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

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

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

SECTION 3. Said subsection (e) of said section 8 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word “commission”, in line 59, the first time it appears, the following words:—; and (iii) in the case of the assistant secretary for MassHealth, testimony concerning the structure, benefits, caseload and financing related programs administered by the office or entered into in partnership with other state and federal agencies and the agency’s activities to align or redesign those programs in order to encourage the development of more integrated and efficient health care delivery systems.
SECTION 4. Chapter 32A of the General Laws is hereby amended by adding the following section:-

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

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

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

“Eligible health care services”, primary care services, behavioral health services and chronic disease management when delivered via telehealth to a patient while the patient is located in their place of residence. Eligible health care services shall also include: (i) all health care services delivered through provider-to-provider consultation via telehealth; (ii) all health care services delivered to a patient via telehealth when the patient is located in a health care facility licensed or certified by the department of public health or the department of mental health or otherwise in the physical presence of a health care professional licensed pursuant to chapter 112; and (iii) any additional health care services to be delivered to a patient via telehealth, while located in their place of residence, that are approved by bulletins or regulations issued or promulgated by the division of insurance and division of medical assistance based on recommendations from the health policy commission.
“Primary care services”, services delivered by a primary care provider as defined in section 1 of chapter 111.

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

(b) Coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission shall provide coverage for eligible health care services via telehealth by a contracted health care provider if: (i) the health care services are covered by way of in-person consultation or delivery, and (ii) the health care services may be appropriately provided through the use of telehealth; provided, however, that the commission, or its carriers or other contracted entities providing health benefits, shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request.
(c) Coverage for telehealth services may include utilization review, including
preauthorization, to determine the appropriateness of telehealth as a means of delivering a health
care service; provided, however, that the determination shall be made in the same manner as if
the service was delivered in-person. A carrier shall not be required to reimburse a health care
provider for a health care service that is not a covered benefit under the plan or reimburse a
health care provider not contracted under the plan except as provided for under subclause (i) of
clause (4) of subsection (a) of section 6 of chapter 176O.

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

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

(f) Coverage that reimburses a provider with a global payment, as defined in section 1 of
chapter 6D, shall account for the provision of telehealth services to set the global payment
amount.
(g) The commission shall ensure that the rate of payment for in-network providers of behavioral health services delivered via interactive audio-video technology and audio-only telephone shall be no less than the rate of payment for the same behavioral health service delivered via in-person methods.

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

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

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

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

SECTION 7. The definition of “Practitioner” in said section 1 of said chapter 94C, as so appearing, is hereby amended by adding the following 2 clauses:-
(d) A nurse practitioner registered pursuant to subsection (f) of section 7 and authorized pursuant to section 80E of chapter 112 to issue written prescriptions and medication orders and order tests and therapeutics in the course of professional practice or research in the commonwealth.

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

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

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

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

SECTION 11. Subsection (g) of said section 7 of said chapter 94C, as so appearing, is hereby amended by striking out the second paragraph.
SECTION 12. Section 9 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “podiatrist”, in line 1, the following words: -, nurse practitioner, psychiatric nurse mental health clinical specialist.

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

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

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

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

Section 5O. (a) For the purposes of this section, “telehealth” shall mean the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including, but not limited to, interactive audio-video technology, remote patient monitoring devices, audio-only telephone, and online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring of a patient's physical, oral or mental health; provided, however, that “telehealth” shall not include text messaging or text-only email; and provided, further, that prescribing via telehealth shall be limited to the
treatment of a condition previously diagnosed during an in-person visit by the telehealth
provider, and to the issuance of a one-time prescription to treat the sudden onset of an illness or
injury or acute mental health or behavioral health episode, manifesting itself by acute symptoms,
and as many refills of that prescription as a provider may issue within their discretion.

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 21. Section 14A of said chapter 118E, as so appearing, is hereby amended by adding the following paragraph:-
In the event that a nursing facility resident who is a MassHealth recipient enters a hospital for treatment related to the 2019 novel coronavirus, also known as COVID-19, the division shall pay to preserve their bed in the nursing facility for a period of up to and including 20 days per medical event. The division shall reimburse the nursing facility for the medical leave of absence, which shall include an observation stay in a hospital in excess of 24 hours.

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

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

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

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

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

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

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

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

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

(d) A health care provider shall not be required to document a barrier to an in-person
visit, nor shall the type of setting where telehealth services are provided be limited for health
care services provided via telehealth, except as provided in the definition of the term “eligible
health care services” in subsection (a); provided, however, that a patient may decline receiving
services via telehealth in order to receive in-person services.
(e) Coverage may include a deductible, copayment or coinsurance requirement for a health care service provided via telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. The rate of payment for telehealth services provided via interactive audio-video technology and audio-only telephone may be greater than the rate of payment for the same service delivered by other telehealth modalities.

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

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

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

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

SECTION 24. Said chapter 175 is hereby further amended by inserting after section 47II the following section:-
Section 47MM. (a) For the purposes of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

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

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

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

“Primary care services”, services delivered by a primary care provider as defined in section 1 of chapter 111.
“Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including but not limited to: (i) interactive audio-video technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring of a patient's physical, oral or mental health; provided, however, that telehealth shall not include text messaging or text-only email; and provided further, that prescribing via telehealth shall be limited to the treatment of a condition previously diagnosed during an in-person visit by the telehealth provider, and to the issuance of a one-time prescription to treat the sudden onset of an illness or injury or acute mental health or behavioral health episode, manifesting itself by acute symptoms, and as many refills of that prescription as a provider may issue within their discretion.

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

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

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

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

(f) Coverage that reimburses a provider with a global payment, as defined in section 1 of
chapter 6D, shall account for the provision of telehealth services to set the global payment
amount.
(g) Insurance companies organized under this chapter shall ensure that the rate of payment for in-network providers of behavioral health services delivered via interactive audio-video technology and audio-only telephone shall be no less than the rate of payment for the same behavioral health service delivered via in-person methods.

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

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

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

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

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

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

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

“Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or
other telecommunications technology, including but not limited to: (i) interactive audio-video
technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online
adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating
or monitoring of a patient's physical, oral or mental health; provided, however, that telehealth
shall not include text messaging or text-only email, and provided further, that prescribing via
telehealth shall be limited to the treatment of a condition previously diagnosed during an in-
person visit by the telehealth provider, and to the issuance of a one-time prescription to treat the
sudden onset of an illness or injury or acute mental health or behavioral health episode,
manifesting itself by acute symptoms, and as many refills of that prescription as a provider may
issue within their discretion.
(b) A contract between a subscriber and a nonprofit hospital service corporation under an individual or group hospital service plan shall provide coverage for eligible health care services via telehealth by a contracted health care provider if: (i) the health care services are covered by way of in-person consultation or delivery, and (ii) the health care services may be appropriately provided through the use of telehealth; provided, however, that an insurer shall not meet network adequacy through significant reliance on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request.

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

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

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

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

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

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

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

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

“Behavioral health services”, care and services for the evaluation, diagnosis, treatment or management of patients with mental health, developmental or substance use disorders.
'Chronic disease management”, care and services for the management of chronic conditions, as defined by the federal Centers for Medicare and Medicaid Services, that include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke and coronary artery disease.

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

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

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

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

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

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

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

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

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

(h) Health care services provided via telehealth shall conform to the standards of care
applicable to the telehealth provider’s profession and specialty. Such services shall also conform
to applicable federal and state health information privacy and security standards as well as
standards for informed consent.
SECTION 27. Chapter 176G of the General Laws is hereby amended by adding the following section:-

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

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

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

“Eligible health care services”, primary care services, behavioral health services, and chronic disease management when delivered via telehealth to a patient while the patient is located in their place of residence. Eligible health care services shall also include: (i) all health care services delivered through provider-to-provider consultation via telehealth; (ii) all health care services delivered to a patient via telehealth when the patient is located in a health care facility licensed or certified by the department of public health or department of mental health or otherwise in the physical presence of a health care professional licensed under chapter 112; and (iii) any additional health care services to be delivered to a patient via telehealth, while located in their place of residence, that are approved by bulletins or regulations issued or promulgated by the division of insurance and division of medical assistance based on recommendations from the health policy commission.
“Primary care services”, services delivered by primary care providers as defined in section 1 of chapter 111.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Coverage may include a deductible, copayment or coinsurance requirement for a
health care service provided via telehealth as long as the deductible, copayment or coinsurance
does not exceed the deductible, copayment or coinsurance applicable to an in-person
consultation or in-person delivery of services. The rate of payment for telehealth services
provided via interactive audio-video technology may be greater than the rate of payment for the
same service delivered by other telehealth modalities.
(f) Coverage that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall account for the provision of telehealth services to set the global payment amount.

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

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

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

The report shall include, but not be limited to: (i) an analysis of the use of telehealth services by patient demographics, geographic region and type of service; (ii) total health care expenditures on telehealth services by type of service and type of telecommunication technology used; (iii) any barriers to increased use of telehealth services, including cost and availability of technology infrastructure for health care providers and patients with limited access to technology; (iv) the estimated aggregate savings or additional costs of telehealth on total health care expenditures, including the impact on insurance premiums; (v) recommendations on the
appropriate relationship of reimbursement rates for services provided via telehealth, including facility fees, compared to comparable in-person services in order to maximize health care access and public health outcomes and limit health care cost growth; and (vi) recommendations on additional health care services that may be delivered to a patient via telehealth while the patient is located in their place of residence, which shall take into consideration which telehealth modalities are most appropriate for the delivery of the health care service.

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

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

(b) The secretary may require as a condition of receiving payment any such reasonable condition of payment that the secretary determines necessary to ensure the availability, to the extent possible, of federal financial participation for the payments, and the secretary may incur
expenses and the comptroller may certify amounts for payment in anticipation of expected
receipt of federal financial participation for the payments.

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

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

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

SECTION 31. For the purposes of section 30 of chapter 32A, section 79 of chapter 118E,
section 47MM of chapter 175, section 38 of chapter 176A, section 25 of chapter 176B, section
33 of chapter 176G and section 13 of chapter 176I of the General Laws, network adequacy may
be met through significant reliance on telehealth providers until the termination of the governor’s
March 10, 2020 declaration of a state of emergency.

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

SECTION 33. Notwithstanding any general or special law to the contrary, all temporary
licenses issued to physicians by the board of registration in medicine pursuant to the governor’s
March 17, 2020 Order Expanding Access to Physician Services, and to other health care
providers from their respective boards of registration pursuant to the commissioner of public
health’s April 3, 2020 Order Rescinding and Replacing the March 29, 2020 Order of the
Commissioner of Public Health Maximizing Health Care Provider Availability, shall expire on
December 31, 2021.
For the purposes of this section, the term “health care providers” shall include registered
nurses, licensed practical nurses, advanced practice registered nurses, dentists, dental hygienists,
dental assistants, pharmacists, pharmacy technicians, nursing home administrators, physician
assistants, respiratory therapists, perfusionists, genetic counselors, community health workers,
emergency medical technicians, social workers, psychologists, marriage and family therapists,
licensed mental health counselors, rehabilitation counselors, applied behavior analysts, assistant
behavior analysts, licensed school psychologists, licensed alcohol and drug counselors,
radiologic technologists, radiologist assistants and nuclear medicine advanced associates.

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

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

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

(b) Notwithstanding any special or general law to the contrary, each facility shall
establish and develop a health care workforce care planning committee within 90 days of the
effective date of this act. The membership of the planning committee shall include at least one
registered nurse, one unlicensed assistive personnel, one service or maintenance worker, one
professional or technical worker, one clerical worker, and one representative for each labor
organization representing bargaining units at the facility. The membership of the planning
committee shall include no more than the same number of management representatives relative
to the number of appointed members of the health care workforce. The committee shall
participate in at least one meeting of labor management committee training.

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

(d) The department of public health, in consultation with the health policy commission,
shall develop rules and regulations as needed to implement this section.
SECTION 33B. (a) Notwithstanding any general or special law to the contrary, the executive office of health and human services shall study the feasibility and cost of converting multiple occupancy bedrooms into single occupancy bedrooms within long-term care facilities for the purpose of compliance with infection control standards and to provide private isolation space for residents to protect against the spread of contagious diseases.

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

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

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

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

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

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

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

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

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

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

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

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

“In-network cost-sharing amount”, the cost-sharing amount that the insured is required to pay for a covered health care service received from a network provider. Cost sharing includes any copayment, coinsurance or deductible, or any other form of cost sharing paid by the insured other than premium or share of premium.
“Inpatient services”, health care services requiring at least 1 overnight stay, provided to patients on an elective, urgent or emergency basis.

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

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

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

(c) When an out-of-network provider does not contract with a carrier and such out-of-network provider renders emergency services to an insured, a carrier shall pay such out-of-network provider the greater of: (i) 115 per cent of the average rate the carrier pays for that service performed by a health care provider in the same or similar specialty and provided in
Massachusetts, as determined by the commissioner of the division of insurance, and in consultation with the center for health information and analysis; and (ii) 135 per cent of the Medicare rate for that service; provided, however, that such payment shall constitute payment in full to the out-of-network provider. The out-of-network provider shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured received such service or services from a network provider under the terms of the insured’s health benefit plan.

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

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

(f) If a carrier delegates payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, the delegated entity shall comply with this section.
(g) Nothing in this section shall require a carrier to pay for health care services delivered
to an insured that are not covered benefits under the terms of the insured’s health benefit plan.

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

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

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

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

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

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

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

(h) The commission shall annually review the standards published by each certified ACO
pursuant to subsection (f) and shall issue a report of its findings, including any recommendations.
At a minimum, the commission’s review shall include whether the standards of each ACO
ensure consideration and participation by providers sufficient to ensure the goals of subsection
(c) and to maximize value to patients by minimizing price and health status adjusted total medical expenses and maximizing quality and access. Such findings shall be used by the commission in the examination and cross examination of witnesses at the annual cost trend hearings pursuant to section 8. The commission shall biennially amend the minimum standards established under subsection (b) in order to ensure processes by which participants and out-of-ACO arrangements are approved and structured by certified ACOs, including through joint venture arrangements.

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

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

In any case where the monthly income of an applicant or recipient is in excess of the exemptions allowed, the applicant or recipient, if otherwise eligible for Medicaid under this chapter, shall be liable to pay to the provider of medical care or service an amount which shall be equal to the excess income for a period of six consecutive months, which includes the period when such service was provided; provided, however that in such cases where the individual’s gross income is greater than 300% of the federal Supplemental Security Income level but less than the average monthly cost of nursing home care as calculated by the division and the individual is participating in a Home and Community Based Waiver, under 42 USC
1396a(10)(a)(ii)(VI) or a PACE Program, under 42 USC 1396u-4 or 42 USC 1395eee, the division shall charge a premium, equal to the difference between the individual’s gross income and 300% of the federal Supplemental Security Income level, on a monthly basis. The division shall apply for any federal waivers necessary to implement this provision.

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

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

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

“Inducement”, paying a person money, including a lump sum or salary payment, to participate in a cancer clinical trial.

“Subject”, a person who participates in a cancer clinical trial.

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

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

(ii) The informed consent process should inform potential subjects if:
(A) Reimbursement for travel and ancillary costs is available to subjects based on financial need;

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

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

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

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

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

Section 238. Notwithstanding any general or special law to the contrary, there shall be established Advisory Council on pediatric autoimmune neuropsychiatric disorder associated with
streptococcal infections (PANDAS) and pediatric acute neuropsychiatric syndrome (PANS) within the Department of Public Health. Said advisory council shall advise the Commissioner of Public Health on research, diagnosis, treatment, and education relating to the disorder and syndrome.

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

One physician specialized in infectious diseases, licensed and practicing in the state with experience treating persons with pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections and pediatric acute neuropsychiatric syndrome and the use of intravenous immunoglobulin. One pediatrician licensed and practicing in the state who has experience treating persons with pediatric autoimmune neuropsychiatric disorder associated with streptococcal infection pediatric acute neuropsychiatric syndrome. One child psychiatric practitioner with experience treating persons with pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections and pediatric acute neuropsychiatric syndrome. Two health care provider/medical specialist licensed and practicing in the state who have experience in treating persons with pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections and pediatric acute neuropsychiatric syndrome. One medical researcher with experience conducting research concerning pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections, pediatric acute neuropsychiatric syndrome, obsessive-compulsive disorder, tic disorder, and other neuro-inflammatory disorders. One representative of a Massachusetts non-profit PANDAS/PANS Advocacy Organization. One representative of a professional organization in the state for school
nurses. Two parents with a child who has been diagnosed with pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections or pediatric acute neuropsychiatric syndrome. One social worker licensed and practicing in this state who has experience working persons & families impacted by pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections and pediatric acute neuropsychiatric syndrome. One Special Educator Administrator who has experience working persons & families impacted by pediatric autoimmune neuropsychiatric disorder associated with streptococcal infections and pediatric acute neuropsychiatric syndrome. and three additional members as appointed by the Commissioner.

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

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

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

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

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

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

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

(b) This section shall not apply to the temporary discontinuation or closure of an essential health service by an acute care hospital when such discontinuation or closure is consistent with any rule, requirement, or procedure authorized under the governor’s declaration.
SECTION 43. Notwithstanding any law or rule to the contrary, for fiscal year 2021 and beyond, in establishing Medicaid reimbursement rates for Medicaid Eligible inpatient services provided by chronic disease rehabilitation hospitals located in the commonwealth that serve solely children and adolescents, the department of health and human services shall apply a multiplier of 1.5 times the hospital’s FY 20 current inpatient per diem rate in fiscal year 2021. For fiscal year 2022 and beyond, such rates of reimbursement shall not be lower than the rates in effect for the prior fiscal year.

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

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

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

“Rare disease care”, the academic research of a rare disease or the medical treatment of individuals diagnosed with a rare disease.

(b) There is hereby established the rare disease advisory council consisting of the following 29 members: the commissioner, or a designee who shall serve as chair; the executive director, or a designee, of the Massachusetts health policy commission; 2 members of the state senate, or their designee, 1 of whom shall be appointed by the senate president and 1 appointed by the minority leader; 2 members of the house of representatives, or their designee, 1 of whom shall be appointed by the speaker of the house and 1 appointed by the minority leader; 4 persons
appointed by the senate president, 1 of whom shall be a pharmacist with experience with drugs used to treat rare diseases, 1 of whom shall be a geneticist licensed and practicing in the state and 1 of whom shall be a registered nurse or advanced practice registered nurse licensed and practicing in the commonwealth with experience treating rare diseases; 4 persons appointed by the speaker of the house, 1 of whom shall be a representative of a health plan or accountable care organization certified by the health policy commission and 1 of whom shall be a genetic counselor with experience providing services to persons diagnosed with a rare disease and 1 of whom shall be a representative from a rehabilitation facility that provides rare disease care; and 15 persons to be appointed by the governor, 2 of whom shall be from academic research institutions that receive grant funding for rare diseases research; 2 of whom shall be physicians licensed and practicing in the state with experience researching, diagnosing or treating rare diseases; 2 of whom shall be hospital administrators, or their designee, from hospitals in the commonwealth that provide care to persons diagnosed with a rare disease, 1 of whom shall represent a hospital in which the scope of service focuses on rare diseases of pediatric patients; 3 of whom shall be representatives of rare disease patient organizations that operate in the commonwealth; 2 of whom shall be a representative of the biotechnology and scientific community who is engaged in rare disease research, including, but not limited to, a medical researcher with experience conducting research on rare diseases; 1 of whom shall be a dietician licensed and practicing in the state with experience administering dietary therapies to those with rare diseases; 2 of whom shall be persons age 18 or older who have a rare disease; and 1 of whom shall be a caregiver of a person with a rare disease.

(c) Each member of the rare disease advisory council shall serve for a term of 3 years and shall serve until their successors have been appointed. The advisory council shall meet
periodically no fewer than 4 times annually, with members able to participate in any meeting by
teleconference. The members of the advisory council shall serve without compensation. The
commissioner shall provide the advisory council with suitable accommodations for its meetings
and the department shall further provide administrative support to assist the advisory council.

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

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

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

(iii) receive and consider reports and testimony from expert individuals, the department,
community-based organizations, voluntary health organizations, healthcare providers and other
public and private organizations recognized as having expertise in rare disease care, to learn
about their contributions to rare disease care and possibilities for the improvement of rare disease
care in the commonwealth;
(iv) develop methods to publicize the profile of the social and economic burden of rare disease in the commonwealth to ensure that the public and healthcare providers are sufficiently informed of the most effective strategies for recognizing and treating rare disease;

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

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

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

(viii) examine the feasibility of developing a rare disease information and patient support network in the commonwealth to aid in determining any genetic or environmental contributors to rare diseases; and
(ix) develop and maintain a comprehensive rare disease plan for the commonwealth, utilizing any information and materials received or developed by the advisory council pursuant to this subsection, and which shall include information specifically directed toward the general public, state and local officials, state agencies, private organizations and associations, and businesses and industries.

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

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

Section 2. Prior to appointing the members of the rare disease advisory council established in this act, the governor or the secretary of the executive office of health and human services shall research and report to the general court, within 30 days of the effective date of this act, existing sources of funding that may be used to finance the formation and operation of the advisory council.
Section 3. On or before 180 days following the effective date of this act, the rare disease advisory council shall provide a preliminary report to the governor, the department of public health and to the general court, by filing the same with the clerks of the house of representatives and the senate. The preliminary report shall include, but is not limited to, an estimate the financial, informational and other resources needed to achieve the goals and duties of the advisory council.

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

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

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

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

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

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

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

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