SENATE . . . . . No. 2984

The Commonwealth of Massachusetts

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

SENATE, December 23, 2020

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

For the Committee:

Cindy F. Friedman	Ronald A. Mariano
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An Act promoting a resilient health care system that puts patients first.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 10. Said section 7 of said chapter 94C, as so appearing, is hereby further amended by inserting after the word “podiatrist”, in line 122 and in lines 125 and126, each time it appears, the following words:- , nurse practitioner, nurse anesthetist, psychiatric nurse mental health clinical specialist.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Inducement", paying a person money, including a lump sum or salary payment, to participate in a cancer clinical trial.

"Subject", a person who participates in a cancer clinical trial.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Division", the division of medical assistance within the executive office of health and human services.

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

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

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

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

The division may promulgate regulations to implement this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 70. Any coverage offered by the group insurance commission pursuant to chapter 32A of the General Laws, 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 under chapter 118E of the General Laws, any individual policy of accident or sickness insurance issued under chapter 175 of the General Laws, any contract between a subscriber and a corporation under an individual group or hospital service plan under chapter 176A of the General Laws, any subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth under chapter 176B of the General Laws, any individual or group health maintenance contract under chapter 176G of the General Laws, and any preferred provider contract between a covered person and an

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

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

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

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

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

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

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

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

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

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

SECTION 74. Section 17R of chapter 32A of the General Laws, section 47NN of chapter 175 of the General Laws, section 8OO of chapter 176A of the General Laws, section 4OO of chapter 176B of the General laws and section 4GG of chapter 176G of the General Laws shall apply to contracts that take effect or are renewed on or after January 1, 2022.

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

SECTION 76. Sections 63 and 69 are hereby repealed.

SECTION 77. Section 68 is hereby repealed.

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

SECTION 79. Section 77 shall take effect 90 days after termination of the governor's March 10, 2020 declaration of a state of emergency.