HOUSE . . . . No. 4916

Text of House document No. 4888, being House amendments and committee on Bills in the Third Reading changes of the Senate Bill Senate Bill putting patients first (Senate bill No. 2796), as amended by the House on July 28 and 29. July 29, 2020.

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:–

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

6 SECTION 2. Subsection (e) of said section 8 of said chapter 6D, as so appearing, is
7 hereby amended by striking out, in line 48, the first time it appears, the word "and".

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

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

17 Section 30. (a) For the purposes of this section, the following words shall, unless the
18 context clearly requires otherwise, have the following meanings:

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

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

25 "Eligible health care services", primary care services, behavioral health services and
26 chronic disease management when delivered via telehealth to a patient while the patient is
27 located in their place of residence. Eligible health care services shall also include: (i) all health
28 care services delivered through provider-to-provider consultation via telehealth; (ii) all health
29 care services delivered to a patient via telehealth when the patient is located in a health care
30 facility licensed or certified by the department of public health or the department of mental
31 health or otherwise in the physical presence of a health care professional licensed pursuant to
32 chapter 112; and (iii) any additional health care services to be delivered to a patient via
33 telehealth, while located in their place of residence, that are approved by bulletins or regulations
34 issued or promulgated by the division of insurance and division of medical assistance based on
35 recommendations from the health policy commission.

36 “Primary care services”, services delivered by a primary care provider as defined in
37 section 1 of chapter 111.

38 “Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or
39 other telecommunications technology, including, but not limited to: (i) interactive audio-video
40 technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online
41 adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating
42 or monitoring of a patient's physical, oral or mental health; provided, however, that telehealth
43 shall not include text messaging or text-only email; and provided, further, that prescribing via
44 telehealth shall be limited to the treatment of a condition previously diagnosed during an in-
45 person visit by the telehealth provider, and to the issuance of a one-time prescription to treat the
46 sudden onset of an illness or injury or acute mental health or behavioral health episode,
47 manifesting itself by acute symptoms, and as many refills of that prescription as a provider may
48 issue within their discretion.

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

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

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

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

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

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

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

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

90 "Medication order", an order for medication entered on a patient's medical record
91 maintained at a hospital, other health facility or ambulatory health care setting registered under
92 this chapter, that is dispensed only for immediate administration at the facility to the ultimate
93 user by an individual who administers such medication under this chapter.

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

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

100 (d) A nurse practitioner registered pursuant to subsection (f) of section 7 and authorized
101 pursuant to section 80E of chapter 112 to issue written prescriptions and medication orders and
102 order tests and therapeutics in the course of professional practice or research in the
103 commonwealth.

104 (e) A psychiatric nurse mental health clinical specialist registered pursuant to subsection
105 (f) of section 7 and authorized pursuant to section 80E of chapter 112 to issue written
106 prescriptions and medication orders and order tests and therapeutics in the course of professional
107 practice or research in the commonwealth.

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

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

116 SECTION 10. Said section 7 of said chapter 94C, as so appearing, is hereby amended by
117 inserting after the word "podiatrist", in line 122 and in lines 125 to 126, inclusive, each time it
118 appears, the following words:- , nurse practitioner, psychiatric nurse mental health clinical
119 specialist.

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

122 SECTION 12. Section 9 of said chapter 94C, as so appearing, is hereby amended by
123 inserting after the word "podiatrist", in line 1, the following words:- , nurse practitioner,
124 psychiatric nurse mental health clinical specialist.

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

129 SECTION 14. Section 9 of said chapter 94C, as so appearing, is hereby further amended
130 by inserting after the word "nurse-midwifery", in line 32, the following words:- , advanced
131 practice nursing.

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

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

137 Section 5O. (a) For the purposes of this section, "telehealth" shall mean the use of
138 synchronous or asynchronous audio, video, electronic media or other telecommunications
139 technology, including, but not limited to, interactive audio-video technology, remote patient
140 monitoring devices, audio-only telephone, and online adaptive interviews, for the purpose of
141 evaluating, diagnosing, consulting, prescribing, treating or monitoring of a patient's physical,
142 oral or mental health; provided, however, that "telehealth" shall not include text messaging or
143 text-only email; and provided, further, that prescribing via telehealth shall be limited to the

144 treatment of a condition previously diagnosed during an in-person visit by the telehealth
145 provider, and to the issuance of a one-time prescription to treat the sudden onset of an illness or
146 injury or acute mental health or behavioral health episode, manifesting itself by acute symptoms,
147 and as many refills of that prescription as a provider may issue within their discretion.

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

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

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

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

164 Section 80E. (a) A nurse practitioner or psychiatric nurse mental health clinical specialist
165 may issue written prescriptions and medication orders and order tests and therapeutics pursuant

166 to guidelines mutually developed, agreed upon and signed by the nurse and either a supervising
167 nurse practitioner who has independent practice authority, a supervising psychiatric nurse mental
168 health clinical specialist who has independent practice authority, or a supervising physician, in
169 accordance with regulations promulgated by the board. A prescription issued by a nurse
170 practitioner or psychiatric nurse mental health clinical specialist under this subsection shall
171 include the name of the supervising nurse practitioner who has independent practice authority,
172 the supervising psychiatric nurse mental health clinical specialist who has independent practice
173 authority or the supervising physician with whom the nurse practitioner or psychiatric nurse
174 mental health clinical specialist developed and signed mutually agreed upon guidelines.

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

183 (c) The board may allow a nurse practitioner or psychiatric nurse mental health clinical
184 specialist to exercise such independent practice authority upon satisfactory demonstration of not
185 less than 2 years of alternative professional experience; provided, however, that the board
186 determines that the nurse practitioner or psychiatric nurse mental health clinical specialist has a
187 demonstrated record of safe prescribing and good conduct consistent with professional licensure

188 obligations required by each jurisdiction in which the nurse practitioner or psychiatric nurse
189 mental health clinical specialist has been licensed.

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

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

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

195 Section 10N. The division and its contracted health insurers, health plans, health
196 maintenance organizations, behavioral health management firms and third party administrators
197 under contract to a Medicaid managed care organization or primary care clinician plan shall not
198 require an enrollee to obtain a referral from a primary care provider prior to obtaining health care
199 services from an urgent care facility; provided, however, that any urgent care facility providing
200 health care services to an enrollee shall provide the enrollee with names of primary care
201 providers contracted with MassHealth and practicing in the municipality of residence of the
202 enrollee or an adjacent municipality.

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

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

209 In the event that a nursing facility resident who is a MassHealth recipient enters a
210 hospital for treatment related to the 2019 novel coronavirus, also known as COVID-19, the
211 division shall pay to preserve their bed in the nursing facility for a period of up to and including
212 20 days per medical event. The division shall reimburse the nursing facility for the medical leave
213 of absence, which shall include an observation stay in a hospital in excess of 24 hours.

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

216 Section 79. (a) For the purposes of this section, the following words shall, unless the
217 context clearly requires otherwise, have the following meanings:

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

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

224 "Eligible health care services", primary care services, behavioral health services and
225 chronic disease management when delivered via telehealth to a patient while the patient is
226 located in their place of residence. Eligible health care services shall also include: (i) all health
227 care services delivered through provider-to-provider consultation via telehealth; (ii) all health
228 care services delivered to a patient via telehealth when the patient is located in a health care
229 facility licensed or certified by the department of public health or the department of mental
230 health or otherwise in the physical presence of a health care professional licensed pursuant to

231 chapter 112; and (iii) any additional health care services to be delivered to a patient via
232 telehealth, while located in their place of residence, that are approved by bulletins or regulations
233 issued or promulgated by the division of insurance and division of medical assistance based on
234 recommendations from the health policy commission.

235 "Primary care services", services delivered by a primary care provider as defined
236 in section 1 of chapter 111.

237 "Telehealth", the use of synchronous or asynchronous audio, video, electronic media or
238 other telecommunications technology, including, but not limited to: (i) interactive audio-video
239 technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online
240 adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating
241 or monitoring of a patient's physical, oral or mental health; provided, however, that telehealth
242 shall not include text messaging or text-only email; and provided further, that prescribing via
243 telehealth shall be limited to the treatment of a condition previously diagnosed during an in-
244 person visit by the telehealth provider, and to the issuance of a one-time prescription to treat the
245 sudden onset of an illness or injury or acute mental health or behavioral health episode,
246 manifesting itself by acute symptoms, and as many refills of that prescription as a provider may
247 issue within their discretion.

248 (b) The division and its contracted health insurers, health plans, health maintenance
249 organizations, behavioral health management firms and third-party administrators under contract
250 to a Medicaid managed care organization, accountable care organization or primary care
251 clinician plan shall provide coverage for eligible health care services via telehealth by a
252 contracted health care provider if: (i) the health care services are covered by way of in-person

253 consultation or delivery, and (ii) the health care services may be appropriately provided through
254 the use of telehealth; provided, however, that Medicaid contracted health insurers, health plans,
255 health maintenance organizations, behavioral health management firms and third-party
256 administrators under contract to a Medicaid managed care organization or primary care clinician
257 plan shall not meet network adequacy through significant reliance on telehealth providers and
258 shall not be considered to have an adequate network if patients are not able to access appropriate
259 in-person services in a timely manner upon request.

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

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

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

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

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

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

291 SECTION 23. Section 47BB of chapter 175 of the General Laws, inserted by section 158
292 of chapter 224 of the acts of 2012, is hereby repealed.

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

295 Section 47MM. (a) For the purposes of this section, the following words shall, unless the
296 context clearly requires otherwise, have the following meanings:

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

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

303 "Eligible health care services", primary care services, behavioral health services and
304 chronic disease management when delivered via telehealth to a patient while the patient is
305 located in their place of residence. Eligible health care services shall also include: (i) all health
306 care services delivered through provider-to-provider consultation via telehealth; (ii) all health
307 care services delivered to a patient via telehealth when the patient is located in a health care
308 facility licensed or certified by the department of public health or the department of mental
309 health or otherwise in the physical presence of a health care professional licensed pursuant to
310 chapter 112; and (iii) any additional health care services to be delivered to a patient via
311 telehealth, while located in their place of residence, that are approved by bulletins or regulations
312 issued or promulgated by the division of insurance and division of medical assistance based on
313 recommendations from the health policy commission.

314 "Primary care services", services delivered by a primary care provider as defined in
315 section 1 of chapter 111.

316 “Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or
317 other telecommunications technology, including but not limited to: (i) interactive audio-video
318 technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online
319 adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating
320 or monitoring of a patient's physical, oral or mental health; provided, however, that telehealth
321 shall not include text messaging or text-only email; and provided further, that prescribing via
322 telehealth shall be limited to the treatment of a condition previously diagnosed during an in-
323 person visit by the telehealth provider, and to the issuance of a one-time prescription to treat the
324 sudden onset of an illness or injury or acute mental health or behavioral health episode,
325 manifesting itself by acute symptoms, and as many refills of that prescription as a provider may
326 issue within their discretion.

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

337 (c) Coverage may include utilization review, including preauthorization, to determine the
338 appropriateness of telehealth as a means of delivering a health care service; provided, however,

339 that the determination shall be made in the same manner as if the service was delivered in-
340 person. A policy, contract, agreement, plan or certificate of insurance issued, delivered or
341 renewed within the commonwealth shall not be required to reimburse a health care provider for a
342 health care service that is not a covered benefit under the plan or reimburse a health care
343 provider not contracted under the plan except as provided for under clause (i) of paragraph (4) of
344 subsection (a) of section 6 of chapter 176O.

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

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

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

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

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

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

371 Section 38. (a) For the purposes of this section, the following words shall, unless the
372 context clearly requires otherwise, have the following meanings:

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

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

379 "Eligible health care services", primary care services, behavioral health services and
380 chronic disease management when delivered via telehealth to a patient while the patient is
381 located in their place of residence. Eligible health care services shall also include: (i) all health

382 care services delivered through provider-to-provider consultation via telehealth; (ii) all health
383 care services delivered to a patient via telehealth when the patient is located in a health care
384 facility licensed or certified by the department of public health or the department of mental
385 health or otherwise in the physical presence of a health care professional licensed pursuant to
386 chapter 112; and (iii) any additional health care services to be delivered to a patient via telehealth
387 while located in their place of residence that are approved by bulletins or regulations issued or
388 promulgated by the division of insurance and division of medical assistance based on
389 recommendations from the health policy commission.

390 "Primary care services", services delivered by a primary care provider as defined in
391 section 1 of chapter 111.

392 "Telehealth", the use of synchronous or asynchronous audio, video, electronic media or
393 other telecommunications technology, including but not limited to: (i) interactive audio-video
394 technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online
395 adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating
396 or monitoring of a patient's physical, oral or mental health; provided, however, that telehealth
397 shall not include text messaging or text-only email, and provided further, that prescribing via
398 telehealth shall be limited to the treatment of a condition previously diagnosed during an in-
399 person visit by the telehealth provider, and to the issuance of a one-time prescription to treat the
400 sudden onset of an illness or injury or acute mental health or behavioral health episode,
401 manifesting itself by acute symptoms, and as many refills of that prescription as a provider may
402 issue within their discretion.

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

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

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

423 (e) Coverage may include a deductible, copayment or coinsurance requirement for a
424 health care service provided via telehealth as long as the deductible, copayment or coinsurance

425 does not exceed the deductible, copayment or coinsurance applicable to an in-person
426 consultation or in-person delivery of services. The rate of payment for telehealth services
427 provided via interactive audio-video technology may be greater than the rate of payment for the
428 same service delivered by other telehealth modalities.

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

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

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

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

442 Section 25. (a) For the purposes of this section, the following words shall, unless the
443 context clearly requires otherwise, have the following meanings:

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

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

450 “Eligible health care services”, primary care services, behavioral health services and
451 chronic disease management when delivered via telehealth to a patient while the patient is
452 located in their place of residence. Eligible health care services shall also include: (i) all health
453 care services delivered through provider-to-provider consultation via telehealth; (ii) all health
454 care services delivered to a patient via telehealth when the patient is located in a health care
455 facility licensed or certified by the department of public health or the department of mental
456 health or otherwise in the physical presence of a health care professional licensed pursuant to
457 chapter 112; and (iii) any additional health care services to be delivered to a patient via telehealth
458 while located in their place of residence that are approved by bulletins or regulations issued or
459 promulgated by the division of insurance and division of medical assistance based on
460 recommendations from the health policy commission.

461 “Primary care services”, services delivered by a primary care provider as defined
462 in section 1 of chapter 111.

463 “Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or
464 other telecommunications technology, including but not limited to: (i) interactive audio-video
465 technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online
466 adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating
467 or monitoring of a patient's physical, oral or mental health; provided, however, that telehealth

468 shall not include text messaging or text-only email; and provided further, that prescribing via
469 telehealth shall be limited to the treatment of a condition previously diagnosed during an in-
470 person visit by the telehealth provider, and to the issuance of a one-time prescription to treat the
471 sudden onset of an illness or injury or acute mental health or behavioral health episode,
472 manifesting itself by acute symptoms, and as many refills of that prescription as a provider may
473 issue within their discretion.

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

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

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

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

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

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

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

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

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

513 Section 33. (a) For the purposes of this section, the following words shall, unless the
514 context clearly requires otherwise, have the following meanings:

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

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

521 “Eligible health care services”, primary care services, behavioral health services, and
522 chronic disease management when delivered via telehealth to a patient while the patient is
523 located in their place of residence. Eligible health care services shall also include: (i) all health
524 care services delivered through provider-to-provider consultation via telehealth; (ii) all health
525 care services delivered to a patient via telehealth when the patient is located in a health care
526 facility licensed or certified by the department of public health or department of mental health or
527 otherwise in the physical presence of a health care professional licensed under chapter 112; and
528 (iii) any additional health care services to be delivered to a patient via telehealth, while located in
529 their place of residence, that are approved by bulletins or regulations issued or promulgated by
530 the division of insurance and division of medical assistance based on recommendations from the
531 health policy commission.

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

534 “Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or
535 other telecommunications technology, including, but not limited to: (i) interactive audio-video
536 technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online
537 adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating,
538 or monitoring of a patient's physical, oral or mental health; provided, however, that telehealth
539 shall not include text messaging or text-only email, and provided further, that prescribing via
540 telehealth shall be limited to the treatment of a condition previously diagnosed during an in-
541 person visit by the telehealth provider, and to the issuance of a one-time prescription to treat the
542 sudden onset of an illness or injury or acute mental health or behavioral health episode,
543 manifesting itself by acute symptoms, and as many refills of that prescription as a provider may
544 issue within their discretion.

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

552 (c) Coverage may include utilization review, including preauthorization, to determine the
553 appropriateness of telehealth as a means of delivering a health care service; provided, however,

554 that the determination shall be made in the same manner as if the service was delivered in-
555 person. A carrier shall not be required to reimburse a health care provider for a health care
556 service that is not a covered benefit under the plan or reimburse a health care provider not
557 contracted under the plan except as provided for under clause (i) of paragraph (4) of subsection
558 (a) of section 6 of chapter 176O.

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

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

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

573 (g) Health maintenance organizations shall ensure that the rate of payment for in-network
574 providers of behavioral health services delivered via interactive audio-video technology and

575 audio-only telephone shall be no less than the rate of payment for the same behavioral health
576 service delivered via in-person methods.

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

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

583 Section 13. (a) For the purposes of this section, the following words shall, unless the
584 context clearly requires otherwise, have the following meanings:

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

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

591 “Eligible health care services”, primary care services, behavioral health services and
592 chronic disease management when delivered via telehealth to a patient while the patient is
593 located in their place of residence. Eligible health care services shall also include: (i) all health
594 care services delivered through provider-to-provider consultation via telehealth; (ii) all health
595 care services delivered to a patient via telehealth when the patient is located in a health care

596 facility licensed or certified by the department of public health or the department of mental
597 health or otherwise in the physical presence of a health care professional licensed pursuant to
598 chapter 112; and (iii) any additional health care services to be delivered to a patient via
599 telehealth, while located in their place of residence, that are approved by bulletins or regulations
600 issued or promulgated by the division of insurance and division of medical assistance based on
601 recommendations from the health policy commission.

602 "Primary care services", services delivered by a primary care provider as defined in
603 section 1 of chapter 111.

604 "Telehealth", the use of synchronous or asynchronous audio, video, electronic media or
605 other telecommunications technology, including but not limited to: (i) interactive audio-video
606 technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online
607 adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating
608 or monitoring of a patient's physical, oral or mental health; provided, however, that telehealth
609 shall not include text messaging or text-only email; and provided further, that prescribing via
610 telehealth shall be limited to the treatment of a condition previously diagnosed during an in-
611 person visit by the telehealth provider, and to the issuance of a one-time prescription to treat the
612 sudden onset of an illness or injury or acute mental health or behavioral health episode,
613 manifesting itself by acute symptoms, and as many refills of that prescription as a provider may
614 issue within their discretion.

615 (b) A preferred provider contract between a covered person and an organization shall
616 provide coverage for eligible health care services via telehealth by a contracted health care
617 provider if: (i) the health care services are covered by way of in-person consultation or delivery

618 and (ii) the health care services may be appropriately provided through the use of telehealth;
619 provided, however, that an insurer shall not meet network adequacy through significant reliance
620 on telehealth providers and shall not be considered to have an adequate network if patients are
621 not able to access appropriate in-person services in a timely manner upon request.

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

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

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

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

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

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

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

655 The report shall include, but not be limited to: (i) an analysis of the use of telehealth
656 services by patient demographics, geographic region and type of service; (ii) total health care
657 expenditures on telehealth services by type of service and type of telecommunication technology
658 used; (iii) any barriers to increased use of telehealth services, including cost and availability of
659 technology infrastructure for health care providers and patients with limited access to
660 technology; (iv) the estimated aggregate savings or additional costs of telehealth on total health
661 care expenditures, including the impact on insurance premiums; (v) recommendations on the

662 appropriate relationship of reimbursement rates for services provided via telehealth, including
663 facility fees, compared to comparable in-person services in order to maximize health care access
664 and public health outcomes and limit health care cost growth; and (vi) recommendations on
665 additional health care services that may be delivered to a patient via telehealth while the patient
666 is located in their place of residence, which shall take into consideration which telehealth
667 modalities are most appropriate for the delivery of the health care service.

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

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

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

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

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

687 (d) For the purposes of this section “eligible hospital” shall mean a non-profit or
688 municipal acute care hospital licensed under section 51 of chapter 111 that: (i) has a statewide
689 relative price less than 0.90, as calculated by the center for health information and analysis
690 pursuant to section 10 of chapter 12C according to data from the most recent available year; (ii)
691 that has a public payer mix equal to or greater than 60 per cent, as calculated by the center for
692 health information and analysis according to data from the most recent available year; and (iii)
693 that is not owned, financially consolidated, or corporately affiliated with a provider organization,
694 as defined by section 1 of chapter 6D, that (1) owns or controls 2 or more acute care hospitals
695 licensed under section 51 of chapter 111, and (2) the total net assets of all affiliated acute care
696 hospitals within the provider organization is greater than $600,000,000, as calculated by the
697 center for health information and analysis according to data from the most recent available year.

698 (e) For the purposes of subsection (d), a hospital’s mere clinical affiliation with a
699 provider organization, absent ownership, financial consolidation or corporate affiliation, shall not
700 be construed to disqualify an eligible hospital from payments authorized under this section.

701 SECTION 31. For the purposes of section 30 of chapter 32A, section 79 of chapter 118E,
702 section 47MM of chapter 175, section 38 of chapter 176A, section 25 of chapter 176B, section
703 33 of chapter 176G and section 13 of chapter 176I of the General Laws, network adequacy may

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

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

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

725 For the purposes of this section, the term "health care providers" shall include registered
726 nurses, licensed practical nurses, advanced practice registered nurses, dentists, dental hygienists,
727 dental assistants, pharmacists, pharmacy technicians, nursing home administrators, physician
728 assistants, respiratory therapists, perfusionists, genetic counselors, community health workers,
729 emergency medical technicians, social workers, psychologists, marriage and family therapists,
730 licensed mental health counselors, rehabilitation counselors, applied behavior analysts, assistant
731 behavior analysts, licensed school psychologists, licensed alcohol and drug counselors,
732 radiologic technologists, radiologist assistants and nuclear medicine advanced associates.

733 SECTION 33A. (a) For the purposes of this section the following words shall, unless the
734 context clearly requires otherwise, have the following meanings:

735 "Health Care Workforce", personnel employed by or contracted to work at a facility that
736 have an effect upon the delivery of quality care to patients, including but not limited to registered
737 nurses, licensed practical nurses, unlicensed assistive personnel, service, maintenance, clerical,
738 professional and technical workers, and all other health care workers.

739 "Facility" shall mean a hospital licensed under section 51 of this chapter, the teaching
740 hospital of the University of Massachusetts medical school, any licensed private or state-owned
741 and state-operated general acute care hospital, an acute psychiatric hospital, an acute care
742 specialty hospital, or any acute care unit within a state operated healthcare facility. This
743 definition shall not include rehabilitation facilities or long-term care facilities.

744 (b) Notwithstanding any special or general law to the contrary, each facility shall
745 establish and develop a health care workforce care planning committee within 90 days of the
746 effective date of this act. The membership of the planning committee shall include at least one

747 registered nurse, one unlicensed assistive personnel, one service or maintenance worker, one
748 professional or technical worker, one clerical worker, and one representative for each labor
749 organization representing bargaining units at the facility. The membership of the planning
750 committee shall include no more than the same number of management representatives relative
751 to the number of appointed members of the health care workforce. The committee shall
752 participate in at least one meeting of labor management committee training.

753 (c) Each facility's health care workforce planning committee shall develop, implement,
754 monitor and regularly adjust a comprehensive care team plan that accounts for each unit or other
755 facility division in which direct patient care is provided. The care team plan shall be developed
756 to ensure that the assigned health care workforce members are sufficient to ensure a safe working
757 environment and to provide quality care to the facility's patients. Further, the care team plan
758 shall account for all anticipated variables that can influence a facility's delivery of quality patient
759 care including but not limited to the development of a comprehensive acuity-based classification
760 system. The care team plan shall include account for (i) the numbers and skill mix of needed
761 health care workforce members to be assigned to patients, (ii) anticipated patient volume, (iii) the
762 time needed to complete expected care tasks, (iv) the need for specialized equipment and
763 technology, (v) the physical environment of the facility; (vi) the necessity of ensuring a safe
764 working environment; and (vii) all quality and safety data submitted on a unit-by-unit basis for
765 each facility through PatientCareLink or any similar system.

766 (d) The department of public health, in consultation with the health policy commission,
767 shall develop rules and regulations as needed to implement this section.

768 SECTION 33B. (a) Notwithstanding any general or special law to the contrary, the
769 executive office of health and human services shall study the feasibility and cost of converting
770 multiple occupancy bedrooms into single occupancy bedrooms within long-term care facilities
771 for the purpose of compliance with infection control standards and to provide private isolation
772 space for residents to protect against the spread of contagious diseases.

773 The secretary shall file the report with the joint committee on health care financing and
774 the house and senate committees on ways and means not later than December 31, 2021. The
775 report shall include, but not be limited to: (i) an analysis of the estimated cost of converting
776 multiple occupancy bedrooms; (ii) the projected health benefits to residents; and (iii)
777 recommendations for an enhanced Medicaid payment structure to support the creation of private
778 isolation space within long-term care facilities.

779 (b) For the purposes of this section, the “long-term care facilities”, shall mean the
780 Soldiers’ Home in Massachusetts, the Soldiers’ Home in Holyoke or a convalescent home, a
781 nursing home, a skilled nursing facility, a rest home or a charitable home for the aged licensed
782 under the provisions of section 71 of chapter 111 of the General Laws.

783 SECTION 33C. On or before October 1, 2020, due to the 2019 novel coronavirus, also
784 known as COVID-19, the house of representatives commonwealth resilience and recovery
785 special committee shall hold a hearing to determine the available supplies for personal
786 protective equipment, which meet the standards of the federal Center for Disease Control that
787 were in effect on January 6, 2020, held by (i) acute care hospitals licensed under section 51 of
788 chapter 111; (ii) any facility as defined under section 1 of chapter 6D; and (iii) any other entities

789 identified by the special committee. The special committee shall also determine anticipated
790 demand for personal protective equipment.

791 SECTION 34. Any coverage offered by the group insurance commission pursuant to
792 chapter 32A of the General Laws, the division of medical assistance and its contracted health
793 insurers, health plans, health maintenance organizations, behavioral health management firms
794 and third-party administrators under contract to a Medicaid managed care organization or
795 primary care clinician plan under chapter 118E of the General Laws, any individual policy of
796 accident or sickness insurance issued under chapter 175 of the General Laws, any contract
797 between a subscriber and a corporation under an individual group or hospital service plan under
798 chapter 176A of the General Laws; any subscription certificate under an individual or group
799 medical service agreement delivered, issued or renewed within the commonwealth under chapter
800 176B of the General Laws, any individual or group health maintenance contract under chapter
801 176G of the General Laws, and any preferred provider contract between a covered person and an
802 organization under chapter 176I of the General Laws, shall provide coverage, without any
803 requirement of cost sharing by the insured, for all emergency, inpatient services and cognitive
804 rehabilitation services, including all professional, diagnostic and laboratory services, related to
805 the 2019 novel coronavirus, also known as COVID-19, at both in-network and out-of-network
806 providers.

807 (b) Coverage shall also provide for medically necessary outpatient testing, which shall
808 include testing for asymptomatic individuals under circumstances to be defined by guidelines
809 established by the secretary of health and human services, hereinafter "the secretary".

810 The secretary shall promulgate guidelines for COVID-19 testing of asymptomatic
811 individuals that work in industries with increased exposure to SARS-CoV-2, the virus that causes
812 COVID-19, which shall include but not be limited to the health care, restaurant, retail, and
813 hospitality industries. The secretary may consider the availability of tests and statewide testing
814 capacity when issuing guidelines under this section.

815 For the purposes of this subsection, the term "COVID-19 testing" shall mean polymerase
816 chain reaction and antigen tests approved to diagnose SARS-CoV-2, the virus that causes
817 COVID-19.

818 The secretary shall issue guidelines in accordance with this section within 30 days of the
819 effective date of this act.

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

822 “Carrier”, as defined in section 1 of chapter 176O of the General Laws.

823 "Emergency services", as defined in section 1 of chapter 6D of the General Laws.

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

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

831 “Inpatient services”, health care services requiring at least 1 overnight stay, provided to
832 patients on an elective, urgent or emergency basis.

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

836 “Out-of-network provider”, a provider, other than a person licensed under chapter 111C
837 of the General Laws, that does not participate in the network of an insured’s health benefit plan
838 because: (i) the provider contracts with a carrier to participate in the carrier’s network but does
839 not contract as a participating provider for the specific health benefit plan to which an insured is
840 enrolled; or (ii) the provider does not contract with a carrier to participate in any of the carrier's
841 network plans, policies, contracts or other arrangements.

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

849 (c) When an out-of-network provider does not contract with a carrier and such out-of-
850 network provider renders emergency services to an insured, a carrier shall pay such out-of-
851 network provider the greater of: (i) 115 per cent of the average rate the carrier pays for that
852 service performed by a health care provider in the same or similar specialty and provided in

853 Massachusetts, as determined by the commissioner of the division of insurance, and in
854 consultation with the center for health information and analysis; and (ii) 135 per cent of the
855 Medicare rate for that service; provided, however, that such payment shall constitute payment in
856 full to the out-of-network provider. The out-of-network provider shall not bill the insured except
857 for any applicable copayment, coinsurance or deductible that would be owed if the insured
858 received such service or services from a network provider under the terms of the insured's health
859 benefit plan.

860 (d) When an out-of-network provider renders inpatient services on an emergency basis to
861 an insured, the carrier shall pay that provider the greater of: (i) 115 per cent of the average rate
862 the carrier pays for that service performed by a health care provider in the same or similar
863 specialty and provided in Massachusetts, as determined by the commissioner of the division of
864 insurance, and in consultation with the center for health information and analysis; and (ii) 135
865 per cent of the Medicare rate for that service. Such payment shall constitute payment in full to
866 the out-of-network provider. The out-of-network provider shall not bill the insured except for
867 any inpatient cost sharing under the terms of the insured's health benefit plan.

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

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

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

876 SECTION 36. Sections 32, 33A, 34, 38 and 35 are hereby repealed.

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

878 SECTION 37A. Subsection (f) of said section 15 of said chapter 6D, as so appearing, is
879 hereby amended by inserting after the words "which providers of" the following:- health care
880 services and

881 SECTION 37B. Said subsection (f) of said section 15 of said chapter 6D, as so
882 appearing, is hereby further amended by striking out words "of these services".

883 SECTION 37C. Said Subsection (f) of said section 15 of said chapter 6D, as so
884 appearing, is hereby further amended by striking out the words "as an approved provider of these
885 free-standing ancillary services for ACO patients".

886 SECTION 37D. Said Subsection (f) of said section 15 of said chapter 6D, as so
887 appearing, is hereby further amended by striking out the words "of free-standing ancillary
888 services".

889 SECTION 37E. Said section 15 of said chapter 6D, as so appearing, is hereby amended
890 by adding the following subsection:-

891 (h) The commission shall annually review the standards published by each certified ACO
892 pursuant to subsection (f) and shall issue a report of its findings, including any recommendations.
893 At a minimum, the commission's review shall include whether the standards of each ACO
894 ensure consideration and participation by providers sufficient to ensure the goals of subsection

895 (c) and to maximize value to patients by minimizing price and health status adjusted total
896 medical expenses and maximizing quality and access. Such findings shall be used by the
897 commission in the examination and cross examination of witnesses at the annual cost trend
898 hearings pursuant to section 8. The commission shall biennially amend the minimum standards
899 established under subsection (b) in order to ensure processes by which participants and out-of-
900 ACO arrangements are approved and structured by certified ACOs, including through joint
901 venture arrangements.

902 SECTION 37F. Notwithstanding any other general or special law to the contrary, not
903 later than January 1, 2021, the health policy commission shall promulgate regulations to
904 implement the aggrieved provider review process established in subsection (f) of section 15 of
905 chapter 6D of the General Laws.

906 SECTION 38. Section 25 of Chapter 118E of the General Laws, as appearing in the 2010
907 Official Edition, is hereby amended in subsection (5) by striking the second paragraph and
908 inserting in place thereof the following paragraph:-

909 In any case where the monthly income of an applicant or recipient is in excess of the
910 exemptions allowed, the applicant or recipient, if otherwise eligible for Medicaid under this
911 chapter, shall be liable to pay to the provider of medical care or service an amount which shall be
912 equal to the excess income for a period of six consecutive months, which includes the period
913 when such service was provided; provided, however that in such cases where the individual's
914 gross income is greater than 300% of the federal Supplemental Security Income level but less
915 than the average monthly cost of nursing home care as calculated by the division and the
916 individual is participating in a Home and Community Based Waiver, under 42 USC

917 1396a(10)(a)(ii)(VI) or a PACE Program, under 42 USC 1396u-4 or 42 USC 1395eee, the
918 division shall charge a premium, equal to the difference between the individual's gross income
919 and 300% of the federal Supplemental Security Income level, on a monthly basis. The division
920 shall apply for any federal waivers necessary to implement this provision.

921 SECTION 39. Chapter 111 of the General Laws, as appearing in the 2018 Official
922 Edition, is hereby amended by adding the following section:-

923 Section 238. (a) As used in this section, the following words shall have the following
924 meanings:

925 "Cancer clinical trials", research studies that test new cancer treatments on people,
926 including but not limited to, medications, chemotherapies, stem cell therapies, and other
927 treatments.

928 "Inducement", paying a person money, including a lump sum or salary payment, to
929 participate in a cancer clinical trial.

930 "Subject", a person who participates in a cancer clinical trial.

931 "Travel and ancillary costs", any reasonable costs incurred by a person in connection
932 with their participation in a cancer clinical trial, including but not limited to travel and lodging
933 expenses.

934 (b) (i) Reimbursement of a subject's travel and ancillary costs shall not be deemed an
935 inducement or as exerting undue influence to participate in a cancer clinical trial.

936 (ii) The informed consent process should inform potential subjects if:

937 (A) Reimbursement for travel and ancillary costs is available to subjects based on
938 financial need;

939 (B) Reimbursement of travel and ancillary costs is provided to eliminate financial barriers
940 to enrollment in order to retain subjects in the clinical trial; and

941 (C) Family, friends, or chaperones that attend the cancer clinical trial treatments to
942 support the subject are eligible for reimbursement of their reasonable travel and ancillary
943 expenses.

944 (c) Governmental entities, study sponsors, public and private foundations, corporations,
945 and individuals may offer financial support to cover travel and ancillary costs through their
946 support of third party nonprofit corporations and public charities that seek to increase enrollment,
947 retention, and minority participation in cancer clinical trials.

948 (d) Reimbursement plans to cover travel and ancillary costs must be reviewed and
949 approved by the Institutional Review Board (IRB) or Independent Ethics Committee (IEC)
950 reviewing on behalf of a health care facility in conjunction with the review of the proposed
951 cancer clinical trial. The nature of the support for travel and ancillary costs and general
952 guidelines on financial eligibility must be disclosed to subjects. The reimbursement process must
953 conform to state and federal laws and guidance.

954 SECTION 40. Chapter 111 of the General Laws is hereby amended by adding the
955 following section:

956 Section 238. Notwithstanding any general or special law to the contrary, there shall be
957 established Advisory Council on pediatric autoimmune neuropsychiatric disorder associated with

958 streptococcal infections (PANDAS) and pediatric acute neuropsychiatric syndrome (PANS)
959 within the Department of Public Health. Said advisory council shall advise the Commissioner of
960 Public Health on research, diagnosis, treatment, and education relating to the disorder and
961 syndrome.

962 Said advisory council shall be comprised of the following members, who shall be
963 appointed by the Commissioner of Public Health within 60 days after the effective date of this
964 act. Advisory Council Members shall serve a term of 3 years;

965 One physician specialized in infectious diseases, licensed and practicing in the state with
966 experience treating persons with pediatric autoimmune neuropsychiatric disorder associated with
967 streptococcal infections and pediatric acute neuropsychiatric syndrome and the use of
968 intravenous immunoglobulin. One pediatrician licensed and practicing in the state who has
969 experience treating persons with pediatric autoimmune neuropsychiatric disorder associated with
970 streptococcal infection pediatric acute neuropsychiatric syndrome. One child psychiatric
971 practitioner with experience treating persons with pediatric autoimmune neuropsychiatric
972 disorder associated with streptococcal infections and pediatric acute neuropsychiatric syndrome.
973 Two health care provider/medical specialist licensed and practicing in the state who have
974 experience in treating persons with pediatric autoimmune neuropsychiatric disorder associated
975 with streptococcal infections and pediatric acute neuropsychiatric syndrome. One medical
976 researcher with experience conducting research concerning pediatric autoimmune
977 neuropsychiatric disorder associated with streptococcal infections, pediatric acute
978 neuropsychiatric syndrome, obsessive-compulsive disorder, tic disorder, and other neuro-
979 inflammatory disorders. One representative of a Massachusetts non-profit PANDAS/PANS
980 Advocacy Organization. One representative of a professional organization in the state for school

981 nurses. Two parents with a child who has been diagnosed with pediatric autoimmune
982 neuropsychiatric disorder associated with streptococcal infections or pediatric acute
983 neuropsychiatric syndrome. One social worker licensed and practicing in this state who has
984 experience working persons & families impacted by pediatric autoimmune neuropsychiatric
985 disorder associated with streptococcal infections and pediatric acute neuropsychiatric syndrome.
986 One Special Educator Administrator who has experience working persons & families impacted
987 by pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections and
988 pediatric acute neuropsychiatric syndrome. and three additional members as appointed by the
989 Commissioner.

990 The Commissioner of Public Health, or his or her designee, shall be an ex-officio,
991 nonvoting member. Any member of the advisory council appointed under this Section may be a
992 member of the General Court. Members shall receive no compensation for their services.

993 The Commissioner of Public Health shall schedule the first meeting of the advisory
994 council, which shall be held not later than 90 days after the effective date of this act. A majority
995 of the council members shall constitute a quorum. A majority vote of a quorum shall be required
996 for any official action of the advisory council. The advisory council shall meet upon the call of
997 the chairperson or upon the request of a majority of council members.

998 The advisory council shall issue a report to the General Court annually with
999 recommendations concerning: practice guidelines for the diagnosis and treatment of the disorder
1000 and syndrome; development of screening protocol; mechanisms to increase clinical awareness
1001 and education regarding the disorder and syndrome among physicians, including pediatricians,
1002 school-based health centers, and providers of mental health services; outreach to educators and

1003 parents to increase awareness of the disorder and syndrome; and development of a network of
1004 volunteer experts on the diagnosis and treatment of the disorder and syndrome.

1005 The advisory council may request from all state agencies such information and assistance
1006 as the council may require.

1007 The advisory council may accept and solicit funds, including any gifts, donations, grants
1008 or bequests or any federal funds, for any of the purposes of this section. Such funds shall be
1009 deposited in a separate account with the state treasurer, be received by said treasurer on behalf of
1010 the commonwealth, and be expended by the advisory council in accordance with council bylaws
1011 and state and federal law.

1012 SECTION 41. Notwithstanding any general or special law to the contrary, the department
1013 of public health shall publish daily on its website the data it receives from health care facilities
1014 pursuant to the federal COVID-19 guidance for hospitals. The report shall include data in the
1015 aggregate and broken down by health care facility.

1016 SECTION 42. (a) Notwithstanding section 51G of chapter 111 or any general or special
1017 law or regulation to the contrary, no acute care hospital, as defined by section 25B of said
1018 chapter 111, shall close or discontinue any essential health service, as defined in 105 CMR
1019 130.020, for the remainder of the governor's March 10, 2020 declaration of a state of emergency
1020 or any subsequent declaration of a state of emergency in response the outbreak of the 2019 novel
1021 coronavirus, also known as COVID-19.

1022 (b) This section shall not apply to the temporary discontinuation or closure of an essential
1023 health service by an acute care hospital when such discontinuation or closure is consistent with
1024 any rule, requirement, or procedure authorized under the governor's declaration.

1025 SECTION 43. Notwithstanding any law or rule to the contrary, for fiscal year 2021 and
1026 beyond, in establishing Medicaid reimbursement rates for Medicaid Eligible inpatient services
1027 provided by chronic disease rehabilitation hospitals located in the commonwealth that serve
1028 solely children and adolescents, the department of health and human services shall apply a
1029 multiplier of 1.5 times the hospital's FY 20 current inpatient per diem rate in fiscal year 2021.
1030 For fiscal year 2022 and beyond, such rates of reimbursement shall not be lower than the rates in
1031 effect for the prior fiscal year.

1032 SECTION 44. Section 1. Chapter 111 of the General Laws is hereby amended by adding
1033 the following section:-

1034 Section 238. (a) For the purposes of this section the following words shall, unless the
1035 context clearly requires otherwise, have the following meanings:-

1036 "Rare disease", any disease that affects fewer than 200,000 people in the United States,
1037 has status as an orphan disease for research purposes or is known to be substantially under-
1038 diagnosed and unrecognized as a result of lack of adequate diagnostic and research information.

1039 "Rare disease care", the academic research of a rare disease or the medical treatment of
1040 individuals diagnosed with a rare disease.

1041 (b) There is hereby established the rare disease advisory council consisting of the
1042 following 29 members: the commissioner, or a designee who shall serve as chair; the executive
1043 director, or a designee, of the Massachusetts health policy commission; 2 members of the state
1044 senate, or their designee, 1 of whom shall be appointed by the senate president and 1 appointed
1045 by the minority leader; 2 members of the house of representatives, or their designee, 1 of whom
1046 shall be appointed by the speaker of the house and 1 appointed by the minority leader; 4 persons

1047 appointed by the senate president, 1 of whom shall be a pharmacist with experience with drugs
1048 used to treat rare diseases, 1 of whom shall be a geneticist licensed and practicing in the state and
1049 1 of whom shall be a registered nurse or advanced practice registered nurse licensed and
1050 practicing in the commonwealth with experience treating rare diseases; 4 persons appointed by
1051 the speaker of the house, 1 of whom shall be a representative of a health plan or accountable care
1052 organization certified by the health policy commission and 1 of whom shall be a genetic
1053 counselor with experience providing services to persons diagnosed with a rare disease and 1 of
1054 whom shall be a representative from a rehabilitation facility that provides rare disease care; and
1055 15 persons to be appointed by the governor, 2 of whom shall be from academic research
1056 institutions that receive grant funding for rare diseases research; 2 of whom shall be physicians
1057 licensed and practicing in the state with experience researching, diagnosing or treating rare
1058 diseases; 2 of whom shall be hospital administrators, or their designee, from hospitals in the
1059 commonwealth that provide care to persons diagnosed with a rare disease, 1 of whom shall
1060 represent a hospital in which the scope of service focuses on rare diseases of pediatric patients; 3
1061 of whom shall be representatives of rare disease patient organizations that operate in the
1062 commonwealth; 2 of whom shall be a representative of the biotechnology and scientific
1063 community who is engaged in rare disease research, including, but not limited to, a medical
1064 researcher with experience conducting research on rare diseases; 1 of whom shall be a dietician
1065 licensed and practicing in the state with experience administering dietary therapies to those with
1066 rare diseases; 2 of whom shall be persons age 18 or older who have a rare disease; and 1 of
1067 whom shall be a caregiver of a person with a rare disease.

1068 (c) Each member of the rare disease advisory council shall serve for a term of 3 years and
1069 shall serve until their successors have been appointed. The advisory council shall meet

1070 periodically no fewer than 4 times annually, with members able to participate in any meeting by
1071 teleconference. The members of the advisory council shall serve without compensation. The
1072 commissioner shall provide the advisory council with suitable accommodations for its meetings
1073 and the department shall further provide administrative support to assist the advisory council.

1074 (d) The rare disease advisory council shall advise the governor, the general court and the
1075 department on the incidence of rare disease within the commonwealth and the status of the rare
1076 disease community. To achieve its purpose, the advisory council shall:

1077 (i) coordinate the performance of the rare disease advisory council's duties with those of
1078 other rare disease advisory bodies, community-based organizations and other public and private
1079 organizations within the state for the purpose of ensuring greater cooperation regarding the
1080 research, diagnosis and treatment of rare diseases. The coordination shall require, when
1081 appropriate: (1) disseminating the outcomes of the advisory council's research, identified best
1082 practices and policy recommendations; and (2) utilizing common research collection and
1083 dissemination procedures;

1084 (ii) using existing publicly available records and information, undertake a statistical and
1085 qualitative examination of the prevalence and causes of rare disease to develop a profile of the
1086 social and economic burden of rare disease in the commonwealth;

1087 (iii) receive and consider reports and testimony from expert individuals, the department,
1088 community-based organizations, voluntary health organizations, healthcare providers and other
1089 public and private organizations recognized as having expertise in rare disease care, to learn
1090 about their contributions to rare disease care and possibilities for the improvement of rare disease
1091 care in the commonwealth;

1092 (iv) develop methods to publicize the profile of the social and economic burden of rare
1093 disease in the commonwealth to ensure that the public and healthcare providers are sufficiently
1094 informed of the most effective strategies for recognizing and treating rare disease;

1095 (v) determine the human impact and economic implications of early treatment of rare
1096 diseases versus delayed or inappropriate treatment of rare disease as it pertains to the quality of
1097 care, the quality of patients' and their families' lives, and the economic burdens; including
1098 insurance reimbursements, rehabilitation, hospitalization and related services on patients,
1099 families and the commonwealth;

1100 (vi) evaluate the current system of rare disease treatment and available public resources
1101 to develop recommendations to increase rare disease survival rates, improve quality of life and
1102 prevent and control risks of co-morbidities for rare disease, based on available scientific
1103 evidence;

1104 (vii) research and determine the most appropriate method for the commonwealth to
1105 collect rare disease data, including a database of all rare diseases identified in the commonwealth
1106 along with known best practices for care of said diseases and such additional information
1107 concerning these cases as the advisory committee deems necessary and appropriate to conduct
1108 thorough and complete epidemiological surveys of rare diseases, subject to all applicable privacy
1109 laws and protections;

1110 (viii) examine the feasibility of developing a rare disease information and patient support
1111 network in the commonwealth to aid in determining any genetic or environmental contributors to
1112 rare diseases; and

1113 (ix) develop and maintain a comprehensive rare disease plan for the commonwealth,
1114 utilizing any information and materials received or developed by the advisory council pursuant
1115 to this subsection, and which shall include information specifically directed toward the general
1116 public, state and local officials, state agencies, private organizations and associations, and
1117 businesses and industries.

1118 (e) The advisory council may apply for, and accept, any grants of money from the federal
1119 government, private foundations, or any other source which may be available for programs
1120 related to rare diseases or to advance the mission of the advisory council.

1121 (f) On or before December 31st of each calendar year, the advisory council shall file a
1122 report with the clerks of the house of representatives and the senate and the executive office for
1123 administration and finance, which shall include, but is not limited to: (i) a summary of the
1124 current state of comprehensive rare disease plan for the commonwealth; (ii) those actions taken
1125 and progress made toward achieving implementation of the comprehensive rare disease plan; (iii)
1126 an accounting of all funds received by the council, and the source of those funds; (iv) an
1127 accounting of all funds expended by the council; and (v) to the extent practicable, an estimate of
1128 any cost savings on the part of individuals and the commonwealth that will occur upon full
1129 implementation of the comprehensive rare disease plan and accompanying programs.

1130 Section 2. Prior to appointing the members of the rare disease advisory council
1131 established in this act, the governor or the secretary of the executive office of health and human
1132 services shall research and report to the general court, within 30 days of the effective date of this
1133 act, existing sources of funding that may be used to finance the formation and operation of the
1134 advisory council.

1135 Section 3. On or before 180 days following the effective date of this act, the rare disease
1136 advisory council shall provide a preliminary report to the governor, the department of public
1137 health and to the general court, by filing the same with the clerks of the house of representatives
1138 and the senate. The preliminary report shall include, but is not limited to, an estimate the
1139 financial, informational and other resources needed to achieve the goals and duties of the
1140 advisory council.

1141 SECTION 45. Notwithstanding any general or special law to the contrary, the Executive
1142 Office of Health and Human Services shall organize and establish an online Personal Protective
1143 Equipment Exchange for the purpose of identifying, aggregating and making available for
1144 purchase and procurement necessary personal protective equipment to be utilized by health care
1145 and elder care providers including, but not limited to, nursing facilities, acute care hospitals,
1146 resident care facilities, assisted living residences, adult day programs, physician practices,
1147 community health centers, ambulatory surgery centers, home health agencies and home care
1148 agencies within the Commonwealth. The Executive Office of Health and Human Services shall:

1149 (A) identify and offer qualified wholesalers, manufacturers and suppliers the opportunity
1150 to participate on the Exchange;

1151 (B) ensure that the personal protective equipment offered on the Exchange complies with
1152 all federal and state requirements and specifications; and

1153 (C) establish and implement a process to receive, negotiate and finalize competitive
1154 pricing to be offered for the personal protective equipment placed on the Exchange.

1155 All sales of the personal protective equipment from the Exchange shall be private
1156 transactions completed by and between the parties and the Executive Office of Health and

1157 Human Services shall have no responsibility to arrange for the processing of such transactions or
1158 the delivery of the personal protective equipment. In developing the Exchange. The Executive
1159 Office of Health and Human Services shall establish a stakeholder group which shall be
1160 comprised of representatives from the Massachusetts Senior Care Association, Massachusetts
1161 Health and Hospital Association, Massachusetts Medical Society, SEIU 1199, manufacturers and
1162 suppliers and others the Executive Office of Health and Human Services deem necessary to
1163 organize and establish the Exchange. The Exchange shall be established within 30 days of
1164 enactment of this law.

1165 SECTION 46. (a) Notwithstanding any general of special law to the contrary, the health
1166 policy commission shall, from time to time, issue recommendations for additional health care
1167 services to be delivered to a patient while the patient is located in their place of residence.

1168 (b) The division of insurance and the division of medical assistance shall issue bulletins
1169 or promulgate regulations incorporating the recommendations of the health policy commission
1170 on additional health care services that to be provided via telehealth, and such recommendations
1171 shall be incorporated not later than 6 months after the health policy commission issues said
1172 recommendations."; by striking out the title and inserting in place thereof the following title: "An
1173 Act to promote resilience in our health care system".