) any other information specified by the center.

470 (b) The center shall analyze the information and data collected under subsection (a) and
471 shall publish an annual report detailing, at minimum, each pharmacy benefit manager's
472 aggregated percentage of spread pricing, as defined by the center, related to drugs provided to
473 Massachusetts residents.

474 (c) Except as specifically provided otherwise by the center or under this chapter,
475 pharmacy benefit manager data collected by the center under this section shall not be a public
476 record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66. The center may
477 confidentially provide pharmacy benefit manager data collected by the center under this section
478 to the health policy commission.

479 SECTION 16. Section 14 of said chapter 12C is hereby repealed.

480 SECTION 17. Section 16 of said chapter 12C, as appearing in the 2018 Official Edition,
481 is hereby amended by striking out subsection (a) and inserting in place thereof the following
482 subsection:-

483 (a) The center shall publish an annual report based on the information submitted under
484 this chapter concerning health care provider, provider organization and private and public health
485 care payer costs and cost trends, section 13 of chapter 6D relative to market power reviews and
486 section 15 relative to quality data. The center shall compare the costs, cost trends, and
487 expenditures with the health care cost growth benchmark established under section 9 of chapter
488 6D, analyzed by regions of the commonwealth, and shall compare the costs, cost trends, and
489 expenditures with the aggregate primary care and behavioral health expenditure target
490 established under section 9A of said chapter 6D, and shall detail: (1) baseline information about
491 cost, price, quality, utilization and market power in the commonwealth's health care system; (2)
492 cost growth trends for care provided within and outside of accountable care organizations and
493 patient-centered medical homes; (3) cost growth trends by provider sector, including but not
494 limited to, hospitals, hospital systems, non-acute providers, pharmaceuticals, medical devices
495 and durable medical equipment; provided, however, that any detailed cost growth trend in the
496 pharmaceutical sector shall consider the effect of drug rebates and other price concessions in the
497 aggregate without disclosure of any product or manufacturer-specific rebate or price concession
498 information, and without limiting or otherwise affecting the confidential or proprietary nature of
499 any rebate or price concession agreement; (4) factors that contribute to cost growth within the
500 commonwealth's health care system and to the relationship between provider costs and payer
501 premium rates; (5) primary care and behavioral health expenditure trends as compared to the
502 aggregate baseline expenditures, as defined in section 1 said chapter 6D; (6) the proportion of

503 health care expenditures reimbursed under fee-for-service and alternative payment
504 methodologies; (7) the impact of health care payment and delivery reform efforts on health care
505 costs including, but not limited to, the development of limited and tiered networks, increased
506 price transparency, increased utilization of electronic medical records and other health
507 technology; (8) the impact of any assessments including, but not limited to, the health system
508 benefit surcharge collected under section 68 of chapter 118E, on health insurance premiums; (9)
509 trends in utilization of unnecessary or duplicative services, with particular emphasis on imaging
510 and other high-cost services; (10) the prevalence and trends in adoption of alternative payment
511 methodologies and impact of alternative payment methodologies on overall health care spending,
512 insurance premiums and provider rates; (11) the development and status of provider
513 organizations in the commonwealth including, but not limited to, acquisitions, mergers,
514 consolidations and any evidence of excess consolidation or anti-competitive behavior by
515 provider organizations; and (12) the impact of health care payment and delivery reform on the
516 quality of care delivered in the commonwealth.

517 As part of its annual report, the center shall report on price variation between health care
518 providers, by payer and provider type. The center's report shall include: (1) baseline information
519 about price variation between health care providers by payer including, but not limited to,
520 identifying providers or provider organizations that are paid more than 10 per cent above or more
521 than 10 per cent below the average relative price and identifying payers which have entered into
522 alternative payment contracts that vary by more than 10 per cent; (2) the annual change in price
523 variation, by payer, among the payer's participating providers; (3) factors that contribute to price
524 variation in the commonwealth's health care system; (4) the impact of price variations on
525 disproportionate share hospitals and other safety net providers; and (5) the impact of health

526 reform efforts on price variation including, but not limited to, the impact of increased price
527 transparency, increased prevalence of alternative payment contracts and increased prevalence of
528 accountable care organizations and patient centered medical homes.

529 The center shall publish and provide the report to health policy commission at least 30
530 days before any hearing required under section 8 of chapter 6D. The center may contract with an
531 outside organization with expertise in issues related to the topics of the hearings to produce this
532 report.

533 The center shall publish the aggregate baseline expenditures starting in the 2020 annual
534 report.

535 The center, in consultation with the commission, shall determine the baseline
536 expenditures for individual health care entities and shall report to each health care entity its
537 respective baseline expenditures by October 1, 2020.

538 SECTION 18. Said chapter 12C is hereby further amended by striking out section 18, as
539 appearing in the 2018 Official Edition, and inserting in place thereof the following section:-

540 Section 18. The center shall perform ongoing analysis of data it receives under this
541 chapter to identify any payers, providers or provider organizations whose:

542 (1) Contribution to health care spending growth, including but not limited to spending
543 levels and growth as measured by total medical expense is considered excessive and who
544 threaten the ability of the state to meet the health care cost growth benchmark established by the
545 health policy commission under section 10 of chapter 6D; or

546 (2) Expenditures fail to meet the primary care and behavioral health expenditure
547 target under section 9A of chapter 6D.

548 The center shall confidentially provide a list of the payers, providers and provider
549 organizations to the health policy commission such that the commission may pursue further
550 action under sections 10 and 10A of chapter 6D.

551 SECTION 19. Said chapter 12C is hereby further amended by striking out section 23, as
552 so appearing, and inserting in place thereof the following section:-

553 Section 23. Subject to appropriation and notwithstanding any other general or special law
554 to the contrary, the center shall transfer annually \$10,000,000 to the Community Hospital and
555 Health Center Investment Trust Fund established in section 2TTTT of chapter 29, not later than
556 June 30; provided, however, that such transfer shall not result in an increase in the assessment
557 calculated under section 7.

558 SECTION 20. Said chapter 12C is hereby further amended by adding the following
559 section:-

560 Section 24. (a) Not later than April 1, the center shall analyze, for public and private
561 health care payers in Massachusetts, the average annual gross cost per utilizer of each drug
562 approved during the preceding 5 calendar years by the U.S. Food and Drug Administration.

563 (b) For each drug described in subsection (a) that the center projects has a current average
564 annual gross cost per utilizer for public and private health care payers in Massachusetts of
565 greater than \$50,000, the center shall refer the drug to the health policy commission for review

566 under section 8B of chapter 6D, and provide notice of the referral to the manufacturer of the
567 drug.

568 (c) Not later than May 1, the center shall publish an annual report detailing, at minimum:
569 (1) each drug referred to the health policy commission under subsection (b); and (2) the
570 projected current average annual gross cost per utilizer for public and private health care payers
571 in Massachusetts of each such drug.

572 (d) The center shall adopt any written policies, procedures or regulations necessary to
573 implement this section.

574 SECTION 21. Section 9 of chapter 13 of the General Laws, as appearing in the 2018
575 Official Edition, is hereby amended by inserting after the word “workers”, in line 8, the
576 following words:- , the board of registration in naturopathy, the board of registration of recovery
577 coaches, the board of registration of social workers, the board of registration of psychologists,
578 the board of registration of allied mental health and human services professions, the board of
579 allied health professions, the board of registration of dieticians and nutritionists, the board of
580 registration in podiatry, the board of registration in optometry, the board of registration of
581 dispensing opticians, the board of registration of chiropractors, the board of registration of
582 speech-language pathology and audiology, the board of registration of hearing instrument
583 specialists.

584 SECTION 22. Section 11D of said chapter 13, as so appearing, is hereby amended by
585 striking out, in lines 1 and 2, the words “division of professional licensure” and inserting in place
586 thereof, the following words:- department of public health.

587 SECTION 23. Subsection (c) of section 14 of said chapter 13, as so appearing, is hereby
588 amended by inserting, in line 4, after the words “twelve,”, the following words:- and chapter
589 112A.

590 SECTION 24. Section 79 of said chapter 13, as so appearing, is hereby amended by
591 striking out, in lines 17 and 18 and in line 27, the words “director of consumer affairs and
592 business regulations” and inserting in place thereof, each time they appear, the following words:-
593 commissioner of public health.

594 SECTION 25. Said chapter 13, as so appearing, is hereby amended by striking out
595 section 80 and inserting in place thereof the following section:-

596 Section 80. There shall be a board of registration of social workers hereinafter called the
597 board, which shall consist of 9 members: the commissioner of children and families, or a
598 designee; the commissioner of mental health, or a designee; 7 members to be appointed by the
599 Governor, 1 of whom is a representative from an accredited Massachusetts school of social work,
600 3 of whom are licensed under sections 130 to 137, inclusive, of chapter 112, 1 of whom is
601 licensed under sections 130 to 137, inclusive, of chapter 112 and is an active member of an
602 organized labor organization representing social workers , and 2 of whom are member of the
603 general public. Members of the board shall be residents of the commonwealth and citizens of the
604 United States. At least 1 licensed social work member and 1 member representing the general
605 public shall be from a minority group, as defined by the federal Department of Health and
606 Human Services. No more than 6 members of the board shall belong to any 1 political party.

607 SECTION 26. Section 84 of said chapter 13, as so appearing, is hereby amended by
608 striking out, in lines 8 and 9, the words “division of professional licensure” and inserting in place
609 thereof the following words:- department of public health.

610 SECTION 27. Said section 84 of said chapter 13, as so appearing, is hereby further
611 amended by striking out, in lines 44 and 45, inclusive, the words “Division of Professional
612 Licensure Trust Fund established in section 35V” and inserting in place thereof the following
613 words:- Quality in Health Professions Trust Fund established in section 35X.

614 SECTION 28. Section 88 of said chapter 13, as so appearing, is hereby amended by
615 striking out, in lines 1 and 2, the words “division of professional licensure” and inserting in place
616 thereof the following words:- department of public health.

617 SECTION 29. The first paragraph of section 90 of said chapter 13, as so appearing, is
618 hereby amended by striking out the third sentence.

619 SECTION 30. Said section 90 of said chapter 13, as so appearing, is hereby amended by
620 striking out the third paragraph and inserting in place thereof the following paragraph:- The
621 commissioner of public health shall have authority to review and approve rules and regulations
622 proposed by the board.

623 SECTION 31. Section 94 of said chapter 13, as so appearing, is hereby amended by
624 striking out, in line 13, the words “director of registration” and inserting in place thereof, the
625 following words:- commissioner of public health.

626 SECTION 32. Said chapter 13 is hereby further amended by adding the following
627 section:-

628 Section 110. (a) There shall be, within the department of public health, a board of
629 registration of recovery coaches which shall consist of 7 members to be appointed by the
630 governor, 1 of whom shall be the commissioner of public health or a designee, 1 of whom shall
631 be the commissioner of mental health or a designee; 1 of whom shall be employed as a recovery
632 coach, 1 of whom shall be a family member to an individual with a substance use disorder, 1 of
633 whom shall represent a health plan, 1 of whom shall be a licensed physician or nurse specializing
634 in addiction, and 1 member of the general public.

635 Members of the board shall be residents of the commonwealth.

636 (b) Each member of the board shall serve for a term of 3 years. Upon the expiration of a
637 term of office, a member shall continue to serve until a successor has been appointed. A member
638 shall not serve for more than 2 consecutive terms; provided, however, that a person who is
639 chosen to fill a vacancy in an unexpired term of a prior board member may serve for 2
640 consecutive terms in addition to the remainder of that unexpired term.

641 (c) A member may be removed by the governor for neglect of duty, misconduct or
642 malfeasance or misfeasance in office.

643 (d) The board shall, at its first meeting and annually thereafter, organize by electing from
644 its membership a chair, a vice-chair and a secretary. Those officers shall serve until their
645 successors are elected.

646 (e) The board shall meet at least four times annually and may hold additional meetings at
647 the call of the chair or at such times as may be determined by the board. Board members shall
648 serve without compensation but shall be reimbursed for actual and reasonable expenses incurred
649 in the performance of their duties.

650 SECTION 33. Section 8K of chapter 26 of the General Laws, as appearing in the 2018
651 Official Edition, is hereby amended by adding the following paragraphs:-

652 As part of its annual review of health insurance carriers' compliance with state and
653 federal mental health parity provisions, the commissioner of insurance shall require health
654 insurance carriers licensed or authorized to do business under chapters 175, 176A, 176B and
655 176G to submit utilization reports that document the number of requests, approvals, denials and
656 denial appeals for behavioral health and the number of requests, approvals, denials and denial
657 appeals for non-behavioral health services, and the number of approved out-of-network services
658 for behavioral health services and the number of approved out-of-network services for non-
659 behavioral health services. In creating guidance for these reports, the Division of Insurance shall
660 specify that information be broken down by region and behavioral health service category and
661 shall use this information as part of its evaluation of whether a health carrier's provider network
662 is adequate to provide access to covered behavioral health services.

663 The commissioner of insurance shall promulgate regulations to define provider
664 reimbursement parity rules that would apply similar rates of reimbursement to evaluation and
665 management office visits whether the evaluation and management office visits were provided by
666 primary care providers or licensed mental health professionals. Under these rules, the
667 commissioner shall require carriers to establish rates of reimbursement, by geographic region, for
668 evaluation and management office visits by licensed behavioral health providers that are no less
669 than the average rates of reimbursement for evaluation and management office visits by licensed
670 primary care providers in the same geographic region during the prior calendar year. The
671 commissioner shall, at least annually, convene a panel of experts from medical and behavioral
672 health specialties to define the list of office visit codes that will be subject to these rules.

673 SECTION 34. Chapter 29 of the General Laws is hereby amending by striking out
674 section 2TTTT and inserting in place thereof the following section:-

675 Section 2TTTT. (a) There shall be a Community Hospital and Health Center Investment
676 Trust Fund to be expended, without further appropriation, by the secretary of health and human
677 services. The fund shall consist of money from public and private sources, including gifts, grants
678 and donations, interest earned on such money, any other money authorized by the general court
679 and specifically designated to be credited to the fund and any funds provided from other sources.
680 Money in the fund shall be used to provide annual financial support, consistent with the terms of
681 this section, to eligible acute care hospitals and community health centers. The secretary, as
682 trustee, shall administer the fund and shall make expenditures from the fund consistent with this
683 section.

684 (b) The secretary may incur expenses and the comptroller may certify amounts for
685 payment in anticipation of expected receipts; provided, however, that, subject to subsection (e),
686 no expenditure shall be made from the fund which shall cause the fund to be deficient at the
687 close of a fiscal year. Revenues deposited in the fund that are unexpended at the end of a fiscal
688 year shall not revert to the General Fund and shall be available for expenditure in the following
689 fiscal year.

690 (c) The secretary shall periodically direct payments from the fund to eligible acute care
691 hospitals and community health centers. To be eligible to receive payment from the fund, an
692 acute care hospital (1) shall be licensed under section 51 of chapter 111; (2) shall not be or be
693 corporately affiliated with an academic medical center, teaching hospital or specialty hospital;
694 and (3) shall not be a hospital with relative prices that are at or above 90 per cent of the statewide

695 average relative price, as determined by the center for health information analysis. To be eligible
696 to receive payment from the fund, a community health center must be certified as a community
697 health center by the MassHealth program under 101 CMR 405.000 or any successor regulation.

698 (d) In directing payments in a given fiscal year, the secretary shall allocate payments to
699 eligible acute care hospitals and community health centers in the following manner: (1) 50 per
700 cent of payments shall be directed to eligible acute care hospitals in form of Medicaid
701 supplemental payments or other appropriate mechanism; and (2) 50 per cent of payments shall be
702 directed to community health centers in the following manner and allocation: 25 per cent of the
703 total community health center allocation shall be directed to community health centers in the
704 form of grants, and 75 per cent of the total community health center allocation shall be directed
705 to community health centers in the form of enhanced Medicaid payments. The secretary shall
706 establish by regulation or other appropriate written issuance any further eligibility criteria for
707 allocation of payments pursuant to this subsection.

708 (e) The secretary may require as a condition of receiving payment from the fund any such
709 reasonable condition of payment that the secretary determines necessary to ensure the
710 availability, to the extent possible, of federal financial participation for the payments, and the
711 secretary may incur expenses and the comptroller may certify amounts for payment in
712 anticipation of expected receipt of federal financial participation for the payments. Subject to
713 appropriation, an amount equal to the total annual anticipated federal financial participation
714 generated by the payments shall be transferred to the Community Hospital and Health Center
715 Investment Trust Fund not later than June 30.

716 (f) The executive office of health and human services may promulgate regulations as
717 necessary to carry out this section.

718 (g) Not later than October 15 of each fiscal year, the secretary shall file a report with the
719 joint committee on health care finance and the house and senate committees on ways and means
720 detailing the allocation and recipient of each payment during the prior fiscal year.

721 (h) An amount equal to the total receipts from the penalty established under chapter 63D
722 shall be transferred from the General Fund to the Community Hospital and Health Center
723 Investment Trust Fund before the end of each fiscal year.

724 SECTION 35. Chapter 32A of the General Laws is hereby amended by adding the
725 following 2 sections:-

726 Section 29. (a) As used in this section, “facility fee” and “health care provider” shall have
727 the same meanings as provided in section 51L of chapter 111.

728 (b) Coverage offered by the commission to an active or retired employee of the
729 commonwealth insured under the group insurance commission shall not provide reimbursement
730 to a health care provider for a facility fee for a service for which a facility fee is prohibited
731 pursuant to section 20 of chapter 6D and section 51L of chapter 111.

732 (c) Nothing in this section shall be construed to prohibit the commission from offering
733 coverage that restricts the reimbursement of facility fees beyond the limitations set forth in
734 section 51L of chapter 111.

735 Section 30. (a) For the purposes of this section, “Telehealth” as it pertains to the delivery
736 of health care services, shall mean the use of synchronous or asynchronous telecommunications

737 technology, including but not limited to live video, text messaging and application-based
738 communications, by a telehealth provider, as defined in section 4P of chapter 111, to provide
739 health care services, including, but not limited to, assessment, diagnosis, consultation, treatment
740 and monitoring of a patient. The term does not include audio-only telephone calls, e-mail
741 messages or facsimile transmissions.

742 (b) Coverage offered by the commission to an active or retired employee of the
743 commonwealth insured under the group insurance commission shall provide coverage, for health
744 care services through the use of telehealth by a contracted health care provider, consistent with
745 clause (i) of paragraph (4) of subsection (a) of section 6 of chapter 176O, if (i) the health care
746 services are covered by way of in-person consultation or delivery and (ii) the health care services
747 may be appropriately provided through the use of telehealth.

748 (c) A contract that provides coverage for services under this section may contain a
749 provision for a deductible, copayment or coinsurance requirement for a health care service
750 provided through telehealth as long as the deductible, copayment or coinsurance does not exceed
751 the deductible, copayment or coinsurance applicable to an in-person consultation.

752 (d) When determining coverage for telehealth services, carriers may use utilization
753 review systems, including preauthorization, to determine the appropriateness of telehealth as a
754 means of delivering a health care service, provided that the determination shall be made in the
755 same manner as if the service was provided via in-person consultation or delivery.

756 (e) Coverage for telehealth services shall not be required to reimburse a health care
757 provider for a health care service that is not a covered benefit under the plan nor to reimburse a

758 health care provider not contracted under the plan except as provided for under clause (i) of
759 paragraph (4) of subsection (a) of section 6 of chapter 176O.

760 (f) Coverage that reimburses a provider with a global payment, as defined in section 1 of
761 chapter 6D, shall account for the provision of telehealth services when the carrier calculates the
762 global payment allowed amount.

763 SECTION 36. Section 2 of chapter 62C of the General Laws, as appearing in the 2018
764 Official Edition, is hereby amended by adding the following words:- , and to the penalty imposed
765 by chapter 63D.

766 SECTION 37. The General Laws are hereby amended by inserting after chapter 63B the
767 following 2 chapters:-

768 Chapter 63C. Excise on manufacture and sale of certain opioids for distribution in the
769 commonwealth.

770 Section 1. “Commissioner”, the commissioner of revenue.

771 “Gross receipts”, receipts from sales made by a person to a purchaser that is not a related
772 party. In the case of sales to a related party or parties for subsequent resale to an unrelated buyer,
773 the gross receipts are the amount paid for the product by the first unrelated buyer.

774 “Opioid”, any product included in the pharmacological class category of full opioid
775 agonist, opioid agonist or partial opioid agonist in the National Drug Code (NDC) Directory
776 NDC Product File, except for products approved by the U.S. Food and Drug Administration for
777 the treatment of opioid use disorder.

778 “Person”, any natural person or legal entity.

779 “Related parties”, an entity that belongs to the same affiliated group as the person under
780 section 1504 of the Internal Revenue Code, as amended and in effect for the taxable year, or if
781 the entity and the person are otherwise commonly owned and controlled.

782 Section 2. (a) Any person who manufactures opioids and sells such products, directly or
783 through another person, for distribution in the commonwealth shall pay an excise of 15 per cent
784 of its gross receipts from such sales; provided, however, that gross receipts subject to the excise
785 under this section shall be limited to the sales of opioids that are ultimately dispensed in the
786 commonwealth pursuant to a valid prescription issued under section 18 of chapter 94C.

787 (b) A person who manufactures opioids and sells such products, directly or through
788 another person, for distribution in the commonwealth as described in subsection (a) shall file a
789 return as provided in subsection (a) of section 4 declaring total sales subject to excise in the
790 immediately preceding calendar quarter. In the event that a person filing such a return pays an
791 excise of 15 per cent of its gross receipts from sales of opioids that are not ultimately dispensed
792 in the commonwealth pursuant to a valid prescription issued under section 18 of chapter 94C, the
793 person may claim a credit for such excise amounts on the return for the tax period during which
794 such sales are ultimately dispensed.

795 Section 3. The excise under section 2 shall apply only to persons who maintain a place of
796 business in the commonwealth or whose total sales of all products, directly or through another
797 person, for distribution in the commonwealth are more than \$25,000 in the calendar quarter to
798 which the excise under section 2 otherwise would apply, or in the case of the 6 months ending
799 December 31, 2019, more than \$50,000 for such 6 month period.

800 Section 4. (a) Any person subject to the excise under section 2 shall file a return with the
801 commissioner and shall pay such excise by the fifteenth day of the third month following the end
802 of each calendar quarter. Such return shall set out the person's total sales subject to excise in the
803 immediately preceding calendar quarter and shall provide such other information as the
804 commissioner may require.

805 (b) Each person subject to the excise under section 2 shall provide to the commissioner
806 annually, on or before June 1st, a report detailing all opioids sold, directly or through another
807 person, for distribution in the commonwealth in the prior calendar year. Such report shall
808 include:

809 (i) the person's name, address, phone number, federal Drug Enforcement Administration
810 (DEA) registration number and controlled substance registration number issued by the
811 department;

812 (ii) the name and NDC of the opioid;

813 (iii) the unit of measure and quantity of the opioid;

814 (iv) the name, address and DEA registration number of the first unrelated buyer of the
815 opioid;

816 (v) the date of the sale of the opioid;

817 (vi) whether the opioid was ultimately dispensed in the commonwealth pursuant to a
818 valid prescription

819 issued under section 18 of chapter 94C;

820 (vii) the gross receipt total, in dollars, of all opioids sold;

821 (viii) the gross receipt total, in dollars, and quantity by NDC of all opioids ultimately
822 dispensed in the commonwealth pursuant to a valid prescription issued under section 18 of
823 chapter 94C; and

824 (ix) any other elements required by the commissioner.

825 Section 5. The excise imposed under this chapter shall be in addition to, and not a
826 substitute for or credit against any other tax or excise imposed under the General Laws.

827 Section 6. The commissioner may disclose information contained in returns and reports
828 filed under this chapter to the department of public health for purposes of verifying that the
829 appropriate amount of a filer's sales subject to excise are properly declared and that all reporting
830 is otherwise correct. Return and report information so disclosed shall remain confidential and
831 shall not be public record.

832 Section 7. To the extent that a person subject to excise under section 2 fails to pay
833 amounts due under this chapter, a related party of such person that directly or indirectly
834 distributes the opioid of such person in the commonwealth shall be jointly and severally liable
835 for the excise due.

836 Section 8. The commissioner may promulgate regulations or issue other guidance for the
837 implementation of this chapter.

838 Chapter 63D. Penalty on drug manufacturers for excessive price increases

839 Section 1. "Commissioner", the commissioner of revenue.

840 “Consumer price index”, the consumer price index for all urban consumers for Boston, as
841 most recently reported by the federal Bureau of Labor Statistics.

842 “Drug”, any medication, as identified by a National Drug Code, approved for sale by the
843 U.S. Food and Drug Administration.

844 “Excessive price,” the price of a drug if it exceeds the sum of (a) the reference price of
845 that drug, as adjusted for any increase or decrease in the consumer price index since the
846 reference price was determined, and (b) an additional two percent of the reference price for each
847 twelve month period that has elapsed since the date on which the reference price was determined.
848 The two percent increment provided in (b) of the preceding sentence shall compound annually on
849 the first day of the first calendar quarter commencing after the end of each 12 month period
850 described therein.

851 “Excessive price increase”, the amount by which the price of a drug exceeds the sum of
852 (a) the reference price of that drug, as adjusted for any increase or decrease in the consumer price
853 index since the reference price was determined, and (b) an additional two percent of the
854 reference price for each twelve month period that has elapsed since the date on which the
855 reference price was determined. The two percent increment provided in (b) shall compound
856 annually on the first day of the first calendar quarter commencing after the end of each twelve
857 month period described therein.

858 “Person”, any natural person or legal entity.

859 “Price”, the wholesale acquisition cost of a drug, per unit, as reported to the First Data
860 Bank or other applicable price compendium designated by the commissioner .

861 “Reference price”, the price of a drug as of October 1, 2019, or in the case of any drug
862 first commercially marketed in the United States after October 1, 2019, the price of the drug on
863 the date when first marketed.

864 “Related party”, an entity is a related party with respect to a person if that entity belongs
865 to the same affiliated group as that person under section 1504 of the Internal Revenue Code, as
866 amended and in effect for the taxable year, or if the entity and the person are otherwise under
867 common ownership and control.

868 “Unit”, the lowest dispensable amount of a drug.

869 Section 2. (a) Any person who manufactures and sells drugs, directly or through another
870 person, for distribution in the commonwealth and who establishes an excessive price for any
871 such drug directly or in cooperation with a related party, shall pay a per unit penalty on all units
872 of the drug ultimately dispensed or administered in the commonwealth. The penalty for each unit
873 shall be 80 per cent of the excessive price increase for each unit, determined at the beginning of
874 the calendar quarter.

875 (b) A person who establishes an excessive price for a drug as described in subsection (a)
876 shall file a return as provided in section 4 declaring all units of excessively priced drug sold for
877 distribution in the commonwealth during the quarter. In the event that a person filing such a
878 return pays a penalty with regard to one or more units of drug that are ultimately dispensed or
879 administered outside of the commonwealth, the person may claim a credit for such penalty
880 amounts on the return for the tax period during which such units are ultimately dispensed or
881 administered.

882 Section 3. The penalty under section 2 shall apply for any calendar quarter only to a
883 person who maintains a place of business in the commonwealth or whose total sales of all
884 products, directly or through another person, for distribution in the commonwealth were more
885 than \$100,000 in the prior twelve month period. The penalty shall not apply more than once to
886 any unit of drug sold.

887 Section 4. Any person subject to the penalty under section 2 shall file a return with the
888 commissioner and shall pay the penalty by the fifteenth day of the third month following the end
889 of each calendar quarter, subject to such reasonable extensions of time for filing as the
890 commissioner may allow. The return shall set out the person's total sales subject to penalty in the
891 immediately preceding calendar quarter and shall provide such other information as the
892 commissioner may require.

893 Section 5. The penalty imposed under this chapter shall be in addition to, and not a
894 substitute for or credit against, any other penalty, tax or excise imposed under the General Laws.

895 Section 6. The commissioner may disclose information contained in returns filed under
896 this chapter to the department of public health for purposes of verifying that a filer's sales subject
897 to penalty are properly declared and that all reporting is otherwise correct. Return information so
898 disclosed shall remain confidential and shall not be public record.

899 Section 7. To the extent that a person subject to penalty under section 2 fails to pay
900 amounts due under this chapter, a related party of such person that directly or indirectly
901 distributes in the commonwealth any drug whose sales are subject to this chapter shall be jointly
902 and severally liable for the penalty due.

903 Section 8. The commissioner may promulgate regulations or issue other guidance for the
904 implementation of this chapter.

905 SECTION 38. Section 1 of chapter 94C of the General Laws, as appearing in the 2018
906 Official Edition, is hereby amended by inserting after the definition for “Marihuana” the
907 following definition:-

908 “Medication Order”, an order for medication entered on a patient’s medical record
909 maintained at a hospital, other health facility or ambulatory health care setting registered under
910 this chapter; provided, however, that the order is dispensed only for immediate administration at
911 the facility to the ultimate user by an individual who is authorized to administer such medication
912 under this chapter.

913 SECTION 39. Said section 1 of said chapter 94C, as so appearing, is hereby further
914 amended by striking out, in line 290, the words “practitioner, registered nurse, or practical nurse”
915 and inserting in place thereof the following words:- an individual who is authorized to administer
916 such medication under this chapter.

917 SECTION 40. Said section 1 of said chapter 94C, as so appearing, is hereby further
918 amended by striking out the definition of “Practitioner” and inserting in place thereof the
919 following definition:-

920 “Practitioner”,

921 (a) A physician, dentist, veterinarian, podiatrist, scientific investigator, or other person
922 registered to distribute, dispense, conduct research with respect to, or use in teaching or chemical

923 analysis, a controlled substance in the course of professional practice or research in the
924 commonwealth;

925 (b) A pharmacy, hospital, or other institution registered to distribute, dispense, conduct
926 research with respect to or to administer a controlled substance in the course of professional
927 practice or research in the commonwealth.

928 (c) An optometrist authorized by sections 66, 66B and 66C of chapter 112 and registered
929 pursuant to paragraph (h) of section 7 to utilize and prescribe therapeutic pharmaceutical agents
930 in the course of professional practice in the commonwealth.

931 (d) A nurse practitioner or psychiatric nurse mental health clinical specialist authorized
932 by section 80E of chapter 112 and registered pursuant to subsection (f) of section 7 to distribute,
933 dispense, conduct research with respect to or use in teaching or chemical analysis a controlled
934 substance in the course of professional practice or research in the commonwealth.

935 (e) A nurse anesthetist authorized by section 80H of chapter 112 and registered pursuant
936 to subsection (g) of section 7 to distribute, dispense, conduct research with respect to or use in
937 teaching or chemical analysis a controlled substance in the course of professional practice or
938 research in the commonwealth.

939 SECTION 41. Said section 1 of said chapter 94C, as so appearing, is hereby further
940 amended by striking out, in lines 367 and 368, the words “practitioner, registered nurse or
941 practical nurse” and inserting in place thereof the following words:- an individual who is
942 authorized to administer such medication under this chapter.

943 SECTION 42. Subsection (a) of section 7 of said chapter 94C, as so appearing, is hereby
944 amended by inserting after the word “issuance”, in line 9, the following words:-

945 or until completion of the term of the registrant’s license issued pursuant to chapter 112,
946 whichever occurs later.

947 SECTION 43. Paragraph (4) of subsection (d) of said section 7 of said chapter 94C, as so
948 appearing, is hereby amended by inserting after the words “licensed practical nurse”, in line 80,
949 the following words:- or a licensed dental therapist under the supervision of a practitioner for the
950 purposes of administering analgesics, anti-inflammatories and antibiotics.

951 SECTION 44. Subsection (f) of said section 7 of said chapter 94C, as so appearing, is
952 hereby amended by inserting after the word “podiatrist”, in line 122 and in lines 125 through
953 126, each time it appears, the following words:- , nurse practitioner, nurse anesthetist, psychiatric
954 nurse mental health clinical specialist.

955 SECTION 45. Subsection (g) of said section 7 of said chapter 94C, as so appearing, is
956 hereby amended by striking out the second paragraph.

957 SECTION 46. Said subsection (g) of said section 7 of said chapter 94C, as so appearing,
958 is hereby further amended by striking out the last paragraph.

959 SECTION 47. Subsection (h) of said section 7 of said chapter 94C, as so appearing, is
960 hereby amended by striking out, in line 213, the words “and 66B” and inserting in place thereof
961 the following words:- , 66B and 66C.

962 SECTION 48. Subsection (a) of section 9 of said chapter 94C, as so appearing, is hereby
963 amended by inserting after the word “podiatrist”, in line 1, the following words:- , nurse
964 practitioner, nurse anesthetist, psychiatric nurse mental health clinical specialist.

965 SECTION 49. Said subsection (a) of said section 9 of said chapter 94C, as so appearing,
966 is hereby further amended by striking out, in line 2, the words “and 66B” and inserting in place
967 thereof the following words:- , 66B and 66C.

968 SECTION 50. Said subsection (a) of said section 9 of said chapter 94C, as so appearing,
969 is hereby further amended by striking out, in lines 3 to 5, inclusive, the words “, nurse
970 practitioner and psychiatric nurse mental health clinical specialist as limited by subsection (g) of
971 said section 7 and section 80E of said chapter 112”.

972 SECTION 51. Said subsection (a) of said section 9 of said chapter 94C, as so appearing,
973 is hereby further amended by striking out, in lines 8 and 9, the words “, nurse anesthetist, as
974 limited by subsection (g) of said section 7 and section 80H of said chapter 112”.

975 SECTION 52. Said subsection (a) of said section 9 of said chapter 94C, as so appearing,
976 is hereby further amended by adding the following paragraph:-

977 A practitioner may cause controlled substances to be administered under the
978 practitioner’s direction by a licensed dental therapist, for the purposes of administering
979 analgesics, anti-inflammatories and antibiotics.

980 SECTION 53. Subsection (b) of said section 9 of said chapter 94C, as so appearing, is
981 hereby amended by inserting after the word “nurse-midwifery”, in line 32, the following words:-
982 , advanced practice nursing.

983 SECTION 54. Subsection (c) of said section 9 of said chapter 94C, as so appearing, is
984 hereby amended by inserting after the word “podiatrist”, in lines 72 and 80, each time it appears,
985 the following word:- , optometrist.

986 SECTION 55. Said subsection (c) of said section 9 of said chapter 94C, as so appearing,
987 is hereby further amended by adding the following paragraph:-

988 A licensed dental therapist who has obtained a controlled substance from a practitioner
989 for dispensing to an ultimate user under subsection (a) shall return any unused portion of the
990 substance that is no longer required by the patient to the practitioner.

991 SECTION 56. Subsection (e) of said section 9 of said chapter 94C, as so appearing, is
992 hereby amended by inserting after the word “practitioner”, in lines 100 and 107, each time it
993 appears, the following words:- , nurse anesthetist, psychiatric nurse mental health clinical
994 specialist.

995 SECTION 57. Section 18 of said chapter 94C, as so appearing, is hereby amended by
996 striking out, in lines 10, 39 and 72, the words “to practice medicine” and inserting in place
997 thereof, in each instance, the following words:- and authorized to engage in prescriptive practice.

998 SECTION 58. Said section 18 of said chapter 94C, as so appearing, is hereby further
999 amended by striking out the word “physician”, in lines 25, 34 and 35, 38, 72 and 74, and
1000 inserting in place thereof, in each instance, the following word:- practitioner.

1001 SECTION 59. Said section 18 of said chapter 94C, as so appearing, is hereby further
1002 amended by striking out, in lines 27, 54 and 55, and in line 88, the word “medicine”.

1003 SECTION 60. Said chapter 94C is hereby further amended by inserting after section 21B
1004 the following section:-

1005 Section 21C. (a) For the purposes of this section, the following words shall have the
1006 following meanings unless the context clearly requires otherwise:

1007 “Cost sharing”, amounts owed by a consumer under the terms of the consumer’s health
1008 benefit plan as defined in section 1 of chapter 176O or as required by a pharmacy benefit
1009 manager as defined in subsection (a) of section 226 of chapter 175.

1010 “Pharmacy retail price”, the amount an individual would pay for a prescription
1011 medication at a pharmacy if the individual purchased that prescription medication at that
1012 pharmacy without using a health benefit plan as defined in section 1 of chapter 176O or any
1013 other prescription medication benefit or discount.

1014 “Registered pharmacist”, a pharmacist who holds a valid certificate of registration issued
1015 by the board of registration in pharmacy pursuant to section 24 of chapter 112.

1016 (b) The pharmacist, or an authorized individual at the direction of a pharmacist, shall
1017 charge an insured the lower of (i) the applicable cost sharing amount under the terms of the
1018 insured’s health benefit plan, (ii) the pharmacy benefits manager’s contracted rate of payment to
1019 the pharmacy for the prescription drug or (iii) the retail price of the prescription drug if
1020 purchased without insurance, pursuant to requirements under section 2 of chapter 176O.

1021 (c) A contractual obligation shall not prohibit a pharmacist from complying with this
1022 section; provided, however, that a pharmacist shall submit a claim to the consumer’s health

1023 benefit plan or its pharmacy benefit manager if the pharmacist has knowledge that the
1024 prescription medication is covered under the consumer's health benefit plan.

1025 SECTION 61. Section 32I of said chapter 94C, as appearing in the 2018 Official Edition,
1026 is hereby amended by adding the following subsection:-

1027 (e) This section shall not apply to mass spectrometers.

1028 SECTION 62. Chapter 111 of the General Laws is hereby amended by inserting after
1029 section 4O the following section:-

1030 Section 4P. (a) As used in this section, the following terms shall have the following
1031 meanings unless the context clearly requires otherwise: "Telehealth", as it pertains to the
1032 delivery of health care services, the use of synchronous or asynchronous telecommunications
1033 technology, including but not limited to live video, text messaging and application-based
1034 communications, by a telehealth provider to provide health care services, including, but not
1035 limited to, assessment, diagnosis, consultation, treatment and monitoring of a patient. The term
1036 does not include audio-only telephone calls, e-mail messages or facsimile transmissions.

1037 "Telehealth provider", any individual who provides health care and related services using
1038 telehealth and who is licensed or certified to practice in the commonwealth, provided that a
1039 telehealth provider has the duty to practice in a manner consistent with his or her scope of
1040 practice and the prevailing professional standard of practice in the commonwealth.

1041 (b) Notwithstanding any general or special laws to the contrary, a telehealth provider may
1042 render telehealth services to a patient, whether or not the telehealth provider has previously

1043 conducted an in-person examination of or consultation with the patient, provided that such
1044 telehealth service is provided in accordance with subsection (a).

1045 SECTION 63. Said chapter 111 is hereby further amended by inserting after section 51½
1046 the following section:-

1047 Section 51¾. The department shall promulgate regulations requiring all acute care
1048 hospitals licensed under section 51G to provide or arrange for qualified behavioral health
1049 clinicians to evaluate and stabilize a person admitted to the emergency department with a
1050 behavioral health presentation and, to refer such person for appropriate treatment or inpatient
1051 admission.

1052 SECTION 64. Said chapter 111 is hereby further amended by inserting after section 51K
1053 the following 2 sections:-

1054 Section 51L. (a) As used in this section and section 51M, the following terms shall have
1055 the following meanings unless the context clearly requires otherwise:

1056 “Campus”, a hospital’s main buildings, the physical area immediately adjacent to a
1057 hospital’s main buildings and other areas and structures that are not strictly contiguous to the
1058 main buildings but are located within 250 yards of the main buildings or other area that has been
1059 determined by the Centers for Medicare and Medicaid Services to be part of a hospital’s campus.

1060 “Facility fee”, a fee charged, billed or collected by a health care provider for hospital
1061 services provided in a facility that is owned or operated, in whole or in part, by a hospital or
1062 health system that is intended to compensate the health care provider for operational expenses
1063 and is separate and distinct from a professional fee.

1064 “Health care provider”, shall have the same meaning as in section 1 of chapter 6D.

1065 “Hospital”, a hospital licensed pursuant to section 51 of chapter 111.

1066 “Professional fee”, a fee charged or billed by a health care provider for professional
1067 medical services.

1068 (b) A health care provider shall not charge, bill or collect a facility fee except for: (i)
1069 services provided on a hospital’s campus; (ii) services provided at a facility that includes a
1070 licensed hospital emergency department; or (iii) emergency services provided at a licensed
1071 satellite emergency facility.

1072 (c) Notwithstanding subsection (b), a health care provider shall not charge, bill, or collect
1073 a facility fee for a service identified by the commission pursuant to its authority in section 20 of
1074 chapter 6D as a service that may reliably be provided safely and effectively in settings other than
1075 hospitals.

1076 (d) The department may promulgate regulations necessary to implement this section and
1077 impose penalties for non-compliance consistent with the department’s authority to regulate
1078 health care providers. A health care provider that violates any provision of this section or the
1079 rules and regulations adopted pursuant hereto shall be punished by a fine of not more than
1080 \$1,000 per occurrence.

1081 Section 51M. (a) If a health care provider charges or bills a facility fee for services, the
1082 health care provider shall provide any patient receiving such service with written notice that such
1083 a fee will be charged and may be billed separately.

1084 (b) If a health care provider is required to provide a patient with notice under subsection
1085 (a) and a patient's appointment is scheduled to occur not less than 10 days after the appointment
1086 is made, the health care provider shall provide written notice and explanation to the patient by
1087 first class mail, encrypted electronic means or a secure patient Internet portal not less than 3 days
1088 after the appointment is made. If an appointment is scheduled to occur less than 10 days after the
1089 appointment is made or if the patient arrives without an appointment, the notice shall be provided
1090 to the patient on the facility's premises.

1091 If a patient arrives without an appointment, a health care provider shall provide written
1092 notice and explanation to the patient prior to the care if practicable, or if prior notice is not
1093 practicable, the health care provider shall provide an explanation of the fee to the patient within a
1094 reasonable period of time; provided, however, that the explanation of the fee shall be provided
1095 before the patient leaves the facility. If the patient is incapacitated or otherwise unable to read,
1096 understand and act on the patient's rights, the notice and explanation of the fee shall be provided
1097 to the patient's representative within a reasonable period of time.

1098 (c) A facility at which facility fees for services are charged, billed, or collected shall
1099 clearly identify itself as being associated with a hospital, including by stating the name of the
1100 hospital that owns or operates the location in its signage, marketing materials, Internet web sites,
1101 and stationery.

1102 (d) If a health care provider charges, bills, or collects facility fees at a given facility,
1103 notice shall be posted in that facility informing patients that a patient may incur higher financial
1104 liability as compared to receiving the service in a non-hospital facility. Notice shall be

1105 prominently displayed in locations accessible to and visible by patients, including in patient
1106 waiting areas.

1107 (e)(1) If a location at which health care services are provided without facility fees
1108 changes status such that facility fees would be permissible at that location under section 51L, and
1109 the health care provider that owns or operates the location elects to charge, bill, or collect facility
1110 fees, the health care provider shall provide written notice to all patients who received services at
1111 the location during the previous calendar year not later than 30 days after the change of status.
1112 The notice shall state that: (i) the location is now owned or operated by a hospital; (ii) certain
1113 health care services delivered at the facility may result in separate facility and professional bills
1114 for services; and (iii) patients seeking care at the facility may incur higher financial liability at
1115 that location due to its change in status.

1116 (2) In cases in which a written notice is required by paragraph (1), the health care
1117 provider that owns or operates the location shall not charge or bill a facility fee for services
1118 provided at that location until not less than 30 days after the written notice is provided.

1119 (3) A notice required or provided under paragraph (1) shall be filed with the department
1120 not later than 30 days after its issuance.

1121 (f) The department may promulgate regulations necessary to implement this section and
1122 impose penalties for non-compliance consistent with the department's authority to regulate
1123 health care providers. A health care provider that violates any provision of this section or the
1124 rules and regulations adopted pursuant hereto shall be punished by a fine of not more than
1125 \$1,000 per occurrence. In addition to any penalties for noncompliance that may be established by
1126 the department, a violation of this section shall be an unfair trade practice under chapter 93A.

1127 SECTION 65. Section 52 of said chapter 111, as appearing in the 2018 Official Edition,
1128 is hereby amended striking out the definition of “clinic” and inserting in place thereof the
1129 following definition:-

1130 “Clinic”, any entity, however organized, whether conducted for profit or not for profit,
1131 which is advertised, announced, established, or maintained for the purpose of providing
1132 ambulatory medical, surgical, dental, physical rehabilitation, or mental health services. In
1133 addition, “clinic” shall include any entity, however organized, whether conducted for profit or
1134 not for profit, which is advertised, announced, established, or maintained under a name which
1135 includes the words “clinic”, “dispensary”, “institute”, or “urgent care” and which suggests that
1136 ambulatory medical, surgical, dental, physical rehabilitation, or mental health services are
1137 rendered therein. With respect to any entity which is not advertised, announced, established, or
1138 maintained under one of the names in the preceding sentence, “clinic” shall not include a medical
1139 office building, or one or more practitioners engaged in a solo or group practice, whether
1140 conducted for profit or not for profit, and however organized, so long as such practice is wholly
1141 owned and controlled by one or more of the practitioners so associated, or, in the case of a not
1142 for profit organization, its only members are one or more of the practitioners so associated or a
1143 clinic established solely to provide service to employees or students of such corporation or
1144 institution.

1145 SECTION 66. Said section 52 of said chapter 111, as so appearing, is hereby further
1146 amended by adding the following 2 definitions:-

1147 “Urgent care clinic”, any entity, however organized, whether conducted for profit or not
1148 for profit, which is advertised, announced, established, or maintained for the purpose of

1149 providing urgent care services in an office or a group of offices, or any portion thereof, or an
1150 entity which is advertised, announced, established, or maintained under a name which includes
1151 the words “urgent care” or which suggests that urgent care services are provided therein. Urgent
1152 care clinics cannot serve as a patient’s primary care provider.

1153 “Urgent care services”, delivery of episodic care for the diagnosis, treatment,
1154 management or monitoring of acute and chronic disease or injury that is: (i) for the treatment of
1155 illness or injury that is immediate in nature but does not require emergency services; (ii)
1156 generally provided on a walk-in basis without a prior appointment; (iii) available to the general
1157 public; and is not intended as the patient’s primary care provider.

1158 SECTION 67. Said chapter 111 of the General Laws, as so appearing, is hereby further
1159 amended by inserting after section 52 the following 2 sections:-

1160 Section 52A. The department shall promulgate regulations regarding licensure of urgent
1161 care clinics. Such regulations shall include requirements regarding the coordination by urgent
1162 care clinics with a patient’s primary care provider.

1163 Any such urgent care clinic shall apply to participate as a MassHealth billing provider
1164 and participate as a provider if said application is approved. An urgent care clinic shall not serve
1165 as a patient’s primary care provider.

1166 The department may impose a fine of up to \$10,000 on a person or entity that advertises,
1167 announces, establishes, or maintains an urgent care center without a license granted by the
1168 department. The department may impose a fine of not more than \$10,000 on a licensed urgent
1169 care center that violates this section or any rule or regulation promulgated hereunder. Each day

1170 during which a violation continues shall constitute a separate offense. The department may
1171 conduct surveys and investigations to enforce compliance with this section.

1172 Section 52B. The department, in consultation with the department of mental health, shall
1173 promulgate regulations regarding provision of behavioral health care in clinics licensed pursuant
1174 to section 51 of chapter 111. Such regulations shall require provision of behavioral health care in
1175 clinics licensed to provide medical, mental health, substance use disorder or urgent care services.

1176 SECTION 68. Said chapter 111 of the General Laws is hereby further amended by
1177 striking out section 228 and inserting in place thereof the following section:-

1178 Section 228. (a) For the purposes of this section, “allowed amount”, shall mean the
1179 contractually agreed-upon amount paid by a carrier to a health care provider for health care
1180 services provided to an insured.

1181 (b) Prior to an admission, procedure or service and upon request by a patient or
1182 prospective patient, a health care provider shall, within 2 working days, disclose the allowed
1183 amount or charge of the admission, procedure or service, including the amount for any health
1184 care services rendered by an out-of-network provider and any facility fees required; provided,
1185 however, that if a health care provider is unable to quote a specific amount in advance due to the
1186 health care provider’s inability to predict the specific treatment or diagnostic code, the health
1187 care provider shall disclose the estimated maximum allowed amount or charge for a proposed
1188 admission, procedure or service, including the amount for any facility fees required.

1189 (c) If a patient or prospective patient is covered by a health benefit plan, a health care
1190 provider who participates as a network provider shall, at the time of scheduling a procedure or
1191 service, (i) provide sufficient information regarding the proposed admission, procedure or

1192 service for the patient or prospective patient to make an informed decision about the costs
1193 associated with that admission, procedure or service based on information available to the
1194 provider at that time, including the amount of any facility fees; and (ii) if the patient is in an
1195 insured health benefit plan, inform the patient or prospective patient that the patient or
1196 prospective patient may obtain additional information about any applicable out-of-pocket costs,
1197 pursuant to section 23 of chapter 176O. A health care provider may assist a patient or
1198 prospective patient in using the health plan's toll-free number and website pursuant to said
1199 section 23 of said chapter 176O.

1200 (d) Each health care provider shall determine whether it is an out-of-network provider, as
1201 defined in section 1 of chapter 176O, for a patient prior to an admission, procedure or service for
1202 conditions that are not emergency medical conditions. If the health care provider is an out-of-
1203 network provider under the terms of the patient's health benefit plan, such provider shall notify
1204 the patient in writing of that fact no less than 48 hours before the scheduled admission, procedure
1205 or service.

1206 (e) A health care provider referring a patient to another provider shall disclose: (i) if the
1207 provider to whom the patient is being referred is part of or represented by the same provider
1208 organization, as used in section 11 of chapter 6D; (ii) the possibility that the provider to whom
1209 the patient is being referred is not in the patient's health benefit plan network, and that if the
1210 provider is out-of-network under the terms of the patient's health benefit plan then any out-of-
1211 network applicable rates under such health benefit plan may apply, and that the patient has the
1212 opportunity to verify said provider's network status in the patient's health benefit plan network
1213 prior to making an appointment or agreeing to use the services of said provider; and (iii)
1214 sufficient information about the referred provider for the patient to obtain additional information

1215 about that provider's network status under the patient's health benefit plan and any applicable
1216 out-of-pocket costs for services sought from the referred provider, including those that may be
1217 required under section 23 of chapter 176O, based on information available to the provider at that
1218 time.

1219 (f) A health care provider referring a patient to another provider by directly scheduling,
1220 ordering, or otherwise arranging for the health care services on the patient's behalf shall, prior to
1221 scheduling, ordering or otherwise arranging for the health care services on the patient's behalf:
1222 (i) verify the network status of the provider to whom the patient is being referred relative to the
1223 patient's health benefit plan; and (ii) notify the patient if the provider to whom the patient is
1224 being referred is an out-of-network provider.

1225 (g) As provided in section 29 of chapter 176O, an out-of-network provider in an insured
1226 health benefit plan shall not bill an insured for health care services in excess of the applicable
1227 coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for
1228 such health care services if the services were rendered by a participating provider.

1229 (h) The commissioner shall implement this section and impose penalties for non-
1230 compliance consistent with the department's authority to regulate health care providers. A health
1231 care provider that violates any provision of this section or the rules and regulations adopted
1232 pursuant hereto shall be liable for penalties as provided in this subsection.

1233 SECTION 69. Section 1 of chapter 112 of the General Laws, as appearing in the 2018
1234 Official Edition, is hereby amended by inserting after the word "dentistry", in line 12, the
1235 following words:- , the board of registration of genetic counselors, the board of registration of
1236 community health workers, the board of registration in naturopathy, the board of registration of

1237 recovery coaches, the board of registration of social workers, the board of registration of
1238 psychologists, the board of registration of allied mental health and human services professions,
1239 the board of allied health professions, the board of registration of dieticians and nutritionists, the
1240 board of registration in podiatry, the board of registration in optometry, the board of registration
1241 of dispensing opticians, the board of registration of chiropractors, the board of registration of
1242 speech-language pathology and audiology, the board of registration of hearing instrument
1243 specialists.

1244 SECTION 70. Said chapter 112 is hereby further amended by striking out section 13, as
1245 so appearing, and inserting in place thereof the following section:-

1246 Section 13. (a) As used in this chapter, “podiatry” shall mean the diagnosis and treatment,
1247 by medical, mechanical, electrical or surgical means, of ailments of the human foot and lower
1248 leg.

1249 (b) As used in sections 12B, 12G and 80B, “physician” shall include a podiatrist
1250 registered under section 16.

1251 (c) The provisions of this section to section 1318, inclusive, shall not apply to surgeons
1252 of the United States army, United States navy or of the United States Public Health Service or to
1253 physicians registered in the commonwealth.

1254 SECTION 71. Section 16 of said chapter 112, as appearing in the 2018 Official Edition,
1255 is hereby amended by adding the following paragraph:- All application fees and civil
1256 administrative penalties and fines collected by the board under sections 13 to 23, inclusive, and
1257 section 61, shall be deposited into the Quality in Health Professions Trust Fund established in
1258 section 35X of chapter 10.

1259 SECTION 72. Section 23B of said chapter 112, as so appearing, is hereby amended by
1260 adding the following paragraph:- All application fees and civil administrative penalties and fines
1261 collected by the board under sections 23A to 23P½, inclusive, and section 61, shall be deposited
1262 into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

1263 SECTION 73. Section 23M½ of said chapter 112, as so appearing, is hereby amended by
1264 striking out, in lines 78 to 79, the words “Division of Professional Licensure Trust Fund
1265 established by section 35V” and inserting in place thereof the following words:- Quality in
1266 Health Professions Trust Fund established in section 35X.

1267 SECTION 74. Section 43A of said chapter 112, as so appearing, is hereby amended by
1268 inserting after the definition of “Appropriate supervision” the following 2 definitions:-

1269 “Board”, the board of registration in dentistry established pursuant to section 19 of
1270 chapter 13 or a committee or subcommittee of the board.

1271 “Collaborative management agreement”, a written agreement that complies with section

1272 51B between a dental therapist and a supervising dentist, as defined in section 43A, who
1273 holds a valid license issued pursuant to section 45, who agrees to provide the appropriate level of
1274 communication and consultation with a licensed dental therapist to ensure patient health and
1275 safety.

1276 SECTION 75. Said section 43A of said chapter 112, as so appearing, is hereby further
1277 amended by inserting after the definition of “Dental hygienist” the following definition:-

1278 “Dental therapist”, a person who: (i) is registered by the board to practice as a dental
1279 therapist pursuant to section 51B and as a dental hygienist pursuant to section 51; and (ii)
1280 provides oral health

1281 SECTION 76. Said section 43A of said chapter 112, as so appearing, is hereby further
1282 amended by adding the following definition:-

1283 “Supervising dentist”, a licensed dentist licensed in Massachusetts pursuant to section 45
1284 of this chapter who enters into a collaborative management agreement with a dental therapist.

1285 SECTION 77. Section 45A of said chapter 112, as so appearing, is hereby amended by
1286 striking out, in lines 4 and 5, the words “the faculty of a reputable dental college as defined in
1287 section forty-six” and inserting place thereof the following words:- a dental college approved by
1288 the board.

1289 SECTION 78. Section 46 of said chapter 112 is hereby repealed.

1290 SECTION 79. Section 51 of said chapter 112, as appearing in the 2018 Official Edition,
1291 is hereby amended by striking out, in line 17, the word “revoked.” and inserting in place thereof
1292 the following words:- null and void.

1293 SECTION 80. Section 51½ of said chapter 112, as so appearing, is hereby amended by
1294 striking out, in line 10, the word “revoked” and inserting in place thereof the following words:-
1295 null and void.

1296 SECTION 81. Said section 51½ of said chapter 112, as so appearing, is hereby further
1297 amended by inserting after the word “dentist” in lines 18 and 31, in both instances, the following
1298 words:- , or a licensed dental therapist to the extent provided in section 51B.

1299 SECTION 82. Said section 51½ of said chapter 112, as so appearing, is hereby further
1300 amended by inserting after the word “practice” in line 78, the following words:- , or a dental
1301 therapist licensed under section 51B,.

1302 SECTION 83. Said chapter 112 is hereby further amended by inserting after section 51A
1303 the following section:-

1304 Section 51B. (a) Any person of good moral character, 19 years old or over, who: (i) is a
1305 graduate of a master’s level dental therapist education program that includes both dental therapy
1306 and dental hygiene education, or an equivalent combination of both dental therapy education and
1307 dental hygiene education, if all education programs are accredited by the Commission on Dental
1308 Accreditation; (ii) passes a comprehensive, competency-based clinical examination that is
1309 approved by the board and administered by a recognized national or regional dental testing
1310 service that administers testing for dentists and other dental professionals or equivalent
1311 examination administered by another entity approved by the board; and (iii) obtains a policy of
1312 professional liability insurance and shows proof of such insurance as required by rules and
1313 regulations shall, upon payment of a fee to be determined annually by the secretary of
1314 administration and finance under the provision of section 3B of chapter 7, be registered as a
1315 dental therapist and be given a certificate to practice in this capacity. A licensed dental therapist
1316 shall have practiced under the direct supervision of a supervising dentist for a minimum of 2
1317 years or 2,500 hours, whichever is longer, before practicing under general supervision pursuant
1318 to a collaborative management agreement. Dental therapists licensed under this section shall
1319 renew licensure biennially, on a date determined by the board, upon application and payment of
1320 a fee, as determined by the secretary of administration and finance under section 3B of chapter 7.

1321 Upon receipt of a license pursuant to section 45, any certificate issued hereunder shall be null
1322 and void.

1323 Notwithstanding section 43A, as used in this section and in any rules and regulations
1324 promulgated by the board or the department of health to implement this section, “general
1325 supervision” shall mean supervision of procedures and services based on a written collaborative
1326 management agreement between a licensed dentist and a licensed dental therapist but not
1327 requiring a prior exam or diagnosis by a supervising dentist or the physical presence of a
1328 supervising dentist during the performance of those procedures and services unless required by
1329 the supervising dentist in the collaborative management agreement.

1330 (b) Any person who has met the requirements to be registered as a dental therapist under
1331 any provision of this section may also be registered as a dental hygienist and be given a
1332 certificate to practice in this capacity.

1333 (c) Dental therapists educated in the commonwealth must graduate from a master’s level
1334 dental therapy education program that is accredited by the Commission on Dental Accreditation
1335 provided by a post-secondary institution accredited by the New England Association of Schools
1336 and Colleges, Inc. All dental therapy educational programs in the commonwealth must include at
1337 least one licensed dentist as an instructor. The board shall provide guidance for any educational
1338 entity or institution that may operate all or some portion of a master’s level program, or may
1339 collaborate with other educational entities, including but not limited to universities, colleges,
1340 community colleges, and technical colleges, to operate all or some portion of a master’s level
1341 program. The board may also provide guidance to develop mechanisms to award advanced
1342 standing to students who have completed coursework at other educational programs accredited

1343 by the Commission on Dental Accreditation. All education programs must prepare students to
1344 perform all procedures and services within the dental therapy scope of practice as set forth in this
1345 section.

1346 The educational curriculum for a dental therapist educated in the commonwealth shall
1347 include training on serving patients with special needs including, but not limited to, people with
1348 developmental disabilities including autism spectrum disorders, mental illness, cognitive
1349 impairment, complex medical problems, or significant physical limitations, and the vulnerable
1350 elderly.

1351 Not later than January 1, 2024, the board shall approve a comprehensive, competency
1352 based clinical dental therapy examination that includes assessment of technical competency in
1353 performing the procedures and services within the scope of practice as set forth in this section, to
1354 be administered by a recognized national or regional dental testing service that administers
1355 testing for dentists and other dental professionals. The examination shall be comparable to the
1356 examination given to applicants for a dental license but only for the limited scope of dental
1357 services in the dental therapy scope of practice as set forth in this section.

1358 (d) The board shall grant a dental therapy license by examination to an applicant, upon
1359 payment of a fee as determined under subsection (a), provided the applicant is of good moral
1360 character and has: (i) met the eligibility requirements as defined by the board; (ii) submitted
1361 documentation to the board of a passing score on a comprehensive, competency-based clinical
1362 examination or combination of examinations that includes both dental therapy and dental
1363 hygiene components and are approved by the board and administered by a recognized national or
1364 regional dental testing service that administers testing for dentists and other dental professionals;

1365 and (iii) submitted to the board documentation of a passing score on the Massachusetts Dental
1366 Ethics and Jurisprudence Examination or any other successor examination. An applicant failing
1367 to pass the examination shall be entitled to re-examination pursuant to the rules and guidelines
1368 established by the Commission on Dental Competency Assessments (formerly NERB), for which
1369 the applicant shall pay a fee determined annually by the secretary of administration and finance
1370 under the provision of section 3B of chapter 7.

1371 The board shall require as a condition of granting or renewing authorization in dental
1372 therapy, that the dental therapist apply to participate in the medical assistance program
1373 administered by the secretary of health and human services in accordance with chapter 118E and
1374 Title XIX of the Social Security Act and any federal demonstration or waiver relating to such
1375 medical assistance program for the limited purposes of ordering and referring services covered
1376 under such program, provided that regulations governing such limited participation are
1377 promulgated under said chapter 118E. A dental therapist practicing in a dental therapist role who
1378 chooses to participate in such medical assistance program as a provider of services shall be
1379 deemed to have fulfilled this requirement.

1380 The board shall grant a license by credentials, without further professional examination,
1381 to a dental therapist licensed in another jurisdiction, upon payment of a fee as determined under
1382 subsection (a), provided the applicant is of good moral character and has: (i) met the eligibility
1383 requirements as defined by the board; (ii) furnished the board with satisfactory proof of
1384 graduation from an education program or combination of education programs providing both
1385 dental therapy and dental hygiene education that meets the standards of the Commission on
1386 Dental Accreditation, provided, however, that an applicant who graduated from a dental therapy
1387 education program established before the Commission on Dental Accreditation established a

1388 dental therapy accreditation program is eligible notwithstanding the lack of accreditation
1389 of the program at the time the education was received; (iii) submitted documentation of a passing
1390 score on a dental therapy examination administered by another state or testing agency that is
1391 substantially equivalent to the board-approved dental therapy examination for dental therapists as
1392 defined in this section; (iv) submitted documentation of a passing score on the Massachusetts
1393 Dental Ethics and Jurisprudence Examination or any other successor examination; and (v)
1394 submitted documentation of completion of 2 years or 2,500 hours, whichever is longer, of
1395 practice. If such practice requirement is not met, a dental therapist shall be required to complete
1396 the remaining hours or years, whichever is longer, under direct supervision in the commonwealth
1397 prior to practicing under general supervision.

1398 (e) Pursuant to a collaborative management agreement, a dental therapist licensed and
1399 registered by the board may perform: (i) all acts of a public health dental hygienist as set forth in
1400 regulations of the board and (ii) all acts in the Commission on Dental Accreditation's dental
1401 therapy standards. Dental therapists shall have the authority to perform an oral evaluation and
1402 assessment of dental disease and formulate an individualized treatment plan as authorized by the
1403 supervising dentist in the collaborative management agreement. A dental therapist may dispense
1404 and administer the following medications within the parameters of the collaborative management
1405 agreement and with the authorization of the supervising dentist: non-narcotic analgesics, anti-
1406 inflammatories and antibiotics. The authority to dispense and administer shall extend only to the
1407 categories of drugs identified in this paragraph and may be further limited by the collaborative
1408 management agreement. A dental therapist is prohibited from dispensing or administering
1409 narcotic analgesics. A dental therapist may oversee not more than 2 dental hygienists and 2
1410 dental assistants, but shall not oversee public health dental hygienists.

1411 After entering into a collaborative management agreement with a supervising dentist,
1412 dental therapists shall practice under direct supervision for not less than 2,500 clinical hours or
1413 two years, whichever is longer. After completing 2,500 clinical hours or two years, whichever is
1414 longer, of practice under direct supervision, dental therapists are authorized to perform all
1415 procedures and services listed in the Commission on Dental Accreditation's dental therapy
1416 standards and all procedures and services within the scope of a public health dental hygienist, as
1417 set forth in regulations by the board, under general supervision if authorized by a supervising
1418 dentist pursuant to a written collaborative agreement. In addition, the following procedures,
1419 referred to in this section as advanced procedures, may be performed under direct supervision: (i)
1420 preparation and placement of direct restoration in primary and permanent teeth; (ii) fabrication
1421 and placement of single-tooth temporary crowns; (iii) preparation and placement of preformed
1422 crowns on primary teeth; (iv) indirect and direct pulp capping on permanent teeth; (v) indirect
1423 pulp capping on primary teeth; and (vi) simple extractions of erupted primary teeth, provided
1424 however that the advanced procedures may be performed under general supervision if authorized
1425 by the board pursuant to subsection (f) of this section.

1426 Pursuant to a collaborative management agreement, a dental therapist may provide
1427 procedures and services permitted under general supervision when the supervising dentist is not
1428 on-site and has not previously examined or diagnosed the patient provided the supervising
1429 dentist is available for consultation and supervision if needed through telehealth, as that term is
1430 defined in section 4P of chapter 111 or by other means of communication. If the supervising
1431 dentist will not be available, arrangements shall be made for another licensed dentist to be
1432 available to provide timely consultation and supervision. A dental therapist may not operate
1433 independently of, and may not practice or treat any patients without, a supervising dentist. A

1434 dental therapist is prohibited from practicing without entering into a collaborative management
1435 agreement with a supervising dentist.

1436 (f) By January 1, 2024, the department of public health in consultation with the board and
1437 any other entity they deem appropriate, shall begin an evaluation assessing the impact of dental
1438 therapists practicing under general supervision in Massachusetts and the rest of the United States,
1439 specifically on: (i) dental therapists' progress in expanding access to safe and effective dental
1440 services for vulnerable populations including, at a minimum, Medicaid beneficiaries and
1441 individuals who are underserved as defined in this section; (ii) an appropriate geographic
1442 distance limitation between the dental therapist and supervising dentist that permits the dental
1443 therapist to expand access to vulnerable populations including, at a minimum, Medicaid
1444 beneficiaries and individuals who are underserved as defined in this section; and (iii) the number
1445 of dental hygienists and dental assistants a dental therapist may oversee.

1446 Not before January 1, 2025, and no later than December 1, 2026, the department in
1447 consultation with the board and any other entity they deem appropriate, shall make a
1448 recommendation, based on its assessment of whether dental therapists should be authorized to
1449 perform one or more of the advanced procedures, as defined in subsection (e) under general
1450 supervision pursuant to a collaborative management agreement. The department shall also make
1451 a recommendation on an appropriate geographic distance limitation between the dental therapist
1452 and supervising dentist that permits the dental therapist to expand access to vulnerable
1453 populations including, at a minimum, Medicaid beneficiaries and individuals who are
1454 underserved as defined in this section. After the department completes its assessment and
1455 submits its recommendations to the board, the board shall make a determination, with
1456 consideration to how authorizing general supervision will expand access to safe and effective

1457 dental services for vulnerable populations including, at a minimum, Medicaid beneficiaries and
1458 individuals who are underserved as defined in this section, whether to authorize performance of
1459 one or more of the procedures as identified in subsection (e), under general supervision pursuant
1460 to a collaborative management agreement.

1461 Should the board, in consultation with the department and any other appropriate entity,
1462 determine that dental therapists shall have the authority to perform one or more of the procedures
1463 and services as identified in subsection (e) in their scope of practice under general supervision,
1464 then the board shall establish regulations no later than six months following the recommendation,
1465 authorizing dental therapists to perform one or more procedures as identified in subsection (e)
1466 under general supervision pursuant to a collaborative management agreement after receiving
1467 advanced practice certification.

1468 The board shall grant advanced practice certification for a dental therapist licensed and
1469 registered by the board to perform all services within the authorized scope of practice under
1470 general supervision pursuant to a collaborative management agreement if the dental therapist
1471 provides documentation of completion of at least two years or 2,500 hours, whichever is longer,
1472 of direct supervision pursuant to subsection (a) of this section, payment of a fee to be determined
1473 annually by the secretary of administration and finance under the provision of section 3B of
1474 chapter 7, and satisfying any other criteria established by regulation adopted by the board as
1475 authorized in this section.

1476 Should the board determine that dental therapists shall continue to perform one or more
1477 of the advanced procedures under direct supervision, the department, in consultation with the
1478 board, shall re-evaluate annually the impact of dental therapists practicing under general

1479 supervision in Massachusetts and the rest of the United States, and the board shall annually
1480 reassess whether to authorize general supervision for the advanced procedures in order to
1481 improve dental therapists' progress in expanding access to safe and effective dental services for
1482 vulnerable populations including, at a minimum, Medicaid beneficiaries and individuals who are
1483 underserved as defined in this section.

1484 (g) The board shall establish appropriate guidelines for a written collaborative
1485 management agreement. A collaborative management agreement shall be signed and maintained
1486 by the supervising dentist and the dental therapist and shall be submitted annually to the board.
1487 The agreement may be updated as necessary. The agreement shall serve as standing orders from
1488 the supervising dentist and shall address: (i) practice settings; (ii) any limitation on services
1489 established by the supervising dentist; (iii) the level of supervision required for various services
1490 or treatment settings; (iv) patient populations that may be served; (v) practice protocols; (vi)
1491 record keeping; (vii) managing medical emergencies; (viii) quality assurance; (ix) administering
1492 and dispensing medications; (x) geographic distance limitations; (xi) oversight of dental
1493 hygienists and dental assistants; and (xii) referrals for services outside of the dental therapy
1494 scope of practice. The collaborative management agreement shall include specific protocols to
1495 govern situations in which the dental therapist encounters a patient who requires treatment that
1496 exceeds the authorized scope of practice of the dental therapist. The supervising dentist is
1497 responsible for directly providing, or arranging for another dentist or specialist within an
1498 accessible geographic distance to provide, any necessary additional services outside of the dental
1499 therapy scope of practice needed by the patient. A supervising dentist may have a collaborative
1500 management agreement with not more than 3 dental therapists at the same time. Not more than 2
1501 of such dental therapists may practice under general supervision with certification to perform one

1502 or more of the advanced procedures. A practice or organization with more than one practice
1503 location listed under the same business name may not employ more than 6 dental therapists,
1504 provided, however, that this requirement shall not apply if such an organization or practice is a
1505 federally qualified health center or look-alike, a community health center, a non-profit practice
1506 or organization, or a public health setting, which for purposes of this section shall be as defined
1507 by 234 CMR 2.02, or as otherwise permitted by the board.

1508 (h) No medical malpractice insurer shall refuse primary medical malpractice insurance
1509 coverage to a licensed dentist on the basis of whether they entered into a collaborative
1510 management agreement with a dental therapist or public health dental hygienist. A dental
1511 therapist may not bill separately for services rendered; the services of the dental therapist are the
1512 services of the supervising dentist and shall be billed as such.

1513 (i) Not less than 50 per cent of the patient panel of a dental therapist, as determined in
1514 each calendar year, shall consist of patients who receive coverage through MassHealth or its
1515 contracted health insurers, health plans, health maintenance organizations, behavioral health
1516 management firms, and third-party administrators under contract to a MassHealth managed care
1517 organization or primary care clinician plan; or are considered underserved provided, however,
1518 that this requirement shall not apply if the dental therapist is operating in a federally qualified
1519 health center or look-alike, community-health center, non-profit practice or organization, or other
1520 public health setting as defined by the board by regulation, or as otherwise permitted by the
1521 board. As used in this section, “underserved” means individuals who: (i) receive, or are eligible
1522 to receive, benefits through MassHealth or its contracted health insurers, health plans, health
1523 maintenance organizations, behavioral health management firms, and third-party administrators
1524 under contract to a MassHealth managed care organization or primary care clinician plan; (ii)

1525 receive, or are eligible to receive, Social Security Disability Benefits (SSDI), Supplemental
1526 Security Income (SSI), and/or Massachusetts State Supplement Program (SSP); (iii) live in a
1527 dental health professional shortage area (DPSA) as designated by the U.S. Department of Health
1528 and Human Services; (iv) reside in a nursing home, skilled nursing facility, veterans home, or
1529 long-term care facility; (v) receive dental services at a public health setting as defined by the
1530 board by regulation; (vi) receive benefits, or are eligible to receive benefits, through plans sold
1531 by the connector; (viii) receive benefits, or are eligible to receive benefits, through the Indian
1532 Health Service, tribal or urban Indian organizations, or through the Contract Health Service
1533 Program; (ix) receive benefits, or are eligible to receive benefits, through the Department of
1534 Veterans Affairs or other organization serving veterans; (x) are elderly and have trouble
1535 accessing dental care due to mobility or transportation challenges; (xi) meet the Commission on
1536 Dental Accreditation's definition of people with special needs; (xii) are uninsured and living at
1537 305 per cent of the Federal Poverty Level; or (xiii) as otherwise permitted by the board.

1538 An employer of a dental therapist shall submit quarterly reports to the board that provide
1539 information concerning the makeup of the dental therapist's patient panel, including the
1540 percentage of individuals who are underserved in the patient panel. No later than January 1,
1541 2024, the secretary of health and human services may establish by regulation penalties for
1542 employers who fail to meet the requirements pertaining to the percentage of individuals who are
1543 underserved in the dental therapist's patient panel.

1544 (j) Not later than January 1, 2024, the board, in consultation with the department shall
1545 establish regulations to implement the provisions of this section for the licensure and practice of
1546 dental therapy including

1547 (k) Not later than January 1, 2024, the board, in consultation with the department shall
1548 establish regulations to implement the provisions of this section for the licensure and practice of
1549 dental therapy to protect the public health, safety and welfare, including but without limitation
1550 guidelines for collaborative management agreements, continuing education requirements, license
1551 renewal, standards of conduct and the investigation of complaints, and disciplinary actions.

1552 SECTION 84. Section 61 of said chapter 112, as appearing in the 2018 Official Edition,
1553 is hereby amended by striking out the words “A board of registration”, in line 18, and inserting
1554 in place thereof the following words:- each board of registration under the supervision of the
1555 department of public health may discipline a holder of a license, certificate, registration or
1556 authority issued pursuant to this chapter, and each board of registration.

1557 SECTION 85. Said section 61 of said chapter 112, as so appearing, is hereby further
1558 amended by striking out the words “a board of registration”, in lines 49 through 50, and inserting
1559 in place thereof the following words:- Each board of registration under the supervision of the
1560 department of public health and each board of registration.

1561 SECTION 86. Section 65B of said chapter 112, as so appearing, is hereby amended by
1562 striking out the words “a board of registration”, in line 1, and inserting in place thereof the
1563 following words:- Each board of registration under the supervision of the department of public
1564 health and each board of registration.

1565 SECTION 87. Section 65F of said chapter 112, as so appearing, is hereby amended by
1566 inserting, after the word "licensure" in line 4, the following words:- , or a board of registration
1567 under the supervision of the department of public health,.

1568 SECTION 88. Said chapter 112 is hereby further amended by striking out section 66, as
1569 so appearing, and inserting in place thereof the following section:-

1570 Section 66. As used in this chapter, “practice of optometry” shall mean the diagnosis,
1571 prevention, correction, management or treatment of optical deficiencies, optical deformities,
1572 visual anomalies, muscular anomalies, ocular diseases and ocular abnormalities of the human eye
1573 and adjacent tissue, including removal of superficial foreign bodies and misaligned eyelashes, by
1574 utilization of pharmaceutical agents, by the prescription, adaptation and application of
1575 ophthalmic lenses, devices containing lenses, prisms, contact lenses, orthoptics, vision therapy,
1576 prosthetic devices and other optical aids and the utilization of corrective procedures to preserve,
1577 restore or improve vision, consistent with sections 66A, 66B and 66C.

1578 SECTION 89. Section 66B of said chapter 112, as appearing in the 2018 Official Edition,
1579 is hereby amended by striking out, in line 31, the following words:- , except glaucoma.

1580 SECTION 90. Said chapter 112 is hereby further amended by inserting after section 66B
1581 the following section:-

1582 Section 66C. (a) A registered optometrist who is qualified by an examination for practice
1583 under section 68, certified under section 68C and registered to issue written prescriptions
1584 pursuant to subsection (h) of section 7 of chapter 94C, may:

1585 (1) use and prescribe topical and oral therapeutic pharmaceutical agents, as defined in
1586 section 66B, that are used in the practice of optometry, including those placed in schedules III,
1587 IV, V and VI pursuant to section 2 of said chapter 94C, for the purpose of diagnosing,
1588 preventing, correcting, managing or treating glaucoma and other ocular abnormalities of the
1589 human eye and adjacent tissue; and

1590 (2) prescribe all necessary eye-related medications, including oral anti-infective
1591 medications; provided, however, that a registered optometrist shall not use or prescribe: (i)
1592 therapeutic pharmaceutical agents for the treatment of systemic diseases; (ii) invasive surgical
1593 procedures; (iii) pharmaceutical agents administered by subdermal injection, intramuscular
1594 injection, intravenous injection, subcutaneous injection, intraocular injection or retrobulbar
1595 injection; or (iv) an opioid substance or drug product.

1596 (b) If an optometrist, while examining or treating a patient with the aid of a diagnostic or
1597 therapeutic pharmaceutical agent and exercising professional judgment and the degree of
1598 expertise, care and knowledge ordinarily possessed and exercised by optometrists under like
1599 circumstances, encounters a sign of a previously unevaluated disease that would require
1600 treatment not included in the scope of the practice of optometry, the optometrist shall refer the
1601 patient to a licensed physician or other qualified health care practitioner.

1602 (c) If an optometrist diagnoses a patient with congenital glaucoma or if, during the course
1603 of examining, managing or treating a patient with glaucoma, the optometrist determines that
1604 surgical treatment is indicated, the optometrist shall refer the patient to a qualified health care
1605 provider for treatment.

1606 (d) An optometrist licensed under this chapter shall participate in any relevant state or
1607 federal report or data collection effort relative to patient safety and medical error reduction
1608 coordinated by the betsy lehman center for patient safety and medical error reduction established
1609 in section 15 of chapter 12C.

1610 SECTION 91. Section 68 of said chapter 112, as appearing in the 2018 Official Edition,
1611 is hereby amended by adding the following paragraph:- All application fees and civil

1612 administrative penalties and fines collected by the board under sections 61, 66 to 73B, inclusive,
1613 shall be deposited into the Quality in Health Professions Trust Fund established in section 35X
1614 of chapter 10.

1615 SECTION 92. Said chapter 112 is hereby further amended by inserting after section 68B
1616 the following section:-

1617 Section 68C. (a) The board of registration in optometry shall administer an examination
1618 to permit the use and prescription of therapeutic pharmaceutical agents as authorized in section
1619 66C. The examination shall: (i) be held in conjunction with examinations provided for in
1620 sections 68, 68A and 68B; and (ii) include any portion of the examination administered by the
1621 National Board of Examiners in Optometry or other appropriate examination covering the
1622 subject matter of therapeutic pharmaceutical agents as authorized in section 66C. The board may
1623 administer a single examination to measure the qualifications necessary under sections 68, 68A,
1624 68B and this section. The board shall qualify optometrists to use and prescribe therapeutic
1625 pharmaceutical agents in accordance with said sections 68, 68A, 68B and this section.

1626 (b) Examination for the use and prescription of therapeutic pharmaceutical agents placed
1627 in schedules III, IV, V and VI under section 2 of chapter 94C and defined in section 66C shall,
1628 upon application, be open to an optometrist registered under section 68, 68A or 68B and to any
1629 person who meets the qualifications for examination under said sections 68, 68A and 68B. An
1630 applicant registered as an optometrist under said section 68, 68A or 68B shall:

1631 (1) be registered pursuant to paragraph (h) of section 7 to use or prescribe pharmaceutical
1632 agents for the purpose of diagnosing or treating glaucoma and other ocular abnormalities of the
1633 human eye and adjacent tissue; and

1634 (2) furnish to the board of registration in optometry evidence of the satisfactory
1635 completion of 40 hours of didactic education and 20 hours of supervised clinical education
1636 relating to the use and prescription of therapeutic pharmaceutical agents under section 66C;
1637 provided, however, that such education shall: (i) be administered by the Massachusetts Society
1638 of Optometrists, Inc.; (ii) be accredited by a college of optometry or medicine; and (iii) meet the
1639 guidelines and requirements of the board of registration in optometry. The board of registration
1640 in optometry shall provide to each successful applicant a certificate of qualification in the use
1641 and prescription of all therapeutic pharmaceutical agents as authorized under said section 66C
1642 and shall forward to the department of public health notice of such certification for each
1643 successful applicant.

1644 (c) An optometrist licensed in another jurisdiction shall be deemed an applicant under
1645 this section by the board of registration in optometry. An optometrist licensed in another
1646 jurisdiction may submit evidence to the board of registration in optometry of practice equivalent
1647 to that required in section 68, 68A or 68B and the board, in its discretion, may accept the
1648 evidence in order to satisfy any of the requirements of this section. An optometrist in another
1649 jurisdiction licensed to utilize and prescribe therapeutic pharmaceutical agents for treating
1650 glaucoma and other ocular abnormalities of the human eye and adjacent tissue may submit
1651 evidence to the board of registration in optometry of equivalent didactic and supervised clinical
1652 education, and the board, in its discretion, may accept the evidence in order to satisfy any of the
1653 requirements of this section.

1654 (d) A licensed optometrist who has completed a postgraduate residency program
1655 approved by the Accreditation Council on Optometric Education of the American Optometric
1656 Association may submit an affidavit to the board of registration in optometry from the licensed

1657 optometrist’s residency supervisor or the director of residencies at the affiliated college of
1658 optometry attesting that the optometrist has completed an equivalent level of instruction and
1659 supervision and the board, in its discretion, may accept the evidence in order to satisfy any of the
1660 requirements of this section.

1661 (e) As a condition of license renewal, an optometrist licensed under this section shall
1662 submit to the board of registration in optometry evidence attesting to the completion of 3 hours
1663 of continuing education specific to glaucoma and the board, in its discretion, may accept the
1664 evidence to satisfy this condition for license renewal.

1665 SECTION 93. Section 73E of said chapter 112, as appearing in the 2018 Official Edition,
1666 is hereby amended by adding the following paragraph:- All application fees and civil
1667 administrative penalties and fines collected by the board under sections 61, and 73C to 73M,
1668 inclusive, shall be deposited into the Quality in Health Professions Trust Fund established in
1669 section 35X of chapter 10.

1670 SECTION 94. Section 79 of said chapter 112, as so appearing, is hereby amended by
1671 adding the following two sentences:-

1672 The board may assess a licensed nurse a penalty of not more than \$2,000 for each
1673 violation of regulations promulgated pursuant to this section and for each violation of any
1674 general law that governs the practice of nursing. The board, through regulation, shall ensure that
1675 any fine levied is commensurate with the severity of the violation.

1676 SECTION 95. Section 80B of said chapter 112, as so appearing, is hereby amended by
1677 inserting after the word “practitioners”, in line 12, the following words:- , nurse anesthetists.

1678 SECTION 96. Said section 80B of said chapter 112, as so appearing, is hereby further
1679 amended by striking out the seventh paragraph and inserting in place thereof the following
1680 paragraph:-

1681 The board shall promulgate advanced practice nursing regulations which govern the
1682 provision of advanced practice nursing services and related care including, but not limited to, the
1683 ordering and interpreting of tests, the ordering and evaluation of treatment and the use of
1684 therapeutics.

1685 SECTION 97. Said section 80B of said chapter 112, as so appearing, is hereby further
1686 amended by striking out, in lines 64 and 65, the words “in the ordering of tests, therapeutics and
1687 the prescribing of medications, to” and inserting in place thereof the following word:- to.

1688 SECTION 98. Said chapter 112 is hereby further amended by striking out section 80E, as
1689 so appearing, and inserting in place thereof the following section:-

1690 Section 80E. (a) A nurse practitioner or psychiatric nurse mental health clinical specialist
1691 may issue written prescriptions and medication orders and order tests and therapeutics pursuant
1692 to guidelines mutually developed and agreed upon by the nurse and either a supervising nurse
1693 practitioner or psychiatric nurse mental health clinical specialist who has independent practice
1694 authority or a supervising physician, in accordance with regulations promulgated by the board. A
1695 prescription issued by a nurse practitioner or psychiatric nurse mental health clinical specialist
1696 under this subsection shall include the name of the nurse practitioner or the psychiatric nurse
1697 mental health clinical specialist who has independent practice authority or the supervising
1698 physician with whom the nurse practitioner or psychiatric nurse mental health clinical specialist
1699 developed and signed mutually agreed upon guidelines.

1700 A nurse practitioner or psychiatric nurse mental health clinical specialist shall have
1701 independent practice authority to issue written prescriptions and medication orders and order
1702 tests and therapeutics without the supervision described in this subsection if the nurse
1703 practitioner or psychiatric nurse mental health clinical specialist has completed not less than 2
1704 years of supervised practice following certification from a board-recognized certifying body;
1705 provided, however, that supervision of clinical practice shall be conducted by a health care
1706 professional who meets minimum qualification criteria promulgated by the board, which shall
1707 include a minimum number of years of independent practice authority.

1708 The board may allow a nurse practitioner or psychiatric nurse mental health clinical
1709 specialist to exercise such independent practice authority upon satisfactory demonstration of not
1710 less than 2 years of alternative professional experience; provided, however, that the board
1711 determines that the nurse practitioner or psychiatric nurse mental health clinical specialist has a
1712 demonstrated record of safe prescribing and good conduct consistent with professional licensure
1713 obligations required by each jurisdiction in which the nurse practitioner or psychiatric nurse
1714 mental health clinical specialist has been licensed.

1715 (b) The board shall promulgate regulations to implement this section.

1716 SECTION 99. Said chapter 112 is hereby further amended by striking out section 80H, as
1717 so appearing, and inserting in place thereof the following section:-

1718 Section 80H. (a) A nurse anesthetist may issue written prescriptions and medication
1719 orders and order tests and therapeutics pursuant to guidelines mutually developed and agreed
1720 upon by the nurse and either a supervising nurse anesthetist with independent practice authority
1721 or a supervising physician, in accordance with regulations promulgated by the board; provided,

1722 however, that supervision under this section by a nurse anesthetist with independent practice
1723 authority or by a physician shall be limited to written prescriptions and medication orders and the
1724 ordering of tests and therapeutics. A prescription issued by a nurse anesthetist under this
1725 subsection shall include the name of the nurse anesthetist with independent practice authority or
1726 the supervising physician with whom the nurse anesthetist developed and signed mutually agreed
1727 upon guidelines. Nothing in this section shall require a nurse anesthetist to obtain prescriptive
1728 authority to deliver anesthesia care, including the proper administration of the drugs or medicine
1729 necessary for the delivery of anesthesia care.

1730 A nurse anesthetist shall have independent practice authority to issue written
1731 prescriptions and medication orders and order tests and therapeutics without the supervision
1732 described in this subsection if the nurse anesthetist has completed not less than 2 years of
1733 supervised practice following certification from a board-recognized certifying body; provided,
1734 however, that supervision of practice shall be conducted by a health care professional who meets
1735 minimum qualification criteria promulgated by the board which shall include a minimum number
1736 of years of independent practice experience.

1737 The board, in its discretion, may allow a nurse anesthetist to exercise such independent
1738 practice authority upon satisfactory demonstration of alternative professional experience if the
1739 board determines that the nurse anesthetist has a demonstrated record of safe prescribing and
1740 good conduct consistent with professional licensure obligations required by each jurisdiction in
1741 which the nurse anesthetist has been licensed.

1742 (b) The board shall promulgate regulations to implement this section.

1743 SECTION 100. Section 80I of said chapter 112, as appearing in the 2018 Official
1744 Edition, is hereby amended by striking out the second and third sentences.

1745 SECTION 101. Section 91 of said chapter 112, as so appearing, is hereby amended by
1746 adding the following paragraph:- All application fees and civil administrative penalties and fines
1747 collected by the board under sections 61 and 89 to 97, inclusive, shall be deposited into the
1748 Quality in Health Professions Trust Fund established in section 35X of chapter 10.

1749 SECTION 102. Section 126 of said chapter 112, as so appearing, is hereby amended by
1750 adding the following paragraph:- All application fees and civil administrative penalties and fines
1751 collected by the board under sections 61 and 118 to 129B, inclusive, shall be deposited into the
1752 Quality in Health Professions Trust Fund established in section 35X of chapter 10.

1753 SECTION 103. Section 136 of said chapter 112, as so appearing, is hereby amended by
1754 adding the following paragraph:- All application fees and civil administrative penalties and fines
1755 collected by the board under sections 61 and 130 to 137, inclusive, shall be deposited into the
1756 Quality in Health Professions Trust Fund established in section 35X of chapter 10.

1757 SECTION 104. Section 140 of said chapter 112, as so appearing, is hereby amended by
1758 adding the following paragraph:- All application fees and civil administrative penalties and fines
1759 collected by the board under sections 61 and 138 to 147, inclusive, shall be deposited into the
1760 Quality in Health Professions Trust Fund established in section 35X of chapter 10.

1761 SECTION 105. Section 164 of said chapter 112, as so appearing, is hereby amended by
1762 inserting after the word “therapist”, in line 23, the following words:- , recovery coach, authorized
1763 to practice under sections 290 to 293, inclusive,

1764 SECTION 106. Section 168 of said chapter 112, as so appearing, is hereby amended by
1765 adding the following paragraph:- All application fees and civil administrative penalties and fines
1766 collected by the board under sections 61 and 163 to 172, inclusive, shall be deposited into the
1767 Quality in Health Professions Trust Fund established in section 35X of chapter 10.

1768 SECTION 107. Section 197 of said chapter 112, as so appearing, is hereby amended by
1769 adding the following subsection:-

1770 (h) All application fees and civil administrative penalties and fines collected by the board
1771 under sections 61 and this section to 200, inclusive, shall be deposited into the Quality in Health
1772 Professions Trust Fund established in section 35X of chapter 10.

1773 SECTION 108. Section 203 of said chapter 112, as so appearing, is hereby amended by
1774 adding the following paragraph:- All application fees and civil administrative penalties and fines
1775 collected by the board under sections 61 and 201 to 210, inclusive, shall be deposited into the
1776 Quality in Health Professions Trust Fund established in section 35X of chapter 10.

1777 SECTION 109. Subsection (c) of section 265 of said chapter 112, as so appearing, is
1778 hereby amended by inserting, after the first sentence, the following sentence:-The board of
1779 registration in medicine, in consultation with the department of public health, shall promulgate
1780 regulations governing the qualifications and scope of practice of certified medical assistants.

1781 SECTION 110. Said chapter 112 is hereby further amended by adding the following 4
1782 sections:-

1783 Section 275. (a) The following words as used in sections 275 to 278, inclusive, unless the
1784 context otherwise requires, shall have the following meanings:--

1785 “Board”, the board of registration of recovery coaches, established under section 110 of
1786 chapter 13.

1787 “Recovery Coach”, an individual who is authorized to practice by the board under this
1788 chapter and who uses shared understanding, respect and mutual empowerment to help others
1789 become and stay engaged in the process of recovery from a substance use disorder.

1790 “Lived experience”, the experience of addiction and recovery from a substance use
1791 disorder.

1792 (b) The board shall have the following powers and duties:

1793 (1) to promulgate regulations and adopt such rules as are necessary to regulate recovery
1794 coaches;

1795 (2) to receive, review, approve or disapprove initial applications, renewals and
1796 reinstatement requests and to issue those authorizations to practice;

1797 (3) to establish administrative procedures for processing applications submitted under
1798 clause (2) and to hire or appoint such agents as are appropriate for processing applications;

1799 (4) to retain records of its actions and proceedings in accordance with public records
1800 laws;

1801 (5) to establish specifications for the authorized practice of recovery coaching; provided,
1802 that the specifications shall require individuals to have lived experience and demonstrate at least
1803 2 years of sustained recovery; provided further, that the lived experience requirement may be
1804 waived for individuals who were credentialed by the Massachusetts Board of Substance Abuse
1805 Counselor Certification before the establishment of the board.

1806 (6) to define by regulation the appropriate standards for education, core competencies,
1807 and experience necessary to qualify as an authorized recovery coach, including, but not limited
1808 to, continuing professional education requirements; provided, that the board shall consider any
1809 standards contained within recovery coach training programs established by the department of
1810 public health;

1811 (7) to establish an ethical code of conduct for recovery coaches authorized to practice by
1812 the board; provided, that the board shall consider any codes of conduct for recovery coach
1813 training programs established by the department of public health;

1814 (8) to establish standards of supervision for students or persons in training to become a
1815 recovery coach; provided, that the board shall consider standards contained within recovery
1816 coach training programs established by the department of public health;

1817 (9) to fine, censure, revoke, suspend or deny a recovery coaches authorization to practice,
1818 place on probation, reprimand or otherwise discipline a recovery coach for violations of the code
1819 of ethics or the rules of the board.

1820 (10) to summarily suspend a recovery coach who poses an imminent danger to the public;
1821 provided, that the recovery coach shall be afforded a hearing within 7 business days to determine
1822 whether the summary action is warranted; and

1823 (11) to perform other functions and duties as may be required to carry out this section.

1824 Section 276. An application to be a recovery coach, under section 275, shall be made on
1825 forms approved by the board, signed under the penalties of perjury by the person certifying the
1826 information contained therein and accompanied by the required fee. The fee shall be determined

1827 by the secretary of administration and finance under section 3B of chapter 7. A recovery coach
1828 applicant shall furnish satisfactory proof that the applicant is at least 18 years of age, is of good
1829 moral character and has met all the education, training and experience requirements and
1830 qualifications as established by the board.

1831 The board, in consultation with the department of public health, shall determine the
1832 renewal cycle and renewal period for recovery coaches. A recovery coach authorized to practice
1833 under this chapter shall apply to the board for a renewal not later than the expiration date, as
1834 determined by the board, unless earlier revoked, suspended or canceled as a result of a
1835 disciplinary proceeding. As a condition for renewal under this section, the board may require
1836 satisfactory proof that the recovery coach has successfully completed the required number of
1837 hours of continuing education in courses or programs approved by the board or has complied
1838 with such other requirements or equivalent requirements as approved by the board. Upon
1839 satisfactory compliance with the requirements and successful completion of the continuing
1840 education requirements, the board shall issue a renewal. The board may provide for the late
1841 renewal that has lapsed and may require payment of a late fee. Each renewal application
1842 submitted to the board shall be accompanied by a fee as determined by the secretary of
1843 administration and finance under section 3B of chapter 7.

1844 The board may authorize a recovery coach to practice by reciprocity. The board shall
1845 promulgate rules and regulations as may be necessary to implement this section.

1846 Section 277. (a) The title “recovery coach” shall only be used by individuals who have
1847 met the requirements and qualifications and hold a valid, current authorization issued by the
1848 board. No person may act as a recovery coach for a fee unless such person holds a valid, current

1849 authorization issued by the board. The use by any person not so authorized of any words, letters,
1850 abbreviations or insignia indicating or implying a person is an authorized recovery coach shall be
1851 a violation of this section for which the board may issue a cease and desist order and seek
1852 additional appropriate legal remedies.

1853 (b) A person who violates subsection (a) shall be liable for a fine as determined by
1854 the Board.

1855 (c) No person filing a complaint alleging a violation of law or of the regulations of the
1856 board, reporting information pursuant to such laws or regulations or assisting the board at its
1857 request in any manner in discharging its duties and functions shall be liable in any cause of
1858 action arising out of the board's receipt of such information or assistance, if the person making
1859 the complaint, or reporting or providing such information or assistance, does so in good faith and
1860 without malice.

1861 Section 278. All application fees and civil administrative penalties and fines collected
1862 under sections 275 to this section, inclusive, shall be deposited into the Quality in Health
1863 Professions Trust Fund established in section 35X of chapter 10.

1864 SECTION 111. The General Laws are hereby amended by inserting after chapter 112 the
1865 following chapter:-

1866 Chapter 112A. Nurse Licensure Compact

1867 Section 1.

1868 As used in this chapter, the following words shall have the following meanings:

1869 “Adverse action”, any administrative, civil, equitable or criminal action permitted by a
1870 state’s laws which is imposed by a licensing board or other authority against a nurse, including
1871 actions against an individual’s license or multistate licensure privilege such as revocation,
1872 suspension, probation, monitoring of the licensee, limitation on the licensee’s practice, or any
1873 other encumbrance on licensure affecting a nurse’s authorization to practice, including issuance
1874 of a cease and desist action.

1875 “Alternative program”, a non-disciplinary monitoring program approved by a licensing
1876 board.

1877 “Compact” or “Nurse Licensure Compact”, the legally binding agreement between party
1878 states as adopted by the National Council of State Boards of Nursing Nurse Licensure Compact
1879 in its Final Version dated May 4, 2015, and entered into by the commonwealth in accordance
1880 with this chapter.

1881 “Coordinated licensure information system”, an integrated process for collecting, storing
1882 and sharing information on nurse licensure and enforcement activities related to nurse licensure
1883 laws that is administered by a nonprofit organization composed of and controlled by licensing
1884 boards.

1885 “Current significant investigative information”, (i) investigative information that a
1886 licensing board, after a preliminary inquiry that includes notification and an opportunity for the
1887 nurse to respond, if required by state law, has reason to believe is not groundless and, if proved
1888 true, would indicate more than a minor infraction or (ii) investigative information that indicates
1889 that the nurse represents an immediate threat to public health and safety regardless of whether
1890 the nurse has been notified and had an opportunity to respond.

1891 “Encumbrance”, a revocation or suspension of, or any limitation on, the full and
1892 unrestricted practice of nursing imposed by a licensing board.

1893 “Home state”, the party state which is the nurse’s primary state of residence.

1894 “Interstate commission”, the Interstate Commission of Nurse Licensure Compact
1895 Administrators as established in section 6 of this chapter.

1896 “Licensing board”, a party state’s regulatory body responsible for issuing nurse licenses.

1897 “Multistate license”, a license to practice as a registered nurse or a licensed practical or
1898 vocational nurse issued by a home state licensing board that authorizes the licensed nurse to
1899 practice in all party states under a multistate licensure privilege.

1900 “Multistate licensure privilege”, a legal authorization associated with a multistate license
1901 permitting the practice of nursing as either a registered nurse or as a licensed practical or
1902 vocational nurse in a remote state.

1903 “Nurse”, registered nurse or a licensed practical or vocational nurse, as those terms are
1904 defined by each party state’s practice laws.

1905 “Party state”, the commonwealth and any other state that has adopted this compact.

1906 “Remote state”, a party state other than the home state.

1907 “Single-state license”, a nurse license issued by a party state that authorizes practice only
1908 within the issuing state and does not include a multistate licensure privilege to practice in any
1909 other party state.

1910 “State”, a state, territory or possession of the United States and the District of Columbia.

1911 “State practice laws”, a party state’s laws, rules and regulations that govern the practice
1912 of nursing, define the scope of nursing practice, and establish the methods and grounds for
1913 imposing discipline. “State practice laws” do not include requirements necessary to obtain and
1914 retain a license, except for qualifications or requirements of the home state.

1915 Section 2.

1916 (a) A multistate license to practice as a nurse issued by a home state to a resident in that
1917 state will be recognized by each party state as authorizing a nurse to practice as a registered
1918 nurse or as a licensed practical or vocational nurse, under a multistate licensure privilege, in each
1919 party state.

1920 (b) A state must implement procedures for considering the criminal history records of
1921 applicants for initial multistate license or licensure by endorsement. Such procedures shall
1922 include the submission of fingerprints or other biometric-based information by applicants for the
1923 purpose of obtaining an applicant’s criminal history record information from the Federal Bureau
1924 of Investigation and the agency responsible for retaining that state’s criminal records.

1925 (c) Each party state shall require the following for an applicant to obtain or retain a
1926 multistate license in the home state:

1927 (1) Meets the home state’s qualifications for licensure or renewal of licensure, as well as,
1928 all other applicable state laws;

1929 (2) (i) Has graduated or is eligible to graduate from a licensing board-approved registered
1930 nurse or practical or vocational nurse pre-licensure education program; or (ii) has graduated from
1931 a foreign registered nurse or practical or vocational nurse pre-licensure education program that

1932 (A) has been approved by the authorized accrediting body in the applicable country and (B) has
1933 been verified by an independent credentials review agency to be comparable to a licensing
1934 board-approved pre-licensure education program;

1935 (3) Has, if a graduate of a foreign pre-licensure education program not taught in English
1936 or if English is not the individual's native language, successfully passed an English proficiency
1937 examination that includes the components of reading, speaking, writing and listening;

1938 (4) Has successfully passed an NCLEX-RN® or NCLEX-PN® Examination or
1939 recognized predecessor, as applicable;

1940 (5) Is eligible for or holds an active, unencumbered license;

1941 (6) Has submitted, in connection with an application for initial licensure or licensure by
1942 endorsement, fingerprints or other biometric data for the purpose of obtaining criminal history
1943 record information from the Federal Bureau of Investigation and the agency responsible for
1944 retaining that state's criminal records;

1945 (7) Has not been convicted or found guilty, or entered into an agreed disposition, of a
1946 felony offense under applicable state or federal criminal law;

1947 (8) Has not been convicted or found guilty, or entered into an agreed disposition, of a
1948 misdemeanor offense related to the practice of nursing as determined on a case-by-case basis;

1949 (9) Is not currently enrolled in an alternative program;

1950 (10) Is subject to self-disclosure requirements regarding current participation in an
1951 alternative program; and

1952 (11) Has a valid United States Social Security number.

1953 (d) All party states shall be authorized, in accordance with existing state due process law,
1954 to take adverse action against a nurse's multistate licensure privilege such as revocation,
1955 suspension, probation or any other action that affects a nurse's authorization to practice under a
1956 multistate licensure privilege, including cease and desist actions. If a party state takes such
1957 action, it shall promptly notify the administrator of the coordinated licensure information system.
1958 The administrator of the coordinated licensure information system shall promptly notify the
1959 home state of any such actions by remote states.

1960 (e) A nurse practicing in a party state must comply with the state practice laws of the
1961 state in which the client is located at the time service is provided. The practice of nursing is not
1962 limited to patient care, but shall include all nursing practice as defined by the state practice laws
1963 of the party state in which the client is located. The practice of nursing in a party state under a
1964 multistate licensure privilege will subject a nurse to the jurisdiction of the licensing board, the
1965 courts and the laws of the party state in which the client is located at the time service is provided.

1966 (f) Individuals not residing in a party state shall continue to be able to apply for a party
1967 state's single-state license as provided under the laws of each party state. However, the single-
1968 state license granted to these individuals will not be recognized as granting the privilege to
1969 practice nursing in any other party state. Nothing in this compact shall affect the requirements
1970 established by a party state for the issuance of a single-state license.

1971 (g) Any nurse holding a home state multistate license, on the effective date of this
1972 compact, may retain and renew the multistate license issued by the nurse's then-current home
1973 state, provided that:

1974 (1) A nurse, who changes primary state of residence after this compact's effective date,
1975 must meet all applicable requirements under section 2 to obtain a multistate license from a new
1976 home state.

1977 (2) A nurse who fails to satisfy the multistate licensure requirements in section 2 due to a
1978 disqualifying event occurring after this compact's effective date shall be ineligible to retain or
1979 renew a multistate license, and the nurse's multistate license shall be revoked or deactivated in
1980 accordance with applicable rules adopted by the interstate commission.

1981 Section 3.

1982 (a) Upon application for a multistate license, the licensing board in the issuing party state
1983 shall ascertain, through the coordinated licensure information system, whether the applicant has
1984 ever held, or is the holder of, a license issued by any other state, whether there are any
1985 encumbrances on any license or multistate licensure privilege held by the applicant, whether any
1986 adverse action has been taken against any license or multistate licensure privilege held by the
1987 applicant and whether the applicant is currently participating in an alternative program.

1988 (b) A nurse may hold a multistate license, issued by the home state, in only one party
1989 state at a time.

1990 (c) If a nurse changes primary state of residence by moving between two party states, the
1991 nurse must apply for licensure in the new home state, and the multistate license issued by the
1992 prior home state will be deactivated in accordance with applicable rules adopted by the interstate
1993 commission.

1994 (1) The nurse may apply for licensure in advance of a change in primary state of
1995 residence.

1996 (2) A multistate license shall not be issued by the new home state until the nurse provides
1997 satisfactory evidence of a change in primary state of residence to the new home state and
1998 satisfies all applicable requirements to obtain a multistate license from the new home state.

1999 (d) If a nurse changes primary state of residence by moving from a party state to a non-
2000 party state, the multistate license issued by the prior home state will convert to a single-state
2001 license, valid only in the former home state.

2002 Section 4.

2003 (a) In addition to the other powers conferred by state law, a licensing board shall have the
2004 authority to:

2005 (1) Take adverse action against a nurse's multistate licensure privilege to practice within
2006 that party state.

2007 (i) Only the home state shall have the power to take adverse action against a nurse's
2008 license issued by the home state.

2009 (ii) For purposes of taking adverse action, the home state licensing board shall give the
2010 same priority and effect to reported conduct received from a remote state as it would if such
2011 conduct had occurred within the home state. In so doing, the home state shall apply its own state
2012 laws to determine appropriate action.

2013 (2) Issue cease and desist orders or impose an encumbrance on a nurse's authority to
2014 practice within that party state.

2015 (3) Complete any pending investigations of a nurse who changes primary state of
2016 residence during the course of such investigations. The licensing board shall also have the
2017 authority to take appropriate action(s) and shall promptly report the conclusions of such
2018 investigations to the administrator of the coordinated licensure information system. The
2019 administrator of the coordinated licensure information system shall promptly notify the new
2020 home state of any such actions.

2021 (4) Issue subpoenas for both hearings and investigations that require the attendance and
2022 testimony of witnesses, as well as, the production of evidence. Subpoenas issued by a licensing
2023 board in a party state for the attendance and testimony of witnesses or the production of evidence
2024 from another party state shall be enforced in the latter state by any court of competent
2025 jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued
2026 in proceedings pending before it. The issuing authority shall pay any witness fees, travel
2027 expenses, mileage and other fees required by the service statutes of the state in which the
2028 witnesses or evidence are located.

2029 (5) Obtain and submit, for each nurse licensure applicant, fingerprint or other biometric-
2030 based information to the Federal Bureau of Investigation for criminal background checks,
2031 receive the results of the Federal Bureau of Investigation record search on criminal background
2032 checks and use the results in making licensure decisions.

2033 (6) If otherwise permitted by state law, recover from the affected nurse the costs of
2034 investigations and disposition of cases resulting from any adverse action taken against that nurse.

2035 (7) Take adverse action based on the factual findings of the remote state, provided that
2036 the licensing board follows its own procedures for taking such adverse action.

2037 (b) If adverse action is taken by the home state against a nurse's multistate license, the
2038 nurse's multistate licensure privilege to practice in all other party states shall be deactivated until
2039 all encumbrances have been removed from the multistate license. All home state disciplinary
2040 orders that impose adverse action against a nurse's multistate license shall include a statement
2041 that the nurse's multistate licensure privilege is deactivated in all party states during the
2042 pendency of the order.

2043 (c) Nothing in this compact shall override a party state's decision that participation in an
2044 alternative program may be used in lieu of adverse action. The home state licensing board shall
2045 deactivate the multistate licensure privilege under the multistate license of any nurse for the
2046 duration of the nurse's participation in an alternative program.

2047 Section 5.

2048 (a) All party states shall participate in a coordinated licensure information system of all
2049 licensed registered nurses and licensed practical or vocational nurses. This system will include
2050 information on the licensure and disciplinary history of each nurse, as submitted by party states,
2051 to assist in the coordination of nurse licensure and enforcement efforts.

2052 (b) The interstate commission, in consultation with the administrator of the coordinated
2053 licensure information system, shall formulate necessary and proper procedures for the
2054 identification, collection and exchange of information under this compact.

2055 (c) All licensing boards shall promptly report to the coordinated licensure information
2056 system any adverse action, any current significant investigative information, denials of
2057 applications (with the reasons for such denials) and nurse participation in alternative programs

2058 known to the licensing board regardless of whether such participation is deemed nonpublic or
2059 confidential under state law.

2060 (d) Current significant investigative information and participation in nonpublic or
2061 confidential alternative programs shall be transmitted through the coordinated licensure
2062 information system only to party state licensing boards.

2063 (e) Notwithstanding any other provision of law, all party state licensing boards
2064 contributing information to the coordinated licensure information system may designate
2065 information that may not be shared with non-party states or disclosed to other entities or
2066 individuals without the express permission of the contributing state.

2067 (f) Any personally identifiable information obtained from the coordinated licensure
2068 information system by a party state licensing board shall not be shared with non-party states or
2069 disclosed to other entities or individuals except to the extent permitted by the laws of the party
2070 state contributing the information.

2071 (g) Any information contributed to the coordinated licensure information system that is
2072 subsequently required to be expunged by the laws of the party state contributing that information
2073 shall also be expunged from the coordinated licensure information system.

2074 (h) The compact administrator of each party state shall furnish a uniform data set to the
2075 compact administrator of each other party state, which shall include, at a minimum:

2076 (1) Identifying information;

2077 (2) Licensure data;

2078 (3) Information related to alternative program participation; and

2079 (4) Other information that may facilitate the administration of this compact, as
2080 determined by interstate commission rules.

2081 (i) The compact administrator of a party state shall provide all investigative documents
2082 and information requested by another party state.

2083 Section 6.

2084 (a) The party states hereby create and establish a joint public entity known as the
2085 Interstate Commission of Nurse Licensure Compact Administrators.

2086 (1) The interstate commission is an instrumentality of the party states.

2087 (2) Venue is proper, and judicial proceedings by or against the interstate commission
2088 shall be brought solely and exclusively, in a court of competent jurisdiction where the principal
2089 office of the interstate commission is located. The interstate commission may waive venue and
2090 jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute
2091 resolution proceedings.

2092 (3) Nothing in this compact shall be construed to be a waiver of sovereign immunity.

2093 (b) Membership, Voting and Meetings

2094 (1) Each party state shall have and be limited to one administrator. The head of the state
2095 licensing board or designee shall be the administrator of this compact for each party state. Any
2096 administrator may be removed or suspended from office as provided by the law of the state from
2097 which the administrator is appointed. Any vacancy occurring in the interstate commission shall
2098 be filled in accordance with the laws of the party state in which the vacancy exists.

2099 (2) Each administrator shall be entitled to 1 vote with regard to the promulgation of rules
2100 and creation of bylaws and shall otherwise have an opportunity to participate in the business and
2101 affairs of the interstate commission. An administrator shall vote in person or by such other means
2102 as provided in the bylaws. The bylaws may provide for an administrator's participation in
2103 meetings by telephone or other means of communication.

2104 (3) The interstate commission shall meet at least once during each calendar year.
2105 Additional meetings shall be held as set forth in the bylaws or rules of the interstate commission.

2106 (4) All meetings shall be open to the public, and public notice of meetings shall be given
2107 in the same manner as required under the rulemaking provisions in section 7.

2108 (5) The interstate commission may convene in a closed, nonpublic meeting if the
2109 interstate commission must discuss:

2110 (i) Noncompliance of a party state with its obligations under this compact;

2111 (ii) The employment, compensation, discipline or other personnel matters, practices or
2112 procedures related to specific employees or other matters related to the interstate commission's
2113 internal personnel practices and procedures;

2114 (iii) Current, threatened or reasonably anticipated litigation;

2115 (iv) Negotiation of contracts for the purchase or sale of goods, services or real estate;

2116 (v) Accusing any person of a crime or formally censuring any person;

2117 (vi) Disclosure of trade secrets or commercial or financial information that is privileged
2118 or confidential;

2119 (vii) Disclosure of information of a personal nature where disclosure would constitute a
2120 clearly unwarranted invasion of personal privacy;

2121 (viii) Disclosure of investigatory records compiled for law enforcement purposes;

2122 (ix) Disclosure of information related to any reports prepared by or on behalf of the
2123 interstate commission for the purpose of investigation of compliance with this compact; or

2124 (x) Matters specifically exempted from disclosure by federal or state statute.

2125 (6) If a meeting, or portion of a meeting, is closed pursuant to this provision, the
2126 interstate commission's legal counsel or designee shall certify that the meeting may be closed
2127 and shall reference each relevant exempting provision. The interstate commission shall keep
2128 minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full
2129 and accurate summary of actions taken, and the reasons therefor, including a description of the
2130 views expressed. All documents considered in connection with an action shall be identified in
2131 such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to
2132 release by a majority vote of the interstate commission or order of a court of competent
2133 jurisdiction.

2134 (c) The interstate commission shall, by a majority vote of the administrators, prescribe
2135 bylaws or rules to govern its conduct as may be necessary or appropriate to carry out the
2136 purposes and exercise the powers of this compact, including but not limited to:

2137 (1) Establishing the fiscal year of the interstate commission;

2138 (2) Providing reasonable standards and procedures:

2139 (i) For the establishment and meetings of other committees; and

2140 (ii) Governing any general or specific delegation of any authority or function of the
2141 interstate commission;

2142 (3) Providing reasonable procedures for calling and conducting meetings of the interstate
2143 commission, ensuring reasonable advance notice of all meetings and providing an opportunity
2144 for attendance of such meetings by interested parties, with enumerated exceptions designed to
2145 protect the public's interest, the privacy of individuals, and proprietary information, including
2146 trade secrets. The interstate commission may meet in closed session only after a majority of the
2147 administrators vote to close a meeting in whole or in part. As soon as practicable, the interstate
2148 commission must make public a copy of the vote to close the meeting revealing the vote of each
2149 administrator, with no proxy votes allowed;

2150 (4) Establishing the titles, duties and authority and reasonable procedures for the election
2151 of the officers of the interstate commission;

2152 (5) Providing reasonable standards and procedures for the establishment of the personnel
2153 policies and programs of the interstate commission. Notwithstanding any civil service or other
2154 similar laws of any party state, the bylaws shall exclusively govern the personnel policies and
2155 programs of the interstate commission; and

2156 (6) Providing a mechanism for winding up the operations of the interstate commission
2157 and the equitable disposition of any surplus funds that may exist after the termination of this
2158 compact after the payment or reserving of all of its debts and obligations;

2159 (d) The interstate commission shall publish its bylaws and rules, and any amendments
2160 thereto, in a convenient form on the website of the interstate commission.

2161 (e) The interstate commission shall maintain its financial records in accordance with the
2162 bylaws.

2163 (f) The interstate commission shall meet and take such actions as are consistent with the
2164 provisions of this compact and the bylaws.

2165 (g) The interstate commission shall have the following powers:

2166 (1) To promulgate uniform rules to facilitate and coordinate implementation and
2167 administration of this compact. The rules shall have the force and effect of law and shall be
2168 binding in all party states;

2169 (2) To bring and prosecute legal proceedings or actions in the name of the interstate
2170 commission, provided that the standing of any licensing board to sue or be sued under applicable
2171 law shall not be affected;

2172 (3) To purchase and maintain insurance and bonds;

2173 (4) To borrow, accept or contract for services of personnel, including, but not limited to,
2174 employees of a party state or nonprofit organizations;

2175 (5) To cooperate with other organizations that administer state compacts related to the
2176 regulation of nursing, including but not limited to sharing administrative or staff expenses, office
2177 space or other resources;

2178 (6) To hire employees, elect or appoint officers, fix compensation, define duties, grant
2179 such individuals appropriate authority to carry out the purposes of this compact, and to establish
2180 the interstate commission's personnel policies and programs relating to conflicts of interest,
2181 qualifications of personnel and other related personnel matters;

2182 (7) To accept any and all appropriate donations, grants and gifts of money, equipment,
2183 supplies, materials and services, and to receive, utilize and dispose of the same; provided that at
2184 all times the interstate commission shall avoid any appearance of impropriety or conflict of
2185 interest;

2186 (8) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own,
2187 hold, improve or use, any property, whether real, personal or mixed; provided that at all times the
2188 interstate commission shall avoid any appearance of impropriety;

2189 (9) To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of
2190 any property, whether real, personal or mixed;

2191 (10) To establish a budget and make expenditures;

2192 (11) To borrow money;

2193 (12) To appoint committees, including advisory committees comprised of administrators,
2194 state nursing regulators, state legislators or their representatives, and consumer representatives,
2195 and other such interested persons;

2196 (13) To provide and receive information from, and to cooperate with, law enforcement
2197 agencies;

2198 (14) To adopt and use an official seal; and

2199 (15) To perform such other functions as may be necessary or appropriate to achieve the
2200 purposes of this compact consistent with the state regulation of nurse licensure and practice.

2201 (h) Financing of the interstate commission

2202 (1) The interstate commission shall pay, or provide for the payment of, the reasonable
2203 expenses of its establishment, organization and ongoing activities.

2204 (2) The interstate commission may also levy on and collect an annual assessment from
2205 each party state to cover the cost of its operations, activities and staff in its annual budget as
2206 approved each year. The aggregate annual assessment amount, if any, shall be allocated based
2207 upon a formula to be determined by the interstate commission, which shall promulgate a rule that
2208 is binding upon all party states.

2209 (3) The interstate commission shall not incur obligations of any kind prior to securing
2210 the funds adequate to meet the same; nor shall the interstate commission pledge the credit of any
2211 of the party states, except by, and with the authority of, such party state.

2212 (4) The interstate commission shall keep accurate accounts of all receipts and
2213 disbursements. The receipts and disbursements of the interstate commission shall be subject to
2214 the audit and accounting procedures established under its bylaws. However, all receipts and
2215 disbursements of funds handled by the interstate commission shall be audited yearly by a
2216 certified or licensed public accountant, and the report of the audit shall be included in and
2217 become part of the annual report of the interstate commission.

2218 (i) Qualified Immunity, Defense and Indemnification

2219 (1) The administrators, officers, executive director, employees and representatives of the
2220 interstate commission shall be immune from suit and liability, either personally or in their
2221 official capacity, for any claim for damage to or loss of property or personal injury or other civil
2222 liability caused by or arising out of any actual or alleged act, error or omission that occurred, or
2223 that the person against whom the claim is made had a reasonable basis for believing occurred,

2224 within the scope of interstate commission employment, duties or responsibilities; provided that
2225 nothing in this paragraph shall be construed to protect any such person from suit or liability for
2226 any damage, loss, injury or liability caused by the intentional, willful or wanton misconduct of
2227 that person.

2228 (2) The interstate commission shall defend any administrator, officer, executive director,
2229 employee or representative of the interstate commission in any civil action seeking to impose
2230 liability arising out of any actual or alleged act, error or omission that occurred within the scope
2231 of interstate commission employment, duties or responsibilities, or that the person against whom
2232 the claim is made had a reasonable basis for believing occurred within the scope of interstate
2233 commission employment, duties or responsibilities; provided that nothing herein shall be
2234 construed to prohibit that person from retaining his or her own counsel; and provided further that
2235 the actual or alleged act, error or omission did not result from that person's intentional, willful or
2236 wanton misconduct.

2237 (3) The interstate commission shall indemnify and hold harmless any administrator,
2238 officer, executive director, employee or representative of the interstate commission for the
2239 amount of any settlement or judgment obtained against that person arising out of any actual or
2240 alleged act, error or omission that occurred within the scope of interstate commission
2241 employment, duties or responsibilities, or that such person had a reasonable basis for believing
2242 occurred within the scope of interstate commission employment, duties or responsibilities,
2243 provided that the actual or alleged act, error or omission did not result from the intentional,
2244 willful or wanton misconduct of that person.

2245 Section 7.

2246 (a) The interstate commission shall exercise its rulemaking powers pursuant to the
2247 criteria set forth in this section and the rules adopted thereunder. Rules and amendments shall
2248 become binding as of the date specified in each rule or amendment and shall have the same force
2249 and effect as provisions of this compact.

2250 (b) Rules or amendments to the rules shall be adopted at a regular or special meeting of
2251 the interstate commission.

2252 (c) Prior to promulgation and adoption of a final rule or rules by the interstate
2253 commission, and at least 60 days in advance of the meeting at which the rule will be considered
2254 and voted upon, the interstate commission shall file a notice of proposed rulemaking:

2255 (1) On the website of the interstate commission; and

2256 (2) On the website of each licensing board or the publication in which each state would
2257 otherwise publish proposed rules.

2258 (d) The notice of proposed rulemaking shall include:

2259 (1) The proposed time, date and location of the meeting in which the rule will be
2260 considered and voted upon;

2261 (2) The text of the proposed rule or amendment, and the reason for the proposed rule;

2262 (3) A request for comments on the proposed rule from any interested person; and

2263 (4) The manner in which interested persons may submit notice to the interstate
2264 commission of their intention to attend the public hearing and any written comments.

2265 (e) Prior to adoption of a proposed rule, the interstate commission shall allow persons to
2266 submit written data, facts, opinions and arguments, which shall be made available to the public.

2267 (f) The interstate commission shall grant an opportunity for a public hearing before it
2268 adopts a rule or amendment.

2269 (g) The interstate commission shall publish the place, time and date of the scheduled
2270 public hearing.

2271 (1) Hearings shall be conducted in a manner providing each person who wishes to
2272 comment a fair and reasonable opportunity to comment orally or in writing. All hearings will be
2273 recorded, and a copy will be made available upon request.

2274 (2) Nothing in this section shall be construed as requiring a separate hearing on each rule.
2275 Rules may be grouped for the convenience of the interstate commission at hearings required by
2276 this section.

2277 (h) If no one appears at the public hearing, the interstate commission may proceed with
2278 promulgation of the proposed rule.

2279 (i) Following the scheduled hearing date, or by the close of business on the scheduled
2280 hearing date if the hearing was not held, the interstate commission shall consider all written and
2281 oral comments received.

2282 (j) The interstate commission shall, by majority vote of all administrators, take final
2283 action on the proposed rule and shall determine the effective date of the rule, if any, based on the
2284 rulemaking record and the full text of the rule.

2285 (k) Upon determination that an emergency exists, the interstate commission may
2286 consider and adopt an emergency rule without prior notice, opportunity for comment or hearing,
2287 provided that the usual rulemaking procedures provided in this compact and in this section shall
2288 be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days
2289 after the effective date of the rule. For the purposes of this provision, an emergency rule is one
2290 that must be adopted immediately in order to:

2291 (1) Meet an imminent threat to public health, safety or welfare;

2292 (2) Prevent a loss of interstate commission or party state funds; or

2293 (3) Meet a deadline for the promulgation of an administrative rule that is required by
2294 federal law or rule.

2295 (l) The interstate commission may direct revisions to a previously adopted rule or
2296 amendment for purposes of correcting typographical errors, errors in format, errors in
2297 consistency or grammatical errors. Public notice of any revisions shall be posted on the website
2298 of the interstate commission. The revision shall be subject to challenge by any person for a
2299 period of thirty (30) days after posting. The revision may be challenged only on grounds that the
2300 revision results in a material change to a rule. A challenge shall be made in writing, and
2301 delivered to the interstate commission, prior to the end of the notice period. If no challenge is
2302 made, the revision will take effect without further action. If the revision is challenged, the
2303 revision may not take effect without the approval of the interstate commission.

2304 Section 8.

2305 (a) Oversight

2306 (1) Each party state shall enforce this compact and take all actions necessary and
2307 appropriate to effectuate this compact's purposes and intent.

2308 (2) The interstate commission shall be entitled to receive service of process in any
2309 proceeding that may affect the powers, responsibilities or actions of the interstate commission,
2310 and shall have standing to intervene in such a proceeding for all purposes. Failure to provide
2311 service of process in such proceeding to the interstate commission shall render a judgment or
2312 order void as to the interstate commission, this compact or promulgated rules.

2313 (b) Default, Technical Assistance and Termination

2314 (1) If the interstate commission determines that a party state has defaulted in the
2315 performance of its obligations or responsibilities under this compact or the promulgated rules,
2316 the interstate commission shall:

2317 (i) Provide written notice to the defaulting state and other party states of the nature of the
2318 default, the proposed means of curing the default or any other action to be taken by the interstate
2319 commission; and

2320 (ii) Provide remedial training and specific technical assistance regarding the default.

2321 (2) If a state in default fails to cure the default, the defaulting state's membership in this
2322 compact may be terminated upon an affirmative vote of a majority of the administrators, and all
2323 rights, privileges and benefits conferred by this compact may be terminated on the effective date
2324 of termination. A cure of the default does not relieve the offending state of obligations or
2325 liabilities incurred during the period of default.

2326 (3) Termination of membership in this compact shall be imposed only after all other
2327 means of securing compliance have been exhausted. Notice of intent to suspend or terminate
2328 shall be given by the interstate commission to the governor of the defaulting state and to the
2329 executive officer of the defaulting state's licensing board and each of the party states.

2330 (4) A state whose membership in this compact has been terminated is responsible for all
2331 assessments, obligations and liabilities incurred through the effective date of termination,
2332 including obligations that extend beyond the effective date of termination.

2333 (5) The interstate commission shall not bear any costs related to a state that is found to be
2334 in default or whose membership in this compact has been terminated unless agreed upon in
2335 writing between the interstate commission and the defaulting state.

2336 (6) The defaulting state may appeal the action of the interstate commission by petitioning
2337 the U.S. District Court for the District of Columbia or the federal district in which the interstate
2338 commission has its principal offices. The prevailing party shall be awarded all costs of such
2339 litigation, including reasonable attorneys' fees.

2340 (c) Dispute Resolution

2341 (1) Upon request by a party state, the interstate commission shall attempt to resolve
2342 disputes related to the Compact that arise among party states and between party and non-party
2343 states.

2344 (2) The interstate commission shall promulgate a rule providing for both mediation and
2345 binding dispute resolution for disputes, as appropriate.

2346 (3) In the event the interstate commission cannot resolve disputes among party states
2347 arising under this compact:

2348 (i) The party states may submit the issues in dispute to an arbitration panel, which will be
2349 comprised of individuals appointed by the compact administrator in each of the affected party
2350 states and an individual mutually agreed upon by the compact administrators of all the party
2351 states involved in the dispute.

2352 (ii) The decision of a majority of the arbitrators shall be final and binding.

2353 (d) Enforcement

2354 (1) The interstate commission, in the reasonable exercise of its discretion, shall enforce
2355 the provisions and rules of this compact.

2356 (2) By majority vote, the interstate commission may initiate legal action in the U.S.
2357 District Court for the District of Columbia or the federal district in which the interstate
2358 commission has its principal offices against a party state that is in default to enforce compliance
2359 with the provisions of this compact and its promulgated rules and bylaws. The relief sought may
2360 include both injunctive relief and damages. In the event judicial enforcement is necessary, the
2361 prevailing party shall be awarded all costs of such litigation, including reasonable attorneys'
2362 fees.

2363 (3) The remedies herein shall not be the exclusive remedies of the interstate commission.
2364 The interstate commission may pursue any other remedies available under federal or state law.

2365 Section 9.

2366 (a) This compact shall become effective and binding on the earlier of the date of
2367 legislative enactment of this compact into law by no less than twenty-six (26) states or December
2368 31, 2018. All party states to this compact, that also were parties to the prior Nurse Licensure
2369 Compact, superseded by this compact, (“prior compact”), shall be deemed to have withdrawn
2370 from said prior compact within 6 months after the effective date of this compact.

2371 (b) Each party state to this compact shall continue to recognize a nurse’s multistate
2372 licensure privilege to practice in that party state issued under the prior compact until such party
2373 state has withdrawn from the prior compact.

2374 (c) Any party state may withdraw from this compact by enacting a statute repealing the
2375 same. A party state’s withdrawal shall not take effect until 6 months after enactment of the
2376 repealing statute.

2377 (d) A party state’s withdrawal or termination shall not affect the continuing requirement
2378 of the withdrawing or terminated state’s licensing board to report adverse actions and significant
2379 investigations occurring prior to the effective date of such withdrawal or termination.

2380 (e) Nothing contained in this compact shall be construed to invalidate or prevent any
2381 nurse licensure agreement or other cooperative arrangement between a party state and a non-
2382 party state that is made in accordance with the other provisions of this compact.

2383 (f) This compact may be amended by the party states. No amendment to this compact
2384 shall become effective and binding upon the party states unless and until it is enacted into the
2385 laws of all party states.

2386 (g) Representatives of non-party states to this compact shall be invited to participate in
2387 the activities of the interstate commission, on a nonvoting basis, prior to the adoption of this
2388 compact by all states.

2389 Section 10.

2390 This compact shall be liberally construed so as to effectuate the purposes thereof. The
2391 provisions of this compact shall be severable, and if any phrase, clause, sentence or provision of
2392 this compact is declared to be contrary to the constitution of any party state or of the United
2393 States, or if the applicability thereof to any government, agency, person or circumstance is held
2394 invalid, the validity of the remainder of this compact and the applicability thereof to any
2395 government, agency, person or circumstance shall not be affected thereby. If this compact shall
2396 be held to be contrary to the constitution of any party state, this compact shall remain in full
2397 force and effect as to the remaining party states and in full force and effect as to the party state
2398 affected as to all severable matters.

2399 Section 11. The executive director of the board of registration in nursing, or the board
2400 executive director's designee, shall be the administrator of the Nurse Licensure Compact for the
2401 commonwealth.

2402 Section 12. The board of registration in nursing shall adopt regulations in the same
2403 manner as all other with states legally joining in the compact and may adopt additional
2404 regulations as necessary to implement the provisions of this chapter.

2405 Section 13. The board of registration in nursing may recover from a nurse the costs of
2406 investigation and disposition of cases resulting in any adverse disciplinary action taken against
2407 that nurse's license or privilege to practice. Funds collected pursuant to this section shall be

2408 deposited in the Quality in Health Professions Trust Fund established pursuant to section 35X of
2409 chapter 10.

2410 Section 14. The board of registration in nursing may take disciplinary action against the
2411 practice privilege of a registered nurse or of a licensed practical or vocational nurse practicing in
2412 the commonwealth under a license issued by party state. The board's disciplinary action may be
2413 based on disciplinary action against the nurse's license taken by the nurse's home state.

2414 Section 15. In reporting information to the coordinated licensure information system
2415 under section 8 of this chapter related to the Nurse Licensure Compact, the board of registration
2416 in nursing may disclose personally identifiable information about the nurse, including social
2417 security number.

2418 Section 16. Nothing in this chapter, nor the entrance of the commonwealth into the Nurse
2419 Licensure Compact shall be construed to supersede existing labor laws.

2420 Section 17. The commonwealth, its officers and employees, and the board of registration
2421 in nursing and its agents who act in accordance with the provisions of this chapter shall not be
2422 liable on account of any act or omission in good faith while engaged in the performance of their
2423 duties under this chapter. Good faith shall not include willful misconduct, gross negligence, or
2424 recklessness.

2425 Section 18. As part of the licensure and background check process for a multistate license
2426 and to determine the suitability of an applicant for multistate licensure, the board of registration
2427 in nursing, prior to issuing any multistate license, shall conduct a fingerprint-based check of the
2428 state and national criminal history databases, as authorized by 28 CFR 20.33 and Public Law 92-
2429 544.

2430 Fingerprints shall be submitted to the identification section of the department of state
2431 police for a state criminal history check and forwarded to the Federal Bureau of Investigation for
2432 a national criminal history check, according to the policies and procedures established by the
2433 state identification section and by the department of criminal justice information services.
2434 Fingerprint submissions may be retained by the Federal Bureau of Investigation, the state
2435 identification section and the department of criminal justice information services for requests
2436 submitted by the board of registration in nursing as authorized under this section to ensure the
2437 continued suitability of these individuals for licensure. The department of criminal justice
2438 information services may disseminate the results of the state and national criminal background
2439 checks to the executive director of the board of registration in nursing and authorized staff of the
2440 board.

2441 All applicants shall pay a fee to be established by the secretary of administration and
2442 finance, in consultation with the secretary of public safety, to offset the costs of operating and
2443 administering a fingerprint-based criminal background check system. The secretary of
2444 administration and finance, in consultation with the secretary of public safety, may increase the
2445 fee accordingly if the Federal Bureau of Investigation increases its fingerprint background check
2446 service fee. Any fees collected from fingerprinting activity under this chapter shall be deposited
2447 into the Fingerprint-Based Background Check Trust Fund, established in section 2HHHH of
2448 chapter 29.

2449 The board of registration in nursing may receive all criminal offender record information
2450 and the results of checks of state and national criminal history databases under said Public Law
2451 92-544. When the board of registration in nursing obtains the results of checks of state and
2452 national criminal history databases, it shall treat the information according to sections 167 to

2453 178, inclusive, of chapter 6 and the regulations thereunder regarding criminal offender record
2454 information.

2455 Notwithstanding subsections 9 and 9 1/2 of section 4 of chapter 151B, if the board of
2456 registration in nursing receives criminal record information from the state or national fingerprint-
2457 based criminal background checks that includes no disposition or is otherwise incomplete, the
2458 agency head may request that an applicant for licensure provide additional information regarding
2459 the results of the criminal background checks to assist the agency head in determining the
2460 applicant's suitability for licensure.

2461 SECTION 112. Section 12 of Chapter 118E, as appearing in the 2018 Official Edition, is
2462 hereby amended by inserting after the eighth paragraph the following paragraph:-

2463 Such rules and regulations shall also include provisions requiring providers applying to
2464 participate in the medical assistance programs established under this chapter to utilize an
2465 application specified by the division, such as a standard credentialing form.

2466 SECTION 113. The General Laws are hereby amended by striking out chapter 118I and
2467 inserting in place thereof the following chapter:-

2468 Chapter 118I. Health Information Technology

2469 Section 1. As used in this chapter, the following words shall, unless the context clearly
2470 requires otherwise, have the following meanings:

2471 "Council", the health information technology council established under section 2 of this
2472 chapter.

2473 “Electronic health record”, an electronic record of patient health information generated
2474 by 1 or more encounters in any care delivery setting.

2475 “Executive office”, the executive office of health and human services.

2476 “Health care entity”, a payer, health care provider or provider organization.

2477 “Health care provider”, a provider of medical or health services or any other person or
2478 organization that furnishes, bills or is paid for health care service delivery in the normal course
2479 of business.

2480 “Health information exchange”, the electronic transmission of health care-related data
2481 and information among health care entities.

2482 “Office of the National Coordinator” or “ONC”, the Office of the National Coordinator
2483 for Health Information Technology within the United States Department of Health and Human
2484 Services.

2485 “Payer”, any entity, other than an individual, that pays providers for the provision of
2486 health care services; provided, that “payer” shall include both governmental and private entities.

2487 “Provider organization”, any corporation, partnership, business trust, association or
2488 organized group of persons, which is in the business of health care delivery or management,
2489 whether incorporated or not that represents 1 or more health care providers in contracting with
2490 carriers for the payments of health care services; provided, that “provider organization” shall
2491 include, but not be limited to, physician organizations, physician-hospital organizations,
2492 independent practice associations, provider networks, accountable care organizations and any
2493 other organization that contracts with carriers for payment for health care services.

2494 “Statewide health information exchange”, health information exchange established,
2495 operated, facilitated or funded by a governmental entity or entities in the commonwealth.

2496 Section 2. (a) There shall be a health information technology council within the executive
2497 office. The council shall advise the executive office on design, implementation, operation and
2498 use of statewide health information exchange.

2499 (b) The council shall consist of the following 17 members: the secretary of the executive
2500 office or a designee, who shall serve as the chair; the executive director of the health policy
2501 commission or a designee; the executive director of the center for health information analysis or
2502 a designee; the director of the Massachusetts eHealth Institute or a designee; the secretary of
2503 housing and economic development or a designee; the director of the office of Medicaid or a
2504 designee; and 11 members who shall be appointed by the governor: of whom at least 2 shall be
2505 representatives from the from the health information technology industry; 1 shall be an expert in
2506 health information technology from a provider-based setting; 1 shall be an expert in health data
2507 privacy; 1 shall be an expert in health information security; 3 shall be from provider
2508 organizations; 1 shall be from a behavioral health provider organization; 1 shall represent a
2509 payer; and 1 shall be a representative of the Massachusetts Life Science Center. Appointed
2510 members of the council shall serve for terms of 2 years or until a successor is appointed.
2511 Members shall be eligible to be reappointed and shall serve without compensation.

2512 (c) In carrying out this chapter, the council may consult with various organizations of
2513 health care entities on the design, implementation, operation and use of statewide health
2514 information exchange.

2515 (d) Chapter 268A shall apply to all council members, except that the council may
2516 purchase from, sell to, borrow from, contract with or otherwise deal with any organization in
2517 which any council member is in anyway interested or involved; provided, however, that interest
2518 or involvement shall be disclosed in advance to the council and recorded in the minutes of the
2519 proceedings of the council; and provided, further, that no member shall be considered to have
2520 violated section 4 of chapter 268A of the General Laws because of the member's receipt of usual
2521 and regular compensation from the member's employer during the time in which the member
2522 participates in the activities of the council.

2523 Section 3. (a) The executive office shall establish, operate, facilitate or fund statewide
2524 health information exchange between health care entities, including, but not limited to, the
2525 defining of and overseeing the exchange of minimum data requirements.

2526 (b) The executive office may:

2527 (i) conduct procurements and enter into contracts for the purchase, development or
2528 management of hardware, software or related services, in connection with the creation and
2529 implementation of statewide health information exchange; and

2530 (ii) in consultation with the council, oversee the development, dissemination,
2531 implementation and operation of statewide health information exchange, including, but not
2532 limited to, any modules, applications, interfaces or other technology infrastructure for statewide
2533 health information exchange.

2534 (c) In carrying out this chapter, the executive office may undertake any activities
2535 necessary to implement the powers and duties under this chapter, which may include the
2536 adoption of policies consistent with those adopted by the Office of the National Coordinator for

2537 Health Information Technology of the United States Department of Health and Human Services;
2538 provided, however, that nothing herein shall be construed to limit the executive office's ability to
2539 advance interoperability and other health information technology beyond the standards adopted
2540 by the ONC, including without limitation any applicable meaningful use standards.

2541 Section 4. Every patient shall have electronic access to that patient's own health records.
2542 The executive office shall ensure that each patient has secure electronic access to that patient's
2543 own electronic health records with each of that patient's health care providers. The executive
2544 office shall ensure that statewide health information exchange includes the ability to transmit
2545 copies of electronic health records to patients directly or allow facilities to provide mechanisms
2546 for that patient to access that patient's own electronic health record.

2547 Section 5. All health care entities in the commonwealth shall participate in statewide
2548 health information exchange as defined by the executive office; provided that all health care
2549 providers shall implement fully interoperable electronic records systems necessary to participate
2550 in statewide health information exchange; and further provided that all payers shall implement
2551 electronic claims management systems that can transmit claims data necessary to participate in
2552 statewide health information exchange. The executive office shall ensure that statewide health
2553 information exchange, the associated electronic records systems and electronic claims
2554 management systems, comply with all state and federal privacy requirements, including those
2555 imposed by the Health Insurance Portability and Accountability Act of 1996, P.L. 104–191, the
2556 American Recovery and Reinvestment Act of 2009, P.L. 111–5, 42 C.F.R. §§ 2.11 et seq. and 45
2557 C.F.R. §§ 160, 162 and 164.

2558 Section 6. The executive office shall prescribe by regulation penalties for non-compliance
2559 by health care entities with the requirements of section 5; provided, however, that the executive
2560 office may waive penalties for good cause. Penalties collected under this section shall be
2561 deposited into the Health Information Technology Trust Fund, established in section 35RR of
2562 chapter 10.

2563 Section 7. In the event of an unauthorized access to or disclosure of individually
2564 identifiable patient health information by or through a health care entity or a vendor contracted
2565 through services of a health care entity as participants of statewide health information exchange,
2566 the health care entity or vendor shall:

2567 (a) report the conditions of the unauthorized access or disclosure as required by the
2568 executive office; and

2569 (b) provide notice, as defined in section 1 of chapter 93H, as soon as practicable, but not
2570 later than 10 business days after the unauthorized access or disclosure, to any person whose
2571 patient health information may have been compromised as a result of the unauthorized access or
2572 disclosure, and shall report the conditions of the unauthorized access or disclosure, and further
2573 shall concurrently provide a copy of the report to the executive office. Any unauthorized access
2574 or disclosures shall be punishable by the civil penalties under section 10.

2575 Section 8. The executive office shall pursue and maximize all opportunities to qualify for
2576 federal financial participation under the matching grant program established under the Health
2577 Information Technology for Economic and Clinical Health Act of the American Recovery and
2578 Reinvestment Act of 2009, P.L. 111–5.

2579 Section 9. The council shall file an annual report, not later than January 30, with the joint
2580 committee on health care financing, the joint committee on economic development and emerging
2581 technologies, the house and senate committees on ways and means and the clerks of the house
2582 and senate concerning the activities of the council in general, describing the progress to date in
2583 developing statewide health information exchange and recommending further legislative action
2584 as it deems appropriate.

2585 Section 10. Unauthorized access to or disclosure of individually identifiable patient
2586 health information shall be subject to fines or penalties as determined by the executive office.
2587 The executive office shall promulgate regulations to assess fair and reasonable fines or penalties.

2588 Section 11. Cybersecurity-based documentation, including, but not limited to, security
2589 audit reports, provided to the executive office shall be exempt from public records laws
2590 established in clause 26 of section 7 of chapter 4.

2591 SECTION 114. Section 1 of Chapter 123 of the General Laws, as appearing in the 2018
2592 Official Edition, is hereby amended by inserting after the definition of “Psychologist” the
2593 following definition:-

2594 “Qualified advanced practice registered nurse”, an advanced practice registered nurse
2595 (APRN), authorized by the board of registration in nursing pursuant to section 80B of chapter
2596 112 who holds certification in the field of psychiatric mental health from a certifying
2597 organization recognized by said board or its equivalent approved by said board. The APRN must
2598 meet qualifications required by regulations of the department provided that different
2599 qualifications may be established for different purposes of this chapter. A qualified advanced

2600 practice registered nurse need not be an employee of the department or any facility of the
2601 department.

2602 SECTION 115. Section 11 of said chapter 123, as so appearing, is hereby amended, in
2603 line 22 and in line 29, by inserting after the word “physician”, in both instances the following
2604 words:- or qualified advanced practice registered nurse.

2605 SECTION 116. Said chapter 123 is hereby further amended by striking out section 12
2606 and inserting in place thereof the following section:-

2607 Section 12. (a) Any physician who is licensed pursuant to section 2 of chapter 112 or
2608 qualified nurse practitioner authorized to practice as such under regulations promulgated
2609 pursuant to the provisions of section 80B of said chapter 112 or a qualified psychologist licensed
2610 pursuant to sections 118 to 129, inclusive, of said chapter 112, or a licensed independent clinical
2611 social worker licensed pursuant to sections 130 to 137, inclusive, of said chapter 112 who, after
2612 examining a person, has reason to believe that failure to hospitalize such person would create a
2613 likelihood of serious harm by reason of mental illness may restrain or authorize the restraint of
2614 such person and apply for the hospitalization of such person for a 3 day period at a public facility
2615 or at a private facility authorized for such purposes by the department. If an examination is not
2616 possible because of the emergency nature of the case and because of the refusal of the person to
2617 consent to such examination, the physician, qualified psychologist, qualified advanced practice
2618 registered nurse or licensed independent clinical social worker on the basis of the facts and
2619 circumstances may determine that hospitalization is necessary and may apply therefore. In an
2620 emergency situation, if a physician, qualified psychologist, qualified advanced practice
2621 registered nurse or licensed independent clinical social worker is not available, a police officer,

2622 who believes that failure to hospitalize a person would create a likelihood of serious harm by
2623 reason of mental illness may restrain such person and apply for the hospitalization of such person
2624 for a 3 day period at a public facility or a private facility authorized for such purpose by the
2625 department. An application for hospitalization shall state the reasons for the restraint of such
2626 person and any other relevant information which may assist the admitting physician or
2627 physicians or qualified advanced practice registered nurse. Whenever practicable, prior to
2628 transporting such person, the applicant shall telephone or otherwise communicate with a facility
2629 to describe the circumstances and known clinical history and to determine whether the facility is
2630 the proper facility to receive such person and also to give notice of any restraint to be used and to
2631 determine whether such restraint is necessary.

2632 (b) Only if the application for hospitalization under the provisions of this section is made
2633 by a physician, or a qualified advanced practice registered nurse specifically designated to have
2634 the authority to admit to a facility in accordance with the regulations of the department, shall
2635 such person be admitted to the facility immediately after his reception. If the application is made
2636 by someone other than a designated physician, or a qualified advanced practice registered nurse,
2637 such person shall be given a psychiatric examination by a designated physician, or a qualified
2638 advanced practice registered nurse immediately after his reception at such facility. If the
2639 physician, or a qualified advanced practice registered nurse determines that failure to hospitalize
2640 such person would create a likelihood of serious harm by reason of mental illness he may admit
2641 such person to the facility for care and treatment. Upon admission of a person under the
2642 provisions of this subsection, the facility shall inform the person that it shall, upon such person's
2643 request, notify the committee for public counsel services of the name and location of the person
2644 admitted. Said committee for public counsel services shall forthwith appoint an attorney who

2645 shall meet with the person. If the appointed attorney determines that the person voluntarily and
2646 knowingly waives the right to be, represented, or is presently represented or will be represented
2647 by another attorney, the appointed attorney shall so notify said committee for public counsel
2648 services, which shall withdraw the appointment.

2649 Any person admitted under the provisions of this subsection, who has reason to believe
2650 that such admission is the result of an abuse or misuse of the provisions of this subsection, may
2651 request, or request through counsel an emergency hearing in the district court in whose
2652 jurisdiction the facility is located, and unless a delay is requested by the person or through
2653 counsel, the district court shall hold such hearing on the day the request is filed with the court or
2654 not later than the next business day.

2655 (c) No person shall be admitted to a facility under the provisions of this section unless he,
2656 or his parent or legal guardian in his behalf, is given an opportunity to apply for voluntary
2657 admission under the provisions of paragraph (a) of section 10 and unless he, or such parent or
2658 legal guardian has been informed (i) that he has a right to such voluntary admission, and (ii) that
2659 the period of hospitalization under the provisions of this section cannot exceed 3 days. At any
2660 time during such period of hospitalization, the superintendent may discharge such person if he
2661 determines that such person is not in need of care and treatment.

2662 (d) A person shall be discharged at the end of the 3 day period unless the superintendent
2663 applies for a commitment under the provisions of sections seven and eight of this chapter or the
2664 person remains on a voluntary status.

2665 (e) Any person may make application to a district court justice or a justice of the juvenile
2666 court department for a 3 day commitment to a facility of a mentally ill person whom the failure

2667 to confine would cause a likelihood of serious harm. The court shall appoint counsel to represent
2668 said person. After hearing such evidence as he may consider sufficient, a district court justice or
2669 a justice of the juvenile court department may issue a warrant for the apprehension and
2670 appearance before him of the alleged mentally ill person, if in his judgment the condition or
2671 conduct of such person makes such action necessary or proper. Following apprehension, the
2672 court shall have the person examined by a physician, or a qualified advanced practice registered
2673 nurse designated to have the authority to admit to a facility or examined by a qualified
2674 psychologist in accordance with the regulations of the department. If said physician, qualified
2675 advanced practice registered nurse or qualified psychologist reports that the failure to hospitalize
2676 the person would create a likelihood of serious harm by reason of mental illness, the court may
2677 order the person committed to a facility for a period not to exceed 3 days, but the superintendent
2678 may discharge him at any time within the three day period. The periods of time prescribed or
2679 allowed under the provisions of this section shall be computed pursuant to Rule 6 of the
2680 Massachusetts Rules of Civil Procedure.

2681 SECTION 117. Said chapter 123 is hereby further amended by striking out section 21
2682 and inserting in place thereof the following section:-

2683 Section 21. Any person who transports a mentally ill person to or from a facility for any
2684 purpose authorized under this chapter shall not use any restraint which is unnecessary for the
2685 safety of the person being transported or other persons likely to come in contact with him.

2686 In the case of persons being hospitalized under the provisions of section six, the applicant
2687 shall authorize practicable and safe means of transport, including where appropriate,
2688 departmental or police transport.

2689 Restraint of a mentally ill patient may only be used in cases of emergency, such as the
2690 occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide;
2691 provided, however, that written authorization for such restraint is given by the superintendent or
2692 director of the facility or by a physician or qualified advanced practice registered nurse
2693 designated by him for this purpose who is present at the time of the emergency or if the
2694 superintendent or director or designated physician or qualified advanced practice registered nurse
2695 is not present at the time of the emergency, non-chemical means of restraint may be used for a
2696 period of 1 hour provided that within 1 hour the person in restraint shall be examined by the
2697 superintendent, director or designated physician or qualified advanced practice registered nurse.
2698 Provided further, that if said examination has not occurred within 1 hour, the patient may be
2699 restrained for up to an additional 1 hour period until such examination is conducted, and the
2700 superintendent, director, or designated physician or qualified advanced practice registered nurse
2701 shall attach to the restraint form a written report as to why the examination was not completed by
2702 the end of the first hour of restraint.

2703 Any minor placed in restraint shall be examined within fifteen minutes of the order for
2704 restraint by a physician or qualified advanced practice registered nurse or, if a physician or
2705 qualified advanced practice registered nurse is not available, by a registered nurse or a certified
2706 physician assistant; provided, however, that said minor shall be examined by a physician or
2707 qualified advanced practice registered nurse within one hour of the order for restraint. A
2708 physician or qualified advanced practice registered nurse or, if a physician or qualified advanced
2709 practice registered nurse is not available, a registered nurse or a certified physician assistant,
2710 shall review the restraint order, by personal examination of the minor or consultation with ward
2711 staff attending the minor, every hour thereafter.

2712 No minor shall be secluded for more than two hours in any 24 hour period; provided,
2713 however, that no such seclusion of a minor may occur except in a facility with authority to use
2714 such seclusion after said facility has been inspected and specially certified by the department.
2715 The department shall issue regulations establishing procedures by which a facility may be
2716 specially certified with authority to seclude a minor. Such regulations shall provide for review
2717 and approval or disapproval by the commissioner of a biannual application by the facility which
2718 shall include (i) a comprehensive statement of the facility's policies and procedures for the
2719 utilization and monitoring of restraint of minors including a statistical analysis of the facility's
2720 actual use of such restraint, and (ii) a certification by the facility of its ability and intent to
2721 comply with all applicable statutes and regulations regarding physical space, staff training, staff
2722 authorization, record keeping, monitoring and other requirements for the use of restraints.

2723 Any use of restraint on a minor exceeding one hour in any 24 hour period shall be
2724 reviewed within two working days by the director of the facility. The director shall forward a
2725 copy of his report on each such instance of restraint to the human rights committee of that
2726 facility and, in the event that there is no human rights committee, to the appropriate body
2727 designated by the commissioner of mental health. The director shall also compile a record of
2728 every instance of restraint in the facility and shall forward a copy of said report on a monthly
2729 basis to the human rights committee or the body designated by the commissioner of mental
2730 health.

2731 No order for restraint for an individual shall be valid for a period of more than three
2732 hours beyond which time it may be renewed upon personal examination by the superintendent,
2733 director, authorized physician or qualified advanced practice registered nurse or, for adults, by a
2734 registered nurse or a certified physician assistant; provided, however, that no adult shall be

2735 restrained for more than 6 hours beyond which time an order may be renewed only upon
2736 personal examination by a physician or qualified advanced practice registered nurse. The reasons
2737 for the original use of restraint, the reason for its continuation after each renewal, and the reason
2738 for its cessation shall be noted upon the restraining form by the superintendent, director or
2739 authorized physician or qualified advanced practice registered nurse or, when applicable, by the
2740 registered nurse or certified physician or qualified advanced practice registered nurse assistant at
2741 the time of each occurrence.

2742 When a designated physician or qualified advanced practice registered nurse is not
2743 present at the time and site of the emergency, an order for chemical restraint may be issued by a
2744 designated physician or qualified advanced practice registered nurse who has determined, after
2745 telephone consultation with a physician or qualified advanced practice registered nurse,
2746 registered nurse or certified physician assistant who is present at the time and site of the
2747 emergency and who has personally examined the patient, that such chemical restraint is the least
2748 restrictive, most appropriate alternative available; provided, however, that the medication so
2749 ordered has been previously authorized as part of the individual's current treatment plan.

2750 No person shall be kept in restraint without a person in attendance specially trained to
2751 understand, assist and afford therapy to the person in restraint. The person may be in attendance
2752 immediately outside the room in full view of the patient when an individual is being secluded
2753 without mechanical restraint; provided, however, that in emergency situations when a person
2754 specially trained is not available, an adult, may be kept in restraint unattended for a period not to
2755 exceed two hours. In that event, the person kept in restraints must be observed at least every 5
2756 minutes; provided, further, that the superintendent, director, or designated physician or qualified
2757 advanced practice registered nurse shall attach to the restraint form a written report as to why the

2758 specially trained attendant was not available. The maintenance of any adult in restraint for more
2759 than eight hours in any 24 hour period must be authorized by the superintendent or facility
2760 director or the person specifically designated to act in the absence of the superintendent or
2761 facility director; provided, however, that when such restraint is authorized in the absence of the
2762 superintendent or facility director, such authorization must be reviewed by the superintendent or
2763 facility director upon his return.

2764 No "P.R.N." or "as required" authorization of restraint may be written. No restraint is
2765 authorized except as specified in this section in any public or private facility for the care and
2766 treatment of mentally ill persons including Bridgewater.

2767 No later than 24 hours after the period of restraint, a copy of the restraint form shall be
2768 delivered to the person who was in restraint. A place shall be provided on the form or on
2769 attachments thereto, for the person to comment on the circumstances leading to the use of
2770 restraint and on the manner of restraint used.

2771 A copy of the restraint form and any such attachments shall become part of the chart of
2772 the patient. Copies of all restraint forms and attachments shall be sent to the commissioner of
2773 mental health, or with respect to Bridgewater state hospital to the commissioner of correction,
2774 who shall review and sign them within thirty days, and statistical records shall be kept thereof for
2775 each facility including Bridgewater state hospital, and each designated physician or qualified
2776 advanced practice registered nurse. Furthermore, such reports, excluding patient identification,
2777 shall be made available to the general public at the department's central office, or with respect to
2778 Bridgewater state hospital at the department of correction's central office.

2779 Responsibility and liability for the implementation of the provisions of this section shall
2780 rest with the department, the superintendent or director of each facility or the physician or
2781 qualified advanced practice registered nurse designated by such superintendent or director for
2782 this purpose.

2783 SECTION 118. Section 22 of said chapter 123, as appearing in the 2018 Official Edition,
2784 is hereby amended by inserting, in line 1, after the word “physicians” the following words:-
2785 qualified advanced practice registered nurse.

2786 SECTION 119. Said section 22 of said chapter 123, as so appearing, is hereby further
2787 amended by inserting, in line 6, after the word “physician” the following words:- , qualified
2788 advanced practice registered nurse.

2789 SECTION 120. Subsection (i) of section 47B of chapter 175 of the General Laws, as so
2790 appearing, is hereby amended by striking out the second paragraph and inserting in place thereof
2791 the following 3 paragraphs:-

2792 For the purposes of this section, “licensed mental health professional” shall mean a
2793 licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a
2794 licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse
2795 mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1
2796 of chapter 111J, a licensed marriage and family therapist within the lawful scope of practice for
2797 such therapist, or a clinician practicing under the supervision of licensed professional, and
2798 working towards licensure, in a clinic licensed under chapter 111.

2799 An insurer may not deny coverage for any behavioral health service or any evaluation
2800 and management office visit solely because the two services were delivered on the same day in

2801 the same practice or facility; provided, however, an insurer may deny coverage if the two
2802 services are delivered by the same provider, or providers of the same specialty.

2803 The division shall provide guidance relative to implementation of this section.

2804 SECTION 121. Said chapter 175 is hereby further amended by inserting after section
2805 47XX the following section:-

2806 Section 47YY. (a) For the purposes of this section, “Telehealth” as it pertains to the
2807 delivery of health care services, shall mean the use of synchronous or asynchronous
2808 telecommunications technology, including but not limited to live video, text messaging and
2809 application-based communications, by a telehealth provider, as defined in section 4P of chapter
2810 111, to provide health care services, including, but not limited to, assessment, diagnosis,
2811 consultation, treatment and monitoring of a patient. The term does not include audio-only
2812 telephone calls, e-mail messages or facsimile transmissions.

2813 (b) For an individual policy of accident and sickness insurance issued under section 108
2814 that provides hospital expense and surgical expense insurance and any group blanket or general
2815 policy of accident and sickness insurance issued under section 110 that provides hospital expense
2816 and surgical expense insurance which is issued or renewed within or without the commonwealth,
2817 an insurer shall implement procedures, so that the insurer shall not decline to provide coverage
2818 for health care services solely on the basis that those services were delivered through the use of
2819 telehealth by a contracted health care provider, consistent with clause (i) of paragraph (4) of
2820 subsection (a) of section 6 of chapter 176O, if (i) the health care services are covered by way of
2821 in-person consultation or delivery and (ii) the health care services may be appropriately provided
2822 through the use of telehealth.

2823 (c) A contract that provides coverage for services under this section may contain a
2824 provision for a deductible, copayment or coinsurance requirement for a health care service
2825 provided through telehealth as long as the deductible, copayment or coinsurance does not exceed
2826 the deductible, copayment or coinsurance applicable to an in-person consultation.

2827 (d) When determining coverage for telehealth services, carriers may use utilization
2828 review systems, including preauthorization, to determine the appropriateness of telehealth as a
2829 means of delivering a health care service, provided that the determination shall be made in the
2830 same manner as if the service was provided via in-person consultation or delivery.

2831 (e) Coverage for telehealth services shall not be required to reimburse a health care
2832 provider for a health care service that is not a covered benefit under the plan nor to reimburse a
2833 health care provider not contracted under the plan except as provided for under clause (i) of
2834 paragraph (4) of subsection (a) of section 6 of chapter 176O.

2835 (f) Coverage that reimburses a provider with a global payment, as defined in section 1 of
2836 chapter 6D, shall account for the provision of telehealth services when the carrier calculates the
2837 global payment allowed amount.

2838 SECTION 122. Section 1 of chapter 175H of the General Laws, as appearing in the 2018
2839 Official Edition, is hereby amended by inserting after the definition of “Health care insurer” the
2840 following definition:

2841 “Impermissible facility fee,” a facility fee, as defined in section 51L of chapter 111, that
2842 is not charged, billed or collected in accordance with paragraphs (b) or (c) of said section 51L of
2843 chapter 111.

2844 SECTION 123. Said section 1 of said chapter 175H, as so appearing, is hereby amended
2845 by inserting after the definition of “Person” the following definition:-

2846 “Surprise bill,” a bill, received by an insured who is covered under a preferred or closed
2847 network health plan, for dollar amounts, other than plan copayments, coinsurance or amounts
2848 subject to a deductible, for covered services provided by an out-of-network provider for services
2849 rendered for emergency medical conditions or rendered by an out-of-network provider at an in-
2850 network facility, including, but not limited to:

2851 (i) health care services rendered by an out-of-network provider without the insured’s
2852 knowledge;

2853 (ii) health care services rendered by an out-of-network provider where an in-network
2854 provider is not reasonably available to the insured at the in-network facility, even if the out-of-
2855 network provider’s network status is disclosed to the insured;

2856 (iii) health care services rendered on an emergency basis or by an out-of-network
2857 provider that are necessary to provide immediate prophylaxis, diagnosis or treatment for a
2858 disease that the department of public health has determined is dangerous to the public health
2859 pursuant to section 6 of chapter 111;

2860 (iv) health care services rendered by an out-of-network provider, including an out-of-
2861 network laboratory, radiologist or pathologist, where the health care services were referred, or an
2862 insured’s specimen was sent, by a participating provider to an out-of-network provider without
2863 the prior written consent of the insured acknowledging that the participating provider is referring
2864 the insured or sending the insured’s specimen to an out-of-network provider, which may result in
2865 uncovered costs; and

2866 (v) unforeseen health care services that arise at the time health care services are rendered
2867 that must necessarily be rendered by an out-of-network provider;

2868 provided, however, that a surprise bill shall not mean a bill received by an insured for
2869 health care services when a participating provider is available and the insured knowingly,
2870 voluntarily and specifically elects to obtain services from an out-of-network provider.

2871 SECTION 124. Chapter 175H of the General Laws is hereby amended by striking out
2872 section 5, and inserting in place thereof the following section:-

2873 Section 5. The attorney general may conduct an investigation of an alleged violation of
2874 this chapter and may commence a proceeding pursuant to section 4. Additionally, the attorney
2875 general has the authority to initiate a civil action under this chapter. When the attorney general
2876 has determined that a provider has violated this chapter, the attorney general shall notify the
2877 department of public health, the department of mental health, the board of registration in
2878 medicine or any other relevant licensing authorities, of that determination. Those licensing
2879 authorities may, upon their own investigation or upon notification from the attorney general that
2880 a provider licensed by that authority has violated this section, impose penalties for non-
2881 compliance consistent with their authority to regulate those providers.

2882 SECTION 125. Said chapter 175H of the General Laws is hereby amended by striking
2883 out section 6 and inserting in place thereof the following section:-

2884 Section 6. A person who receives a health care benefit or payment from a health care
2885 corporation or health care insurer or other person or entity, which such person knows that he or
2886 she is not entitled to receive or be paid, or a person who knowingly presents or causes to be
2887 presented with fraudulent intent a claim which contains a false statement, including but not

2888 limited to a payment or false statement regarding an impermissible facility fee shall be liable to
2889 the health care corporation or health care insurer or other person or entity for the full amount of
2890 the benefit or payment made, and for reasonable attorneys' fees and costs, inclusive of costs of
2891 investigation. A health care corporation or health care insurer or other injured person or entity
2892 may bring a civil action under this chapter in the superior court department of the trial court.

2893 SECTION 126. Said chapter 175H of the General Laws is hereby amended by adding the
2894 following section:-

2895 Section 6A. A person who receives a health care benefit or payment from a health care
2896 corporation or health care insurer or other person or entity, shall not be permitted to forward a
2897 surprise bill to a person covered under an insured health plan. A person who violates this section
2898 shall be liable to the health care corporation or health care insurer or other person or entity for
2899 penalties and for reasonable attorneys' fees and costs, inclusive of costs of investigation. A
2900 health care corporation or health care insurer or other injured person or entity may bring a civil
2901 action under this chapter in the superior court department of the trial court.

2902 SECTION 127. The General Laws are hereby amended by inserting after chapter 175M
2903 the following chapter:-

2904 CHAPTER 175N. Pharmacy Benefit Managers

2905 Section 1.

2906 As used in this chapter the following words shall, unless the context clearly requires
2907 otherwise, have the following meanings:

2908 “Carrier,” an insurer licensed or otherwise authorized to transact accident or health
2909 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
2910 176A; a nonprofit medical service corporation organized under chapter 176B; a health
2911 maintenance organization organized under chapter 176G; and an organization entering into a
2912 preferred provider arrangement under chapter 176I, but not including an employer purchasing
2913 coverage or acting on behalf of its employees or the employees of or more subsidiaries or
2914 affiliated corporations of the employer; provided, however, that, unless otherwise noted,
2915 “carrier” shall not include any entity to the extent it offers a policy, certificate or contract that
2916 provides coverage solely for dental care services or vision care services.

2917 “Center”, the center for health information and analysis established in chapter 12C.

2918 “Commissioner”, the commissioner of insurance.

2919 “Division”, the division of insurance.

2920 ”Health benefit plan”, a policy, contract, certificate or agreement entered into, offered or
2921 issued by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health
2922 care services.

2923 “Pharmacy Benefit Manager,” any person, business or entity, however organized, that
2924 administers, either directly or through subsidiaries, pharmacy benefit services for prescription
2925 drugs and devices on behalf of health benefit plan sponsors, including, but not limited to, self-
2926 insured employers, insurance companies and labor unions; provided however, that “pharmacy
2927 benefit services” shall include, but not be limited to, formulary administration; drug benefit
2928 design; pharmacy network contracting; pharmacy claims processing; mail and specialty drug
2929 pharmacy services; and cost containment, clinical, safety and adherence programs for pharmacy

2930 services; provided, further, that a health benefit plan that does not contract with a pharmacy
2931 benefit manager shall be considered a pharmacy benefit manager for the purposes of this section.

2932 Section 2.

2933 (a) A person or organization shall not establish or operate as a pharmacy benefit manager
2934 to administer prescription drug benefits or services for a carrier's health benefit plans in the
2935 commonwealth without obtaining certification from the commissioner pursuant to this section.

2936 (b) The commissioner shall promulgate regulations regarding pharmacy benefit managers
2937 that shall establish the certification, application, standards and reporting requirements of
2938 pharmacy benefit managers. The commissioner shall charge application and renewal fees in the
2939 amount of \$1,000.

2940 (c) An entity certified as a pharmacy benefit manager shall be required to submit data and
2941 reporting information to the center, including information associated with discounts, retained
2942 rebates and earned margins on payments to pharmacy providers on behalf of health plans,
2943 according to standards and methods specified by the center pursuant to section 10A of chapter
2944 12C.

2945 (d) Certification obtained under this section is valid for a period of 2 years and may be
2946 renewed. Certification is not transferable.

2947 (e) A pharmacy benefit manager shall report to the division material changes to the
2948 information contained in its application, certified by an officer of the pharmacy benefit manager,
2949 within 30 days of such changes.

2950 Section 3.

2951 (a) The commissioner may make an examination of the affairs of a Pharmacy Benefit
2952 Manager when the commissioner deems prudent but not less frequently than once every 3 years.
2953 The focus of the examination shall be to ensure that a pharmacy benefit manager is able to meet
2954 its responsibilities under contracts with carriers licensed under chapters 175, 176A, 176B, or
2955 176G. The examination shall be conducted according to the procedures set forth in subsection (6)
2956 of section 4 of chapter 175.

2957 (b) The commissioner, a deputy or an examiner may conduct an on-site examination of
2958 each pharmacy benefit manager in the commonwealth to thoroughly inspect and examine its
2959 affairs.

2960 (c) The charge for each such examination shall be determined annually according to the
2961 procedures set forth in subsection (6) of section 4 of chapter 175.

2962 (d) Not later than 60 days following completion of the examination, the examiner in
2963 charge shall file with the commissioner a verified written report of examination under oath.
2964 Upon receipt of the verified report, the commissioner shall transmit the report to the pharmacy
2965 benefit manager examined with a notice which shall afford the pharmacy benefit manager
2966 examined a reasonable opportunity of not more than 30 days to make a written submission or
2967 rebuttal with respect to any matters contained in the examination report. Within 30 days of the
2968 end of the period allowed for the receipt of written submissions or rebuttals, the commissioner
2969 shall consider and review the reports together with any written submissions or rebuttals and any
2970 relevant portions of the examiner's work papers and enter an order:

2971 (i) adopting the examination report as filed with modifications or corrections and, if the
2972 examination report reveals that the pharmacy benefit manager is operating in violation of this

2973 section or any regulation or prior order of the commissioner, the commissioner may order the
2974 pharmacy benefit manager to take any action the commissioner considered necessary and
2975 appropriate to cure such violation;

2976 (ii) rejecting the examination report with directions to examiners to reopen the
2977 examination for the purposes of obtaining additional data, documentation or information and re-
2978 filing pursuant to the above provisions; or

2979 (iii) calling for an investigatory hearing with no less than 20 days' notice to the pharmacy
2980 benefit manager for purposes of obtaining additional documentation, data, information and
2981 testimony.

2982 (e) Notwithstanding any general or special law to the contrary, including clause 26 of
2983 section 7 of chapter 4 and chapter 66, the records of any such audit, examination or other
2984 inspection and the information contained in the records, reports or books of any pharmacy
2985 benefit manager examined pursuant to this section shall be confidential and open only to the
2986 inspection of the commissioner, or the examiners and assistants. Access to such confidential
2987 material may be granted by the commissioner to law enforcement officials of the commonwealth
2988 or any other state or agency of the federal government at any time, so long as the agency or
2989 office receiving the information agrees in writing to keep such material confidential. Nothing
2990 herein shall be construed to prohibit the required production of such records, and information
2991 contained in the reports of such company or organization before any court of the commonwealth
2992 or any master or auditor appointed by any such court, in any criminal or civil proceeding,
2993 affecting such pharmacy benefit manager, its officers, partners, directors or employees. The final

2994 report of any such audit, examination or any other inspection by or on behalf of the division of
2995 insurance shall be a public record.

2996 Section 4.

2997 A pharmacy benefit manager shall be required to submit to periodic audits by a carrier
2998 licensed under chapters 175, 176A, 176B, or 176G, if the pharmacy benefit manager has entered
2999 into a contract with the carrier to provide pharmacy benefits to the carrier or its members. The
3000 commissioner may direct or provide specifications for such audits.

3001 Section 5.

3002 (a) The division may suspend, revoke, or place on probation a pharmacy benefit manager
3003 certification if the pharmacy benefit manager:

3004 (1) has engaged in fraudulent activity that constitutes a violation of state or federal law;

3005 (2) is the subject of consumer complaints received and verified by the division that justify
3006 action under this section to protect the health, safety and interests of consumers;

3007 (3) fails to pay an application fee;

3008 (4) fails to comply with reporting requirements of the center under section 10A of chapter
3009 12C;

3010 (5) appears upon examination to be unable to fulfill its contractual obligations; or

3011 (6) fails to comply with a requirement set forth in this section.

3012 (b) The commissioner shall notify the pharmacy benefit manager and advise, in writing,
3013 of the reason for any suspension or any refusal to issue or non-renew a certificate under this
3014 chapter. A copy of the notice shall be forwarded to the center. The applicant or pharmacy benefit
3015 manager may make written demand upon the commissioner within 30 days of receipt of such
3016 notification for a hearing before the commissioner to determine the reasonableness of the
3017 commissioner's action. The hearing shall be held pursuant to chapter 30A.

3018 (c) The commissioner shall not suspend or cancel a certificate unless the commissioner
3019 has first afforded the pharmacy benefit manager an opportunity for a hearing pursuant to chapter
3020 30A.

3021 SECTION 128. Subsection (i) of section 8A of chapter 176A of the General Laws, as
3022 appearing in the 2018 Official Edition, is hereby amended by striking out the second paragraph
3023 and inserting in place thereof the following 3 paragraphs:-

3024 For the purposes of this section, "licensed mental health professional" shall mean a
3025 licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a
3026 licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse
3027 mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1
3028 of chapter 111J, a licensed marriage and family therapist within the lawful scope of practice for
3029 such therapist, or a clinician practicing under the supervision of licensed professional, and
3030 working towards licensure, in a clinic licensed under chapter 111.

3031 A carrier may not deny coverage for any behavioral health service or any evaluation and
3032 management office visit solely because the two services were delivered on the same day in the

3033 same practice or facility; provided, however, an insurer may deny coverage if the two services
3034 are delivered by the same provider, or providers of the same specialty.

3035 The Division shall provide guidance relative to implementation of this section.

3036 SECTION 129. Chapter 176A of the General Laws is hereby amended by adding the
3037 following section:-

3038 Section 38. (a) “Telehealth” as it pertains to the delivery of health care services, the use
3039 of synchronous or asynchronous telecommunications technology, including but not limited to
3040 live video, text messaging and application-based communications, by a telehealth provider, as
3041 defined in section 4P of chapter 111, to provide health care services, including, but not limited
3042 to, assessment, diagnosis, consultation, treatment and monitoring of a patient. The term does not
3043 include audio-only telephone calls, e-mail messages or facsimile transmissions.

3044 (b) For a contract between a subscriber and a nonprofit hospital service corporation, the
3045 corporation shall implement procedures so that the insurer shall not decline to provide coverage
3046 for health care services solely on the basis that those services were delivered through the use of
3047 telehealth by a contracted health care provider, consistent with paragraph (4)(i) of subsection (a)
3048 of section 6 of chapter 176O, if (i) the health care services are covered by way of in-person
3049 consultation or delivery and (ii) the health care services may be appropriately provided through
3050 the use of telehealth.

3051 (c) A contract that provides coverage for services under this section may contain a
3052 provision for a deductible, copayment or coinsurance requirement for a health care service
3053 provided through telehealth as long as the deductible, copayment or coinsurance does not exceed
3054 the deductible, copayment or coinsurance applicable to an in-person consultation.

3055 (d) When determining coverage for telehealth services, carriers may use utilization
3056 review systems, including preauthorization, to determine the appropriateness of telehealth as a
3057 means of delivering a health care service, provided that the determination shall be made in the
3058 same manner as if the service was provided via in-person consultation or delivery

3059 (e) Coverage for telehealth services shall not be required to reimburse a health care
3060 provider for a health care service that is not a covered benefit under the plan nor to reimburse a
3061 health care provider not contracted under the plan except as provided for under paragraph (4)(i)
3062 of subsection (a) of Section 6 of Chapter 176O.

3063 (f) Coverage that reimburses a provider with a global payment, as defined in section 1 of
3064 chapter 6D, shall account for the provision of telehealth services when the carrier calculates the
3065 global payment allowed amount.

3066 SECTION 130. Subsection (i) of section 4A of chapter 176B of the General Laws, as
3067 appearing in the 2018 Official Edition, is hereby amended by striking out the second paragraph
3068 and inserting in place thereof the following 3 paragraphs:-

3069 For the purposes of this section, “licensed mental health professional” shall mean a
3070 licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a
3071 licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse
3072 mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1
3073 of chapter 111J, a licensed marriage and family therapist within the lawful scope of practice for
3074 such therapist, or a clinician practicing under the supervision of licensed professional, and
3075 working towards licensure, in a clinic licensed under chapter 111.

3076 A carrier may not deny coverage for any behavioral health service or any evaluation and
3077 management office visit solely because the two services were delivered on the same day in the
3078 same practice or facility; provided, however, an insurer may deny coverage if the two services
3079 are delivered by the same provider, or providers of the same specialty.

3080 The Division shall provide guidance relative to implementation of this section.

3081 SECTION 131. Chapter 176B of the General Laws is hereby amended by adding the
3082 following section:-

3083 Section 25. (a) For the purposes of this section, “Telehealth” as it pertains to the delivery
3084 of health care services, shall mean the use of synchronous or asynchronous telecommunications
3085 technology, including but not limited to live video, text messaging and application-based
3086 communications, by a telehealth provider, as defined in section 4P of chapter 111, to provide
3087 health care services, including, but not limited to, assessment, diagnosis, consultation, treatment
3088 and monitoring of a patient. The term does not include audio-only telephone calls, e-mail
3089 messages or facsimile transmissions.

3090 (b) For a contract between a subscriber and a medical service corporation, the corporation
3091 shall implement procedures so that it shall not decline to provide coverage for health care
3092 services solely on the basis that those services were delivered through the use of telehealth by a
3093 contracted health care provider, consistent with clause (i) of paragraph (4) of subsection (a) of
3094 section 6 of chapter 176O, if (i) the health care services are covered by way of in-person
3095 consultation or delivery and (ii) the health care services may be appropriately provided through
3096 the use of telehealth.

3097 (c) A contract that provides coverage for services under this section may contain a
3098 provision for a deductible, copayment or coinsurance requirement for a health care service
3099 provided through telehealth as long as the deductible, copayment or coinsurance does not exceed
3100 the deductible, copayment or coinsurance applicable to an in-person consultation.

3101 (d) When determining coverage for telehealth services, carriers may use utilization
3102 review systems, including preauthorization, to determine the appropriateness of telehealth as a
3103 means of delivering a health care service, provided that the determination shall be made in the
3104 same manner as if the service was provided via in-person consultation or delivery

3105 (e) Coverage for telehealth services shall not be required to reimburse a health care
3106 provider for a health care service that is not a covered benefit under the plan nor to reimburse a
3107 health care provider not contracted under the plan except as provided for under clause (i) of
3108 paragraph (4) of subsection (a) of Section 6 of Chapter 176O.

3109 (f) Coverage that reimburses a provider with a global payment, as defined in section 1 of
3110 chapter 6D, shall account for the provision of telehealth services when the carrier calculates the
3111 global payment allowed amount.

3112 SECTION 132. Subsection (i) of section 4M of chapter 176G of the General Laws, as
3113 appearing in the 2018 Official Edition, is hereby amended by striking out the second paragraph
3114 and inserting in place thereof the following 3 paragraphs:-

3115 For the purposes of this section, “licensed mental health professional” shall mean a
3116 licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a
3117 licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse
3118 mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1

3119 of chapter 111J, a licensed marriage and family therapist within the lawful scope of practice for
3120 such therapist, or a clinician practicing under the supervision of licensed professional, and
3121 working towards licensure, in a clinic licensed under chapter 111.

3122 A carrier may not deny coverage for any behavioral health service or any evaluation and
3123 management office visit solely because the two services were delivered on the same day in the
3124 same practice or facility; provided, however, an insurer may deny coverage if the two services
3125 are delivered by the same provider, or providers of the same specialty.

3126 The Division shall provide guidance relative to implementation of this section.

3127 SECTION 133. Said chapter 176G of the General laws is hereby further amended by
3128 adding the following section:-

3129 Section 33. (a) For the purposes of this section, “Telehealth” as it pertains to the delivery
3130 of health care services, shall mean the use of synchronous or asynchronous telecommunications
3131 technology, including but not limited to live video, text messaging and application-based
3132 communications, by a telehealth provider, as defined in section 4P of chapter 111, to provide
3133 health care services, including, but not limited to, assessment, diagnosis, consultation, treatment
3134 and monitoring of a patient. The term does not include audio-only telephone calls, e-mail
3135 messages or facsimile transmissions.

3136 (b) For a contract between a member and a health maintenance organization, the
3137 organization shall implement procedures so that it shall not decline to provide coverage for
3138 health care services solely on the basis that those services were delivered through the use of
3139 telehealth by a contracted health care provider, consistent with clause (i) of paragraph (4) of
3140 subsection (a) of section 6 of chapter 176O, if (i) the health care services are covered by way of

3141 in-person consultation or delivery and (ii) the health care services may be appropriately provided
3142 through the use of telehealth.

3143 (c) A contract that provides coverage for services under this section may contain a
3144 provision for a deductible, copayment or coinsurance requirement for a health care service
3145 provided through telehealth as long as the deductible, copayment or coinsurance does not exceed
3146 the deductible, copayment or coinsurance applicable to an in-person consultation.

3147 (d) When determining coverage for telehealth services, carriers may use utilization
3148 review systems, including preauthorization, to determine the appropriateness of telehealth as a
3149 means of delivering a health care service, provided that the determination shall be made in the
3150 same manner as if the service was provided via in-person consultation or delivery

3151 (e) Coverage for telehealth services shall not be required to reimburse a health care
3152 provider for a health care service that is not a covered benefit under the plan nor to reimburse a
3153 health care provider not contracted under the plan except as provided for under clause (i) of
3154 paragraph (4) of subsection (a) of Section 6 of Chapter 176O.

3155 (f) Coverage that reimburses a provider with a global payment, as defined in section 1 of
3156 chapter 6D, shall account for the provision of telehealth services when the carrier calculates the
3157 global payment allowed amount.

3158 SECTION 134. Subsection (a) of section 4 of chapter 176J of the General Laws, as
3159 appearing in the 2018 Official Edition, is hereby amended by striking out the words, “Every
3160 carrier shall make available,” and inserting in place thereof the following words:- “Every carrier
3161 shall maintain a website on which it will display every available plan and shall offer.”

3162 SECTION 135. Subsection (b) of said section 4 of said chapter 176J of the General Laws,
3163 as so appearing, is hereby amended by striking out the fourth paragraph.

3164 SECTION 136. Section 7 of said chapter 176J, as so appearing, is hereby amended by
3165 striking out subsection (b) and inserting in place thereof the following subsection:

3166 (b) Every carrier, as a condition of doing business under the jurisdiction of this chapter,
3167 shall electronically file with the commissioner an annual actuarial opinion that the carrier's
3168 rating methodologies and rates to be applied in the upcoming calendar year comply with the
3169 requirements of this chapter and any regulations promulgated under the authority of this chapter.
3170 In addition, every carrier shall file electronically an annual statement of the number of eligible
3171 individuals, eligible employees and eligible dependents, as of the close of the preceding calendar
3172 year, enrolled in a health benefit plan offered by the carrier. A carrier that utilizes intermediaries
3173 shall file a list of those intermediaries, with associated contact information. Every carrier shall
3174 maintain at its principal place of business a complete and detailed description of its rating
3175 practices including information and documentation which demonstrates that its rating methods
3176 and practices are based upon commonly accepted actuarial assumptions, are under sound
3177 actuarial principles, and comply with this chapter. Such information shall be made available to
3178 the commissioner upon request, but shall remain confidential.

3179 SECTION 137. Said chapter 176J of the General Laws is hereby amended by striking out
3180 section 11 and inserting in place thereof the following section:

3181 Section 11. (a) A carrier that offers a health benefit plan that: (i) provides or arranges for
3182 the delivery of health care services through a closed network of health care providers; and (ii) as
3183 of the close of any preceding calendar year, has a combined total of 5,000 or more eligible

3184 individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans
3185 sold, issued, delivered, made effective or renewed to qualified small businesses or eligible
3186 individuals, shall offer to all eligible individuals and small businesses in at least 2 geographic
3187 areas at least 1 of the following plans:

3188 (1) a reduced or selective network of providers;

3189 (2) a plan in which providers are tiered and member cost sharing is based on the tier
3190 placement of the provider;

3191 (3) a plan in which an enrollee's premium varies based on the primary care provider
3192 selected at the time of enrollment; or

3193 (4) any other innovative plan designed by the carrier and approved by the commissioner.

3194 Carriers are to establish a base premium rate discount of at least 20 per cent for the plan
3195 offered pursuant to this section compared to the base premium of the carrier's most actuarially
3196 similar plan with the carrier's non-selective or non-tiered network of providers. The savings may
3197 be achieved by means including, but not limited to: (i) the exclusion of providers with similar or
3198 lower quality based on the standard quality measure set with higher health status adjusted total
3199 medical expenses or relative prices, as determined under section 10 of chapter 12C; or (ii)
3200 increased member cost-sharing for members who utilize providers for non-emergency services
3201 with similar or lower quality based on the standard quality measure set and with higher health
3202 status adjusted total medical expenses or relative prices, as determined under said section 10 of
3203 said chapter 12C.

3204 The commissioner may apply waivers to the base premium rate discount determined by
3205 the commissioner under this section to carriers who receive 80 per cent or more of their incomes
3206 from government programs or the subsidized ConnectorCare Program sponsored by the
3207 Commonwealth Health Insurance Connector Authority or which have service areas which do not
3208 include either Suffolk or Middlesex counties and who were first admitted to do business by the
3209 division of insurance on January 1, 1986, as health maintenance organizations under chapter
3210 176G.

3211 (b) A tiered network plan shall only include variations in member cost-sharing between
3212 provider tiers which are reasonable in relation to the premium charged and ensure adequate
3213 access to covered services. Carriers shall tier providers based on quality performance as
3214 measured by the standard quality measure set and by cost performance as measured by health
3215 status adjusted total medical expenses and relative prices. Where applicable quality measures are
3216 not available, tiering may be based solely on health status adjusted total medical expenses or
3217 relative prices or both.

3218 The commissioner shall promulgate regulations requiring the uniform reporting of
3219 information for all products subject to this section, including, but not limited to, for tiered
3220 network plans requiring at least 90 days before the proposed effective date of any tiered network
3221 plan or any modification in the tiering methodology for any existing tiered network plan, the
3222 reporting of a detailed description of the methodology used for tiering providers, including: the
3223 statistical basis for tiering; a list of providers to be tiered at each member cost-sharing level; a
3224 description of how the methodology and resulting tiers will be communicated to each network
3225 provider, eligible individuals and small groups; and a description of the appeals process a
3226 provider may pursue to challenge the assigned tier level.

3227 (c) The commissioner shall determine network adequacy for a tiered network plan based
3228 on the availability of sufficient network providers in the carrier's overall network of providers.

3229 (d) The commissioner shall determine network adequacy for a selective network plan
3230 based on the availability of sufficient network providers in the carrier's selective network.

3231 (e) In determining network adequacy under this section the commissioner may take into
3232 consideration factors such as the location of providers participating in the plan and employers or
3233 members that enroll in the plan, the range of services provided by providers in the plan and plan
3234 benefits that recognize and provide for extraordinary medical needs of members that may not be
3235 adequately dealt with by the providers within the plan network.

3236 (f) Carriers may: (i) reclassify provider tiers; and (ii) determine provider participation in
3237 selective and tiered plans not more than once per calendar year except that carriers may
3238 reclassify providers from a higher cost tier to a lower cost tier or add providers to a selective
3239 network at any time. If the carrier reclassifies provider tiers or providers participating in a
3240 selective plan during the course of an account year, the carrier shall provide affected members of
3241 the account with information regarding the plan changes at least 30 days before the changes take
3242 effect. Carriers shall provide information on their websites about any tiered or selective plan,
3243 including but not limited to, the providers participating in the plan, the selection criteria for those
3244 providers and where applicable, the tier in which each provider is classified.

3245 (g) The division of insurance shall report annually specific findings and legislative
3246 recommendations for all products subject to this section, including the following: (1) the
3247 utilization trends of eligible employers and eligible individuals enrolled in plans offered under
3248 this section; (2) the extent to which tiered product offerings have reduced health care costs for

3249 patients and employers; (3) the effects that tiered product offerings have on patient education
3250 relating to health care costs and quality; (4) the effects that tiered product offerings have on
3251 patient utilization of local hospitals and the resulting impact on overall state health care costs,
3252 including the state's compliance with the health care cost growth benchmark established under
3253 section 9 of chapter 6D; (5) opportunities to incentivize tiered product offerings for both health
3254 systems and employers. The report shall also include the number of members enrolled by plan
3255 type, aggregate demographic, geographic information on all members and the average direct
3256 premium claims incurred, as defined in section 6, for selective and tiered network products
3257 compared to non-selective and non-tiered products. The report shall be submitted to clerks of the
3258 house of representatives and the senate, the senate and house committees on ways and means and
3259 the joint committee on health care financing.

3260 SECTION 138. Section 1 of chapter 176O of the General Laws, as appearing in the 2018
3261 Official Edition, is hereby amended by inserting after the definition of “Office of patient
3262 protection” the following definition:-

3263 “Out-of-network provider,” a health care provider that does not participate in the network
3264 of an insured’s health benefit plan because: (i) the provider contracts with a carrier to participate
3265 in the carrier’s network but does not contract with the carrier for the specific health benefit plan
3266 in which an insured is enrolled; or (ii) the provider does not contract with a carrier to participate
3267 in any of the carrier's network plans, policies, contracts or other arrangements.

3268 SECTION 139. Said section 1 of said chapter 176O of the General Laws, as so appearing,
3269 is hereby amended by inserting after the definition of “Person” the following definition:-

3270 “Pharmacy Benefit Manager,” any person, business or entity, however organized, that
3271 administers, either directly or through subsidiaries, pharmacy benefit services for prescription
3272 drugs and devices on behalf of health benefit plan sponsors, including, but not limited to, self-
3273 insured employers, insurance companies and labor unions; provided however, that “pharmacy
3274 benefit services” shall include, but not be limited to, formulary administration; drug benefit
3275 design; pharmacy network contracting; pharmacy claims processing; mail and specialty drug
3276 pharmacy services; and cost containment, clinical, safety and adherence programs for pharmacy
3277 services; provided, further, that a health benefit plan that does not contract with a pharmacy
3278 benefit manager shall be considered a pharmacy benefit manager for the purposes of this section.

3279 SECTION 140. Said section 1 of said chapter 176O, as so appearing, is hereby amended
3280 by striking out the definition of “Primary care provider” and inserting in place thereof the
3281 following definition:-

3282 “Primary care provider”, a health care professional qualified to provide general medical
3283 care for common health care problems who: (i) supervises, coordinates, prescribes, or otherwise
3284 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
3285 maintains continuity of care within the scope of practice. Urgent care clinics, as defined in
3286 section 52 of chapter 111, and emergency departments shall not be considered primary care
3287 providers.

3288 SECTION 141. Said section 1 of said chapter 176O of the General Laws, as so appearing,
3289 is hereby amended by inserting after the definition of “Second opinion” the following
3290 definition:-

3291 “Surprise bill,” a bill, received by an insured who is covered under a preferred or closed
3292 network health plan, for dollar amounts, other than plan copayments, coinsurance or amounts
3293 subject to a deductible, for covered services provided by an out-of-network provider for services
3294 rendered for emergency medical conditions or rendered by an out-of-network provider at an in-
3295 network facility, including, but not limited to:

3296 (i) health care services rendered by an out-of-network provider without the insured’s
3297 knowledge;

3298 (ii) health care services rendered by an out-of-network provider where an in- network
3299 provider is not reasonably available to the insured at the in-network facility, even if the out-of-
3300 network provider’s network status is disclosed to the insured;

3301 (iii) health care services rendered on an emergency basis or by an out-of-network
3302 provider that are necessary to provide immediate prophylaxis, diagnosis, or treatment for a
3303 disease that the department of public health has determined is dangerous to the public health
3304 pursuant to section 6 of chapter 111;

3305 (iv) health care services rendered by an out-of-network provider, including an out-of-
3306 network laboratory, radiologist or pathologist, where the health care services were referred, or an
3307 insured’s specimen was sent, by a participating provider to an out-of-network provider without
3308 the prior written consent of the insured acknowledging that the participating provider is referring
3309 the insured or sending the insured’s specimen to an out-of-network provider, which may result in
3310 uncovered costs; and

3311 (v) unforeseen health care services that arise at the time health care services are
3312 rendered that must necessarily be rendered by an out-of-network provider; provided, however,

3313 that a surprise bill shall not mean a bill received by an insured for health care services when a
3314 participating provider is available and the insured knowingly, voluntarily, and specifically elects
3315 to obtain services from an out-of-network provider.

3316 SECTION 142. Chapter 176O of the General Laws is hereby amended by striking out
3317 section 2 and inserting in place thereof the following section:-

3318 Section 2. (a) There is hereby established within the division a bureau of managed care.
3319 The bureau shall by regulation establish minimum standards for the accreditation of carriers in
3320 the following areas:

- 3321 (1) utilization review;
- 3322 (2) quality management and improvement;
- 3323 (3) credentialing;
- 3324 (4) preventive health services; and
- 3325 (5) compliance with sections 2 to 12, inclusive.

3326 (b) In establishing the minimum standards, the bureau shall consult and use, where
3327 appropriate, standards established by national accreditation organizations. Notwithstanding the
3328 foregoing, the bureau shall not be bound by the standards established by such organizations;
3329 provided, however, that wherever the bureau promulgates standards different from the national
3330 standards, it shall:

- 3331 (1) be subject to chapter 30A;
- 3332 (2) state the reason for such variation; and

3333 (3) take into consideration any projected compliance costs for such variation.

3334 Accreditation by the bureau shall be valid for a period of 24 months. For the purposes of
3335 accreditation review in the area of pain management, the division shall consult with the health
3336 policy commission, established under chapter 6D, for assistance in determining appropriate
3337 standards for evidence-based pain management, including non-opioid pain management products
3338 and services, and shall publish guidelines to assist and evaluate carriers' development and
3339 submission of pain management access plans as required under clause (5) of the second sentence
3340 of subsection (a).

3341 The bureau shall develop and implement standard credentialing forms for health care
3342 providers, and any entities acting for an insurance carrier under contract shall use the uniform
3343 form designated by the division for the health care provider. Six months after the full set of
3344 forms has been developed, every insurance carrier shall accept the standard credentialing form
3345 for contracting providers as sufficient information necessary to conduct its credentialing process.

3346 In order to reduce health care costs and improve access to health care services, the bureau
3347 shall establish by regulation as a condition of accreditation that carriers use uniform standards
3348 and methodologies for credentialing of providers, including a health care provider type that is
3349 licensed under chapter 112 and that provides identical services. Such uniform standards and
3350 methodologies for credentialing of providers shall include but not be limited to the following
3351 requirements:

3352 (i) An insurance carrier or any entity acting for an insurance carrier, when conducting a
3353 credentialing review of a health care provider, shall use and accept only the credentialing forms
3354 designated by the commissioner;

3355 (ii) An insurance carrier or an entity acting for an insurance carrier, when conducting a
3356 credentialing review of a health care provider, shall review a submitted credentialing form for a
3357 health care provider and respond to the health care provider within 20 business days after
3358 receiving a completed credentialing request; and

3359 (iii) Nothing in this section shall prohibit an insurance carrier or an entity acting for an
3360 insurance carrier, when conducting a credentialing review of a health care provider from using a
3361 credentialing methodology that utilizes an internet webpage, internet webpage portal or similar
3362 electronic, internet and web-based system in lieu of a paper form, provided that a carrier shall
3363 make a paper credentialing form available to a health care provide, upon request.

3364 (c) Regulations promulgated by the bureau shall be consistent with and not duplicate or
3365 overlap with the regulations promulgated by the office of patient protection in the health policy
3366 commission established by section 16 of chapter 6D.

3367 (d) A carrier that contracts with another entity to perform some or all of the functions
3368 governed by this chapter shall be responsible for ensuring compliance by the contracted entity
3369 with the provisions of this chapter. Any failure by the contracted entity to meet the requirements
3370 of this chapter shall be the responsibility of the carrier to remedy and shall subject the carrier to
3371 enforcement actions, including financial penalties, authorized under this chapter.

3372 (e) A carrier that contracts with a pharmacy benefit manager shall (i) be responsible for
3373 coordinating an audit, at least once per year, of the operations of the pharmacy benefit manager
3374 to ensure compliance with the provisions of this chapter and to examine the pricing and rebates
3375 applicable to prescription drugs that are provided to the carrier's covered persons; and (ii) require
3376 that the pharmacies with which the pharmacy benefit manager contracts have systems in place to

3377 ensure that the insured, at the point of sale for any prescription, is charged the lower of: the
3378 applicable cost sharing amount under the terms of the insured's health benefit plan; the pharmacy
3379 benefits manager's contracted rate of payment to the pharmacy for the prescription drug; or the
3380 retail price of the prescription drug if purchased without insurance.

3381 (f) A carrier may apply to the bureau for deemed accreditation status. A carrier may be
3382 deemed to be in compliance with the bureau's standards, and may be so accredited by the bureau,
3383 only if the carrier, or an entity with which it contracts: (1) is accredited by a national
3384 accreditation organization; (2) is in compliance with all of the requirements of this chapter; and
3385 (3) demonstrates compliance with, and has obtained the highest possible rating from the national
3386 accreditation organization for: (i) utilization review, (ii) quality management, and (iii) member
3387 rights and responsibilities, as promulgated by the bureau pursuant to this chapter. The bureau
3388 shall publish by regulation the highest possible rating level in each such category used by every
3389 national accreditation organization recognized by the bureau. Nothing in this subsection shall be
3390 construed to require a carrier, as a condition of certification, to be in compliance at the highest
3391 possible rating with each of the accreditation requirements of a national accreditation
3392 organization.

3393 (g) A carrier which is not accredited by the bureau pursuant to this section, and is not
3394 otherwise exempt from accreditation, shall not offer for sale, provide or arrange for the provision
3395 of a defined set of health care services to insureds through affiliated and contracting providers or
3396 employ utilization review in making decisions about whether services are covered benefits under
3397 a health benefit plan.

3398 (h) A carrier shall be exempt from accreditation if in the written opinion of the attorney
3399 general, the commissioner of insurance and the commissioner of public health, the health and
3400 safety of health care consumers would be materially jeopardized by requiring accreditation of the
3401 carrier. Before publishing such written exemption, the attorney general, the commissioner of
3402 insurance and the commissioner of public health shall jointly hold at least one public hearing at
3403 which testimony from interested parties on the subject of the exemption shall be solicited. A
3404 carrier granted such an exemption shall be provisionally accredited and, during such provisional
3405 accreditation, shall be subject to review not less than every 4 months and shall be subject to those
3406 requirements of this chapter as deemed appropriate by the commissioner of insurance.

3407 (i) Nothing in this chapter shall relieve any carrier of its obligations pursuant to the
3408 applicable provisions of chapters 175, 176A, 176B, 176G and 176I. Compliance with such
3409 applicable provisions of chapter 175, 176A, 176B, 176G and 176I shall be a condition of
3410 accreditation.

3411 SECTION 143. Subsection (a) of section 6 of said chapter 176O of the General Laws, as
3412 appearing in the 2018 Official Edition, is hereby amended by striking out paragraph (4) and
3413 inserting in place thereof the following paragraph:-

3414 (4) (a) a provider directory showing the locations where, and the manner in which, health
3415 care services and other benefits may be obtained, including: (i) an explanation that whenever a
3416 proposed admission, procedure or service that is a medically necessary covered benefit is not
3417 available to an insured within the carrier's network, the carrier shall cover the out-of-network
3418 admission, procedure or service and the insured will not be billed for or responsible to pay more
3419 than the amount which would be required for similar admissions, procedures or services offered

3420 within the carrier's network; (ii) an explanation that whenever a location is part of the carrier's
3421 network, that the carrier shall cover medically necessary covered benefits delivered at that
3422 location and the insured shall not be billed for or responsible to pay more than the amount
3423 required for network services even if part of the medically necessary covered benefits are
3424 performed by out-of-network providers unless the insured has a reasonable opportunity to choose
3425 to have the service performed by a network provider; and (iv) that out-of-network providers may
3426 not send surprise bills and if providers do that the insured may submit a complaint to the office
3427 of the attorney general for investigation according to in chapter 175H.

3428 (b) A carrier shall ensure the accuracy of the information concerning each provider listed
3429 in the carrier's provider directories for each network plan and shall review and update the entire
3430 provider directory for each network plan in accordance with the provisions of this section. A
3431 carrier shall: (i) make the provider directory available to the public through electronic means and
3432 in a searchable format; (ii) ensure the general public is able to view all current health care
3433 providers for a network plan through a clearly identifiable link or tab; (iii) provide detail about
3434 medical or behavioral health specialty services regularly provided by the practitioner in their
3435 normal course of treatment, as defined within division guidance and (iv) not require the creation
3436 or use of an account, a policy or contract number, other identifying information, demonstration
3437 of coverage or an interest in obtaining coverage with the network plan in order to access the
3438 directory. A carrier shall update each electronic network plan provider directory not less than
3439 monthly; provided, however that the commissioner may require more frequent directory updates;
3440 provided further that the division may promulgate regulations that require electronic network
3441 plan provider directories to be updated more frequently than monthly when a plan is informed of
3442 and confirms:

3443 (i) that a contracting provider is no longer accepting new patients for that network plan or
3444 an individual provider within a provider group is no longer accepting new patients;

3445 (ii) that a provider or provider group is no longer under contract for a particular network
3446 plan;

3447 (iii) that a provider's practice location, telephone number, e-mail or other information
3448 required under this section has changed;

3449 (iv) that a provider has retired or otherwise has ceased to practice; or

3450 (v) any other information that affects the content or accuracy of the provider directory or
3451 directories.

3452 (c) A provider directory shall not list or include information on a provider who is not
3453 currently under contract with the network plan.

3454 (d) A carrier shall regularly, and at least once every quarter, audit its provider directories
3455 for accuracy and retain documentation of the audit to be made available to the commissioner
3456 upon request. A carrier shall take steps to ensure all contracted providers promptly notify the
3457 carrier of any change to information needed by the carrier to maintain an accurate directory, up
3458 to and including removal of any provider who fails to do so from the carrier's provider directory.

3459 (e) A carrier shall provide a print copy of the requested directory information or a print
3460 copy of a current provider directory upon request of an insured or a prospective insured by mail
3461 postmarked no later than 5 business days following the date of the request; provided, however,
3462 that the print copy of the provider directory or requested directory information provided by the

3463 carrier may be limited to the geographic region in which the requester resides or works or intends
3464 to reside or work.

3465 (f) The carrier shall include in both its electronic and print formats of the provider
3466 directory a dedicated customer service email address and telephone number or electronic link
3467 that insureds, providers and the general public may use to notify the carrier of inaccurate
3468 provider directory information. This information shall be displayed prominently in the directory
3469 and on the carrier's website. The carrier shall be required to investigate reports of inaccuracies
3470 within 30 days of receiving notice and modify the electronic provider directories in accordance
3471 with any findings within 30 days of such findings.

3472 (g) A provider directory shall inform enrollees and potential enrollees that they are
3473 entitled to language interpreter services, at no cost to the enrollee, and full and equal access to
3474 covered benefits as required under the federal Americans with Disabilities Act of 1990 and
3475 Section 504 of the Rehabilitation Act of 1973. A provider directory, whether in electronic or
3476 print format, shall accommodate the communication needs of individuals with disabilities and
3477 include a link to or information regarding available assistance for persons with limited English
3478 proficiency, including how to obtain interpretation and translation services.

3479 (h) A carrier shall include a disclosure in the print format of a provider directory that the
3480 information included in the directory is accurate as of the date of printing and that an insured or
3481 prospective insured should consult the carrier's electronic provider directory on its website or
3482 call a specified customer service telephone number to obtain the most current provider directory
3483 information.

3484 (i) A carrier shall update the print copies of the carrier's provider directory not less than
3485 annually; provided, however that the division may promulgate regulations requiring that the print
3486 copies of the provider directories be updated more frequently than annually.

3487 (j) A carrier shall use a taxonomy of licensed behavioral health clinical specialties
3488 designated by the division. In designating the taxonomy, the division shall consider the
3489 recommendations of the commission created by section 102 of chapter 208 of the acts of 2018.
3490 The division shall review and update said taxonomy on an ongoing basis, as necessary.

3491 SECTION 144. Said subsection (a) of said section 6 of said chapter 176O of the General
3492 Laws, as so appearing, is hereby further amended by striking out paragraph (8) and inserting in
3493 place thereof the following paragraph:-

3494 (8) a summary description of the procedure, if any, for out-of-network referrals and any
3495 additional charge for utilizing out-of-network providers, and a description of the out-of-network
3496 consumer protections, including prohibition on surprise bills as detailed in this chapter.

3497 SECTION 145. Section 9A of said chapter 176O of the General Laws, as so appearing, is
3498 hereby further amended by striking out subsection (a) and inserting in place thereof the following
3499 subsection:-

3500 (a)(i) limits the ability of the carrier to introduce or modify a select network plan or tiered
3501 network plan by granting the health care provider a guaranteed right of participation; (ii) requires
3502 the carrier to place all members of a provider group, whether local practice groups or facilities, in
3503 the same tier of a tiered network plan; (iii) requires the carrier to include all members of a
3504 provider group, whether local practice groups or facilities, in a select network plan on an all-or-
3505 nothing basis.

3506 SECTION 146. Section 23 of said chapter 176O of the General Laws, as so appearing, is
3507 hereby amended by inserting after the word “time”, in line 3, the following words:- “, the
3508 network status of an identified health care provider.”

3509 SECTION 147. Subsection (a) of section 27(a) of Chapter 176O of the General Laws, as
3510 so appearing, is hereby amended by adding the following sentence:-

3511 The common summary of payments form shall include a description of the out-of-
3512 network consumer protections, including for surprise bills, as detailed in this chapter.

3513 SECTION 148. Said chapter 176O of the General Laws is hereby further amended by
3514 adding the following 3 sections:-

3515 Section 28. (a) As used in this section, “facility fee” shall have the meaning as provided
3516 in section 51L of chapter 111.

3517 (b) A carrier shall not provide reimbursement for a facility fee for a service for which a
3518 facility fee is prohibited pursuant to section 51L of chapter 111.

3519 (c) Nothing in this section shall be construed to prohibit a carrier from restricting the
3520 reimbursement of facility fees beyond the limitations set forth in section 51L of chapter 111.

3521 Section 29. (a) This section shall apply to the following circumstances involving an
3522 insured: (i) health care services rendered by an out-of-network provider for emergency medical
3523 conditions or any associated admission or care resulting from an emergency medical condition;
3524 or (ii) health care services that result in an insured receiving a surprise bill, as defined in section
3525 1 of this chapter.

3526 (b) If an insured receives health care services as set forth in subsection (a), the insured
3527 shall only be required to pay the applicable coinsurance, copayment, deductible or other out-of-
3528 pocket expense that would be imposed for such health care services if the services were rendered
3529 by a participating provider. Pursuant to subsection (g) of section 228 of chapter 111, the out-of-
3530 network provider shall not bill the insured in excess of such amount. Payments made by an
3531 insured pursuant to this section shall count towards any applicable deductible or out-of-pocket
3532 maximum pursuant to the terms and conditions of an insured's health benefit plan.

3533 (c) If an insured receives health care services as set forth in subsection (a), benefits
3534 provided by a carrier that the insured receives for health care services shall be assigned to the
3535 out-of-network provider, which shall require no action on the part of the insured. Once the
3536 benefit is assigned as provided in this subsection, any payment paid by the carrier shall be paid
3537 directly to the out-of-network provider, and the carrier shall provide the out-of-network provider
3538 with a written remittance of payment that specifies the proposed payment and the amount of any
3539 applicable coinsurance, copayment, deductible or other out-of-pocket expense owed by the
3540 insured.

3541 (d) When an out-of-network provider renders health care services to an insured pursuant
3542 to subsection (a):

3543 (i) if the out-of-network provider contracts with a carrier to participate in the carrier's
3544 network but does not contract with the carrier for the specific health benefit plan in which an
3545 insured is enrolled, the carrier shall pay the out-of-network provider directly in the amount of
3546 one hundred percent of the contractually agreed-upon amount paid by the carrier, minus any
3547 member cost sharing in the form of the applicable coinsurance, copayment, or deductible, for

3548 health care services provided to an insured, or, if the out-of-network provider and carrier have
3549 more than one contract for health benefit plans, the carrier shall pay the out-of-network provider
3550 directly the average contractually agreed-upon amount, minus any member cost sharing in the
3551 form of the applicable coinsurance, copayment, or deductible, for health care services provided
3552 to an insured; or

3553 (ii) if the out-of-network provider does not contract with a carrier to participate in any of
3554 the carrier's network plans, policies, contracts or other arrangements, the carrier shall pay the
3555 out-of-network provider directly the amount established by the division pursuant to subsection
3556 (e).

3557 (e) The health policy commission, in consultation with the center for health information
3558 and analysis, shall recommend to the division a payment level equal to a percentage of the
3559 Medicare reimbursement rate, for out-of-network providers that do not contract with the
3560 insured's carrier, as defined in subsection (d)(ii), not later than one year following the effective
3561 date of subsection (d). In determining the appropriate payment level, the commission shall
3562 consider the impact of the payment level for out-of-network providers that do not contract with
3563 the insured's carrier on: (i) provider participation in insurance products, including tiered and
3564 limited network products; (ii) provider financial stability; (iii) provider price variation; and (iv)
3565 any other factors that the commission determines, in consultation with the center for health and
3566 information analysis, to be in the public interest. The commission shall hold hearings for public
3567 comment. The commission shall conduct a review and retain or revise the payment level for out-
3568 of-network providers that do not contract with the insured's carrier no less frequently than every
3569 5 years. The division shall have the option within 30 days of receipt of the recommendation of
3570 the health policy commission to accept and implement the recommendation of the health policy

3571 commission, or the division may reject the recommendation of the health policy division and
3572 implement its own payment level for out-of-network providers that do not contract with the
3573 insured's carrier, as defined in clause (ii) of subsection (d); provided, however, that if the
3574 division rejects the recommendation of the health policy commission, then the division shall,
3575 within 30 days of the division's rejection, report in writing to the clerks of the house of
3576 representatives and the senate, the senate and house committees on ways and means and the joint
3577 committee on health care financing the reasons for the division's rejection of the
3578 recommendation and its alternative decision. If the division takes no action to either accept or
3579 reject the recommendation of the health policy commission, then the recommendation of the
3580 health policy commission regarding the payment level for out-of-network providers that do not
3581 contract with the insured's carrier, as defined in clause (ii) of subsection (d), shall automatically
3582 take effect 30 days after receipt of the recommendation by the division.

3583 (f) With respect to an entity providing or administering a self-funded health benefit plan
3584 governed by the provisions of the federal Employee Retirement Income Security Act of 1974, 29
3585 U.S.C. § 1001 et seq. and its plan members, this section shall only apply if the plan elects to be
3586 subject to the provisions of this section. To elect to be subject to the provisions of this section,
3587 the self-funded health benefit plan shall provide notice to the division on an annual basis, in a
3588 form and manner prescribed by the division, attesting to the plan's participation and agreeing to
3589 be bound by the provisions of this section. The self-funded health benefit plan shall amend the
3590 health benefit plan, coverage policies, contracts and any other plan documents to reflect that the
3591 benefits of this section shall apply to the plan's members.

3592 (g) In a form and manner to be prescribed by the division, carriers shall indicate to
3593 insureds that the plan is subject to these provisions. In the case of self-funded health benefit

3594 plans that elect to be subject to this section pursuant to subsection (f), the plan shall indicate to
3595 its members that it is self-funded and has elected to be subject to these provisions.

3596 (h) The commissioner shall promulgate regulations to implement this section.

3597 (i) This section shall not be construed to require a carrier to cover health care services not
3598 required by law or by the terms and conditions of an insured's health benefit plan.

3599 (j) The attorney general shall have the authority to conduct investigations of alleged
3600 violations of this section pursuant to section 5 of chapter 175H and may enforce this section by
3601 bringing an action pursuant to either section 4 or section 5 of said chapter 175H.

3602 (k) A violation of this section shall be an unfair trade practice under chapter 93A.

3603 Section 30. The bureau of managed care shall develop and implement standard
3604 credentialing forms for health care providers, and any entities acting for an insurance carrier
3605 under contract shall use the uniform form designated by the division for the health care provider.
3606 Six months after the full set of forms has been developed, every insurance carrier shall accept the
3607 standard credentialing form for contracting providers as sufficient information necessary to
3608 conduct its credentialing process.

3609 SECTION 149. Section 158 of chapter 224 of the acts of 2012 is hereby repealed.

3610 SECTION 150. Sections 3A and 11 of chapter 115 of the acts of 2016 are hereby
3611 repealed.

3612 SECTION 151. Notwithstanding any general or special law to the contrary, the secretary
3613 of administration and finance, following a public hearing, shall increase the fee for obtaining or
3614 renewing a license, certificate, registration, permit or authority issued by a board within the

3615 department of public health, excluding the board of registration in medicine, as necessary to
3616 implement the provisions of the chapter 112A of the General Laws. The amount of the increase
3617 in fees shall be deposited in the Quality in Health Professions Trust Fund established in section
3618 35X of chapter 10.

3619 SECTION 152. No person shall be found to have violated section 292 of chapter 112 of
3620 the General Laws until 6 months after the board of registration of recovery coaches first issues an
3621 authorization to practice under said chapter 112.

3622 SECTION 153. (a) As used in this section the following words shall, unless the context
3623 clearly requires otherwise, have the following meanings:-

3624 “Department”, the department of public health.

3625 “Division”, the division of professional licensure.

3626 “Transferring Boards”, the board of registration of social workers, the board of
3627 registration of psychologists, the board of registration of allied mental health and human services
3628 professions, the board of allied health professions, the board of registration of dieticians and
3629 nutritionists, the board of registration in podiatry, the board of registration in optometry, the
3630 board of registration of dispensing opticians, the board of registration of chiropractors, the board
3631 of registration of speech-language pathology and audiology, and the board of registration of
3632 hearing instrument specialists.

3633 (b) Notwithstanding any general or special law to the contrary, the division and the
3634 department shall develop and implement a transfer agreement providing for the orderly transfer

3635 of personnel, proceeds, rules and regulations, property and legal obligations and functions of the
3636 transferring boards from the division to the department.

3637 (c) All petitions, requests, investigations, filings and other proceedings appropriately and
3638 duly brought before, or pending before, the transferring boards, before the transfer, shall
3639 continue unabated and remain in force, and shall be assumed and completed by the transferring
3640 boards after transfer to the department.

3641 (d) All orders, advisories, findings, rules and regulations duly made and all approvals
3642 duly granted by the transferring boards, which are in force immediately before the transfer, shall
3643 continue in force and shall thereafter be enforced, until superseded, revised, rescinded or
3644 canceled, in accordance with law, by the transferring boards after transfer to the department.

3645 (e) All books, papers, records, documents, equipment, cash and other property, both
3646 personal and real, including all such property held in trust, which immediately before the transfer
3647 are in the custody of the transferring board or the division on behalf of the transferring board,
3648 shall be transferred to the department.

3649 (f) All duly existing contracts, leases and obligations of the transferring boards, shall
3650 continue in effect after transfer to the department. No such existing right or remedy of any
3651 character shall be lost, impaired or affected by this act.

3652 (g) In consultation with the secretary of administration and finance, the department and
3653 the division, in developing the transfer agreement required under subsection (b), shall identify
3654 the portion of unexpended balances of the Division of Professional Licensure Trust Fund
3655 established in section 35V of chapter 10 that are allocated to the operations of the transferring
3656 boards, including but not limited to payment of salaries, wages, fringe and indirect costs, and all

3657 compensation for those employees identified in subsection (i); administrative expenses;
3658 information technology expenses; and indirect expenses. Notwithstanding any general or special
3659 law to the contrary, upon transfer of the transferring boards, the comptroller shall transfer such
3660 portion of the unexpended balances of the Division of Professional Licensure Trust Fund
3661 established in section 35V of chapter 10 of the General Laws to the Quality in Health Professions
3662 Trust Fund established in section 35X of chapter 10 of the General Laws.

3663 (h) The comptroller shall take the overall cash flow needs of the commonwealth into
3664 consideration in determining the timing of any transfer of funds provided for in subsection (g).
3665 The comptroller shall provide a schedule of transfers to the secretary of administration and
3666 finance and to the chairs of the house and senate committees on ways and means.

3667 (i) The transfer agreement required under subsection (b) shall identify the number of
3668 allocated employees of the division, rounded to the nearest full time employee equivalent, who
3669 are engaged in the work of the transferring boards, in whole or in part, including but not limited
3670 to licensing functions, investigation, prosecution and adjudication. Notwithstanding any general
3671 or special law to the contrary, an equivalent number of division employees shall become
3672 employees of the department upon the execution of the transfer agreement required under
3673 subsection (b) or 18 months from the effective date of this act, whichever occurs first. The
3674 employees selected to transfer from the division to the department shall have been engaged in the
3675 work of the transferring boards, in whole or in part, prior to the transfer.

3676 All officers and employees of the division transferred to the department as required under
3677 subsection (i) shall be transferred without impairment of seniority, retirement or other statutory
3678 rights of employees, without loss of accrued rights to holidays, sick leave, vacation and other

3679 benefits, and without change in union representation or certified collective bargaining unit as
3680 certified by the state labor relations commission or in local union representation or affiliation,
3681 except as otherwise provided in this act. Terms of service of employees of the program shall not
3682 be deemed to be interrupted by virtue of transfer to the department.

3683 Nothing in this section shall be construed to confer upon any employee of the division
3684 transferred to the department as required under subsection (i) any right not held immediately
3685 before the date of said transfer or to prohibit any reduction of salary grade, transfer,
3686 reassignment, suspension, discharge, layoff or abolition of position not prohibited before such
3687 date.

3688 (j) Notwithstanding any general or special law to the contrary, the terms and conditions
3689 of any collective bargaining agreement that is in effect upon the transfer with respect to
3690 employees of the division transferred to the department as required under subsection (i) shall
3691 continue in effect until the stated expiration date of such agreement, at which point the
3692 agreement shall expire; provided, however, that all such employees shall continue to retain their
3693 right to collectively bargain under chapter 150E of the General Laws and shall be considered
3694 employees of the department.

3695 SECTION 154. Sections 21 to 22, 24 to 31, 69, 71 to 73, 84 to 87, 91, 93, 101 to 108 and
3696 153, inclusive, shall take effect upon the execution of a transfer agreement between the
3697 department of public health and the division of professional licensure or 18 months after the
3698 effective date of this act, whichever occurs first.

3699 SECTION 155. Section 30 of chapter 32A of the General Laws, as inserted by section 35,
3700 and sections 10, 12, 35, 64, 121 to 122, 125, 129, 131, 133 and 149 shall take effect January 1,
3701 2021.

3702 SECTION 156. Chapter 63C of the General Laws, as inserted by section 37, shall apply
3703 to all sales commencing on or after a date 6 months after the effective date of this act. The
3704 commissioner of revenue shall issue regulations or other guidance regarding the timing of returns
3705 required under said chapter 63C, as so inserted, not later than 6 months after the effective date of
3706 this act.

3707 SECTION 157. Chapter 63D of the General Laws, as inserted by section 37, shall apply
3708 to sales commencing on or after the effective date of this act. The commissioner of revenue shall
3709 issue regulations or other guidance regarding the reporting and payment of the penalty as soon as
3710 practicable after the effective date of this act.

3711 SECTION 158. The commissioner of insurance shall promulgate regulations to
3712 implement chapter 175N of the General Laws, as inserted by section 127, not later than 1 year
3713 after the effective date of this act.

3714 SECTION 159. Section 60 and clause (ii) of subsection (e) of section 2 of chapter 176O
3715 of the General Laws, as inserted by section 142, shall take effect on July 1, 2021.

3716 SECTION 160. Sections 134 to 135, 137 and 145 shall take effect 6 months after the
3717 effective date of this act.