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HOUSE . . . . . No. 4134

The Commonwealth of Massachusetts

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October 18, 2019

To the Honorable Senate and House of Representatives,

For the past 50 years, the US health care system has been focused primarily on promoting and supporting the technological advancement of medicine. That focus has cured disease, enhanced therapies, and saved lives. But as that focus, and the success it has achieved, has dominated what and how we pay for health care, we have failed to appreciate the changing nature of illness, and the systemic gaps in care delivery that have been created by this approach.

One need look no further than the opioid epidemic to understand what we have missed. The overprescribing of addictive and potentially deadly pain medication, brought on by a system in which it is more financially beneficial to write a prescription than it is to provide supportive and sustained therapy, created an addiction epidemic of gargantuan proportions.

While many people would argue that the fundamental problems with our health care system are rooted in some provider organizations being paid too much, and others being paid too little, we would argue the problem is more fundamental than that. Our health care system rewards those providers that invest in technology and transactional specialty services, at the expense of those that choose to invest in primary care, geriatrics, addiction services and behavioral health care.

This is problematic for three reasons. First, the nature of illness is changing. Chronic illnesses are far more prevalent than they used to be, in part because of the success of modern medicine in solving many kinds of acute illness over the past five decades. Second, we are an

aging population. Many of us who live to the age of 60 will make it into our 80s and 90s, where brain diseases are far more common than they used to be, again in part because of our success in treating heart disease and many forms of cancer. Third, for a variety of clinical and sociological reasons, mental health, addiction and behavioral health issues are far more challenging than they were in the past, and we increasingly recognize how they are intertwined with physical illnesses.

And the primary care shortage that was identified over 30 years ago has gotten worse over the past three decades.

Simply put, the care delivery and financing system we have today is not designed to take care of the people and the patients we have become. We pay for a system that is built on transactions and technological advances, not on collaborative care delivery, therapeutic support, or a combination of both. While technological advances remain a critical component of delivering effective health care, a 21st century health system should presume that collaboration and time are at least as important as technology, and that for many people, physical and mental health are related. It should reward providers and provider organizations that invest in a comprehensive set of physical and behavioral health services, and understand that population based health management requires time and connection.

Solving this problem at the state level is complicated by the overarching role played by public and private national payors in health care in this country. For the most part, national payors, including Medicare, use payment policies that favor technology and transactional medicine at the expense of primary care, mental and behavioral health and addiction services, and ironically, geriatrics. Almost all providers and payors build their financial models and their operations using the Medicare fee schedule as their baseline. This makes any decision to deviate from that model – for example, to offer more mental health services – extremely hard to do.

Federal policy and research funding also drive provider organizations to focus on specialty services and care, instead of on addiction, mental or behavioral health, primary care or geriatrics. This makes it financially difficult for any care delivery organization to double down in the areas where the greatest gaps in the existing care delivery system exist.

The bill I am filing today, "An Act to Improve Health Care by Investing in VALUE," is designed to create positive financial incentives for health care providers and payors to rethink their service delivery and investment decisions. This bill encourages providers and payors to invest in the behavioral health, addiction and recovery, and primary care and geriatric services that are underfunded by today's payment models and incorporate these services more directly into their care delivery strategies.

The legislation targets those challenges by requiring investments in behavioral and primary care and establishing a statewide spending target.

- Providers and insurers, including MassHealth, will be required to increase spending on behavioral health and primary care by 30% over three years.

- Calendar year 2019 spending will serve as the baseline, and providers and insurers will be measured on their performance beginning in calendar year 2023.

- The legislation does not suggest a standard pathway for providers and insurers to achieve the target.

- Providers and insurers will be required to report their progress on an annual basis through the Center for Health Information Analysis' (CHIA) and Health Policy Commission's (HPC) existing processes.

- If the target is not achieved, providers and insurers will be referred by CHIA to the HPC and may be subject to a performance improvement plan which may require them to identify strategies and opportunities to increase investments in primary care and behavioral health.

The legislation proposes these increased investments in primary care and behavioral health while requiring overall spending to stay within the parameters of the state's overall health care cost growth benchmark.

This will be a break from the trajectory of the past several decades and may cause some modest disruptions. But even a cursory review of the literature makes clear that this is the right direction for our payment systems and our health care providers to move in if we want to create a payment and care delivery model that properly and cost effectively serves the people of the Commonwealth.

Our bill also builds upon the foundation put forth by prior health care legislation, including Chapter 224, the 2012 cost containment legislation. Recent efforts have yielded moderate success in bending the cost growth curve. However, increasing health care costs disproportionately fall to individuals and employers, as increases in premiums and cost-sharing continue to outpace overall expenditures.

This legislation seeks to address excess costs and spending through a multi-faceted approach that both targets systemic cost drivers and promotes consumer access to high-value, affordable coverage. The bill strengthens the process by which the Health Policy Commission (HPC) evaluates, and holds accountable, entities that exceed the cost growth benchmark.

To address year-over-year increases in pharmacy spend, we seek to:

- hold high-cost drug manufacturers accountable through a similar framework used for payors and providers that exceed the benchmark;

- penalize manufacturers for excessive price increases; and

- establish new oversight authority of pharmacy benefit managers (PBMs).

The bill also includes several consumer protections and measures to reduce consumers' out-of-pocket costs, including prohibitions on surprise billing practices and facility fees, and reforms promoting access to more affordable, innovative health plans for individuals and employers, alike.

Further, a stable and affordable insurance market is key to maintaining our near-universal coverage levels and a well-functioning health care system. To address many of the emerging federal policy changes and dynamics that may impact the Massachusetts merged market, I will be issuing an executive order in parallel, to establish an advisory council to conduct an independent actuarial analysis of the merged market and provide recommendations, including any regulatory or statutory reforms, for improved market functioning no later than April 30, 2020.

Finally, this legislation promotes access to quality, coordinated care and modernizes policies to bring Massachusetts in line with other states in areas where we have lagged behind. These measures include: removing outdated practice restrictions for mid-level clinicians, creating a new mid-level dental therapist, standardizing urgent care services and advancing telemedicine through aligned regulatory and coverage policies.

Managing excess costs in the system and promoting increased access to vital services will support the Commonwealth in recalibrating its health care financing and delivery system towards a model that values time and positive outcomes, and stands prepared to meet the evolving needs of our changing patient populations. Many of the reforms we have proposed will also reduce costs – including to patients and small businesses – while maintaining the quality of care the people of Massachusetts deserve.

We can't afford to wait. I look forward to working with the Legislature to enact comprehensive health care legislation that delivers a more cost-effective, nimble and patient-centric health care system for the 21st century.

Respectfully submitted,

Charles D. Baker,
Governor

HOUSE . . . . . No. 4134

The Commonwealth of Massachusetts

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

An Act to improve health care by investing in VALUE.

Whereas, The deferred operation of this act would tend to defeat its purpose, which is to improve the delivery of health care and reduce health care costs, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public convenience.

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 6A of the General Laws is hereby amended by inserting after section 16BB the following section:-

Section 16CC. (a) There shall be a task force to make recommendations on aligned measures of health care provider quality and health system performance to ensure consistency in the use of quality measures in contracts between payers, including the commonwealth and carriers, and health care providers in the commonwealth, ensure consistency in methods for evaluating providers for tiered network products, reduce administrative burden, improve transparency for consumers, improve health system monitoring and oversight by relevant state agencies and improve quality of care. Through May 2021, the members of the task force shall be the members of the existing Executive Office of Health and Human Services Quality Measurement Taskforce. After May 2021, the task force shall include the following members or their designees: the secretary of health and human services, who shall serve as chair; the

commissioner of public health; the commissioner of mental health; the executive director of the center for health information and analysis; the executive director of the health policy commission; the executive director of the group insurance commission; the assistant secretary for MassHealth; the commissioner of insurance; and at a minimum, 12 members who shall be appointed by the governor, 1 of whom shall be a representative of a provider trade association; 1 of whom shall be a representative of a medical society; 1 of whom shall be a behavioral health provider; 1 of whom shall be a long-term supports and services provider; 1 of whom shall be a representative of a community health center serving the Medicaid population; 1 of whom shall be a representative of a Medicaid managed care organization; 1 of whom shall be a representative of a statewide ACO;1 of whom shall be a representative of a commercial managed care organization; 1 of whom shall be a representative for persons with complex health conditions; 1 of whom shall be a representative for consumers; 1 of whom shall be a representative of a hospital; at least 1 of whom shall be an academic with expertise in health care quality measurement and 1 of whom shall be a representative of an employer with experience in health care quality measurement. Members appointed to the task force shall have experience with and expertise in health care quality measurement. The task force shall convene annually, with its first meeting occurring not later than January 15, and shall meet not less than monthly or as determined necessary by the chair of the task force. The task force shall submit an annual report with its recommendations, including any changes or updates to aligned measures of health care provider quality and health system performance, to the secretary of health and human services and the joint committee on health care financing not later than January 31 of each year with the first report due in the year following the effective date of this section.

(b) The task force shall make recommendations on aligned measures of health care provider quality and health system performance for use in: (i) contracts between payers, including the commonwealth and carriers, and health care providers, provider organizations and accountable care organizations, which incorporate quality measures into payment terms, including the designation of a set of core measures and a set of non-core measures; (ii) assigning tiers to health care providers in the design of any health plan; (iii) consumer transparency websites and other methods of providing consumer information and (iv) monitoring system-wide performance. The task force shall regularly review its recommended aligned measures of health care provider quality and health system performance, and shall update its recommendations each year.

(c) In developing its recommendations, the task force shall consider evidence-based, scientifically acceptable, nationally-endorsed quality measures, including, but not limited to, measures endorsed by the National Committee for Quality Assurance or the National Quality Forum. Such quality measures shall include, but not be limited to, measures used by the commonwealth, the Centers for Medicare and Medicaid Services, the group insurance commission, carriers, and provider organizations in the commonwealth and other states, as well as other valid measures of health care provider performance, outcomes, including patient-reported outcomes and functional status, patient experience, disparities, and population health. The task force shall consider measures applicable to primary care providers, specialists, hospitals, provider organizations, accountable care organizations, oral health providers and other types of providers and measures applicable to different patient populations.

(d) No later than March 31 of each year, the secretary of health and human services in consultation with the commissioner of insurance, may establish an aligned measure set to be

used by the commonwealth and carriers in contracts with health care providers that incorporate quality measures into the payment terms pursuant to sections 4 and 4A of chapter 32A, section 10K of chapter 118E, section 108N of chapter 175, section 8W of chapter 176A, section 4W of chapter 176B, section 4O of chapter 176G, and for assigning tiers to health care providers in tiered network plans pursuant to section 11 of chapter 176J. The aligned measure set shall designate: (i) core measures that shall be used in contracts between payers, including the commonwealth and carriers, and health care providers, including provider organizations and accountable care organizations, which incorporate quality measures into payment terms; and (ii) non-core measures that may be used in such contracts. In establishing the aligned measure set, the secretary of health and human services may consider factors including but not limited to quality improvement priorities for the Commonwealth, quality measurement innovation, data collection methodology, and measure feasibility.

SECTION 2. Section 1 of chapter 6D of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the definition of "After-hours care" the following 2 definitions:-

"Aggregate baseline expenditures", the sum of all primary care and behavioral health expenditures, as defined by the center, in the commonwealth in the calendar year preceding the three year period to which the aggregate target applies; provided, however, that aggregate baseline expenditures shall initially be calculated using calendar year 2019.

"Aggregate primary care and behavioral health expenditure target", hereinafter "the aggregate target", the targeted percentage change in total expenditures on primary care and behavioral health in the commonwealth from aggregate baseline expenditures.

SECTION 3. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Alternative payment methodologies or methods" the following definition:-

"Baseline expenditures", the sum of all primary care and behavioral health expenditures, as defined by the center, by or attributed to an individual health care entity in the calendar year preceding the three year period to which the target applies; provided, however, that baseline expenditures shall initially be calculated using as calendar year 2019.

SECTION 4. Said section 1 of said chapter 6D, as so appearing, is hereby further amended by inserting after the definition of "Physician" the following definition:-

"Primary care and behavioral health expenditure target", hereinafter "the target", the targeted percentage change in expenditures on primary care and behavioral health by or attributed to an individual health care entity compared to the entity's baseline expenditures.

SECTION 5. Section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out subsection (a), and inserting in place thereof the following subsection:-

(a) Not later than October 1 of every year, the commission shall hold public hearings based on the report submitted by the center under section 16 of chapter 12C comparing the growth in total health care expenditures to the health care cost growth benchmark for the previous calendar year and comparing actual aggregate primary care and behavioral health expenditures for the previous calendar year to the aggregate primary care and behavioral health expenditure target. The hearings shall examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system and

challenge the ability of the commonwealth's health care system to meet the benchmark or the aggregate primary care and behavioral health expenditure target established under section 9A.

SECTION 6. Subsection (d) of said section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 32, the words "and (xi)" and inserting in place thereof the following words:- (xi) at least 3 representatives of pharmaceutical or biopharmaceutical companies doing business in the commonwealth, including 1 publicly-traded company, 1 company that primarily manufactures generic drugs and 1 company that has been in existence for less than 10 years; and (xii).

SECTION 7. Said chapter 6D is hereby further amended by inserting after section 8A, as inserted by section 6 of chapter 41 of the acts of 2019, the following section:-

Section 8B. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meaning:

"Manufacturer", an entity that manufactures a pharmaceutical drug.

(b) The commission may require a manufacturer specified in subsection (c) to disclose to the commission within a reasonable time information relating to the manufacturer's pricing of that drug, on a standard reporting form developed by the commission with the input of the manufacturers, which includes but shall not be limited to, the following:

(1) A schedule of the drug's wholesale acquisition cost increases over the previous five calendar years;

(2) The manufacturer's aggregate, company-level research and development and other relevant capital expenditures, including facility construction, for the most recent year for which final audited data are available;

(3) A written, narrative description, suitable for public release, of factors that contributed to reported changes in wholesale acquisition cost during the previous five calendar years; and

(4) Any other information that the manufacturer wishes to provide to the commission.

Based on the records furnished, the commission may identify a proposed value for a prescribed drug specified in subsection (c). The commission may request additional relevant information that it deems necessary to identify a proposed value of the drug.

(c) A manufacturer of a drug for which the commission has received a referral from the center under subsection (b) of section 24 of chapter 12C shall comply with the requirements set forth in this section; provided that the commission may select or prioritize a subset of the referred drugs for the commission's review.

(d) Records disclosed by a manufacturer under this section shall: (i) be accompanied by an attestation that all information provided is true and correct; (ii) not be public records under section 7 of chapter 4 or chapter 66; and (iii) remain confidential; provided, however, that the commission may produce reports summarizing any findings; provided that any such report shall not be in a form that identifies specific prices charged for or rebate amounts associated with drugs by a manufacturer, or in a manner that is likely to compromise the financial, competitive or proprietary nature of the information.

(e) If, after review of any records furnished to the commission under subsection (b), the commission determines that the manufacturer's pricing of the drug is potentially unreasonable or excessive in relation to the commission's proposed value under subsection (b), the commission shall, with 30 days' advance notice to the manufacturer, request that the manufacturer provide further information related to the pricing of the prescribed drug and the manufacturer's justification for the pricing. In addition to the manufacturer, the commission may identify other relevant parties including but not limited to patients, providers, provider organizations and payers who may provide information to the commission.

(f) Any information, analyses or reports regarding a particular drug reviewed or used in assessing the proposed value of the drug shall be provided to the manufacturer for review and input. The commission shall consider any clarifications or data provided by the manufacturer with respect to its drug. The commission may not base its determination regarding the proposed value or the reasonableness of the drug pricing solely on the analysis or research of an outside third party.

(g) If the commission relies upon a third party to provide cost-effectiveness analysis or research related to the proposed value, such analysis or research shall also provide, but not be limited in scope to, (i) a description of the methodologies and models used in its analysis; (ii) any assumptions and potential limitations of research findings in the context of the results; and (iii) outcomes for affected subpopulations that utilize the drug.

(h) Not later than 60 days after receiving information from the manufacturer, as required under subsection (b) or (e), the commission shall issue a determination on whether the

manufacturer's pricing of a drug is unreasonable or excessive in relation to the commission's proposed value of the drug.

(i) If the manufacturer fails to timely comply with the commission's request for records under subsections (b) or (e), or otherwise knowingly obstructs the commission's ability to issue its determination under subsection (h), including, but not limited to, providing incomplete, false or misleading information, the commission may impose appropriate sanctions against the manufacturer, including reasonable monetary penalties not to exceed $500,000, in each instance. The commission shall seek to promote compliance with this section and shall only impose a civil penalty on the manufacturer as a last resort.

(j) The commission shall adopt any written policies, procedures or regulations that the commission determines necessary to implement this section.

SECTION 8. Said chapter 6D is hereby further amended by inserting after section 9 the following section:-

Section 9A. (a) The board shall establish an aggregate primary care and behavioral health expenditure target for the commonwealth, which the commission shall prominently publish on its website.

(b) The commission shall establish the aggregate primary care and behavioral health expenditure target as follows:

(1) For the three year period ending with calendar year 2022, the aggregate target shall be equal to a 30 per cent increase above aggregate baseline expenditures and the target shall be equal to a 30 per cent increase above baseline expenditures.

(2) For calendar years 2023 and beyond, the commission may modify the target and aggregate target, to be effective for a three year period provided that the target and aggregate target shall be approved by a two thirds vote of the board not later than December 31 of the final calendar year of the preceding three year period. If the commission does not act to establish an updated target and aggregate target pursuant to this subsection, the target shall be equal to a 30 per cent increase above baseline expenditures, and the aggregate target shall be equal to a 30 per cent increase above aggregate baseline expenditures until such time as the commission acts to modify the target and aggregate target. If the commission modifies the target and aggregate target, the modification shall not take effect until the three year period beginning with the next full calendar year.

(c) Prior to establishing the target and aggregate target, the commission shall hold a public hearing. The public hearing shall be based on the report submitted by the center under section 16 of chapter 12C, comparing the actual aggregate expenditures on primary care and behavioral health services to the aggregate target, any other data submitted by the center and such other pertinent information or data as may be available to the board. The hearings shall examine the performance of health care entities in meeting the target and the commonwealth's health care system in meeting the aggregate target. The commission shall provide public notice of the hearing at least 45 days prior to the date of the hearing, including notice to the joint committee on health care financing. The joint committee on health care financing may participate in the hearing. The commission shall identify as witnesses for the public hearing a representative sample of providers, provider organizations, payers and such other interested parties as the commission may determine. Any other interested parties may testify at the hearing.

SECTION 9. Chapter 6D of the General Laws is hereby further amended by striking out section 10, as appearing in the 2018 Official Edition, and inserting in place thereof the following 2 sections:-

Section 10. (a) For the purposes of this section, “health care entity” shall mean any entity identified by the center under section 18 of chapter 12C.

(b) The commission shall provide notice to all health care entities that have been identified by the center under section 18 of chapter 12C. Such notice shall state that the commission may analyze the spending growth of individual health care entities and the commission may require certain actions, as established in this section, from health care entities so identified.

(c) In addition to the notice provided under subsection (b), the commission may require any health care entity that is identified by the center under section 18 of chapter 12C to file a performance improvement plan with the commission. The commission shall provide written notice to such health care entity that they are required to file a performance improvement plan. Within 45 days of receipt of such written notice, the health care entity shall either:

(1) file a performance improvement plan with the commission; or

(2) file an application with the commission to waive or extend the requirement to file a performance improvement plan.

(d) The health care entity may file any documentation or supporting evidence with the commission to support the health care entity’s application to waive or extend the requirement to file a performance improvement plan. The commission shall require the health care entity to

submit any other relevant information it deems necessary in considering the waiver or extension application; provided, however, that such information shall be made public at the discretion of the commission.

(e) The commission may waive or delay the requirement for a health care entity to file a performance improvement plan in response to a waiver or extension request filed under subsection (e) in light of all information received from the health care entity, based on a consideration of the following factors:

(1) the costs, price and utilization trends of the health care entity over time, and any demonstrated improvement to reduce health status total medical expenses;

(2) any ongoing strategies or investments that the health care entity is implementing to improve future long-term efficiency and reduce spending growth;

(3) whether the factors that led to increased spending for the health care entity can reasonably be considered to be unanticipated and outside of the control of the entity. Such factors may include, but shall not be limited to, age and other health status adjusted factors and other cost inputs such as pharmaceutical expenses and medical device expenses;

(4) the overall financial condition of the health care entity;

(5) a significant difference between the growth rate of potential gross state product and the growth rate of actual gross state product, as determined under section 7H 1/2 of chapter 29; and

(6) any other factors the commission considers relevant.

(f) If the commission declines to waive or extend the requirement for the health care entity to file a performance improvement plan, the commission shall provide written notice to the health care entity that its application for a waiver or extension was denied and the health care entity shall file a performance improvement plan.

(g) A health care entity shall file a performance improvement plan: (1) within 45 days of receipt of a notice under subsection (c); (2) if the health care entity has requested a waiver or extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or (3) if the health care entity is granted an extension, on the date given on such extension. The performance improvement plan shall identify the causes of the entity's spending growth and shall include, but not be limited to, specific strategies, adjustments and action steps the entity proposes to implement to improve spending performance. The proposed performance improvement plan shall include specific identifiable and measurable expected outcomes and a timetable for implementation. The timetable for a performance improvement plan shall not exceed 18 months.

(h) The commission shall approve any performance improvement plan that it determines is reasonably likely to address the underlying cause of the entity's spending growth and has a reasonable expectation for successful implementation.

(i) If the board determines that the performance improvement plan is unacceptable or incomplete, the commission may provide consultation on the criteria that have not been met and may allow an additional time period, up to 30 calendar days, for resubmission.

(j) Upon approval of the proposed performance improvement plan, the commission shall notify the health care entity to begin immediate implementation of the performance improvement plan. Public notice shall be provided by the commission on its website, identifying that the health

care entity is implementing a performance improvement plan. All health care entities implementing an approved performance improvement plan shall be subject to additional reporting requirements and compliance monitoring, as determined by the commission. The commission shall provide assistance to the health care entity in the successful implementation of the performance improvement plan.

(k) All health care entities shall, in good faith, work to implement the performance improvement plan. At any point during the implementation of the performance improvement plan the health care entity may file amendments to the performance improvement plan, subject to approval of the commission.

(l) At the conclusion of the timetable established in the performance improvement plan, the health care entity shall report to the commission regarding the outcome of the performance improvement plan. If the commission finds that the performance improvement plan was unsuccessful, the commission shall either: (i) extend the implementation timetable of the existing performance improvement plan; (ii) approve amendments to the performance improvement plan as proposed by the health care entity; (iii) require the health care entity to submit a new performance improvement plan under subsection (c) or (iv) waive or delay the requirement to file any additional performance improvement plans.

(m) Upon the successful completion of the performance improvement plan, the identity of the health care entity shall be removed from the commission's website.

(n) The commission may submit a recommendation for proposed legislation to the joint committee on health care financing if the commission determines that further legislative authority is needed to achieve the health care quality and spending sustainability objectives of

this act, assist health care entities with the implementation of performance improvement plans, or otherwise ensure compliance with the provisions of this section.

(o) (1) If the commission determines that a health care entity has: (i) willfully neglected to file a performance improvement plan with the commission within 45 days as required under subsection (c); (ii) failed to file an acceptable performance improvement plan in good faith with the commission; (iii) failed to implement the performance improvement plan in good faith; or (iv) knowingly failed to provide information required by this section to the commission or that knowingly falsifies the same, the commission may assess a civil penalty to the health care entity of not more than $500,000 the first time that a determination is made, not more than $750,000 for a second determination and not more than $1,000,000 for a third or subsequent determination; provided, however, that a civil penalty assessed pursuant to 1 of the above clauses shall be a first offense if a previously assessed penalty was assessed pursuant to a different clause. A civil penalty assessed under this subsection shall be deposited into the Community Hospital and Health Center Investment Trust Fund established under section 2TTTT of chapter 29. The commission shall seek to promote compliance with this section and shall only impose a civil penalty as a last resort.

(2) In lieu of requiring a performance improvement plan pursuant to this section, the commission may assess a civil penalty on a health care entity identified by the center pursuant to section 18 of chapter 12C if the commission determines that a performance improvement plan is not an appropriate remedial measure. The civil penalty may be an amount up to the total cost attributable to the health care entity’s spending in excess of the health care cost growth benchmark in the most recent year for which data is available and shall be deposited into the

Community Hospital and Health Center Investment Trust Fund established under section 2TTTT of chapter 29.

(p) The commission shall promulgate regulations necessary to implement this section; provided, however, that notice of any proposed regulations shall be filed with the joint committee on state administration and regulatory oversight and the joint committee on health care financing at least 180 days before adoption.

Section 10A. (a) For the purposes of this section, "health care entity" shall mean any entity identified by the center under section 18 of chapter 12C.

(b) The commission shall provide notice to all health care entities that have been identified by the center under section 18 of chapter 12C for failure to meet the target. Such notice shall state that the center may analyze the performance of individual health care entities in meeting the target and, beginning in calendar year 2023, the commission may require certain actions, as established in this section, from health care entities so identified.

(c) In addition to the notice provided under subsection (b), the commission may require any health care entity that is identified by the center under section 18 of chapter 12C for failure to meet the primary care and behavioral health expenditure target to file and implement a performance improvement plan. The commission shall provide written notice to such health care entity that they are required to file a performance improvement plan. Within 45 days of receipt of such written notice, the health care entity shall either:

(1) file a performance improvement plan with the commission; or

(2) file an application with the commission to waive or extend the requirement to file a performance improvement plan.

(d) The health care entity may file any documentation or supporting evidence with the commission to support the health care entity's application to waive or extend the requirement to file a performance improvement plan. The commission shall require the health care entity to submit any other relevant information it deems necessary in considering the waiver or extension application; provided, however, that such information shall be made public at the discretion of the commission.

(e) The commission may waive or delay the requirement for a health care entity to file a performance improvement plan in response to a waiver or extension request filed under subsection (c) in light of all information received from the health care entity, based on a consideration of the following factors:

(1) the baseline expenditures, costs, price and utilization trends of the health care entity over time, and any demonstrated improvement to increase the proportion of primary care and behavioral health expenditures;

(2) any ongoing strategies or investments that the health care entity is implementing to invest in or expand access to primary care and behavioral health services;

(3) whether the factors that led to the inability of the health care entity to meet the target can reasonably be considered to be unanticipated and outside of the control of the entity. Such factors may include, but shall not be limited to market dynamics, technological changes and other drivers of non-primary care and non-behavioral health spending such as pharmaceutical and medical devices expenses.

(4) the overall financial condition of the health care entity;

(5) any other factors the commission considers relevant.

(f) If the commission declines to waive or extend the requirement for the health care entity to file a performance improvement plan, the commission shall provide written notice to the health care entity that its application for a waiver or extension was denied and the health care entity shall file a performance improvement plan.

(g) The commission shall provide the department of public health any notice requiring a health care entity to file and implement a performance improvement plan pursuant to this section. In the event a health care entity required to file a performance improvement plan under this section submits an application for a notice of determination of need under section 25C or 51 of chapter 111, the notice of the commission requiring the health care entity to file and implement a performance improvement plan pursuant to this section shall be considered part of the written record pursuant to said section 25C of chapter 111.

(h) A health care entity shall file a performance improvement plan: (1) within 45 days of receipt of a notice under subsection (c); (2) if the health care entity has requested a waiver or extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or (3) if the health care entity is granted an extension, on the date given on such extension. The performance improvement plan shall identify specific strategies, adjustments and action steps the entity proposes to implement to increase the proportion of primary care and behavioral health expenditures. The proposed performance improvement plan shall include specific identifiable and measurable expected outcomes and a timetable for implementation.

(i) The commission shall approve any performance improvement plan that it determines is reasonably likely to address the underlying cause of the entity's inability to meet the target and has a reasonable expectation for successful implementation.

(j) If the board determines that the performance improvement plan is unacceptable or incomplete, the commission may provide consultation on the criteria that have not been met and may allow an additional time period, up to 30 calendar days, for resubmission.

(k) Upon approval of the proposed performance improvement plan, the commission shall notify the health care entity to begin immediate implementation of the performance improvement plan. Public notice shall be provided by the commission on its website, identifying that the health care entity is implementing a performance improvement plan. All health care entities implementing an approved performance improvement plan shall be subject to additional reporting requirements and compliance monitoring, as determined by the commission. The commission shall provide assistance to the health care entity in the successful implementation of the performance improvement plan.

(l) All health care entities shall, in good faith, work to implement the performance improvement plan. At any point during the implementation of the performance improvement plan the health care entity may file amendments to the performance improvement plan, subject to approval of the commission.

(m) At the conclusion of the timetable established in the performance improvement plan, the health care entity shall report to the commission regarding the outcome of the performance improvement plan. If the performance improvement plan was found to be unsuccessful, the commission shall either: (i) extend the implementation timetable of the existing performance

improvement plan; (ii) approve amendments to the performance improvement plan as proposed by the health care entity; (iii) require the health care entity to submit a new performance improvement plan under subsection (c) or (iv) waive or delay the requirement to file any additional performance improvement plans.

(n) Upon the successful completion of the performance improvement plan, the identity of the health care entity shall be removed from the commission's website.

(o) The commission may submit a recommendation for proposed legislation to the joint committee on health care financing if the commission determines that further legislative authority is needed to achieve the health care quality and spending sustainability objectives of this act, assist health care entities with the implementation of performance improvement plans or otherwise ensure compliance with the provisions of this section.

(p) If the commission determines that a health care entity has: (i) willfully neglected to file a performance improvement plan with the commission by the time required in subsection (h); (ii) failed to file an acceptable performance improvement plan in good faith with the commission; (iii) failed to implement the performance improvement plan in good faith; or (iv) knowingly failed to provide information required by this section to the commission or that knowingly falsifies the same, the commission may assess a civil penalty to the health care entity of not more than $500,000 the first time that a determination is made, not more than $750,000 for a second determination and not more than $1,000,000 for a third or subsequent determination; provided, however, that a civil penalty assessed pursuant to 1 of the above clauses shall be a first offense if a previously assessed penalty was assessed pursuant to a different clause. A civil penalty assessed under this subsection shall be deposited into the Community

Hospital and Health Center Investment Trust Fund established under section 2TTTT of chapter 29. The commission shall seek to promote compliance with this section and shall only impose a civil penalty as a last resort.

(q) The commission shall promulgate regulations necessary to implement this section.

(r) Nothing in this section shall be construed as affecting or limiting the applicability of the health care cost growth benchmark established under section 9 of chapter 6D, and the obligations of a health care entity thereto.

SECTION 10. Section 11 of said chapter 6D of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting, in lines 20 to 21, after the words “the name and address of licensed facilities”, the following words:- , including whether any such facilities charge a facility fee as defined in section 51L of chapter 111.

SECTION 11. Section 13 of said chapter 6D, as so appearing, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) In addition to the grounds for a cost and market impact review set forth in subsection (a), if the commission finds, based on the center’s annual report, that the percentage change in total health care expenditures exceeded the health care cost growth benchmark in the previous calendar year, the commission may conduct a cost and market impact review of any provider or provider organization identified by the center under section 18 of chapter 12C.

SECTION 12. Said chapter 6D of the General Laws is hereby further amended by adding the following section:-

Section 20. (a) The commission shall annually identify services subject to the limitations on facility fees provided in subsection (c) of section 51L of chapter 111.

(b) Services identified by the commission under this section shall include evaluation and management services, diagnostics and imaging services, and other outpatient services that the commission determines may reliably be provided safely and effectively in settings other than hospitals.

SECTION 13. Section 7 of chapter 12C of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by striking out each time they appear, in lines 5 and 11, the words “Community Hospital Reinvestment Trust Fund” and inserting in place thereof the following words:-

Community Hospital and Health Center Investment Trust Fund.

SECTION 14. Said section 7 of said chapter 12C, as so appearing, is hereby further amended by striking out each time they appear, in lines 15 to 16 and 49 to 50, the words “or received retroactively for expenses of predecessor agencies” and inserting in place thereof the following words:-

excluding those made from the Community Hospital and Health Center Investment Trust Fund.

SECTION 15. Said chapter 12C is hereby amended by inserting after section 10 the following section:-

Section 10A. (a) The center shall promulgate regulations necessary to ensure the uniform annual reporting of information from pharmacy benefit managers certified under chapter 175N,

including but not limited to information on (1) payments received by pharmacy benefit managers by payers related to drugs provided to Massachusetts residents; (2) payments made by pharmacy benefit managers to pharmacies related to drugs provided to Massachusetts residents; (3) rebates received by pharmacy benefit managers from drug manufacturers related to drugs provided to Massachusetts residents; (4) rebates paid by pharmacy benefit managers to payers related to drugs provided to Massachusetts residents; (5) other payments made or received by pharmacy benefit managers by payers or pharmacies, including but not limited to administrative or performance-based payments, related to doing business in Massachusetts; (6) other rebates paid to or received by pharmacy benefit managers by drug manufacturers or payers related to doing business in Massachusetts; and (7) any other information specified by the center.

(b) The center shall analyze the information and data collected under subsection (a) and shall publish an annual report detailing, at minimum, each pharmacy benefit manager's aggregated percentage of spread pricing, as defined by the center, related to drugs provided to Massachusetts residents.

(c) Except as specifically provided otherwise by the center or under this chapter, pharmacy benefit manager data collected by the center under this section shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66. The center may confidentially provide pharmacy benefit manager data collected by the center under this section to the health policy commission.

SECTION 16. Section 14 of said chapter 12C is hereby repealed.

SECTION 17. Section 16 of said chapter 12C, as appearing in the 2018 Official Edition, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

(a) The center shall publish an annual report based on the information submitted under this chapter concerning health care provider, provider organization and private and public health care payer costs and cost trends, section 13 of chapter 6D relative to market power reviews and section 15 relative to quality data. The center shall compare the costs, cost trends, and expenditures with the health care cost growth benchmark established under section 9 of chapter 6D, analyzed by regions of the commonwealth, and shall compare the costs, cost trends, and expenditures with the aggregate primary care and behavioral health expenditure target established under section 9A of said chapter 6D, and shall detail: (1) baseline information about cost, price, quality, utilization and market power in the commonwealth's health care system; (2) cost growth trends for care provided within and outside of accountable care organizations and patient-centered medical homes; (3) cost growth trends by provider sector, including but not limited to, hospitals, hospital systems, non-acute providers, pharmaceuticals, medical devices and durable medical equipment; provided, however, that any detailed cost growth trend in the pharmaceutical sector shall consider the effect of drug rebates and other price concessions in the aggregate without disclosure of any product or manufacturer-specific rebate or price concession information, and without limiting or otherwise affecting the confidential or proprietary nature of any rebate or price concession agreement; (4) factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates; (5) primary care and behavioral health expenditure trends as compared to the aggregate baseline expenditures, as defined in section 1 said chapter 6D; (6) the proportion of

health care expenditures reimbursed under fee-for-service and alternative payment methodologies; (7) the impact of health care payment and delivery reform efforts on health care costs including, but not limited to, the development of limited and tiered networks, increased price transparency, increased utilization of electronic medical records and other health technology; (8) the impact of any assessments including, but not limited to, the health system benefit surcharge collected under section 68 of chapter 118E, on health insurance premiums; (9) trends in utilization of unnecessary or duplicative services, with particular emphasis on imaging and other high-cost services; (10) the prevalence and trends in adoption of alternative payment methodologies and impact of alternative payment methodologies on overall health care spending, insurance premiums and provider rates; (11) the development and status of provider organizations in the commonwealth including, but not limited to, acquisitions, mergers, consolidations and any evidence of excess consolidation or anti-competitive behavior by provider organizations; and (12) the impact of health care payment and delivery reform on the quality of care delivered in the commonwealth.

As part of its annual report, the center shall report on price variation between health care providers, by payer and provider type. The center’s report shall include: (1) baseline information about price variation between health care providers by payer including, but not limited to, identifying providers or provider organizations that are paid more than 10 per cent above or more than 10 per cent below the average relative price and identifying payers which have entered into alternative payment contracts that vary by more than 10 per cent; (2) the annual change in price variation, by payer, among the payer's participating providers; (3) factors that contribute to price variation in the commonwealth's health care system; (4) the impact of price variations on disproportionate share hospitals and other safety net providers; and (5) the impact of health

reform efforts on price variation including, but not limited to, the impact of increased price transparency, increased prevalence of alternative payment contracts and increased prevalence of accountable care organizations and patient centered medical homes.

The center shall publish and provide the report to health policy commission at least 30 days before any hearing required under section 8 of chapter 6D. The center may contract with an outside organization with expertise in issues related to the topics of the hearings to produce this report.

The center shall publish the aggregate baseline expenditures starting in the 2020 annual report.

The center, in consultation with the commission, shall determine the baseline expenditures for individual health care entities and shall report to each health care entity its respective baseline expenditures by October 1, 2020.

SECTION 18. Said chapter 12C is hereby further amended by striking out section 18, as appearing in the 2018 Official Edition, and inserting in place thereof the following section:-

Section 18. The center shall perform ongoing analysis of data it receives under this chapter to identify any payers, providers or provider organizations whose:

(1) Contribution to health care spending growth, including but not limited to spending levels and growth as measured by total medical expense is considered excessive and who threaten the ability of the state to meet the health care cost growth benchmark established by the health policy commission under section 10 of chapter 6D; or

(2) Expenditures fail to meet the primary care and behavioral health expenditure target under section 9A of chapter 6D.

The center shall confidentially provide a list of the payers, providers and provider organizations to the health policy commission such that the commission may pursue further action under sections 10 and 10A of chapter 6D.

SECTION 19. Said chapter 12C is hereby further amended by striking out section 23, as so appearing, and inserting in place thereof the following section:-

Section 23. Subject to appropriation and notwithstanding any other general or special law to the contrary, the center shall transfer annually $10,000,000 to the Community Hospital and Health Center Investment Trust Fund established in section 2TTTT of chapter 29, not later than June 30; provided, however, that such transfer shall not result in an increase in the assessment calculated under section 7.

SECTION 20. Said chapter 12C is hereby further amended by adding the following section:-

Section 24. (a) Not later than April 1, the center shall analyze, for public and private health care payers in Massachusetts, the average annual gross cost per utilizer of each drug approved during the preceding 5 calendar years by the U.S. Food and Drug Administration.

(b) For each drug described in subsection (a) that the center projects has a current average annual gross cost per utilizer for public and private health care payers in Massachusetts of greater than $50,000, the center shall refer the drug to the health policy commission for review

under section 8B of chapter 6D, and provide notice of the referral to the manufacturer of the drug.

(c) Not later than May 1, the center shall publish an annual report detailing, at minimum: (1) each drug referred to the health policy commission under subsection (b); and (2) the projected current average annual gross cost per utilizer for public and private health care payers in Massachusetts of each such drug.

(d) The center shall adopt any written policies, procedures or regulations necessary to implement this section.

SECTION 21. Section 9 of chapter 13 of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the word “workers”, in line 8, the following words:- , the board of registration in naturopathy, the board of registration of recovery coaches, the board of registration of social workers, the board of registration of psychologists, the board of registration of allied mental health and human services professions, the board of allied health professions, the board of registration of dieticians and nutritionists, the board of registration in podiatry, the board of registration in optometry, the board of registration of dispensing opticians, the board of registration of chiropractors, the board of registration of speech-language pathology and audiology, the board of registration of hearing instrument specialists.

SECTION 22. Section 11D of said chapter 13, as so appearing, is hereby amended by striking out, in lines 1 and 2, the words “division of professional licensure” and inserting in place thereof, the following words:- department of public health.

SECTION 23. Subsection (c) of section 14 of said chapter 13, as so appearing, is hereby amended by inserting, in line 4, after the words “twelve,”, the following words:- and chapter 112A.

SECTION 24. Section 79 of said chapter 13, as so appearing, is hereby amended by striking out, in lines 17 and 18 and in line 27, the words “director of consumer affairs and business regulations” and inserting in place thereof, each time they appear, the following words:- commissioner of public health.

SECTION 25. Said chapter 13, as so appearing, is hereby amended by striking out section 80 and inserting in place thereof the following section:-

Section 80. There shall be a board of registration of social workers hereinafter called the board, which shall consist of 9 members: the commissioner of children and families, or a designee; the commissioner of mental health, or a designee; 7 members to be appointed by the Governor, 1 of whom is a representative from an accredited Massachusetts school of social work, 3 of whom are licensed under sections 130 to 137, inclusive, of chapter 112, 1 of whom is licensed under sections 130 to 137, inclusive, of chapter 112 and is an active member of an organized labor organization representing social workers , and 2 of whom are member of the general public. Members of the board shall be residents of the commonwealth and citizens of the United States. At least 1 licensed social work member and 1 member representing the general public shall be from a minority group, as defined by the federal Department of Health and Human Services. No more than 6 members of the board shall belong to any 1 political party.

SECTION 26. Section 84 of said chapter 13, as so appearing, is hereby amended by striking out, in lines 8 and 9, the words “division of professional licensure” and inserting in place thereof the following words:- department of public health.

SECTION 27. Said section 84 of said chapter 13, as so appearing, is hereby further amended by striking out, in lines 44 and 45, inclusive, the words “Division of Professional Licensure Trust Fund established in section 35V” and inserting in place thereof the following words:- Quality in Health Professions Trust Fund established in section 35X.

SECTION 28. Section 88 of said chapter 13, as so appearing, is hereby amended by striking out, in lines 1 and 2, the words “division of professional licensure” and inserting in place thereof the following words:- department of public health.

SECTION 29. The first paragraph of section 90 of said chapter 13, as so appearing, is hereby amended by striking out the third sentence.

SECTION 30. Said section 90 of said chapter 13, as so appearing, is hereby amended by striking out the third paragraph and inserting in place thereof the following paragraph:- The commissioner of public health shall have authority to review and approve rules and regulations proposed by the board.

SECTION 31. Section 94 of said chapter 13, as so appearing, is hereby amended by striking out, in line 13, the words “director of registration” and inserting in place thereof, the following words:- commissioner of public health.

SECTION 32. Said chapter 13 is hereby further amended by adding the following section:-

Section 110. (a) There shall be, within the department of public health, a board of registration of recovery coaches which shall consist of 7 members to be appointed by the governor, 1 of whom shall be the commissioner of public health or a designee, 1 of whom shall be the commissioner of mental health or a designee; 1 of whom shall be employed as a recovery coach, 1 of whom shall be a family member to an individual with a substance use disorder, 1 of whom shall represent a health plan, 1 of whom shall be a licensed physician or nurse specializing in addiction, and 1 member of the general public.

Members of the board shall be residents of the commonwealth.

(b) Each member of the board shall serve for a term of 3 years. Upon the expiration of a term of office, a member shall continue to serve until a successor has been appointed. A member shall not serve for more than 2 consecutive terms; provided, however, that a person who is chosen to fill a vacancy in an unexpired term of a prior board member may serve for 2 consecutive terms in addition to the remainder of that unexpired term.

(c) A member may be removed by the governor for neglect of duty, misconduct or malfeasance or misfeasance in office.

(d) The board shall, at its first meeting and annually thereafter, organize by electing from its membership a chair, a vice-chair and a secretary. Those officers shall serve until their successors are elected.

(e) The board shall meet at least four times annually and may hold additional meetings at the call of the chair or at such times as may be determined by the board. Board members shall serve without compensation but shall be reimbursed for actual and reasonable expenses incurred in the performance of their duties.

SECTION 33. Section 8K of chapter 26 of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by adding the following paragraphs:-

As part of its annual review of health insurance carriers' compliance with state and federal mental health parity provisions, the commissioner of insurance shall require health insurance carriers licensed or authorized to do business under chapters 175, 176A, 176B and 176G to submit utilization reports that document the number of requests, approvals, denials and denial appeals for behavioral health and the number of requests, approvals, denials and denial appeals for non-behavioral health services, and the number of approved out-of-network services for behavioral health services and the number of approved out-of-network services for non-behavioral health services. In creating guidance for these reports, the Division of Insurance shall specify that information be broken down by region and behavioral health service category and shall use this information as part of its evaluation of whether a health carrier's provider network is adequate to provide access to covered behavioral health services.

The commissioner of insurance shall promulgate regulations to define provider reimbursement parity rules that would apply similar rates of reimbursement to evaluation and management office visits whether the evaluation and management office visits were provided by primary care providers or licensed mental health professionals. Under these rules, the commissioner shall require carriers to establish rates of reimbursement, by geographic region, for evaluation and management office visits by licensed behavioral health providers that are no less than the average rates of reimbursement for evaluation and management office visits by licensed primary care providers in the same geographic region during the prior calendar year. The commissioner shall, at least annually, convene a panel of experts from medical and behavioral health specialties to define the list of office visit codes that will be subject to these rules.

SECTION 34. Chapter 29 of the General Laws is hereby amending by striking out section 2TTTT and inserting in place thereof the following section:-

Section 2TTTT. (a) There shall be a Community Hospital and Health Center Investment Trust Fund to be expended, without further appropriation, by the secretary of health and human services. The fund shall consist of money from public and private sources, including gifts, grants and donations, interest earned on such money, any other money authorized by the general court and specifically designated to be credited to the fund and any funds provided from other sources. Money in the fund shall be used to provide annual financial support, consistent with the terms of this section, to eligible acute care hospitals and community health centers. The secretary, as trustee, shall administer the fund and shall make expenditures from the fund consistent with this section.

(b) The secretary may incur expenses and the comptroller may certify amounts for payment in anticipation of expected receipts; provided, however, that, subject to subsection (e), no expenditure shall be made from the fund which shall cause the fund to be deficient at the close of a fiscal year. Revenues deposited in the fund that are unexpended at the end of a fiscal year shall not revert to the General Fund and shall be available for expenditure in the following fiscal year.

(c) The secretary shall periodically direct payments from the fund to eligible acute care hospitals and community health centers. To be eligible to receive payment from the fund, an acute care hospital (1) shall be licensed under section 51 of chapter 111; (2) shall not be or be corporately affiliated with an academic medical center, teaching hospital or specialty hospital; and (3) shall not be a hospital with relative prices that are at or above 90 per cent of the statewide

average relative price, as determined by the center for health information analysis. To be eligible to receive payment from the fund, a community health center must be certified as a community health center by the MassHealth program under 101 CMR 405.000 or any successor regulation.

(d) In directing payments in a given fiscal year, the secretary shall allocate payments to eligible acute care hospitals and community health centers in the following manner: (1) 50 per cent of payments shall be directed to eligible acute care hospitals in form of Medicaid supplemental payments or other appropriate mechanism; and (2) 50 per cent of payments shall be directed to community health centers in the following manner and allocation: 25 per cent of the total community health center allocation shall be directed to community health centers in the form of grants, and 75 per cent of the total community health center allocation shall be directed to community health centers in the form of enhanced Medicaid payments. The secretary shall establish by regulation or other appropriate written issuance any further eligibility criteria for allocation of payments pursuant to this subsection.

(e) The secretary may require as a condition of receiving payment from the fund any such reasonable condition of payment that the secretary determines necessary to ensure the availability, to the extent possible, of federal financial participation for the payments, and the secretary may incur expenses and the comptroller may certify amounts for payment in anticipation of expected receipt of federal financial participation for the payments. Subject to appropriation, an amount equal to the total annual anticipated federal financial participation generated by the payments shall be transferred to the Community Hospital and Health Center Investment Trust Fund not later than June 30.

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

(g) Not later than October 15 of each fiscal year, the secretary shall file a report with the joint committee on health care finance and the house and senate committees on ways and means detailing the allocation and recipient of each payment during the prior fiscal year.

(h) An amount equal to the total receipts from the penalty established under chapter 63D shall be transferred from the General Fund to the Community Hospital and Health Center Investment Trust Fund before the end of each fiscal year.

SECTION 35. Chapter 32A of the General Laws is hereby amended by adding the following 2 sections:-

Section 29. (a) As used in this section, “facility fee” and “health care provider” shall have the same meanings as provided in section 51L of chapter 111.

(b) Coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission shall not provide reimbursement to a health care provider for a facility fee for a service for which a facility fee is prohibited pursuant to section 20 of chapter 6D and section 51L of chapter 111.

(c) Nothing in this section shall be construed to prohibit the commission from offering coverage that restricts the reimbursement of facility fees beyond the limitations set forth in section 51L of chapter 111.

Section 30. (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) 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 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 36. Section 2 of chapter 62C of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by adding the following words:- , and to the penalty imposed by chapter 63D.

SECTION 37. The General Laws are hereby amended by inserting after chapter 63B the following 2 chapters:-

Chapter 63C. Excise on manufacture and sale of certain opioids for distribution in the commonwealth.

Section 1. “Commissioner”, the commissioner of revenue.

“Gross receipts”, receipts from sales made by a person to a purchaser that is not a related party. In the case of sales to a related party or parties for subsequent resale to an unrelated buyer, the gross receipts are the amount paid for the product by the first unrelated buyer.

“Opioid”, any product included in the pharmacological class category of full opioid agonist, opioid agonist or partial opioid agonist in the National Drug Code (NDC) Directory NDC Product File, except for products approved by the U.S. Food and Drug Administration for the treatment of opioid use disorder.

“Person”, any natural person or legal entity.

"Related parties", an entity that belongs to the same affiliated group as the person under section 1504 of the Internal Revenue Code, as amended and in effect for the taxable year, or if the entity and the person are otherwise commonly owned and controlled.

Section 2. (a) Any person who manufactures opioids and sells such products, directly or through another person, for distribution in the commonwealth shall pay an excise of 15 per cent of its gross receipts from such sales; provided, however, that gross receipts subject to the excise under this section shall be limited to the sales of opioids that are ultimately dispensed in the commonwealth pursuant to a valid prescription issued under section 18 of chapter 94C.

(b) A person who manufactures opioids and sells such products, directly or through another person, for distribution in the commonwealth as described in subsection (a) shall file a return as provided in subsection (a) of section 4 declaring total sales subject to excise in the immediately preceding calendar quarter. In the event that a person filing such a return pays an excise of 15 per cent of its gross receipts from sales of opioids that are not ultimately dispensed in the commonwealth pursuant to a valid prescription issued under section 18 of chapter 94C, the person may claim a credit for such excise amounts on the return for the tax period during which such sales are ultimately dispensed.

Section 3. The excise under section 2 shall apply only to persons who maintain a place of business in the commonwealth or whose total sales of all products, directly or through another person, for distribution in the commonwealth are more than $25,000 in the calendar quarter to which the excise under section 2 otherwise would apply, or in the case of the 6 months ending December 31, 2019, more than $50,000 for such 6 month period.

Section 4. (a) Any person subject to the excise under section 2 shall file a return with the commissioner and shall pay such excise by the fifteenth day of the third month following the end of each calendar quarter. Such return shall set out the person's total sales subject to excise in the immediately preceding calendar quarter and shall provide such other information as the commissioner may require.

(b) Each person subject to the excise under section 2 shall provide to the commissioner annually, on or before June 1st, a report detailing all opioids sold, directly or through another person, for distribution in the commonwealth in the prior calendar year. Such report shall include:

(i) the person's name, address, phone number, federal Drug Enforcement Administration (DEA) registration number and controlled substance registration number issued by the department;

(ii) the name and NDC of the opioid;

(iii) the unit of measure and quantity of the opioid;

(iv) the name, address and DEA registration number of the first unrelated buyer of the opioid;

(v) the date of the sale of the opioid;

(vi) whether the opioid was ultimately dispensed in the commonwealth pursuant to a valid prescription

issued under section 18 of chapter 94C;

(vii) the gross receipt total, in dollars, of all opioids sold;

(viii) the gross receipt total, in dollars, and quantity by NDC of all opioids ultimately dispensed in the commonwealth pursuant to a valid prescription issued under section 18 of chapter 94C; and

(ix) any other elements required by the commissioner.

Section 5. The excise imposed under this chapter shall be in addition to, and not a substitute for or credit against any other tax or excise imposed under the General Laws.

Section 6. The commissioner may disclose information contained in returns and reports filed under this chapter to the department of public health for purposes of verifying that the appropriate amount of a filer's sales subject to excise are properly declared and that all reporting is otherwise correct. Return and report information so disclosed shall remain confidential and shall not be public record.

Section 7. To the extent that a person subject to excise under section 2 fails to pay amounts due under this chapter, a related party of such person that directly or indirectly distributes the opioid of such person in the commonwealth shall be jointly and severally liable for the excise due.

Section 8. The commissioner may promulgate regulations or issue other guidance for the implementation of this chapter.

Chapter 63D. Penalty on drug manufacturers for excessive price increases

Section 1. "Commissioner", the commissioner of revenue.

"Consumer price index", the consumer price index for all urban consumers for Boston, as most recently reported by the federal Bureau of Labor Statistics.

"Drug", any medication, as identified by a National Drug Code, approved for sale by the U.S. Food and Drug Administration.

"Excessive price," the price of a drug if it exceeds the sum of (a) the reference price of that drug, as adjusted for any increase or decrease in the consumer price index since the reference price was determined, and (b) an additional two percent of the reference price for each twelve month period that has elapsed since the date on which the reference price was determined. The two percent increment provided in (b) of the preceding sentence shall compound annually on the first day of the first calendar quarter commencing after the end of each 12 month period described therein.

"Excessive price increase", the amount by which the price of a drug exceeds the sum of (a) the reference price of that drug, as adjusted for any increase or decrease in the consumer price index since the reference price was determined, and (b) an additional two percent of the reference price for each twelve month period that has elapsed since the date on which the reference price was determined. The two percent increment provided in (b) shall compound annually on the first day of the first calendar quarter commencing after the end of each twelve month period described therein.

"Person", any natural person or legal entity.

"Price", the wholesale acquisition cost of a drug, per unit, as reported to the First Data Bank or other applicable price compendium designated by the commissioner .

"Reference price", the price of a drug as of October 1, 2019, or in the case of any drug first commercially marketed in the United States after October 1, 2019, the price of the drug on the date when first marketed.

"Related party", an entity is a related party with respect to a person if that entity belongs to the same affiliated group as that person under section 1504 of the Internal Revenue Code, as amended and in effect for the taxable year, or if the entity and the person are otherwise under common ownership and control.

"Unit", the lowest dispensable amount of a drug.

Section 2. (a) Any person who manufactures and sells drugs, directly or through another person, for distribution in the commonwealth and who establishes an excessive price for any such drug directly or in cooperation with a related party, shall pay a per unit penalty on all units of the drug ultimately dispensed or administered in the commonwealth. The penalty for each unit shall be 80 per cent of the excessive price increase for each unit, determined at the beginning of the calendar quarter.

(b) A person who establishes an excessive price for a drug as described in subsection (a) shall file a return as provided in section 4 declaring all units of excessively priced drug sold for distribution in the commonwealth during the quarter. In the event that a person filing such a return pays a penalty with regard to one or more units of drug that are ultimately dispensed or administered outside of the commonwealth, the person may claim a credit for such penalty amounts on the return for the tax period during which such units are ultimately dispensed or administered.

Section 3. The penalty under section 2 shall apply for any calendar quarter only to a person who maintains a place of business in the commonwealth or whose total sales of all products, directly or through another person, for distribution in the commonwealth were more than $100,000 in the prior twelve month period. The penalty shall not apply more than once to any unit of drug sold.

Section 4. Any person subject to the penalty under section 2 shall file a return with the commissioner and shall pay the penalty by the fifteenth day of the third month following the end of each calendar quarter, subject to such reasonable extensions of time for filing as the commissioner may allow. The return shall set out the person's total sales subject to penalty in the immediately preceding calendar quarter and shall provide such other information as the commissioner may require.

Section 5. The penalty imposed under this chapter shall be in addition to, and not a substitute for or credit against, any other penalty, tax or excise imposed under the General Laws.

Section 6. The commissioner may disclose information contained in returns filed under this chapter to the department of public health for purposes of verifying that a filer's sales subject to penalty are properly declared and that all reporting is otherwise correct. Return information so disclosed shall remain confidential and shall not be public record.

Section 7. To the extent that a person subject to penalty under section 2 fails to pay amounts due under this chapter, a related party of such person that directly or indirectly distributes in the commonwealth any drug whose sales are subject to this chapter shall be jointly and severally liable for the penalty due.

Section 8. The commissioner may promulgate regulations or issue other guidance for the implementation of this chapter.

SECTION 38. Section 1 of chapter 94C of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the definition for “Marihuana” the following definition:-

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

SECTION 39. Said section 1 of said chapter 94C, as so appearing, 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 40. 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.

(e) A nurse anesthetist authorized by section 80H of chapter 112 and registered pursuant to subsection (g) 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 41. 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 42. 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 43. Paragraph (4) of subsection (d) of said section 7 of said chapter 94C, as so appearing, is hereby amended by inserting after the words “licensed practical nurse”, in line 80, the following words:- or a licensed dental therapist under the supervision of a practitioner for the purposes of administering analgesics, anti-inflammatories and antibiotics.

SECTION 44. 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, nurse anesthetist, psychiatric nurse mental health clinical specialist.

SECTION 45. Subsection (g) of said section 7 of said chapter 94C, as so appearing, is hereby amended by striking out the second paragraph.

SECTION 46. 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 47. 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 48. 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, nurse anesthetist, psychiatric nurse mental health clinical specialist.

SECTION 49. 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 50. 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 51. Said subsection (a) of said section 9 of said chapter 94C, as so appearing, is hereby further amended by striking out, in lines 8 and 9, the words “, nurse anesthetist, as limited by subsection (g) of said section 7 and section 80H of said chapter 112”.

SECTION 52. 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 53. 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 54. 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 55. Said subsection (c) of said section 9 of said chapter 94C, as so appearing, is hereby further amended by adding the following paragraph:-

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

SECTION 56. 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:- , nurse anesthetist, psychiatric nurse mental health clinical specialist.

SECTION 57. 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 58. 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 59. 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 60. Said chapter 94C is hereby further amended by inserting after section 21B the following section:-

Section 21C. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Cost sharing", amounts owed by a consumer under the terms of the consumer's health benefit plan as defined in section 1 of chapter 176O or as required by a pharmacy benefit manager as defined in subsection (a) of section 226 of chapter 175.

"Pharmacy retail price", the amount an individual would pay for a prescription medication at a pharmacy if the individual purchased that prescription medication at that pharmacy without using a health benefit plan as defined in section 1 of chapter 176O or any other prescription medication benefit or discount.

"Registered pharmacist", a pharmacist who holds a valid certificate of registration issued by the board of registration in pharmacy pursuant to section 24 of chapter 112.

(b) The pharmacist, or an authorized individual at the direction of a pharmacist, shall charge an insured the lower of (i) the applicable cost sharing amount under the terms of the insured's health benefit plan, (ii) the pharmacy benefits manager's contracted rate of payment to the pharmacy for the prescription drug or (iii) the retail price of the prescription drug if purchased without insurance, pursuant to requirements under section 2 of chapter 176O.

(c) A contractual obligation shall not prohibit a pharmacist from complying with this section; provided, however, that a pharmacist shall submit a claim to the consumer's health

benefit plan or its pharmacy benefit manager if the pharmacist has knowledge that the prescription medication is covered under the consumer's health benefit plan.

SECTION 61. Section 32I of said chapter 94C, as appearing in the 2018 Official Edition, is hereby amended by adding the following subsection:-

(e) This section shall not apply to mass spectrometers.

SECTION 62. 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 63. 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 64. Said chapter 111 is hereby further amended by inserting after section 51K the following 2 sections:-

Section 51L. (a) As used in this section and section 51M, the following terms shall have the following meanings unless the context clearly requires otherwise:

"Campus", a hospital's main buildings, the physical area immediately adjacent to a hospital's main buildings and other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings or other area that has been determined by the Centers for Medicare and Medicaid Services to be part of a hospital's campus.

"Facility fee", a fee charged, billed or collected by a health care provider for hospital services provided in a facility that is owned or operated, in whole or in part, by a hospital or health system that is intended to compensate the health care provider for operational expenses and is separate and distinct from a professional fee.

"Health care provider", shall have the same meaning as in section 1 of chapter 6D.

"Hospital", a hospital licensed pursuant to section 51 of chapter 111.

"Professional fee", a fee charged or billed by a health care provider for professional medical services.

(b) A health care provider shall not charge, bill or collect a facility fee except for: (i) services provided on a hospital's campus; (ii) services provided at a facility that includes a licensed hospital emergency department; or (iii) emergency services provided at a licensed satellite emergency facility.

(c) Notwithstanding subsection (b), a health care provider shall not charge, bill, or collect a facility fee for a service identified by the commission pursuant to its authority in section 20 of chapter 6D as a service that may reliably be provided safely and effectively in settings other than hospitals.

(d) The department may promulgate regulations necessary to implement this section and impose penalties for non-compliance consistent with the department's authority to regulate health care providers. A health care provider that violates any provision of this section or the rules and regulations adopted pursuant hereto shall be punished by a fine of not more than $1,000 per occurrence.

Section 51M. (a) If a health care provider charges or bills a facility fee for services, the health care provider shall provide any patient receiving such service with written notice that such a fee will be charged and may be billed separately.

(b) If a health care provider is required to provide a patient with notice under subsection (a) and a patient's appointment is scheduled to occur not less than 10 days after the appointment is made, the health care provider shall provide written notice and explanation to the patient by first class mail, encrypted electronic means or a secure patient Internet portal not less than 3 days after the appointment is made. If an appointment is scheduled to occur less than 10 days after the appointment is made or if the patient arrives without an appointment, the notice shall be provided to the patient on the facility’s premises.

If a patient arrives without an appointment, a health care provider shall provide written notice and explanation to the patient prior to the care if practicable, or if prior notice is not practicable, the health care provider shall provide an explanation of the fee to the patient within a reasonable period of time; provided, however, that the explanation of the fee shall be provided before the patient leaves the facility. If the patient is incapacitated or otherwise unable to read, understand and act on the patient’s rights, the notice and explanation of the fee shall be provided to the patient's representative within a reasonable period of time.

(c) A facility at which facility fees for services are charged, billed, or collected shall clearly identify itself as being associated with a hospital, including by stating the name of the hospital that owns or operates the location in its signage, marketing materials, Internet web sites, and stationery.

(d) If a health care provider charges, bills, or collects facility fees at a given facility, notice shall be posted in that facility informing patients that a patient may incur higher financial liability as compared to receiving the service in a non-hospital facility. Notice shall be

prominently displayed in locations accessible to and visible by patients, including in patient waiting areas.

(e)(1) If a location at which health care services are provided without facility fees changes status such that facility fees would be permissible at that location under section 51L, and the health care provider that owns or operates the location elects to charge, bill, or collect facility fees, the health care provider shall provide written notice to all patients who received services at the location during the previous calendar year not later than 30 days after the change of status. The notice shall state that: (i) the location is now owned or operated by a hospital; (ii) certain health care services delivered at the facility may result in separate facility and professional bills for services; and (iii) patients seeking care at the facility may incur higher financial liability at that location due to its change in status.

(2) In cases in which a written notice is required by paragraph (1), the health care provider that owns or operates the location shall not charge or bill a facility fee for services provided at that location until not less than 30 days after the written notice is provided.

(3) A notice required or provided under paragraph (1) shall be filed with the department not later than 30 days after its issuance.

(f) The department may promulgate regulations necessary to implement this section and impose penalties for non-compliance consistent with the department's authority to regulate health care providers. A health care provider that violates any provision of this section or the rules and regulations adopted pursuant hereto shall be punished by a fine of not more than $1,000 per occurrence. In addition to any penalties for noncompliance that may be established by the department, a violation of this section shall be an unfair trade practice under chapter 93A.

SECTION 65. Section 52 of said chapter 111, as appearing in the 2018 Official Edition, is hereby amended striking out the definition of "clinic" and inserting in place thereof the following definition:-

"Clinic", any entity, however organized, whether conducted for profit or not for profit, which is advertised, announced, established, or maintained for the purpose of providing ambulatory medical, surgical, dental, physical rehabilitation, or mental health services. In addition, "clinic" shall include any entity, however organized, whether conducted for profit or not for profit, which is advertised, announced, established, or maintained under a name which includes the words "clinic", "dispensary", "institute", or "urgent care" and which suggests that ambulatory medical, surgical, dental, physical rehabilitation, or mental health services are rendered therein. With respect to any entity which is not advertised, announced, established, or maintained under one of the names in the preceding sentence, "clinic" shall not include a medical office building, or one or more practitioners engaged in a solo or group practice, whether conducted for profit or not for profit, and however organized, so long as such practice is wholly owned and controlled by one or more of the practitioners so associated, or, in the case of a not for profit organization, its only members are one or more of the practitioners so associated or a clinic established solely to provide service to employees or students of such corporation or institution.

SECTION 66. Said section 52 of said chapter 111, as so appearing, is hereby further amended by adding the following 2 definitions:-

"Urgent care clinic", any entity, however organized, whether conducted for profit or not for profit, which is advertised, announced, established, or maintained for the purpose of

providing urgent care services in an office or a group of offices, or any portion thereof, or an entity which is advertised, announced, established, or maintained under a name which includes the words “urgent care” or which suggests that urgent care services are provided therein. Urgent care clinics cannot serve as a patient’s primary care provider.

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

SECTION 67. Said chapter 111 of the General Laws, as so appearing, is hereby further amended by inserting after section 52 the following 2 sections:-

Section 52A. The department shall promulgate regulations regarding licensure of urgent care clinics. Such regulations shall include requirements regarding the coordination by urgent care clinics with a patient’s primary care provider.

Any such urgent care clinic shall apply to participate as a MassHealth billing provider and participate as a provider if said application is approved. An urgent care clinic shall not serve as a patient’s primary care provider.

The department may impose a fine of up to $10,000 on a person or entity that advertises, announces, establishes, or maintains an urgent care center without a license granted by the department. The department may impose a fine of not more than $10,000 on a licensed urgent care center that violates this section or any rule or regulation promulgated hereunder. Each day

during which a violation continues shall constitute a separate offense. The department may conduct surveys and investigations to enforce compliance with this section.

Section 52B. The department, in consultation with the department of mental health, shall promulgate regulations regarding provision of behavioral health care in clinics licensed pursuant to section 51 of chapter 111. Such regulations shall require provision of behavioral health care in clinics licensed to provide medical, mental health, substance use disorder or urgent care services.

SECTION 68. Said chapter 111 of the General Laws is hereby further amended by striking out section 228 and inserting in place thereof the following section:-

Section 228. (a) For the purposes of this section, “allowed amount”, shall mean the contractually agreed-upon amount paid by a carrier to a health care provider for health care services provided to an insured.

(b) Prior to an admission, procedure or service and upon request by a patient or prospective patient, a health care provider shall, within 2 working days, disclose the allowed amount or charge of the admission, procedure or service, including the amount for any health care services rendered by an out-of-network provider and any facility fees required; provided, however, that if a health care provider is unable to quote a specific amount in advance due to the health care provider’s inability to predict the specific treatment or diagnostic code, the health care provider shall disclose the estimated maximum allowed amount or charge for a proposed admission, procedure or service, including the amount for any facility fees required.

(c) If a patient or prospective patient is covered by a health benefit plan, a health care provider who participates as a network provider shall, at the time of scheduling a procedure or service, (i) provide sufficient information regarding the proposed admission, procedure or

service for the patient or prospective patient to make an informed decision about the costs associated with that admission, procedure or service based on information available to the provider at that time, including the amount of any facility fees; and (ii) if the patient is in an insured health benefit plan, inform the patient or prospective patient that the patient or prospective patient may obtain additional information about any applicable out-of-pocket costs, pursuant to section 23 of chapter 176O. A health care provider may assist a patient or prospective patient in using the health plan's toll-free number and website pursuant to said section 23 of said chapter 176O.

(d) Each health care provider shall determine whether it is an out-of-network provider, as defined in section 1 of chapter 176O, for a patient prior to an admission, procedure or service for conditions that are not emergency medical conditions. If the health care provider is an out-of-network provider under the terms of the patient's health benefit plan, such provider shall notify the patient in writing of that fact no less than 48 hours before the scheduled admission, procedure or service.

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

about that provider's network status under the patient's health benefit plan and any applicable out-of-pocket costs for services sought from the referred provider, including those that may be required under section 23 of chapter 176O, based on information available to the provider at that time.

(f) A health care provider referring a patient to another provider by directly scheduling, ordering, or otherwise arranging for the health care services on the patient's behalf shall, prior to scheduling, ordering or otherwise arranging for the health care services on the patient's behalf: (i) verify the network status of the provider to whom the patient is being referred relative to the patient's health benefit plan; and (ii) notify the patient if the provider to whom the patient is being referred is an out-of-network provider.

(g) As provided in section 29 of chapter 176O, an out-of-network provider in an insured health benefit plan shall not bill an insured for health care services in excess of the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for such health care services if the services were rendered by a participating provider.

(h) The commissioner shall implement this section and impose penalties for non-compliance consistent with the department's authority to regulate health care providers. A health care provider that violates any provision of this section or the rules and regulations adopted pursuant hereto shall be liable for penalties as provided in this subsection.

SECTION 69. Section 1 of chapter 112 of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the word "dentistry", in line 12, the following words:- , the board of registration of genetic counselors, the board of registration of community health workers, the board of registration in naturopathy, the board of registration of

recovery coaches, the board of registration of social workers, the board of registration of psychologists, the board of registration of allied mental health and human services professions, the board of allied health professions, the board of registration of dieticians and nutritionists, the board of registration in podiatry, the board of registration in optometry, the board of registration of dispensing opticians, the board of registration of chiropractors, the board of registration of speech-language pathology and audiology, the board of registration of hearing instrument specialists.

SECTION 70. 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 71. Section 16 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 13 to 23, inclusive, and section 61, shall be deposited into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 72. Section 23B 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 23A to 23P½, inclusive, and section 61,shall be deposited into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 73. Section 23M½ of said chapter 112, as so appearing, is hereby amended by striking out, in lines 78 to 79, the words “Division of Professional Licensure Trust Fund established by section 35V” and inserting in place thereof the following words:- Quality in Health Professions Trust Fund established in section 35X.

SECTION 74. Section 43A of said chapter 112, as so appearing, is hereby amended by inserting after the definition of “Appropriate supervision” the following 2 definitions:-

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

“Collaborative management agreement”, a written agreement that complies with section 51B between a dental therapist and a supervising dentist, as defined in section 43A, who holds a valid license issued pursuant to section 45, who agrees to provide the appropriate level of communication and consultation with a licensed dental therapist to ensure patient health and safety.

SECTION 75. Said section 43A of said chapter 112, as so appearing, is hereby further amended by inserting after the definition of “Dental hygienist” the following definition:-

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

SECTION 76. Said section 43A of said chapter 112, as so appearing, is hereby further amended by adding the following definition:-

“Supervising dentist”, a licensed dentist licensed in Massachusetts pursuant to section 45 of this chapter who enters into a collaborative management agreement with a dental therapist.

SECTION 77. Section 45A of said chapter 112, as so appearing, is hereby amended by striking out, in lines 4 and 5, the words “the faculty of a reputable dental college as defined in section forty-six” and inserting place thereof the following words:- a dental college approved by the board.

SECTION 78. Section 46 of said chapter 112 is hereby repealed.

SECTION 79. Section 51 of said chapter 112, as appearing in the 2018 Official Edition, is hereby amended by striking out, in line 17, the word “revoked.” and inserting in place thereof the following words:- null and void.

SECTION 80. Section 51½ of said chapter 112, as so appearing, is hereby amended by striking out, in line 10, the word “revoked” and inserting in place thereof the following words:- null and void.

SECTION 81. Said section 51½ of said chapter 112, as so appearing, is hereby further amended by inserting after the word “dentist” in lines 18 and 31, in both instances, the following words:- , or a licensed dental therapist to the extent provided in section 51B.

SECTION 82. Said section 51½ of said chapter 112, as so appearing, is hereby further amended by inserting after the word “practice” in line 78, the following words:- , or a dental therapist licensed under section 51B,.

SECTION 83. Said chapter 112 is hereby further amended by inserting after section 51A the following section:-

Section 51B. (a) Any person of good moral character, 19 years old or over, who: (i) is a graduate of a master’s level dental therapist education program that includes both dental therapy and dental hygiene education, or an equivalent combination of both dental therapy education and dental hygiene education, if all education programs are accredited by the Commission on Dental Accreditation; (ii) passes a comprehensive, competency-based clinical examination that is approved by the board and administered by a recognized national or regional dental testing service that administers testing for dentists and other dental professionals or equivalent examination administered by another entity approved by the board; and (iii) obtains a policy of professional liability insurance and shows proof of such insurance as required by rules and regulations shall, upon payment of a fee to be determined annually by the secretary of administration and finance under the provision of section 3B of chapter 7, be registered as a dental therapist and be given a certificate to practice in this capacity. A licensed dental therapist shall have practiced under the direct supervision of a supervising dentist for a minimum of 2 years or 2,500 hours, whichever is longer, before practicing under general supervision pursuant to a collaborative management agreement. Dental therapists licensed under this section shall renew licensure biennially, on a date determined by the board, upon application and payment of a fee, as determined by the secretary of administration and finance under section 3B of chapter 7.

Upon receipt of a license pursuant to section 45, any certificate issued hereunder shall be null and void.

Notwithstanding section 43A, as used in this section and in any rules and regulations promulgated by the board or the department of health to implement this section, "general supervision" shall mean supervision of procedures and services based on a written collaborative management agreement between a licensed dentist and a licensed dental therapist but not requiring a prior exam or diagnosis by a supervising dentist or the physical presence of a supervising dentist during the performance of those procedures and services unless required by the supervising dentist in the collaborative management agreement.

(b) Any person who has met the requirements to be registered as a dental therapist under any provision of this section may also be registered as a dental hygienist and be given a certificate to practice in this capacity.

(c) Dental therapists educated in the commonwealth must graduate from a master's level dental therapy education program that is accredited by the Commission on Dental Accreditation provided by a post-secondary institution accredited by the New England Association of Schools and Colleges, Inc. All dental therapy educational programs in the commonwealth must include at least one licensed dentist as an instructor. The board shall provide guidance for any educational entity or institution that may operate all or some portion of a master's level program, or may collaborate with other educational entities, including but not limited to universities, colleges, community colleges, and technical colleges, to operate all or some portion of a master's level program. The board may also provide guidance to develop mechanisms to award advanced standing to students who have completed coursework at other educational programs accredited

by the Commission on Dental Accreditation. All education programs must prepare students to perform all procedures and services within the dental therapy scope of practice as set forth in this section.

The educational curriculum for a dental therapist educated in the commonwealth shall include training on serving patients with special needs including, but not limited to, people with developmental disabilities including autism spectrum disorders, mental illness, cognitive impairment, complex medical problems, or significant physical limitations, and the vulnerable elderly.

Not later than January 1, 2024, the board shall approve a comprehensive, competency based clinical dental therapy examination that includes assessment of technical competency in performing the procedures and services within the scope of practice as set forth in this section, to be administered by a recognized national or regional dental testing service that administers testing for dentists and other dental professionals. The examination shall be comparable to the examination given to applicants for a dental license but only for the limited scope of dental services in the dental therapy scope of practice as set forth in this section.

(d) The board shall grant a dental therapy license by examination to an applicant, upon payment of a fee as determined under subsection (a), provided the applicant is of good moral character and has: (i) met the eligibility requirements as defined by the board; (ii) submitted documentation to the board of a passing score on a comprehensive, competency-based clinical examination or combination of examinations that includes both dental therapy and dental hygiene components and are approved by the board and administered by a recognized national or regional dental testing service that administers testing for dentists and other dental professionals;

and (iii) submitted to the board documentation of a passing score on the Massachusetts Dental Ethics and Jurisprudence Examination or any other successor examination. An applicant failing to pass the examination shall be entitled to re-examination pursuant to the rules and guidelines established by the Commission on Dental Competency Assessments (formerly NERB), for which the applicant shall pay a fee determined annually by the secretary of administration and finance under the provision of section 3B of chapter 7.

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

The board shall grant a license by credentials, without further professional examination, to a dental therapist licensed in another jurisdiction, upon payment of a fee as determined under subsection (a), provided the applicant is of good moral character and has: (i) met the eligibility requirements as defined by the board; (ii) furnished the board with satisfactory proof of graduation from an education program or combination of education programs providing both dental therapy and dental hygiene education that meets the standards of the Commission on Dental Accreditation, provided, however, that an applicant who graduated from a dental therapy education program established before the Commission on Dental Accreditation established a

dental therapy accreditation program is eligible notwithstanding the lack of accreditation of the program at the time the education was received; (iii) submitted documentation of a passing score on a dental therapy examination administered by another state or testing agency that is substantially equivalent to the board-approved dental therapy examination for dental therapists as defined in this section; (iv) submitted documentation of a passing score on the Massachusetts Dental Ethics and Jurisprudence Examination or any other successor examination; and (v) submitted documentation of completion of 2 years or 2,500 hours, whichever is longer, of practice. If such practice requirement is not met, a dental therapist shall be required to complete the remaining hours or years, whichever is longer, under direct supervision in the commonwealth prior to practicing under general supervision.

(e) Pursuant to a collaborative management agreement, a dental therapist licensed and registered by the board may perform: (i) all acts of a public health dental hygienist as set forth in regulations of the board and (ii) all acts in the Commission on Dental Accreditation's dental therapy standards. Dental therapists shall have the authority to perform an oral evaluation and assessment of dental disease and formulate an individualized treatment plan as authorized by the supervising dentist in the collaborative management agreement. A dental therapist may dispense and administer the following medications within the parameters of the collaborative management agreement and with the authorization of the supervising dentist: non-narcotic analgesics, anti-inflammatories and antibiotics. The authority to dispense and administer shall extend only to the categories of drugs identified in this paragraph and may be further limited by the collaborative management agreement. A dental therapist is prohibited from dispensing or administering narcotic analgesics. A dental therapist may oversee not more than 2 dental hygienists and 2 dental assistants, but shall not oversee public health dental hygienists.

After entering into a collaborative management agreement with a supervising dentist, dental therapists shall practice under direct supervision for not less than 2,500 clinical hours or two years, whichever is longer. After completing 2,500 clinical hours or two years, whichever is longer, of practice under direct supervision, dental therapists are authorized to perform all procedures and services listed in the Commission on Dental Accreditation's dental therapy standards and all procedures and services within the scope of a public health dental hygienist, as set forth in regulations by the board, under general supervision if authorized by a supervising dentist pursuant to a written collaborative agreement. In addition, the following procedures, referred to in this section as advanced procedures, may be performed under direct supervision: (i) preparation and placement of direct restoration in primary and permanent teeth; (ii) fabrication and placement of single-tooth temporary crowns; (iii) preparation and placement of preformed crowns on primary teeth; (iv) indirect and direct pulp capping on permanent teeth; (v) indirect pulp capping on primary teeth; and (vi) simple extractions of erupted primary teeth, provided however that the advanced procedures may be performed under general supervision if authorized by the board pursuant to subsection (f) of this section.

Pursuant to a collaborative management agreement, a dental therapist may provide procedures and services permitted under general supervision when the supervising dentist is not on-site and has not previously examined or diagnosed the patient provided the supervising dentist is available for consultation and supervision if needed through telehealth, as that term is defined in section 4P of chapter 111 or by other means of communication. If the supervising dentist will not be available, arrangements shall be made for another licensed dentist to be available to provide timely consultation and supervision. A dental therapist may not operate independently of, and may not practice or treat any patients without, a supervising dentist. A

dental therapist is prohibited from practicing without entering into a collaborative management agreement with a supervising dentist.

(f) By January 1, 2024, the department of public health in consultation with the board and any other entity they deem appropriate, shall begin an evaluation assessing the impact of dental therapists practicing under general supervision in Massachusetts and the rest of the United States, specifically on: (i) dental therapists' progress in expanding access to safe and effective dental services for vulnerable populations including, at a minimum, Medicaid beneficiaries and individuals who are underserved as defined in this section; (ii) an appropriate geographic distance limitation between the dental therapist and supervising dentist that permits the dental therapist to expand access to vulnerable populations including, at a minimum, Medicaid beneficiaries and individuals who are underserved as defined in this section; and (iii) the number of dental hygienists and dental assistants a dental therapist may oversee.

Not before January 1, 2025, and no later than December 1, 2026, the department in consultation with the board and any other entity they deem appropriate, shall make a recommendation, based on its assessment of whether dental therapists should be authorized to perform one or more of the advanced procedures, as defined in subsection (e) under general supervision pursuant to a collaborative management agreement. The department shall also make a recommendation on an appropriate geographic distance limitation between the dental therapist and supervising dentist that permits the dental therapist to expand access to vulnerable populations including, at a minimum, Medicaid beneficiaries and individuals who are underserved as defined in this section. After the department completes its assessment and submits its recommendations to the board, the board shall make a determination, with consideration to how authorizing general supervision will expand access to safe and effective

dental services for vulnerable populations including, at a minimum, Medicaid beneficiaries and individuals who are underserved as defined in this section, whether to authorize performance of one or more of the procedures as identified in subsection (e), under general supervision pursuant to a collaborative management agreement.

Should the board, in consultation with the department and any other appropriate entity, determine that dental therapists shall have the authority to perform one or more of the procedures and services as identified in subsection (e) in their scope of practice under general supervision, then the board shall establish regulations no later than six months following the recommendation, authorizing dental therapists to perform one or more procedures as identified in subsection (e) under general supervision pursuant to a collaborative management agreement after receiving advanced practice certification.

The board shall grant advanced practice certification for a dental therapist licensed and registered by the board to perform all services within the authorized scope of practice under general supervision pursuant to a collaborative management agreement if the dental therapist provides documentation of completion of at least two years or 2,500 hours, whichever is longer, of direct supervision pursuant to subsection (a) of this section, payment of a fee to be determined annually by the secretary of administration and finance under the provision of section 3B of chapter 7, and satisfying any other criteria established by regulation adopted by the board as authorized in this section.

Should the board determine that dental therapists shall continue to perform one or more of the advanced procedures under direct supervision, the department, in consultation with the board, shall re-evaluate annually the impact of dental therapists practicing under general

supervision in Massachusetts and the rest of the United States, and the board shall annually reassess whether to authorize general supervision for the advanced procedures in order to improve dental therapists' progress in expanding access to safe and effective dental services for vulnerable populations including, at a minimum, Medicaid beneficiaries and individuals who are underserved as defined in this section.

(g) The board shall establish appropriate guidelines for a written collaborative management agreement. A collaborative management agreement shall be signed and maintained by the supervising dentist and the dental therapist and shall be submitted annually to the board. The agreement may be updated as necessary. The agreement shall serve as standing orders from the supervising dentist and shall address: (i) practice settings; (ii) any limitation on services established by the supervising dentist; (iii) the level of supervision required for various services or treatment settings; (iv) patient populations that may be served; (v) practice protocols; (vi) record keeping; (vii) managing medical emergencies; (viii) quality assurance; (ix) administering and dispensing medications; (x) geographic distance limitations; (xi) oversight of dental hygienists and dental assistants; and (xii) referrals for services outside of the dental therapy scope of practice. The collaborative management agreement shall include specific protocols to govern situations in which the dental therapist encounters a patient who requires treatment that exceeds the authorized scope of practice of the dental therapist. The supervising dentist is responsible for directly providing, or arranging for another dentist or specialist within an accessible geographic distance to provide, any necessary additional services outside of the dental therapy scope of practice needed by the patient. A supervising dentist may have a collaborative management agreement with not more than 3 dental therapists at the same time. Not more than 2 of such dental therapists may practice under general supervision with certification to perform one

or more of the advanced procedures. A practice or organization with more than one practice location listed under the same business name may not employ more than 6 dental therapists, provided, however, that this requirement shall not apply if such an organization or practice is a federally qualified health center or look-alike, a community health center, a non-profit practice or organization, or a public health setting, which for purposes of this section shall be as defined by 234 CMR 2.02, or as otherwise permitted by the board.

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

(i) Not less than 50 per cent of the patient panel of a dental therapist, as determined in each calendar year, shall consist of patients who receive coverage through MassHealth or its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms, and third-party administrators under contract to a MassHealth managed care organization or primary care clinician plan; or are considered underserved provided, however, that this requirement shall not apply if the dental therapist is operating in a federally qualified health center or look-alike, community-health center, non-profit practice or organization, or other public health setting as defined by the board by regulation, or as otherwise permitted by the board. As used in this section, “underserved” means individuals who: (i) receive, or are eligible to receive, benefits through MassHealth or its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms, and third-party administrators under contract to a MassHealth managed care organization or primary care clinician plan; (ii)

receive, or are eligible to receive, Social Security Disability Benefits (SSDI), Supplemental Security Income (SSI), and/or Massachusetts State Supplement Program (SSP); (iii) live in a dental health professional shortage area (DPSA) as designated by the U.S. Department of Health and Human Services; (iv) reside in a nursing home, skilled nursing facility, veterans home, or long-term care facility; (v) receive dental services at a public health setting as defined by the board by regulation; (vi) receive benefits, or are eligible to receive benefits, through plans sold by the connector; (viii) receive benefits, or are eligible to receive benefits, through the Indian Health Service, tribal or urban Indian organizations, or through the Contract Health Service Program; (ix) receive benefits, or are eligible to receive benefits, through the Department of Veterans Affairs or other organization serving veterans; (x) are elderly and have trouble accessing dental care due to mobility or transportation challenges; (xi) meet the Commission on Dental Accreditation's definition of people with special needs; (xii) are uninsured and living at 305 per cent of the Federal Poverty Level; or (xiii) as otherwise permitted by the board.

An employer of a dental therapist shall submit quarterly reports to the board that provide information concerning the makeup of the dental therapist's patient panel, including the percentage of individuals who are underserved in the patient panel. No later than January 1, 2024, the secretary of health and human services may establish by regulation penalties for employers who fail to meet the requirements pertaining to the percentage of individuals who are underserved in the dental therapist's patient panel.

(j) Not later than January 1, 2024, the board, in consultation with the department shall establish regulations to implement the provisions of this section for the licensure and practice of dental therapy including

(k) Not later than January 1, 2024, the board, in consultation with the department shall establish regulations to implement the provisions of this section for the licensure and practice of dental therapy to protect the public health, safety and welfare, including but without limitation guidelines for collaborative management agreements, continuing education requirements, license renewal, standards of conduct and the investigation of complaints, and disciplinary actions.

SECTION 84. Section 61 of said chapter 112, as appearing in the 2018 Official Edition, is hereby amended by striking out the words “A board of registration”, in line 18, and inserting in place thereof the following words:- each board of registration under the supervision of the department of public health may discipline a holder of a license, certificate, registration or authority issued pursuant to this chapter, and each board of registration.

SECTION 85. Said section 61 of said chapter 112, as so appearing, is hereby further amended by striking out the words “a board of registration”, in lines 49 through 50, and inserting in place thereof the following words:- Each board of registration under the supervision of the department of public health and each board of registration.

SECTION 86. Section 65B of said chapter 112, as so appearing, is hereby amended by striking out the words “a board of registration”, in line 1, and inserting in place thereof the following words:- Each board of registration under the supervision of the department of public health and each board of registration.

SECTION 87. Section 65F of said chapter 112, as so appearing, is hereby amended by inserting, after the word "licensure" in line 4, the following words:- , or a board of registration under the supervision of the department of public health,.

SECTION 88. 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 89. Section 66B of said chapter 112, as appearing in the 2018 Official Edition, is hereby amended by striking out, in line 31, the following words:- , except glaucoma.

SECTION 90. 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 91. 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 92. 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 93. 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 94. Section 79 of said chapter 112, as so appearing, is hereby amended by adding the following two sentences:-

The board may assess a licensed nurse a penalty of not more than $2,000 for each violation of regulations promulgated pursuant to this section and for each violation of any general law that governs the practice of nursing. The board, through regulation, shall ensure that any fine levied is commensurate with the severity of the violation.

SECTION 95. Section 80B of said chapter 112, as so appearing, is hereby amended by inserting after the word "practitioners", in line 12, the following words:- , nurse anesthetists.

SECTION 96. 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 97. Said section 80B of said chapter 112, as so appearing, is hereby further amended by striking out, in lines 64 and 65, the words “in the ordering of tests, therapeutics and the prescribing of medications, to” and inserting in place thereof the following word:- to.

SECTION 98. 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 99. Said chapter 112 is hereby further amended by striking out section 80H, as so appearing, and inserting in place thereof the following section:-

Section 80H. (a) A nurse anesthetist may issue written prescriptions and medication orders and order tests and therapeutics pursuant to guidelines mutually developed and agreed upon by the nurse and either a supervising nurse anesthetist with independent practice authority or a supervising physician, in accordance with regulations promulgated by the board; provided,

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

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

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

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

SECTION 100. Section 80I of said chapter 112, as appearing in the 2018 Official Edition, is hereby amended by striking out the second and third sentences.

SECTION 101. 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 102. 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 103. 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 104. 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 105. Section 164 of said chapter 112, as so appearing, is hereby amended by inserting after the word “therapist”, in line 23, the following words:- , recovery coach, authorized to practice under sections 290 to 293, inclusive,

SECTION 106. Section 168 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 163 to 172, inclusive, shall be deposited into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 107. Section 197 of said chapter 112, as so appearing, is hereby amended by adding the following subsection:-

(h) All application fees and civil administrative penalties and fines collected by the board under sections 61 and this section to 200, inclusive, shall be deposited into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 108. Section 203 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 201 to 210, inclusive, shall be deposited into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 109. Subsection (c) of section 265 of said chapter 112, as so appearing, is hereby amended by inserting, after the first sentence, the following sentence:-The board of registration in medicine, in consultation with the department of public health, shall promulgate regulations governing the qualifications and scope of practice of certified medical assistants.

SECTION 110. Said chapter 112 is hereby further amended by adding the following 4 sections:-

Section 275. (a) The following words as used in sections 275 to 278, inclusive, unless the context otherwise requires, shall have the following meanings:--

"Board", the board of registration of recovery coaches, established under section 110 of chapter 13.

"Recovery Coach", an individual who is authorized to practice by the board under this chapter and who uses shared understanding, respect and mutual empowerment to help others become and stay engaged in the process of recovery from a substance use disorder.

"Lived experience", the experience of addiction and recovery from a substance use disorder.

(b) The board shall have the following powers and duties:

(1) to promulgate regulations and adopt such rules as are necessary to regulate recovery coaches;

(2) to receive, review, approve or disapprove initial applications, renewals and reinstatement requests and to issue those authorizations to practice;

(3) to establish administrative procedures for processing applications submitted under clause (2) and to hire or appoint such agents as are appropriate for processing applications;

(4) to retain records of its actions and proceedings in accordance with public records laws;

(5) to establish specifications for the authorized practice of recovery coaching; provided, that the specifications shall require individuals to have lived experience and demonstrate at least 2 years of sustained recovery; provided further, that the lived experience requirement may be waived for individuals who were credentialed by the Massachusetts Board of Substance Abuse Counselor Certification before the establishment of the board.

(6) to define by regulation the appropriate standards for education, core competencies, and experience necessary to qualify as an authorized recovery coach, including, but not limited to, continuing professional education requirements; provided, that the board shall consider any standards contained within recovery coach training programs established by the department of public health;

(7) to establish an ethical code of conduct for recovery coaches authorized to practice by the board; provided, that the board shall consider any codes of conduct for recovery coach training programs established by the department of public health;

(8) to establish standards of supervision for students or persons in training to become a recovery coach; provided, that the board shall consider standards contained within recovery coach training programs established by the department of public health;

(9) to fine, censure, revoke, suspend or deny a recovery coaches authorization to practice, place on probation, reprimand or otherwise discipline a recovery coach for violations of the code of ethics or the rules of the board.

(10) to summarily suspend a recovery coach who poses an imminent danger to the public; provided, that the recovery coach shall be afforded a hearing within 7 business days to determine whether the summary action is warranted; and

(11) to perform other functions and duties as may be required to carry out this section.

Section 276. An application to be a recovery coach, under section 275, shall be made on forms approved by the board, signed under the penalties of perjury by the person certifying the information contained therein and accompanied by the required fee. The fee shall be determined

by the secretary of administration and finance under section 3B of chapter 7. A recovery coach applicant shall furnish satisfactory proof that the applicant is at least 18 years of age, is of good moral character and has met all the education, training and experience requirements and qualifications as established by the board.

The board, in consultation with the department of public health, shall determine the renewal cycle and renewal period for recovery coaches. A recovery coach authorized to practice under this chapter shall apply to the board for a renewal not later than the expiration date, as determined by the board, unless earlier revoked, suspended or canceled as a result of a disciplinary proceeding. As a condition for renewal under this section, the board may require satisfactory proof that the recovery coach has successfully completed the required number of hours of continuing education in courses or programs approved by the board or has complied with such other requirements or equivalent requirements as approved by the board. Upon satisfactory compliance with the requirements and successful completion of the continuing education requirements, the board shall issue a renewal. The board may provide for the late renewal that has lapsed and may require payment of a late fee. Each renewal application submitted to the board shall be accompanied by a fee as determined by the secretary of administration and finance under section 3B of chapter 7.

The board may authorize a recovery coach to practice by reciprocity. The board shall promulgate rules and regulations as may be necessary to implement this section.

Section 277. (a) The title “recovery coach” shall only be used by individuals who have met the requirements and qualifications and hold a valid, current authorization issued by the board. No person may act as a recovery coach for a fee unless such person holds a valid, current

authorization issued by the board. The use by any person not so authorized of any words, letters, abbreviations or insignia indicating or implying a person is an authorized recovery coach shall be a violation of this section for which the board may issue a cease and desist order and seek additional appropriate legal remedies.

(b) A person who violates subsection (a) shall be liable for a fine as determined by the Board.

(c) No person filing a complaint alleging a violation of law or of the regulations of the board, reporting information pursuant to such laws or regulations or assisting the board at its request in any manner in discharging its duties and functions shall be liable in any cause of action arising out of the board's receipt of such information or assistance, if the person making the complaint, or reporting or providing such information or assistance, does so in good faith and without malice.

Section 278. All application fees and civil administrative penalties and fines collected under sections 275 to this section, inclusive, shall be deposited into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 111. The General Laws are hereby amended by inserting after chapter 112 the following chapter:-

Chapter 112A. Nurse Licensure Compact

Section 1.

As used in this chapter, the following words shall have the following meanings:

"Adverse action", any administrative, civil, equitable or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against a nurse, including actions against an individual's license or multistate licensure privilege such as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting a nurse's authorization to practice, including issuance of a cease and desist action.

"Alternative program", a non-disciplinary monitoring program approved by a licensing board.

"Compact" or "Nurse Licensure Compact", the legally binding agreement between party states as adopted by the National Council of State Boards of Nursing Nurse Licensure Compact in its Final Version dated May 4, 2015, and entered into by the commonwealth in accordance with this chapter.

"Coordinated licensure information system", an integrated process for collecting, storing and sharing information on nurse licensure and enforcement activities related to nurse licensure laws that is administered by a nonprofit organization composed of and controlled by licensing boards.

"Current significant investigative information", (i) investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction or (ii) investigative information that indicates that the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond.

"Encumbrance", a revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing imposed by a licensing board.

"Home state", the party state which is the nurse's primary state of residence.

"Interstate commission", the Interstate Commission of Nurse Licensure Compact Administrators as established in section 6 of this chapter.

"Licensing board", a party state's regulatory body responsible for issuing nurse licenses.

"Multistate license", a license to practice as a registered nurse or a licensed practical or vocational nurse issued by a home state licensing board that authorizes the licensed nurse to practice in all party states under a multistate licensure privilege.

"Multistate licensure privilege", a legal authorization associated with a multistate license permitting the practice of nursing as either a registered nurse or as a licensed practical or vocational nurse in a remote state.

"Nurse", registered nurse or a licensed practical or vocational nurse, as those terms are defined by each party state's practice laws.

"Party state", the commonwealth and any other state that has adopted this compact.

"Remote state", a party state other than the home state.

"Single-state license", a nurse license issued by a party state that authorizes practice only within the issuing state and does not include a multistate licensure privilege to practice in any other party state.

"State", a state, territory or possession of the United States and the District of Columbia.

"State practice laws", a party state's laws, rules and regulations that govern the practice of nursing, define the scope of nursing practice, and establish the methods and grounds for imposing discipline. "State practice laws" do not include requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

Section 2.

(a) A multistate license to practice as a nurse issued by a home state to a resident in that state will be recognized by each party state as authorizing a nurse to practice as a registered nurse or as a licensed practical or vocational nurse, under a multistate licensure privilege, in each party state.

(b) A state must implement procedures for considering the criminal history records of applicants for initial multistate license or licensure by endorsement. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records.

(c) Each party state shall require the following for an applicant to obtain or retain a multistate license in the home state:

(1) Meets the home state's qualifications for licensure or renewal of licensure, as well as, all other applicable state laws;

(2) (i) Has graduated or is eligible to graduate from a licensing board-approved registered nurse or practical or vocational nurse pre-licensure education program; or (ii) has graduated from a foreign registered nurse or practical or vocational nurse pre-licensure education program that

(A) has been approved by the authorized accrediting body in the applicable country and (B) has been verified by an independent credentials review agency to be comparable to a licensing board-approved pre-licensure education program;

(3) Has, if a graduate of a foreign pre-licensure education program not taught in English or if English is not the individual's native language, successfully passed an English proficiency examination that includes the components of reading, speaking, writing and listening;

(4) Has successfully passed an NCLEX-RN® or NCLEX-PN® Examination or recognized predecessor, as applicable;

(5) Is eligible for or holds an active, unencumbered license;

(6) Has submitted, in connection with an application for initial licensure or licensure by endorsement, fingerprints or other biometric data for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records;

(7) Has not been convicted or found guilty, or entered into an agreed disposition, of a felony offense under applicable state or federal criminal law;

(8) Has not been convicted or found guilty, or entered into an agreed disposition, of a misdemeanor offense related to the practice of nursing as determined on a case-by-case basis;

(9) Is not currently enrolled in an alternative program;

(10) Is subject to self-disclosure requirements regarding current participation in an alternative program; and

(11) Has a valid United States Social Security number.

(d) All party states shall be authorized, in accordance with existing state due process law, to take adverse action against a nurse's multistate licensure privilege such as revocation, suspension, probation or any other action that affects a nurse's authorization to practice under a multistate licensure privilege, including cease and desist actions. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.

(e) A nurse practicing in a party state must comply with the state practice laws of the state in which the client is located at the time service is provided. The practice of nursing is not limited to patient care, but shall include all nursing practice as defined by the state practice laws of the party state in which the client is located. The practice of nursing in a party state under a multistate licensure privilege will subject a nurse to the jurisdiction of the licensing board, the courts and the laws of the party state in which the client is located at the time service is provided.

(f) Individuals not residing in a party state shall continue to be able to apply for a party state's single-state license as provided under the laws of each party state. However, the single-state license granted to these individuals will not be recognized as granting the privilege to practice nursing in any other party state. Nothing in this compact shall affect the requirements established by a party state for the issuance of a single-state license.

(g) Any nurse holding a home state multistate license, on the effective date of this compact, may retain and renew the multistate license issued by the nurse's then-current home state, provided that:

(1) A nurse, who changes primary state of residence after this compact's effective date, must meet all applicable requirements under section 2 to obtain a multistate license from a new home state.

(2) A nurse who fails to satisfy the multistate licensure requirements in section 2 due to a disqualifying event occurring after this compact's effective date shall be ineligible to retain or renew a multistate license, and the nurse's multistate license shall be revoked or deactivated in accordance with applicable rules adopted by the interstate commission.

Section 3.

(a) Upon application for a multistate license, the licensing board in the issuing party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any encumbrances on any license or multistate licensure privilege held by the applicant, whether any adverse action has been taken against any license or multistate licensure privilege held by the applicant and whether the applicant is currently participating in an alternative program.

(b) A nurse may hold a multistate license, issued by the home state, in only one party state at a time.

(c) If a nurse changes primary state of residence by moving between two party states, the nurse must apply for licensure in the new home state, and the multistate license issued by the prior home state will be deactivated in accordance with applicable rules adopted by the interstate commission.

(1) The nurse may apply for licensure in advance of a change in primary state of residence.

(2) A multistate license shall not be issued by the new home state until the nurse provides satisfactory evidence of a change in primary state of residence to the new home state and satisfies all applicable requirements to obtain a multistate license from the new home state.

(d) If a nurse changes primary state of residence by moving from a party state to a non-party state, the multistate license issued by the prior home state will convert to a single-state license, valid only in the former home state.

Section 4.

(a) In addition to the other powers conferred by state law, a licensing board shall have the authority to:

(1) Take adverse action against a nurse's multistate licensure privilege to practice within that party state.

(i) Only the home state shall have the power to take adverse action against a nurse's license issued by the home state.

(ii) For purposes of taking adverse action, the home state licensing board shall give the same priority and effect to reported conduct received from a remote state as it would if such conduct had occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action.

(2) Issue cease and desist orders or impose an encumbrance on a nurse's authority to practice within that party state.

(3) Complete any pending investigations of a nurse who changes primary state of residence during the course of such investigations. The licensing board shall also have the authority to take appropriate action(s) and shall promptly report the conclusions of such investigations to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such actions.

(4) Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, as well as, the production of evidence. Subpoenas issued by a licensing board in a party state for the attendance and testimony of witnesses or the production of evidence from another party state shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state in which the witnesses or evidence are located.

(5) Obtain and submit, for each nurse licensure applicant, fingerprint or other biometric-based information to the Federal Bureau of Investigation for criminal background checks, receive the results of the Federal Bureau of Investigation record search on criminal background checks and use the results in making licensure decisions.

(6) If otherwise permitted by state law, recover from the affected nurse the costs of investigations and disposition of cases resulting from any adverse action taken against that nurse.

(7) Take adverse action based on the factual findings of the remote state, provided that the licensing board follows its own procedures for taking such adverse action.

(b) If adverse action is taken by the home state against a nurse's multistate license, the nurse's multistate licensure privilege to practice in all other party states shall be deactivated until all encumbrances have been removed from the multistate license. All home state disciplinary orders that impose adverse action against a nurse's multistate license shall include a statement that the nurse's multistate licensure privilege is deactivated in all party states during the pendency of the order.

(c) Nothing in this compact shall override a party state's decision that participation in an alternative program may be used in lieu of adverse action. The home state licensing board shall deactivate the multistate licensure privilege under the multistate license of any nurse for the duration of the nurse's participation in an alternative program.

Section 5.

(a) All party states shall participate in a coordinated licensure information system of all licensed registered nurses and licensed practical or vocational nurses. This system will include information on the licensure and disciplinary history of each nurse, as submitted by party states, to assist in the coordination of nurse licensure and enforcement efforts.

(b) The interstate commission, in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection and exchange of information under this compact.

(c) All licensing boards shall promptly report to the coordinated licensure information system any adverse action, any current significant investigative information, denials of applications (with the reasons for such denials) and nurse participation in alternative programs

known to the licensing board regardless of whether such participation is deemed nonpublic or confidential under state law.

(d) Current significant investigative information and participation in nonpublic or confidential alternative programs shall be transmitted through the coordinated licensure information system only to party state licensing boards.

(e) Notwithstanding any other provision of law, all party state licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with non-party states or disclosed to other entities or individuals without the express permission of the contributing state.

(f) Any personally identifiable information obtained from the coordinated licensure information system by a party state licensing board shall not be shared with non-party states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.

(g) Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information shall also be expunged from the coordinated licensure information system.

(h) The compact administrator of each party state shall furnish a uniform data set to the compact administrator of each other party state, which shall include, at a minimum:

(1) Identifying information;

(2) Licensure data;

(3) Information related to alternative program participation; and

(4) Other information that may facilitate the administration of this compact, as determined by interstate commission rules.

(i) The compact administrator of a party state shall provide all investigative documents and information requested by another party state.

Section 6.

(a) The party states hereby create and establish a joint public entity known as the Interstate Commission of Nurse Licensure Compact Administrators.

(1) The interstate commission is an instrumentality of the party states.

(2) Venue is proper, and judicial proceedings by or against the interstate commission shall be brought solely and exclusively, in a court of competent jurisdiction where the principal office of the interstate commission is located. The interstate commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(3) Nothing in this compact shall be construed to be a waiver of sovereign immunity.

(b) Membership, Voting and Meetings

(1) Each party state shall have and be limited to one administrator. The head of the state licensing board or designee shall be the administrator of this compact for each party state. Any administrator may be removed or suspended from office as provided by the law of the state from which the administrator is appointed. Any vacancy occurring in the interstate commission shall be filled in accordance with the laws of the party state in which the vacancy exists.

(2) Each administrator shall be entitled to 1 vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the interstate commission. An administrator shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for an administrator's participation in meetings by telephone or other means of communication.

(3) The interstate commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws or rules of the interstate commission.

(4) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in section 7.

(5) The interstate commission may convene in a closed, nonpublic meeting if the interstate commission must discuss:

(i) Noncompliance of a party state with its obligations under this compact;

(ii) The employment, compensation, discipline or other personnel matters, practices or procedures related to specific employees or other matters related to the interstate commission's internal personnel practices and procedures;

(iii) Current, threatened or reasonably anticipated litigation;

(iv) Negotiation of contracts for the purchase or sale of goods, services or real estate;

(v) Accusing any person of a crime or formally censuring any person;

(vi) Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

(vii) Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

(viii) Disclosure of investigatory records compiled for law enforcement purposes;

(ix) Disclosure of information related to any reports prepared by or on behalf of the interstate commission for the purpose of investigation of compliance with this compact; or

(x) Matters specifically exempted from disclosure by federal or state statute.

(6) If a meeting, or portion of a meeting, is closed pursuant to this provision, the interstate commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The interstate commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the interstate commission or order of a court of competent jurisdiction.

(c) The interstate commission shall, by a majority vote of the administrators, prescribe bylaws or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of this compact, including but not limited to:

(1) Establishing the fiscal year of the interstate commission;

(2) Providing reasonable standards and procedures:

(i) For the establishment and meetings of other committees; and

(ii) Governing any general or specific delegation of any authority or function of the interstate commission;

(3) Providing reasonable procedures for calling and conducting meetings of the interstate commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and proprietary information, including trade secrets. The interstate commission may meet in closed session only after a majority of the administrators vote to close a meeting in whole or in part. As soon as practicable, the interstate commission must make public a copy of the vote to close the meeting revealing the vote of each administrator, with no proxy votes allowed;

(4) Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the interstate commission;

(5) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the interstate commission. Notwithstanding any civil service or other similar laws of any party state, the bylaws shall exclusively govern the personnel policies and programs of the interstate commission; and

(6) Providing a mechanism for winding up the operations of the interstate commission and the equitable disposition of any surplus funds that may exist after the termination of this compact after the payment or reserving of all of its debts and obligations;

(d) The interstate commission shall publish its bylaws and rules, and any amendments thereto, in a convenient form on the website of the interstate commission.

(e) The interstate commission shall maintain its financial records in accordance with the bylaws.

(f) The interstate commission shall meet and take such actions as are consistent with the provisions of this compact and the bylaws.

(g) The interstate commission shall have the following powers:

(1) To promulgate uniform rules to facilitate and coordinate implementation and administration of this compact. The rules shall have the force and effect of law and shall be binding in all party states;

(2) To bring and prosecute legal proceedings or actions in the name of the interstate commission, provided that the standing of any licensing board to sue or be sued under applicable law shall not be affected;

(3) To purchase and maintain insurance and bonds;

(4) To borrow, accept or contract for services of personnel, including, but not limited to, employees of a party state or nonprofit organizations;

(5) To cooperate with other organizations that administer state compacts related to the regulation of nursing, including but not limited to sharing administrative or staff expenses, office space or other resources;

(6) To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of this compact, and to establish the interstate commission’s personnel policies and programs relating to conflicts of interest, qualifications of personnel and other related personnel matters;

(7) To accept any and all appropriate donations, grants and gifts of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the interstate commission shall avoid any appearance of impropriety or conflict of interest;

(8) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, whether real, personal or mixed; provided that at all times the interstate commission shall avoid any appearance of impropriety;

(9) To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, whether real, personal or mixed;

(10) To establish a budget and make expenditures;

(11) To borrow money;

(12) To appoint committees, including advisory committees comprised of administrators, state nursing regulators, state legislators or their representatives, and consumer representatives, and other such interested persons;

(13) To provide and receive information from, and to cooperate with, law enforcement agencies;

(14) To adopt and use an official seal; and

(15) To perform such other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of nurse licensure and practice.

(h) Financing of the interstate commission

(1) The interstate commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization and ongoing activities.

(2) The interstate commission may also levy on and collect an annual assessment from each party state to cover the cost of its operations, activities and staff in its annual budget as approved each year. The aggregate annual assessment amount, if any, shall be allocated based upon a formula to be determined by the interstate commission, which shall promulgate a rule that is binding upon all party states.

(3) The interstate commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the interstate commission pledge the credit of any of the party states, except by, and with the authority of, such party state.

(4) The interstate commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the interstate commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the interstate commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the interstate commission.

(i) Qualified Immunity, Defense and Indemnification

(1) The administrators, officers, executive director, employees and representatives of the interstate commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred,

within the scope of interstate commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit or liability for any damage, loss, injury or liability caused by the intentional, willful or wanton misconduct of that person.

(2) The interstate commission shall defend any administrator, officer, executive director, employee or representative of the interstate commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of interstate commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of interstate commission employment, duties or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further that the actual or alleged act, error or omission did not result from that person's intentional, willful or wanton misconduct.

(3) The interstate commission shall indemnify and hold harmless any administrator, officer, executive director, employee or representative of the interstate commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of interstate commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of interstate commission employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional, willful or wanton misconduct of that person.

Section 7.

(a) The interstate commission shall exercise its rulemaking powers pursuant to the criteria set forth in this section and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment and shall have the same force and effect as provisions of this compact.

(b) Rules or amendments to the rules shall be adopted at a regular or special meeting of the interstate commission.

(c) Prior to promulgation and adoption of a final rule or rules by the interstate commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the interstate commission shall file a notice of proposed rulemaking:

(1) On the website of the interstate commission; and

(2) On the website of each licensing board or the publication in which each state would otherwise publish proposed rules.

(d) The notice of proposed rulemaking shall include:

(1) The proposed time, date and location of the meeting in which the rule will be considered and voted upon;

(2) The text of the proposed rule or amendment, and the reason for the proposed rule;

(3) A request for comments on the proposed rule from any interested person; and

(4) The manner in which interested persons may submit notice to the interstate commission of their intention to attend the public hearing and any written comments.

(e) Prior to adoption of a proposed rule, the interstate commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

(f) The interstate commission shall grant an opportunity for a public hearing before it adopts a rule or amendment.

(g) The interstate commission shall publish the place, time and date of the scheduled public hearing.

(1) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing. All hearings will be recorded, and a copy will be made available upon request.

(2) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the interstate commission at hearings required by this section.

(h) If no one appears at the public hearing, the interstate commission may proceed with promulgation of the proposed rule.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the interstate commission shall consider all written and oral comments received.

(j) The interstate commission shall, by majority vote of all administrators, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

(k) Upon determination that an emergency exists, the interstate commission may consider and adopt an emergency rule without prior notice, opportunity for comment or hearing, provided that the usual rulemaking procedures provided in this compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

(1) Meet an imminent threat to public health, safety or welfare;

(2) Prevent a loss of interstate commission or party state funds; or

(3) Meet a deadline for the promulgation of an administrative rule that is required by federal law or rule.

(l) The interstate commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency or grammatical errors. Public notice of any revisions shall be posted on the website of the interstate commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the interstate commission, prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the interstate commission.

Section 8.

(a) Oversight

(1) Each party state shall enforce this compact and take all actions necessary and appropriate to effectuate this compact's purposes and intent.

(2) The interstate commission shall be entitled to receive service of process in any proceeding that may affect the powers, responsibilities or actions of the interstate commission, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process in such proceeding to the interstate commission shall render a judgment or order void as to the interstate commission, this compact or promulgated rules.

(b) Default, Technical Assistance and Termination

(1) If the interstate commission determines that a party state has defaulted in the performance of its obligations or responsibilities under this compact or the promulgated rules, the interstate commission shall:

(i) Provide written notice to the defaulting state and other party states of the nature of the default, the proposed means of curing the default or any other action to be taken by the interstate commission; and

(ii) Provide remedial training and specific technical assistance regarding the default.

(2) If a state in default fails to cure the default, the defaulting state's membership in this compact may be terminated upon an affirmative vote of a majority of the administrators, and all rights, privileges and benefits conferred by this compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(3) Termination of membership in this compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the interstate commission to the governor of the defaulting state and to the executive officer of the defaulting state's licensing board and each of the party states.

(4) A state whose membership in this compact has been terminated is responsible for all assessments, obligations and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

(5) The interstate commission shall not bear any costs related to a state that is found to be in default or whose membership in this compact has been terminated unless agreed upon in writing between the interstate commission and the defaulting state.

(6) The defaulting state may appeal the action of the interstate commission by petitioning the U.S. District Court for the District of Columbia or the federal district in which the interstate commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(c) Dispute Resolution

(1) Upon request by a party state, the interstate commission shall attempt to resolve disputes related to the Compact that arise among party states and between party and non-party states.

(2) The interstate commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes, as appropriate.

(3) In the event the interstate commission cannot resolve disputes among party states arising under this compact:

(i) The party states may submit the issues in dispute to an arbitration panel, which will be comprised of individuals appointed by the compact administrator in each of the affected party states and an individual mutually agreed upon by the compact administrators of all the party states involved in the dispute.

(ii) The decision of a majority of the arbitrators shall be final and binding.

(d) Enforcement

(1) The interstate commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this compact.

(2) By majority vote, the interstate commission may initiate legal action in the U.S. District Court for the District of Columbia or the federal district in which the interstate commission has its principal offices against a party state that is in default to enforce compliance with the provisions of this compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(3) The remedies herein shall not be the exclusive remedies of the interstate commission. The interstate commission may pursue any other remedies available under federal or state law.

Section 9.

(a) This compact shall become effective and binding on the earlier of the date of legislative enactment of this compact into law by no less than twenty-six (26) states or December 31, 2018. All party states to this compact, that also were parties to the prior Nurse Licensure Compact, superseded by this compact, ("prior compact"), shall be deemed to have withdrawn from said prior compact within 6 months after the effective date of this compact.

(b) Each party state to this compact shall continue to recognize a nurse's multistate licensure privilege to practice in that party state issued under the prior compact until such party state has withdrawn from the prior compact.

(c) Any party state may withdraw from this compact by enacting a statute repealing the same. A party state's withdrawal shall not take effect until 6 months after enactment of the repealing statute.

(d) A party state's withdrawal or termination shall not affect the continuing requirement of the withdrawing or terminated state's licensing board to report adverse actions and significant investigations occurring prior to the effective date of such withdrawal or termination.

(e) Nothing contained in this compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a non-party state that is made in accordance with the other provisions of this compact.

(f) This compact may be amended by the party states. No amendment to this compact shall become effective and binding upon the party states unless and until it is enacted into the laws of all party states.

(g) Representatives of non-party states to this compact shall be invited to participate in the activities of the interstate commission, on a nonvoting basis, prior to the adoption of this compact by all states.

Section 10.

This compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this compact shall be severable, and if any phrase, clause, sentence or provision of this compact is declared to be contrary to the constitution of any party state or of the United States, or if the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this compact shall be held to be contrary to the constitution of any party state, this compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

Section 11. The executive director of the board of registration in nursing, or the board executive director's designee, shall be the administrator of the Nurse Licensure Compact for the commonwealth.

Section 12. The board of registration in nursing shall adopt regulations in the same manner as all other with states legally joining in the compact and may adopt additional regulations as necessary to implement the provisions of this chapter.

Section 13. The board of registration in nursing may recover from a nurse the costs of investigation and disposition of cases resulting in any adverse disciplinary action taken against that nurse's license or privilege to practice. Funds collected pursuant to this section shall be

deposited in the Quality in Health Professions Trust Fund established pursuant to section 35X of chapter 10.

Section 14. The board of registration in nursing may take disciplinary action against the practice privilege of a registered nurse or of a licensed practical or vocational nurse practicing in the commonwealth under a license issued by party state. The board's disciplinary action may be based on disciplinary action against the nurse's license taken by the nurse's home state.

Section 15. In reporting information to the coordinated licensure information system under section 8 of this chapter related to the Nurse Licensure Compact, the board of registration in nursing may disclose personally identifiable information about the nurse, including social security number.

Section 16. Nothing in this chapter, nor the entrance of the commonwealth into the Nurse Licensure Compact shall be construed to supersede existing labor laws.

Section 17. The commonwealth, its officers and employees, and the board of registration in nursing and its agents who act in accordance with the provisions of this chapter shall not be liable on account of any act or omission in good faith while engaged in the performance of their duties under this chapter. Good faith shall not include willful misconduct, gross negligence, or recklessness.

Section 18. As part of the licensure and background check process for a multistate license and to determine the suitability of an applicant for multistate licensure, the board of registration in nursing, prior to issuing any multistate license, shall conduct a fingerprint-based check of the state and national criminal history databases, as authorized by 28 CFR 20.33 and Public Law 92-544.

Fingerprints shall be submitted to the identification section of the department of state police for a state criminal history check and forwarded to the Federal Bureau of Investigation for a national criminal history check, according to the policies and procedures established by the state identification section and by the department of criminal justice information services. Fingerprint submissions may be retained by the Federal Bureau of Investigation, the state identification section and the department of criminal justice information services for requests submitted by the board of registration in nursing as authorized under this section to ensure the continued suitability of these individuals for licensure. The department of criminal justice information services may disseminate the results of the state and national criminal background checks to the executive director of the board of registration in nursing and authorized staff of the board.

All applicants shall pay a fee to be established by the secretary of administration and finance, in consultation with the secretary of public safety, to offset the costs of operating and administering a fingerprint-based criminal background check system. The secretary of administration and finance, in consultation with the secretary of public safety, may increase the fee accordingly if the Federal Bureau of Investigation increases its fingerprint background check service fee. Any fees collected from fingerprinting activity under this chapter shall be deposited into the Fingerprint-Based Background Check Trust Fund, established in section 2HHHH of chapter 29.

The board of registration in nursing may receive all criminal offender record information and the results of checks of state and national criminal history databases under said Public Law 92-544. When the board of registration in nursing obtains the results of checks of state and national criminal history databases, it shall treat the information according to sections 167 to

178, inclusive, of chapter 6 and the regulations thereunder regarding criminal offender record information.

Notwithstanding subsections 9 and 9 1/2 of section 4 of chapter 151B, if the board of registration in nursing receives criminal record information from the state or national fingerprint-based criminal background checks that includes no disposition or is otherwise incomplete, the agency head may request that an applicant for licensure provide additional information regarding the results of the criminal background checks to assist the agency head in determining the applicant's suitability for licensure.

SECTION 112. Section 12 of Chapter 118E, as appearing in the 2018 Official Edition, is hereby amended by inserting after the eighth paragraph the following paragraph:-

Such rules and regulations shall also include provisions requiring providers applying to participate in the medical assistance programs established under this chapter to utilize an application specified by the division, such as a standard credentialing form.

SECTION 113. The General Laws are hereby amended by striking out chapter 118I and inserting in place thereof the following chapter:-

Chapter 118I. Health Information Technology

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

"Council", the health information technology council established under section 2 of this chapter.

"Electronic health record", an electronic record of patient health information generated by 1 or more encounters in any care delivery setting.

"Executive office", the executive office of health and human services.

"Health care entity", a payer, health care provider or provider organization.

"Health care provider", a provider of medical or health services or any other person or organization that furnishes, bills or is paid for health care service delivery in the normal course of business.

"Health information exchange", the electronic transmission of health care-related data and information among health care entities.

"Office of the National Coordinator" or "ONC", the Office of the National Coordinator for Health Information Technology within the United States Department of Health and Human Services.

"Payer", any entity, other than an individual, that pays providers for the provision of health care services; provided, that "payer" shall include both governmental and private entities.

"Provider organization", any corporation, partnership, business trust, association or organized group of persons, which is in the business of health care delivery or management, whether incorporated or not that represents 1 or more health care providers in contracting with carriers for the payments of health care services; provided, that "provider organization" shall include, but not be limited to, physician organizations, physician-hospital organizations, independent practice associations, provider networks, accountable care organizations and any other organization that contracts with carriers for payment for health care services.

"Statewide health information exchange", health information exchange established, operated, facilitated or funded by a governmental entity or entities in the commonwealth.

Section 2. (a) There shall be a health information technology council within the executive office. The council shall advise the executive office on design, implementation, operation and use of statewide health information exchange.

(b) The council shall consist of the following 17 members: the secretary of the executive office or a designee, who shall serve as the chair; the executive director of the health policy commission or a designee; the executive director of the center for health information analysis or a designee; the director of the Massachusetts eHealth Institute or a designee; the secretary of housing and economic development or a designee; the director of the office of Medicaid or a designee; and 11 members who shall be appointed by the governor: of whom at least 2 shall be representatives from the from the health information technology industry; 1 shall be an expert in health information technology from a provider-based setting; 1 shall be an expert in health data privacy; 1 shall be an expert in health information security; 3 shall be from provider organizations; 1 shall be from a behavioral health provider organization; 1 shall represent a payer; and 1 shall be a representative of the Massachusetts Life Science Center. Appointed members of the council shall serve for terms of 2 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation.

(c) In carrying out this chapter, the council may consult with various organizations of health care entities on the design, implementation, operation and use of statewide health information exchange.

(d) Chapter 268A shall apply to all council members, except that the council may purchase from, sell to, borrow from, contract with or otherwise deal with any organization in which any council member is in anyway interested or involved; provided, however, that interest or involvement shall be disclosed in advance to the council and recorded in the minutes of the proceedings of the council; and provided, further, that no member shall be considered to have violated section 4 of chapter 268A of the General Laws because of the member's receipt of usual and regular compensation from the member's employer during the time in which the member participates in the activities of the council.

Section 3. (a) The executive office shall establish, operate, facilitate or fund statewide health information exchange between health care entities, including, but not limited to, the defining of and overseeing the exchange of minimum data requirements.

(b) The executive office may:

(i) conduct procurements and enter into contracts for the purchase, development or management of hardware, software or related services, in connection with the creation and implementation of statewide health information exchange; and

(ii) in consultation with the council, oversee the development, dissemination, implementation and operation of statewide health information exchange, including, but not limited to, any modules, applications, interfaces or other technology infrastructure for statewide health information exchange.

(c) In carrying out this chapter, the executive office may undertake any activities necessary to implement the powers and duties under this chapter, which may include the adoption of policies consistent with those adopted by the Office of the National Coordinator for

Health Information Technology of the United States Department of Health and Human Services; provided, however, that nothing herein shall be construed to limit the executive office's ability to advance interoperability and other health information technology beyond the standards adopted by the ONC, including without limitation any applicable meaningful use standards.

Section 4. Every patient shall have electronic access to that patient's own health records. The executive office shall ensure that each patient has secure electronic access to that patient’s own electronic health records with each of that patient's health care providers. The executive office shall ensure that statewide health information exchange includes the ability to transmit copies of electronic health records to patients directly or allow facilities to provide mechanisms for that patient to access that patient's own electronic health record.

Section 5. All health care entities in the commonwealth shall participate in statewide health information exchange as defined by the executive office; provided that all health care providers shall implement fully interoperable electronic records systems necessary to participate in statewide health information exchange; and further provided that all payers shall implement electronic claims management systems that can transmit claims data necessary to participate in statewide health information exchange. The executive office shall ensure that statewide health information exchange, the associated electronic records systems and electronic claims management systems, comply with all state and federal privacy requirements, including those imposed by the Health Insurance Portability and Accountability Act of 1996, P.L. 104–191, the American Recovery and Reinvestment Act of 2009, P.L. 111–5, 42 C.F.R. §§ 2.11 et seq. and 45 C.F.R. §§ 160, 162 and 164.

Section 6. The executive office shall prescribe by regulation penalties for non-compliance by health care entities with the requirements of section 5; provided, however, that the executive office may waive penalties for good cause. Penalties collected under this section shall be deposited into the Health Information Technology Trust Fund, established in section 35RR of chapter 10.

Section 7. In the event of an unauthorized access to or disclosure of individually identifiable patient health information by or through a health care entity or a vendor contracted through services of a health care entity as participants of statewide health information exchange, the health care entity or vendor shall:

(a) report the conditions of the unauthorized access or disclosure as required by the executive office; and

(b) provide notice, as defined in section 1 of chapter 93H, as soon as practicable, but not later than 10 business days after the unauthorized access or disclosure, to any person whose patient health information may have been compromised as a result of the unauthorized access or disclosure, and shall report the conditions of the unauthorized access or disclosure, and further shall concurrently provide a copy of the report to the executive office. Any unauthorized access or disclosures shall be punishable by the civil penalties under section 10.

Section 8. The executive office shall pursue and maximize all opportunities to qualify for federal financial participation under the matching grant program established under the Health Information Technology for Economic and Clinical Health Act of the American Recovery and Reinvestment Act of 2009, P.L. 111–5.

Section 9. The council shall file an annual report, not later than January 30, with the joint committee on health care financing, the joint committee on economic development and emerging technologies, the house and senate committees on ways and means and the clerks of the house and senate concerning the activities of the council in general, describing the progress to date in developing statewide health information exchange and recommending further legislative action as it deems appropriate.

Section 10. Unauthorized access to or disclosure of individually identifiable patient health information shall be subject to fines or penalties as determined by the executive office. The executive office shall promulgate regulations to assess fair and reasonable fines or penalties.

Section 11. Cybersecurity-based documentation, including, but not limited to, security audit reports, provided to the executive office shall be exempt from public records laws established in clause 26 of section 7 of chapter 4.

SECTION 114. Section 1 of Chapter 123 of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the definition of "Psychologist" the following definition:-

"Qualified advanced practice registered nurse", an advanced practice registered nurse (APRN), authorized by the board of registration in nursing pursuant to section 80B of chapter 112 who holds certification in the field of psychiatric mental health from a certifying organization recognized by said board or its equivalent approved by said board. The APRN must meet qualifications required by regulations of the department provided that different qualifications may be established for different purposes of this chapter. A qualified advanced

practice registered nurse need not be an employee of the department or any facility of the department.

SECTION 115. Section 11 of said chapter 123, as so appearing, is hereby amended, in line 22 and in line 29, by inserting after the word “physician”, in both instances the following words:- or qualified advanced practice registered nurse.

SECTION 116. Said chapter 123 is hereby further amended by striking out section 12 and inserting in place thereof the following section:-

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

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

(b) Only if the application for hospitalization under the provisions of this section is made by a physician, or a qualified advanced practice registered nurse specifically designated to have the authority to admit to a facility in accordance with the regulations of the department, shall such person be admitted to the facility immediately after his reception. If the application is made by someone other than a designated physician, or a qualified advanced practice registered nurse, such person shall be given a psychiatric examination by a designated physician, or a qualified advanced practice registered nurse immediately after his reception at such facility. If the physician, or a qualified advanced practice registered nurse determines that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness he may admit such person to the facility for care and treatment. Upon admission of a person under the provisions of this subsection, the facility shall inform the person that it shall, upon such person's request, notify the committee for public counsel services of the name and location of the person admitted. Said committee for public counsel services shall forthwith appoint an attorney who

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

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

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

(d) A person shall be discharged at the end of the 3 day period unless the superintendent applies for a commitment under the provisions of sections seven and eight of this chapter or the person remains on a voluntary status.

(e) Any person may make application to a district court justice or a justice of the juvenile court department for a 3 day commitment to a facility of a mentally ill person whom the failure

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

SECTION 117. Said chapter 123 is hereby further amended by striking out section 21 and inserting in place thereof the following section:-

Section 21. Any person who transports a mentally ill person to or from a facility for any purpose authorized under this chapter shall not use any restraint which is unnecessary for the safety of the person being transported or other persons likely to come in contact with him.

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

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

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

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

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

No order for restraint for an individual shall be valid for a period of more than three hours beyond which time it may be renewed upon personal examination by the superintendent, director, authorized physician or qualified advanced practice registered nurse or, for adults, by a registered nurse or a certified physician assistant; provided, however, that no adult shall be

restrained for more than 6 hours beyond which time an order may be renewed only upon personal examination by a physician or qualified advanced practice registered nurse. The reasons for the original use of restraint, the reason for its continuation after each renewal, and the reason for its cessation shall be noted upon the restraining form by the superintendent, director or authorized physician or qualified advanced practice registered nurse or, when applicable, by the registered nurse or certified physician or qualified advanced practice registered nurse assistant at the time of each occurrence.

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

No person shall be kept in restraint without a person in attendance specially trained to understand, assist and afford therapy to the person in restraint. The person may be in attendance immediately outside the room in full view of the patient when an individual is being secluded without mechanical restraint; provided, however, that in emergency situations when a person specially trained is not available, an adult, may be kept in restraint unattended for a period not to exceed two hours. In that event, the person kept in restraints must be observed at least every 5 minutes; provided, further, that the superintendent, director, or designated physician or qualified advanced practice registered nurse shall attach to the restraint form a written report as to why the

specially trained attendant was not available. The maintenance of any adult in restraint for more than eight hours in any 24 hour period must be authorized by the superintendent or facility director or the person specifically designated to act in the absence of the superintendent or facility director; provided, however, that when such restraint is authorized in the absence of the superintendent or facility director, such authorization must be reviewed by the superintendent or facility director upon his return.

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

No later than 24 hours after the period of restraint, a copy of the restraint form shall be delivered to the person who was in restraint. A place shall be provided on the form or on attachments thereto, for the person to comment on the circumstances leading to the use of restraint and on the manner of restraint used.

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

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

SECTION 118. Section 22 of said chapter 123, as appearing in the 2018 Official Edition, is hereby amended by inserting, in line 1, after the word “physicians” the following words:- qualified advanced practice registered nurse.

SECTION 119. Said section 22 of said chapter 123, as so appearing, is hereby further amended by inserting, in line 6, after the word “physician” the following words:- , qualified advanced practice registered nurse.

SECTION 120. Subsection (i) of section 47B of chapter 175 of the General Laws, as so appearing, is hereby amended by striking out the second paragraph and inserting in place thereof the following 3 paragraphs:-

For the purposes of this section, "“licensed mental health professional” shall mean a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J, a licensed marriage and family therapist within the lawful scope of practice for such therapist, or a clinician practicing under the supervision of licensed professional, and working towards licensure, in a clinic licensed under chapter 111.

An insurer may not deny coverage for any behavioral health service or any evaluation and management office visit solely because the two services were delivered on the same day in

the same practice or facility; provided, however, an insurer may deny coverage if the two services are delivered by the same provider, or providers of the same specialty.

The division shall provide guidance relative to implementation of this section.

SECTION 121. 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 122. Section 1 of chapter 175H of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the definition of "Health care insurer" the following definition:

"Impermissible facility fee," a facility fee, as defined in section 51L of chapter 111, that is not charged, billed or collected in accordance with paragraphs (b) or (c) of said section 51L of chapter 111.

SECTION 123. Said section 1 of said chapter 175H, as so appearing, is hereby amended by inserting after the definition of "Person" the following definition:-

"Surprise bill," a bill, received by an insured who is covered under a preferred or closed network health plan, for dollar amounts, other than plan copayments, coinsurance or amounts subject to a deductible, for covered services provided by an out-of-network provider for services rendered for emergency medical conditions or rendered by an out-of-network provider at an in-network facility, including, but not limited to:

(i) health care services rendered by an out-of-network provider without the insured's knowledge;

(ii) health care services rendered by an out-of-network provider where an in-network provider is not reasonably available to the insured at the in-network facility, even if the out-of-network provider's network status is disclosed to the insured;

(iii) health care services rendered on an emergency basis or by an out-of-network provider that are necessary to provide immediate prophylaxis, diagnosis or treatment for a disease that the department of public health has determined is dangerous to the public health pursuant to section 6 of chapter 111;

(iv) health care services rendered by an out-of-network provider, including an out-of-network laboratory, radiologist or pathologist, where the health care services were referred, or an insured's specimen was sent, by a participating provider to an out-of-network provider without the prior written consent of the insured acknowledging that the participating provider is referring the insured or sending the insured's specimen to an out-of-network provider, which may result in uncovered costs; and

(v) unforeseen health care services that arise at the time health care services are rendered that must necessarily be rendered by an out-of-network provider;

provided, however, that a surprise bill shall not mean a bill received by an insured for health care services when a participating provider is available and the insured knowingly, voluntarily and specifically elects to obtain services from an out-of-network provider.

SECTION 124. Chapter 175H of the General Laws is hereby amended by striking out section 5, and inserting in place thereof the following section:-

Section 5. The attorney general may conduct an investigation of an alleged violation of this chapter and may commence a proceeding pursuant to section 4. Additionally, the attorney general has the authority to initiate a civil action under this chapter. When the attorney general has determined that a provider has violated this chapter, the attorney general shall notify the department of public health, the department of mental health, the board of registration in medicine or any other relevant licensing authorities, of that determination. Those licensing authorities may, upon their own investigation or upon notification from the attorney general that a provider licensed by that authority has violated this section, impose penalties for non-compliance consistent with their authority to regulate those providers.

SECTION 125. Said chapter 175H of the General Laws is hereby amended by striking out section 6 and inserting in place thereof the following section:-

Section 6. A person who receives a health care benefit or payment from a health care corporation or health care insurer or other person or entity, which such person knows that he or she is not entitled to receive or be paid, or a person who knowingly presents or causes to be presented with fraudulent intent a claim which contains a false statement, including but not

limited to a payment or false statement regarding an impermissible facility fee shall be liable to the health care corporation or health care insurer or other person or entity for the full amount of the benefit or payment made, and for reasonable attorneys' fees and costs, inclusive of costs of investigation. A health care corporation or health care insurer or other injured person or entity may bring a civil action under this chapter in the superior court department of the trial court.

SECTION 126. Said chapter 175H of the General Laws is hereby amended by adding the following section:-

Section 6A. A person who receives a health care benefit or payment from a health care corporation or health care insurer or other person or entity, shall not be permitted to forward a surprise bill to a person covered under an insured health plan. A person who violates this section shall be liable to the health care corporation or health care insurer or other person or entity for penalties and for reasonable attorneys' fees and costs, inclusive of costs of investigation. A health care corporation or health care insurer or other injured person or entity may bring a civil action under this chapter in the superior court department of the trial court.

SECTION 127. 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 128. Subsection (i) of section 8A of chapter 176A 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 3 paragraphs:-

For the purposes of this section, '"licensed mental health professional" shall mean a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J, a licensed marriage and family therapist within the lawful scope of practice for such therapist, or a clinician practicing under the supervision of licensed professional, and working towards licensure, in a clinic licensed under chapter 111.

A carrier may not deny coverage for any behavioral health service or any evaluation and management office visit solely because the two services were delivered on the same day in the

same practice or facility; provided, however, an insurer may deny coverage if the two services are delivered by the same provider, or providers of the same specialty.

The Division shall provide guidance relative to implementation of this section.

SECTION 129. 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 130. Subsection (i) of section 4A of chapter 176B 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 3 paragraphs:-

For the purposes of this section, “licensed mental health professional” shall mean a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J, a licensed marriage and family therapist within the lawful scope of practice for such therapist, or a clinician practicing under the supervision of licensed professional, and working towards licensure, in a clinic licensed under chapter 111.

A carrier may not deny coverage for any behavioral health service or any evaluation and management office visit solely because the two services were delivered on the same day in the same practice or facility; provided, however, an insurer may deny coverage if the two services are delivered by the same provider, or providers of the same specialty.

The Division shall provide guidance relative to implementation of this section.

SECTION 131. 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 132. Subsection (i) of section 4M of chapter 176G 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 3 paragraphs:-

For the purposes of this section, “licensed mental health professional” shall mean a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1

of chapter 111J, a licensed marriage and family therapist within the lawful scope of practice for such therapist, or a clinician practicing under the supervision of licensed professional, and working towards licensure, in a clinic licensed under chapter 111.

A carrier may not deny coverage for any behavioral health service or any evaluation and management office visit solely because the two services were delivered on the same day in the same practice or facility; provided, however, an insurer may deny coverage if the two services are delivered by the same provider, or providers of the same specialty.

The Division shall provide guidance relative to implementation of this section.

SECTION 133. 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 134. Subsection (a) of section 4 of chapter 176J of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by striking out the words, “Every carrier shall make available,” and inserting in place thereof the following words:- “Every carrier shall maintain a website on which it will display every available plan and shall offer.”

SECTION 135. Subsection (b) of said section 4 of said chapter 176J of the General Laws, as so appearing, is hereby amended by striking out the fourth paragraph.

SECTION 136. Section 7 of said chapter 176J, as so appearing, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:

(b) Every carrier, as a condition of doing business under the jurisdiction of this chapter, shall electronically file with the commissioner an annual actuarial opinion that the carrier's rating methodologies and rates to be applied in the upcoming calendar year comply with the requirements of this chapter and any regulations promulgated under the authority of this chapter. In addition, every carrier shall file electronically an annual statement of the number of eligible individuals, eligible employees and eligible dependents, as of the close of the preceding calendar year, enrolled in a health benefit plan offered by the carrier. A carrier that utilizes intermediaries shall file a list of those intermediaries, with associated contact information. Every carrier shall maintain at its principal place of business a complete and detailed description of its rating practices including information and documentation which demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions, are under sound actuarial principles, and comply with this chapter. Such information shall be made available to the commissioner upon request, but shall remain confidential.

SECTION 137. Said chapter176J of the General Laws is hereby amended by striking out section 11 and inserting in place thereof the following section:

Section 11. (a) A carrier that offers a health benefit plan that: (i) provides or arranges for the delivery of health care services through a closed network of health care providers; and (ii) as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible

individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals, shall offer to all eligible individuals and small businesses in at least 2 geographic areas at least 1 of the following plans:

(1) a reduced or selective network of providers;

(2) a plan in which providers are tiered and member cost sharing is based on the tier placement of the provider;

(3) a plan in which an enrollee’s premium varies based on the primary care provider selected at the time of enrollment; or

(4) any other innovative plan designed by the carrier and approved by the commissioner.

Carriers are to establish a base premium rate discount of at least 20 per cent for the plan offered pursuant to this section compared to the base premium of the carrier's most actuarially similar plan with the carrier's non-selective or non-tiered network of providers. The savings may be achieved by means including, but not limited to: (i) the exclusion of providers with similar or lower quality based on the standard quality measure set with higher health status adjusted total medical expenses or relative prices, as determined under section 10 of chapter 12C; or (ii) increased member cost-sharing for members who utilize providers for non-emergency services with similar or lower quality based on the standard quality measure set and with higher health status adjusted total medical expenses or relative prices, as determined under said section 10 of said chapter 12C.

The commissioner may apply waivers to the base premium rate discount determined by the commissioner under this section to carriers who receive 80 per cent or more of their incomes from government programs or the subsidized ConnectorCare Program sponsored by the Commonwealth Health Insurance Connector Authority or which have service areas which do not include either Suffolk or Middlesex counties and who were first admitted to do business by the division of insurance on January 1, 1986, as health maintenance organizations under chapter 176G.

(b) A tiered network plan shall only include variations in member cost-sharing between provider tiers which are reasonable in relation to the premium charged and ensure adequate access to covered services. Carriers shall tier providers based on quality performance as measured by the standard quality measure set and by cost performance as measured by health status adjusted total medical expenses and relative prices. Where applicable quality measures are not available, tiering may be based solely on health status adjusted total medical expenses or relative prices or both.

The commissioner shall promulgate regulations requiring the uniform reporting of information for all products subject to this section, including, but not limited to, for tiered network plans requiring at least 90 days before the proposed effective date of any tiered network plan or any modification in the tiering methodology for any existing tiered network plan, the reporting of a detailed description of the methodology used for tiering providers, including: the statistical basis for tiering; a list of providers to be tiered at each member cost-sharing level; a description of how the methodology and resulting tiers will be communicated to each network provider, eligible individuals and small groups; and a description of the appeals process a provider may pursue to challenge the assigned tier level.

(c) The commissioner shall determine network adequacy for a tiered network plan based on the availability of sufficient network providers in the carrier's overall network of providers.

(d) The commissioner shall determine network adequacy for a selective network plan based on the availability of sufficient network providers in the carrier's selective network.

(e) In determining network adequacy under this section the commissioner may take into consideration factors such as the location of providers participating in the plan and employers or members that enroll in the plan, the range of services provided by providers in the plan and plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network.

(f) Carriers may: (i) reclassify provider tiers; and (ii) determine provider participation in selective and tiered plans not more than once per calendar year except that carriers may reclassify providers from a higher cost tier to a lower cost tier or add providers to a selective network at any time. If the carrier reclassifies provider tiers or providers participating in a selective plan during the course of an account year, the carrier shall provide affected members of the account with information regarding the plan changes at least 30 days before the changes take effect. Carriers shall provide information on their websites about any tiered or selective plan, including but not limited to, the providers participating in the plan, the selection criteria for those providers and where applicable, the tier in which each provider is classified.

(g) The division of insurance shall report annually specific findings and legislative recommendations for all products subject to this section, including the following: (1) the utilization trends of eligible employers and eligible individuals enrolled in plans offered under this section; (2) the extent to which tiered product offerings have reduced health care costs for

patients and employers; (3) the effects that tiered product offerings have on patient education relating to health care costs and quality; (4) the effects that tiered product offerings have on patient utilization of local hospitals and the resulting impact on overall state health care costs, including the state's compliance with the health care cost growth benchmark established under section 9 of chapter 6D; (5) opportunities to incentivize tiered product offerings for both health systems and employers. The report shall also include the number of members enrolled by plan type, aggregate demographic, geographic information on all members and the average direct premium claims incurred, as defined in section 6, for selective and tiered network products compared to non-selective and non-tiered products. The report shall be submitted to clerks of the house of representatives and the senate, the senate and house committees on ways and means and the joint committee on health care financing.

SECTION 138. Section 1 of chapter 176O of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the definition of “Office of patient protection” the following definition:-

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

SECTION 139. Said section 1 of said chapter 176O of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Person” the following definition:-

"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 140. Said section 1 of said chapter 176O, as so appearing, is hereby amended by striking out the definition of "Primary care provider" and inserting in place thereof the following definition:-

"Primary care provider", a health care professional qualified to provide general medical care for common health care problems who: (i) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii) maintains continuity of care within the scope of practice. Urgent care clinics, as defined in section 52 of chapter 111, and emergency departments shall not be considered primary care providers.

SECTION 141. Said section 1 of said chapter 176O of the General Laws, as so appearing, is hereby amended by inserting after the definition of "Second opinion" the following definition:-

"Surprise bill," a bill, received by an insured who is covered under a preferred or closed network health plan, for dollar amounts, other than plan copayments, coinsurance or amounts subject to a deductible, for covered services provided by an out-of-network provider for services rendered for emergency medical conditions or rendered by an out-of-network provider at an in-network facility, including, but not limited to:

(i) health care services rendered by an out-of-network provider without the insured's knowledge;

(ii) health care services rendered by an out-of-network provider where an in- network provider is not reasonably available to the insured at the in-network facility, even if the out-of-network provider's network status is disclosed to the insured;

(iii) health care services rendered on an emergency basis or by an out-of-network provider that are necessary to provide immediate prophylaxis, diagnosis, or treatment for a disease that the department of public health has determined is dangerous to the public health pursuant to section 6 of chapter 111;

(iv) health care services rendered by an out-of-network provider, including an out-of-network laboratory, radiologist or pathologist, where the health care services were referred, or an insured's specimen was sent, by a participating provider to an out-of-network provider without the prior written consent of the insured acknowledging that the participating provider is referring the insured or sending the insured's specimen to an out-of-network provider, which may result in uncovered costs; and

(v) unforeseen health care services that arise at the time health care services are rendered that must necessarily be rendered by an out-of-network provider; provided, however,

that a surprise bill shall not mean a bill received by an insured for health care services when a participating provider is available and the insured knowingly, voluntarily, and specifically elects to obtain services from an out-of-network provider.

SECTION 142. Chapter 176O of the General Laws is hereby amended by striking out section 2 and inserting in place thereof the following section:-

Section 2. (a) There is hereby established within the division a bureau of managed care. The bureau shall by regulation establish minimum standards for the accreditation of carriers in the following areas:

(1) utilization review;

(2) quality management and improvement;

(3) credentialing;

(4) preventive health services; and

(5) compliance with sections 2 to 12, inclusive.

(b) In establishing the minimum standards, the bureau shall consult and use, where appropriate, standards established by national accreditation organizations. Notwithstanding the foregoing, the bureau shall not be bound by the standards established by such organizations; provided, however, that wherever the bureau promulgates standards different from the national standards, it shall:

(1) be subject to chapter 30A;

(2) state the reason for such variation; and

(3) take into consideration any projected compliance costs for such variation.

Accreditation by the bureau shall be valid for a period of 24 months. For the purposes of accreditation review in the area of pain management, the division shall consult with the health policy commission, established under chapter 6D, for assistance in determining appropriate standards for evidence-based pain management, including non-opioid pain management products and services, and shall publish guidelines to assist and evaluate carriers' development and submission of pain management access plans as required under clause (5) of the second sentence of subsection (a).

The bureau shall develop and implement standard credentialing forms for health care providers, and any entities acting for an insurance carrier under contract shall use the uniform form designated by the division for the health care provider. Six months after the full set of forms has been developed, every insurance carrier shall accept the standard credentialing form for contracting providers as sufficient information necessary to conduct its credentialing process.

In order to reduce health care costs and improve access to health care services, the bureau shall establish by regulation as a condition of accreditation that carriers use uniform standards and methodologies for credentialing of providers, including a health care provider type that is licensed under chapter 112 and that provides identical services. Such uniform standards and methodologies for credentialing of providers shall include but not be limited to the following requirements:

(i) An insurance carrier or any entity acting for an insurance carrier, when conducting a credentialing review of a health care provider, shall use and accept only the credentialing forms designated by the commissioner;

(ii) An insurance carrier or an entity acting for an insurance carrier, when conducting a credentialing review of a health care provider, shall review a submitted credentialing form for a health care provider and respond to the health care provider within 20 business days after receiving a completed credentialing request; and

(iii) Nothing in this section shall prohibit an insurance carrier or an entity acting for an insurance carrier, when conducting a credentialing review of a health care provider from using a credentialing methodology that utilizes an internet webpage, internet webpage portal or similar electronic, internet and web-based system in lieu of a paper form, provided that a carrier shall make a paper credentialing form available to a health care provide, upon request.

(c) Regulations promulgated by the bureau shall be consistent with and not duplicate or overlap with the regulations promulgated by the office of patient protection in the health policy commission established by section 16 of chapter 6D.

(d) A carrier that contracts with another entity to perform some or all of the functions governed by this chapter shall be responsible for ensuring compliance by the contracted entity with the provisions of this chapter. Any failure by the contracted entity to meet the requirements of this chapter shall be the responsibility of the carrier to remedy and shall subject the carrier to enforcement actions, including financial penalties, authorized under this chapter.

(e) A carrier that contracts with a pharmacy benefit manager shall (i) be responsible for coordinating an audit, at least once per year, of the operations of the pharmacy benefit manager to ensure compliance with the provisions of this chapter and to examine the pricing and rebates applicable to prescription drugs that are provided to the carrier’s covered persons; and (ii) require that the pharmacies with which the pharmacy benefit manager contracts have systems in place to

ensure that the insured, at the point of sale for any prescription, is charged the lower of: the applicable cost sharing amount under the terms of the insured's health benefit plan; the pharmacy benefits manager's contracted rate of payment to the pharmacy for the prescription drug; or the retail price of the prescription drug if purchased without insurance.

(f) A carrier may apply to the bureau for deemed accreditation status. A carrier may be deemed to be in compliance with the bureau's standards, and may be so accredited by the bureau, only if the carrier, or an entity with which it contracts: (1) is accredited by a national accreditation organization; (2) is in compliance with all of the requirements of this chapter; and (3) demonstrates compliance with, and has obtained the highest possible rating from the national accreditation organization for: (i) utilization review, (ii) quality management, and (iii) member rights and responsibilities, as promulgated by the bureau pursuant to this chapter. The bureau shall publish by regulation the highest possible rating level in each such category used by every national accreditation organization recognized by the bureau. Nothing in this subsection shall be construed to require a carrier, as a condition of certification, to be in compliance at the highest possible rating with each of the accreditation requirements of a national accreditation organization.

(g) A carrier which is not accredited by the bureau pursuant to this section, and is not otherwise exempt from accreditation, shall not offer for sale, provide or arrange for the provision of a defined set of health care services to insureds through affiliated and contracting providers or employ utilization review in making decisions about whether services are covered benefits under a health benefit plan.

(h) A carrier shall be exempt from accreditation if in the written opinion of the attorney general, the commissioner of insurance and the commissioner of public health, the health and safety of health care consumers would be materially jeopardized by requiring accreditation of the carrier. Before publishing such written exemption, the attorney general, the commissioner of insurance and the commissioner of public health shall jointly hold at least one public hearing at which testimony from interested parties on the subject of the exemption shall be solicited. A carrier granted such an exemption shall be provisionally accredited and, during such provisional accreditation, shall be subject to review not less than every 4 months and shall be subject to those requirements of this chapter as deemed appropriate by the commissioner of insurance.

(i) Nothing in this chapter shall relieve any carrier of its obligations pursuant to the applicable provisions of chapters 175, 176A, 176B, 176G and 176I. Compliance with such applicable provisions of chapter 175, 176A, 176B, 176G and 176I shall be a condition of accreditation.

SECTION 143. Subsection (a) of section 6 of said chapter 176O of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by striking out paragraph (4) and inserting in place thereof the following paragraph:-

(4) (a) a provider directory showing the locations where, and the manner in which, health care services and other benefits may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to an insured within the carrier's network, the carrier shall cover the out-of-network admission, procedure or service and the insured will not be billed for or responsible to pay more than the amount which would be required for similar admissions, procedures or services offered

within the carrier's network; (ii) an explanation that whenever a location is part of the carrier's network, that the carrier shall cover medically necessary covered benefits delivered at that location and the insured shall not be billed for or responsible to pay more than the amount required for network services even if part of the medically necessary covered benefits are performed by out-of-network providers unless the insured has a reasonable opportunity to choose to have the service performed by a network provider; and (iv) that out-of-network providers may not send surprise bills and if providers do that the insured may submit a complaint to the office of the attorney general for investigation according to in chapter 175H.

(b) A carrier shall ensure the accuracy of the information concerning each provider listed in the carrier's provider directories for each network plan and shall review and update the entire provider directory for each network plan in accordance with the provisions of this section. A carrier shall: (i) make the provider directory available to the public through electronic means and in a searchable format; (ii) ensure the general public is able to view all current health care providers for a network plan through a clearly identifiable link or tab; (iii) provide detail about medical or behavioral health specialty services regularly provided by the practitioner in their normal course of treatment, as defined within division guidance and (iv) not require the creation or use of an account, a policy or contract number, other identifying information, demonstration of coverage or an interest in obtaining coverage with the network plan in order to access the directory. A carrier shall update each electronic network plan provider directory not less than monthly; provided, however that the commissioner may require more frequent directory updates; provided further that the division may promulgate regulations that require electronic network plan provider directories to be updated more frequently than monthly when a plan is informed of and confirms:

(i) that a contracting provider is no longer accepting new patients for that network plan or an individual provider within a provider group is no longer accepting new patients;

(ii) that a provider or provider group is no longer under contract for a particular network plan;

(iii) that a provider's practice location, telephone number, e-mail or other information required under this section has changed;

(iv) that a provider has retired or otherwise has ceased to practice; or

(v) any other information that affects the content or accuracy of the provider directory or directories.

(c) A provider directory shall not list or include information on a provider who is not currently under contract with the network plan.

(d) A carrier shall regularly, and at least once every quarter, audit its provider directories for accuracy and retain documentation of the audit to be made available to the commissioner upon request. A carrier shall take steps to ensure all contracted providers promptly notify the carrier of any change to information needed by the carrier to maintain an accurate directory, up to and including removal of any provider who fails to do so from the carrier's provider directory.

(e) A carrier shall provide a print copy of the requested directory information or a print copy of a current provider directory upon request of an insured or a prospective insured by mail postmarked no later than 5 business days following the date of the request; provided, however, that the print copy of the provider directory or requested directory information provided by the

carrier may be limited to the geographic region in which the requester resides or works or intends to reside or work.

(f) The carrier shall include in both its electronic and print formats of the provider directory a dedicated customer service email address and telephone number or electronic link that insureds, providers and the general public may use to notify the carrier of inaccurate provider directory information. This information shall be displayed prominently in the directory and on the carrier's website. The carrier shall be required to investigate reports of inaccuracies within 30 days of receiving notice and modify the electronic provider directories in accordance with any findings within 30 days of such findings.

(g) A provider directory shall inform enrollees and potential enrollees that they are entitled to language interpreter services, at no cost to the enrollee, and full and equal access to covered benefits as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities and include a link to or information regarding available assistance for persons with limited English proficiency, including how to obtain interpretation and translation services.

(h) A carrier shall include a disclosure in the print format of a provider directory that the information included in the directory is accurate as of the date of printing and that an insured or prospective insured should consult the carrier's electronic provider directory on its website or call a specified customer service telephone number to obtain the most current provider directory information.

(i) A carrier shall update the print copies of the carrier's provider directory not less than annually; provided, however that the division may promulgate regulations requiring that the print copies of the provider directories be updated more frequently than annually.

(j) A carrier shall use a taxonomy of licensed behavioral health clinical specialties designated by the division. In designating the taxonomy, the division shall consider the recommendations of the commission created by section 102 of chapter 208 of the acts of 2018. The division shall review and update said taxonomy on an ongoing basis, as necessary.

SECTION 144. Said subsection (a) of said section 6 of said chapter 176O of the General Laws, as so appearing, is hereby further amended by striking out paragraph (8) and inserting in place thereof the following paragraph:-

(8) a summary description of the procedure, if any, for out-of-network referrals and any additional charge for utilizing out-of-network providers, and a description of the out-of-network consumer protections, including prohibition on surprise bills as detailed in this chapter.

SECTION 145. Section 9A of said chapter 176O of the General Laws, as so appearing, is hereby further amended by striking out subsection (a) and inserting in place thereof the following subsection:-

(a)(i) limits the ability of the carrier to introduce or modify a select network plan or tiered network plan by granting the health care provider a guaranteed right of participation; (ii) requires the carrier to place all members of a provider group, whether local practice groups or facilities, in the same tier of a tiered network plan; (iii) requires the carrier to include all members of a provider group, whether local practice groups or facilities, in a select network plan on an all-or-nothing basis.

SECTION 146. Section 23 of said chapter 176O of the General Laws, as so appearing, is hereby amended by inserting after the word “time”, in line 3, the following words:- “, the network status of an identified health care provider.”

SECTION 147. Subsection (a) of section 27(a) of Chapter 176O of the General Laws, as so appearing, is hereby amended by adding the following sentence:-

The common summary of payments form shall include a description of the out-of-network consumer protections, including for surprise bills, as detailed in this chapter.

SECTION 148. Said chapter 176O of the General Laws is hereby further amended by adding the following 3 sections:-

Section 28. (a) As used in this section, “facility fee” shall have the meaning as provided in section 51L of chapter 111.

(b) A carrier shall not provide reimbursement for a facility fee for a service for which a facility fee is prohibited pursuant to section 51L of chapter 111.

(c) Nothing in this section shall be construed to prohibit a carrier from restricting the reimbursement of facility fees beyond the limitations set forth in section 51L of chapter 111.

Section 29. (a) This section shall apply to the following circumstances involving an insured: (i) health care services rendered by an out-of-network provider for emergency medical conditions or any associated admission or care resulting from an emergency medical condition; or (ii) health care services that result in an insured receiving a surprise bill, as defined in section 1 of this chapter.

(b) If an insured receives health care services as set forth in subsection (a), the insured shall only be required to pay the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for such health care services if the services were rendered by a participating provider. Pursuant to subsection (g) of section 228 of chapter 111, the out-of-network provider shall not bill the insured in excess of such amount. Payments made by an insured pursuant to this section shall count towards any applicable deductible or out-of-pocket maximum pursuant to the terms and conditions of an insured's health benefit plan.

(c) If an insured receives health care services as set forth in subsection (a), benefits provided by a carrier that the insured receives for health care services shall be assigned to the out-of-network provider, which shall require no action on the part of the insured. Once the benefit is assigned as provided in this subsection, any payment paid by the carrier shall be paid directly to the out-of-network provider, and the carrier shall provide the out-of-network provider with a written remittance of payment that specifies the proposed payment and the amount of any applicable coinsurance, copayment, deductible or other out-of-pocket expense owed by the insured.

(d) When an out-of-network provider renders health care services to an insured pursuant to subsection (a):

(i) if the out-of-network provider contracts with a carrier to participate in the carrier's network but does not contract with the carrier for the specific health benefit plan in which an insured is enrolled, the carrier shall pay the out-of-network provider directly in the amount of one hundred percent of the contractually agreed-upon amount paid by the carrier, minus any member cost sharing in the form of the applicable coinsurance, copayment, aor deductible, for

health care services provided to an insured, or, if the out-of-network provider and carrier have more than one contract for health benefit plans, the carrier shall pay the out-of-network provider directly the average contractually agreed-upon amount, minus any member cost sharing in the form of the applicable coinsurance, copayment, or deductible, for health care services provided to an insured; or

(ii) if the out-of-network provider does not contract with a carrier to participate in any of the carrier's network plans, policies, contracts or other arrangements, the carrier shall pay the out-of-network provider directly the amount established by the division pursuant to subsection (e).

(e) The health policy commission, in consultation with the center for health information and analysis, shall recommend to the division a payment level equal to a percentage of the Medicare reimbursement rate, for out-of-network providers that do not contract with the insured's carrier, as defined in subsection (d)(ii), not later than one year following the effective date of subsection (d). In determining the appropriate payment level, the commission shall consider the impact of the payment level for out-of-network providers that do not contract with the insured's carrier on: (i) provider participation in insurance products, including tiered and limited network products; (ii) provider financial stability; (iii) provider price variation; and (iv) any other factors that the commission determines, in consultation with the center for health and information analysis, to be in the public interest. The commission shall hold hearings for public comment. The commission shall conduct a review and retain or revise the payment level for out-of-network providers that do not contract with the insured's carrier no less frequently than every 5 years. The division shall have the option within 30 days of receipt of the recommendation of the health policy commission to accept and implement the recommendation of the health policy

commission, or the division may reject the recommendation of the health policy division and implement its own payment level for out-of-network providers that do not contract with the insured's carrier, as defined in clause (ii) of subsection (d); provided, however, that if the division rejects the recommendation of the health policy commission, then the division shall, within 30 days of the division's rejection, report in writing to the clerks of the house of representatives and the senate, the senate and house committees on ways and means and the joint committee on health care financing the reasons for the division's rejection of the recommendation and its alternative decision. If the division takes no action to either accept or reject the recommendation of the health policy commission, then the recommendation of the health policy commission regarding the payment level for out-of-network providers that do not contract with the insured's carrier, as defined in clause (ii) of subsection (d), shall automatically take effect 30 days after receipt of the recommendation by the division.

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

(g) In a form and manner to be prescribed by the division, carriers shall indicate to insureds that the plan is subject to these provisions. In the case of self-funded health benefit

plans that elect to be subject to this section pursuant to subsection (f), the plan shall indicate to its members that it is self-funded and has elected to be subject to these provisions.

(h) The commissioner shall promulgate regulations to implement this section.

(i) This section shall not be construed to require a carrier to cover health care services not required by law or by the terms and conditions of an insured's health benefit plan.

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

(k) A violation of this section shall be an unfair trade practice under chapter 93A.

Section 30. The bureau of managed care shall develop and implement standard credentialing forms for health care providers, and any entities acting for an insurance carrier under contract shall use the uniform form designated by the division for the health care provider. Six months after the full set of forms has been developed, every insurance carrier shall accept the standard credentialing form for contracting providers as sufficient information necessary to conduct its credentialing process.

SECTION 149. Section 158 of chapter 224 of the acts of 2012 is hereby repealed.

SECTION 150. Sections 3A and 11 of chapter 115 of the acts of 2016 are hereby repealed.

SECTION 151. Notwithstanding any general or special law to the contrary, the secretary of administration and finance, following a public hearing, shall increase the fee for obtaining or renewing a license, certificate, registration, permit or authority issued by a board within the

department of public health, excluding the board of registration in medicine, as necessary to implement the provisions of the chapter 112A of the General Laws. The amount of the increase in fees shall be deposited in the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 152. No person shall be found to have violated section 292 of chapter 112 of the General Laws until 6 months after the board of registration of recovery coaches first issues an authorization to practice under said chapter 112.

SECTION 153. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Department", the department of public health.

"Division", the division of professional licensure.

"Transferring Boards", the board of registration of social workers, the board of registration of psychologists, the board of registration of allied mental health and human services professions, the board of allied health professions, the board of registration of dieticians and nutritionists, the board of registration in podiatry, the board of registration in optometry, the board of registration of dispensing opticians, the board of registration of chiropractors, the board of registration of speech-language pathology and audiology, and the board of registration of hearing instrument specialists.

(b) Notwithstanding any general or special law to the contrary, the division and the department shall develop and implement a transfer agreement providing for the orderly transfer

of personnel, proceeds, rules and regulations, property and legal obligations and functions of the transferring boards from the division to the department.

(c) All petitions, requests, investigations, filings and other proceedings appropriately and duly brought before, or pending before, the transferring boards, before the transfer, shall continue unabated and remain in force, and shall be assumed and completed by the transferring boards after transfer to the department.

(d) All orders, advisories, findings, rules and regulations duly made and all approvals duly granted by the transferring boards, which are in force immediately before the transfer, shall continue in force and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in accordance with law, by the transferring boards after transfer to the department.

(e) All books, papers, records, documents, equipment, cash and other property, both personal and real, including all such property held in trust, which immediately before the transfer are in the custody of the transferring board or the division on behalf of the transferring board, shall be transferred to the department.

(f) All duly existing contracts, leases and obligations of the transferring boards, shall continue in effect after transfer to the department. No such existing right or remedy of any character shall be lost, impaired or affected by this act.

(g) In consultation with the secretary of administration and finance, the department and the division, in developing the transfer agreement required under subsection (b), shall identify the portion of unexpended balances of the Division of Professional Licensure Trust Fund established in section 35V of chapter 10 that are allocated to the operations of the transferring boards, including but not limited to payment of salaries, wages, fringe and indirect costs, and all

compensation for those employees identified in subsection (i); administrative expenses; information technology expenses; and indirect expenses. Notwithstanding any general or special law to the contrary, upon transfer of the transferring boards, the comptroller shall transfer such portion of the unexpended balances of the Division of Professional Licensure Trust Fund established in section 35V of chapter 10 of the General Laws to the Quality in Health Professions Trust Fund established in section 35X of chapter 10 of the General Laws.

(h) The comptroller shall take the overall cash flow needs of the commonwealth into consideration in determining the timing of any transfer of funds provided for in subsection (g). The comptroller shall provide a schedule of transfers to the secretary of administration and finance and to the chairs of the house and senate committees on ways and means.

(i) The transfer agreement required under subsection (b) shall identify the number of allocated employees of the division, rounded to the nearest full time employee equivalent, who are engaged in the work of the transferring boards, in whole or in part, including but not limited to licensing functions, investigation, prosecution and adjudication. Notwithstanding any general or special law to the contrary, an equivalent number of division employees shall become employees of the department upon the execution of the transfer agreement required under subsection (b) or 18 months from the effective date of this act, whichever occurs first. The employees selected to transfer from the division to the department shall have been engaged in the work of the transferring boards, in whole or in part, prior to the transfer.

All officers and employees of the division transferred to the department as required under subsection (i) shall be transferred without impairment of seniority, retirement or other statutory rights of employees, without loss of accrued rights to holidays, sick leave, vacation and other

benefits, and without change in union representation or certified collective bargaining unit as certified by the state labor relations commission or in local union representation or affiliation, except as otherwise provided in this act. Terms of service of employees of the program shall not be deemed to be interrupted by virtue of transfer to the department.

Nothing in this section shall be construed to confer upon any employee of the division transferred to the department as required under subsection (i) any right not held immediately before the date of said transfer or to prohibit any reduction of salary grade, transfer, reassignment, suspension, discharge, layoff or abolition of position not prohibited before such date.

(j) Notwithstanding any general or special law to the contrary, the terms and conditions of any collective bargaining agreement that is in effect upon the transfer with respect to employees of the division transferred to the department as required under subsection (i) shall continue in effect until the stated expiration date of such agreement, at which point the agreement shall expire; provided, however, that all such employees shall continue to retain their right to collectively bargain under chapter 150E of the General Laws and shall be considered employees of the department.

SECTION 154. Sections 21 to 22, 24 to 31, 69, 71 to 73, 84 to 87, 91, 93, 101 to 108 and 153, inclusive, shall take effect upon the execution of a transfer agreement between the department of public health and the division of professional licensure or 18 months after the effective date of this act, whichever occurs first.

SECTION 155. Section 30 of chapter 32A of the General Laws, as inserted by section 35, and sections 10, 12, 35, 64, 121 to 122, 125, 129, 131, 133 and 149 shall take effect January 1, 2021.

SECTION 156. Chapter 63C of the General Laws, as inserted by section 37, shall apply to all sales commencing on or after a date 6 months after the effective date of this act. The commissioner of revenue shall issue regulations or other guidance regarding the timing of returns required under said chapter 63C, as so inserted, not later than 6 months after the effective date of this act.

SECTION 157. Chapter 63D of the General Laws, as inserted by section 37, shall apply to sales commencing on or after the effective date of this act. The commissioner of revenue shall issue regulations or other guidance regarding the reporting and payment of the penalty as soon as practicable after the effective date of this act.

SECTION 158. The commissioner of insurance shall promulgate regulations to implement chapter 175N of the General Laws, as inserted by section 127, not later than 1 year after the effective date of this act.

SECTION 159. Section 60 and clause (ii) of subsection (e) of section 2 of chapter 176O of the General Laws, as inserted by section 142, shall take effect on July 1, 2021.

SECTION 160. Sections 134 to 135, 137 and 145 shall take effect 6 months after the effective date of this act.