# HOUSE . . . . . No. 4934

## The Commonwealth of Massachusetts

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HOUSE OF REPRESENTATIVES, January 22, 2026.

The committee on Financial Services, to whom was referred the petition (accompanied by bill, House, No. 1134) of Marjorie C. Decker for legislation to improve access and care coordination for people with pain, reports recommending that the accompanying bill (House, No. 4934) ought to pass.

For the committee,

JAMES M. MURPHY.

FILED ON: 12/16/2025

# HOUSE . . . . . No. 4934

## The Commonwealth of Massachusetts

**In the One Hundred and Ninety-Fourth General Court**
**(2025-2026)**

An Act to improve access and care coordination for people with pain.

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

SECTION 2. Chapter 118E of the General Laws is hereby amended by inserting after section 10Z the following new section:-

Section 10AA. Coverage for non-opioid pain medications.

(a) As used in this section, the following word shall, unless the context clearly requires otherwise, have the following meaning:

"Non-opioid drug" means a non-opioid drug approved by the federal Food and Drug Administration for the treatment or management of pain.

(b) The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization or primary care clinician plan shall provide coverage such that no non-opioid drug shall be disadvantaged or discouraged with respect to coverage

relative to any opioid or narcotic drug for the treatment or management of pain, where impermissible disadvantaging or discouragement includes, without limitation:

(1) designating any such non-opioid drug as a non-preferred drug if any opioid or narcotic drug is designated as a preferred drug on the MassHealth Drug List; or

(2) establishing more restrictive or more extensive utilization management procedures, including, but not limited to, more restrictive or more extensive prior authorization or step therapy protocols, for such non-opioid drug than the least restrictive or extensive utilization management procedures applicable to any such opioid or narcotic drug.

SECTION 3. (a) Notwithstanding any general or special law to the contrary, the division of medical assistance shall ensure the availability of accessible, quality health care for individuals with chronic pain who are enrolled in Medicaid managed care organizations or accountable care organizations that have a contract with the division to provide services to individuals enrolled under MassHealth pursuant to section 9 of chapter 118E of the General Laws. Such health care shall include, but not be limited to the following:

(1) comprehensive integrated care management for chronic pain patients, including primary care, medical specialty care (including but not limited to pain management specialists, neurologists, rheumatologists), and specialized treatment providers (including but not limited to physical therapists, occupational therapists, chiropractors, acupuncturists, psychologists, massage therapists) as specified in individualized pain treatment plans;

(2) social work services as well as education on chronic pain management for patients, caregivers, and providers; and

(3) support navigating health insurance coverage and support with transportation to primary care and specialty providers.

(b) Not later than January 1, 2027, the division of medical assistance shall require Medicaid managed care or accountable care organizations to implement a chronic pain quality strategy for children and adults with chronic pain that includes, but is not limited to, the following components:

(1) measurable goals to improve the identification of members with chronic pain within 90 days after enrolling in the contracted health plan;

(2) to the extent practicable, adequate provider network capacity to ensure timely access to chronic pain specialty service providers as listed above;

(3) care coordination strategies and supports to help members with chronic pain access appropriate providers including primary care, medical specialists, other specialized care providers of therapies included in the treatment plan and other related care supports; and

(4) delivery of a training curriculum approved by the division of medical assistance to educate primary care providers on the treatment of those with chronic pain, including information on the components of comprehensive chronic pain treatment including but not limited to pain assessment and diagnosis, administration of a validated pain rating tool, the development, implementation and revision of an individualized treatment plan, medication management, any necessary chronic pain crisis management, and care coordination and communication among providers furnishing various treatments; and on multidisciplinary pain care encompassing the full range of evidence-based treatments in five areas: restorative

therapies, medications, interventional procedures, behavioral therapies and complementary treatments.

(c) The division of medical assistance shall also, not later than January 1, 2026, and in partnership with Medicaid managed care organizations and accountable care organizations, identify, document, and share best practices regarding chronic pain care management and care coordination with Medicaid-enrolled primary care and specialty providers with a goal of improving services for members with chronic pain and their families.

SECTION 1. Chapter 12C of the General Laws is hereby amended by inserting after section 24 the following new section:-

Section 25. Data collection and reports on the incidence and prevalence of chronic pain in the commonwealth.

(a) The center shall utilize available federal and state data, including health care data collected under sections 8, 9, and 10, to clarify the incidence and prevalence of chronic pain experienced by individuals in the commonwealth from any source, including injuries, surgeries, diseases and conditions.

(b) The center shall also identify gaps in the available research data and collect deidentified population research data using medical claims and survey data to fill gaps in available research data.

(c) In its review of the relevant research data, the center shall identify information concerning:

(1) incidence and prevalence of chronic pain and of all specific known chronic pain conditions as well as of diseases and conditions that include or lead to chronic pain;

(2) demographics and other information, such as age, race, ethnicity, gender, and geographic location overall and for specific known chronic pain conditions;

(3) risk factors that may be associated with chronic pain conditions, such as genetic and environmental risk factors and other information, as appropriate;

(4) diagnosis and progression markers;

(5) direct health care costs of chronic pain treatment, both traditional and alternative, and indirect costs of chronic pain; (such as missed work, public and private disability, and reduction in productivity);

(6) the epidemiology of the conditions;

(7) the detection, management, and treatment of the conditions;

(8) the epidemiology, detection, management, and treatment of secondary or co-occurring conditions, such as depressive, anxiety, and substance use disorders;

(9) the utilization of medical and social services by patients with chronic pain conditions; and

(10) the effectiveness of evidence-based treatment approaches for chronic pain conditions.

(d) Not later than 2 years after the date of enactment of this Act, and every two years thereafter, the center shall publish a report concerning the incidence, prevalence and

demographics of chronic pain and specific chronic pain conditions experienced by individuals in the commonwealth. Such report shall address the information outlined in subsection (c). Such report shall also include an analysis of any data gaps identified by the center, and any recommendations with respect to efforts to address such gaps.