HOUSE . . . . . No. 4866

Text of a further amendment, offered by Ms. Garlick of Needham, to the Senate amendment (striking out all after the enacting clause and inserting in place thereof the text contained in Senate document numbered 2623, amended) of the House Bill for prevention and access to appropriate care and treatment of addiction (House, No. 4742). July 31, 2018.

The Commonwealth of Massachusetts

In the One Hundred and Ninetieth General Court
(2017-2018)

By striking out all after the enacting clause and inserting in place thereof the following:–

SECTION 1. Chapter 6 of the General Laws is hereby amended by adding the following section:-

Section 219. (a) There shall be a commission on community behavioral health promotion and prevention located within, but not subject to the control of, the executive office of health and human services. The commission shall work to promote positive mental, emotional and behavioral health and early intervention for persons with a mental illness, and to prevent substance use disorders among residents of the commonwealth.

(b)(1) The commission shall consist of 21 members, as follows: the secretary of health and human services or a designee, who shall serve as the chair; the commissioner of mental health or a designee; the commissioner of public health or a designee; the chief justice of the trial court or a designee; the director of the center for health information and analysis or a designee; the house chair of the joint committee on mental health, substance use and recovery; the senate chair of the joint committee on mental health, substance use and recovery; 1 person appointed by

the speaker of the house; 1 person appointed by the senate president; 1 person appointed by the house minority leader; 1 person appointed by the senate minority leader; and 1 representative from each of the following 10 organizations: the Association for Behavioral Healthcare, Inc.; the Massachusetts Association of Community Health Workers, Inc.; the Massachusetts Association for Mental Health, Inc.; the Massachusetts Organization for Addiction Recovery, Inc.; the Massachusetts Public Health Association; the Massachusetts Society for the Prevention of Cruelty to Children; the National Alliance on Mental Illness of Massachusetts, Inc.; the Social-Emotional Learning Alliance for Massachusetts, Inc.; the Freedman Center at William James College; and the Massachusetts chapter of the National Association of Social Workers, Inc.

(2) Members of the commission shall serve for a term of 4 years, without compensation. Any member shall be eligible for reappointment. Vacancies shall be filled in accordance with paragraph (1) for the remainder of the unexpired term. Any member who is appointed by the governor may be removed by the governor for cause.

(c) The commission may establish advisory committees to assist its work.

(d) The commission shall:

(1) promote an understanding of: (i) the science of prevention; (ii) population health; (iii) risk and protective factors; (iv) social determinants of health; (v) evidence-based programming and policymaking; (vi) health equity; and (vii) trauma-informed care; provided that the commission may use, as a guide for its work, the recommendations of the report of the special commission on behavioral health promotion and upstream prevention established pursuant to section 193 of chapter 133 of the acts of 2016;

(2) consult with the secretary of health and human services on grants from the community behavioral health promotion and prevention trust fund established in section 35EEE of chapter 10;

(3) collaborate, as appropriate, with other active state commissions, including but not limited to the safe and supportive schools commission, the Ellen Story commission on postpartum depression and the commission on autism;

(4) make recommendations to the legislature that: (i) promote behavioral health and prevention issues at the universal, selective and indicated levels; (ii) strengthen community or state-level promotion and prevention systems; advance the identification, selection and funding of evidence-based programs, practices or systems designed to promote behavioral health and early intervention for persons with a mental illness and to prevent substance use disorders; and (iv) reduce healthcare and other public costs through evidence-based promotion and prevention; provided that the commission may use state and local prevalence and cost data to ensure commission recommendations are data-informed and address risks at the universal, selective and indicated levels of prevention;

(5) hold public hearings and meetings to accept comment from the general public and to seek advice from experts, including, but not limited to, those in the fields of neuroscience, public health, behavioral health, education and prevention science; and

(6) submit an annual report to the legislature as provided in subsection (e) on the state of preventing substance use disorder and promoting behavioral health in the commonwealth.

(e) Annually, not later than March 1, the commission shall file a report with the joint committee on health care financing and the joint committee on mental health, substance use and

recovery on its activities and any recommendations. The commission shall monitor the implementation of its recommendations and update recommendations to reflect current science and evidence-based practices.

SECTION 2. Section 16R of chapter 6A of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the first paragraph the following paragraph:-

If, after 14 days from the date that the team determines which services a child is eligible for, the team is unable to reach a consensus on the responsibility of payment, and the child is unable to access those services because of disagreement about responsibility for payment among state agencies and local education agencies, the child advocate shall be notified and shall have the authority to impose a binding temporary cost share agreement on those state agencies and local education agencies. The cost share agreement shall remain in effect until the child advocate is informed in writing of a permanent cost share or payment agreement having been implemented or until the child no longer qualifies for the services.

SECTION 3. Said chapter 6A is hereby further amended by inserting after section 16Z the following 2 sections:-

Section 16AA. (a) Subject to appropriation, the executive office of health and human services shall develop and implement a statewide program to provide remote consultations not less than 5 days a week to primary care practices, nurse practitioners and other health care providers who are providing care for persons who are over the age of 17 and are experiencing chronic pain; provided, however, that the remote consultations shall include, but not be limited

to, support for screening, diagnosis, pain management strategies, pharmacological and non-pharmacological treatments and referrals for chronic pain.

(b) Expenditures by the executive office of health and human services that are for the program and related to services provided on behalf of commercially-insured clients may be assessed by the secretary of health and human services on surcharge payors, as defined in section 64 of chapter 118E.

Section 16BB. (a) Subject to appropriation, the executive office of health and human services shall develop and implement a statewide program to provide remote consultations available for not less than 5 days a week to primary care practices, nurse practitioners and other health care providers for persons over the age of 17 who exhibit symptoms of a substance use disorder. Consultation services shall include, but not be limited to, support of screening, diagnosis, treatment, other interventions and referrals for substance use disorder.

(b) Expenditures by the executive office of health and human services that for the program are related to services provided on behalf of commercially-insured clients may be assessed by the secretary of health and human services on surcharge payors, as defined in section 64 of chapter 118E.

SECTION 4. Section 15 of chapter 6D of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the word “abuse”, in line 65, the following words:- ; pain management, including non-opioid and non-pharmaceutical pain management.

SECTION 5. Said section 15 of said chapter 6D, as so appearing, is hereby further amended by inserting after the word “illnesses”, in line 91, the following words:- , including chronic pain,.

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

Section 19. Subject to appropriation, the health policy commission, in consultation with the department of public health, shall create and administer an early childhood investment opportunity grant program for programs to support and care for families with substance exposed newborns, including the study of long-term effects of neonatal abstinence syndrome on children up to the age of 18. The program shall support a model that includes both medical services and traditionally non-reimbursed services and may support services provided in clinic settings or in-home visits. The commission shall report to the joint committee on mental health, substance use and recovery and the house and senate committees on ways and means not later than 12 months following completion of the grant program on the results of the programs and the findings of the study on the long-term effects of neonatal abstinence syndrome, including their effectiveness, efficiency, and sustainability.

SECTION 7. Chapter 10 of the General Laws is hereby amended by inserting after section 35FFF, inserted by section 1 of chapter 91 of the acts of 2018, the following section:-

Section 35GGG. (a) There shall be established and set up on the books of the commonwealth a Community Behavioral Health Promotion and Prevention Trust Fund. The purpose of the fund shall be to promote positive mental, emotional and behavioral health among children and young adults and to prevent substance use disorders among children and young adults.

(b) The fund shall be administered by the secretary of health and human services who, in consultation with the community behavioral health promotion and prevention commission

established in section 219 of chapter 6, shall issue grants from the fund to community organizations to establish or support evidence-based and evidence-informed programs for children and young adults. The community organizations may include, but not be limited to, public and private agencies, community coalitions and other entities that offer resources or support to children or young adults. A community organization or coalition may include more than one community.

(c) The secretary of health and human services shall establish application procedures and evidence-based and evidence-informed criteria upon which to base approval or disapproval of a proposal for a grant under this section. The criteria may include, but are not limited to, the following:

(i) programs that educate children and young adults on addiction, substance misuse and other risky behaviors and that identify and support children and young adults at risk for alcohol or substance misuse; (ii) programs that use evidence-based or evidence-informed prevention programs, early detection protocols and policies, risk assessment tools or counseling in a community setting; (iii) support for underserved populations of children and young adults including, but not limited to, children with multiple adverse childhood experiences; (iv) programs that offer culturally and linguistically competent services that meet the needs of the population to be served; and (v) programs that employ the science of prevention, including, but not limited to, consideration of population health, risk and protective factors, social determinants of health, health equity, adverse childhood experiences and trauma-informed care.

(d) The secretary may use the fund for necessary and reasonable administrative and personnel costs related to administering the grants, including providing funds to the department

of public health to provide technical assistance, training and guidance to support applicants in completing grant applications and to grantees to develop and evaluate programs. Expenditures made pursuant to this subsection may not exceed, in 1 fiscal year, 5 per cent of the total amount deposited into the fund during that fiscal year. The fund shall consist of revenue from appropriations or other money authorized by the general court and specifically designated to be credited to the fund and revenue from private sources including, but not limited to, grants, gifts and donations received by the commonwealth that are specifically designated to be credited to the fund. Amounts credited to the fund shall not be subject to further appropriation and any money remaining in the fund at the end of a fiscal year shall not revert to the General Fund and shall be available for expenditure in subsequent fiscal years.

(e) Annually, not later than March 1, the secretary shall file a report on its activities with the joint committee on health care financing and the joint committee on mental health, substance use and recovery.

SECTION 8. Section 21A of chapter 12C of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the words “mental health”, in line 2, the following words:- , chronic pain.

SECTION 9. Section 13 of chapter 13 of the General Laws, as so appearing, is hereby amended by striking out, in line 6, the words “9 registered nurses; 4” and inserting in place thereof the following words:- 11 registered nurses; 2.

SECTION 10. Subsection (c) of said section 13 of said chapter 13, as so appearing, is hereby amended by striking out clause (1) and inserting in place thereof the following clause:-

(1) 3 representatives with expertise in nursing education whose graduates are eligible to write nursing licensure examinations, including 1 representative from pre-licensure level, 1 representative from graduate level and 1 representative from post-graduate level; provided, that none of these 3 representatives shall be from the same institution;

SECTION 11. Said subsection (c) of said section 13 of said chapter 13, as so appearing, is hereby further amended by striking out clause (4) and inserting in place thereof the following 4 clauses:-

(4) 2 registered nurses not authorized in advanced nursing practice and who provide direct patient care;

(5) 1 registered nurse currently providing direct care to patients with a substance use disorder;

(6) 1 registered nurse currently providing direct care to patients in an outpatient, community-based, behavioral health setting; and

(7) 1 registered nurse currently providing direct care to patients living with chronic pain.

SECTION 12. Said section 13 of said chapter 13, as so appearing, is hereby amended by striking out subsection (d) and inserting in place thereof the following subsection:-

(d) Licensed practical nurse board members shall include representatives from at least 2 of the following 3 settings: long-term care, acute care, and community health settings.

SECTION 13. Section 2 of chapter 18C of the General Laws, as so appearing, is hereby amended by striking out, in line 14, the word “and”.

SECTION 14. Said section 2 of said chapter 18C, as so appearing, is hereby further amended by inserting after the word “families”, in line 17, the following words:-

; and

(e) impose temporary cost share agreements, as necessary pursuant to section 16R of chapter 6A to ensure children’s timely access to services.

SECTION 15. Section 19 of chapter 19 of the General Laws, as so appearing, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

(a) The department shall issue for a term of 2 years, and may renew for like terms, a license, subject to revocation by the department for cause, to any private, county or municipal facility or department or unit of any such facility that: (i) offers to the public inpatient psychiatric, residential or day care services; (ii) is represented as providing treatment of persons with a mental illness; and (iii) meets the department’s applicable licensure standards and requirements, set forth in regulations of the department; provided, however, that: (1) the department may issue a license to those facilities, departments or units providing care but not treatment of persons with a mental illness; and (2) licensing by the department shall not be required where such residential or day care treatment is provided within an institution or facility licensed by the department of public health pursuant to chapter 111, unless such services are provided on an involuntary basis. Whether or not a license is issued under clause (1), the department shall make regulations for the operation of such facilities, departments or units. The department may issue a provisional license to a facility, department or unit that has not previously operated, or is operating but is temporarily unable to meet applicable standards and requirements. No original license shall be issued to establish or maintain a facility, department or

unit subject to licensure under this section, unless there is determination by the department, in accordance with its regulations, that there is need for such a facility, department or unit, as described in subsection (c). The department may grant the type of license that it deems suitable for the facility, department or unit. The department shall fix reasonable fees for licenses and renewal of licenses. In order to be licensed by the department under this section, a facility, department or unit shall provide services to commonwealth residents with public health insurance on a non-discriminatory basis and shall report the facility's payer mix to the department on a quarterly basis.

SECTION 16. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out, in line 20, the word "ward" and inserting in place thereof the following word:- unit.

SECTION 17. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out subsection (c) and inserting in place thereof the following subsection:-

(c) Each facility, department or unit licensed by the department shall be subject to supervision, visitation and inspection by the department. The department shall inspect each facility, department or unit prior to granting or renewing a license pursuant to this section. The department shall establish regulations to administer licensing standards and to provide operational standards for such facilities, departments or units, including, but not limited to, the standards or criteria that an applicant shall meet to demonstrate the need for an original license; provided, however, that those standards or criteria shall be reviewed by the department every 2 years and shall be limited to: (i) the health needs of persons with a mental illness in the commonwealth, including underserved populations and persons with co-occurring mental illness

and substance use disorder; and (ii) the demonstrated ability and history of a prospective licensee to meet the needs of those persons.

The regulations promulgated by the department pursuant to this section shall provide that no facility, department or unit shall discriminate against an individual, qualified within the scope of the individual's license, when considering or acting on an application of a licensed independent clinical social worker for staff membership or clinical privileges. The regulations shall further provide that each application shall be considered solely on the basis of the applicant's education, training, current competence and experience. Each facility, department or unit shall establish, in consultation with the director of social work or, if none, a consulting licensed independent clinical social worker, the specific standards, criteria and procedures to admit an applicant for staff membership and clinical privileges. Such standards shall be available to the department upon request.

SECTION 18. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out, in line 44, the word "ward" and inserting in place thereof the following words:- unit, including the denial or conditional issuance of an original license if an application does not meet the department's standards or criteria for demonstrating need, as described in subsection (c).

SECTION 19. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out subsections (e) to (g), inclusive, and inserting in place there of the following 5 subsections:-

(e) The department may conduct surveys and investigations to enforce compliance with this section and any rule or regulation promulgated pursuant to this section. The department may

examine the books and accounts of any facility, department or unit if it deems such examination necessary for the purposes of this section. If upon inspection or through information in its possession, the department finds that a facility, department or unit licensed by the department is not in compliance with a requirement established under this section, the department may order the facility, department or unit to correct the deficiency by providing the facility, department or unit a deficiency notice in writing of each deficiency. The notice shall specify a reasonable time, not more than 60 days after receipt of the notice, by which time the facility, department or unit shall remedy or correct each deficiency cited in the notice; provided, however, that in the case of a deficiency which, in the opinion of the department, is not capable of correction within 60 days, the department shall require that the facility, department or unit submit a written plan for correction of the deficiency in a reasonable manner. The department may modify a nonconforming written plan for correction upon notice in writing to the facility, department or unit. Not more than 7 days after the receipt of notice of such a modification of a written plan for correction, the affected facility, department or unit may file a written request with the department for administrative reconsideration of the modified plan for correction or any portion thereof.

Nothing in this section shall be construed to prohibit the department from enforcing a rule, regulation, deficiency notice or plan for correction, administratively or in court, without first affording formal opportunity to make correction, or to seek administrative reconsideration under this section, where, in the opinion of the department, the violation of such rule, regulation, deficiency notice or plan for correction jeopardizes the health or safety of patients or the public or seriously limits the capacity of a facility, department or unit to provide adequate care, or where the violation of such rule, regulation, deficiency notice or plan for correction is the second or subsequent such violation occurring during a period of 12 months.

If a facility, department or unit fails to remedy or correct a cited deficiency by the date specified in the written deficiency notice or fails to remedy or correct a cited deficiency by the date specified in a plan for correction, as accepted or modified by the department, the department may: (i) suspend, limit, restrict or revoke the license of the facility, department or unit; (ii) impose a civil fine upon the facility, department or unit; (iii) pursue any other sanction as the department may impose administratively upon the facility, department or unit; or (iv) impose any combination of the penalties set forth in clauses (i) to (iii), inclusive, of this paragraph. A civil fine imposed pursuant to this subsection shall not exceed $1,000 per deficiency for each day the deficiency continues to exist beyond the date prescribed for correction.

(f) No facility, department or unit, for which a license is required under subsection (a), shall provide inpatient psychiatric, residential or day care services for the treatment or care of persons with a mental illness, unless it has obtained a license under this section. The superior court sitting in equity shall have jurisdiction, upon petition of the department, to restrain any violation of this section or to take such other action as equity and justice may require. Whoever violates this section shall be punished for the first offense by a fine of not more than $500 and for subsequent offenses by a fine of not more than $1,000 or by imprisonment for not more than 2 years, or both.

(g) No patient at a facility, department or unit subject to licensure under this section shall be commercially exploited. No patient shall be photographed, interviewed or exposed to public view without the express written consent of the patient or the patient’s legal guardian.

(h) Notwithstanding subsections (a) to (g), inclusive, a child care center, family child care home, family child care system, family foster care or group care facility, as defined in section 1A of chapter 15D, shall not be subject to this section.

(i) As used in this section, "original license" shall mean a license, including a provisional license, issued to a facility, department or unit not previously licensed, or a license issued to an existing facility, department or unit in which there has been a change in ownership or location or a change in class of license or specialized service as provided in regulations of the department.

SECTION 20. Said chapter 19 is hereby further amended by adding the following section:-

Section 25. (a) Subject to appropriation, within the department of mental health, there shall be a center for police training in crisis intervention, in this section hereinafter referred to as the center. The center shall serve as a source for cost-effective, evidence-based mental health and substance use crisis response training programs for municipal police and other public safety personnel throughout the commonwealth. The center shall conduct activities as the advisory council, pursuant to subsection (e), directs, which shall include: (i) supporting the establishment and availability of community policing and behavioral health training curricula for law enforcement personnel, particularly in interventions that provide alternatives to arrest and incarceration; (ii) serving as a clearinghouse for best practices in police interactions with individuals suffering from mental illness and substance use disorders; (iii) developing and implementing crisis intervention training curricula for all veteran and new recruit officers; (iv) providing technical assistance to cities and towns by establishing collaborative partnerships

between law enforcement and human services providers that maximize referrals to treatment services; and (v) establishing metrics for success and evaluation of outcomes of these programs.

(b) The center shall be funded with revenue from appropriations or other money authorized by the general court and specifically credited to the center, and revenue from private sources including, but not limited to, grants, both state and federal, gifts and donations received by the commonwealth that are specifically credited to the center.

(c)(1) The center shall: (i) establish regional training opportunities for municipal police as needed throughout the commonwealth; (ii) develop and maintain curricula that is updated with the latest research on best practices in community policing and behavioral health; (iii) recruit, reimburse and support trainers with experience in community policing and behavioral health crisis intervention; (iv) ensure the training is targeted to meet specific local needs of participating cities and towns and the commonwealth; (v) support police departments in implementing improved behavioral health responses through responsive policies and procedures and partnerships with community behavioral health providers; (vi) assist municipal police departments to cover backfill costs incurred in sending staff to training, provided that said reimbursement shall not exceed the actual cost of the sending department's backfill; and (vii) stipulate that each municipal police department receiving reimbursement provide information necessary for the center to evaluate the goals described in subsection (c)(3), including the percentage of the municipality's police sergeants, lieutenants and other officers who directly oversee patrol officers who have received the center's recommended training and the percentage of the municipality's patrol officers who have received the center's recommended training.

(2) Training shall include, but not be limited to, information on: (i) the signs and symptoms of mental illnesses and substance misuse; (ii) mental health treatment; (iii) co-occurring disorders; (iv) responding to a mental health or substance use crisis; (v) best practices and (vi) community policing principles.

(3) The center shall develop and ensure sufficient training resources and opportunities to enable each municipality in the commonwealth to obtain the center's recommended training for not less than 25 per cent of their police sergeants, lieutenants and other officers who directly oversee patrol officers, and not less than 50 per cent of their patrol officers within a time determined by the community policing and behavioral health advisory council as described in subsection (e).

(d) The center shall publish an annual report including: (i) narrative and statistical information about training demand, delivery, cost and identified service gaps during the prior year; (ii) the effectiveness of the services delivered during the prior year; (iii) the communities that participated in the training; (iv) the number of officers, and their ranks, that participated in the training; (v) the progress each municipality has made in reaching the goals described in subsection (c)(3), including the percentage of each municipality's police sergeants, lieutenants and other officers who directly oversee patrol officers who have received the center's recommended training, and the percentage of each municipality's patrol officers who have received the center's recommended training; and (vi) a review of research analyzed or conducted during the prior year. The center shall submit the annual report not later than February 1 to the governor, the secretary of health and human services, the commissioner of mental health, the secretary of public safety and security, the clerks of the house of representatives and the senate ,

the joint committee on mental health, substance use and recovery, the joint committee on public safety and homeland security and the house and senate committees on ways and means.

(e) There shall be a community policing and behavioral health advisory council, in this section called the council, consisting of 11 members: the secretary of health and human services or the secretary's designee, and the secretary of public safety and security or the secretary's designee who shall serve as co-chairs of the council; the commissioner of the department of mental health or the commissioner's designee; the commissioner of the department of public health or the commissioner's designee; the executive director of the municipal police training committee or the director's designee; a representative of a mental health consumer advocacy group, as appointed by the secretary of health and human services; 2 community members who are consumers of behavioral health services, appointed by the secretary of health and human services; and 3 municipal police chiefs or commanding officers to be selected by the executive director of the Massachusetts Chiefs of Police Association, which shall include 1 police chief or commanding officer employed by a community with fewer than 10,000 residents; 1 police chief or commanding officer employed by a community with 10,000 or more residents and fewer than 60,000 residents; and 1 police chief or commanding officer employed by a community with 60,000 or more residents. Members of the council shall be appointed for a term of 3 years, and may be reappointed for consecutive 3-year terms. Each member shall be reimbursed by the commonwealth for all expenses incurred in the performance of their official duties.

The council shall advise the chairs in directing the activities of the center consistent with subsection (c), and shall receive ongoing reports from the center concerning its activities. The council shall solicit public comment in the area of community policing and behavioral health, and in so doing may convene public hearings throughout the commonwealth. The council shall

hold not less than 2 meetings per year and may convene special meetings at the call of the chair or a majority of the council.

SECTION 21. Subsection (a) of section 2RRRR of chapter 29 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the second sentence the following sentence:- A sheriff of a house of correction that contracts with the department of public health may also participate in the program; provided, however, that such participation shall be pursuant to terms that the department may establish for such contract.

SECTION 22. Section 17M of chapter 32A of the General Laws, as so appearing, is hereby amended by striking out, in line 3, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 23. Section 17N of said chapter 32A, as so appearing, is hereby amended by striking out, in line 31, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 24. Said chapter 32A is hereby further amended by inserting after section 17O the following 2 sections:-

Section 17P. The commission shall provide, to an active or retired employee of the commonwealth who is insured under the group insurance commission, for any covered drug that is a narcotic substance contained in schedule II pursuant to chapter 94C and subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, that person shall not be subject to an additional payment obligation, including but not limited to co-payments, if that person fills the remaining portion of the prescription.

Section 17Q. (a) The commission shall develop a plan to provide active or retired employees adequate coverage and access to a broad spectrum of pain management services, including, but not limited to, those that serve as alternatives to opioid prescribing, in accordance with guidelines developed by the division of insurance.

(b) The plan shall be subject to review by the division of insurance. In its review, the division shall consider the adequacy of access to a broad spectrum of pain management services and any carrier policies that may create unduly preferential coverage to prescribing opioids without other pain management modalities.

(c) The commission shall distribute educational materials to providers within their networks about the pain management access plan and make information about its plan publicly available on its website.

SECTION 25. Section 97 of chapter 71 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the word “law”, in line 27, the following words:-; provided, however, that the screening required under this section shall be implemented in accordance with applicable state and federal laws and regulations pertaining to student confidentiality, including rules and regulations promulgated pursuant to section 34D.

SECTION 26. Section 1 of chapter 94C of the General Laws so, is hereby amended by inserting after the definition of “Drug paraphernalia”, as so appearing, the following definition:-

“Electronic prescription”, a lawful order from a practitioner for a drug or device for a specific patient that is generated on an electronic prescribing system that meets federal requirements for electronic prescriptions for controlled substances, and is transmitted electronically to a pharmacy designated by the patient without alteration of the prescription

information, except that third-party intermediaries may act as conduits to route the prescription from the prescriber to the pharmacist; provided however, that electronic prescription shall not include an order for medication, which is dispensed for immediate administration to the ultimate user; and provided further, that the electronic prescription shall be received by the pharmacy on an electronic system that meets federal requirements for electronic prescriptions. For the purposes of this chapter, a prescription generated on an electronic system that is printed out or transmitted via facsimile is not considered an electronic prescription.

SECTION 27. Section 8 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “oral”, in line 60, the following word:- , electronic.

SECTION 28. Section 17 of said chapter 94C, as so appearing, is hereby amended by striking out, in line 2, the words “the written prescription of” and inserting in place thereof the following words:- an electronic prescription from.

SECTION 29. Said section 17 of said chapter 94C, as so appearing, is hereby further amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) In emergency situations, as defined by the commissioner, a schedule II, III, IV, V or VI substance may be dispensed upon written prescription or oral prescription in accordance with section 20 and related regulations.

SECTION 30. Said section 17 of said chapter 94C, as so appearing, is hereby further amended by striking out, in line 11, the words “a written or oral prescription of” and inserting in place thereof the following words:- an electronic prescription from.

SECTION 31. Section 18 of said chapter 94C is hereby amended by striking out subsection (d¾), as so appearing, and inserting in place thereof the following subsection:-

(d¾) A pharmacist filling a prescription for a schedule II substance shall, if requested by the patient, dispense the prescribed substance in a lesser quantity than indicated on the prescription. The remaining portion may be filled upon patient request in accordance with federal law; provided, however, that only the same pharmacy that originally dispensed the lesser quantity shall dispense the remaining portion. Upon an initial partial dispensing of a prescription or a subsequent dispensing of a remaining portion, the pharmacist or the pharmacist's designee shall make a notation in the patient's record maintained by the pharmacy, which shall be accessible to the prescribing practitioner by request, indicating that the prescription was partially filled and the quantity dispensed. The initial partial dispensing of a prescription filled pursuant to subsection (d) or (d1/2) shall be filled not more than 5 days after the prescription issue date. The remaining portion filled pursuant to this subsection must be filled not later than 30 days after the prescription issue date.

SECTION 32. Said chapter 94C is hereby further amended by striking out section 19B and inserting in place thereof the following 2 sections:-

Section 19B. (a) As used in this section and unless the context clearly requires otherwise, "opioid antagonist" shall mean naloxone or any other drug approved by the federal Food and Drug Administration as a competitive narcotic antagonist used in the reversal of overdoses caused by opioids.

(b) The department shall ensure that a statewide standing order is issued to authorize the dispensing of an opioid antagonist in the commonwealth by any licensed pharmacist. The

statewide standing order shall include, but not be limited to, written, standardized procedures or protocols for the dispensing of an opioid antagonist by a licensed pharmacist. Notwithstanding any general or special law to the contrary, the commissioner, or a physician who is designated by the commissioner and is registered to distribute or dispense a controlled substance in the course of professional practice under section 7, may issue a statewide standing order that may be used for a licensed pharmacist to dispense an opioid antagonist under this section.

(c) Notwithstanding any general or special law to the contrary, a licensed pharmacist may dispense an opioid antagonist in accordance with the statewide standing order issued under subsection (b). Except for an act of gross negligence or willful misconduct, a pharmacist who, acting in good faith, dispenses an opioid antagonist shall not be subject to any criminal or civil liability or any professional disciplinary action by the board of registration in pharmacy related to the use or administration of an opioid antagonist.

(d) A pharmacist who dispenses an opioid antagonist shall annually report to the department the number of opioid antagonist doses dispensed. Reports shall not identify an individual patient, shall be confidential and shall not constitute a public record as defined in clause Twenty-sixth of section 7 of chapter 4. The department shall publish an annual report that includes aggregate information about the dispensing of opioid antagonists in the commonwealth.

(e) A pharmacist or designee who dispenses an opioid antagonist pursuant to this section shall, for the purposes of health insurance billing and cost-sharing, treat the transaction as the dispensing of a prescription to the person purchasing the opioid antagonist regardless of the ultimate user of the opioid antagonist. Unless the person purchasing the opioid antagonist requests to pay for the prescription out-of-pocket, the pharmacist or designee shall make a

reasonable effort to identify the purchaser's insurance coverage and to submit a claim for the opioid antagonist to the insurance carrier prior to dispensing the opioid antagonist.

(f) Except for an act of gross negligence or willful misconduct, the commissioner or a physician who issues the statewide standing order under subsection (b) and any practitioner who, acting in good faith, directly or through the standing order, prescribes or dispenses an opioid antagonist shall not be subject to any criminal or civil liability or any professional disciplinary action.

(g) A person acting in good faith may receive a prescription for an opioid antagonist, possess an opioid antagonist and administer an opioid antagonist to an individual appearing to experience an opioid-related overdose. A person who, acting in good faith, administers an opioid antagonist to an individual appearing to experience an opioid-related overdose shall not, as a result of the person's acts or omissions, be subject to any criminal or civil liability or any professional disciplinary action. The immunity established under section 34A shall also apply to a person administering an opioid antagonist pursuant to this section.

(h) The department, the board of registration in medicine and the board of registration in pharmacy shall adopt regulations to implement this section.

Section 19B½. Notwithstanding any special or general law to the contrary, a municipality or non-municipal public agency that is duly registered pursuant to subsection (g) of section 7 may convey or exchange naloxone or another opioid antagonist approved by the department to or with another duly registered entity to ensure the availability and use of unexpired naloxone or other approved opioid antagonist; provided, however, that such an exchange shall be recorded in a memorandum between the registered entities in a manner prescribed by the department.

SECTION 33. Subsection (c) of section 20 of said chapter 94C, as appearing in the 2016 Official Edition, is hereby amended by striking out the first and second sentences and inserting in place thereof the following 3 sentences:- Whenever a practitioner prescribes a controlled substance by oral prescription, the practitioner shall cause an electronic prescription for the prescribed controlled substance to be delivered to the dispensing pharmacy within 2 days; provided, however, that if the practitioner has received an exception from using an electronic prescription from the commissioner pursuant to subsection (h) of section 23, the practitioner shall, within a period of not more than 7 days or such shorter period that is required by federal law, cause a written prescription for the prescribed controlled substance to be delivered to the dispensing pharmacy. The written prescription may be delivered to the pharmacy in person or by mail, but shall be postmarked within 7 days or such shorter period that is required by federal law. When an electronic or written prescription is issued pursuant to this subsection, the practitioner shall indicate on the electronic or written prescription that such prescription is being issued to document an oral prescription.

SECTION 34. Section 21 of said chapter 94C is hereby amended by inserting after the word “written”, in line 1, as so appearing, the following word:-, electronic.

SECTION 35. Said section 21 of said chapter 94C is hereby further amended by inserting after the word “oral”, in line 28, as so appearing, the following word:-, electronic.

SECTION 36. Section 22 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “written”, in line 2, the following words:- or electronic.

SECTION 37. Said section 22 of said chapter 94C, as so appearing, is hereby further amended by striking out, in line 21, the words “recommended full quantity indicated” and inserting in place thereof the following words:- full prescribed quantity.

SECTION 38. Section 23 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “written”, in lines 1 and 6, each time it appears, the following words:- or electronic.

SECTION 39. Said section 23 of said chapter 94C, as so appearing, is hereby further amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) A written or electronic prescription for a controlled substance in schedule II shall not be refilled. Written prescriptions for a controlled substance in schedule II shall be kept in a separate file.

SECTION 40. Said section 23 of said chapter 94C, as so appearing, is hereby further amended by striking out subsections (g) and (h) and inserting in place thereof the following 3 subsections:-

(g) Prescribers shall issue an electronic prescription for all controlled substances and medical devices. The department shall promulgate regulations setting forth standards for electronic prescriptions.

(h) The commissioner, through regulation, shall establish exceptions to section 17 and subsection (g) authorizing the limited use of a written and oral prescription where appropriate. The exceptions shall be limited to: (i) prescriptions that are issued by veterinarians; (ii) prescriptions issued or dispensed in circumstances where electronic prescribing is not available

due to temporary technological or electrical failure; (iii) a time-limited waiver process for practitioners who demonstrate economic hardship, technological limitations that are not reasonably within the control of the practitioner, or other exceptional circumstance; (iv) prescriptions that are issued or dispensed in emergency situations as defined by the commissioner pursuant to said section 17, including situations where the electronic prescription requirement would result in a delay that would adversely impact the patient's medical condition; (v) when a prescription cannot be issued electronically under federal or state law or regulations; (vi) prescriptions issued outside the jurisdiction of the commonwealth; and (vii) other exceptions to said section 17 and said subsection (g) as the commissioner determines necessary; provided, however, that 90 days before promulgating or amending any regulations regarding other exceptions to said section 17 and said subsection (g), the commissioner shall file with the house and senate committees on ways and means, the joint committee on public health, and the joint committee on mental health, substance use and recovery a written report setting forth justification for such changes.

(i) All written prescriptions shall be written in ink, indelible pencil or by other means on a tamper resistant form consistent with federal requirements for Medicaid and signed by the prescribing practitioner.

SECTION 41. Subsection (c) of section 24A of said chapter 94C, as so appearing, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-

The department shall promulgate rules and regulations relative to the use of the prescription monitoring program by registered participants. The regulations shall include the

requirement that prior to issuance, participants shall utilize the prescription monitoring program each time a prescription for a narcotic drug that is contained in schedule II or III, or a prescription for a benzodiazepine, is issued. The department may require participants to utilize the prescription monitoring program prior to the issuance of any schedule IV or V prescription drug, that is commonly misused and may lead to physical or psychological dependence or that causes patients with a history of substance dependence to experience significant addictive symptoms. The regulations shall specify the circumstances under which such narcotics or benzodiazepines may be prescribed without first utilizing the prescription monitoring program. The regulations may also specify the circumstances under which support staff may use the prescription monitoring program on behalf of a registered participant. When promulgating the rules and regulations, the department shall also require that pharmacists be trained in the use of the prescription monitoring program as part of the continuing education requirements mandated for licensure by the board of registration in pharmacy, under section 24A of chapter 112. The department shall also study the feasibility and value of expanding the prescription monitoring program to include schedule VI prescription drugs.

SECTION 42. Subsection (f) of said section 24A of said chapter 94C, as so appearing, is hereby amended by striking out clause (4)and inserting in place thereof the following clause:-

(4) local, state and federal law enforcement or prosecutorial officials working with the executive office of public safety and security engaged in the administration, investigation or enforcement of the laws governing prescription drugs; provided, however, that the data request is in connection with a bona fide specific controlled substance or additional drug-related investigation and accompanied by a probable cause warrant issued pursuant to chapter 276;

SECTION 43. Said section 24A of said chapter 94C, as so appearing, is hereby further amended by striking out, in line 94, the word “or”.

SECTION 44. Subsection (f) of said section 24A of said chapter 94C, as so appearing, is hereby amended by striking out clause (6)and inserting in place thereof the following 2 clauses:-

(6) personnel of the United States attorney, office of the attorney general or a district attorney; provided, however, that the data request is in connection with a bona fide specific controlled substance or additional drug related investigation and accompanied by a probable cause warrant issued pursuant to chapter 276; or

(7) personnel of the Medicaid fraud control unit within the office of the attorney general, which shall be exempted from the probable cause warrant requirement in paragraphs 4 and 6; provided however, that the data request is made in connection with a bona fide specific controlled substance or additional drug related investigation of a practitioner, pharmacist, pharmacy, person required to be a registered participant by this chapter or any other provider subject to the jurisdiction of a Medicaid fraud control unit under federal law, including, but not limited to, 42 USC section 1396b, et. seq.

SECTION 45. Said section 24A of said chapter 94C, as so appearing, is hereby further amended by striking out subsection (g) and inserting in place thereof the following subsection:-

(g) The department may provide data from the prescription monitoring program to practitioners in accordance with this section; provided, however, that practitioners shall be able to access the data directly through a secure electronic medical record or other similar secure software or information system that enables automated query and retrieval of prescription monitoring program data to a practitioner. This data may be used only for the purpose of

diagnosis, treatment or coordinating care of the practitioner's patient, unless otherwise permitted by this section. Any such secure software or information system shall identify the registered participant on whose behalf the prescription monitoring program was accessed. The department may enter into data use agreements to allow summary prescription monitoring program data to be securely retained in the patient's medical record as a clinical note associated with a clinical encounter; provided, however, that prescription monitoring program data shall not be retained separately from said clinical note; and provided further, that no such agreement shall allow for prescription monitoring program data to be used for purposes inconsistent with this section.

SECTION 46. Said section 24A of said chapter 94C, as so appearing, is hereby further amended by adding the following subsection:-

(m) The department may enter into agreements to permit health care facilities to integrate secure software or information systems into their electronic medical records for the purpose of using prescription monitoring program data to perform data analysis, compilation, or visualization, for purposes of diagnosis, treatment or coordinating care of the practitioner's patient. Any such secure software or information system shall comply with requirements established by the department to ensure the security and confidentiality of any data transferred.

SECTION 47. Section 27 of said chapter 94C, as so appearing, is hereby amended by striking out, in lines 3 and 4, the words ", but only to persons who have attained the age of 18 years and".

SECTION 48. Said section 27 of said chapter 94C, as so appearing, is hereby further amended by striking out the second sentence.

SECTION 49. Section 32I of said chapter 94C is hereby amended by striking out, in line 27, as so appearing, the words “to persons over the age of 18”.

SECTION 50. Chapter 111 of the General Laws is hereby amended by inserting after section 25J the following section:-

Section 25J½. An acute-care hospital, as defined in section 25B, that provides emergency services in an emergency department and a satellite emergency facility, as defined in section 51½, shall maintain, as part of its emergency services, protocols and capacity to provide appropriate, evidence-based interventions prior to discharge that reduce the risk of subsequent harm and fatality following an opioid-related overdose including, but not limited to, institutional protocols and capacity to possess, dispense, administer and prescribe opioid agonist treatment, including partial agonist treatment, and offer such treatment to patients who present in an acute-care hospital emergency department or a satellite emergency facility for care and treatment of an opioid-related overdose; provided, however, that such treatment shall occur when it is recommended by the treating healthcare provider and is voluntarily agreed to by the patient. An acute-care hospital that provides emergency services in an emergency department, and a satellite emergency facility, shall demonstrate compliance with applicable training and waiver requirements established by the federal drug enforcement agency and the substance abuse and mental health services administration relative to prescribing opioid agonist treatment. Prior to discharge, any patient who is administered or prescribed an opioid agonist treatment in an acute care hospital emergency department or satellite emergency facility shall be directly connected to an appropriate provider or treatment site to voluntarily continue said treatment.

The department may issue regulations pursuant to this section.

SECTION 51. Subsection (a) of said section 51½ of said chapter 111, as appearing in the 2016 Official Edition, is hereby amended by striking out the definition of "Licensed mental health professional" and inserting in place thereof the following definition:-

"Licensed mental health professional", a: (i) licensed physician who specializes in the practice of psychiatry or addiction medicine; (ii) licensed psychologist; (iii) licensed independent clinical social worker; (iv) licensed certified social worker; (v) licensed mental health counselor; (vi) licensed psychiatric clinical nurse specialist; (vii) certified addictions registered nurse; (viii) licensed alcohol and drug counselor I as defined in section 1 of chapter 111J; or (ix) healthcare provider, as defined in section 1, qualified within the scope of the individual's license to perform substance use disorder evaluations, including an intern, resident or fellow pursuant to medical staff policies and practice.

SECTION 52. Said section 51½ of said chapter 111, as so appearing, is hereby further amended by striking out, in lines 18, 35, 36, 50, 56, 73, 78 and 94, the word "abuse" and inserting in place thereof, in each instance, the following words:- use disorder.

SECTION 53. Said section 51½ of said chapter 111, as so appearing, is hereby further amended by inserting after the word "program", in line 20, the following words:- by a licensed mental health professional.

SECTION 54. Said section 51½ of said chapter 111, as so appearing, is hereby further amended by striking out, in lines 33, 79, 82 and lines 84 and 85, the word "opiate-related" and inserting in place thereof, in each instance, the following word:- opioid-related.

SECTION 55. Said section 51½ of said chapter 111, as so appearing, is hereby further amended by striking out subsection (c) and inserting in place thereof the following subsection:-

(c) During or after a substance use disorder evaluation conducted pursuant to subsection (b), treatment may occur within the acute-care hospital or satellite emergency facility, if appropriate services are available, which may include induction to medication-assisted treatment. If the acute care hospital or satellite emergency facility is unable to provide such services, the acute care hospital or satellite emergency facility shall refer the patient to an appropriate and available hospital or treatment provider; provided, however, that nothing in this section shall relieve an acute care hospital or satellite emergency facility from the requirements of section 25J½. Medical necessity for further treatment shall be determined by the treating clinician and noted in the patient's medical record.

If a patient refuses further treatment after the evaluation is complete, and is otherwise medically stable, the acute-care hospital or satellite emergency facility may initiate discharge proceedings; provided, however, that if the patient is in need of and agrees to further treatment following discharge pursuant to the substance use disorder evaluation, then the acute care hospital or satellite emergency facility shall directly connect the patient with a community-based program prior to discharge or within a reasonable time following discharge when the community-based program is available. All patients receiving an evaluation under subsection (b) shall receive, upon discharge, information on local and statewide treatment options, providers and other relevant information as deemed appropriate by the treating clinician.

SECTION 56. Said section 51½ of said chapter 111, as so appearing, is hereby further amended by striking out subsection (g) and inserting in place thereof the following subsection:-

(g) Upon discharge of a patient who experienced an opioid-related overdose, the acute-care hospital, satellite emergency facility or emergency service program shall record the opioid-

related overdose and substance use disorder evaluation in the patient's electronic medical record and shall make the evaluation directly accessible by other healthcare providers and facilities consistent with federal and state privacy requirements through a secure electronic medical record, health information exchange, or other similar software or information systems to: (i) improve ease of access and utilization of such data for treatment or diagnosis; (ii) support integration of such data within the electronic health records of a healthcare provider for purposes of treatment or diagnosis; or (iii) allow healthcare providers and their vendors to maintain such data for the purposes of compiling and visualizing such data within the electronic health records of a healthcare provider that supports treatment or diagnosis.

SECTION 57. Said section 51½ of said chapter 111, as so appearing, is hereby further amended by striking out subsection (i).

SECTION 58. Section 1 of chapter 111E of the General Laws, as so appearing, is hereby amended by inserting after the definition of "Assignment" the following definition:-

"Commissioner", the commissioner of public health.

SECTION 59. Said section 1 of said chapter 111E is hereby further amended by inserting after the definition of "Independent addiction specialist", inserted by section 63 of chapter 69 of the acts of 2018, the following definition:-

"Original license", a license, including a provisional license, issued to a facility not previously licensed; or a license issued to an existing facility, in which there has been a change in ownership or location.

SECTION 60. Section 7 of said chapter 111E, as appearing in the 2016 Official Edition, is hereby amended by striking out, in lines 1, 10, 13, 26, 27, 33, 39, 44, 50, 75, 77 and 80, the word “division”, each time it appears, and inserting in place thereof, in each instance, the following word:- department.

SECTION 61. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by inserting after the word “requirements”, in line 8, the following words:- set forth in regulations of the department.

SECTION 62. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in lines 17 and 18, the words “but such standards and requirements shall concern only” and inserting in place thereof the following words:- which shall include, but not be limited to.

SECTION 63. The fourth sentence of the first paragraph of said section 7 of said chapter 111E, as so appearing, is hereby amended by striking out clauses (1) to (6), inclusive, and inserting in place thereof the following 8 clauses:-

(1) the health standards to be met by a facility;

(2) misrepresentations regarding the treatment that would be provided to patients at a facility;

(3) licensing fees;

(4) procedures for making and approving license applications;

(5) the services and treatment provided by programs at a facility;

(6) certification of capability of self-preservation;

(7) a requirement that a facility provide services to commonwealth residents with public health insurance on a non-discriminatory basis and report the facility's payer mix to the department on a quarterly basis; and

(8) the standards or criteria that a facility shall meet to demonstrate the need for an original license; provided, however, that such standards or criteria shall be reviewed by the department every 2 years and shall be limited to: (i) the health needs of drug dependent persons and persons with alcoholism, as defined in section 3 of chapter 111B, in the commonwealth, including underserved populations and persons with co-occurring mental illness and substance use disorder; and (ii) the demonstrated ability and history of a prospective licensee to meet the needs of such persons.

SECTION 64. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in lines 26 and 27, the words "from time to time, on request,".

SECTION 65. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in lines 28 to 32, inclusive, the words "reasonably require for the purposes of this section, and any licensee or other person operating a private facility who fails to furnish any such data, statistics, schedules or information as requested, or who files fraudulent returns thereof, shall be punished by a fine of not more than five hundred dollars" and inserting in place thereof the following word:- require.

SECTION 66. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in line 42, the second time it appears, the word "or".

SECTION 67. The third paragraph of said section 7 of said chapter 111E, as so appearing, is hereby amended by striking out clause (3) and inserting in place thereof the following 2 clauses:-

(3) failure to comply with section 10; or

(4) an application for an original license fails to meet the department's standards or criteria for demonstrating need.

SECTION 68. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in line 49, the word "director" and inserting in place thereof the following word:- commissioner.

SECTION 69. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out the fifth to seventh paragraphs, inclusive, and inserting in place thereof the following 6 paragraphs:-

The department may conduct surveys and investigations to enforce compliance with this section and any rule or regulation promulgated pursuant to this chapter. If upon inspection, or through information in its possession, the department finds that a facility licensed by the department is not in compliance with a requirement established under this chapter, the department may order the facility to correct such deficiency by issuing a corrective action order, which shall provide the facility written notice of each deficiency. The order shall specify a reasonable time, not more than 60 days after receipt of the notice, by which time the facility shall remedy or correct each deficiency cited in the notice; provided, however, that in the case of any deficiency which, in the opinion of the department, is not capable of correction within 60 days, the department shall require that the facility submit a written plan for correction of the deficiency

in a reasonable manner. The department may modify any nonconforming written plan for correction upon notice in writing to the facility. Not more than 7 days after the receipt of notice of such modification of a written plan for correction, the affected facility may file a written request with the department for administrative reconsideration of the modified plan for correction or any portion thereof.

Nothing in this section shall be construed to prohibit the department from enforcing a rule, regulation, corrective action order or plan for correction, administratively or in court, without first affording formal opportunity to make correction, or to seek administrative reconsideration under this section, where, in the opinion of the department, the violation of such rule, regulation, corrective action order or plan for correction jeopardizes the health or safety of patients or the public or seriously limits the capacity of a facility to provide adequate care, or where the violation of such rule, regulation, corrective action order or plan for correction is the second or subsequent such violation occurring during a period of 12 months.

If a facility fails to remedy or correct a cited deficiency by the date specified in the corrective action order or fails to remedy or correct a cited deficiency by the date specified in a plan for correction as accepted or modified by the department, the department may: (i) suspend, limit, restrict or revoke the facility's license; (ii) impose a civil fine upon the facility; (iii) pursue any other sanction as the department may impose administratively upon the facility; or (iv) impose any combination of the penalties set forth in clauses (i) to (iii), inclusive, of this paragraph. A civil fine imposed pursuant to this section shall not exceed $1,000 per deficiency for each day the deficiency continues to exist beyond the date prescribed for correction.

No person, partnership, corporation, society, association, other agency, or entity of any kind, except a licensed general hospital, a department, agency or institution of the federal government, the commonwealth or any political subdivision thereof, shall operate a facility without a license and no department, agency or institution of the commonwealth or any political subdivision thereof shall operate a facility without approval from the department pursuant to this section. Upon petition of the department, the superior court shall have jurisdiction in equity to restrain any violation of this section and to take such other action as equity and justice may require to enforce its provisions.

Whoever knowingly establishes or maintains a private facility, other than a licensed general hospital, without a license granted pursuant to this section shall, for a first offense, be punished by a fine of not more than $500 and for each subsequent offense by a fine of not more than $1,000 or imprisonment for not more than 2 years, or both.

A facility shall be subject to visitation and inspection by the department to enforce compliance with this chapter and any rule or regulation issued thereunder. The department shall inspect each facility prior to granting or renewing a license or approval. The department may examine the books and accounts of any facility if it deems such examination necessary for the purposes of this section.

SECTION 70. Section 10H of chapter 118E of the General Laws, as inserted by section 19 of chapter 258 of the acts of 2014, is hereby amended by striking out, in line 55, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 71. Said chapter 118E is hereby further amended by inserting after section 10K, inserted by section 2 of chapter 120 of the acts of 2017, the following section:-

Section 10L. The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract to a Medicaid managed care organization or primary care clinician plan shall provide, for any covered drug that is a narcotic substance contained in schedule II pursuant to chapter 94C and subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, said person shall not be subject to an additional payment obligation, including, but not limited, to co-payments, if said person fills the remaining portion of the prescription.

SECTION 72. Section 35 of chapter 123 of the General Laws is hereby amended by inserting after the word “harm”, in line 59, appearing in the 2016 Official Edition, the following words:- ; provided, that the superintendent shall provide timely notification to the committing court and, if consent is obtained from the committed person, to the petitioner; provided further, that the superintendent shall request such consent from all committed persons.

SECTION 73. Said section 35 of said chapter 123 is hereby further amended by striking out, in lines 66 and 67, as so appearing, the words “notification of the transfer to the committing court” and inserting in place thereof the following words:- timely notification of the transfer to the committing court and, if consent is obtained from the committed person, to the petitioner; provided further, that the superintendent shall request such consent from all committed persons.

SECTION 74. Said section 35 of said chapter 123 is hereby further amended by inserting after the seventh paragraph, as so appearing, the following paragraph:-

A facility used for commitment under this section for a person found to be a person with a substance use disorder shall maintain or provide for the capacity to possess, dispense and

administer all drugs approved by the federal Food and Drug Administration for use in opioid agonist treatment, including partial agonist treatment, and opioid antagonist treatment for opioid use disorder and shall make such treatment available to any person for whom such treatment is medically appropriate.

SECTION 75. Section 1 of chapter 127 of the General Laws is hereby amended by striking out the definition of "Commissioner", as appearing in the 2016 Official Edition, and inserting in place thereof the following 2 definitions:-

"Behavioral health counseling", a non-pharmacological intervention carried out by a qualified behavioral health professional in a therapeutic context at an individual, family or group level; provided, however, that such an intervention may include a structured, professionally administered intervention delivered in person or an intervention delivered remotely via telemedicine.

"Commissioner", the commissioner of correction.

SECTION 76. Said section 1 of said chapter 127, as so appearing, is hereby further amended by inserting after the definition of "Exigent circumstances", inserted by section 85 of chapter 69 of" the acts of 2018, the following definition:-

"Medication-assisted treatment", treatment for an opioid-related substance use disorder that: (i) is determined to be medically necessary by a qualified addiction specialist; (ii) involves the use of medication that is approved by the federal Food and Drug Administration for treatment of an opioid-related substance use disorder; and (iii) is offered in accordance with a treatment plan that is reviewed by a qualified addiction specialist at a frequency consistent with appropriate clinical standards.

SECTION 77. Said section 1 of said chapter 127 is hereby further amended by inserting after the definition of "Placement review", inserted by section 86 of chapter 69 of the acts of 2018, the following definition:-

"Qualified addiction specialist", a treatment provider who is: (i) a physician licensed by the board of registration of medicine, a licensed advanced practice registered nurse or a licensed physician assistant; and (ii) a qualifying practitioner or qualifying other practitioner, as defined in the federal Controlled Substances Act, as codified at 21 U.S.C. 823(G), who has been issued an identification number by the United States Drug Enforcement Administration pursuant to the federal Controlled Substances Act, as codified at 21 U.S.C. 823(g)(2)(D)(ii) or 21 U.S.C. 823(g)(2)(D)(iii).

SECTION 78. Said chapter 127 is hereby further amended by inserting after section 17A the following 3 sections:-

Section 17B. The commissioner, in consultation with the commissioner of public health, shall offer medication-assisted treatment for opioid use disorder to a state detainee or prisoner at the Massachusetts alcohol and substance abuse center, the Massachusetts correctional institution at Framingham or the South Middlesex correctional center, upon the recommendation of a qualified addiction specialist. The medication-assisted treatment program shall not be required to be administered in any other state correctional facility; provided, however, that the commissioner shall, upon the recommendation of a qualified addiction specialist, offer medication-assisted treatment at the Massachusetts correctional institution at Cedar Junction to: (i) a state detainee or prisoner, including a state detainee or prisoner who was receiving opioid agonist or partial agonist treatment immediately preceding incarceration, during the first 90 days during which

such state detainee or prisoner is serving a sentence, as part of a medically managed detoxification which shall comply with the federal Substance Abuse and Mental Health Services Administration's treatment improvement protocols for detoxification; and (ii) a state detainee or prisoner during the last 90 days during which such state detainee or prisoner is serving a sentence, pursuant to a re-entry treatment plan under section 17C. The Massachusetts alcohol and substance abuse center, the Massachusetts correctional institution at Framingham, the South Middlesex correctional center and the Massachusetts correctional institution at Cedar Junction shall maintain or provide for the capacity to possess, dispense and administer all drugs approved by the federal Food and Drug Administration for use in medication-assisted treatment for opioid use disorder; provided however, that such facilities shall not be required to maintain or provide a drug that is not also a MassHealth covered benefit.

The commissioner shall ensure that each state detainee or prisoner at the Massachusetts alcohol and substance abuse center, the Massachusetts correctional institution at Framingham and the South Middlesex correctional center who is receiving medication-assisted treatment for opioid use disorder, including immediately preceding incarceration or commitment, continues to have such treatment available unless such person voluntarily discontinues the treatment or unless a qualified addiction specialist determines that treatment is no longer medically necessary.

Such facilities shall ensure access to a qualified addiction specialist by a state detainee or prisoner.

Treatment established under this section shall include behavioral health counseling for individuals diagnosed with opioid use disorder; provided, however, that counseling services shall be consistent with current therapeutic standards for these therapies in a community setting.

No incentives, rewards or punishments shall be used to encourage or discourage a state detainee's or prisoner's decision to receive medication-assisted treatment.

Section 17C. The commissioner shall ensure that, not later than 120 days prior to the expected discharge date of a state detainee or prisoner serving a sentence to a state prison, a state detainee or prisoner shall have access to a qualified addiction specialist who shall conduct an assessment of the state detainee or prisoner. Upon a determination by the qualified addiction specialist that the state detainee or prisoner requires treatment for opioid use disorder, the qualified addiction specialist shall establish a medically appropriate re-entry treatment plan for the state detainee or prisoner, which may include, but shall not be limited to, medication-assisted treatment during the final 90 days of incarceration; provided, however, that if medication-assisted treatment is included in a re-entry treatment plan, such treatment plan shall be provided to the state detainee or prisoner at a facility included in section 17B. A re-entry treatment plan may include any treatment upon discharge that the qualified addiction specialist shall recommend and deem appropriate, which may include, but shall not be limited to, all drugs approved by the federal Food and Drug Administration for use in medication-assisted treatment for opioid use disorder. A re-entry treatment plan shall ensure that a state detainee or prisoner is directly connected to an appropriate provider or treatment site in the geographic region to which the state detainee or prisoner shall reside upon release. The commissioner shall further ensure that, for a state detainee or prisoner with a re-entry treatment plan under this section, the facility shall request reinstatement or apply for MassHealth benefits for the state detainee or prisoner at least 30 days prior to release.

The re-entry treatment plan shall be forwarded to the parole board and may be incorporated into any treatment plan included within the terms and conditions of parole.

Section 17D. (a) Annually, not later than February 1, the commissioner shall report to the house and senate committees on ways and means, the joint committee on mental health, substance use and recovery, the joint committee on public safety and homeland security and the joint committee on the judiciary the following information for the prior calendar year for each facility included in section 17B: (i) the cost to the facility of providing medication-assisted treatment for opioid use disorder; (ii) the cost to the facility of providing re-entry treatment plans under section 17C; (iii) the type and prevalence of medication-assisted treatment provided for opioid use disorder; (iv) the number of persons in the custody of the facility, in any status, who continued to receive the same medication-assisted treatment as they received prior to incarceration, by medication type; (v) the number of persons in the custody of the facility, in any status, who changed or discontinued medication-assisted treatment for opioid use disorder that they received prior to incarceration, by medication type; (vi) the number of persons in the custody of the facility, in any status, who received medication-assisted treatment for opioid use disorder during the 90 days prior to release, by medication type; (vii) the number of persons in the custody of a facility, in any status, with a re-entry treatment plan that included medication-assisted treatment but did not receive such treatment prior to release; (viii) the number of persons in the custody of the facility, in any status, who received medication-assisted treatment for opioid use disorder who did not receive such treatment prior to incarceration, by medication type; (ix) a summary of facility practices and any changes to those practices related to medication-assisted treatment for opioid use disorder; (x) the number of persons who were connected to treatment after release; (xi) the number of persons who received a re-entry treatment plan under section 17C and were subsequently enrolled in MassHealth upon discharge; provided, however, that the commissioner, the commissioner of medical assistance and the commissioner of public health

shall coordinate to provide such information; and (xii) any other information requested by the commissioner related to the provision of medication-assisted treatment for opioid use disorder.

Every 2 years, not later than the April 30, the commissioner of public health shall prepare a report, pursuant to section 237 of chapter 111, regarding outcomes for the medication-assisted treatment programs established under sections 17B and 17C to the house and senate committees on ways and means, the joint committee on mental health, substance use and recovery, the joint committee on public safety and homeland security and the joint committee on the judiciary. The department of correction shall provide, upon request from the commissioner of public health, information necessary to prepare the report. The report shall, to the extent possible, provide a comparison between the state detainees and prisoners who did not receive medication-assisted treatment for opioid use disorder and those who did, reported separately for each medication type, in order to determine the impact of the treatment programs on the following: (i) retention in treatment after release; (ii) substance use and relapse after release; (iii) rates of recidivism; (iv) rates of nonfatal and fatal overdose; (v) treatment retention after release; and (vi) other outcome measures identified by the commissioner of public health.

SECTION 79. Section 47FF of chapter 175 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out, in line 3, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 80. Section 47GG of said chapter 175, as so appearing, is hereby amended by striking out, in line 33, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 81. Said chapter 175 is hereby further amended by inserting after section 47II the following 2 sections:-

Section 47JJ. Any policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth, which is considered creditable coverage under section 1 of chapter 111M, shall provide, for any covered drug that is a narcotic substance contained in schedule II pursuant to chapter 94C and subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, said person shall not be subject to an additional payment obligation, including, but not limited to, co-payments, if said person fills the remaining portion of the prescription.

Section 47KK. (a) Any policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth, which is considered creditable coverage under section 1 of chapter 111M, shall develop a plan to provide adequate coverage and access to a broad spectrum of pain management services, including, but not limited to, those that serve as alternatives to opioid prescribing, in accordance with guidelines developed by the division of insurance.

(b) The plan shall be subject to approval and shall be a component of carrier accreditation by the division of insurance pursuant to section 2 of chapter 176O. In its review, the division shall consider the adequacy of access to a broad spectrum of pain management services and any carrier policies that may create unduly preferential coverage to prescribing opioids without other pain management modalities.

(c) Carriers shall distribute educational materials to providers within their networks about the pain management access plan and make information about their plans publicly available on their websites.

SECTION 82. Section 3 of chapter 175H of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after the word “Administration”, in line 38, the following words:- or for any prescription drug that is an opioid placed by the commissioner of public health on schedule II pursuant to subsection (a) of section 2 of said chapter 94C.

SECTION 83. Section 8HH of chapter 176A of the General Laws, as so appearing, is hereby amended by striking out, in line 3, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 84. Section 8II of said chapter 176A, as so appearing, is hereby amended by striking out, in line 32, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 85. Said chapter 176A is hereby further amended by inserting after section 8KK the following 2 sections:-

Section 8LL. Any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall provide, for any covered drug that is a narcotic substance contained in schedule II pursuant to chapter 94C and subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, said person shall not be subject to an additional payment obligation, including but not limited to co-payments, if said person fills the remaining portion of the prescription.

Section 8MM. (a) Any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall develop a plan to provide adequate coverage and access to a broad spectrum of pain management services, including, but not limited to, those that serve as alternatives to opioid prescribing, in accordance with guidelines developed by the division of insurance.

(b) The plan shall be subject to approval and shall be a component of carrier accreditation by the division of insurance pursuant to section 2 of chapter 176O. In its review, the division shall consider the adequacy of access to a broad spectrum of pain management services and any carrier policies that may create unduly preferential coverage to prescribing opioids without other pain management modalities.

(c) Carriers shall distribute educational materials to providers within their networks about the pain management access plan and make information about their plans publicly available on their websites.

SECTION 86. Section 4HH of chapter 176B of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out, in line 3, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 87. Section 4II of said chapter 176B, as so appearing, is hereby amended by striking out, in line 31, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 88. Said chapter 176B is hereby further amended by inserting after section 4KK the following 2 sections:-

Section 4LL. Any subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall provide, for any covered drug that is a narcotic substance contained in schedule II pursuant to chapter 94C and subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, said person shall not be subject to an additional payment obligation, including but not limited to co-payments, if said person fills the remaining portion of the prescription.

Section 4MM. (a) Any subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall develop a plan to provide adequate coverage and access to a broad spectrum of pain management services, including, but not limited to, those that serve as alternatives to opioid prescribing, in accordance with guidelines developed by the division of insurance.

(b) The plan shall be subject to approval and shall be a component of carrier accreditation by the division of insurance pursuant to section 2 of chapter 176O. In its review, the division shall consider the adequacy of access to a broad spectrum of pain management services and any carrier policies that may create unduly preferential coverage to prescribing opioids without other pain management modalities.

(c) Carriers shall distribute educational materials to providers within their networks about the pain management access plan and make information about their plans publicly available on their websites.

SECTION 89. Section 4Z of chapter 176G of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out, in line 3, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 90. Section 4AA of said chapter 176G, as so appearing, is hereby amended by striking out, in line 30, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 91. Said chapter 176G is hereby further amended by inserting after section 4CC the following 2 sections:-

Section 4DD. An individual or group health maintenance contract that is issued or renewed shall provide, for any covered drug that is a narcotic substance contained in schedule II pursuant to chapter 94C and subject to cost sharing, that if a person receives a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C, said person shall not be subject to an additional payment obligation, including but not limited to co-payments, if said person fills the remaining portion of the prescription.

Section 4EE. (a) Any individual or group health maintenance contract that is issued or renewed shall develop a plan to provide adequate coverage and access to a broad spectrum of pain management services, including, but not limited to, those that serve as alternatives to opioid prescribing, in accordance with guidelines developed by the division of insurance.

(b) The plan shall be subject to approval and shall be a component of carrier accreditation by the division of insurance pursuant to section 2 of chapter 176O. In its review, the division shall consider the adequacy of access to a broad spectrum of pain management services and any

carrier policies that may create unduly preferential coverage to prescribing opioids without other pain management modalities.

(c) Carriers shall distribute educational materials to providers within their networks about the pain management access plan and make information about their plans publicly available on their websites.

SECTION 92. The second sentence of subsection (a) of section 2 of chapter 176O of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out clauses (4) and (5) and inserting in place thereof the following 3 clauses:-

(4) preventive health services;

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

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

SECTION 93. Said section 2 of said chapter 176O, as so appearing, is hereby further amended by striking out, in line 24, the words “of health care finance and policy” and inserting in place thereof the following words:- for health information and analysis.

SECTION 94. Subsection (b) of said section 2 of said chapter 176O, as so appearing, is hereby amended by adding the following paragraph:-

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).

SECTION 95. When developing the programs pursuant to sections 16AA and 16BB of chapter 6A of the General Laws, the executive office of health and human services shall consider the following: (i) how to most effectively adapt the program model of the Massachusetts child psychiatry access program, established pursuant to section 16A of chapter 19 of the General Laws, for chronic pain management consultation services and for substance use disorder consultation services; (ii) program structure, including whether to use regionally based teams; (iii) the necessity of a needs assessment; (iv) outreach methods to educate and engage providers, patients and health insurance carriers; (v) program metrics to gauge program usage and efficacy in expanding access to appropriate pain management and substance use disorder consultation services; and (vi) program costs. The executive office of health and human services may consult with stakeholders in the development of the programs under this section.

SECTION 96. Notwithstanding any general or special law to the contrary, not later than January 1, 2019, and annually thereafter for the next 5 years, the center for health information and analysis shall submit to the department of public health, the joint committee on mental health, substance use and recovery, the joint committee on public health, the joint committee on health care financing and the house and senate committees on ways and means a report regarding the frequency and location of substance use disorder evaluations ordered pursuant to section 51½ of chapter 111 of the General Laws utilizing the center for health information and analysis' merged case-mix discharge database.

SECTION 97. Notwithstanding any general or special law to the contrary, the department of correction shall establish protocols to ensure that medication-assisted treatment provided under sections 17B and 17C of chapter 127 of the General Laws meets the following criteria: (i) consent provided to receive medication-assisted treatment is voluntarily given by the state detainee or prisoner; (ii) that consent is recorded on a consent form signed by the state detainee or prisoner; and (iii) consent is given after a written and verbal explanation of the following information: (1) the nature of federal Food and Drug Administration-approved medication used in substance use disorder treatment, including benefits and risks; (2) available alternative treatment options, including benefits and risks; (3) the need for the state detainee or prisoner to inform the qualified addiction specialist as defined in section 1 of chapter 127 of the General Laws, of medical conditions, including pregnancy, and medications that the state detainee or prisoner is currently taking; (4) acknowledgement that the state detainee or prisoner may withdraw voluntarily from treatment and discontinue use of medications; and (5) the options following termination of treatment, including detoxification. The department of correction shall establish the protocols not later than March 1, 2019, and shall make the protocols publicly available on its website and forward a copy of the protocols to the joint committee on mental health, substance use and recovery.

SECTION 98. (a) Notwithstanding any general or special law to the contrary, there shall be, subject to appropriation, a pilot program for the delivery of medication-assisted treatment for opioid use disorder at the county correctional facilities located in Franklin, Hampden, Hampshire, Middlesex and Norfolk counties. The pilot program shall be implemented by the department of public health, in collaboration with the executive office of public safety and security, the office of Medicaid, and the county sheriffs who have jurisdiction over the county

correctional facilities located in Franklin, Hampden, Hampshire, Middlesex and Norfolk counties.

(b) A county correctional facility participating in the pilot program shall:

(1) maintain or provide for the capacity to possess, dispense and administer all drugs approved by the federal Food and Drug Administration for use in medication-assisted treatment for opioid use disorder; provided, however, that a facility shall not be required to maintain or provide a drug that is not also included as a MassHealth covered benefit;

(2) provide medication-assisted treatment to a person in the custody of the facility, in any status, who was receiving medication-assisted treatment for opioid use disorder through a legally authorized medical program or by a valid prescription immediately before incarceration; provided, however, that treatment shall not be involuntarily changed or discontinued except upon a determination by a qualified addiction specialist, as defined in section 1 of chapter 127 of the General Laws, that the treatment is no longer appropriate;

(3) provide medication-assisted treatment not less than 30 days prior to release to a sentenced inmate in the custody of the facility for whom such treatment is determined to be medically appropriate by a qualified addiction specialist;

(4) provide, as part of the facility's opioid use disorder treatment program, behavioral health counseling, as defined in section 1 of chapter 127 of the General Laws, for individuals consistent with current therapeutic standards for these therapies in a community setting; provided, however, that those standards shall be consistent with the safety and security requirements of the facility;

(5) not use incentives, rewards or punishments to encourage or discourage a person's decision to receive medication-assisted treatment while in the custody of the facility;

(6) make every possible effort to directly connect, prior to release, a person in the custody of the facility who is receiving medication-assisted treatment to an appropriate provider or treatment site in the geographic region in which the person will reside upon release; provided, however, that if such connection is not possible, the facility shall document its efforts in the person's record;

(7) request reinstatement or apply for MassHealth benefits for a person in the custody of the facility who is receiving medication-assisted treatment not less than 30 days before that person's release; and

(8) provide a status report every 6 months, in a format determined by the commissioner of public health, to the secretary of public safety, the commissioner of public health, the joint committee on public safety and homeland security and the joint committee on mental health, substance use and recovery, which shall include following information: (i) the cost to the facility of providing medication-assisted treatment, behavioral health counseling and post-release case management for opioid use disorder; (ii) the type and prevalence of medication-assisted treatment provided for opioid use disorder; (iii) the number of persons in the custody of the facility, in any status, who continued to receive the same medication-assisted treatment as they received prior to incarceration; (iv) the number of persons in the custody of the facility, in any status, who voluntarily changed or discontinued medication-assisted treatment for opioid use disorder that they received prior to incarceration; (v) the number of persons in the custody of the facility, in any status, who changed or discontinued medication-assisted treatment for opioid use

disorder that they received prior to incarceration due to a determination by a qualified addiction specialist; (vi) the number of persons in the custody of the facility, in any status, who received medication-assisted treatment for opioid use disorder during the 30 days before their release; (vii) a summary of facility practices and any changes to those practices related to medication-assisted treatment and behavioral health counseling for opioid use disorder; (viii) a list of program participants, which shall be provided to the department of public health in order to track aggregated outcome data post release; and (ix) any other information requested by the commissioner related to the provision of medication-assisted treatment for opioid use disorder.

(c) A county sheriff with jurisdiction over a county correctional facility participating in the pilot program shall, in consultation with the commissioner of public health, the secretary of public safety and security, the director of Medicaid, the Association for Behavioral Healthcare, Inc., the Advocates for Human Potential, Inc., and other county sheriffs who have jurisdiction over the county correctional facilities participating in the pilot program, develop an implementation plan for the pilot program in their facility. An implementation plan shall consider: (i) best practices for the delivery of medication-assisted treatment and behavioral health counseling for opioid use disorder; (ii) uniform guidelines to ensure the safety and security of correctional facility personnel and people in the custody of the facility during the administration of medication-assisted treatment and behavioral health counseling; (iii) the projected cost of providing medication-assisted treatment and behavioral health counseling; (iv) health insurance coverage, including Medicaid; (v) protocols for technical medical assistance that may be required by the department of public health, including appropriate personnel and physical space to safely administer medication-assisted treatment; (vi) the availability of appropriate community services after release, including a process for directly connecting a

person upon release to an appropriate provider or treatment site in the geographic region in which the person will reside upon release in order to continue treatment; (vii) appropriate metrics for evaluating and tracking pilot program outcomes; and (viii) any other information necessary to implement the pilot program.

The commissioner of public health shall evaluate and approve, pursuant to section 7 of chapter 111E, implementation plans for a pilot program under this section. The commissioner of public health shall send copies of approved implementation plans to the senate and house committees on ways and means, the joint committee on mental health, substance use and recovery and the joint committee on public safety and homeland security not less than 30 days before the implementation of the pilot program.

(d) The pilot program under this section shall be implemented not later than September 1, 2019.

(e) After implementation of the pilot program, the commissioner of public health shall submit a report regarding outcomes for the pilot program not later than September 1, 2020, and annually thereafter for the next 3 years, to the senate and house committees on ways and means, the joint committee on mental health, substance use and recovery and the joint committee on public safety and homeland security. The report shall include, to the extent possible, a comparison between people in custody who did not receive medication-assisted treatment for opioid use disorder and those who did, reported separately for each medication type, in order to determine the impact of the treatment programs on the following: (i) retention in treatment after release, including regions where direct connection to treatment was less likely; (ii) substance use

and relapse after release; (iii) rates of recidivism; (iv) rates of nonfatal and fatal overdose; and (v) other outcome measures identified by the commissioner of public health.

(f) Notwithstanding any general or special law to the contrary, the department of public health shall establish protocols that ensure that medication-assisted treatment provided under this section meets the following criteria: (i) consent provided to receive medication-assisted treatment is voluntarily given by the person in custody; (ii) that consent is recorded on a consent form signed by the person in custody; and (iii) consent is given after a written and verbal explanation of the following information: (A) the nature of federal Food and Drug Administration-approved medication used in substance use disorder treatment, including benefits and risks; (B) available alternative treatment options, including benefits and risks; (C) the need for the person in custody to inform the qualified addiction specialist, as defined in section 1 of chapter 127 of the General Laws, of medical conditions, including pregnancy, and medications that the person in custody is currently taking; (D) acknowledgement that the person in custody may withdraw voluntarily from treatment and discontinue use of medications; and (E) the options following termination of treatment, including detoxification. The department of public health shall establish the protocols not later than March 1, 2019, and shall make the protocols publicly available on its website and forward a copy of the protocols to the joint committee on mental health, substance use and recovery.

(g) The commissioner of public health may promulgate regulations and guidelines necessary to implement the pilot program under this section.

SECTION 99. Not later than January 1, 2019, the department of public health shall submit recommendations, together with drafts of any legislation, for improving access to

voluntary rehabilitative alternatives to traditional disciplinary actions for licensed health care professionals who have a substance use disorder, including, but not limited to, dentists who have a substance use disorder, to the clerks of the house of representatives and the senate, the chairs of the joint committee on mental health, substance use and recovery and the chairs of the joint committee on public health.

SECTION 100. There shall be a harm reduction commission to review and make recommendations regarding harm reduction opportunities to address substance use disorder.

The commission shall consist of 15 members: the secretary of health and human services or a designee, who shall serve as chair; the commissioner of public health; the house and senate chairs of the joint committee on mental health, substance use and recovery or their designees; the mayor of the city of Boston or a designee; the mayor of the city of Cambridge or a designee; a representative from the Massachusetts Medical Society; a representative from the Massachusetts Health and Hospital Association, Inc.; and 7 members appointed by the secretary, 2 of whom shall be persons with a substance use disorder, 1 of whom shall be a clinician with experience providing direct care to individuals with a co-occurring mental health and substance use disorder, 1 of whom shall be a person working in an established harm reduction program providing direct support to persons with substance use disorders, 1 of whom shall be a representative of the Massachusetts Chiefs of Police Association Incorporated, 1 of whom shall have expertise in relevant state and federal law and regulation and 1 of whom shall be a representative of local municipal boards of health. In making appointments, the secretary shall, to the maximum extent feasible, ensure that the commission represents a broad distribution of diverse perspectives and geographic regions.

As part of its review, the commission shall consider: (i) the feasibility of operating harm reduction sites in which (A) a person with a substance use disorder may consume pre-obtained controlled substances, (B) medical assistance by health care professionals is made immediately available to a person with a substance use disorder as necessary to prevent fatal overdose, and (C) counseling, referrals to treatment and other appropriate services are available on a voluntary basis; (ii) the potential public health and public safety benefits and risks of harm reduction sites; (iii) the potential federal, state and local legal issues involved with establishing harm reduction sites; (iv) appropriate guidance that would be necessary and required for professional licensure boards and any necessary changes to the regulations of such boards; (v) existing harm reduction efforts in the commonwealth and whether there is potential for collaboration with existing public health harm reduction organizations; (vi) opportunities to maximize public health benefits, including educating persons utilizing the sites of the risks of contracting HIV and viral hepatitis and on proper disposal of hypodermic needles and syringes; (vii) ways to support persons utilizing the sites who express an interest in seeking substance use disorder treatment, including providing information on evidence-based treatment options and direct referral to treatment providers; (viii) other harm reduction opportunities, including but not limited to, broadening the availability of narcotic testing products, including fentanyl test strips; (ix) alternatives and recommendations to broaden the availability of naloxone without prescription; and (x) other matters deemed appropriate by the commission. In developing its report, the commission shall review the experiences and results of other states and countries that have established supervised drug consumption sites and other harm reduction strategies and report on the impact of those harm reduction sites and strategies.

The commission shall submit its findings and recommendations to the clerks of the senate and the house of representatives, the joint committee on mental health, substance use and recovery, the joint committee on public health, the joint committee on the judiciary and the senate and house committees on ways and means not later than February 1, 2019. The secretary shall also make the report publicly available on the executive office of health and human services' website.

SECTION 101. There shall be a commission to review and make recommendations regarding recovery coaching in the commonwealth. The commission shall review training opportunities for recovery coaches and recommend the standards for credentialing a recovery coach, including whether recovery coaches should be subject to a board of registration through the department of public health. The commission shall gather all relevant data related to recovery coaches, including, but not limited to: (i) the total number of recovery coaches in the commonwealth; (ii) the number of people receiving compensation as recovery coaches in the commonwealth; (iii) the average and median compensation for a recovery coach; (iv) the average and median caseload for a recovery coach; and (v) the projected need for certified recovery coach services. The commission shall develop recommendations for a streamlined process to certify recovery coaches and adequate protections to ensure unauthorized individuals are not engaging in the practice of recovery coaching.

The commission shall consist of 15 members: the secretary of health and human services or a designee, who shall serve as chair; the commissioner of public health or a designee; the director of Medicaid or a designee; 1 person appointed by the speaker of the house; 1 person appointed by the senate president; 1 representative from the Massachusetts Association of Health Plans, Inc.; 1 representative from the Massachusetts Psychiatric Society, Inc., who shall be a

psychiatrist specializing in addiction; 1 representative from Blue Cross Blue Shield of Massachusetts, Inc.; 1 representative from the Massachusetts Organization for Addiction Recovery, Inc.; and 6 persons who shall be appointed by the secretary of health and human services, 1 of whom shall have expertise in training recovery coaches, 1 of whom shall be a community provider who employs recovery coaches, 1 of whom shall represent a hospital that employs recovery coaches, 1 of whom shall be a family member to an individual with a substance use disorder, 1 of whom shall currently be employed as a recovery coach and 1 of whom shall be a consumer of recovery coach services.

The commission may hold public meetings or fact-finding hearings or solicit public comment as it considers necessary. The commission shall submit its findings and recommendations, together with drafts of legislation, if any, necessary to carry those recommendations into effect, to the clerks of the senate and the house of representatives and the joint committee on mental health, substance use and recovery not later than 1 year from the effective date of this act.

SECTION 102. There shall be a commission to review evidence-based treatment for individuals with a substance use disorder, mental illness or co-occurring substance use disorder and mental illness. The commission shall recommend a taxonomy of licensed behavioral health clinician specialties. Notwithstanding any general or special law to the contrary, the taxonomy of licensed behavioral health clinician specialties may be used by insurance carriers to develop a provider network. The commission shall recommend a process that may be used by carriers to validate a licensed behavioral health clinician’s specialty.

The commission shall consist of 11 members: the secretary of health and human services or a designee, who shall serve as chair; the commissioner of insurance or a designee; and 9 persons to be appointed by the secretary of health and human services, 1 of whom shall have expertise in the treatment of individuals with a substance use disorder, 1 of whom shall have expertise in the treatment of adults with a mental illness, 1 of whom shall have expertise in children's behavioral health, 1 of whom shall be an emergency medicine expert with expertise in the treatment of addiction, 1 of whom shall be a hospital medicine expert with expertise in the treatment of addiction, 1 of whom shall be a licensed behavioral health clinician, 1 of whom shall be a representative of the National Association of Social Workers, Inc., 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., and 1 of whom shall be a representative of Blue Cross Blue Shield of Massachusetts, Inc. The secretary may appoint additional members who shall have expertise to aid the commission in producing its recommendations.

The commission shall file a report of its findings and recommendations, together with drafts of legislation necessary to carry those recommendations into effect, with the clerks of the senate and the house of representatives not later than 180 days after the effective date of this act.

SECTION 103. (a) There shall be a special commission to study and make recommendations regarding the use of medication-assisted treatment for opioid use disorder in the commonwealth, including methadone, buprenorphine and injectable long-acting naltrexone.

(b) The commission shall: (i) create aggregate demographic and geographic profiles of individuals who use medication-assisted treatment; (ii) examine the availability of and barriers to accessing medication-assisted treatment, including federal, state and local laws and regulations;

(iii) determine the current utilization of, and projected need for, medication-assisted treatment in inpatient and outpatient settings, including, but not limited to, inpatient and residential substance use treatment facilities, inpatient psychiatric settings, pharmacy settings, mobile settings and primary care settings; (iv) identify ways to expand access to medication-assisted treatment in both inpatient and outpatient settings; (v) identify ways to encourage practitioners to seek waivers to administer buprenorphine to treat patients with opioid use disorder; (vi) study the availability of and concurrent use of behavioral health therapy for individuals receiving medication-assisted treatment; and (vii) study other related matters.

(c) The commission shall consist of 19 members: the commissioner of public health or a designee, who shall serve as chair; the executive director of the health policy commission or a designee; the director of Medicaid or a designee; the house and senate chairs of the joint committee on mental health, substance use, and recovery or their designees; the ranking house and senate minority members of the joint committee on mental health, substance use and recovery or their designees; 3 representatives appointed by the commissioner of public health, 1 of whom shall be a representative of community health centers, 1 of whom shall be a primary care provider with experience providing medication-assisted treatment, and 1 of whom shall be an expert in substance use disorder treatment; and 1 representative of each of the following 9 organizations: the Massachusetts Medical Society; the Massachusetts Health and Hospital Association, Inc.; the Association for Behavioral Healthcare, Inc.; the Massachusetts Association of Behavioral Health Systems, Inc.; the Massachusetts Association of Health Plans, Inc.; Blue Cross Blue Shield of Massachusetts, Inc.; the Massachusetts Pharmacists Association; Advocates for Human Potential, Inc.; and the Massachusetts Organization for Addiction Recovery, Inc.

(d) The commission shall file a report on its findings and recommendations, together with any recommendations for legislation, with the clerks of the house of representatives and the senate no later than 1 year from the effective date of this act.

SECTION 104. There shall be a section 35 involuntary commitment commission to study the efficacy of involuntary inpatient treatment for non-court involved individuals diagnosed with substance use disorder. The commission shall: (a) review medical literature and expert opinions on the long-term relapse rates of individuals diagnosed with substance use disorder following involuntary inpatient treatment including: (1) the differences in outcomes for coerced and non-coerced patients, (2) any potential increased risk of an individual suffering a fatal overdose following a period of involuntary treatment, (3) medical literature on length of time necessary for detoxification of opioids and recommended time following detoxification to begin medication-assisted treatment, (4) the legal implications of holding a non-court involved individual who is diagnosed with substance use disorder but is no longer under the influence of substances, (5) whether the current capacity, including acute treatment services, clinical stabilization services, transitional support services and recovery homes, is sufficient to treat individuals seeking voluntary treatment for substance use disorder, (6) the availability of other treatments for substance use disorder, including those treatments used in less restrictive settings, and (7) the effectiveness of the existing involuntary commitment procedures pursuant to section 35 of chapter 123 of the General Laws at reducing long-term relapse rates; and

(b) evaluate and develop a proposal for a consistent statewide standard for the medical review of individuals who are involuntarily committed due to an alcohol or substance use disorder pursuant to section 35 of chapter 123 of the General Laws, including, but not limited to, developing: (1) a proposed standardized form and criteria for releasing medical information for

use in a commitment hearing under said section 35 of said chapter 123 that is in compliance with federal and state privacy requirements and (2) criteria and guidance to medical staff about filing a petition under said section 35 of said chapter 123.

The commission shall consist of: the secretary of health and human services or a designee, who shall serve as chair; the house and senate chairs of the joint committee on mental health, substance use and recovery or their designees; the house and senate chairs of the joint committee on judiciary or their designees; the minority leader of the house or a designee; the minority leader of the senate or a designee; 1 representative of an academic institution appointed by the speaker of the house; 1 representative of an academic institution appointed by the senate president; the chief justice of the trial court or a designee; the commissioner of the department of mental health or a designee; the commissioner of the department of public health or a designee; the director of the office of health equity in the department of public health; an addiction expert with experience in federal and state policy on substance use disorder; and 1 representative from each of the following organizations: Massachusetts Organization for Addiction Recovery, Inc.; The Boston Health Care for the Homeless Program, Inc.; Massachusetts Nurses Association; the Massachusetts Association of Advanced Practice Psychiatric Nurses; the Massachusetts chapter of the National Association of Social Workers, Inc.; American Civil Liberties Union of Massachusetts, Inc.; the committee for public counsel services; Massachusetts Health & Hospital Association, Inc.; the Massachusetts Psychological Association, Inc.; Massachusetts Medical Society; Massachusetts Psychiatric Society, Inc.; Massachusetts College of Emergency Physicians, Inc.; Massachusetts Society of Addiction Medicine, Inc.; Association for Behavioral Healthcare, Inc.; and Massachusetts Association of Behavioral Health Systems, Inc. The

commission shall file recommendations, including any proposed legislation, with the clerks of the house of representatives and the senate not later July 1, 2019.

SECTION 105. For the purposes of this section, the following terms shall have the following meanings unless the context clearly requires otherwise:-

"Community-based acute treatment" or "CBAT", 24-hour clinically managed mental health diversionary or step-down services for children and adolescents, as defined by the department of early education and care, usually provided as an alternative to mental health acute treatment.

"Intensive community-based acute treatment" or "ICBAT", intensive 24-hour clinically managed mental health diversionary or step-down services for children and adolescents, as defined by the department of early education and care, usually provided as an alternative to mental health acute treatment.

"Mental health acute treatment", 24-hour medically supervised mental health services provided in an inpatient facility, licensed by the department of mental health, that provides psychiatric evaluation, management, treatment and discharge planning in a structured treatment setting.

"Mental health crisis stabilization services", 24-hour clinically managed mental health diversionary or step-down services for adults or adolescents, as defined by MassHealth, usually provided as an alternative to mental health acute treatment or following mental health acute treatment, which may include intensive crisis stabilization counseling, outreach to families and significant others and aftercare planning.

Notwithstanding any general or special law to the contrary, the center for health information and analysis shall conduct a review of a mandated health benefit proposal to require coverage for: (i) medically necessary mental health acute treatment that does not require preauthorization prior to obtaining treatment; provided, however, that medical necessity shall be determined by the treating clinician in consultation with the patient and noted in the patient's medical record; (ii) medically necessary mental health crisis stabilization services for not more than 14 days that does not require preauthorization prior to obtaining such services; provided, however, that a facility shall provide the carrier with both notification of admission and the initial treatment plan within 48 hours of admission; provided further, that utilization review procedures may be initiated on day 7 and medical necessity shall be determined by the treating clinician in consultation with the patient and noted in the patient's medical record; (iii) medically necessary community-based acute treatment for not more than 21 days; provided, however, that a facility shall provide the carrier both notification of admission and the initial treatment plan within 48 hours of admission; provided further, that utilization review procedures may be initiated on day 10; and provided further, that medical necessity shall be determined by the treating clinician in consultation with the patient and noted in the patient's medical record; and (iv) medically necessary intensive community-based acute treatment services for not more than 14 days; provided, however, that a facility shall provide the carrier with both notification of admission and the initial treatment plan within 48 hours of admission, provided further, that utilization review procedures may be initiated on day 7; and provided further, that medical necessity shall be determined by the treating clinician in consultation with the patient and noted in the patient's medical record.

The review shall be performed by the center consistent with section 38C of chapter 3 of the General Laws. The center shall evaluate the impact of such a mandate as a requirement for all of the health plans and policies under subsection (a) of said section 38C of said chapter 3, as well as the impact of such a mandate on the division of medical assistance and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract to a Medicaid managed care organization or primary care clinician plan. The center shall file its review with the clerks of the house of representatives and senate, the joint committee on mental health, substance use and recovery, the joint committee on health care financing and the house and senate committees on ways and means not later July 1, 2019.

SECTION 106. The division of insurance and the office of Medicaid shall jointly develop and issue bulletins identifying the healthcare common procedure coding system codes that are used by carriers, as defined in section 1 of chapter 176O of the General Laws, behavioral health management firms and third party administrators under contract to a carrier, Medicaid managed care organization, accountable care organization or the MassHealth primary care clinician plan for initiation and continuation of opioid agonist treatment, including partial agonist treatment, of opioid use disorders provided in: (i) acute care hospital emergency departments or satellite emergency facilities; (ii) community-based treatment facilities, outpatient clinics, primary care practices or office-based treatment clinics; (iii) inpatient facilities providing treatment for substance use disorders; and (iv) any facility used for commitment pursuant to section 35 of chapter 123 of the General Laws for persons with a substance use disorder; provided, however, that the procedures identified in the bulletins shall be based on medical necessity, pursuant to said chapter 176O, and shall ensure at least 1 opioid agonist treatment and at least 1 partial

agonist treatment are available without preauthorization. Prior to the issuance of the bulletins, the division and the office of Medicaid shall convene and consult with a group of carriers and providers regarding opioid agonist treatment in each of the treatment settings described in clauses (i) to (iv), inclusive. The division and the office of Medicaid shall publish the bulletins on their respective websites not later than January 1, 2019.

SECTION 107. There shall be a special commission to study the ways consumer protection laws in the commonwealth may be strengthened to hold corporate entities responsible for their role in furthering the opioid epidemic. The commission shall issue a report that shall include, but not be limited to, a review of and recommendations regarding: (i) the personal liability standard for executives of pharmaceutical companies; (ii) the use of deceptive or misleading marketing practices by pharmaceutical companies; (iii) the need to strengthen existing penalties against pharmaceutical companies engaged in unfair or deceptive acts or practices related to the opioid epidemic; and (iv) remedial action pharmaceutical companies may take to mitigate the harmful effects of the opioid epidemic.

The commission shall consist of the following members: the governor or a designee; the attorney general or a designee; the commissioner of public health or a designee; the senate president, who shall serve as co-chair; the senate minority leader; the speaker of the house, who shall serve as co-chair; the house minority leader; and 6 members appointed by the attorney general: 1 of whom shall be a legal expert in consumer protection and liability, 1 of whom shall be an expert in the field of pain medication and management, 1 of whom shall be a medical expert in the area of substance use disorder and treatment, 1 of whom shall be a provider with extensive experience in the field of pain medication prescription and 2 of whom shall be persons who have had a substance use disorder.

The commission shall file a report, including any recommendations, with the clerks of the house of representatives and senate, the joint committee on mental health, substance use and recovery, the joint committee on consumer protection and professional licensure, the joint committee on the judiciary and the house and senate committees on ways and means annually not later than January 1, 2019.

SECTION 108. Section 6 is hereby repealed.

SECTION 109. Section 108 shall take effect on July 1, 2021.

SECTION 110. Sections 26 to 30, inclusive, 33 to 36, inclusive, and 38 to 40, inclusive, shall take effect on January 1, 2020.

SECTION 111. Section 78 shall take effect on April 1, 2019.

SECTION 112. Sections 100 to 104, inclusive, and 107 are hereby repealed.

SECTION 113. Section 112 shall take effect on January 1, 2021.”.