

# SENATE . . . . . No. 2984

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## The Commonwealth of Massachusetts

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In the One Hundred and Ninety-First General Court  
(2019-2020)  
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SENATE, December 23, 2020

Report of the committee of conference on the disagreeing votes of the two branches, with reference to the House amendments to the Senate Bill putting Patients First (Senate, No. 2796) (amended by the House by striking out all after the enacting clause and inserting in place thereof the text of House document numbered 4888),-- reports, a "Bill promoting a resilient health care system that puts patients first" (Senate, No. 2984).

For the Committee:

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**The Commonwealth of Massachusetts**

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

An Act promoting a resilient health care system that puts 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:*

1           SECTION 1. Section 2 of chapter 6D of the General Laws, as appearing in the 2018  
2 Official Edition, is hereby amended by striking out, in lines 47 to 50, inclusive, the words “have  
3 demonstrated expertise in the development and utilization of innovative medical technologies  
4 and treatments for patient care and shall be initially appointed for a term of 2” and inserting in  
5 place thereof the following words:- be a registered nurse with demonstrated expertise in the  
6 development and utilization of innovative treatments for patient care and shall be appointed for a  
7 term of 5.

8           SECTION 2. Chapter 32A of the General Laws is hereby amended by inserting after  
9 section 17Q the following section:-

10           Section 17R. The commission shall provide to any active or retired employee of the  
11 commonwealth who is insured under the group insurance commission coverage for treatment of  
12 pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and  
13 pediatric acute-onset neuropsychiatric syndrome, including, but not limited to, the use of  
14 intravenous immunoglobulin therapy.

15 SECTION 3. Said chapter 32A is hereby further amended by adding the following  
16 section:-

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

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

21 “Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or  
22 other telecommunications technology, including, but not limited to: (i) interactive audio-video  
23 technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online  
24 adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating  
25 or monitoring of a patient's physical health, oral health, mental health or substance use disorder  
26 condition.

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

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

44 (d) A health care provider shall not be required to document a barrier to an in-person visit  
45 nor shall the type of setting where telehealth services are provided be limited for health care  
46 services provided via telehealth; provided, however, that a patient may decline receiving services  
47 via telehealth in order to receive in-person services.

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

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

57 (g) The commission shall ensure that the rate of payment for in-network providers of  
58 behavioral health services delivered via interactive audio-video technology and audio-only

59 telephone shall be no less than the rate of payment for the same behavioral health service  
60 delivered via in-person methods; provided, that this subsection shall apply to providers of  
61 behavioral health services covered as required under subclause (i) of clause (4) of the second  
62 sentence of subsection (a) of section 6 of chapter 176O.

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

67 SECTION 4. Section 1 of chapter 94C of the General Laws, as appearing in the 2018  
68 Official Edition, is hereby amended by inserting after the definition for "Marihuana" the  
69 following definition:-

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

74 SECTION 5. Said section 1 of said chapter 94C, as so appearing, is hereby further  
75 amended by striking out, in line 290, the words "a practitioner, registered nurse, or practical  
76 nurse" and inserting in place thereof the following words:- an individual who is authorized to  
77 administer such medication under this chapter.

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

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

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

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

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

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

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

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

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

108 SECTION 12. Said subsection (g) of said section 7 of said chapter 94C, as so appearing,  
109 is hereby further amended by striking out the seventh paragraph.

110 SECTION 13. Said section 7 of said chapter 94C, as so appearing, is hereby further  
111 amended by striking out, in line 213, the words “and 66B” and inserting in place thereof the  
112 following words: - , 66B and 66C.

113 SECTION 14. Section 9 of said chapter 94C, as so appearing, is hereby amended by  
114 inserting after the word “podiatrist”, in line 1, the following words: - , nurse practitioner, nurse  
115 anesthetist, psychiatric nurse mental health clinical specialist.

116 SECTION 15. Said section 9 of said chapter 94C, as so appearing, is hereby further  
117 amended by striking out, in line 2, the words “and 66B” and inserting in place thereof the  
118 following words: - , 66B and 66C.

119 SECTION 16. Said section 9 of said chapter 94C, as so appearing, is hereby further  
120 amended by striking out, in lines 3 to 5, inclusive, the words “, nurse practitioner and psychiatric  
121 nurse mental health clinical specialist as limited by subsection (g) of said section 7 and section  
122 80E of said chapter 112”.

123 SECTION 17. Said section 9 of said chapter 94C, as so appearing, is hereby further  
124 amended by striking out, in lines 8 and 9, the words “, nurse anesthetist, as limited by subsection  
125 (g) of said section 7 and section 80H of said chapter 112”.

126 SECTION 18. Said section 9 of said chapter 94C, as so appearing, is hereby further  
127 amended by inserting after the word “nurse-midwifery”, in line 32, the following words:- ,  
128 advanced practice nursing.

129 SECTION 19. Said section 9 of said chapter 94C, as so appearing, is hereby further  
130 amended by inserting after the word “podiatrist”, in lines 72 and 80, each time it appears, the  
131 following word:- , optometrist.

132 SECTION 20. Said section 9 of said chapter 94C, as so appearing, is hereby further  
133 amended by inserting after the word “practitioner”, in lines 100 and 107, each time it appears,  
134 the following words:- , nurse anesthetist, psychiatric nurse mental health clinical specialist.

135 SECTION 21. Section 18 of said chapter 94C, as so appearing, is hereby amended by  
136 striking out, in lines 10, 39, 72 and 115 and 116, the words “to practice medicine” and inserting  
137 in place thereof, in each instance, the following words:- and authorized to engage in prescriptive  
138 practice.

139 SECTION 22. Said section 18 of said chapter 94C, as so appearing, is hereby further  
140 amended by striking out the word “physician”, in lines 25, 34 and 35, 38, 72, 74 and 115, and  
141 inserting in place thereof, in each instance, the following word:- practitioner.

142 SECTION 23. Said section 18 of said chapter 94C, as so appearing, is hereby further  
143 amended by striking out, in lines 27, 54 and 55 and 88, the word “medicine”.



144 SECTION 24. Section 1 of chapter 111 of the General Laws, as so appearing, is hereby  
145 amended by inserting after the word “nurse”, in line 27, the following words:- , registered  
146 pharmacist.

147 SECTION 25. Said chapter 111 is hereby further amended by striking out section 228, as  
148 so appearing, and inserting in place thereof the following section:-

149 Section 228. (a) As used in this section “allowed amount”, shall mean the contractually  
150 agreed-upon maximum amount paid by a carrier to a health care provider for a health care  
151 service provided to an insured.

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

163 (2) If the health care provider is participating in the patient’s or prospective patient’s  
164 health benefit plan, the health care provider shall, at the time of scheduling the admission,  
165 procedure or service: (i) inform such patient or prospective patient that the patient or prospective

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

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

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

190 (c) A health care provider referring a patient to another provider shall disclose: (i) if the  
191 provider to whom the patient is being referred is part of or represented by the same provider  
192 organization as defined in section 1 of chapter 6D; (ii) the possibility that the provider to whom  
193 the patient is being referred is not participating in the patient's health benefit plan and that if the  
194 provider is out-of-network under the terms of the patient's health benefit plan then any out-of-  
195 network applicable rates under such health benefit plan may apply and that the patient has the  
196 opportunity to verify whether the provider participates in the patient's health benefit plan prior to  
197 making an appointment or agreeing to use the services of said provider; and (iii) sufficient  
198 information about the referred provider for the patient to obtain additional information about the  
199 provider's network status under the patient's health plan and any applicable out-of-pocket costs  
200 for services sought from the referred provider pursuant to section 23 of chapter 176O.

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

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

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

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

231 SECTION 26. Said chapter 111 is hereby further amended by adding the following 3  
232 sections:-

233 Section 240. (a) As used in this section, the following words shall, unless the context  
234 clearly requires otherwise, have the following meanings:

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

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

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

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

244 (b) (1) Reimbursement of a subject’s travel and ancillary costs shall not be deemed an  
245 inducement or as exerting undue influence to participate in a cancer clinical trial.

246 (2) The informed consent process shall inform potential subjects if:

247 (i) reimbursement for travel and ancillary costs is available to subjects based on financial  
248 need;

249 (ii) reimbursement of travel and ancillary costs is provided to eliminate financial barriers  
250 to enrollment in order to retain subjects in the clinical trial; and

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

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

257 (d) Reimbursement plans to cover travel and ancillary costs shall be reviewed and  
258 approved by a duly appointed institutional review board or independent ethics committee  
259 reviewing on behalf of a health care facility in conjunction with the review of the proposed  
260 cancer clinical trial. The nature of the support for travel and ancillary costs and general  
261 guidelines on financial eligibility shall be disclosed to subjects. The reimbursement process shall  
262 conform to state and federal laws and guidance.

263 Section 241. (a) For the purposes of this section the following words shall, unless the  
264 context clearly requires otherwise, have the following meanings:-

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

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

270 (b) There shall be a rare disease advisory council within the department, which shall  
271 consist of: the commissioner, or a designee, who shall serve as chair; the executive director, or a  
272 designee, of the health policy commission; 2 members of the senate, or a designee, 1 of whom  
273 shall be appointed by the minority leader of the senate; 2 members of the house of  
274 representatives, or a designee, 1 of whom shall be appointed by the minority leader of the house;

275 4 persons appointed by the senate president, 1 of whom shall be a pharmacist with experience  
276 with drugs used to treat rare diseases, 1 of whom shall be a geneticist licensed and practicing in  
277 the commonwealth and 1 of whom shall be a registered nurse or advanced practice registered  
278 nurse licensed and practicing in the commonwealth with experience treating rare diseases; 4  
279 persons appointed by the speaker of the house, 1 of whom shall be a representative of a health  
280 plan or accountable care organization certified by the health policy commission, 1 of whom shall  
281 be a genetic counselor with experience providing services to persons diagnosed with a rare  
282 disease and 1 of whom shall be a representative from a rehabilitation facility that provides rare  
283 disease care; and 15 persons to be appointed by the governor, 2 of whom shall be from academic  
284 research institutions that receive grant funding for rare diseases research, 2 of whom shall be  
285 physicians licensed and practicing in the commonwealth with experience researching, diagnosing  
286 or treating rare diseases, 1 of whom shall be a hospital administrator, or a designee, from a  
287 hospital in the commonwealth that provides care to persons diagnosed with a rare disease; 1 of  
288 whom shall be a hospital administrator, or a designee, from a hospital in the commonwealth that  
289 provides care to persons diagnosed with a rare disease and in which the scope of service focuses  
290 on rare diseases of pediatric patients, 3 of whom shall be representatives of rare disease patient  
291 organizations that operate in the commonwealth, 2 of whom shall be representatives of the  
292 biotechnology and scientific community who are engaged in rare disease research, including, but  
293 not limited to, a medical researcher with experience conducting research on rare diseases, 1 of  
294 whom shall be a dietician licensed and practicing in the commonwealth with experience  
295 administering dietary therapies to those with rare diseases, 2 of whom shall be persons age 18 or  
296 older who have a rare disease and 1 of whom shall be a caregiver of a person with a rare disease.

297 (c) Each member of the rare disease advisory council shall serve for a term of 3 years and  
298 shall serve until their successors have been appointed. The advisory council shall meet  
299 periodically not fewer than 4 times annually, with members able to participate in any meeting by  
300 teleconference. The members of the advisory council shall serve without compensation. The  
301 commissioner shall provide the advisory council with suitable accommodations for its meetings  
302 and the department shall further provide administrative support to assist the advisory council.

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

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

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

316 (iii) receive and consider reports and testimony from expert individuals, the department,  
317 community-based organizations, voluntary health organizations, health care providers and other  
318 public and private organizations recognized as having expertise in rare disease care, to learn



319 about their contributions to rare disease care and possibilities for the improvement of rare disease  
320 care in the commonwealth;

321 (iv) develop methods to publicize the profile of the social and economic burden of rare  
322 disease in the commonwealth to ensure that the public and health care providers are sufficiently  
323 informed of the most effective strategies for recognizing and treating rare disease;

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

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

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

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

342 (ix) develop and maintain a comprehensive rare disease plan for the commonwealth  
343 utilizing any information and materials received or developed by the advisory council pursuant  
344 to this subsection and that shall include information specifically directed toward the general  
345 public, state and local officials, state agencies, private organizations and associations and  
346 businesses and industries.

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

351 (f) Annually, not later than December 31, the advisory council shall file a report with the  
352 clerks of the house of representatives and the senate and the executive office for administration  
353 and finance, which shall include, but not be limited to: (i) a summary of the current state of the  
354 comprehensive rare disease plan for the commonwealth; (ii) those actions taken and progress  
355 made toward achieving implementation of the comprehensive rare disease plan; (iii) an  
356 accounting of all funds received by the council and the source of those funds; (iv) an accounting  
357 of all funds expended by the council; and (v) to the extent practicable, an estimate of any cost  
358 savings on the part of individuals and the commonwealth that will occur upon full  
359 implementation of the comprehensive rare disease plan and accompanying programs.

360 Section 242. (a) There shall be an advisory council on pediatric autoimmune  
361 neuropsychiatric disorder associated with streptococcal infections and pediatric acute  
362 neuropsychiatric syndrome within the department, which shall advise the commissioner on  
363 research, diagnosis, treatment and education relating to the disorder and syndrome, hereinafter  
364 referred to as PANDAS/PANS.

365 (b) The council shall consist of the commissioner, or a designee, who shall be an ex-  
366 officio, nonvoting member and the following members appointed by the commissioner: 1  
367 physician specializing in infectious diseases, licensed and practicing in the commonwealth with  
368 experience treating persons with PANDAS/PANS and the use of intravenous immunoglobulin; 1  
369 pediatrician licensed and practicing in the commonwealth who has experience treating persons  
370 with PANDAS/PANS; 1 child psychiatric practitioner with experience treating persons with  
371 PANDAS/PANS; 2 health care providers licensed and practicing in the commonwealth who have  
372 experience in treating persons with PANDAS/PANS; 1 medical researcher with experience  
373 conducting research concerning PANDAS/PANS, obsessive-compulsive disorder, tic disorder  
374 and other neuro-inflammatory disorders; 1 representative of a non-profit PANDAS/PANS  
375 advocacy organization in the commonwealth; 1 representative of a professional organization in  
376 the commonwealth for school nurses; 2 parents with a child who has been diagnosed with  
377 PANDAS/PANS; 1 social worker licensed and practicing in the commonwealth who has  
378 experience working with persons and families impacted by PANDAS/PANS; 1 special education  
379 administrator who has experience working with persons and families impacted by  
380 PANDAS/PANS; and 3 additional persons.

381 Each member of the council shall serve for a term of 3 years and shall serve without  
382 receiving compensation. Any member of the advisory council appointed by the commissioner

383 may be a member of the general court. The advisory council shall meet upon the call of the chair  
384 or upon the request of a majority of council members.

385 (c) The advisory council shall issue a report to the general court annually with  
386 recommendations concerning: (i) practice guidelines for the diagnosis and treatment of the  
387 disorder and syndrome; (ii) development of screening protocols; (iii) mechanisms to increase  
388 clinical awareness and education regarding the disorder and syndrome among physicians,  
389 including pediatricians, school-based health centers and providers of mental health services; (iv)  
390 outreach to educators and parents to increase awareness of the disorder and syndrome; and (v)  
391 development of a network of volunteer experts on the diagnosis and treatment of the disorder and  
392 syndrome.

393 (d) The advisory council may request from all state agencies such information and  
394 assistance as the council may require.

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

399 SECTION 27. Chapter 112 of the General Laws is hereby amended by inserting after  
400 section 5N the following section:-

401 Section 5O. (a) For purposes of this section “telehealth” shall mean the use of  
402 synchronous or asynchronous audio, video, electronic media or other telecommunications  
403 technology, including, but not limited to: (i) interactive audio-video technology; (ii) remote  
404 patient monitoring devices; (iii) audio-only telephone; and (iv) online adaptive interviews, for

405 the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring of a  
406 patient's physical health, oral health, mental health or substance use disorder condition.

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

412 SECTION 28. Said chapter 112 is hereby further amended by striking out section 66, as  
413 appearing in the 2018 Official Edition, and inserting in place thereof the following section:-

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

422 SECTION 29. Section 66B of said chapter 112, as so appearing, is hereby amended by  
423 striking out, in line 31, the following words:- , except glaucoma.

424 SECTION 30. Said chapter 112 is hereby further amended by inserting after section 66B  
425 the following section:-

426           Section 66C. (a) A registered optometrist who is qualified by an examination for practice  
427 under section 68, certified under section 68C and registered to issue written prescriptions  
428 pursuant to subsection (h) of section 7 of chapter 94C may: (i) use and prescribe topical and oral  
429 therapeutic pharmaceutical agents as defined in section 66B that are used in the practice of  
430 optometry, including those placed in schedules III, IV, V and VI pursuant to section 2 of said  
431 chapter 94C, for the purpose of diagnosing, preventing, correcting, managing or treating  
432 glaucoma and other ocular abnormalities of the human eye and adjacent tissue; and (ii) prescribe  
433 all necessary eye-related medications, including oral anti-infective medications; provided,  
434 however, that a registered optometrist shall not use or prescribe: (A) therapeutic pharmaceutical  
435 agents for the treatment of systemic diseases; (B) invasive surgical procedures; (C)  
436 pharmaceutical agents administered by subdermal injection, intramuscular injection, intravenous  
437 injection, subcutaneous injection, intraocular injection or retrobulbar injection; or (D) an opioid  
438 substance or drug product.

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

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

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

453 SECTION 31. Said chapter 112 is hereby further amended by inserting after section 68B  
454 the following section:-

455 Section 68C. (a) The board of registration in optometry shall administer an examination  
456 to permit the use and prescription of therapeutic pharmaceutical agents as authorized in section  
457 66C. The examination shall: (i) be held in conjunction with examinations provided for in  
458 sections 68, 68A and 68B; and (ii) include any portion of the examination administered by the  
459 National Board of Examiners in Optometry or other appropriate examination covering the  
460 subject matter of therapeutic pharmaceutical agents as authorized in section 66C. The board may  
461 administer a single examination to measure the qualifications necessary under this section and  
462 sections 68, 68A, 68B. The board shall qualify optometrists to use and prescribe therapeutic  
463 pharmaceutical agents in accordance with this section and said sections 68, 68A, 68B.

464 (b) Examination for the use and prescription of therapeutic pharmaceutical agents placed  
465 in schedules III, IV, V and VI under section 2 of chapter 94C and defined in section 66C shall,  
466 upon application, be open to an optometrist registered under section 68, 68A or 68B and to any  
467 person who meets the qualifications for examination under said sections 68, 68A and 68B. An  
468 applicant registered as an optometrist under said sections 68, 68A or 68B shall: (i) be registered  
469 pursuant to subsection (h) of section 7 of said chapter 94C to use or prescribe pharmaceutical  
470 agents for the purpose of diagnosing or treating glaucoma and other ocular abnormalities of the

471 human eye and adjacent tissue; and (ii) furnish to the board of registration in optometry evidence  
472 of the satisfactory completion of 40 hours of didactic education and 20 hours of supervised  
473 clinical education relating to the use and prescription of therapeutic pharmaceutical agents under  
474 section 66C; provided, however, that such education shall: (A) be administered by the  
475 Massachusetts Society of Optometrists, Inc.; (B) be accredited by a college of optometry or  
476 medicine; and (C) meet the guidelines and requirements of the board of registration in  
477 optometry. The board of registration in optometry shall provide to each successful applicant a  
478 certificate of qualification in the use and prescription of all therapeutic pharmaceutical agents as  
479 authorized under said section 66C and shall forward to the department of public health notice of  
480 such certification for each successful applicant.

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

490 (d) A licensed optometrist who has completed a postgraduate residency program  
491 approved by the Accreditation Council on Optometric Education of the American Optometric  
492 Association may submit an affidavit to the board of registration in optometry from the licensed  
493 optometrist's residency supervisor or the director of residencies at the affiliated college of



494 optometry attesting that the optometrist has completed an equivalent level of instruction and  
495 supervision and the board may accept the evidence in order to satisfy any of the requirements of  
496 this section.

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

501 SECTION 32. Section 80B of said chapter 112, as appearing in the 2018 Official Edition,  
502 is hereby amended by inserting after the word “practitioners”, in line 12, the following words:- ,  
503 nurse anesthetists.

504 SECTION 33. Said section 80B of said chapter 112, as so appearing, is hereby further  
505 amended by striking out the seventh paragraph and inserting in place thereof the following  
506 paragraph:-

507 The board shall promulgate advanced practice nursing regulations that govern the  
508 provision of advanced practice nursing services and related care including, but not limited to, the  
509 ordering and interpreting of tests, the ordering and evaluation of treatment and the use of  
510 therapeutics; provided, that such services and related care shall not include the interpretation of  
511 tests that are beyond the scope of the nurse’s licensure and training.

512 SECTION 34. Said section 80B of said chapter 112, as so appearing, is hereby further  
513 amended by striking out, in lines 64 and 65, the words “in the ordering of tests, therapeutics and  
514 the prescribing of medications,”.

515 SECTION 35. Said chapter 112 is hereby further amended by striking out section 80E, as  
516 so appearing, and inserting in place thereof the following section:-

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

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

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

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

544           SECTION 36. Said chapter 112 is hereby further amended by striking out section 80H, as  
545 so appearing, and inserting in place thereof the following section:-

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

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

565           The board may allow a nurse anesthetist to exercise such independent practice authority  
566 upon satisfactory demonstration of alternative professional experience if the board determines  
567 that the nurse anesthetist has a demonstrated record of safe prescribing and good conduct  
568 consistent with professional licensure obligations required by each jurisdiction in which the  
569 nurse anesthetist has been licensed.

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

571           SECTION 37. Section 80I of said chapter 112, as so appearing, is hereby amended by  
572 striking out the second and third sentences.

573           SECTION 38. Said chapter 112 is hereby further amended by inserting after section 80I  
574 the following 2 sections:-

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

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

588 SECTION 39. Chapter 118E of the General Laws is hereby amended by inserting after  
589 section 10M, inserted by section 19 of chapter 133 of the acts of 2019, the following section:-

590 Section 10N. (a) For the purposes of this section, the following words shall, unless the  
591 context clearly requires otherwise, have the following meanings:-

592 “Division”, the division of medical assistance within the executive office of health and  
593 human services.

594 “Urgent care facility”, any entity, however organized, whether conducted for profit or not  
595 for profit, which is advertised, announced, established or maintained for the purpose of providing  
596 urgent care services in an office or a group of offices, or any portion thereof, or an entity which  
597 is advertised, announced, established or maintained under a name which includes the words  
598 “urgent care” or which suggests that urgent care services are provided therein; provided,  
599 however, that an urgent care facility shall not serve as a patient’s primary care provider.

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

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

613 Any urgent care facility that provides health care services to an enrollee shall notify the  
614 division, in a manner to be determined by the division, that the urgent care facility provided such  
615 services to the enrollee. The urgent care facility shall also notify the division, in a manner to be  
616 determined by the division, if the enrollee does not have a designated primary care provider, and  
617 the division shall send a notice to the enrollee that shall contain guidance on how to choose a  
618 primary care provider.

619 The division may promulgate regulations to implement this section.

620 SECTION 40. Said chapter 118E is hereby further amended by adding the following  
621 section:-

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

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

626 “Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or  
627 other telecommunications technology, including, but not limited to: (i) interactive audio-video  
628 technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online  
629 adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating  
630 or monitoring of a patient's physical health, oral health, mental health or substance use disorder  
631 condition.

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

643 in-person services in a timely manner upon request. Coverage shall not be limited to services  
644 delivered by third-party providers.

645 (c) The division may undertake utilization review, including preauthorization, to  
646 determine the appropriateness of telehealth as a means of delivering a health care service;  
647 provided, however, that the determination shall be made in the same manner as if service was  
648 delivered in-person. The division, a contracted health insurer, health plan, health maintenance  
649 organization, behavioral health management firm or third-party administrator under contract to a  
650 Medicaid managed care organization or primary care clinician plan shall not be required to  
651 reimburse a health care provider for a health care service that is not a covered benefit under the  
652 plan or reimburse a health care provider not contracted under the plan except as provided for  
653 under subclause (i) of clause (4) of the second sentence of subsection (a) of section 6 of chapter  
654 176O.

655 (d) A health care provider shall not be required to document a barrier to an in-person visit  
656 nor shall the type of setting where telehealth services are provided be limited for health care  
657 services provided via telehealth; provided, however, that a patient may decline receiving services  
658 via telehealth in order to receive in-person services.

659 (e) A contract that provides coverage for telehealth services may include a deductible,  
660 copayment or coinsurance requirement for a health care service provided via telehealth as long as  
661 the deductible, copayment or coinsurance does not exceed the deductible, copayment or  
662 coinsurance applicable to an in-person consultation or in-person delivery of services. The rate of  
663 payment for telehealth services provided via interactive audio-video technology and audio-only



664 telephone may be greater than the rate of payment for the same service delivered by other  
665 telehealth modalities.

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

669 (g) The division shall ensure that the rate of payment for in-network providers of  
670 behavioral health services delivered via interactive audio-video technology and audio-only  
671 telephone shall be no less than the rate of payment for the same behavioral health service  
672 delivered via in-person methods; provided, that this subsection shall apply to providers of  
673 behavioral health services covered as required under subclause (i) of clause (4) of the second  
674 sentence of subsection (a) of section 6 of chapter 176O.

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

679 SECTION 41. Section 1 of chapter 123 of the General Laws, as appearing in the 2018  
680 Official Edition, is hereby amended by inserting after the definition for "Psychologist" the  
681 following definition:-

682 "Qualified advanced practice registered nurse", a certified registered nurse anesthetist, a  
683 certified nurse midwife, certified nurse practitioner, clinical nurse specialist, or psychiatric  
684 clinical nurse specialist authorized to practice as such under regulations promulgated pursuant to  
685 the provisions of section eighty B of chapter one hundred and twelve who is designated by and

686 meets qualifications required by the regulations of the department, provided that different  
687 qualifications may be established for different purposes of this chapter. A qualified advanced  
688 practice registered nurse need not be an employee of the department or of any facility of the  
689 department.

690 SECTION 42. Said chapter 123 is hereby further amended by striking out section 11, as  
691 appearing in the 2018 Official Edition, and inserting in place thereof the following section:-

692 Section 11. Any person retained in a facility under the provisions of paragraph (a) of  
693 section 10 shall be free to leave such facility at any time, and a parent or guardian who requested  
694 the admission of such person may withdraw such person at any time, upon giving written notice  
695 to the superintendent. The superintendent may restrict the right to leave or withdraw to normal  
696 working hours and weekdays and, in the superintendent's discretion, may require persons or the  
697 parent or guardian of a person to give 3 days written notice of their intention to leave or  
698 withdraw. If a person or their parent or guardian is required to give 3 days notice of intention to  
699 leave or withdraw, an examination of the person may be conducted to determine their clinical  
700 progress, their suitability for discharge and to investigate other aspects of their case, including  
701 their legal competency and their family, home or community situation, in the interest of  
702 discharging them from the facility. The person may be retained at the facility beyond the  
703 expiration of the 3-day notice period if prior to the expiration of the 3-day notice period the  
704 superintendent files with the district court a petition for the commitment of the person at the  
705 facility. Before accepting an application for voluntary admission where the superintendent may  
706 require 3 days written notice of intention to leave or withdraw, the admitting or treating  
707 physician or qualified advanced practice registered nurse shall assess the person's capacity to  
708 understand that: (i) the person is agreeing to stay or remain at the hospital; (ii) the person is

709 agreeing to accept treatment; (iii) the person is required to provide the facility with 3 days  
710 written advance notice of the person's intention to leave the facility; and (iv) the facility may  
711 petition a court for an extended commitment of the person and that the person may be held at the  
712 facility until the petition is heard by the court. If the physician or qualified advanced practice  
713 registered nurse determines that the person lacks the capacity to understand these facts and  
714 consequences of hospitalization, the application shall not be accepted.

715 SECTION 43. Said chapter 123 is hereby further amended by striking out section 12, as  
716 so appearing, and inserting in place thereof the following section:-

717 Section 12. (a) A physician who is licensed pursuant to section 2 of chapter 112, an  
718 advanced practice registered nurse authorized to practice as such under regulations promulgated  
719 pursuant to section 80B of said chapter 112, a qualified psychologist licensed pursuant to  
720 sections 118 to 129, inclusive, of said chapter 112 or a licensed independent clinical social  
721 worker licensed pursuant to sections 130 to 137, inclusive, of said chapter 112 who, after  
722 examining a person, has reason to believe that failure to hospitalize such person would create a  
723 likelihood of serious harm by reason of mental illness may restrain or authorize the restraint of  
724 such person and apply for the hospitalization of such person for a 3-day period at a public facility  
725 or at a private facility authorized for such purposes by the department. If an examination is not  
726 possible because of the emergency nature of the case and because of the refusal of the person to  
727 consent to such examination, the physician, qualified psychologist, qualified advanced practice  
728 registered nurse or licensed independent clinical social worker on the basis of the facts and  
729 circumstances may determine that hospitalization is necessary and may therefore apply. In an  
730 emergency situation, if a physician, qualified psychologist, qualified advanced practice  
731 registered nurse or licensed independent clinical social worker is not available, a police officer

732 who believes that failure to hospitalize a person would create a likelihood of serious harm by  
733 reason of mental illness may restrain such person and apply for the hospitalization of such person  
734 for a 3-day period at a public facility or a private facility authorized for such purpose by the  
735 department. An application for hospitalization shall state the reasons for the restraint of such  
736 person and any other relevant information that may assist the admitting physician or qualified  
737 advanced practice registered nurse. Whenever practicable, prior to transporting such person, the  
738 applicant shall telephone or otherwise communicate with a facility to describe the circumstances  
739 and known clinical history and to determine whether the facility is the proper facility to receive  
740 such person and to give notice of any restraint to be used and to determine whether such restraint  
741 is necessary.

742 (b) Only if the application for hospitalization under this section is made by a physician or  
743 a qualified advanced practice registered nurse specifically designated to have the authority to  
744 admit to a facility in accordance with the regulations of the department, shall such person be  
745 admitted to the facility immediately after reception. If the application is made by someone other  
746 than a designated physician or a qualified advanced practice registered nurse such person shall be  
747 given a psychiatric examination by a designated physician or a qualified advanced practice  
748 registered nurse immediately after reception at such facility. If the physician or a qualified  
749 advanced practice registered nurse determines that failure to hospitalize such person would  
750 create a likelihood of serious harm by reason of mental illness, the physician or qualified  
751 advanced practice registered nurse may admit such person to the facility for care and treatment.  
752 Upon admission of a person under this subsection, the facility shall inform the person that it  
753 shall, upon such person's request, notify the committee for public counsel services of the name  
754 and location of the person admitted. The committee for public counsel services shall immediately

755 appoint an attorney who shall meet with the person. If the appointed attorney determines that the  
756 person voluntarily and knowingly waives the right to be represented, is presently represented or  
757 will be represented by another attorney, the appointed attorney shall so notify the committee for  
758 public counsel services, which shall withdraw the appointment.

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

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

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

773 (e) Any person may make an application to a district court justice or a justice of the  
774 juvenile court department for a 3-day commitment to a facility of a person with a mental illness  
775 if the failure to confine said person would cause a likelihood of serious harm. The court shall  
776 appoint counsel to represent said person. After hearing such evidence as the court may consider

777 sufficient, a district court justice or a justice of the juvenile court department may issue a warrant  
778 for the apprehension and appearance before the court of the alleged person with a mental illness  
779 if in the court's judgment the condition or conduct of such person makes such action necessary  
780 or proper. Following apprehension, the court shall have the person examined by a physician or a  
781 qualified advanced practice registered nurse designated to have the authority to admit to a facility  
782 or examined by a qualified psychologist in accordance with the regulations of the department. If  
783 the physician, qualified advanced practice registered nurse or qualified psychologist reports that  
784 the failure to hospitalize the person would create a likelihood of serious harm by reason of  
785 mental illness, the court may order the person committed to a facility for a period not to exceed 3  
786 days; provided, however, that the superintendent may discharge said person at any time within  
787 the 3-day period. The periods of time prescribed or allowed under this section shall be computed  
788 pursuant to Rule 6 of the Massachusetts Rules of Civil Procedure.

789 SECTION 44. Said chapter 123 is hereby further amended by striking out section 21, as  
790 so appearing, and inserting in place thereof the following section:-

791 Section 21. Any person who transports a person with a mental illness to or from a facility  
792 for any purpose authorized under this chapter shall not use any restraint that is unnecessary for  
793 the safety of the person being transported or other persons likely to come in contact with the  
794 person.

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

798           Restraint of a person with a mental illness may only be used in cases of emergency, such  
799 as the occurrence of, or serious threat of, extreme violence, personal injury or attempted suicide;  
800 provided, however, that written authorization for such restraint is given by the superintendent or  
801 director of the facility or by a physician or qualified advanced practice registered nurse  
802 designated by the superintendent or director for this purpose who is present at the time of the  
803 emergency or if the superintendent, director, designated physician or designated qualified  
804 advanced practice registered nurse is not present at the time of the emergency, non-chemical  
805 means of restraint may be used for a period of not more than 1 hour; provided further, that within  
806 1 hour the person in restraint shall be examined by the superintendent, director, designated  
807 physician or designated qualified advanced practice registered nurse; and provided further, that if  
808 the examination has not occurred within 1 hour, the patient may be restrained for an additional  
809 period of not more than 1 hour until such examination is conducted and the superintendent,  
810 director, designated physician or designated qualified advanced practice registered nurse shall  
811 attach to the restraint form a written report as to why the examination was not completed by the  
812 end of the first hour of restraint.

813           Any minor placed in restraint shall be examined within 15 minutes of the order for  
814 restraint by a physician or qualified advanced practice registered nurse or, if a physician or  
815 qualified advanced practice registered nurse is not available, by a registered nurse or a certified  
816 physician assistant; provided, however, that said minor shall be examined by a physician or  
817 qualified advanced practice registered nurse within 1 hour of the order for restraint. A physician  
818 or qualified advanced practice registered nurse or, if a physician or qualified advanced practice  
819 registered nurse is not available, a registered nurse or a certified physician assistant, shall review

820 the restraint order by personal examination of the minor or consultation with ward staff attending  
821 the minor every hour thereafter.

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

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

840 No order for restraint for an individual shall be valid for a period of more than 3 hours  
841 beyond which time it may be renewed upon personal examination by the superintendent,



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

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

858           No person shall be kept in restraint without a person in attendance specially trained to  
859 understand, assist and afford therapy to the person in restraint. The person may be in attendance  
860 immediately outside the room in full view of the patient when an individual is being secluded  
861 without mechanical restraint; provided, however, that in emergency situations when a person  
862 specially trained is not available, an adult may be kept in restraint unattended for a period not to  
863 exceed 2 hours. In that event, the person kept in restraints shall be observed at least every 5  
864 minutes; provided, further, that the superintendent, director, designated physician or designated

865 qualified advanced practice registered nurse shall attach to the restraint form a written report as  
866 to why the specially trained attendant was not available. The maintenance of any adult in  
867 restraint for more than 8 hours in any 24-hour period shall be authorized by the superintendent or  
868 director or the person specifically designated to act in the absence of the superintendent or  
869 director; provided, however, that when such restraint is authorized in the absence of the  
870 superintendent or director, such authorization shall be reviewed by the superintendent or director  
871 upon the return of the superintendent or director.

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

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

879 A copy of the restraint form and any such attachments shall become part of the chart of  
880 the patient. Copies of all restraint forms and attachments shall be sent to the commissioner of  
881 mental health, or, with respect to Bridgewater state hospital to the commissioner of correction,  
882 who shall review and sign them within 30 days and statistical records shall be kept thereof for  
883 each facility, including Bridgewater state hospital, and each designated physician or qualified  
884 advanced practice registered nurse. Furthermore, such reports, excluding personally identifiable  
885 patient identification, shall be made available to the general public at the department's central

886 office, or, with respect to Bridgewater state hospital at the department of correction's central  
887 office.

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

891 SECTION 45. Said chapter 123 is hereby further amended by striking out section 22, as  
892 so appearing, and inserting in place thereof the following section:-

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

900 SECTION 46. Section 47BB of chapter 175 of the General Laws, inserted by section 158  
901 of chapter 224 of the acts of 2012, is hereby repealed.

902 SECTION 47. Said chapter 175 is hereby further amended by inserting after section  
903 47LL, inserted by section 20 of chapter 133 of the acts of 2020, the following 2 sections:-

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

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

908 “Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or  
909 other telecommunications technology, including, but not limited to: (i) interactive audio-video  
910 technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online  
911 adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating  
912 or monitoring of a patient's physical health, oral health, mental health or substance use disorder  
913 condition.

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

925 (c) Coverage for telehealth services may include utilization review, including  
926 preauthorization, to determine the appropriateness of telehealth as a means of delivering a health  
927 care service; provided, however, that the determination shall be made in the same manner as if

928 the service was delivered in-person. A policy, contract, agreement, plan or certificate of  
929 insurance issued, delivered or renewed within or without the commonwealth shall not be  
930 required to reimburse a health care provider for a health care service that is not a covered benefit  
931 under the plan or reimburse a health care provider not contracted under the plan except as  
932 provided for under subclause (i) of clause (4) of the second sentence of subsection (a) of section  
933 6 of chapter 176O.

934 (d) A health care provider shall not be required to document a barrier to an in-person visit  
935 nor shall the type of setting where telehealth services are provided be limited for health care  
936 services provided via telehealth; provided, however, that a patient may decline receiving services  
937 via telehealth in order to receive in-person services.

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

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

949 (g) Insurance companies organized under this chapter shall ensure that the rate of  
950 payment for in-network providers of behavioral health services delivered via interactive audio-  
951 video technology and audio-only telephone shall be no less than the rate of payment for the same  
952 behavioral health service delivered via in-person methods; provided, that this subsection shall  
953 apply to providers of behavioral health services covered as required under subclause (i) of clause  
954 (4) of the second sentence of subsection (a) of section 6 of chapter 176O.

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

959 Section 47NN. Any policy, contract, agreement, plan or certificate of insurance issued,  
960 delivered or renewed within or without the commonwealth shall provide coverage for treatment  
961 of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and  
962 pediatric acute-onset neuropsychiatric syndrome including, but not limited to, the use of  
963 intravenous immunoglobulin therapy.

964 SECTION 48. Chapter 176A of the General Laws is hereby amended by inserting after  
965 section 8NN the following section:-

966 Section 8OO. Any contract between a subscriber and a corporation under an individual or  
967 group hospital service plan delivered, issued or renewed within the commonwealth shall provide  
968 coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with  
969 streptococcal infections and pediatric acute-onset neuropsychiatric syndrome including, but not  
970 limited to, the use of intravenous immunoglobulin therapy.

971 SECTION 49. Said chapter 176A is hereby further amended by adding the following  
972 section:-

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

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

977 “Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or  
978 other telecommunications technology, including, but not limited to: (i) interactive audio-video  
979 technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online  
980 adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating  
981 or monitoring of a patient's physical health, oral health, mental health or substance use disorder  
982 condition.

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

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

999 (d) A health care provider shall not be required to document a barrier to an in-person visit  
1000 nor shall the type of setting where telehealth services are provided be limited for health care  
1001 services provided via telehealth; provided, however, that a patient may decline receiving services  
1002 via telehealth in order to receive in-person services.

1003 (e) Coverage for telehealth services may include a provision for a deductible, copayment  
1004 or coinsurance requirement for a health care service provided via telehealth as long as the  
1005 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance  
1006 applicable to an in-person consultation or in-person delivery of services. The rate of payment for  
1007 telehealth services provided via interactive audio-video technology may be greater than the rate  
1008 of payment for the same service delivered by other telehealth modalities.

1009 (f) Coverage that reimburses a provider with a global payment, as defined in section 1 of  
1010 chapter 6D, shall account for the provision of telehealth services to set the global payment  
1011 amount.

1012 (g) Hospital service corporations shall ensure that the rate of payment for in-network  
1013 providers of behavioral health services delivered via interactive audio-video technology and



1014 audio-only telephone shall be no less than the rate of payment for the same behavioral health  
1015 service delivered via in-person methods; provided, that this subsection shall apply to providers of  
1016 behavioral health services covered as required under subclause (i) of clause (4) of the second  
1017 sentence of subsection (a) of section 6 of chapter 176O.

1018 (h) Health care services provided via telehealth shall conform to the standards of care  
1019 applicable to the telehealth provider's profession and specialty. Such services shall also conform  
1020 to applicable federal and state health information privacy and security standards as well as  
1021 standards for informed consent.

1022 SECTION 50. Chapter 176B of the General Laws is hereby amended by inserting after  
1023 section 4NN the following section:-

1024 Section 4OO. Any subscription certificate under an individual or group medical service  
1025 agreement delivered, issued or renewed within the commonwealth shall provide coverage for  
1026 treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal  
1027 infections and pediatric acute-onset neuropsychiatric syndrome including, but not limited to, the  
1028 use of intravenous immunoglobulin therapy.

1029 SECTION 51. Said chapter 176B is hereby further amended by adding the following  
1030 section:-

1031 Section 25. (a) For the purposes of this section, the following words shall, unless the  
1032 context clearly requires otherwise, have the following meanings:

1033 "Behavioral health services", care and services for the evaluation, diagnosis, treatment or  
1034 management of patients with mental health, developmental or substance use disorders.

1035 “Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or  
1036 other telecommunications technology, including, but not limited to: (i) interactive audio-video  
1037 technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online  
1038 adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating  
1039 or monitoring of a patient's physical health, oral health, mental health or substance use disorder  
1040 condition.

1041 (b) A contract between a subscriber and a medical service corporation shall provide  
1042 coverage for health care services delivered via telehealth by a contracted health care provider if:  
1043 (i) the health care services are covered by way of in-person consultation or delivery; and (ii) the  
1044 health care services may be appropriately provided through the use of telehealth; provided,  
1045 however, that an insurer shall not meet network adequacy through significant reliance on  
1046 telehealth providers and shall not be considered to have an adequate network if patients are not  
1047 able to access appropriate in-person services in a timely manner upon request. Coverage shall not  
1048 be limited to services delivered by third-party providers.

1049 (c) Coverage may include utilization review, including preauthorization, to determine the  
1050 appropriateness of telehealth as a means of delivering a health care service; provided, however,  
1051 that the determination shall be made in the same manner as if the service was delivered in  
1052 person. A carrier shall not be required to reimburse a health care provider for a health care  
1053 service that is not a covered benefit under the plan or reimburse a health care provider not  
1054 contracted under the plan except as provided for under subclause (i) of clause (4) of the second  
1055 sentence of subsection (a) of section 6 of chapter 176O.

1056 (d) A health care provider shall not be required to document a barrier to an in-person visit  
1057 nor shall the type of setting where telehealth services are provided be limited for health care  
1058 services provided via telehealth; provided, however, that a patient may decline receiving services  
1059 via telehealth in order to receive in-person services.

1060 (e) A contract that provides coverage for telehealth services may contain a provision for a  
1061 deductible, copayment or coinsurance requirement for a health care service provided via  
1062 telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible,  
1063 copayment or coinsurance applicable to an in-person consultation or in-person delivery of  
1064 services. The rate of payment for telehealth services provided via interactive audio-video  
1065 technology may be greater than the rate of payment for the same service delivered by other  
1066 telehealth modalities.

1067 (f) Coverage that reimburses a provider with a global payment, as defined in section 1 of  
1068 chapter 6D, shall account for the provision of telehealth services to set the global payment  
1069 amount.

1070 (g) Medical service corporations shall ensure that the rate of payment for in-network  
1071 providers of behavioral health services delivered via interactive audio-video technology and  
1072 audio-only telephone shall be no less than the rate of payment for the same behavioral health  
1073 service delivered via in-person methods; provided, that this subsection shall apply to providers of  
1074 behavioral health services covered as required under subclause (i) of clause (4) of the second  
1075 sentence of subsection (a) of section 6 of chapter 176O.

1076 (h) Health care services provided via telehealth shall conform to the standards of care  
1077 applicable to the telehealth provider's profession and specialty. Such services shall also conform

1078 to applicable federal and state health information privacy and security standards as well as  
1079 standards for informed consent.

1080 SECTION 52. Chapter 176G of the General Laws is hereby amended by inserting after  
1081 section 4FF the following section:-

1082 Section 4GG. Any individual or group health maintenance contract shall provide  
1083 coverage for treatment of pediatric autoimmune neuropsychiatric disorders associated with  
1084 streptococcal infections and pediatric acute-onset neuropsychiatric syndrome including, but not  
1085 limited to, the use of intravenous immunoglobulin therapy.

1086 SECTION 53. Said chapter 176G is hereby further amended by adding the following  
1087 section:-

1088 Section 33. (a) For the purposes of this section, the following words shall, unless the  
1089 context clearly requires otherwise, have the following meanings:

1090 “Behavioral health services”, care and services for the evaluation, diagnosis, treatment or  
1091 management of patients with mental health, developmental or substance use disorders.

1092 “Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or  
1093 other telecommunications technology, including, but not limited to: (i) interactive audio-video  
1094 technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online  
1095 adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating  
1096 or monitoring of a patient's physical health, oral health, mental health or substance use disorder  
1097 condition.

1098 (b) A contract between a member and a health maintenance organization shall provide  
1099 coverage for health care services delivered via telehealth by a contracted health care provider if:  
1100 (i) the health care services are covered by way of in-person consultation or delivery; and (ii) the  
1101 health care services may be appropriately provided through the use of telehealth; provided,  
1102 however, that an insurer shall not meet network adequacy through significant reliance on  
1103 telehealth providers and shall not be considered to have an adequate network if patients are not  
1104 able to access appropriate in-person services in a timely manner upon request. Coverage shall not  
1105 be limited to services delivered by third-party providers.

1106 (c) A carrier may undertake utilization review, including preauthorization, to determine  
1107 the appropriateness of telehealth as a means of delivering a health care service; provided,  
1108 however, that the determination shall be made in the same manner as if the service was delivered  
1109 in person. A carrier shall not be required to reimburse a health care provider for a health care  
1110 service that is not a covered benefit under the plan or reimburse a health care provider not  
1111 contracted under the plan except as provided for under subclause (i) of clause (4) of the second  
1112 sentence of subsection (a) of section 6 of chapter 176O.

1113 (d) A health care provider shall not be required to document a barrier to an in-person visit  
1114 nor shall the type of setting where telehealth services are provided be limited for health care  
1115 services provided via telehealth; provided, however, that a patient may decline receiving services  
1116 via telehealth in order to receive in-person services.

1117 (e) A contract that provides coverage for telehealth services may contain a provision for a  
1118 deductible, copayment or coinsurance requirement for a health care service provided via  
1119 telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible,

1120 copayment or coinsurance applicable to an in-person consultation or in-person delivery of  
1121 services. The rate of payment for telehealth services provided via interactive audio-video  
1122 technology may be greater than the rate of payment for the same service delivered by other  
1123 telehealth modalities.

1124 (f) Coverage that reimburses a provider with a global payment, as defined in section 1 of  
1125 chapter 6D, shall account for the provision of telehealth services to set the global payment  
1126 amount.

1127 (g) Health maintenance organizations shall ensure that the rate of payment for in-network  
1128 providers of behavioral health services delivered via interactive audio-video technology and  
1129 audio-only telephone shall be no less than the rate of payment for the same behavioral health  
1130 service delivered via in-person methods; provided, that this subsection shall apply to providers of  
1131 behavioral health services covered as required under subclause (i) of clause (4) of the second  
1132 sentence of subsection (a) of section 6 of chapter 176O.

1133 (h) Health care services provided via telehealth shall conform to the standards of care  
1134 applicable to the telehealth provider's profession and specialty. Such services shall also conform  
1135 to applicable federal and state health information privacy and security standards as well as  
1136 standards for informed consent.

1137 SECTION 54. Chapter 176I of the General Laws is hereby amended by adding the  
1138 following section:-

1139 Section 13. (a) For the purposes of this section, the following words shall, unless the  
1140 context clearly requires otherwise, have the following meanings:

1141 “Behavioral health services”, care and services for the evaluation, diagnosis, treatment or  
1142 management of patients with mental health, developmental or substance use disorders.

1143 “Telehealth”, the use of synchronous or asynchronous audio, video, electronic media or  
1144 other telecommunications technology, including, but not limited to: (i) interactive audio-video  
1145 technology; (ii) remote patient monitoring devices; (iii) audio-only telephone; and (iv) online  
1146 adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating  
1147 or monitoring of a patient's physical health, oral health, mental health or substance use disorder  
1148 condition.

1149 (b) A preferred provider contract between a covered person and an organization shall  
1150 provide coverage for health care services delivered via telehealth by a contracted health care  
1151 provider if: (i) the health care services are covered by way of in-person consultation or delivery;  
1152 and (ii) the health care services may be appropriately provided through the use of telehealth;  
1153 provided, however, that an insurer shall not meet network adequacy through significant reliance  
1154 on telehealth providers and shall not be considered to have an adequate network if patients are  
1155 not able to access appropriate in-person services in a timely manner upon request. Coverage shall  
1156 not be limited to services delivered by third-party providers.

1157 (c) An organization may undertake utilization review, including preauthorization, to  
1158 determine the appropriateness of telehealth as a means of delivering a health care service;  
1159 provided, however, that the determination shall be made in the same manner as if the service was  
1160 delivered in person. An organization shall not be required to reimburse a health care provider for  
1161 a health care service that is not a covered benefit under the plan or reimburse a health care

1162 provider not contracted under the plan except as provided for under subclause (i) of clause (4) of  
1163 the second sentence of subsection (a) of section 6 of chapter 176O.

1164 (d) A health care provider shall not be required to document a barrier to an in-person visit  
1165 nor shall the type of setting where telehealth services are provided be limited for health care  
1166 services provided via telehealth; provided, however, that a patient may decline receiving services  
1167 via telehealth in order to receive in-person services.

1168 (e) A preferred provider contract that provides coverage for telehealth services may  
1169 contain a provision for a deductible, copayment or coinsurance requirement for a health care  
1170 service provided via telehealth as long as the deductible, copayment or coinsurance does not  
1171 exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-  
1172 person delivery of services. The rate of payment for telehealth services provided via interactive  
1173 audio-video technology may be greater than the rate of payment for the same service delivered  
1174 by other telehealth modalities.

1175 (f) Coverage that reimburses a provider with a global payment, as defined in section 1 of  
1176 chapter 6D, shall account for the provision of telehealth services to set the global payment  
1177 amount.

1178 (g) Organizations shall ensure that the rate of payment for in-network providers of  
1179 behavioral health services delivered via interactive audio-video technology and audio-only  
1180 telephone shall be no less than the rate of payment for the same behavioral health service  
1181 delivered via in-person methods; provided, that this subsection shall apply to providers of  
1182 behavioral health services covered as required under subclause (i) of clause (4) of the second  
1183 sentence of subsection (a) of section 6 of chapter 176O.



1184 (h) Health care services provided via telehealth shall conform to the standards of care  
1185 applicable to the telehealth provider's profession and specialty. Such services shall also conform  
1186 to applicable federal and state health information privacy and security standards as well as  
1187 standards for informed consent.

1188 SECTION 55. Section 1 of chapter 176O of the General Laws, as appearing in the 2018  
1189 Official Edition, is hereby amended by inserting after the definition of "Behavioral health  
1190 manager" the following definition:-

1191 "Behavioral health services", care and services for the evaluation, diagnosis, treatment or  
1192 management of patients with mental health, developmental or substance use disorders.

1193 SECTION 56. Said section 1 of said chapter 176O, as so appearing, is hereby further  
1194 amended by inserting after the definition of "Case management" the following definition:-

1195 "Chronic disease management", care and services for the management of chronic  
1196 conditions, as defined by the federal Centers for Medicare and Medicaid Services, that include,  
1197 but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart  
1198 failure, hypertension, history of stroke, cancer and coronary artery disease.

1199 SECTION 57. Said section 1 of said chapter 176O, as so appearing, is hereby further  
1200 amended by inserting after the definition of "Primary care provider" the following definition:-

1201 "Primary care services", services delivered by a primary care provider.

1202 SECTION 58. The second sentence of subsection (a) of section 2 of said chapter 176O,  
1203 as so appearing, is hereby amended by striking out clauses (5) and (6) and inserting in place  
1204 thereof the following 3 clauses:-

1205 (5) access to pain management services, including non-opioid and non-pharmaceutical  
1206 service options;

1207 (6) access to behavioral health services, chronic disease management and primary care  
1208 services via telehealth; and

1209 (7) compliance with sections 2 to 12, inclusive.

1210 SECTION 59. Subsection (b) of said section 2 of said chapter 176O, as so appearing, is  
1211 hereby amended by adding the following paragraph:-

1212 To establish minimum standards for the accreditation of carriers related to access to  
1213 behavioral health services, chronic disease management and primary care services via telehealth,  
1214 the division shall consult with the health policy commission and the center for health information  
1215 and analysis.

1216 SECTION 60. Section 6 of said chapter 176O, as so appearing, is hereby amended by  
1217 striking out, in line 27, the word “and”.

1218 SECTION 61. Said section 6 of said chapter 176O, as so appearing, is hereby further  
1219 amended by inserting after the word “provider”, in line 34, the following words:- ; and (iii) a  
1220 summary description of the insured’s telehealth coverage and access to telehealth services,  
1221 including, but not limited to, behavioral health services, chronic disease management and  
1222 primary care services via telehealth, as well as the telecommunications technology available to  
1223 access telehealth services.

1224 SECTION 62. Section 23 of said chapter 176O, as so appearing, is hereby amended by  
1225 inserting after the word “time”, in line 3, the following words:- , the network status of an  
1226 identified health care provider.

1227 SECTION 63. (a) Notwithstanding any general or special law to the contrary, the  
1228 secretary of health and human services shall direct monthly payments to eligible hospitals in the  
1229 form of enhanced Medicaid payments, supplemental payments or other appropriate mechanism.  
1230 Each payment made to an eligible hospital shall equal 5 per cent of the eligible hospital’s  
1231 average monthly Medicaid payments, as determined by the secretary, for inpatient and outpatient  
1232 acute hospital services for the preceding year or the most recent year for which data is available;  
1233 provided, however, that such enhanced Medicaid payments shall not be used in subsequent years  
1234 by the secretary to calculate an eligible hospital’s average monthly payment; and provided  
1235 further, that such payments shall not offset existing Medicaid payments for which an eligible  
1236 hospital may be qualified to receive. In any fiscal year, the total sum of all payments made to  
1237 eligible hospitals under this section shall not exceed \$35,000,000.

1238 (b) The secretary may require as a condition of receiving payment any such reasonable  
1239 condition of payment that the secretary determines necessary to ensure the availability, to the  
1240 extent possible, of federal financial participation for the payments, and the secretary may incur  
1241 expenses and the comptroller may certify amounts for payment in anticipation of expected  
1242 receipt of federal financial participation for the payments.

1243 (c) The executive office of health and human services may promulgate regulations as  
1244 necessary to carry out this section.

1245 (d) For the purposes of this section “eligible hospital” shall mean a non-profit or  
1246 municipal acute care hospital licensed under section 51 of chapter 111 that: (i) has a statewide  
1247 relative price less than 0.90, as calculated by the center for health information and analysis  
1248 pursuant to section 10 of chapter 12C according to data from the most recent available year; (ii)  
1249 has a public payer mix equal to or greater than 60 per cent, as calculated by the center for health  
1250 information and analysis according to data from the most recent available year; and (iii) is not  
1251 owned, financially consolidated or corporately affiliated with a provider organization, as defined  
1252 by section 1 of chapter 6D, that: (A) owns or controls 2 or more acute care hospitals licensed  
1253 under section 51 of chapter 111; and (B) the total net assets of all affiliated acute care hospitals  
1254 within the provider organization is greater than \$600,000,000, as calculated by the center for  
1255 health information and analysis according to data from the most recent available year.

1256 (e) For the purposes of subsection (d), a hospital’s mere clinical affiliation with a  
1257 provider organization, absent ownership, financial consolidation or corporate affiliation, shall not  
1258 disqualify an eligible hospital from payments authorized under this section.

1259 SECTION 64. (a) Notwithstanding any general or special law to the contrary, the health  
1260 policy commission shall, in collaboration with the center for health information and analysis,  
1261 conduct an analysis of and issue a report on the effects of the COVID-19 pandemic on the  
1262 commonwealth’s health care delivery system, including on the accessibility, quality and cost of  
1263 health care services and the financial position of health care entities in the short-term, and the  
1264 implications of those effects on long-term policy considerations. In developing the report, the  
1265 commission shall seek input from the executive office of health and human services, other state  
1266 agencies, health care providers and payers, public health and economic experts, patients and

1267 caregivers and a range of diverse stakeholders including those disproportionately impacted by  
1268 COVID-19 or social determinants of health.

1269 (b) The report shall include: (i) an assessment and detailed description of the essential  
1270 components of a robust health care system and the distribution of services and resources  
1271 necessary to deliver high-quality care, from birth to death, to all residents in the commonwealth,  
1272 including, but not limited to, the appropriate level of personal protective equipment at health care  
1273 facilities to ensure the health of facility personnel and patients, and eliminate health care  
1274 disparities due to economic, geographic, racial or other factors; (ii) an inventory and description  
1275 of the location, distribution, nature and sustainability of all health care services, and resources in  
1276 the commonwealth serving residents from birth to death; (iii) an analysis of the impact of  
1277 COVID-19 on the health care workforce and on health care provider efforts to plan and invest in  
1278 worker readiness, including, but not limited to, the engagement of the workforce; (iv) an  
1279 examination of the closures of services classified as essential by the department of public health  
1280 or other relevant agency, the impact that the loss of such essential services have had on access to  
1281 and the quality of health care services to the communities affected by the closure of such  
1282 essential services and the efficacy of existing standards and requirements intended to maintain  
1283 such essential services; and (v) in consultation with the office of health equity in the department  
1284 of public health, an analysis of health care disparities that exist in the commonwealth due to  
1285 economic, geographic, racial or other factors.

1286 The health care system resource inventory compiled under this subsection and all related  
1287 information shall be maintained in a form accessible and usable by the general public on the  
1288 health policy commission's website and shall constitute a public record; provided, however, that  
1289 any item of information that is confidential or privileged in nature or under any other law shall

1290 not be regarded as a public record under clause Twenty-sixth of section 7 of chapter 4 of the  
1291 General Laws.

1292 (c) To assist in its development of the report, the commission may review any data or  
1293 findings collected through an interagency agreement with the department of public health under  
1294 chapter 93 of the acts of 2020.

1295 (d) The commission shall submit an initial report to the clerks of the senate and house of  
1296 representatives, the senate and house committees on ways and means, the joint committee on  
1297 health care financing, the joint committee on public health and the joint committee on mental  
1298 health, substance use and recovery not later than April 1, 2021. The commission shall submit a  
1299 final report to the clerks of the senate and the house of representatives, the senate and house  
1300 committees on ways and means, the joint committee on health care financing, the joint  
1301 committee on public health and the joint committee on mental health, substance use and recovery  
1302 not later than January 1, 2022.

1303 SECTION 65. Notwithstanding any general or special law to the contrary, the department  
1304 of public health and the office of consumer affairs and business regulation shall allow their  
1305 applicable licensees to obtain proxy credentialing and privileging for telehealth services with  
1306 other health care providers as defined in section 1 of chapter 111 of the General Laws or  
1307 facilities that comply with the federal Centers for Medicare & Medicaid Services' conditions of  
1308 participation for telehealth services.

1309 For purposes of this section "telehealth" shall mean the use of synchronous or  
1310 asynchronous audio, video, electronic media or other telecommunications technology, including,  
1311 but not limited to: (i) interactive audio-video technology; (ii) remote patient monitoring devices;

1312 (iii) audio-only telephone; and (iv) online adaptive interviews, for the purpose of evaluating,  
1313 diagnosing, consulting, prescribing, treating or monitoring of a patient's physical health, oral  
1314 health, mental health or substance use disorder condition.

1315 SECTION 66. For the purposes of section 30 of chapter 32A, section 79 of chapter 118E,  
1316 section 47MM of chapter 175, section 38 of chapter 176A, section 25 of chapter 176B, section  
1317 33 of chapter 176G and section 13 of chapter 176I of the General Laws, network adequacy may  
1318 be met through significant reliance on telehealth providers until the termination of the governor's  
1319 March 10, 2020 declaration of a state of emergency.

1320 SECTION 67. Notwithstanding any general or special law to the contrary, the health  
1321 policy commission, in consultation with the center for health information and analysis, the  
1322 executive office of health and human services and the division of insurance shall report on the  
1323 use of telehealth services in the commonwealth and the effect of telehealth on health care access  
1324 and system cost.

1325 The report shall include, but not be limited to: (i) the number of telehealth services  
1326 provided by type of service, provider and provider organization and payer; (ii) an analysis of the  
1327 use of telehealth services by patient demographics, geographic region and type of service; (iii)  
1328 total health care expenditures on telehealth services by type of service and type of  
1329 telecommunication technology used; (iv) an analysis of the impact of payer coverage and  
1330 payment rate of telehealth services on patient access to and cost of care by patient demographics,  
1331 geographic region and type of service; (v) any barriers to increased use of telehealth services,  
1332 including cost and availability of technology infrastructure for health care providers and patients  
1333 with limited access to technology, including access to broadband internet and cellular telephone

1334 service, cost and availability of technology infrastructure for patients, equity in access for low-  
1335 income patients, patient choice of providers offering telehealth services, provider reimbursement  
1336 amounts and method of payment and other payer, patient or provider financial incentives that  
1337 may reduce the availability of telehealth services; (vi) an assessment of the appropriate scope of  
1338 coverage requirements for telehealth services provided through various synchronous or  
1339 asynchronous audio, video, electronic media and other telecommunications technology;  
1340 provided, however, that the assessment shall consider the effect of coverage requirements on  
1341 access to quality care, with special consideration for populations with limited access to  
1342 technology, and the effect of coverage requirements on increasing health care expenditures and  
1343 appropriate utilization; (vii) the estimated impact of the use and coverage of telehealth services  
1344 on health care utilization and total health care expenditures in the commonwealth; (viii) the  
1345 estimated aggregate savings or additional costs of telehealth coverage and rate requirement on  
1346 total health care expenditures, including the impact on insurance premiums, and on health care  
1347 access in the commonwealth; (ix) recommendations on the appropriate reimbursement rates for  
1348 services provided via telehealth, including facility fees, compared to comparable in-person  
1349 services, in order to maximize health care access and public health outcomes and limit health  
1350 care cost growth; (x) recommendations on ways to expand the use of and services provided  
1351 through telehealth services, including, but not limited to, the safe and appropriate provision of  
1352 telehealth services by health care professionals licensed and residing in other states; and (xi) an  
1353 analysis of any impact of pre-authorization or other utilization management tools on access to  
1354 care via telehealth and recommendations for appropriate limitations on those tools to ensure  
1355 access to care; provided, however, that data on the use of telehealth services and related effect on  
1356 access and cost shall differentiate between telehealth services used while the governor's March



1357 10, 2020 declaration of a state of emergency was in effect and telehealth services used after the  
1358 termination of the governor's March 10, 2020 declaration of a state of emergency.

1359 The report, along with a suggested plan to implement its recommendations in order to  
1360 maximize access, quality of care and cost savings, shall be submitted to the joint committee on  
1361 health care financing and the house and senate committees on ways and means not later than 2  
1362 years from the effective date of this act; provided, however, that not later than 1 year from the  
1363 effective date of this act, the commission shall present an interim estimate of the fiscal impact of  
1364 telehealth use in the commonwealth.

1365 SECTION 68. Notwithstanding any general or special law to the contrary, the group  
1366 insurance commission under chapter 32A of the General Laws, the division of medical assistance  
1367 under chapter 118E of the General Laws, insurance companies organized under chapter 175 of  
1368 the General Laws, non-profit hospital service corporations organized under chapter 176A of the  
1369 General Laws, medical service corporations organized under chapter 176B of the General Laws,  
1370 health maintenance organizations organized under chapter 176G of the General Laws and  
1371 preferred provider organizations organized under chapter 176I of the General Laws shall ensure  
1372 that rates of payment for in-network providers for telehealth services provided pursuant to  
1373 section 30 of said chapter 32A, section 79 of said chapter 118E, section 47MM of said chapter  
1374 175, section 38 of said chapter 176A, section 25 of said chapter 176B, section 33 of said chapter  
1375 176G and section 13 of said chapter 176I are not less than the rate of payment for the same  
1376 service delivered via in-person methods.

1377 SECTION 69. Notwithstanding any general or special law to the contrary, the group  
1378 insurance commission under chapter 32A of the General Laws, the division of medical assistance

1379 under chapter 118E of the General Laws, insurance companies organized under chapter 175 of  
1380 the General Laws, non-profit hospital service corporations organized under chapter 176A of the  
1381 General Laws, medical service corporations organized under chapter 176B of the General Laws,  
1382 health maintenance organizations organized under chapter 176G of the General Laws and  
1383 preferred provider organizations organized under chapter 176I of the General Laws shall ensure  
1384 that the rate of payment for in-network providers of chronic disease management, as defined in  
1385 section 1 of chapter 176O of the General Laws, and primary care services, as defined in section 1  
1386 of chapter 176O of the General Laws, delivered via telehealth pursuant to section 30 of said  
1387 chapter 32A, section 79 of said chapter 118E, section 47MM of said chapter 175, section 38 of  
1388 said chapter 176A, section 25 of said chapter 176B, section 33 of said chapter 176G and section  
1389 13 of said chapter 176I are not less than the rate of payment for the same service delivered via  
1390 in-person methods.

1391 SECTION 70. Any coverage offered by the group insurance commission pursuant to  
1392 chapter 32A of the General Laws, the division of medical assistance and its contracted health  
1393 insurers, health plans, health maintenance organizations, behavioral health management firms  
1394 and third-party administrators under contract to a Medicaid managed care organization or  
1395 primary care clinician plan under chapter 118E of the General Laws, any individual policy of  
1396 accident or sickness insurance issued under chapter 175 of the General Laws, any contract  
1397 between a subscriber and a corporation under an individual group or hospital service plan under  
1398 chapter 176A of the General Laws, any subscription certificate under an individual or group  
1399 medical service agreement delivered, issued or renewed within the commonwealth under chapter  
1400 176B of the General Laws, any individual or group health maintenance contract under chapter  
1401 176G of the General Laws, and any preferred provider contract between a covered person and an

1402 organization under chapter 176I of the General Laws, shall provide coverage, without any  
1403 requirement of cost sharing by the insured, for all emergency, inpatient services and cognitive  
1404 rehabilitation services, including all professional, diagnostic and laboratory services, related to  
1405 the 2019 novel coronavirus, also known as COVID-19, at both in-network and out-of-network  
1406 providers.

1407 Coverage shall also provide for medically necessary outpatient testing, which shall  
1408 include testing for asymptomatic individuals under circumstances to be defined by guidelines  
1409 established by the secretary of health and human services.

1410 The secretary shall promulgate guidelines for COVID-19 testing of asymptomatic  
1411 individuals that work in industries with increased exposure to SARS-CoV-2, the virus that causes  
1412 COVID-19, which shall include, but not be limited to, the health care, restaurant, retail and  
1413 hospitality industries. The secretary may consider the availability of tests and statewide testing  
1414 capacity when issuing guidelines under this section.

1415 For the purposes of this subsection, the term "COVID-19 testing" shall mean polymerase  
1416 chain reaction and antigen tests approved to diagnose SARS-CoV-2, the virus that causes  
1417 COVID-19.

1418 The secretary shall issue guidelines in accordance with this section within 30 days of the  
1419 effective date of this act.

1420 SECTION 71. Notwithstanding any general or special law to the contrary, the secretary  
1421 of health and human services, in consultation with the health policy commission, the center for  
1422 health information analysis and the division of insurance, shall develop a report and make  
1423 recommendations on establishing a noncontracted, out-of-network commercial payment rate for

1424 emergency health care services and a noncontracted, out-of-network commercial payment rate  
1425 for non-emergency health care services in the commonwealth. The report shall include, but not  
1426 be limited to: (i) an examination of the rates paid over the previous 3 years for public and private  
1427 in-network and out-of-network health care services and the impact of the out-of-network  
1428 payment rates on the efficiency, accessibility and cost of the health care delivery system in the  
1429 commonwealth; (ii) the advisability of establishing a noncontracted, out-of-network commercial  
1430 payment rate for emergency health care services and a noncontracted, out-of-network  
1431 commercial payment rate for non-emergency health care services that represents the median or  
1432 mean of commercial contracted rates, a percentage of the median or mean of commercial  
1433 contracted rates or a percentage of Medicare rates; (iii) an assessment of potential noncontracted,  
1434 out-of-network commercial payment rates for emergency health care services and potential  
1435 noncontracted, out-of-network commercial payment rates for non-emergency health care services  
1436 and the impact of such rates on: (A) patient access to health care services by geographic location;  
1437 (B) encouraging in-network participation by health care providers and incentivizing carriers to  
1438 contract with health care providers; (C) the financial stability of health care providers and  
1439 systems, including, but not limited to, community hospitals; (D) the growth of total health care  
1440 expenditures; (E) the delivery of care by health care providers predominately serving  
1441 communities that experience health disparities as a result of race, ethnicity, or socioeconomic  
1442 status; (F) insurance premiums and out-of-pocket costs; (G) provider price variation; and (H) the  
1443 likelihood of utilization of the rate by self-insured health plans; (iv) an evaluation of the ease of  
1444 transparency in calculating certain noncontracted, out-of-network commercial payment rates and  
1445 the ease of administration by health care providers and carriers; (v) an analysis of the advisability  
1446 of establishing a process for health care providers or carriers to dispute the accuracy or

1447 appropriateness of a noncontracted, out-of-network commercial payment rate; (vi) best practices  
1448 in other states; and (vii) any other issues deemed relevant by the secretary. The report and  
1449 recommendations shall be submitted to the joint committee on health care financing and the  
1450 house and senate committees on ways and means not later than September 1, 2021.

1451           SECTION 72. The rare disease advisory council established by section 241 of chapter  
1452 111 of the General Laws shall provide a preliminary report to the governor, the department of  
1453 public health and the clerks of the senate and house of representatives not later than 180 days  
1454 after the effective date of this act. The preliminary report shall include, but not be limited to, an  
1455 estimate of the financial, informational and other resources needed to achieve the goals and  
1456 duties of the advisory council.

1457           SECTION 73. The commissioner of the department of public health shall appoint the  
1458 members of the advisory council on pediatric autoimmune neuropsychiatric disorder associated  
1459 with streptococcal infections and pediatric acute neuropsychiatric syndrome, established by  
1460 section 242 of chapter 111 of the General Laws, not later than 90 days after the effective date of  
1461 this act and shall schedule the first meeting of the council not later than 120 days after the  
1462 effective date of this act.

1463           SECTION 74. Section 17R of chapter 32A of the General Laws, section 47NN of chapter  
1464 175 of the General Laws, section 800 of chapter 176A of the General Laws, section 400 of  
1465 chapter 176B of the General laws and section 4GG of chapter 176G of the General Laws shall  
1466 apply to contracts that take effect or are renewed on or after January 1, 2022.

1467           SECTION 75. Subsection (f) of section 228 of chapter 111 of the General Laws shall take  
1468 effect on January 1, 2022.

1469 SECTION 76. Sections 63 and 69 are hereby repealed.

1470 SECTION 77. Section 68 is hereby repealed.

1471 SECTION 78. Section 76 shall take effect 2 years from the effective date of this act.

1472 SECTION 79. Section 77 shall take effect 90 days after termination of the governor's

1473 March 10, 2020 declaration of a state of emergency.