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SENATE . . . . . No. 2796

Senate, June 25, 2020 -- Text of the Senate Bill Putting Patients First (being the text of Senate, No. 2769, printed as amended)

The Commonwealth of Massachusetts

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

An Act Putting Patients First.

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

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

Section 16A. (a) The commission shall, upon consideration of advice or any other pertinent evidence, recommend the noncontracted commercial rate for emergency services and the noncontracted commercial rate for nonemergency services, as defined in section 1 of chapter 176O. The noncontracted commercial rate for emergency services and the noncontracted commercial rate for nonemergency services shall be in effect for a term of 5 years and shall apply to payments under clauses (ii) and (iv) of paragraph (1) of subsection (a) of section 29 of said chapter 176O.

(b) In recommending rates, the commission shall consider:

(i) existing contracted rates by public and private payers and the appropriateness of those rates for covering the cost of care;

(ii) the impact of each rate on: (A) patient access to health care services by geographic location; (B) the growth of total health care expenditures; (C) encouraging in-network participation by health care providers; (D) financial stability of health care providers and systems; (E) insurance premiums; and (F) provider price variation;

(iii) utilization of the rates by self-insured health plans;

(iv) ease of transparency in calculating the rates and ease of administration by health care providers and carriers;

(v) the advisability of establishing a process for providers or payers to dispute the accuracy or appropriateness of a rate;

(vi) best practices in other states; and

(vii) any other factor that the commission deems relevant.

In developing its recommendations, the commission shall determine that the recommended rates do not have a negative impact on the delivery of care by health care providers predominately serving communities that experience health disparities as a result of race, ethnicity, socioeconomic status or other status as determined by the commission. The commission shall not issue its recommendations for the noncontracted commercial rate for emergency services and the noncontracted commercial rate for nonemergency services without the approval of the board established under subsection (b) of section 2.

(c) Prior to recommending the rates, the commission shall hold a public hearing. The hearing shall examine current rates paid for in-network and out-of-network services and the impact of those rates on the operation of the health care delivery system and determine, based on

the provided testimony, information and data, an appropriate noncontracted commercial rate for emergency services and an appropriate noncontracted commercial rate for nonemergency services consistent with subsection (b). The commission shall provide notice to the public and division of insurance of the hearing not less than 45 days before the date of the hearing and the division may participate in the hearing. The commission shall identify as witnesses for the public hearing a representative sample of providers, provider organizations, payers and other interested parties as the commission may determine. Any interested party may testify at the hearing.

(d) If the board approves the recommended rates pursuant to subsection (b), the commission shall submit the recommended rates to the division of insurance. Not later than 45 days after the recommended rates have been submitted, the division may hold a public hearing on the recommended rates. The division shall provide public notice of the hearing not less than 7 days before the date of the hearing. The division shall identify as witnesses for the public hearing a representative sample of providers, provider organizations, payers and other interested parties as the division may determine. Any interested party may testify at the hearing. Not later than 7 days after the division's public hearing, the division shall accept and implement the commission's recommended rates or the division may reject the commission's recommended rates; provided, however, that if the division rejects the commission's recommended rates, the division shall, within 20 days of the division's rejection, report in writing to the commission, the clerks of the senate and house of representatives and the joint committee on health care financing the reasons for the division's rejection. Within 30 days of receipt of the division's rejection of the commission's recommended rates, the commission shall recommend amended rates based on the division's written rejection. If the division takes no action to accept or reject the commission's recommended rates, the recommended rates shall automatically take effect as the

noncontracted commercial rate for emergency services and noncontracted commercial rate for nonemergency services 30 days after the commission submitted said rates to the division and shall be in effect for the applicable 5-year term.

(e) The commission shall conduct a review of established rates in the fourth year of the rates' operation. The commission shall hold a public hearing under subsection (c) in said fourth year and recommend rates consistent with this section to be effective for the next 5-year term.

(f) The noncontracted commercial rate for emergency services and the noncontracted commercial rate for nonemergency services established under subsection (d) shall be calculated by the center for health information and analysis as provided in section 25 of chapter 12C.

SECTION 2. Chapter 12C of the General Laws is hereby amended by adding the following section:-

Section 25. The center shall calculate the noncontracted commercial rate for emergency services and the noncontracted commercial rate for nonemergency services established under subsection (d) of section 16A of chapter 6D. The center may contract with a nonprofit organization with expertise in independent analysis of payment rates for health care services to assist the center in calculating the noncontracted commercial rate for emergency services and the noncontracted commercial rate for nonemergency services; provided, however, that such organization shall not be affiliated with a health carrier or a health care provider.

SECTION 3. Chapter 32A of the General Laws is hereby amended by adding the following section:-

Section 30. (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, text messaging, application-based communications and online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring a patient’s physical, oral, mental health or substance use disorder condition; provided, however, that “telehealth” may include text-only email when it occurs for the purpose of patient management in the context of a pre-existing physician-patient relationship.

(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 health care services via telehealth by a contracted health care provider; 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. Health care services delivered via telehealth shall be covered to the same extent as if they were provided via in-person consultation or delivery. Coverage shall not be limited to services delivered by third-party providers.

(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; 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.

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

SECTION 4. 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 5. 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 6. Said section 1 of said chapter 94C, as so appearing, is hereby further amended by striking out, in line 324, the words “and 66B” and inserting in place thereof the following words:- , 66B and 66C.

SECTION 7. The definition of “Practitioner” in said section 1 of said chapter 94C, as so appearing, is hereby amended by adding the following 3 clauses:-

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

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

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

SECTION 8. Said section 1 of said chapter 94C, as so appearing, is hereby further amended by striking out, in lines 367 and 368, the words “a practitioner, registered nurse or

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. Section 7 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “nurse”, in line 80, the second time it appears, the following words:- , a licensed dental therapist under the supervision of a practitioner for the purposes of administering analgesics, anti-inflammatories and antibiotics.

SECTION 10. Said section 7 of said chapter 94C, as so appearing, is hereby further amended by inserting after the word “podiatrist”, in line 122, the following words:- , nurse practitioner, nurse anesthetist, psychiatric nurse mental health clinical specialist.

SECTION 11. Said section 7 of said chapter 94C, as so appearing, is hereby further amended by inserting after the word “podiatrist,” in lines 125 and 126, the following words:- nurse practitioner, nurse anesthetist, psychiatric nurse mental health clinical specialist.

SECTION 12. Subsection (g) of said section 7 of said chapter 94C, as so appearing, is hereby amended by striking out the second paragraph.

SECTION 13. Said subsection (g) of said section 7 of said chapter 94C, as so appearing, is hereby further amended by striking out the last paragraph.

SECTION 14. Said section 7 of said chapter 94C, as so appearing, is hereby further amended by striking out, in line 213, the words “and 66B” and inserting in place thereof the following words:- , 66B and 66C.

SECTION 15. 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, nurse anesthetist, psychiatric nurse mental health clinical specialist.

SECTION 16. Said section 9 of said chapter 94C, as so appearing, is hereby further amended by striking out, in line 2, the words “and 66B” and inserting in place thereof the following words:- , 66B and 66C.

SECTION 17. Said section 9 of said chapter 94C, as so appearing, is hereby further amended by striking out, in lines 3 to 5, inclusive, the words “, nurse practitioner and psychiatric nurse mental health clinical specialist as limited by subsection (g) of said section 7 and section 80E of said chapter 112”.

SECTION 18. Said section 9 of said chapter 94C, as so appearing, is hereby further amended by striking out, in lines 8 and 9, the words “, nurse anesthetist, as limited by subsection (g) of said section 7 and section 80H of said chapter 112”.

SECTION 19. Subsection (a) of said section 9 of said chapter 94C, as so appearing, is hereby amended by adding the following paragraph:-

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

SECTION 20. Said 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 21. Said section 9 of said chapter 94C, as so appearing, is hereby further amended by inserting after the word “podiatrist”, in lines 72 and 80, each time it appears, the following word:- , optometrist.

SECTION 22. Subsection (c) of said section 9 of said chapter 94C, as so appearing, is hereby amended by adding the following paragraph:-

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

SECTION 23. Said section 9 of said chapter 94C, as so appearing, is hereby further amended by inserting after the word “practitioner”, in lines 100 and 107, each time it appears, the following words:- , nurse anesthetist, psychiatric nurse mental health clinical specialist.

SECTION 24. Section 18 of said chapter 94C, as so appearing, is hereby amended by striking out, in lines 10, 39, 72, 115 and 116, the words “to practice medicine” and inserting in place thereof, in each instance, the following words:- and authorized to engage in prescriptive practice.

SECTION 25. Said section 18 of said chapter 94C, as so appearing, is hereby further amended by striking out the word “physician”, in lines 25, 34 and 35, 38, 72, 74 and 115, and inserting in place thereof, in each instance, the following word:- practitioner.

SECTION 26. Said section 18 of said chapter 94C, as so appearing, is hereby further amended by striking out, in lines 27, 54 and 55 and 88, the word “medicine”.

SECTION 27. Section 1 of chapter 111 of the General Laws, as so appearing, is hereby amended by inserting after the word " nurse", in line 27, the following words:- , registered pharmacist.

SECTION 28. Said chapter 111 is hereby further amended by striking out section 228, as so appearing, and inserting in place thereof the following section:-

Section 228. (a) For the purposes of this section, the following word shall have the following meaning unless the context clearly requires otherwise:

"Allowed amount", the contractually agreed-upon maximum amount paid by a carrier to a health care provider for a health care service provided to an insured.

(b) (1) Upon scheduling an admission, procedure or service for a patient or prospective patient for conditions that are not emergency medical conditions as defined in section 1 of chapter 176O or upon request by a patient or prospective patient, a health care provider shall disclose whether the health care provider is participating in the patient's health benefit plan; provided, however, that if a patient or prospective patient schedules a series of admissions, procedures or services as part of a continued course of treatment, the patient or prospective patient may waive the requirement to receive such disclosure from the health care provider for subsequent admissions, procedures or services for that course of treatment; provided further, that if the health care provider's status as participating in the patient's health benefit plan changes during a continued course of treatment, the health care provider shall inform a patient of this change in status.

(2) If the health care provider is participating in the patient's or prospective patient's health benefit plan, the health care provider shall, at the time of scheduling the admission,

procedure or service: (i) inform such patient or prospective patient that the patient or prospective patient may request disclosure of the allowed amount and the amount of any facility fees for the admission, procedure or service; and (ii) inform the patient or prospective patient that the patient or prospective patient may obtain additional information about any applicable out-of-pocket costs pursuant to section 23 of chapter 176O; provided, however, that if a patient or prospective patient makes a request under clause (i) of this paragraph, a health care provider shall disclose the allowed amount and the amount of any facility fees for the admission, procedure or service not later than 2 days after receipt of such request. If a health care provider is unable to quote a specific amount in advance due to the health care provider's inability to predict the specific treatment or diagnostic code, the health care provider shall disclose the estimated maximum allowed amount for the admission, procedure or service and the amount of any anticipated facility fees. A health care provider may assist a patient or prospective patient in using the patient's or prospective patient's health plan's toll-free number and website pursuant to said section 23 of said chapter 176O.

(3) If the health care provider is not participating in the patient's or prospective patient's health benefit plan, the health care provider shall, at the time of scheduling the admission, procedure or service: (i) provide the charge and the amount of any facility fees for the admission, procedure or service; (ii) inform the patient or prospective patient that the patient or prospective patient will be responsible for the amount of the charge and the amount of any facility fees for the admission, procedure or service not covered through the patient's health benefit plan; and (iii) inform the patient or prospective patient that the patient or prospective patient may be able to obtain the admission, procedure or service at a lower cost from a health care provider who participates in the patient's or prospective patient's health benefit plan. A health care provider

may assist a patient or prospective patient in using the patient's or prospective patient's health plan's toll-free number and website pursuant to said section 23 of said chapter 176O.

(c) A health care provider referring a patient to another provider shall disclose: (i) if the provider to whom the patient is being referred is part of or represented by the same provider organization as used in section 11 of chapter 6D; (ii) the possibility that the provider to whom the patient is being referred is not participating in the patient's health benefit plan and that if the provider is out-of-network under the terms of the patient's health benefit plan then any out-of-network applicable rates under such health benefit plan may apply and that the patient has the opportunity to verify whether the provider participates in the patient's health benefit plan prior to making an appointment or agreeing to use the services of said provider; and (iii) sufficient information about the referred provider for the patient to obtain additional information about the provider's network status under the patient's health plan and any applicable out-of-pocket costs for services sought from the referred provider pursuant to section 23 of chapter 176O.

(d) A health care provider referring a patient to another provider by directly scheduling, ordering or otherwise arranging for the health care services on the patient's behalf shall, prior to scheduling, ordering or otherwise arranging for the health care services on the patient's behalf: (i) verify whether the provider to whom the patient is being referred participates in the patient's health benefit plan; and (ii) notify the patient if the provider to whom the patient is being referred is not a provider who participates in the patient's health benefit plan or if the network status of the provider to whom the patient is being referred could not be verified.

(e) A health care provider shall determine if it participates in a patient's health benefit plan prior to said patient's admission, procedure or service for conditions that are not emergency

medical conditions as defined in section 1 of chapter 176O. If the health care provider does not participate in the patient's health benefit plan and the admission, procedure or service was scheduled more than 7 days in advance of the admission, procedure or service, such provider shall notify the patient verbally and in writing of that fact not less than 7 days before the scheduled admission, procedure or service. If the health care provider does not participate in the patient's health benefit plan and the admission, procedure or service was scheduled less than 7 days in advance of the admission, procedure or service, such provider shall notify the patient verbally of that fact not less than 2 days before the scheduled admission, procedure or service or as soon as is practicable before the scheduled admission, procedure or service, with written notice of that fact to be provided upon the patient's arrival at the scheduled admission, procedure or service. If a health care provider that does not participate in the patient's health benefit plan fails to provide the required notifications under this subsection, the provider shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be payable if the insured received the service from a participating health care provider under the terms of the insured's health benefit plan. Nothing in this subsection shall relieve a health care provider from the requirements under subsections (b) to (d), inclusive.

(f) The commissioner shall implement this section and impose penalties for non-compliance consistent with the department's authority to regulate health care providers; provided, however, that the penalty for non-compliance shall not exceed $2,500 in each instance. A health care provider that violates any provision of this section or the rules and regulations adopted pursuant hereto shall be liable for penalties as provided in this subsection.

SECTION 29. Chapter 112 of the General Laws is hereby amended by striking out section 13, as so appearing, and inserting in place thereof the following section:-

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

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

(c) Sections 13 to 18, inclusive, shall not apply to surgeons of the United States army, United States navy or of the United States Public Health Service or to physicians registered in the commonwealth.

SECTION 30. Section 43A of said chapter 112, as so appearing, is hereby amended by inserting after the definition of “Appropriate supervision” the following 2 definitions:-

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

“Collaborative management agreement”, a written agreement that complies with section 51B between a local, state or federal government agency or institution or a licensed dentist and a dental therapist outlining the procedures, services, responsibilities and limitations of the therapist.

SECTION 31. Said section 43A of said chapter 112, as so appearing, is hereby further amended by inserting after the definition of “Dental supervision” the following definition:-

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

SECTION 32. Said section 43A of said chapter 112, as so appearing, is hereby further amended by adding the following definition:-

“Supervising dentist”, a dentist licensed in the commonwealth pursuant to section 45 who enters into a collaborative management agreement with a dental therapist.

SECTION 33. Section 51½ of said chapter 112, as so appearing, is hereby amended by inserting after the word “dentist” in lines 53 and 75, in each instance, the following words:- , a licensed dental therapist to the extent provided in section 51B.

SECTION 34. Said section 51½ of said chapter 112, as so appearing, is hereby further amended by inserting after the word “practice”, in line 78, the following words:- , a dental therapist licensed under section 51B.

SECTION 35. Said chapter 112 is hereby further amended by inserting after section 51A the following section:-

Section 51B. (a) As used in this section, the following words shall have the following meanings unless the context clearly requires otherwise:

“Advanced procedures”, the following services performed under direct supervision: (i) preparation and placement of direct restoration in primary and permanent teeth; (ii) fabrication and placement of single-tooth temporary crowns; (iii) preparation and placement of preformed crowns on primary teeth; (iv) indirect and direct pulp capping on permanent teeth; (v) indirect pulp capping on primary teeth; and (vi) simple extractions of erupted primary teeth; provided, however, that “advanced procedures” may be performed under general supervision if authorized by the board pursuant to subsection (f).

"General supervision", notwithstanding section 43A, supervision of procedures and services based on a written collaborative management agreement between a licensed dentist and a licensed dental therapist; provided, however, that "general supervision" shall not require a prior exam or diagnosis by a supervising dentist or the physical presence of a supervising dentist during the performance of those procedures and services unless required by the supervising dentist in the collaborative management agreement.

"Individuals who are underserved", individuals who: (i) qualify for benefits through MassHealth or its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a MassHealth managed care organization or primary care clinician plan; (ii) qualify for federal Social Security Disability Benefits, federal Supplemental Security Income or state supplementary payments; (iii) reside in a dental health professional shortage area as designated by the United States Department of Health and Human Services; (iv) reside in a nursing home, skilled nursing facility, veterans home or long-term care facility; (v) receive dental services in a public health setting as defined by the board by regulation; (vi) qualify to receive benefits through plans sold by the commonwealth health insurance connector; (viii) qualify to receive benefits through the federal Indian Health Service, tribal or urban Indian organizations or the federal Contract Health Service Program; (ix) qualify to receive benefits through the department of veterans' services or other organizations serving veterans; (x) are elderly and have trouble accessing dental care due to mobility or transportation challenges; (xi) meet the Commission on Dental Accreditation's definition of people with special needs; (xii) are uninsured and living at 305 per cent of the federal poverty level; or (xiii) meet other eligibility criteria established by the board.

(b) A person of good moral character shall be registered as a dental therapist if the person: (i) is a graduate of a master's level dental therapist education program that includes both dental therapy and dental hygiene education, or an equivalent combination of both dental therapy education and dental hygiene education, if all education programs: (A) are accredited by the Commission on Dental Accreditation and provided by a post-secondary institution accredited by the New England Association of Schools and Colleges, Inc. or an equivalent accrediting body, or (B) otherwise meet criteria established by the board; (ii) passes a comprehensive, competency-based clinical examination approved by the board and administered by a recognized national or regional dental testing service that administers testing for dentists and other dental professionals or an equivalent examination administered by another entity approved by the board; (iii) obtains a policy of professional liability insurance and shows proof of such insurance as required by rules and regulations promulgated by the board; and (iv) pays a fee determined annually by the secretary of administration and finance under section 3B of chapter 7.

A person who has met the requirements to be registered as a dental therapist under this section may also be registered as a dental hygienist.

(c) A dental therapy educational program offered in the commonwealth shall have at least 1 instructor who is a licensed dentist. The board shall provide guidance for any educational entity or institution that may operate all or some portion of a master's level program or may collaborate with other educational entities, including, but not limited to, universities, colleges, community colleges and technical colleges, to operate all or some portion of a master's level program. The board may also provide guidance to award advanced standing to students who have completed coursework at other educational programs accredited by the Commission on Dental Accreditation or another program that meets criteria established by the board. An educational

program shall prepare students to perform all procedures and services, including advanced procedures under general supervision, under this section.

Dental therapist educational curriculum offered in the commonwealth shall include, but not be limited to, training related to serving patients with targeted dental care needs because of developmental disability, including an autism spectrum disorder, mental illness, cognitive disability, complex medical needs or significant physical disability or because of dental needs specific to aging adults.

(d) The board shall grant a dental therapy license by examination to an applicant of good moral character who: (i) meets the eligibility requirements as defined by the board; (ii) submits documentation to the board of a passing score on a comprehensive, competency-based clinical examination or combination of examinations that include both dental therapy and dental hygiene components and are approved by the board and administered by a recognized national or regional dental testing service that administers testing for dentists and other dental professionals; and (iii) submits to the board documentation of a passing score on the Massachusetts Dental Ethics and Jurisprudence Examination or a successor examination. An applicant failing to pass the examination shall be entitled to re-examination pursuant to the rules and guidelines established by the Commission on Dental Competency Assessments.

A licensed dental therapist shall have practiced under the direct supervision of a supervising dentist for not less than 2 years or 2,500 hours, whichever is longer, before practicing under general supervision pursuant to a collaborative management agreement; provided, however, that direct supervision shall be provided pursuant to a collaborative management agreement. A dental therapist license shall be active for a period of 2 years and

eligible for renewal for a subsequent 2-year period; provided, however, that upon receipt of a license under section 45, a dental therapy license granted under this section shall be void.

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

The board shall grant a license by credentials, without further professional examination, to a dental therapist licensed in another jurisdiction if the applicant is of good moral character and has: (i) met the eligibility requirements as defined by the board; (ii) furnished the board with satisfactory proof of graduation from an education program or combination of education programs providing both dental therapy and dental hygiene education that meets the standards of the Commission on Dental Accreditation; provided, however, that an applicant who graduated from a dental therapy education program established before the Commission on Dental Accreditation established a dental therapy accreditation program is eligible notwithstanding the lack of accreditation of the program at the time the education was received; (iii) submitted documentation of a passing score on a dental therapy examination administered by another state or testing agency that is substantially equivalent to the board-approved dental therapy examination for dental therapists as defined in this section; (iv) submitted documentation of a

passing score on the Massachusetts Dental Ethics and Jurisprudence Examination or a successor examination; and (v) submitted documentation of completion of 2 years or 2,500 hours, whichever is longer, of practice; provided, however, that if such practice requirement is not met, a dental therapist shall complete the remaining hours or years, whichever is longer, under direct supervision in the commonwealth before practicing under general supervision.

(e) Pursuant to a collaborative management agreement, a dental therapist licensed and registered by the board may perform: (i) all acts of a public health dental hygienist as set forth in regulations of the board under general supervision; (ii) all acts in the Commission on Dental Accreditation's dental therapy standards under general supervision; and (iii) advanced procedures.

A dental therapist, as authorized in a collaborative management agreement, may: (i) perform an oral evaluation and assessment of dental disease and formulate an individualized treatment plan; and (ii) dispense and administer, unless further limited by a collaborative management agreement, non-narcotic analgesics, anti-inflammatories and antibiotics. A dental therapist shall not dispense or administer narcotic analgesics. A dental therapist shall not oversee more than 2 dental hygienists and 2 dental assistants; provided, however, a dental therapist shall not oversee a public health dental hygienist.

Pursuant to a collaborative management agreement, a dental therapist may provide procedures and services permitted under general supervision when the supervising dentist is not on-site and has not previously examined or diagnosed the patient provided the supervising dentist is available for consultation and supervision as needed through either telemedicine, as defined in section 47CC of chapter 175, or by other means of communication. Arrangements

shall be made in a collaborative management agreement for another licensed dentist to be available to provide timely consultation and supervision if the supervising dentist is unavailable. A dental therapist shall not operate independently of a supervising dentist and shall not practice or treat any patients without a supervising dentist or a collaborative management agreement with a supervising dentist.

(f) The department, in consultation with the board, shall regularly review and recommend: (i) whether a dental therapist may be authorized to perform 1 or more advanced procedures under general supervision pursuant to a collaborative management agreement; and (ii) appropriate geographic distance limitations between a dental therapist and supervising dentist to increase access to dental therapist services by populations including, but not limited to, Medicaid beneficiaries and individuals who are underserved. The department shall submit its recommendation to the board and if the board authorizes the performance of 1 or more advanced procedure under general supervision pursuant to a collaborative management agreement after receiving advanced practice certification, the board shall promulgate regulations implementing the authorization of the advanced procedure not later than 6 months from the determination.

The board shall grant advanced practice certification for a dental therapist licensed and registered by the board to perform all services and procedures within the authorized scope of practice under general supervision pursuant to a collaborative management agreement if the dental therapist provides documentation of completion of the required supervised practice hours pursuant to subsection (b) and satisfies any other criteria established by regulation promulgated by the board as authorized in this section.

(g) A collaborative management agreement shall be signed and maintained by the supervising dentist and the dental therapist and may be updated as necessary. The agreement shall serve as standing orders from the supervising dentist and shall address: (i) practice settings; (ii) any limitation on services established by the supervising dentist; (iii) the level of supervision required for various services or treatment settings; (iv) patient populations that may be served; (v) practice protocols; (vi) record keeping; (vii) managing medical emergencies; (viii) quality assurance; (ix) administering and dispensing medications; (x) geographic distance limitations; (xi) oversight of dental hygienists and dental assistants; and (xii) referrals for services outside of the dental therapy scope of practice.

The collaborative management agreement shall include specific protocols if a dental therapist encounters a patient who requires treatment that exceeds the authorized scope of the collaborative management agreement. The supervising dentist shall be responsible for directly providing, or arranging for another dentist or specialist within an accessible geographic distance to provide, any necessary additional services outside of the collaborative management agreement. A supervising dentist shall not have a collaborative management agreement with more than 3 dental therapists at the same time. Not more than 2 such dental therapists may practice under general supervision with certification to perform 1 or more advanced procedures. A practice or organization with more than 1 practice location listed under the same business name shall not employ more than 6 dental therapists; provided, however, that this requirement shall not apply if such an organization or practice is a federally-qualified health center or look-alike, a community health center, a non-profit practice or organization or a public health setting as defined in regulations promulgated by the board of registration in dentistry or as otherwise permitted by the board.

Each collaborative management agreement shall be filed with the board when it is first entered into by a supervising dentist and dental therapist and biennially thereafter. The board shall establish guidelines for collaborative management agreements.

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

(i) Not less than 50 per cent of the patient panel of a dental therapist, as determined in each calendar year, shall consist of individuals who are underserved as defined in this section; provided, however, that this requirement shall not apply if the dental therapist is operating in a federally-qualified health center or look-alike, community-health center, non-profit practice or organization or other public health setting as defined by the board by regulation or as otherwise permitted by the board.

A dental therapist's employer shall submit quarterly reports on the makeup of the dental therapist's patient panel.

(j) The board, in consultation with the department, shall establish regulations to implement the provisions of this section.

SECTION 36. Said chapter 112 is hereby further amended by striking out section 66, as appearing in the 2018 Official Edition, and inserting in place thereof the following section:-

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

SECTION 37. Section 66B of said chapter 112, as so appearing, is hereby amended by striking out, in line 31, the following words:- , except glaucoma.

SECTION 38. Said chapter 112 is hereby further amended by inserting after section 66B the following section:-

Section 66C. (a) A registered optometrist who is qualified by an examination for practice under section 68, certified under section 68C and registered to issue written prescriptions pursuant to subsection (h) of section 7 of chapter 94C may: (i) use and prescribe topical and oral therapeutic pharmaceutical agents as defined in section 66B that are used in the practice of optometry, including those placed in schedules III, IV, V and VI pursuant to section 2 of said chapter 94C, for the purpose of diagnosing, preventing, correcting, managing or treating glaucoma and other ocular abnormalities of the human eye and adjacent tissue; and (ii) prescribe all necessary eye-related medications, including oral anti-infective medications; provided, however, that a registered optometrist shall not use or prescribe: (A) therapeutic pharmaceutical agents for the treatment of systemic diseases; (B) invasive surgical procedures; (C)

pharmaceutical agents administered by subdermal injection, intramuscular injection, intravenous injection, subcutaneous injection, intraocular injection or retrobulbar injection; or (D) an opioid substance or drug product.

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

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

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

SECTION 39. Said chapter 112 is hereby further amended by inserting after section 68B the following section:-

Section 68C. (a) The board of registration in optometry shall administer an examination to permit the use and prescription of therapeutic pharmaceutical agents as authorized in section 66C. The examination shall: (i) be held in conjunction with examinations provided for in

sections 68, 68A and 68B; and (ii) include any portion of the examination administered by the National Board of Examiners in Optometry or other appropriate examination covering the subject matter of therapeutic pharmaceutical agents as authorized in said section 66C. The board may administer a single examination to measure the qualifications necessary under said sections 68, 68A, 68B and this section. The board shall qualify optometrists to use and prescribe therapeutic pharmaceutical agents in accordance with said sections 68, 68A, 68B and this section.

(b) Examination for the use and prescription of therapeutic pharmaceutical agents placed in schedules III, IV, V and VI under section 2 of chapter 94C and defined in section 66C shall, upon application, be open to an optometrist registered under section 68, 68A or 68B and to any person who meets the qualifications for examination under said sections 68, 68A and 68B. An applicant registered as an optometrist under said sections 68, 68A or 68B shall: (i) be registered pursuant to subsection (h) of section 7 of said chapter 94C to use or prescribe pharmaceutical agents for the purpose of diagnosing or treating glaucoma and other ocular abnormalities of the human eye and adjacent tissue; and (ii) furnish to the board of registration in optometry evidence of the satisfactory completion of 40 hours of didactic education and 20 hours of supervised clinical education relating to the use and prescription of therapeutic pharmaceutical agents under said section 66C; provided, however, that such education shall: (A) be administered by the Massachusetts Society of Optometrists, Inc.; (B) be accredited by a college of optometry or medicine; and (C) meet the guidelines and requirements of the board of registration in optometry. The board of registration in optometry shall provide to each successful applicant a certificate of qualification in the use and prescription of all therapeutic pharmaceutical agents as

authorized under said section 66C and shall forward to the department of public health notice of such certification for each successful applicant.

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

(d) A licensed optometrist who has completed a postgraduate residency program approved by the Accreditation Council on Optometric Education of the American Optometric Association may submit an affidavit to the board of registration in optometry from the licensed optometrist's residency supervisor or the director of residencies at the affiliated college of optometry attesting that the optometrist has completed an equivalent level of instruction and supervision and the board may accept the evidence in order to satisfy any of the requirements of this section.

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

SECTION 40. Section 80B of said chapter 112, as appearing in the 2018 Official Edition, is hereby amended by inserting after the word “practitioners”, in line 12, the following words:- , nurse anesthetists.

SECTION 41. Said section 80B of said chapter 112, as so appearing, is hereby further amended by striking out the seventh paragraph and inserting in place thereof the following paragraph:-

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

SECTION 42. Said section 80B of said chapter 112, as so appearing, is hereby further amended by striking out, in lines 64 and 65, the words “in the ordering of tests, therapeutics and the prescribing of medications,”.

SECTION 43. Said chapter 112 is hereby further amended by striking out section 80E, as so appearing, and inserting in place thereof the following section:-

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

include the name of the supervising nurse practitioner who has independent practice authority, the supervising psychiatric nurse mental health clinical specialist who has independent practice authority or the supervising physician with whom the nurse practitioner or psychiatric nurse mental health clinical specialist developed and signed mutually agreed upon guidelines.

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

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

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

SECTION 44. Said chapter 112 is hereby further amended by striking out section 80H, as so appearing, and inserting in place thereof the following section:-

Section 80H. (a) A nurse anesthetist may issue written prescriptions and medication orders and order tests and therapeutics pursuant to guidelines mutually developed and agreed upon by the nurse anesthetist and a supervising nurse anesthetist with independent practice authority or a supervising physician, in accordance with regulations promulgated by the board; provided, however, that supervision under this section by a supervising nurse anesthetist with independent practice authority or by a physician shall be limited to written prescriptions and medication orders and the ordering of tests and therapeutics. A prescription issued by a nurse anesthetist under this subsection shall include the name of the supervising nurse anesthetist with independent practice authority or the supervising physician with whom the nurse anesthetist developed and signed mutually agreed upon guidelines. Nothing in this section shall require a nurse anesthetist to obtain prescriptive authority to deliver anesthesia care, including the proper administration of the drugs or medicine necessary for the delivery of anesthesia care.

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

The board may allow a nurse anesthetist to exercise such independent practice authority upon satisfactory demonstration of alternative professional experience if the board determines that the nurse anesthetist has a demonstrated record of safe prescribing and good conduct

consistent with professional licensure obligations required by each jurisdiction in which the nurse anesthetist has been licensed.

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

SECTION 45. Section 80I of said chapter 112, as so appearing, is hereby amended by striking out the second and third sentences.

SECTION 46. Said chapter 112 is hereby further amended by inserting after section 80I the following 2 sections:-

Section 80J. A nurse authorized to practice as a psychiatric nurse mental health clinical specialist pursuant to section 80B may order and interpret tests, therapeutics and prescribe medications in accordance with regulations promulgated by the board and subject to subsection (g) of section 7 of chapter 94C.

Section 80K. The board shall promulgate regulations, subject to approval by the commissioner, to ensure that nurse practitioners, nurse anesthetists and psychiatric nurse mental health clinical specialists under the board of registration in nursing are subject to requirements commensurate to those that physicians are subject to under the board of registration in medicine pursuant to the sixth and seventh paragraphs of section 5 and sections 5A to 5M, inclusive, as they apply to the creation and public dissemination of individual profiles and licensure restrictions, disciplinary actions and reports, claims or reports of malpractice, communication with professional organizations, physical and mental examinations, investigation of complaints and other aspects of professional conduct and discipline.

SECTION 47. The definition of “core competencies” in section 259 of said chapter 112, as appearing in the 2018 Official Edition, is hereby amended by striking out clauses (h) and (i) and inserting in place thereof the following 3 clauses:-

(h) community capacity building;

(i) writing and technical communication skills; and

(j) oral health education.

SECTION 48. The second paragraph of section 260 of said chapter 112, as so appearing, is hereby amended by adding the following sentence:- As a condition for licensure or renewal of licensure, the board shall require community health workers to receive education or training in oral health.

SECTION 49. Chapter 118E of the General Laws is hereby amended by adding the following section:-

Section 79. (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, text messaging, application-based communications and online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring a patient’s physical, oral, mental health or substance use disorder condition; provided, however, that “telehealth” may include text-only email when it occurs for the purpose of patient management in the context of a pre-existing physician-patient relationship.

(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 health care services provided via telehealth by a contracted provider; 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. Health care services delivered via telehealth shall be covered to the same extent as if they were provided via in-person consultation or delivery. Coverage shall not be limited to services delivered by third-party providers.

(c) The division may undertake 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 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 plan 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 is provided be limited for health care services provided via telehealth; 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 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.

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

SECTION 50. Chapter 123 of the General Laws is hereby amended by striking out section 11, as appearing in the 2018 Official Edition, and inserting in place thereof the following section:-

Section 11. Any person retained in a facility under the provisions of paragraph (a) of section 10 shall be free to leave such facility at any time, and a parent or guardian who requested the admission of such person may withdraw such person at any time, upon giving written notice to the superintendent. The superintendent may restrict the right to leave or withdraw to normal working hours and weekdays and, in the superintendent's discretion, may require persons or the parent or guardian of a person to give 3 days written notice of their intention to leave or withdraw. If a person or their parent or guardian is required to give 3 days notice of intention to leave or withdraw, an examination of the person may be conducted to determine their clinical progress, their suitability for discharge and to investigate other aspects of their case, including their legal competency and their family, home or community situation, in the interest of discharging them from the facility. The person may be retained at the facility beyond the

expiration of the 3-day notice period if prior to the expiration of the 3-day notice period the superintendent files with the district court a petition for the commitment of the person at the facility. Before accepting an application for voluntary admission where the superintendent may require 3 days written notice of intention to leave or withdraw, the admitting or treating physician or qualified advanced practice registered nurse shall assess the person's capacity to understand that: (i) the person is agreeing to stay or remain at the hospital; (ii) the person is agreeing to accept treatment; (iii) the person is required to provide the facility with 3 days written advance notice of the person's intention to leave the facility; and (iv) the facility may petition a court for an extended commitment of the person and that the person may be held at the facility until the petition is heard by the court. If the physician or qualified advanced practice registered nurse determines that the person lacks the capacity to understand these facts and consequences of hospitalization, the application shall not be accepted.

SECTION 51. Said chapter 123 is hereby further amended by striking out section 12, as so appearing, and inserting in place thereof the following section:-

Section 12. (a) A physician who is licensed pursuant to section 2 of chapter 112, an advanced practice registered nurse authorized to practice as such under regulations promulgated pursuant to section 80B of said chapter 112, a qualified psychologist licensed pursuant to sections 118 to 129, inclusive, of said chapter 112 or a licensed independent clinical social worker licensed pursuant to sections 130 to 137, inclusive, of said chapter 112 who, after examining a person, has reason to believe that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness may restrain or authorize the restraint of such person and apply for the hospitalization of such person for a 3-day period at a public facility or at a private facility authorized for such purposes by the department. If an examination is not

possible because of the emergency nature of the case and because of the refusal of the person to consent to such examination, the physician, qualified psychologist, qualified advanced practice registered nurse or licensed independent clinical social worker on the basis of the facts and circumstances may determine that hospitalization is necessary and may therefore apply. In an emergency situation, if a physician, qualified psychologist, qualified advanced practice registered nurse or licensed independent clinical social worker is not available, a police officer who believes that failure to hospitalize a person would create a likelihood of serious harm by reason of mental illness may restrain such person and apply for the hospitalization of such person for a 3-day period at a public facility or a private facility authorized for such purpose by the department. An application for hospitalization shall state the reasons for the restraint of such person and any other relevant information that may assist the admitting physician or qualified advanced practice registered nurse. Whenever practicable, prior to transporting such person, the applicant shall telephone or otherwise communicate with a facility to describe the circumstances and known clinical history and to determine whether the facility is the proper facility to receive such person and to give notice of any restraint to be used and to determine whether such restraint is necessary.

(b) Only if the application for hospitalization under this section is made by a physician or a qualified advanced practice registered nurse specifically designated to have the authority to admit to a facility in accordance with the regulations of the department shall such person be admitted to the facility immediately after reception. If the application is made by someone other than a designated physician or a qualified advanced practice registered nurse such person shall be given a psychiatric examination by a designated physician or a qualified advanced practice registered nurse immediately after reception at such facility. If the physician or a qualified

advanced practice registered nurse determines that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness, the physician or qualified advanced practice registered nurse may admit such person to the facility for care and treatment. Upon admission of a person under this subsection, the facility shall inform the person that it shall, upon such person's request, notify the committee for public counsel services of the name and location of the person admitted. The committee for public counsel services shall immediately appoint an attorney who shall meet with the person. If the appointed attorney determines that the person voluntarily and knowingly waives the right to be represented, is presently represented or will be represented by another attorney, the appointed attorney shall so notify the committee for public counsel services, which shall withdraw the appointment.

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

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

(d) A person shall be discharged at the end of the 3-day period unless the superintendent applies for a commitment under sections 7 and 8 or the person remains on a voluntary status.

(e) Any person may make an application to a district court justice or a justice of the juvenile court department for a 3-day commitment to a facility of a person with a mental illness if the failure to confine said person would cause a likelihood of serious harm. The court shall appoint counsel to represent said person. After hearing such evidence as the court may consider sufficient, a district court justice or a justice of the juvenile court department may issue a warrant for the apprehension and appearance before the court of the alleged person with a mental illness if in the court's judgment the condition or conduct of such person makes such action necessary or proper. Following apprehension, the court shall have the person examined by a physician or a qualified advanced practice registered nurse designated to have the authority to admit to a facility or examined by a qualified psychologist in accordance with the regulations of the department. If the physician, qualified advanced practice registered nurse or qualified psychologist reports that the failure to hospitalize the person would create a likelihood of serious harm by reason of mental illness, the court may order the person committed to a facility for a period not to exceed 3 days; provided, however, that the superintendent may discharge said person at any time within the 3 day period. The periods of time prescribed or allowed under this section shall be computed pursuant to Rule 6 of the Massachusetts Rules of Civil Procedure.

SECTION 52. Said chapter 123 is hereby further amended by striking out section 21, as so appearing, and inserting in place thereof the following section:-

Section 21. Any person who transports a person with a mental illness to or from a facility for any purpose authorized under this chapter shall not use any restraint that is unnecessary for

the safety of the person being transported or other persons likely to come in contact with said person.

In the case of persons being hospitalized under section 6, the applicant shall authorize practicable and safe means of transport including, where appropriate, departmental or police transport.

Restraint of a person with a mental illness may only be used in cases of emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury or attempted suicide; provided, however, that written authorization for such restraint is given by the superintendent or director of the facility or by a physician or qualified advanced practice registered nurse designated by the superintendent or director for this purpose who is present at the time of the emergency or if the superintendent, director, designated physician or designated qualified advanced practice registered nurse is not present at the time of the emergency, non-chemical means of restraint may be used for a period of not more than 1 hour; provided further, that within 1 hour the person in restraint shall be examined by the superintendent, director, designated physician or designated qualified advanced practice registered nurse; and provided further, that if the examination has not occurred within 1 hour, the patient may be restrained for an additional period of not more than 1 hour until such examination is conducted and the superintendent, director, designated physician or designated qualified advanced practice registered nurse shall attach to the restraint form a written report as to why the examination was not completed by the end of the first hour of restraint.

Any minor placed in restraint shall be examined within 15 minutes of the order for restraint by a physician or qualified advanced practice registered nurse or, if a physician or

qualified advanced practice registered nurse is not available, by a registered nurse or a certified physician assistant; provided, however, that said minor shall be examined by a physician or qualified advanced practice registered nurse within 1 hour of the order for restraint. A physician or qualified advanced practice registered nurse or, if a physician or qualified advanced practice registered nurse is not available, a registered nurse or a certified physician assistant, shall review the restraint order by personal examination of the minor or consultation with ward staff attending the minor every hour thereafter.

No minor shall be secluded for more than 2 hours in any 24-hour period; provided, however, that no such seclusion of a minor may occur except in a facility with authority to use such seclusion after said facility has been inspected and specially certified by the department. The department shall issue regulations establishing procedures by which a facility may be specially certified with authority to seclude a minor. Such regulations shall provide for review and approval or disapproval by the commissioner of a biannual application by the facility, which shall include: (i) a comprehensive statement of the facility's policies and procedures for the utilization and monitoring of restraint of minors including a statistical analysis of the facility's actual use of such restraint; and (ii) a certification by the facility of its ability and intent to comply with all applicable statutes and regulations regarding physical space, staff training, staff authorization, record keeping, monitoring and other requirements for the use of restraints.

Any use of restraint on a minor exceeding 1 hour in any 24-hour period shall be reviewed within 2 working days by the director of the facility. The director shall forward a copy of the report on each such instance of restraint to the human rights committee of that facility and, if there is no human rights committee, to the appropriate body designated by the commissioner of mental health. The director shall also compile a record of every instance of restraint in the

facility and shall forward a copy of said report on a monthly basis to the human rights committee or the body designated by the commissioner of mental health.

No order for restraint for an individual shall be valid for a period of more than 3 hours beyond which time it may be renewed upon personal examination by the superintendent, director, designated physician or designated qualified advanced practice registered nurse or, for adults, by a registered nurse or a certified physician assistant; provided, however, that no adult shall be restrained for more than 6 hours beyond which time an order may be renewed only upon personal examination by a physician or qualified advanced practice registered nurse. The reason for the original use of restraint, the reason for its continuation after each renewal and the reason for its cessation shall be noted upon the restraining form by the superintendent or director or designated physician or, when applicable, by the registered nurse or certified physician or qualified advanced practice registered nurse assistant at the time of each occurrence.

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

No person shall be kept in restraint without a person in attendance specially trained to understand, assist and afford therapy to the person in restraint. The person may be in attendance

immediately outside the room in full view of the patient when an individual is being secluded without mechanical restraint; provided, however, that in emergency situations when a person specially trained is not available, an adult may be kept in restraint unattended for a period not to exceed 2 hours. In that event, the person kept in restraints shall be observed at least every 5 minutes; provided, further, that the superintendent, director, designated physician or designated qualified advanced practice registered nurse shall attach to the restraint form a written report as to why the specially trained attendant was not available. The maintenance of any adult in restraint for more than 8 hours in any 24-hour period shall be authorized by the superintendent or facility director or the person specifically designated to act in the absence of the superintendent or facility director; provided, however, that when such restraint is authorized in the absence of the superintendent or facility director, such authorization shall be reviewed by the superintendent or facility director upon the return of the superintendent or facility director.

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

Not later than 24 hours after the period of restraint, a copy of the restraint form shall be delivered to the person who was in restraint. A place shall be provided on the form or on attachments thereto for the person to comment on the circumstances leading to the use of restraint and on the manner of restraint used.

A copy of the restraint form and any such attachments shall become part of the chart of the patient. Copies of all restraint forms and attachments shall be sent to the commissioner of mental health, or, with respect to Bridgewater state hospital to the commissioner of correction,

who shall review and sign them within 30 days and statistical records shall be kept thereof for each facility, including Bridgewater state hospital, and each designated physician or qualified advanced practice registered nurse. Furthermore, such reports, excluding personally identifiable patient identification, shall be made available to the general public at the department's central office, or, with respect to Bridgewater state hospital at the department of correction's central office.

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

SECTION 53. Said chapter 123 is hereby further amended by striking out section 22, as so appearing, and inserting in place thereof the following section:-

Section 22. Physicians, qualified advanced practice registered nurses, qualified psychologists, qualified psychiatric nurse mental health clinical specialists, police officers and licensed independent clinical social workers shall be immune from civil suits for damages for restraining, transporting, applying for the admission of or admitting any person to a facility or Bridgewater state hospital if the physician, qualified advanced practice registered nurse, qualified psychologist, qualified psychiatric nurse mental health clinical specialist, police officer or licensed independent clinical social workers acts in accordance with this chapter.

SECTION 54. Chapter 175 of the General Laws is hereby amended by inserting after section 47BB the following section:-

Section 47CC. (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, text messaging, application-based communications and online adaptive interviews, for the purposes of evaluating, diagnosing, consulting, prescribing, treating or monitoring a patient's physical, oral, mental health or substance use disorder condition; provided, however, that "telehealth" may include text-only email when it occurs for the purpose of patient management in the context of a pre-existing physician-patient relationship.

(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 health care services delivered via telehealth by a contracted health care provider; 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. Health care services delivered via telehealth shall be covered to the same extent as if they were provided via in-person consultation or delivery. Coverage shall not be limited to services delivered by third-party providers.

(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 is provided be limited for health care services provided via telehealth; 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.

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

SECTION 55. Chapter 176A of the General Laws is hereby amended by adding the following section:-

Section 38. (a) For 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, text messaging, application-based communications and online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing,

treating or monitoring a patient's physical, oral, mental health or substance use disorder condition; provided, however, that "telehealth" may include text-only email when it occurs for the purpose of patient management in the context of a pre-existing physician-patient relationship.

(b) A contract between a subscriber and a nonprofit hospital service corporation under an individual or group hospital service plan shall provide coverage for health care services delivered via telehealth by a contracted health care provider; 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. Health care services delivered via telehealth shall be covered to the same extent as if they were provided via in-person consultation or delivery. Coverage shall not be limited to services delivered by third-party providers.

(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 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 is provided be limited for health care services provided through telehealth; 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 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.

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

SECTION 56. Chapter 176B of the General Laws is hereby amended by adding the following section:-

Section 25. (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, text messaging, application-based communications and online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring a patient's physical, oral, mental health or substance use disorder condition; provided, however, that "telehealth" may include text-only email when it occurs for the purpose of patient management in the context of a pre-existing physician-patient relationship.

(b) A contract between a subscriber and a medical service corporation shall provide coverage for health care services delivered via telehealth by a contracted health care provider; 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. Health care

services delivered via telehealth shall be covered to the same extent as if they were provided via in-person consultation or delivery. Coverage shall not be limited to services delivered by third-party providers.

(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 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 is provided be limited for health care services provided through telehealth; 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.

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

SECTION 57. Chapter 176G of the General Laws is hereby amended by adding the following section:-

Section 33. (a) For the purposes of this section, “telehealth” shall mean the use of synchronous and asynchronous audio, video, electronic media or other telecommunications technology, including, but not limited to, text messaging, application-based communications and online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring a patient’s physical, oral, mental health or substance use disorder condition; provided, however, that “telehealth” may include text-only email when it occurs for the purpose of patient management in the context of a pre-existing physician-patient relationship.

(b) A contract between a member and a health maintenance organization shall provide coverage for health care services delivered via telehealth by a contracted health care provider; 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. Health care services delivered via telehealth shall be covered to the same extent as if they were provided via in-person consultation or delivery. Coverage shall not be limited to services delivered by third-party providers.

(c) A carrier may undertake 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 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 is provided be limited for health care services provided via telehealth; 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 through 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.

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

SECTION 58. Chapter 176I of the General Laws is hereby amended by adding the following section:-

Section 13. (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, text messaging, application-based communications and online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring a patient's physical, oral, mental health or substance use disorder

condition; provided, however, that “telehealth” may include text-only email when it occurs for the purpose of patient management in the context of a pre-existing physician-patient relationship.

(b) A preferred provider contract between a covered person and an organization shall provide coverage for health care services delivered via telehealth by a contracted health care provider; 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. Health care services delivered via telehealth shall be covered to the same extent as if they were provided via in-person consultation or delivery. Coverage shall not be limited to services delivered by third-party providers.

(c) An organization may undertake 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 as if the service was delivered in person. An organization shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan nor 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 is provided be limited for health care services provided through telehealth; provided, however, that a patient may decline receiving services via telehealth in order to receive in-person services.

(e) A preferred provider 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.

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

SECTION 59. Section 1 of chapter 176O of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the definition of "Downside risk" the following definition:-

"Emergency health care services", health care services rendered to an insured experiencing an emergency medical condition.

SECTION 60. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of "Incentive plan" the following definition:-

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

SECTION 61. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of "Network" the following 3 definitions:-

"Noncontracted commercial rate for emergency services", the amount set pursuant to section 16A of chapter 6D and used to determine the rate of payment to a health care provider for the provision of emergency health care services to an insured when the health care provider is not in the carrier's network; provided, however, that "noncontracted commercial rate for emergency services" shall not include emergency health care services that are provided by a person or entity licensed by the department of public health pursuant to section 6 of chapter 111C to establish or maintain an ambulance service.

"Noncontracted commercial rate for nonemergency services", the amount set pursuant to section 16A of chapter 6D and used to determine the rate of payment to a health care provider for the provision of nonemergency health care services to an insured when the health care provider is not in the carrier's network.

"Nonemergency health care services", health care services rendered to an insured experiencing a condition other than an emergency medical condition.

SECTION 62. Subsection (a) of section 6 of said chapter 176O, as so appearing, is hereby amended by striking out clause (8) and inserting in place thereof the following clause:-

(8) a summary description of the procedure, if any, for out-of-network referrals and any additional charge for utilizing out-of-network providers and a description of the out-of-network consumer protections, including the prohibition on certain billing practices under this chapter.

SECTION 63. Section 23 of said chapter 176O, as so appearing, is hereby amended by inserting after the word "time", in line 3, the following words:- , the network status of an identified health care provider.

SECTION 64. Subsection (a) of section 27 of said chapter 176O, as so appearing, is hereby amended by adding the following sentence:-

The common summary of payments form shall include a description of the out-of-network consumer protections, including the prohibition on certain billing practices, under this chapter.

SECTION 65. Said chapter 176O is hereby further amended by adding the following section:-

Section 29. (a)(1) A carrier shall reimburse a health care provider as follows:

(i) where the health care provider is a member of an insured's carrier's network but not a participating provider in the insured's health benefit plan and the health care provider has delivered health care services to the insured to treat an emergency medical condition, the carrier shall pay that provider the in-network contracted rate for each delivered service; provided, however, that such payment shall constitute payment in full to that health care provider and the 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 participating health care provider under the terms of the insured's health benefit plan;

(ii) where the health care provider is not a member of an insured's carrier's network and the health care provider has delivered health care services to the insured to treat an emergency medical condition, the carrier shall pay that provider the noncontracted commercial rate for emergency services for each delivered service; provided, however, that such payment shall constitute payment in full to the health care provider and the 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 participating health care provider under the terms of the insured's health benefit plan;

(iii) where the health care provider is a member of an insured's carrier's network but not a participating provider in the insured's health benefit plan and the health care provider has delivered nonemergency health care services to the insured and a participating provider in the insured's health benefit plan is unavailable or the health care provider renders those nonemergency health care services without proper notice to the insured as described in section 228 of chapter 111, the carrier shall pay that provider the in-network contracted rate for each delivered service; provided, however, that such payment shall constitute payment in full to the health care provider and the provider shall not bill the insured except for any applicable copayment, coinsurance or deductible that would be owed if the insured received such service from a participating health care provider under the terms of the insured's health benefit plan; and

(iv) where the health care provider is not a member of an insured's carrier's network and the health care provider has delivered nonemergency services to the insured and a participating provider in the insured's health benefit plan is unavailable or the health care provider renders those nonemergency health care services without proper notice to the insured as described in section 228 of chapter 111, the carrier shall pay the provider the noncontracted commercial rate for nonemergency services for each delivered service; provided, however, that such payment shall constitute payment in full to the health care provider and the 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 participating health care provider under the terms of the insured's health benefit plan.

(2) It shall be an unfair and deceptive act or practice in violation of section 2 of chapter 93A for any health care provider or carrier to request payment from an enrollee, other than the applicable coinsurance, copayment, deductible or other out-of-pocket expense, for the services described in paragraph (1).

(b) 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.

(c) Nothing in this section shall require a carrier to pay for nonemergency health care services delivered to an insured if the insured had a reasonable opportunity to choose to have the service performed by a network provider participating in the insured's health benefit plan. Evidence that an insured had a reasonable opportunity to choose to have the service performed by a network provider may include, but not be limited to, a written acknowledgement submitted with any claim for reimbursement from the carrier that: (i) is signed by the insured; and (ii) was provided by the health care provider to the insured before the delivery of nonemergency health care services and provided the insured a reasonable amount of time to seek health care services from a participating provider in the insured's health benefit plan.

(d) With respect to an entity providing or administering a self-funded health benefit plan governed by the provisions of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq. and its plan members, this section shall only apply if the plan elects to be subject to the provisions of this section. To elect to be subject to the provisions of this section, the self-funded health benefit plan shall provide notice to the division on an annual basis, in a form and manner prescribed by the division, attesting to the plan's participation and agreeing to be bound by the provisions of this section. The self-funded health benefit plan shall amend the

health benefit plan, coverage policies, contracts and any other plan documents to reflect that the benefits of this section shall apply to the plan's members.

(e) In a form and manner to be prescribed by the division, carriers shall indicate to insureds that the plan is subject to these provisions. In the case of self-funded health benefit plans that elect to be subject to this section pursuant to subsection (d), the plan shall indicate to its members that it is self-funded and has elected to be subject to these provisions.

(f) The commissioner shall promulgate regulations that are necessary to implement this section.

(g) The attorney general shall have the authority to conduct investigations of alleged violations of this section pursuant to section 5 of chapter 175H or section 6 of chapter 93A. The attorney general may enforce this section by bringing an action pursuant to section 4 or said section 5 of said chapter 175H or section 4 of said chapter 93A.

SECTION 66. Section 79L of chapter 233 of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the word "dentist", in line 12, the following words:- , dental therapist.

SECTION 67. (a) Notwithstanding any general or special law to the contrary, the health policy commission shall, in collaboration with the center for health information and analysis, conduct an analysis of and issue a report on the effects of the COVID-19 pandemic on the commonwealth's health care delivery system, including on the accessibility, quality, and cost of health care services and the financial position of health care entities in the short-term, and the implications of those effects on long-term policy considerations. In developing the report, the commission shall seek input from the executive office of health and human services, other state

agencies, health care providers and payers, public health and economic experts, patients and caregivers, and a range of diverse stakeholders including those disproportionally impacted by COVID-19 or social determinants of health.

(b) The report shall include: (i) an assessment and detailed description of the essential components of a robust health care system and the distribution of services and resources necessary to deliver high-quality care, from birth to death, to all residents in the commonwealth, including, but not limited to, the appropriate level of personal protective equipment at health care facilities to ensure the health of facility personnel and patients, and eliminate health care disparities due to economic, geographic, racial, or other factors; (ii)an inventory and description of the location, distribution, nature, and sustainability of all health care services and resources in the commonwealth serving residents from birth to death; (iii) an analysis of the impact of COVID-19 on the health care workforce and on health care provider efforts to plan and invest in worker readiness, including, but not limited to, the engagement of the workforce; (iv) an examination of the closures of services classified as essential by the department of public health or other relevant agency, the impact that the loss of such essential services have had on access to and the quality of health care services to the communities affected by the closure of such essential services and the efficacy of existing standards and requirements intended to maintain such essential services; and (v) in consultation with the office of health equity in the department of public health, an analysis of health care disparities that exist in the commonwealth due to economic, geographic, racial, or other factors.

The health care system resource inventory compiled under this subsection and all related information shall be maintained in a form accessible and usable by the general public on its website and shall constitute a public record; provided, however, that any item of information that

is confidential or privileged in nature or under any other law shall not be regarded as a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

(c) To assist in its development of the report, the commission may review any data or findings collected under chapter 93 of the acts of 2020 through an interagency agreement with the department of public health.

(d) The commission shall submit an initial report to the clerks of the senate and house of representatives, the senate and house committees on ways and means, the joint committee on health care financing, the joint committee on public health and the joint committee on mental health, substance use and recovery not later than November 1, 2020. The commission shall submit a final report to the clerks of the senate and the house of representatives, the senate and house committees on ways and means, the joint committee on health care financing, the joint committee on public health and the joint committee on mental health, substance use and recovery not later than July 1, 2021.

SECTION 68. Notwithstanding any general or special law to the contrary, the department of public health and the office of consumer affairs and business regulation shall allow licensees to obtain proxy credentialing and privileging for telehealth services with other health care providers as defined in section 1 of chapter 111 of the General Laws or facilities that comply with the federal Centers for Medicare & Medicaid Services' conditions of participation for telehealth services.

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, text messaging, application-based communications and online adaptive

interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring a patient's physical, oral, mental health or substance use disorder condition; provided, however, that "telehealth" may include text-only email when it occurs for the purpose of patient management in the context of a pre-existing physician-patient relationship.

SECTION 69. The board of registration in dentistry shall approve a comprehensive, competency based clinical dental therapy examination that includes assessment of technical competency in performing the procedures and services within the scope of practice as set forth in section 51B of chapter 112 of the General Laws, to be administered by a recognized national or regional dental testing service that administers testing for dentists and other dental professionals. The examination shall be comparable to the examination given to applicants for a dental license but only for the limited scope of dental services in the dental therapy scope of practice as set forth in said section 51B of said chapter 112.

SECTION 70. Notwithstanding any general or special law to the contrary, the department of public health, in consultation with the health policy commission and the center for health information and analysis, shall perform a 5-year longitudinal evaluation of the impact of dental therapists, registered to practice under section 51B of chapter 112 of the General Laws, on patient safety, cost-effectiveness and access to dental services.

The department shall collect, analyze and evaluate data at the start of the evaluation and annually thereafter, including, but not limited to the: (i) number of new and total licensed dental therapists in the commonwealth, broken down by practice setting; (ii) number of new and total adult patients served by dental therapists and the number of new and total pediatric patients served by dental therapists, broken down by geographic location and type of insurance coverage;

(iii) impact on wait times for dental services; (iv) impact on patient travel time and expense; (v) impact on emergency room usage for dental care; (vi) impact on costs for dental services; (vii) most commonly performed procedures and services by dental therapists; (viii) level of patient satisfaction; and (ix) a review on the impact of dental therapists on the overall quality of oral health care delivered to patients.

The department shall file an interim 3-year report not later than January 1, 2025 and a final 3-year report not later than January 1, 2027 broken down by calendar year. The reports shall be filed with the clerks of the senate and house of representatives, the joint committee on public health, the joint committee on health care financing and the house and senate committees on ways and means.

SECTION 71. For the purposes of section 30 of chapter 32A, section 79 of chapter 118E, section 47CC of chapter 175, section 38 of chapter 176A, section 25 of chapter 176B, section 33 of chapter 176G and section 13 of chapter 176I of the General Laws, network adequacy may be met through significant reliance on telehealth providers until the termination of the governor's March 10, 2020 declaration of a state of emergency.

SECTION 72. 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) the number of telehealth services provided by type of service, provider and provider organization and payer; (ii) an analysis of the use of telehealth services by patient demographics, geographic region and type of service; (iii) an

analysis of the impact of payer coverage and payment rate of telehealth services on patient access to and cost of care by patient demographics, geographic region and type of service; (iv) total health care expenditures on telehealth services by type of service and type of telecommunication technology used; (v) an assessment of the appropriate scope of coverage requirements for telehealth services provided through various synchronous or asynchronous audio, video, electronic media and other telecommunications technology, provided, however, that the assessment shall consider the effect of coverage requirements on access to quality care, with special consideration for populations with limited access to technology, and the effect of coverage requirements on increasing health care expenditures and appropriate utilization; (vi) the estimated impact of the use and coverage of telehealth services on health care utilization and total health care expenditures in the commonwealth, including the impact on insurance premiums; (vii) any barriers to increased use of telehealth services, including cost and availability of technology infrastructure, including access to broadband internet and cellular telephone service, for patients and health care providers, cost and availability of technology infrastructure for patients, equity in access for low-income patients, patient choice of providers offering telehealth services, provider reimbursement amounts and method of payment and other payer, patient or provider financial incentives that may reduce the availability of telehealth services; (viii) the estimated aggregate savings or additional costs of telehealth rate requirements on total health care expenditures and on health care access in the commonwealth; (ix) recommendations on ways to expand the use of telehealth services including, but not limited to, the safe and appropriate provision of telehealth services by health care professionals licensed and residing in other states; (x) an analysis of any impact of pre-authorization or other utilization management tools on access to care via telehealth and recommendations for appropriate

limitations on those tools to ensure access to care; and (xi) recommendations on appropriate reimbursement rates for services provided via telehealth compared to comparable in-person services in order to maximize health care access and public health outcomes and limit health care cost growth; provided, however, that data on the use of telehealth services and related effect on access and cost shall differentiate between telehealth services used while the governor's March 10, 2020 declaration of a state of emergency was in effect and telehealth services used after the termination of the governor's March 10, 2020 declaration of a state of emergency.

The report, along with a suggested plan to implement its recommendations, in order to maximize access, quality of care and cost savings 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; provided, however, that not later than December 31, 2021, the commission shall present an interim estimate of the fiscal impact of telehealth use in the commonwealth.

SECTION 73. 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 47CC 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 74. Section 73 is hereby repealed.

SECTION 75. Notwithstanding any general or special law to the contrary, the health policy commission shall provide its recommended noncontracted commercial rate for emergency services and the noncontracted commercial rate for nonemergency services under section 16A of chapter 6D of the General Laws not later than May 1, 2021.

SECTION 76. Section 65 shall take effect 1 year from the effective date of this act.

SECTION 77. The first paragraph of subsection (f) and subsections (i) and (j) of section 51B of chapter 112 of the General Laws and section 69 shall take effect on January 1, 2022.

SECTION 78. The second paragraph of subsection (f) of section 51B of chapter 112 of the General Laws shall take effect on December 1, 2024.

SECTION 79. Section 74 shall take effect on July 31, 2022.