SENATE DOCKET, NO. 2863 FILED ON: 3/10/2020

SENATE . . . . . No. 2776

The Commonwealth of Massachusetts

PRESENTED BY:

Bruce E. Tarr

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act relative to healthcare consumer health options and increased care efficiency.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Bruce E. Tarr	*First Essex and Middlesex*
Ryan C. Fattman	*Worcester and Norfolk*
Patrick M. O'Connor	*Plymouth and Norfolk*
Dean A. Tran	*Worcester and Middlesex*

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By Mr. Tarr, a petition (accompanied by bill, Senate, No. 2776) (subject to Joint Rule 12) of Bruce E. Tarr, Ryan C. Fattman, Patrick M. O'Connor and Dean A. Tran for legislation relative to healthcare consumer health options and increased care efficiency. Health Care Financing.

The Commonwealth of Massachusetts

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

An Act relative to healthcare consumer health options and increased care efficiency.

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

SECTION 1. Chapter 6D of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after section 8 the following section:-

Section 8A. (a) The commission shall require a manufacturer of a prescribed drug specified in subsection (b) to disclose to the commission within a reasonable time any records that describe or relate to the manufacturer's pricing of that drug.

(b) A manufacturer of the following prescribed drugs must comply with the requirements set forth in this section: a drug for which the executive office of health and human services was unable to successfully conclude supplemental rebate negotiations with the manufacturer of the drug under subsection (a) of section 12A of chapter 118E, and for which the commission has received notice from the secretary of health and human services under subsection (c) of said section 12A of said chapter 118E.

(c) Records disclosed by a manufacturer under subsection (a) shall not be public records under section 7 of chapter 4 and under chapter 66 and shall remain confidential; provided, however, that the commission may produce reports summarizing any findings related to records received under this section to the extent allowable under applicable state and federal laws.

(d) If, after review of any records furnished to the commission under subsection (a), the commission determines that the drug manufacturer's pricing of the drug is potentially unreasonable or excessive in relation to the executive office's final determined value of the drug under subsection (b) of section 12A of chapter 118E or other appropriate metric, the commission shall, with 30 days advance notice to the drug manufacturer and the public, hold a public hearing at which the drug manufacturer shall be required to appear and testify to provide further information related to the pricing of the prescribed drug and the manufacturer's justification for the pricing. In addition to the drug manufacturer, the commission may identify as witnesses other relevant parties, including patients, providers, provider organizations, payers and others. Witnesses shall provide testimony under oath and subject to examination by the commission, the secretary of health and human services, and the attorney general or their respective designees, at the public hearing in a manner and form to be determined by the commission.

(e) Within 60 days from the date of a public hearing under subsection (d), the commission shall issue a report concerning the reasonableness of the manufacturer's pricing of the drug. In the event the commission concludes that the drug manufacturer's pricing of the drug is unreasonable or excessive in relation to the executive office's final determined value of the drug under subsection (b) of section 12A of chapter 118E or other appropriate metric, the commission may refer the drug manufacturer to the office of attorney general for appropriate action under chapter 93A, or any other applicable provision of the General Laws.

(f) In the event the drug manufacturer does not timely comply with the commission's request for records under subsection (a) or appearance at a public hearing under subsection (c), or otherwise knowingly obstructs the commission's ability to issue the report described in subsection (e), including by providing incomplete, false, or misleading information, the commission may impose appropriate sanctions against the drug manufacturer, including reasonable monetary penalties not to exceed $500,000, and may refer the drug manufacturer to the office of attorney general for appropriate action under chapter 93A, or any other applicable provision of the general laws. The commission shall seek to promote compliance with this section and shall only impose a civil penalty on the drug manufacturer as a last resort.

(g) The commission shall, in consultation with the executive office of health and human services, adopt any written policies, procedures or regulations the commission determines necessary to implement this section.

SECTION 2. Section 10 of said chapter 12C, as appearing in the 2018 Official Edition, is hereby amended by striking out subsection (e) and inserting in place thereof the following:- (e) The center shall under the procedures established by Medicare release at least annually all hospital data including payment and utilization information for services that may be provided in connection with at least the 100 most common inpatient stays. The center may release claims data on at least the 10 most expensive kinds of inpatient stays on average by payer. The center shall release claims data on the 100 most common outpatient procedures. The center may release claims data on the 10 most expensive kinds of outpatient procedures. The center shall release physician, practitioner, and other supplier utilization and payment data that consists of information on services and procedures provided to patients by physicians and other healthcare professionals. The data shall show at least allowed amounts and submitted charges, for those

services and procedures by provider. It should allow for comparisons by physician, specialty, location, types of medical services and procedures delivered, payment and submitted charges. Claims for providers that have provided less than five of a certain procedures or service to patients may be excluded by the center. The center shall release claims data on the 100 most commonly prescribed drugs, and the 10 most expensive rugs on average by payer. The center may release any other related claims data the center already collects as part of the categories listed above.

The center shall not be required to build a consumer tool to sort the date, but at a minimum must make it available to the public on their website on an annual basis in a raw but useable form. The center may also incorporate any of the released data listed above into their consumer health information website as established in section 20 of chapter 12C.

SECTION 3. Subsection (a) of section 12 of chapter 12C of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-

The center shall, to the extent feasible, make data in the payer and provider claims database available to payers and providers in real-time; provided, however, that all data-sharing complies with applicable state and federal privacy laws.

SECTION 4. Subsection (b) of said section 12 is hereby amended is hereby amended by striking out the following:-“The center shall charge user fees sufficient to defray the center's cost of providing such access to non-governmental entities”

SECTION 5. Section 20 of said chapter 12C is hereby amended by striking out subsection (b) and inserting in place thereof the following section:-

(b) The website shall provide updated information on a regular basis, but no more than 90 days after data required to post such information has been reported to the center, and additional comparative quality, price and cost information shall be published as determined by the center. To the extent possible, the website shall include: (1) comparative price and cost information for the most common referral or prescribed services, as determined by the center, categorized by payer and listed by facility, provider, and provider organization or other groupings, as determined by the center; (2) comparative quality information from the standard quality measure set and verified by the center, available by facility, provider, provider organization or any other provider grouping, as determined by the center, for each such service or category of service for which comparative price and cost information is provided; (3) general information related to each service or category of service for which comparative information is provided; (4) comparative quality information from the standard quality measure set and verified by the center, available by facility, provider, provider organization or other groupings, as determined by the center, that is not service-specific, including information related to patient safety and satisfaction; (5) data concerning healthcare-associated infections and serious reportable events reported under section 51H of chapter 111; (6) definitions of common health insurance and medical terms, including, but not limited to, those determined under sections 2715(g) (2) and (3) of the Public Health Service Act, so that consumers may compare health coverage and understand the terms of their coverage; (7) a list of health care provider types, including but not limited to primary care physicians, nurse practitioners and physician assistants, and what types of services they are authorized to perform in the commonwealth under applicable state and federal scope of practice laws; (8) factors consumers should consider when choosing an insurance product or provider group, including, but not limited to, provider network, premium, cost-

sharing, covered services, and tiering; (9) patient decision aids, which are interactive, written or audio-visual tools that provide a balanced presentation of the condition and treatment or screening options, benefits and harms, with attention to the patient's preferences and values, and which may facilitate conversations between patients and their health care providers about preference-sensitive conditions or diseases such as chronic back pain, early stage of breast and prostate cancers, hip osteoarthritis, and cataracts; provided, however, that decision aids shall be made available on, but not be limited to, long-term care and supports and palliative care; (10) a list of provider services that are physically and programmatically accessible for people with disabilities; (11) descriptions of standard quality measures, as determined by the statewide quality advisory committee and verified by the center; and (12)comparative price and cost information for the most common referral or prescribed services, as determined by the center, compared to the price and cost information of other states.

SECTION 6. Chapter 32A of the general laws is hereby amended by inserting at the end thereof the following new section:-

(a) For the purposes of this section, "telemedicine" shall mean the use of interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a patient's physical, oral or mental health; provided, however, that "telemedicine" shall not include audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

(b) Coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission shall provide coverage for health care services through the use of telemedicine by a contracted health care provider if the health care services are covered by way of in-person consultation or delivery. Health care services

delivered by way of telemedicine shall be covered to the same extent as if they were provided via in-person consultation or delivery.

(c) Coverage may include utilization review, including preauthorization, to determine the appropriateness of telemedicine as a means of delivering a health care service, provided that the determination shall be made in the same manner as if the service was delivered in person. A carrier shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan nor reimburse a health care provider not contracted under the plan.

A health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telemedicine is provided be limited for health care services provided through telemedicine.

Coverage for telemedicine services may include a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services.

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

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

SECTION 7. Chapter 62 of the General Laws as most recently appearing in the 2018 Official Edition, is hereby amended by inserting after section 6N the following new section:-

Section 6O (a) The purpose of this section shall be to provide incentives for business to recognize the benefits of wellness programs and provide the Commonwealth the opportunity to evaluate the health benefits of employer wellness programs. Wellness programs implemented by business have resulted in both savings to their premiums as well as overall savings to the cost of health care. The goal of this tax credit is to provide smaller businesses with an expanded opportunity to implement these programs, and a mechanism for the Commonwealth to assess programming benefits.

(b) There is hereby established a Massachusetts wellness program tax credit. The total of all tax credits available to a taxpayer pursuant to this section or section 38FG of chapter 63 shall not exceed $10,000 in any 1 tax year. A business that implements a wellness program shall be allowed a credit, to be computed as hereinafter provided, against taxes owed to the commonwealth under chapter 62 or chapter 63 or other applicable law. For the purposes of this section, "businesses" shall include professions, sole proprietorships, trades, businesses, or partnerships.

(c) The credit allowed under this chapter shall be equal to 25 per cent of the costs associated with implementing a program certified under section 206A of chapter 111, with a maximum credit of $10,000 per business in any 1 fiscal year. The department of public health shall determine the criteria for eligibility for the credit, the criteria to be set forth in regulations promulgated under this section and section 206A of chapter 111. The regulations shall require proof of using a wellness program qualified under section 206A of chapter 111. The department

shall issue a certification to the taxpayer after the taxpayer submits documentation as required by the department. Such certification shall be acceptable as proof that the expenditures related to the implementation of a wellness program for the purposes of the credit allowed under this section.

(d) Wellness program tax credits allowed to a business under this section shall be allowed for the taxable year in which the program is implemented; provided, however, that a tax credit allowed under this section shall not reduce the tax owed below zero. A taxpayer allowed a credit under this section for a taxable year may carry over and apply against such taxpayer's tax liability in any of the succeeding 5 taxable years, the portion, as reduced from year to year, of those credits which exceed the tax for the taxable year.

(e) The department of public health shall consult with the department of revenue and individuals from various business and health care organizations from Massachusetts, including but not limited to; the Associated Industries of Massachusetts, the Massachusetts Society of Certified Public Accountants, the Massachusetts chapter of the International Health, Racquet and Sportsclub Association, the Massachusetts Association of Health Plans, the Massachusetts chapter of the National Federation of Independent Businesses; the Massachusetts Taxpayer Foundation, and the Smaller Business Association of New England on the promotion of the program to eligible entities.

(f) The department of public health shall set health and economic outcome goals for the wellness program tax credit, including but not limited to (i) program participation increase of 25% per year, (ii) slowed increase in employer health costs (iii) improvements in employee well-being, and quality of life, and (iv) growth in existing employee wellness programs. The department of public health in consultation with the department of revenue shall study the health

and economic outcomes of the program and file a report, together with any recommendations regarding whether there should be legislative changes to the tax credit or whether the health and economic goals of the program can better be served through other means, to the clerks of the house of representatives and senate, chairs of the house and senate committees on ways and means, the house and senate chairs of the joint committee on health care financing, the house and senate chairs of the joint committee on public health and the secretary of the executive office of administration and finance on or before December 1 of each calendar year.

SECTION 8. Chapter 63 of the General Laws as most recently appearing in the 2018 Official Edition, is hereby amended by inserting after section 38HH the following new section:- Section 38II:-

(a) The purpose of this section shall be to provide incentives for business to recognize the benefits of wellness programs and provide the Commonwealth the opportunity to evaluate the health benefits of employer wellness programs. Wellness programs implemented by business have resulted in both savings to their premiums as well as overall savings to the cost of health care. The goal of this tax credit is to provide smaller businesses with an expanded opportunity to implement these programs, and a mechanism for the Commonwealth to assess programming benefits.

(b) There is hereby established a Massachusetts wellness program tax credit. The total of all tax credits available to a taxpayer pursuant to this section or section 6O of chapter 62 shall not exceed $10,000 in any 1 tax year. A business that implements a wellness program shall be allowed a credit, to be computed as hereinafter provided, against taxes owed to the commonwealth under chapter 62 or chapter 63 or other applicable law. For the purposes of this

section, "businesses" shall include professions, sole proprietorships, trades, businesses or partnerships.

(c) The credit allowed under this chapter shall be equal to 25 per cent of the costs associated with implementing the program, with a maximum credit of $10,000 per business in any 1 fiscal year. The department of public health shall determine the criteria for eligibility for the credit, such criteria to be set forth in regulations promulgated under this section. The regulations shall require proof of using a wellness program qualified under section 206A of chapter 111. The department shall issue a certification to the taxpayer after the taxpayer submits documentation as required by the department. The certification shall be acceptable as proof that the expenditures related to the implementation of a wellness program for the purposes of the credit allowed under this section.

(d) The credit allowed in this chapter for any taxable year shall not reduce the excise to less than the amount due under subsection (b) of section 39, section 67 or any other applicable section.

(e) Wellness program tax credits allowed to a business under this section shall be allowed for the taxable year in which the program is implemented. A taxpayer allowed a credit under this section for a taxable year may carry over and apply against the taxpayer's tax liability in any of the succeeding 5 taxable years, the portion, as reduced from year to year, of those credits which exceed the tax for the taxable year.

(f) The department of public health shall consult with the department of revenue and individuals from various business and health care organizations from Massachusetts, including but not limited to; the Associated Industries of Massachusetts, the Massachusetts Society of

Certified Public Accountants, the Massachusetts chapter of the International Health, Racquet and Sportsclub Association, the Massachusetts Association of Health Plans, the Massachusetts chapter of the National Federation of Independent Businesses; the Massachusetts Taxpayer Foundation, and the Smaller Business Association of New England on the promotion of the program to eligible entities.

(g) The department of public health shall set health and economic outcome goals for the wellness program tax credit, including but not limited to (i) program participation increase of 25% per year, (ii) slowed increase in employer health costs (iii) improvements in employee well-being, and quality of life, and (iv) growth in existing employee wellness programs. The department of public health in consultation with the department of revenue shall study the health and economic outcomes of the program and file a report, together with any recommendations regarding whether there should be legislative changes to the tax credit or whether the health and economic goals of the program can better be served through other means, to the clerks of the house of representatives and senate, chairs of the house and senate committees on ways and means, the house and senate chairs of the joint committee on health care financing, the house and senate chairs of the joint committee on public health and the secretary of the executive office of administration and finance on or before December 1 of each calendar year.

SECTION 9. Section 6 of Chapter 64H of the General Laws as appearing in the 2018 Official edition is hereby amended, in clause (l), by inserting after the word “insulin;” in line 195, the following words:- sales of blood test strips and lancets; sales of vitamin and mineral supplements when prescribed by a licensed physician

SECTION 10. Section 1 of chapter 94C, as appearing in the 2018 Official Edition, is hereby further amended by striking out, in line 290, the words “practitioner, registered nurse, or practical nurse” and inserting in place thereof the following words:- an individual who is authorized to administer such medication under this chapter.

SECTION 11. Said section 1 of said chapter 94C, as so appearing, is hereby further amended by striking out the definition of “Practitioner” and inserting in place thereof the following definition:-.

“Practitioner”,

(a) A physician, dentist, veterinarian, podiatrist, scientific investigator, or other person registered to distribute, dispense, conduct research with respect to, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research in the commonwealth;

(b) A pharmacy, hospital, or other institution registered to distribute, dispense, conduct research with respect to or to administer a controlled substance in the course of professional practice or research in the commonwealth.

(c) An optometrist authorized by sections 66, 66B and 66C of chapter 112 and registered pursuant to paragraph (h) of section 7 to utilize and prescribe therapeutic pharmaceutical agents in the course of professional practice in the commonwealth.

(d) A nurse practitioner or psychiatric nurse mental health clinical specialist authorized by section 80E of chapter 112 and registered pursuant to subsection (f) of section 7 to distribute,

dispense, conduct research with respect to or use in teaching or chemical analysis a controlled substance in the course of professional practice or research in the commonwealth.

SECTION 12. Said section 1 of said chapter 94C, as so appearing, is hereby further amended by striking out, in lines 367 and 368, the words “practitioner, registered nurse or practical nurse” and inserting in place thereof the following words:- an individual who is authorized to administer such medication under this chapter.

SECTION 13. Subsection (a) of section 7 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “issuance”, in line 9, the following words:- or until completion of the term of the registrant’s license issued pursuant to chapter 112, whichever occurs later.

SECTION 14. Subsection (f) of said section 7 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “podiatrist”, in line 122 and in lines 125 through 126, each time it appears, the following words:- , nurse practitioner, psychiatric nurse mental health clinical specialist.

SECTION 15. Subsection (g) of said section 7 of said chapter 94C, as so appearing, is hereby amended by striking out the second paragraph

SECTION 16. Said subsection (g) of said section 7 of said chapter 94C, as so appearing, is hereby further amended by striking out the last paragraph.

SECTION 17. Subsection (h) of said section 7 of said chapter 94C, as so appearing, is hereby amended by striking out, in line 213, the words “and 66B” and inserting in place thereof the following words:- , 66B and 66C.

SECTION 18. Subsection (a) of section 9 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “podiatrist”, in line 1, the following words:- , nurse practitioner, psychiatric nurse mental health clinical specialist.

SECTION 19. Said subsection (a) of said section 9 of said chapter 94C, as so appearing, is hereby further amended by striking out, in line 2, the words “and 66B” and inserting in place thereof the following words:- , 66B and 66C

SECTION 20. Said subsection (a) of said section 9 of said chapter 94C, as so appearing, is hereby further amended by striking out, in lines 3 to 5, inclusive, the words “, nurse practitioner and psychiatric nurse mental health clinical specialist as limited by subsection (g) of said section 7 and section 80E of said chapter 112”.

SECTION 21. Said subsection (a) of said section 9 of said chapter 94C, as so appearing, is hereby further amended by adding the following paragraph:-

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

SECTION 22. Subsection (b) of said section 9 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “nurse-midwifery”, in line 32, the following words:- , advanced practice nursing.

SECTION 23. Subsection (c) of said section 9 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “podiatrist”, in lines 72 and 80, each time it appears, the following word:- , optometrist.

SECTION 24. Subsection (e) of said section 9 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “practitioner”, in lines 100 and 107, each time it appears, the following words:- , psychiatric nurse mental health clinical specialist.

SECTION 25. Section 18 of said chapter 94C, as so appearing, is hereby amended by striking out, in lines 10, 39 and 72, the words “to practice medicine” and inserting in place thereof, in each instance, the following words:- and authorized to engage in prescriptive practice.

SECTION 26. Said section 18 of said chapter 94C, as so appearing, is hereby further amended by striking out the word “physician”, in lines 25, 34 and 35, 38, 72 and 74, and inserting in place thereof, in each instance, the following word:- practitioner.

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

SECTION 28. Chapter 111 of the General Laws is hereby amended by inserting after section 4O the following section:-

Section 4P. (a) As used in this section, the following terms shall have the following meanings unless the context clearly requires otherwise: “Telehealth”, as it pertains to the delivery of health care services, the use of synchronous or asynchronous telecommunications technology, including but not limited to live video, text messaging and application-based communications, by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment and monitoring of a patient. The term does not include audio-only telephone calls, e-mail messages or facsimile transmissions.

"Telehealth provider", any individual who provides health care and related services using telehealth and who is licensed or certified to practice in the commonwealth, provided that a telehealth provider has the duty to practice in a manner consistent with his or her scope of practice and the prevailing professional standard of practice in the commonwealth.

(b) Notwithstanding any general or special laws to the contrary, a telehealth provider may render telehealth services to a patient, whether or not the telehealth provider has previously conducted an in-person examination of or consultation with the patient, provided that such telehealth service is provided in accordance with subsection (a).

SECTION 29. Said chapter 111 is hereby further amended by inserting after section 51½ the following section:-

Section 51¾. The department shall promulgate regulations requiring all acute care hospitals licensed under section 51G to provide or arrange for qualified behavioral health clinicians to evaluate and stabilize a person admitted to the emergency department with a behavioral health presentation and, to refer such person for appropriate treatment or inpatient admission.

SECTION 30. Section 2 of chapter 112 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by adding the following paragraph:-

For the purposes of this section, "telemedicine" shall mean the use of audio, video or other electronic media for a diagnosis, consultation or treatment of a patient's physical, oral or mental health; provided, however, that "telemedicine" shall not include audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

SECTION 31. Said chapter 112 is hereby further amended by striking out section 13, as so appearing, and inserting in place thereof the following section:-

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

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

(c) The provisions of this section to section 1318, inclusive, shall not apply to surgeons of the United States army, United States navy or of the United States Public Health Service or to physicians registered in the commonwealth.

SECTION 32. Said chapter 112 is hereby further amended by striking out section 66, as so appearing, and inserting in place thereof the following section:-

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

SECTION 33. Said section 66B of said chapter 112, as so appearing, is hereby amended by striking out, in line 31, the following words:- , except glaucoma.

SECTION 34. Said chapter 112 is hereby further amended by inserting after section 66B the following section:-

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

Section 66C. (a) A registered optometrist who is qualified by an examination for practice under section 68, certified under section 68C and registered to issue written prescriptions pursuant to subsection (h) of section 7 of chapter 94C, may:

(1) use and prescribe topical and oral therapeutic pharmaceutical agents, as defined in section 66B, that are used in the practice of optometry, including those placed in schedules III, IV, V and VI pursuant to section 2 of said chapter 94C, for the purpose of diagnosing, preventing, correcting, managing or treating glaucoma and other ocular abnormalities of the human eye and adjacent tissue; and

(2) prescribe all necessary eye-related medications, including oral anti-infective medications; provided, however, that a registered optometrist shall not use or prescribe: (i) therapeutic pharmaceutical agents for the treatment of systemic diseases; (ii) invasive surgical procedures; (iii) pharmaceutical agents administered by subdermal injection, intramuscular injection, intravenous injection, subcutaneous injection, intraocular injection or retrobulbar injection; or (iv) an opioid substance or drug product.

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

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

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

SECTION 35. Section 68 of said chapter 112, as appearing in the 2018 Official Edition, is hereby amended by adding the following paragraph:- All application fees and civil administrative penalties and fines collected by the board under sections 61, 66 to 73B, inclusive, shall be deposited into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 36. Said chapter 112 is hereby further amended by inserting after section 68B the following section:-

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

(b) Examination for the use and prescription of therapeutic pharmaceutical agents placed in schedules III, IV, V and VI under section 2 of chapter 94C and defined in section 66C shall, upon application, be open to an optometrist registered under section 68, 68A or 68B and to any person who meets the qualifications for examination under said sections 68, 68A and 68B. An applicant registered as an optometrist under said section 68, 68A or 68B shall:

(1) be registered pursuant to paragraph (h) of section 7 to use or prescribe pharmaceutical agents for the purpose of diagnosing or treating glaucoma and other ocular abnormalities of the human eye and adjacent tissue; and

(2) furnish to the board of registration in optometry evidence of the satisfactory completion of 40 hours of didactic education and 20 hours of supervised clinical education relating to the use and prescription of therapeutic pharmaceutical agents under section 66C; provided, however, that such education shall: (i) be administered by the Massachusetts Society of Optometrists, Inc.; (ii) be accredited by a college of optometry or medicine; and (iii) meet the

guidelines and requirements of the board of registration in optometry. The board of registration in optometry shall provide to each successful applicant a certificate of qualification in the use and prescription of all therapeutic pharmaceutical agents as authorized under said section 66C and shall forward to the department of public health notice of such certification for each successful applicant.

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

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

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

SECTION 37. Section 73E of said chapter 112, as appearing in the 2018 Official Edition, is hereby amended by adding the following paragraph:- All application fees and civil administrative penalties and fines collected by the board under sections 61, and 73C to 73M, inclusive, shall be deposited into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 38. Said section 80B of said chapter 112, as so appearing, is hereby further amended by striking out the seventh paragraph and inserting in place thereof the following paragraph:-

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

SECTION 39. Said section 80B of said chapter 112, as so appearing, is hereby further amended by striking out in lines 64 and 65 the following words:- “in the ordering of tests, therapeutics and the prescribing of medications,”

SECTION 40. Said chapter 112 is hereby further amended by striking out section 80E, as so appearing, and inserting in place thereof the following section:-

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

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

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

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

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

SECTION 41. Section 80I of chapter 112 of the General Laws, as so appearing, is hereby amended by striking out the second and third sentences.

SECTION 42. Section 91 of said chapter 112, as so appearing, is hereby amended by adding the following paragraph:- All application fees and civil administrative penalties and fines collected by the board under sections 61 and 89 to 97, inclusive, shall be deposited into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 43. Section 126 of said chapter 112, as so appearing, is hereby amended by adding the following paragraph:- All application fees and civil administrative penalties and fines collected by the board under sections 61 and 118 to 129B, inclusive, shall be deposited into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 44. Section 136 of said chapter 112, as so appearing, is hereby amended by adding the following paragraph:- All application fees and civil administrative penalties and fines collected by the board under sections 61 and 130 to 137, inclusive, shall be deposited into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 45. Section 140 of said chapter 112, as so appearing, is hereby amended by adding the following paragraph:- All application fees and civil administrative penalties and fines collected by the board under sections 61 and 138 to 147, inclusive, shall be deposited into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 46. Said chapter 175 is hereby further amended by inserting after section 47XX the following section:-

Section 47YY. (a) For the purposes of this section, “Telehealth” as it pertains to the delivery of health care services, shall mean the use of synchronous or asynchronous telecommunications technology, including but not limited to live video, text messaging and application-based communications, by a telehealth provider, as defined in section 4P of chapter 111, to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment and monitoring of a patient. The term does not include audio-only telephone calls, e-mail messages or facsimile transmissions.

(b) For an individual policy of accident and sickness insurance issued under section 108 that provides hospital expense and surgical expense insurance and any group blanket or general policy of accident and sickness insurance issued under section 110 that provides hospital expense and surgical expense insurance which is issued or renewed within or without the commonwealth, an insurer shall implement procedures, so that the insurer shall not decline to provide coverage for health care services solely on the basis that those services were delivered through the use of telehealth by a contracted health care provider, consistent with clause (i) of paragraph (4) of subsection (a) of section 6 of chapter 176O, if (i) the health care services are covered by way of in-person consultation or delivery and (ii) the health care services may be appropriately provided through the use of telehealth.

(c) A contract that provides coverage for services under this section may contain a provision for a deductible, copayment or coinsurance requirement for a health care service

provided through telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

(d) When determining coverage for telehealth services, carriers may use utilization review systems, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service, provided that the determination shall be made in the same manner as if the service was provided via in-person consultation or delivery.

(e) Coverage for telehealth services shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan nor to reimburse a health care provider not contracted under the plan except as provided for under clause (i) of paragraph (4) of subsection (a) of section 6 of chapter 176O.

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

SECTION 47. The General Laws are hereby amended by inserting after chapter 175M the following chapter:-

CHAPTER 175N. Pharmacy Benefit Managers

Section 1. As used in this chapter the following words shall, unless the context clearly requires otherwise, have the following meanings:

“Carrier,” an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health

maintenance organization organized under chapter 176G; and an organization entering into a preferred provider arrangement under chapter 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of or more subsidiaries or affiliated corporations of the employer; provided, however, that, unless otherwise noted, "carrier" shall not include any entity to the extent it offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services.

"Center", the center for health information and analysis established in chapter 12C.

"Commissioner", the commissioner of insurance.

"Division", the division of insurance.

"Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

"Pharmacy Benefit Manager," any person, business or entity, however organized, that administers, either directly or through subsidiaries, pharmacy benefit services for prescription drugs and devices on behalf of health benefit plan sponsors, including, but not limited to, self-insured employers, insurance companies and labor unions; provided however, that "pharmacy benefit services" shall include, but not be limited to, formulary administration; drug benefit design; pharmacy network contracting; pharmacy claims processing; mail and specialty drug pharmacy services; and cost containment, clinical, safety and adherence programs for pharmacy services; provided, further, that a health benefit plan that does not contract with a pharmacy benefit manager shall be considered a pharmacy benefit manager for the purposes of this section.

Section 2. (a) A person or organization shall not establish or operate as a pharmacy benefit manager to administer prescription drug benefits or services for a carrier's health benefit plans in the commonwealth without obtaining certification from the commissioner pursuant to this section.

(b) The commissioner shall promulgate regulations regarding pharmacy benefit managers that shall establish the certification, application, standards and reporting requirements of pharmacy benefit managers. The commissioner shall charge application and renewal fees in the amount of $1,000.

(c) An entity certified as a pharmacy benefit manager shall be required to submit data and reporting information to the center, including information associated with discounts, retained rebates and earned margins on payments to pharmacy providers on behalf of health plans, according to standards and methods specified by the center pursuant to section 10A of chapter 12C.

(d) Certification obtained under this section is valid for a period of 2 years and may be renewed. Certification is not transferable.

(e) A pharmacy benefit manager shall report to the division material changes to the information contained in its application, certified by an officer of the pharmacy benefit manager, within 30 days of such changes.

Section 3. (a) The commissioner may make an examination of the affairs of a Pharmacy Benefit Manager when the commissioner deems prudent but not less frequently than once every 3 years. The focus of the examination shall be to ensure that a pharmacy benefit manager is able to meet its responsibilities under contracts with carriers licensed under chapters 175, 176A,

176B, or 176G. The examination shall be conducted according to the procedures set forth in subsection (6) of section 4 of chapter 175.

(b) The commissioner, a deputy or an examiner may conduct an on-site examination of each pharmacy benefit manager in the commonwealth to thoroughly inspect and examine its affairs.

(c) The charge for each such examination shall be determined annually according to the procedures set forth in subsection (6) of section 4 of chapter 175.

(d) Not later than 60 days following completion of the examination, the examiner in charge shall file with the commissioner a verified written report of examination under oath. Upon receipt of the verified report, the commissioner shall transmit the report to the pharmacy benefit manager examined with a notice which shall afford the pharmacy benefit manager examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report. Within 30 days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall consider and review the reports together with any written submissions or rebuttals and any relevant portions of the examiner's work papers and enter an order:

(i) adopting the examination report as filed with modifications or corrections and, if the examination report reveals that the pharmacy benefit manager is operating in violation of this section or any regulation or prior order of the commissioner, the commissioner may order the pharmacy benefit manager to take any action the commissioner considered necessary and appropriate to cure such violation;

(ii) rejecting the examination report with directions to examiners to reopen the examination for the purposes of obtaining additional data, documentation or information and re-filing pursuant to the above provisions; or

(iii) calling for an investigatory hearing with no less than 20 days' notice to the pharmacy benefit manager for purposes of obtaining additional documentation, data, information and testimony.

(e) Notwithstanding any general or special law to the contrary, including clause 26 of section 7 of chapter 4 and chapter 66, the records of any such audit, examination or other inspection and the information contained in the records, reports or books of any pharmacy benefit manager examined pursuant to this section shall be confidential and open only to the inspection of the commissioner, or the examiners and assistants. Access to such confidential material may be granted by the commissioner to law enforcement officials of the commonwealth or any other state or agency of the federal government at any time, so long as the agency or office receiving the information agrees in writing to keep such material confidential. Nothing herein shall be construed to prohibit the required production of such records, and information contained in the reports of such company or organization before any court of the commonwealth or any master or auditor appointed by any such court, in any criminal or civil proceeding, affecting such pharmacy benefit manager, its officers, partners, directors or employees. The final report of any such audit, examination or any other inspection by or on behalf of the division of insurance shall be a public record.

Section 4. A pharmacy benefit manager shall be required to submit to periodic audits by a carrier licensed under chapters 175, 176A, 176B, or 176G, if the pharmacy benefit manager has

entered into a contract with the carrier to provide pharmacy benefits to the carrier or its members. The commissioner may direct or provide specifications for such audits.

Section 5. (a) The division may suspend, revoke, or place on probation a pharmacy benefit manager certification if the pharmacy benefit manager:

(1) has engaged in fraudulent activity that constitutes a violation of state or federal law;

(2) is the subject of consumer complaints received and verified by the division that justify action under this section to protect the health, safety and interests of consumers;

(3) fails to pay an application fee;

(4) fails to comply with reporting requirements of the center under section 10A of chapter 12C;

(5) appears upon examination to be unable to fulfill its contractual obligations; or

(6) fails to comply with a requirement set forth in this section.

(b) The commissioner shall notify the pharmacy benefit manager and advise, in writing, of the reason for any suspension or any refusal to issue or non-renew a certificate under this chapter. A copy of the notice shall be forwarded to the center. The applicant or pharmacy benefit manager may make written demand upon the commissioner within 30 days of receipt of such notification for a hearing before the commissioner to determine the reasonableness of the commissioner’s action. The hearing shall be held pursuant to chapter 30A.

(c) The commissioner shall not suspend or cancel a certificate unless the commissioner has first afforded the pharmacy benefit manager an opportunity for a hearing pursuant to chapter 30A.

SECTION 48. Chapter 176A of the General Laws is hereby amended by adding the following section:-

Section 38. (a) “Telehealth” as it pertains to the delivery of health care services, the use of synchronous or asynchronous telecommunications technology, including but not limited to live video, text messaging and application-based communications, by a telehealth provider, as defined in section 4P of chapter 111, to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment and monitoring of a patient. The term does not include audio-only telephone calls, e-mail messages or facsimile transmissions.

(b) For a contract between a subscriber and a nonprofit hospital service corporation, the corporation shall implement procedures so that the insurer shall not decline to provide coverage for health care services solely on the basis that those services were delivered through the use of telehealth by a contracted health care provider, consistent with paragraph (4)(i) of subsection (a) of section 6 of chapter 176O, if (i) the health care services are covered by way of in-person consultation or delivery and (ii) the health care services may be appropriately provided through the use of telehealth.

(c) A contract that provides coverage for services under this section may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

(d) When determining coverage for telehealth services, carriers may use utilization review systems, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service, provided that the determination shall be made in the same manner as if the service was provided via in-person consultation or delivery

(e) Coverage for telehealth services shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan nor to reimburse a health care provider not contracted under the plan except as provided for under paragraph (4)(i) of subsection (a) of Section 6 of Chapter 176O.

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

SECTION 49. Chapter 176B of the General Laws is hereby amended by adding the following section:-

Section 25. (a) For the purposes of this section, “Telehealth” as it pertains to the delivery of health care services, shall mean the use of synchronous or asynchronous telecommunications technology, including but not limited to live video, text messaging and application-based communications, by a telehealth provider, as defined in section 4P of chapter 111, to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment and monitoring of a patient. The term does not include audio-only telephone calls, e-mail messages or facsimile transmissions.

(b) For a contract between a subscriber and a medical service corporation, the corporation shall implement procedures so that it shall not decline to provide coverage for health care

services solely on the basis that those services were delivered through the use of telehealth by a contracted health care provider, consistent with clause (i) of paragraph (4) of subsection (a) of section 6 of chapter 176O, if (i) the health care services are covered by way of in-person consultation or delivery and (ii) the health care services may be appropriately provided through the use of telehealth.

(c) A contract that provides coverage for services under this section may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

(d) When determining coverage for telehealth services, carriers may use utilization review systems, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service, provided that the determination shall be made in the same manner as if the service was provided via in-person consultation or delivery

(e) Coverage for telehealth services shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan nor to reimburse a health care provider not contracted under the plan except as provided for under clause (i) of paragraph (4) of subsection (a) of Section 6 of Chapter 176O.

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

SECTION 50. Said chapter 176G of the General laws is hereby further amended by adding the following section:-

Section 33. (a) For the purposes of this section, “Telehealth” as it pertains to the delivery of health care services, shall mean the use of synchronous or asynchronous telecommunications technology, including but not limited to live video, text messaging and application-based communications, by a telehealth provider, as defined in section 4P of chapter 111, to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment and monitoring of a patient. The term does not include audio-only telephone calls, e-mail messages or facsimile transmissions.

(b) For a contract between a member and a health maintenance organization, the organization shall implement procedures so that it shall not decline to provide coverage for health care services solely on the basis that those services were delivered through the use of telehealth by a contracted health care provider, consistent with clause (i) of paragraph (4) of subsection (a) of section 6 of chapter 176O, if (i) the health care services are covered by way of in-person consultation or delivery and (ii) the health care services may be appropriately provided through the use of telehealth.

(c) A contract that provides coverage for services under this section may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

(d) When determining coverage for telehealth services, carriers may use utilization review systems, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service, provided that the determination shall be made in the same manner as if the service was provided via in-person consultation or delivery

(e) Coverage for telehealth services shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan nor to reimburse a health care provider not contracted under the plan except as provided for under clause (i) of paragraph (4) of subsection (a) of Section 6 of Chapter 176O.

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

SECTION 51. Chapter 176I of the General Laws is hereby amended by adding the following section:-

Section 13(a). For the purposes of this section, "Telehealth" as it pertains to the delivery of health care services, shall mean the use of synchronous or asynchronous telecommunications technology, including but not limited to live video, text messaging and application-based communications, by a telehealth provider, as defined in section 4P of chapter 111, to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment and monitoring of a patient. The term does not include audio-only telephone calls, e-mail messages or facsimile transmissions.

(b) For a contract between a member and a health maintenance organization, the organization shall implement procedures so that it shall not decline to provide coverage for health care services solely on the basis that those services were delivered through the use of telehealth by a contracted health care provider, consistent with clause (i) of paragraph (4) of subsection (a) of section 6 of chapter 176O, if (i) the health care services are covered by way of

in-person consultation or delivery and (ii) the health care services may be appropriately provided through the use of telehealth.

(c) A contract that provides coverage for services under this section may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

(d) When determining coverage for telehealth services, carriers may use utilization review systems, including preauthorization, to determine the appropriateness of telehealth as a means of delivering a health care service, provided that the determination shall be made in the same manner as if the service was provided via in-person consultation or delivery

(e) Coverage for telehealth services shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan nor to reimburse a health care provider not contracted under the plan except as provided for under clause (i) of paragraph (4) of subsection (a) of Section 6 of Chapter 176O.

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

SECTION 52. Paragraph (1) of subsection (a) of section 4 of Chapter 176J of the General Laws, as amended by section 8 of chapter 3 of the acts of 2013, is hereby amended by inserting after the fifth sentence the following:-

Upon the request of an eligible small business, a carrier shall provide that group with the claims data for every health benefit plan that it provides to the eligible small business so that the eligible small business can use such data to help control its health care costs.

SECTION 53. Section 11 of chapter 176J of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out, in line 17, the figure “14” and inserting in place thereof the following figure: - 28.

SECTION 54. Section 12 of Chapter 176J of the General Laws is hereby amended in line 35 by striking the number "6" and inserting in place thereof the following:- "8"

SECTION 55. Said section 12 of chapter 176J of the General Laws is hereby amended in line 39 by striking the number "85,000" and inserting in place thereof the following:-"150,000"

SECTION 56. Section 13(b) of chapter 176J of the General Laws is hereby amended by striking subsection (v) in its entirety.

SECTION 57. Section 2 of Chapter 176O of the General Laws, as so appearing, is hereby amended by adding the following subsection:-

(i) At least annually, a carrier that contracts with a pharmacy benefit manager shall coordinate an audit of the operations of the pharmacy benefit manager to ensure compliance with this chapter and to examine the pricing and rebates applicable to prescription drugs that are provided to the carrier’s covered persons.

SECTION 58. Said chapter 176O of the General Laws is hereby further amended by inserting after section 22 the following section:-

Section 22A. Notwithstanding any other general or special law to the contrary, each carrier shall require that a pharmacy benefit manager receive a license from the division under chapter 176N as a condition of contracting with that carrier.

SECTION 59. Chapter 176U of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after section 9 the following section:-

Section 10. Any individual eligible for a long-term care insurance policy shall be allowed a credit as hereinafter provided against the excise due under chapter 62 of the General Laws for taxable years ending on or after December 31, 2020. The amount of the credit shall be equal to 20 percent of the premiums paid.

An individual claiming a credit under this section shall furnish such information relative to the credit as may be requested by the commissioner of the department of revenue in a form approved by him, and the commissioner shall promulgate such regulations as are necessary to implement this section.

This section shall take effect for taxable years ending on or after December 31, 2020.

SECTION 60. Chapter 176W is hereby amended by inserting at the end thereof the following new chapter:-

Chapter 176X: Association Health Plans

176X:1 Definitions

Section 1. As used in this chapter the following words shall have the following meanings, unless the context clearly requires otherwise:-

“Commissioner”, the commissioner of insurance

"Fund balance" shall mean the total assets in excess of total liabilities, except that assets pledged to secure debts not reflected on the books of the multiple-employer welfare arrangement are not included in the fund balance. This definition also includes other contributed capital, retained earnings and subordinated debt.

"Funding vehicle" shall mean a trust or other legal entity created to receive, hold and administer contributions of employers participating in the arrangement that is composed of assets acceptable to the commissioner equal to or in excess of loss reserves and all other liabilities of the arrangement.

"Master agreement" shall mean a declaration of trust or other arrangement acceptable to the commissioner that provides a joint statement of those employers participating in a multiple-employer welfare arrangement in which the purposes, plan of administration, rights and duties of the participants and the manner of funding obligations arising under the arrangement are established.

"Multiple-employer welfare arrangement" or "arrangement" shall mean an employer welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of 2 or more employers or to their beneficiaries. 2 or more trades or businesses, whether or not incorporated, are deemed a single employer if those trades or businesses are under common ownership or within the same control group as defined under the federal Employee Retirement Income Security Act of 1974, Section 3(40)(B).

i. An arrangement is fully funded if aggregate excess insurance plus surplus and premium contributions are sufficient to fund all potential claims up to the maximum liability under such excess insurance policy, as determined under sound underwriting principles.

ii. An arrangement is “partially funded” if it does not meet the requirements to be fully funded.

iii. A funding vehicle is not fully funded if any part of the corpus consists of a surety bond.

"Participation agreement" shall mean the document pursuant to which an employer undertakes and agrees to fulfill the obligation of employers imposed by the master agreement.

"Qualified financial institution" shall mean an institution that is organized, or in the case of a United States branch or agency office of a foreign banking organization is licensed under the laws of the United States or any state, and has been granted authority to operate with fiduciary powers and is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

"Third-party administrator" or "administrator" shall mean an administrator licensed by the division of insurance

176W:2 Multiple Employer Welfare Arrangement; approval required

Section 2. A person may not commence operations after the effective date of this act of a multiple-employer welfare arrangement unless that arrangement is approved by the commissioner

176W:3 Insurer authorized to transact health insurance

Section 3. This chapter does not apply to a multiple-employer welfare arrangement that offers or provides benefits that are fully insured by an insurer authorized to transact health insurance in the State.

176W:4 General Eligibility

Section 4. (a) Requirements for approval: To meet the requirements for approval and to maintain a multiple-employer welfare arrangement, an arrangement:

i. Except for those associations meeting the criteria of subsection (b), must be established by an association of employers that are in the same trade, industry, line of business or profession.

ii. Must be operated pursuant to a master agreement under which a board has complete fiscal control over the arrangement and is responsible for all operations of the arrangement. The trustees or directors selected for the board must be owners, partners, officers, directors or employees of one or more employers in the arrangement. A trustee or director may not be an owner, officer or employee of the administrator or service company of the arrangement. The board has the authority to approve applications of association members for participation in the arrangement and to contract with a licensed administrator or service company to administer the day-to-day affairs of the arrangement;

iii. May not be offered, advertised or available to employers or other members of the public generally, except as allowed under section (F)(2);

iv. Must be operated in accordance with sound actuarial principles;

v. May not deny coverage to any otherwise eligible employer, employee or dependent on the basis of health status or claims experience; and

vi. Any arrangement covering 50 or more employees is deemed a large employer for the purposes of the applicability

vii. To the extent permitted by federal law, a multiple-employer welfare arrangement may risk rate employer members that have 50 or more employees.

viii. To the extent permitted by federal law, working owners that otherwise satisfy the eligibility requirements may participate in an arrangement.

(b) Eligibility for state-based geographic association: To meet the requirements for approval and to maintain a multiple-employer welfare arrangement, an arrangement for a state-based geographic association:

i. Must be established by an association with a principal office located within the borders of the State.

ii. May establish eligibility standards for membership in the association, subject to the requirements of section (F)(2)(iii); and

iii. Must meet the requirements for approval contained within subsection (a) except for subsection (a)(i).

(c) Eligibility for metropolitan-area-based geographic association: To meet the requirements for approval and to maintain a multiple-employer welfare arrangement, an arrangement for a metropolitan-area-based geographic association:

i. Must be established by an association with a principal office within a metropolitan area that has boundaries in the State;

ii. Must adhere to any multi-state compact applicable to its establishment and operations

iii. May establish eligibility standards for membership in the association, subject to the requirements of section (F)(3)(iv); and

iv. Must meet the requirements for approval contained within subsection (a) except for section (a) (i).

(d) Maintenance of specific excess insurance: The commissioner may require an arrangement to purchase and maintain specific excess insurance with a retention level determined in accordance with sound actuarial principles and approved by the commissioner. The commissioner may also require the arrangement to purchase aggregate excess insurance.

(e) Maintenance of appropriate loss reserves: Each arrangement shall establish and maintain appropriate loss and loss expense reserves determined in accordance with sound actuarial principles and shall fund obligations by depositing assets that will yield in a time frame matching maturing liabilities of the arrangement sufficient funds to discharge claims and other expense payments.

(f) Qualified financial institution: All funds of a multiple-employer welfare arrangement must be held in the name of the arrangement in a qualified financial institution by state or federally chartered financial institutions until such time as they are disbursed.

(g) Replacement of financial institution: The commissioner may not grant or continue approval until the arrangement replaces any financial institution found by the commissioner:

i. To be incompetent, untrustworthy or financially irresponsible;

ii. To be guilty of or to have pled guilty or no contest in any state or country to a criminal offense for which incarceration for one year or more may be imposed or for which incarceration of one year or more could be imposed had the offense occurred in this State, or that involves moral turpitude, dishonesty, false statement or misappropriation or conversion of property or funds;

iii. To have had any type of insurance license revoked in this State or any other state; or

iv. To have improperly manipulated assets, accounts or specific excess insurance or to have otherwise acted in bad faith.

(h) Contracts available for inspection: To qualify for and retain approval to transact business, an arrangement must make all contracts with administrators or service companies available for inspection by the bureau initially and thereafter upon reasonable notice.

(i) Suspension or revocation of approval: Except as otherwise expressly provided in this chapter, failure to maintain compliance with applicable eligibility or filing requirements established by this section is grounds for suspension or revocation of authority of an arrangement

176W:5 Filing Requirements

Section 5. The sponsoring association shall file with the commissioner an application for authorization of the arrangement upon a form to be furnished by the commissioner. The application must include or have attached the following:

(a) Constitution or bylaws. A copy of the constitution or bylaws of the association;

(b) Identification of trustees. The name and address of each trustee or director of the arrangement;

(c) Document governing operation. A copy of the master agreement and any other documents that govern the operation of the arrangement;

(d) Evidence of benefits provided. A copy of the employer participation agreement and the certificate, summary plan description or other evidence of the benefits and coverage provided to covered employees;

(e) Excess insurance agreement. A copy of the arrangement's excess insurance agreement;

(f) Evidence of sound actuarial principles. Evidence satisfactory to the commissioner showing that the arrangement will be operated in accordance with sound actuarial principles, the commissioner may not approve the arrangement unless the commissioner determines that the plan is designed to provide sufficient revenues to pay current and future liabilities, as determined in accordance with sound actuarial principles; and

(g) Additional information. Additional information that the commissioner may reasonably require

176W:6 Reserve & Stop Loss Requirements

Section 6. (a) Fully funded arrangement.

i. The annual actuarial report described in section 12 (b) is not required if aggregate excess insurance includes a run out period of three months or greater.

ii. The commissioner may permit an arrangement up to two years to accumulate the reserve requirement stated in section 4(c), and the commissioner may require such an arrangement to provide collateral until such time as the reserves are fully accumulated.

iii. An employer participating in an arrangement must be required by such arrangement to pay premiums for the entire contract year in which it participates in the arrangement, whether or not such employer withdraws from the arrangement prior to the end of the contact year.

iv. The arrangement must provide for an equitable allocation of unfunded liability among participating employers that is acceptable to the commissioner

v. Sections (a) (1) (iii) and (a)(1)(iv) shall also apply to partially funded arrangements detailed in section (b)(2).

(b) Partially funded arrangement

i. The annual actuarial report described in section 12 (b) of this chapter applies to partially funded arrangements.

ii. The reserve requirement stated in section 4(c) shall be fully funded no later than the later of the date on which the arrangement first provides coverage and the effective date of this chapter.

176W:7 Liability of Participants

Section 7. (a) Liability of each employer participant. Employers participating in an arrangement shall be jointly liable for the obligations of the arrangement.

(b) Contingent assessment liability. Each employer participant has a contingent assessment liability pursuant to section 11 of this chapter for payment of actual losses and expenses incurred while the participation agreement was in force.

(c) Statement of contingent liability. Each participation agreement or contract issued by the arrangement must contain a statement of the contingent liability of employer participants. The participation agreement must contain the following statement: "This is a fully assessable contract. In the event the arrangement is unable to pay its obligations, participating employers will be required to contribute through an equitable assessment the money necessary to meet any unfulfilled obligations."

176W:8 Deficiency in reserves, assets or reinsurance

Section 8. (a) Examination of finances. The commissioner may conduct, upon reasonable notice, an examination to determine the financial condition of an arrangement. Examiners duly qualified by the commissioner may examine the loss reserves, assets, liabilities, excess insurance and working capital of a multiple-employer welfare arrangement. If the commissioner finds that the reserves, excess insurance or assets may be inadequate, or that the arrangement does not have working capital in an amount establishing the financial strength and liquidity of the arrangement to pay claims promptly and showing evidence of the financial ability of the arrangement to meet its obligations to covered employees, the commissioner shall notify the arrangement of the inadequacy. Upon notification, the arrangement shall file within 30 days

with the commissioner its written plan specifying remedial action to be taken and the time for implementation of that plan.

(b) Correction of deficiency. If the commissioner determines, after reviewing the information filed, that a hazardous financial condition exists, the arrangement shall implement within 30 days its plan to correct any deficiencies and shall file with the commissioner proof of remedial action taken within 60 days, if the commissioner is satisfied that the plan submitted to improve the inadequate condition of the arrangement is sufficient, the commissioner shall notify the arrangement of such sufficiency. The arrangement shall report monthly to the commissioner until any deficiencies and their causes have been corrected.

176W:9 Trust Deposit or surety bond

Section 9. If the commissioner determines that a multiple-employer welfare arrangement has failed to establish or maintain the actuarially indicated level of funding as required, the commissioner may require the arrangement to file a security deposit or a surety bond in accordance with this section.

(i) Deposit. If required, deposit funds, which may consist of cash, securities or any combination of cash and securities acceptable to the commissioner, must be filed with the commissioner for deposit with the Treasurer of the commonwealth in an amount prescribed by the commissioner. All income from deposits belongs to the depositing arrangement and must be paid to it when received. An arrangement that has made a security deposit, subject to approval of the commissioner, may withdraw that deposit or any part of that deposit after making a substitute deposit of cash, securities or any combination of cash and securities of equal amount and value.

A judgment creditor or other claimant of a multiple-employer welfare arrangement may not levy upon any of the assets or securities held in this State as a deposit under this section.

(ii) Surety bond in lieu of deposit. In lieu of the deposit required under section 9 (i), an arrangement may file with the commissioner a surety bond for the same amount that would be required as a deposit. The bond must be one issued by an authorized surety insurer, must be for the same purpose as the deposit in lieu of which it is filed and must be in a form prescribed by the commissioner. A bond may not be canceled or subject to cancellation unless at least 60 days' advances notice of cancellation in writing is filed with the commissioner and the chair of the board.

(iii) Insolvency termination. In the event of a termination of an arrangement due to insolvency, a determination of impairment or the failure of the arrangement to pay any final judgment rendered against it in this State within 30 days after the judgment becomes final, the deposit held by the commissioner pursuant to section 9 (i) of this chapter or the bond held by the commissioner pursuant to section 9 (ii) of this chapter must be applied to the extent of the insolvency or to the extent of any default in payment of benefit claims. Any deposit funds remaining in excess of the amount needed to make the arrangement solvent must be distributed in accordance with section (11) of this chapter.

176W:10 Forms

Section 10: (a) Forms available for inspection. All participation agreements, contract forms, application forms, certificates, riders, endorsements, summary plan descriptions and other evidences of coverage must be maintained on file by the arrangement and must be available for inspection by the commissioner upon request.

(b) Grounds for disapproval of forms by commissioner. The commissioner may disapprove a form reviewed under this section only if the form:

i. Violates or does not comply with this chapter;

ii. Contains or incorporates by reference misleading clauses or exceptions and conditions that deceptively misstate the risk proposed to be assumed in the general coverage of the contract; or

iii. Is printed or otherwise reproduced in such manner as to render any material provision of the form substantially illegible.

176W:11 Termination

Section 11. If an arrangement is terminated for any reason, the funding vehicle may not be dissolved until all outstanding claims, debts and obligations of the arrangement are paid. The arrangement may retain sufficient funds to provide coverage for an additional period as board of the arrangement considers prudent. In addition, the board may purchase additional insurance they consider necessary for protection against potential future claims. Any funds remaining in the arrangement after satisfaction of all obligations must be paid to participating employers or covered employees in an equitable manner. Written notice of the termination of the arrangement must be provided to each covered employee and the commissioner at least 10 days before the effective date of the termination.

176W:12 Annual Report; Actuarial Report

Section 12. (a) The commissioner may request no more frequently than annually a report summarizing the business activities of the arrangement for the immediately preceding year

and may additionally request a financial statement of the arrangement, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant, and most recent regulatory filing or other related documents.

(b) At least once every 2 years each arrangement must have a report prepared by an actuary who is an associate or fellow of the Society of Actuaries and the American Academy of Actuaries as to the actuarial soundness of the arrangement. After an arrangement has filed 2 actuarial reports pursuant to this subsection, an arrangement may request that the commissioner grant a waiver of the filing requirement to the arrangement. If required, the report must be filed with the commissioner. The report must consist of at least the following:

i. An assessment of the adequacy of contribution rates in meeting the level of benefits provided and changes, if any, needed in the contribution rates to achieve or preserve a level of funding adequate to enable payment of the benefit amounts provided under the arrangement, which must include a valuation of present assets, valued in accordance with insurance accounting precepts, and prospective assets and liabilities of the plan and the extent of unfunded accrued liabilities;

ii. A plan and schedule to amortize any unfunded liabilities and a description of actions taken to reduce unfunded liabilities;

iii. A description and explanation of actuarial assumptions;

iv. A comparative review illustrating the level of funds available to the arrangement from rates, investment income and other sources realized over the period covered by the report indicating the assumptions used;

v. A certification by the actuary that the report is complete and accurate and that in the actuary's opinion the techniques and assumptions used are reasonable, make good and sufficient provision to meet the obligations of the arrangement and meet the requirements and intent of this chapter; and

vi. Other factors or statements as may be reasonably required by the commissioner in order to determine the actuarial soundness of the plan.

176W:13 Grounds for denial, suspension or revocation of arrangement

Section 13. Subject to other provisions of this chapter, the commissioner may, in the commissioner’s discretion deny, suspend or revoke an arrangement's authorization if the commissioner finds that the arrangement:

i. Has failed to correct any deficiency as provided in section (J);

ii. Has refused to be examined or to produce its accounts, records and files for examination, or if any of its officers has refused to give information with respect to its affairs or to perform any other legal obligation as to such examination when required by the commissioner;

iii. Has failed to pay a judgment rendered against it in the State within 30 days after the judgment becomes final; or

iv. No longer meets the requirements for the authority originally granted.

v. Has violated this chapter or a lawful order or rule of the commissioner; or

vi. Has refused to be examined or to produce its accounts, records and files for examination, or if any of its officers have refused to give information with respect to its affairs or to perform any other legal obligation as to such examination when required by the commissioner.

176W:14 Violations

Section 14. (a) An arrangement that fails to obtain and maintain a valid approval from the commissioner while operating or maintaining a multiple-employer welfare arrangement is subject to a civil penalty in an amount to be determined by the commissioner; and

(b) The commissioner may issue a cease and desist order if the commissioner finds a person operating or maintaining a multiple-employer welfare arrangement without a currently effective certificate of approval.

176W:15 Regulatory Authority

Section 15. The commissioner shall promulgate all rules and regulations necessary for the purposes of carrying out this act. In addition, the commissioner is authorized to enter into interstate compacts permitting arrangements under this chapter to offer coverage through participating employers in other states and to permit arrangements from other states to offer coverage to participating employers in this State, provided that any such interstate compact shall not be materially inconsistent with this chapter and shall comply with the requirements of applicable federal law.

SECTION 61. Notwithstanding any general or special law to the contrary, no contract for pharmacy services between a health insurance carrier or pharmacy benefits manager and a

pharmacy or pharmacist shall contain a provision prohibiting or penalizing a pharmacist's disclosure to an insured individual purchasing a covered prescription medication of information regarding: (i) the cost of the prescription medication to the individual, and (ii) the availability of any equivalent medication or alternative methods of purchasing the prescription medication, including, but not limited to, paying a cash price, which may be less expensive than the cost of the prescription medication to the individual.

(b) No health insurance carrier or pharmacy benefits manager shall require an individual to make a payment at the point of sale for a covered prescription medication in an amount greater than the amount an individual would pay for the prescription medication if the individual purchased the prescription medication without using a health insurance plan.

SECTION 62. Section 226 of chapter 139 of the acts of 2012, is hereby amended by striking "2021" inserted by section 15 of the chapter 142 of the acts of 2019 and inserting in place thereof the following figure:-"2030"

SECTION 63. Notwithstanding any general or special law to the contrary, not later than June 1, 2023, the health policy commission shall conduct an analysis and issue a report evaluating the effect of discounts, rebates, product vouchers and other reductions for biological products and prescription drugs, as authorized under section 3 of chapter 175H, on pharmaceutical spending and health care costs in Massachusetts. The study shall include, but not be limited to, (i) the total number coupons and discounts redeemed in the commonwealth; (ii) the total value of coupons and discounts redeemed in the commonwealth; (iii) an analysis of the types of biological products and prescription drugs for which coupons and discounts were most frequently redeemed; (iv) a comparison of any change in utilization of generic versus brand

name prescription drugs; (v) a comparison of any change in utilization among therapeutically-equivalent brand name drugs; (vi) the effect on patient adherence to prescribed drugs; (vii) patient access to innovative therapies; (viii) an analysis of the availability of the coupons or discounts upon renewals; (ix) an analysis of the cost impact to consumers upon expiration of the coupon or discount; (x) an analysis of the impact on commercial health insurance premiums, attributed to both employers and individuals; (xi) an analysis of the impact on any health care cost containment goals adopted by the commonwealth; and (xii) an analysis of the impact on prescription drug costs and premiums for health plans offered by the group insurance commission. The commission may require manufacturers of biological products and prescription drugs to report on the number and types of coupons that such manufacturers have issued and which have been redeemed in the commonwealth. The report shall be made available electronically on the commission's website, and shall be filed with the secretary of administration and finance, the secretary of health and human services, the clerks of the house of representatives and the senate, the house and senate committees on ways and means and the joint committee on health care financing.

SECTION 64. (a)Notwithstanding any other provision of this chapter, the board shall allow a physician to obtain proxy credentialing and privileging for telemedicine services with other health care providers, as defined in section 1 of chapter 111, or facilities consistent with Medicare conditions of participation telemedicine standards.

The board shall promulgate regulations regarding the appropriate use of telemedicine to provide health care services. These regulations shall provide for and include, but shall not be limited to: (i) prescribing medications; (ii) services that are not appropriate to provide through

telemedicine; (iii) establishing a patient-provider relationship; (iv) consumer protections; and (v) ensuring that services comply with appropriate standards of care.

(b) For the purposes of this section, "telemedicine" shall mean the use of interactive audio, video or other electronic media for a diagnosis, consultation or treatment of a patient's physical, oral or mental health; provided, however, that "telemedicine" shall not include audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

(c) The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract to a Medicaid managed care organization or primary care clinician plan may provide coverage for health care services appropriately provided through telemedicine by a contracted provider.

(d) The division may undertake utilization review, including preauthorization, to determine the appropriateness of telemedicine as a means of delivering a health care service; provided, however, that determinations shall be made in the same manner as if service was delivered in person. The division, a contracted health insurer, health plan, health maintenance organization, behavioral health management firm or third party administrators under contract to a Medicaid managed care organization or primary care clinician plan shall not be required to reimburse a health care provider for a health care service that is not a covered benefit under the plan nor reimburse a health care provider not contracted under the plan.

A health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where telemedicine is provided be limited for health care services provided through telemedicine.

(e) A contract that provides coverage for telemedicine services may include a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of services. Coverage that reimburses a provider with a global payment, as defined in section 1 of chapter 6D, shall account for the provision of telemedicine services in setting that global payment amount.

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

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

For the purposes of this section, "telemedicine" shall mean the use of interactive audio, video or other electronic media for the purposes of a diagnosis, consultation or treatment of a patient's physical, oral or mental health; provided, however, that "telemedicine" shall not include an audio-only telephone, facsimile machine, online questionnaire, texting or text-only e-mail.

SECTION 66. Notwithstanding any general or special law to the contrary the secretary of health and human services shall develop and implement a 3 year pilot program care management

program focused on asthma, diabetes, congestive heart failure, and other high-risk or high-need individuals.

The secretary shall submit annual updates no later than Dec 31 on said program to the joint committee on public health, the joint committee on health care financing and the clerks of the house and senate.

SECTION 67. Notwithstanding any general or special law to the contrary, the commissioner of revenue, in consultation with the department of public health, shall authorize annually an amount not to exceed $1,000,000 for the wellness program tax credit in section 6O of chapter 62 of the General Laws together with chapter 38II of chapter 63 of the General Laws.

SECTION 68. Notwithstanding any general or special law to the contrary, the Secretary of Health and Human Services in conjunction with the Secretary of Elder Affairs shall file an application to seek a waiver with the Center for Medicaid and Medicare Services (CMS) to amend the Commonwealth of Massachusetts' 1915(c) elderly waiver, and that any program of home and community based services in which family members are permitted to serve as paid caregivers, funded pursuant to Section 9 of Chapter 118E shall include spouses within the definition of a family member.

SECTION 69. There shall be, subject to appropriation, a three year pilot program administered by the executive office of health and human services to provide for reimbursement for case management for patients with behavioral health issues.

The secretary shall submit annual updates no later than Dec 31 on said program to the joint committee on mental health, substance use and recovery, the joint committee on health care financing, and the clerks of the house and senate.

The secretary shall submit within 30 days of the conclusion of the pilot program the results of said pilot program along with any recommendations to the joint committee on mental health, substance use and recovery, the joint committee on health care financing, and the clerks of the house and senate.

SECTION 70. Section 6O of chapter 62 General Laws together with chapter 38II of chapter 63 of the General Laws shall expire on December 31, 2022.

SECTION 71. The department of public health shall promulgate any rules and regulations necessary to implement this act, no later than January 1, 2021.