HOUSE . . . . . No. 4871

The Commonwealth of Massachusetts

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

By striking out all after the enacting clause and inserting in place thereof the following:–

SECTION 1. Section 8 of chapter 6D of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by striking out, in lines 32 and 33, the words “and (xi) any witness identified by the attorney general or the center” and inserting in place thereof the following words:- (xi) the assistant secretary for MassHealth; and (xii) any witness identified by the attorney general or the center.

SECTION 2. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 48, the first time it appears, the word “and”.

SECTION 3. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word “commission”, in line 59, the first time it appears, the following words:- ; and (iii) in the case of the assistant secretary for MassHealth, testimony concerning the structure, benefits, caseload and financing related programs administered by the office or entered into in partnership with other state and federal agencies and the agency’s activities to align or redesign those programs in order to encourage the development of more integrated and efficient health care delivery systems.

SECTION 4. Chapter 32A of the General Laws is hereby amended by adding the following section:-

Section 30. (a) For the purposes of this section, the following words shall have the following meanings:

"Behavioral health services", care and services for the diagnosis, treatment, or management of patients with mental health or substance use disorders.

"Chronic disease management", supplies, care, and services for the management of chronic conditions, as defined by the Centers for Medicare and Medicaid Services, which include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, and coronary artery disease.

"Eligible health care services", primary care services, behavioral health services, and chronic disease management when delivered via telehealth to a patient while the patient is located in a private residence. The term also includes all health care services delivered to a patient via telehealth when the patient is located in a health care facility licensed or certified by the department of public health or otherwise in the physical presence of a health care professional licensed under chapter 112.

"Primary care services" services delivered by primary care providers as defined in section 1 of chapter 111.

"Telehealth", the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including but not limited to interactive audio-video technology, audio-only telephone, and online adaptive interviews, for the purpose of evaluating,

diagnosing, consulting, prescribing, treating, or monitoring of a patient's physical, oral or mental health; provided, however, that “telehealth” shall not include text messaging or text-only email, and provided further that prescribing via telehealth shall be limited to the treatment of a condition previously diagnosed during an in-person visit by the telehealth provider.

(b) Coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission shall provide coverage for eligible health care services via telehealth by a contracted health care provider if (i) the health care services are covered by way of in-person consultation or delivery and (ii) the health care services may be appropriately provided through the use of telehealth; provided, however, that the commission, or its carriers or other contracted entities providing health benefits, shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request.

(c) Coverage for telehealth services may include utilization review, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service; provided, however, that the determination shall be made in the same manner as if the service was delivered in-person. A carrier shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan or reimburse a health care provider not contracted under the plan except as provided for under clause (i) of paragraph (4) of subsection (a) of section 6 of chapter 176O.

(d) A health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telehealth services are provided be limited for health

care services provided via telehealth, except as provided in the definition of the term “eligible health care services” in subsection (a) of this section; provided, however, that a patient may decline receiving services via telehealth in order to receive in-person services.

(e) Coverage for telehealth services may include a deductible, copayment or coinsurance requirement for a health care service provided via telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. The rate of payment for telehealth services provided via interactive audio-video technology may be greater than the rate of payment for the same serviced delivered by other telehealth modalities.

(f) Coverage that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall account for the provision of telehealth services to set the global payment amount.

(g) The commission shall ensure that the rate of payment for in-network providers of behavioral health services delivered via interactive audio-video technology and audio-only telephone shall be no less than the rate of payment for the same behavioral health service delivered via in-person methods.

(h) Health care services provided via telehealth shall conform to the standards of care applicable to the telehealth provider’s profession and specialty. Such services shall also conform to applicable federal and state health information privacy and security standards as well as standards for informed consent.

SECTION 5. Section 1 of chapter 94C of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the definition for “Marihuana” the following definition:-

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

SECTION 6. Said section 1 of said chapter 94C, as so appearing, is hereby further amended by striking out, in line 290, the words “a practitioner, registered nurse, or practical nurse” and inserting in place thereof the following words:- an individual who is authorized to administer such medication under this chapter.

SECTION 7. The definition of “Practitioner” in said section 1 of said chapter 94C, as so appearing, is hereby amended by adding the following 2 clauses:-

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

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

SECTION 8. Said section 1 of said chapter 94C, as so appearing, is hereby further amended by striking out, in lines 367 and 368, the words “a practitioner, registered nurse or practical nurse” and inserting in place thereof the following words:- an individual who is authorized to administer such medication under this chapter.

SECTION 9. Subsection (a) of section 7 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “issuance”, in line 9, the following words:- or until completion of the term of the registrant’s license issued pursuant to chapter 112, whichever occurs later.

SECTION 10. Subsection (f) of said section 7 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “podiatrist”, in line 122 and in lines 125 through 126, each time it appears, the following words:- , nurse practitioner, psychiatric nurse mental health clinical specialist.

SECTION 11. Subsection (g) of said section 7 of said chapter 94C, as so appearing, is hereby amended by striking out the second paragraph.

SECTION 12. Subsection (a) of section 9 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “podiatrist”, in line 1, the following words:- , nurse practitioner, psychiatric nurse mental health clinical specialist.

SECTION 13. Said subsection (a) of said section 9 of said chapter 94C, as so appearing, is hereby further amended by striking out, in lines 3 to 5, inclusive, the words “, nurse practitioner and psychiatric nurse mental health clinical specialist as limited by subsection (g) of said section 7 and section 80E of said chapter 112”.

SECTION 14. Subsection (b) of said section 9 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “nurse-midwifery”, in line 32, the following words:- , advanced practice nursing.

SECTION 15. Said section 9 of said chapter 94C, as so appearing, is hereby further amended by inserting after the word “practitioner”, in lines 100 and 107, each time it appears, the following words:- , psychiatric nurse mental health clinical specialist.

SECTION 16. Chapter 112 of the General Laws is hereby amended by inserting after section 5N the following section:-

Section 5O. (a) For the purposes of this section, “telehealth” shall mean the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including but not limited to interactive audio-video technology, audio-only telephone, and online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating, or monitoring of a patient's physical, oral or mental health; provided, however, that “telehealth” shall not include text messaging or text-only email, and provided further that prescribing via telehealth shall be limited to the treatment of a condition previously diagnosed during an in-person visit by the telehealth provider.

(b) Notwithstanding any other provision of this chapter, the board shall allow a physician licensed by the board to obtain proxy credentialing and privileging for telehealth services with other health care providers, as defined in section 1 of chapter 111, or facilities that comply with the federal Centers for Medicare and Medicaid Services’ conditions of participation for telehealth services.

(c) The board shall promulgate regulations regarding the appropriate use of telehealth to provide health care services. These regulations shall provide for and include, but shall not be limited to: (i) services that are not appropriate to provide through telehealth; (ii) establishing a patient-provider relationship; (iii) consumer protections; and (iv) ensuring that services comply with appropriate standards of care.

SECTION 17. Section 80B of said chapter 112, as so appearing, is hereby further amended by inserting after the word “medications” in line 59 the following words:- , except in regard to the independent practice authority of nurse practitioners and psychiatric nurse mental health clinical specialists to issue written prescriptions and medication orders,.

SECTION 18. Said chapter 112 is hereby further amended by striking out section 80E, as so appearing, and inserting in place thereof the following section:-

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

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

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

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

SECTION 19. Section 80I of said chapter 112, as appearing, is hereby amended by striking out the second and third sentences.

SECTION 20. Chapter 118E of the General Laws is hereby amended by inserting after section 10L the following section:-

Section 10M. The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators

under contract to a Medicaid managed care organization or primary care clinician plan shall not require an enrollee to obtain a referral from a primary care provider prior to obtaining health care services from an urgent care facility; provided, however, that any urgent care facility providing health care services to an enrollee shall provide the enrollee with names of primary care providers contracted with MassHealth and practicing in the municipality of residence of the enrollee or an adjacent municipality.

Any urgent care facility providing health care services to an enrollee shall also notify the division, in a manner to be determined by the division, if the enrollee does not have a designated primary care provider, and the division shall send a notice to the enrollee which shall contain guidance on how to choose a primary care provider.

SECTION 21. Section 14A of said chapter 118E, as so appearing, is hereby amended by adding the following paragraphs:-

In the event that a nursing facility resident who is a MassHealth recipient enters a hospital for treatment related to COVID-19, the division shall pay to preserve his or her bed in the nursing facility for a period of up to and including 20 days per medical event. The division shall reimburse the nursing facility for the medical leave of absence, which shall include an observation stay in a hospital in excess of 24 hours.

SECTION 22. Chapter 118E of the General Laws is hereby amended by adding the following section:-

Section 79. (a) For the purposes of this section, the following words shall have the following meanings:

"Behavioral health services", care and services for the diagnosis, treatment, or management of patients with mental health or substance use disorders.

"Chronic disease management", supplies, care, and services for the management of chronic conditions, as defined by the Centers for Medicare and Medicaid Services, which include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, and coronary artery disease.

"Eligible health care services", primary care services, behavioral health services, and chronic disease management when delivered via telehealth to a patient while the patient is located in a private residence. The term also includes all health care services delivered to a patient via telehealth when the patient is located in a health care facility licensed or certified by the department of public health or otherwise in the physical presence of a health care professional licensed under chapter 112.

"Primary care services" services delivered by primary care providers as defined in section 1 of chapter 111.

"Telehealth", the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including but not limited to interactive audio-video technology, audio-only telephone, and online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating, or monitoring of a patient's physical, oral or mental health; provided, however, that "telehealth" shall not include text messaging or text-only email, and provided further that prescribing via telehealth shall be limited to the treatment of a condition previously diagnosed during an in-person visit by the telehealth provider.

(b) The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization, accountable care organization or primary care clinician plan shall provide coverage for eligible health care services via telehealth by a contracted health care provider if (i) the health care services are covered by way of in-person consultation or delivery and (ii) the health care services may be appropriately provided through the use of telehealth; provided, however, that Medicaid contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization or primary care clinician plan shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request.

(c) Coverage for telehealth services may include utilization review, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service; provided, however, that the determination shall be made in the same manner as if the service was delivered in-person. The division, a contracted health insurer, health plan, health maintenance organization, behavioral health management firm or third-party administrators under contract to a Medicaid managed care organization or primary care clinician shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan or reimburse a health care provider not contracted under the plan except as provided for under clause (i) of paragraph (4) of subsection (a) of section 6 of chapter 176O.

(d) A health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telehealth services are provided be limited for health

care services provided via telehealth, except as provided in the definition of the term “eligible health care services” in subsection (a) of this section; provided, however, that a patient may decline receiving services via telehealth in order to receive in-person services.

(e) Coverage may include a deductible, copayment or coinsurance requirement for a health care service provided via telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. The rate of payment for telehealth services provided via interactive audio-video technology and audio-only telephone may be greater than the rate of payment for the same service delivered by other telehealth modalities.

(f) Coverage that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall account for the provision of telehealth services to set the global payment amount.

(g) The division shall ensure that the rate of payment for in-network providers of behavioral health services delivered via interactive audio-video technology and audio-only telephone shall be no less than the rate of payment for the same behavioral health service delivered via in-person methods.

(h) Health care services provided via telehealth shall conform to the standards of care applicable to the telehealth provider’s profession and specialty. Such services shall also conform to applicable federal and state health information privacy and security standards as well as standards for informed consent.

SECTION 23. Section 47BB of chapter 175 of the General Laws is hereby repealed.

SECTION 24. Said chapter 175 is hereby further amended by inserting after section 47II the following section:-

Section 47JJ. (a) For the purposes of this section, the following words shall have the following meanings:

"Behavioral health services", care and services for the diagnosis, treatment, or management of patients with mental health or substance use disorders.

"Chronic disease management", supplies, care, and services for the management of chronic conditions, as defined by the Centers for Medicare and Medicaid Services, which include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, and coronary artery disease.

"Eligible health care services", primary care services, behavioral health services, and chronic disease management when delivered via telehealth to a patient while the patient is located in a private residence. The term also includes all health care services delivered to a patient via telehealth when the patient is located in a health care facility licensed or certified by the department of public health or otherwise in the physical presence of a health care professional licensed under chapter 112.

"Primary care services" services delivered by primary care providers as defined in section 1 of chapter 111.

"Telehealth", the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including but not limited to interactive audio-video technology, audio-only telephone, and online adaptive interviews, for the purpose of evaluating,

diagnosing, consulting, prescribing, treating, or monitoring of a patient's physical, oral or mental health; provided, however, that “telehealth” shall not include text messaging or text-only email, and provided further that prescribing via telehealth shall be limited to the treatment of a condition previously diagnosed during an in-person visit by the telehealth provider.

(b) An individual policy of accident and sickness insurance issued under section 108 that provides hospital expense and surgical expense insurance and any group blanket or general policy of accident and sickness insurance issued under section 110 that provides hospital expense and surgical expense insurance that is issued or renewed within or without the commonwealth shall provide coverage for eligible health care services via telehealth by a contracted health care provider if (i) the health care services are covered by way of in-person consultation or delivery and (ii) the health care services may be appropriately provided through the use of telehealth; provided, however, that an insurer shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request.

(c) Coverage may include utilization review, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service; provided, however, that the determination shall be made in the same manner as if the service was delivered in-person. A policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan or reimburse a health care provider not contracted under the plan except as provided for under clause (i) of paragraph (4) of subsection (a) of section 6 of chapter 176O.

(d) A health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telehealth services are provided be limited for health care services provided via telehealth, except as provided in the definition of the term "eligible health care services" in subsection (a) of this section; provided, however, that a patient may decline receiving services via telehealth in order to receive in-person services.

(e) A policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth that provides coverage for telehealth services may include a deductible, copayment or coinsurance requirement for a health care service provided via telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. The rate of payment for telehealth services provided via interactive audio-video technology may be greater than the rate of payment for the same service delivered by other telehealth modalities.

(f) Coverage that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall account for the provision of telehealth services to set the global payment amount.

(g) Insurance companies organized under this chapter shall ensure that the rate of payment for in-network providers of behavioral health services delivered via interactive audio-video technology and audio-only telephone shall be no less than the rate of payment for the same behavioral health service delivered via in-person methods.

(h) Health care services provided via telehealth shall conform to the standards of care applicable to the telehealth provider's profession and specialty. Such services shall also conform

to applicable federal and state health information privacy and security standards as well as standards for informed consent.

SECTION 25. Chapter 176A of the General Laws is hereby amended by adding the following section:-

Section 38. (a) For the purposes of this section, the following words shall have the following meanings:

"Behavioral health services", care and services for the diagnosis, treatment, or management of patients with mental health or substance use disorders.

"Chronic disease management", supplies, care, and services for the management of chronic conditions, as defined by the Centers for Medicare and Medicaid Services, which include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, and coronary artery disease.

"Eligible health care services", primary care services, behavioral health services, and chronic disease management when delivered via telehealth to a patient while the patient is located in a private residence. The term also includes all health care services delivered to a patient via telehealth when the patient is located in a health care facility licensed or certified by the department of public health or otherwise in the physical presence of a health care professional licensed under chapter 112.

"Primary care services" services delivered by primary care providers as defined in section 1 of chapter 111.

"Telehealth", the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including but not limited to interactive audio-video technology, audio-only telephone, and online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating, or monitoring of a patient's physical, oral or mental health; provided, however, that "telehealth" shall not include text messaging or text-only email, and provided further that prescribing via telehealth shall be limited to the treatment of a condition previously diagnosed during an in-person visit by the telehealth provider.

(b) A contract between a subscriber and a nonprofit hospital service corporation under an individual or group hospital service plan shall provide coverage for eligible health care services via telehealth by a contracted health care provider if (i) the health care services are covered by way of in-person consultation or delivery and (ii) the health care services may be appropriately provided through the use of telehealth; provided, however, that an insurer shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request.

(c) Coverage for telehealth services may include utilization review, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service; provided, however, that the determination shall be made in the same manner as if the service was delivered in-person. A carrier shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan or reimburse a health care provider not contracted under the plan except as provided for under clause (i) of paragraph (4) of subsection (a) of section 6 of chapter 176O.

(d) A health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telehealth services are provided be limited for health care services provided via telehealth, except as provided in the definition of the term "eligible health care services" in subsection (a) of this section; provided, however, that a patient may decline receiving services via telehealth in order to receive in-person services.

(e) Coverage may include a deductible, copayment or coinsurance requirement for a health care service provided via telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. The rate of payment for telehealth services provided via interactive audio-video technology may be greater than the rate of payment for the same service delivered by other telehealth modalities.

(f) Coverage that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall account for the provision of telehealth services to set the global payment amount.

(g) Hospital service corporations shall ensure that the rate of payment for in-network providers of behavioral health services delivered via interactive audio-video technology and audio-only telephone shall be no less than the rate of payment for the same behavioral health service delivered via in-person methods.

(h) Health care services provided via telehealth shall conform to the standards of care applicable to the telehealth provider's profession and specialty. Such services shall also conform to applicable federal and state health information privacy and security standards as well as standards for informed consent.

SECTION 26. Chapter 176B of the General Laws is hereby amended by adding the following section:-

Section 25. (a) For the purposes of this section, the following words shall have the following meanings:

"Behavioral health services", care and services for the diagnosis, treatment, or management of patients with mental health or substance use disorders.

"Chronic disease management", supplies, care, and services for the management of chronic conditions, as defined by the Centers for Medicare and Medicaid Services, which include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, and coronary artery disease.

"Eligible health care services", primary care services, behavioral health services, and chronic disease management when delivered via telehealth to a patient while the patient is located in a private residence. The term also includes all health care services delivered to a patient via telehealth when the patient is located in a health care facility licensed or certified by the department of public health or otherwise in the physical presence of a health care professional licensed under chapter 112.

"Primary care services" services delivered by primary care providers as defined in section 1 of chapter 111.

"Telehealth", the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including but not limited to interactive audio-video technology, audio-only telephone, and online adaptive interviews, for the purpose of evaluating,

diagnosing, consulting, prescribing, treating, or monitoring of a patient's physical, oral or mental health; provided, however, that “telehealth” shall not include text messaging or text-only email, and provided further that prescribing via telehealth shall be limited to the treatment of a condition previously diagnosed during an in-person visit by the telehealth provider.

(b) A contract between a subscriber and a medical service corporation shall provide coverage for eligible health care services via telehealth by a contracted health care provider if (i) the health care services are covered by way of in-person consultation or delivery and (ii) the health care services may be appropriately provided through the use of telehealth; provided, however, that an insurer shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request.

(c) Coverage may include utilization review, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service; provided, however, that the determination shall be made in the same manner as if the service was delivered in-person. A carrier shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan or reimburse a health care provider not contracted under the plan except as provided for under clause (i) of paragraph (4) of subsection (a) of section 6 of chapter 176O.

(d) A health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telehealth services are provided be limited for health care services provided via telehealth, except as provided in the definition of the term “eligible

health care services" in subsection (a) of this section; provided, however, that a patient may decline receiving services via telehealth in order to receive in-person services.

(e) A contract that provides coverage for telehealth services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided via telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. The rate of payment for telehealth services provided via interactive audio-video technology may be greater than the rate of payment for the same service delivered by other telehealth modalities.

(f) Coverage that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall account for the provision of telehealth services to set the global payment amount.

(g) Medical service corporations shall ensure that the rate of payment for in-network providers of behavioral health services delivered via interactive audio-video technology and audio-only telephone shall be no less than the rate of payment for the same behavioral health service delivered via in-person methods.

(h) Health care services provided via telehealth shall conform to the standards of care applicable to the telehealth provider's profession and specialty. Such services shall also conform to applicable federal and state health information privacy and security standards as well as standards for informed consent.

SECTION 27. Chapter 176G of the General Laws is hereby amended by adding the following section:-

Section 33. (a) For the purposes of this section, the following words shall have the following meanings:

“Behavioral health services”, care and services for the diagnosis, treatment, or management of patients with mental health or substance use disorders.

“Chronic disease management”, supplies, care, and services for the management of chronic conditions, as defined by the Centers for Medicare and Medicaid Services, which include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, and coronary artery disease.

“Eligible health care services”, primary care services, behavioral health services, and chronic disease management when delivered via telehealth to a patient while the patient is located in a private residence. The term also includes all health care services delivered to a patient via telehealth when the patient is located in a health care facility licensed or certified by the department of public health or otherwise in the physical presence of a health care professional licensed under chapter 112.

“Primary care services” services delivered by primary care providers as defined in section 1 of chapter 111.

“Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including but not limited to interactive audio-video technology, audio-only telephone, and online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating, or monitoring of a patient's physical, oral or mental health; provided, however, that “telehealth” shall not include text messaging or text-only email,

and provided further that prescribing via telehealth shall be limited to the treatment of a condition previously diagnosed during an in-person visit by the telehealth provider.

(b) A contract between a member and a health maintenance organization shall provide coverage for eligible health care services via telehealth by a contracted health care provider if (i) the health care services are covered by way of in-person consultation or delivery and (ii) the health care services may be appropriately provided through the use of telehealth; provided, however, that an insurer shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request.

(c) Coverage may include utilization review, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service; provided, however, that the determination shall be made in the same manner as if the service was delivered in-person. A carrier shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan or reimburse a health care provider not contracted under the plan except as provided for under clause (i) of paragraph (4) of subsection (a) of section 6 of chapter 176O.

(d) A health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telehealth services are provided be limited for health care services provided via telehealth, except as provided in the definition of the term “eligible health care services” in subsection (a) of this section; provided, however, that a patient may decline receiving services via telehealth in order to receive in-person services.

(e) Coverage may include a deductible, copayment or coinsurance requirement for a health care service provided via telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. The rate of payment for telehealth services provided via interactive audio-video technology may be greater than the rate of payment for the same service delivered by other telehealth modalities.

(f) Coverage that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall account for the provision of telehealth services to set the global payment amount.

(g) Health maintenance organizations shall ensure that the rate of payment for in-network providers of behavioral health services delivered via interactive audio-video technology and audio-only telephone shall be no less than the rate of payment for the same behavioral health service delivered via in-person methods.

(h) Health care services provided via telehealth shall conform to the standards of care applicable to the telehealth provider's profession and specialty. Such services shall also conform to applicable federal and state health information privacy and security standards as well as standards for informed consent.

SECTION 28. Chapter 176I of the General Laws is hereby amended by adding the following section:-

Section 13. (a) For the purposes of this section, the following words shall have the following meanings:

"Behavioral health services", care and services for the diagnosis, treatment, or management of patients with mental health or substance use disorders.

"Chronic disease management", supplies, care, and services for the management of chronic conditions, as defined by the Centers for Medicare and Medicaid Services, which include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, and coronary artery disease.

"Eligible health care services", primary care services, behavioral health services, and chronic disease management when delivered via telehealth to a patient while the patient is located in a private residence. The term also includes all health care services delivered to a patient via telehealth when the patient is located in a health care facility licensed or certified by the department of public health or otherwise in the physical presence of a health care professional licensed under chapter 112.

"Primary care services" services delivered by primary care providers as defined in section 1 of chapter 111.

"Telehealth", the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including but not limited to interactive audio-video technology, audio-only telephone, and online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating, or monitoring of a patient's physical, oral or mental health; provided, however, that "telehealth" shall not include text messaging or text-only email, and provided further that prescribing via telehealth shall be limited to the treatment of a condition previously diagnosed during an in-person visit by the telehealth provider.

(b) A preferred provider contract between a covered person and an organization shall provide coverage for eligible health care services via telehealth by a contracted health care provider if (i) the health care services are covered by way of in-person consultation or delivery and (ii) the health care services may be appropriately provided through the use of telehealth; provided, however, that an insurer shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request.

(c) Coverage may include utilization review, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service; provided, however, that the determination shall be made in the same manner as if the service was delivered in-person. Coverage for telehealth services shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan or reimburse a health care provider not contracted under the plan except as provided for under clause (i) of paragraph (4) of subsection (a) of section 6 of chapter 176O.

(d) A health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telehealth services are provided be limited for health care services provided via telehealth, except as provided in the definition of the term “eligible health care services” in subsection (a) of this section; provided, however, that a patient may decline receiving services via telehealth in order to receive in-person services.

(e) Coverage may include a deductible, copayment or coinsurance requirement for a health care service provided via telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person

consultation or in-person delivery of services. The rate of payment for telehealth services provided via interactive audio-video technology may be greater than the rate of payment for the same service delivered by other telehealth modalities.

(f) Coverage that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall account for the provision of telehealth services to set the global payment amount.

(g) Organizations shall ensure that the rate of payment for in-network providers of behavioral health services delivered via interactive audio-video technology and audio-only telephone shall be no less than the rate of payment for the same behavioral health service delivered via in-person methods.

(h) Health care services provided via telehealth shall conform to the standards of care applicable to the telehealth provider's profession and specialty. Such services shall also conform to applicable federal and state health information privacy and security standards as well as standards for informed consent.

SECTION 29. Notwithstanding any general or special law to the contrary, the health policy commission, in consultation with the center for health information and analysis, shall report on the use of telehealth services in the commonwealth and the effect of telehealth on health care access and system cost.

The report shall include, but not be limited to: (i) an analysis of the use of telehealth services by patient demographics, geographic region and type of service; (ii) total health care expenditures on telehealth services by type of service and type of telecommunication technology used; (iii) any barriers to increased use of telehealth services, including cost and

availability of technology infrastructure for health care providers and patients with limited access to technology; (iv) the estimated aggregate savings or additional costs of telehealth on total health care expenditures, including the impact on insurance premiums; (v) recommendations on the appropriate relationship of reimbursement rates for services provided via telehealth, including facility fees, compared to comparable in-person services in order to maximize health care access and public health outcomes and limit health care cost growth; and (vi) recommendations on additional health care services that may be delivered to a patient via telehealth while the patient is located in a private residence, which shall take into consideration which telehealth modalities are most appropriate for the delivery of the health care service.

The report shall be submitted to the joint committee on health care financing and the house and senate committees on ways and means not later than December 31, 2022.

SECTION 30. (a) Notwithstanding any general or special law to the contrary, the secretary of health and human services shall direct monthly payments to eligible hospitals in the form of enhanced Medicaid payments, supplemental payments or other appropriate mechanism. Each payment made to an eligible hospital shall equal 5 per cent of the eligible hospital's average monthly Medicaid payments, as determined by the secretary, for inpatient and outpatient acute hospital services for the preceding fiscal year or the most recent year for which data is available; provided, however, that such enhanced Medicaid payments shall not be used in subsequent years by the secretary to calculate an eligible hospital's average monthly payment.

(b) The secretary may require as a condition of receiving payment any such reasonable condition of payment that the secretary determines necessary to ensure the availability, to the extent possible, of federal financial participation for the payments, and the secretary may incur

expenses and the comptroller may certify amounts for payment in anticipation of expected receipt of federal financial participation for the payments.

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

(d) For the purposes of this section "eligible hospital" shall mean the teaching hospital of the University of Massachusetts medical school or any hospital licensed under section 51 of chapter 111 or any hospital that (i) is not at or above the 90th per cent of the statewide average relative price, as calculated by the center for health information and analysis pursuant to section 10 of chapter 12C according to data from the most recent available year; (ii) that has a public payer mix at or above 60 per cent as determined by the center for health information and analysis according to data from the most recent available year; and (iii) that is not owned, financially consolidated or corporately affiliated with a provider organization that (1) has two or more acute hospitals in Massachusetts; (2) is at or above the 90th per cent of the statewide system wide average relative price, as calculated by the center for health information and analysis pursuant to section 10 of chapter 12C according to data from the most recent available year; (3) has greater than $600,000,000 in total net assets, as defined in section 1 of chapter 175, among those hospitals as calculated by the center for health information and analysis according to data from the most recent available year; and (4) has a system wide public payer mix as determined by the center for health information and analysis that is less than 70 per cent.

SECTION 31. For the purposes of section 30 of chapter 32A, section 79 of chapter 118E, section 47CC of chapter 175, section 38 of chapter 176A, section 25 of chapter 176B, section 33 of chapter 176G and section 13 of chapter 176I of the General Laws, network adequacy may be

met through significant reliance on telehealth providers until the termination of the governor's March 10, 2020 declaration of a state of emergency.

SECTION 32. Notwithstanding any general or special law to the contrary, the group insurance commission under chapter 32A of the General Laws, the division of medical assistance under chapter 118E of the General Laws, insurance companies organized under chapter 175 of the General Laws, hospital service corporations organized under chapter 176A of the General Laws, medical service corporations organized under chapter 176B of the General Laws, health maintenance organizations organized under chapter 176G of the General Laws and preferred provider organizations organized under chapter 176I of the General Laws shall ensure that rates of payment for in-network providers for telehealth services provided pursuant to section 30 of said chapter 32A, section 79 of said chapter 118E, section 47JJ of said chapter 175, section 38 of said chapter 176A, section 25 of said chapter 176B, section 33 of said chapter 176G and section 13 of said chapter 176I are not less than the rate of payment for the same service delivered via in-person methods.

SECTION 33. Notwithstanding any general or special law to the contrary, all temporary licenses issued to physicians by the board of registration in medicine pursuant to the governor's March 17, 2020 Order Expanding Access to Physician Services, and to other health care providers from their respective boards of registration pursuant to the commissioner of public health's April 3, 2020 Order Rescinding and Replacing the March 29 Order of the Commissioner of Public Health Maximizing Health Care Provider Availability, shall expire on December 31, 2021.

For the purposes of this section, “health care providers” includes registered nurses, licensed practical nurses, advanced practice registered nurses, dentists, dental hygienists, dental assistants, pharmacists, pharmacy technicians, nursing home administrators, physician assistants, respiratory therapists, perfusionists, genetic counselors, community health workers, emergency medical technicians, social workers, psychologists, marriage and family therapists, licensed mental health counselors, rehabilitation counselors, applied behavior analysts, assistant behavior analysts, licensed school psychologists, licensed alcohol and drug counselors, radiologic technologists, radiologist assistants, and nuclear medicine advanced associates.

SECTION 34. (a) Any coverage offered by the group insurance commission under chapter 32A of the General Laws; the division of medical assistance and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization or primary care clinician plan under chapter 118E of the General Laws; any individual policy of accident or sickness insurance issued under chapter 175 of the General Laws; any contract between a subscriber and a corporation under an individual group or hospital service plan under chapter 176A of the General Laws; any subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth under chapter 176B of the General Laws; any individual or group health maintenance contract under chapter 176G of the General Laws; and any preferred provider contract between a covered person and an organization under chapter 176I of the General Laws, shall provide coverage, without any requirement of cost sharing by the insured, for all emergency and inpatient services, including all professional, diagnostic and laboratory services, related to COVID-19 at both in-network and out-of-network providers.

SECTION 35. (a) For the purposes of this section, the following terms shall have the following meanings unless the context clearly requires otherwise:

“Carrier”, as defined in section 1 of chapter 176O.

"Emergency services", as defined under section 1 of chapter 6D.

“In-network contracted rate”, the rate contracted between an insured's carrier and a network provider for the reimbursement of health care services delivered by that network provider to the insured.

“In-network cost-sharing amount”, the cost-sharing amount that the insured is required to pay for a covered health care service received from a network provider. Cost sharing includes any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the insured other than premium or share of premium.

“Inpatient services”, health care services requiring at least one overnight stay, provided to patients on an elective, urgent, or emergency basis.

“Network provider”, a participating provider who, under a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to insureds enrolled in any or all of the carrier's network plans, policies, contracts or other arrangements.

“Out-of-network provider”, a provider, other than a person licensed under chapter 111C, that does not participate in the network of an insured’s health benefit plan because: (i) the provider contracts with a carrier to participate in the carrier’s network but does not contract as a participating provider for the specific health benefit plan to which an insured is enrolled; or (ii)

the provider does not contract with a carrier to participate in any of the carrier's network plans, policies, contracts or other arrangements.

(b) When an out-of-network provider renders emergency services to an insured and such out-of-network provider is a member of an insured’s carrier’s network but not a network provider in the insured’s health benefit plan, a carrier shall pay such out-of-network provider the in-network contracted rate for each delivered service; provided however, that such payment shall constitute payment in full and the out-of-network provider shall not bill the insured for any amount except for any in-network cost sharing amount owed for such service or services under the terms of the insured’s health benefit plan.

(c) When an out-of-network provider does not contract with a carrier and such out-of-network provider renders emergency services to an insured, a carrier shall pay such out-of-network provider 135 per cent of the Medicare rate for that service; provided however, that such payment shall constitute payment in full to the out-of-network provider. The out-of-network provider shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured received such service or services from a network provider under the terms of the insured’s health benefit plan.

(d) When an out-of-network provider renders inpatient services on an emergency basis to an insured, the carrier shall pay that provider 135 per cent of the Medicare rate for that service. Such payment shall constitute payment in full to the out-of-network provider. The out-of-network provider shall not bill the insured except for any inpatient cost sharing under the terms of the insured’s health benefit plan.

(e) At the time of payment by a carrier to an out-of-network provider, a carrier shall inform the insured and the out-of-network provider of the in-network cost-sharing amount owed by the insured.

(f) If a carrier delegates payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, the delegated entity shall comply with this section.

(g) Nothing in this section shall require a carrier to pay for health care services delivered to an insured that are not covered benefits under the terms of the insured's health benefit plan.

SECTION 36. Sections 32, 34, and 35 are hereby repealed.

SECTION 37. Section 36 shall take effect on July 31, 2021.