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SENATE . . . . . No. 2774

The Commonwealth of Massachusetts

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CHARLES D. BAKER
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LIEUTENANT GOVERNOR

March 15, 2022

To the Honorable Senate and House of Representatives,

In October of 2019, I filed a comprehensive health care reform bill that sought to improve outcomes for patients, increase access to primary and behavioral health care, and bring down costs for consumers. I am grateful that the House and Senate included several key components from that legislation in the package of reforms I signed into law on January 1, 2021. That law increases insurance coverage for telehealth services, expands the scope of practice for nurse practitioners, other specialized nurses, and optometrists, and takes steps to protect consumers from surprise medical bills.

A number of provisions from the bill I had originally filed that aimed to address concerning trends in health care delivery and financing did not make it into the legislation that I signed. Those reforms are still critically needed, which is why today I am filing for your consideration "An Act Investing in the Future of Our Health." This bill seeks to prioritize investments in primary care and behavioral health, address continued health care cost drivers, and improve access to high-quality, coordinated care for us, the consumer.

Investing in Primary Care and Behavioral Health

Our current health care system, including the Medicare payment system that finances health care insurance for older Americans, rewards providers that invest in premium priced technology and transactional specialty services at the expense of providers that invest in lower priced services such as primary care, geriatrics, addiction services, and behavioral health care. Every provider and payer uses the Medicare payment system to price their own services and

make investment decisions. The result of this focus on Medicare payments is that the care delivery and financing system we have today is not designed to take care of the people and the patients we have become. What we need instead is a system that rewards providers and provider organizations that invest in a comprehensive set of physical and behavioral health services and that understand that population-based health management requires time and connection.

The Commonwealth's longstanding need for improved access to quality behavioral health care has only been exacerbated by the COVID-19 pandemic. While the expanded availability of telehealth services for behavioral health has been a positive development, too many people – young and old – continue to struggle with feelings of isolation, depression, and despair. We have unfortunately also seen an increase in opioid overdose deaths during the pandemic.

The same is true for primary care. Strategies adopted during the pandemic to preserve hospital capacity for true emergencies, along with the public's general fear and avoidance of the health care system throughout the COVID-19 pandemic, have resulted in a widespread problem of delayed treatment and care. Increased investments in primary care are critical not only to address this existing pent-up demand but also to improving future health outcomes.

The bill I am filing today creates positive financial incentives for health care providers and payors to rethink their service delivery model and investment decisions. This bill encourages providers and payors to invest in the behavioral health, addiction and recovery, and primary care and geriatric services that are underfunded by today's payment models and to prioritize these services in their care delivery strategies.

The legislation targets those challenges by requiring investments in behavioral and primary care through the establishment of a statewide spending target. Under the provisions of the bill:

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

- Calendar year 2019 spending will serve as the baseline; provider and insurer performance against the target will be based on expenditures through calendar year 2024.

- The legislation does not prescribe how providers and insurers must achieve the target, instead leaving decision-making to the discretion of the individual provider and insurer organization.

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

- Providers and insurers that do not meet the 30% increase target will be referred to the HPC for review and may be subject to a performance improvement plan which may require

them to identify strategies and opportunities to increase investments in primary care and behavioral health.

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

While this approach may result in some modest disruptions to the orientation of our current health care system, this is the right direction for our payment systems and our health care providers to move in if we want to create a payment and care delivery model that properly and cost effectively serves the people of the Commonwealth.

Managing Health Care Cost Drivers that Impact Consumers

Our bill also builds upon the foundation put forth by prior health care legislation, including Chapter 224, the 2012 cost containment legislation. Recent efforts have yielded moderate success in bending the cost growth curve. However, increasing health care costs disproportionately fall to individuals and employers, as increases in premiums and cost-sharing continue to outpace overall expenditures. These challenges have been further amplified by the COVID-19 pandemic.

This legislation seeks to address excess costs and spending in our health care system through a multi-faceted approach that targets systemic cost drivers and also promotes consumer access to high-value, affordable coverage and care.

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

- hold high-cost drug manufacturers accountable through a framework similar to that currently used for payors and providers that exceed the comparable cost benchmark;
- penalize manufacturers for excessive drug price increases; and
- establish new oversight authority for pharmacy benefit managers (PBMs).

The bill also includes several consumer protections and measures to reduce consumer premiums and other out-of-pocket costs. These include prohibitions on facility fees, and reforms promoting access to more affordable, innovative health plans for individuals and employers alike. These proposed reforms are drawn from the work of the Merged Market Advisory Council our Administration created in 2019, which recently issued its report.

Improving Access to High Quality, Coordinated Care

Finally, this legislation seeks to address shortages in the health care workforce while promoting access to quality, coordinated care and bringing Massachusetts in line with other states. These measures include joining a multi-state physician licensure compact, removing

outdated practice restrictions for certain clinicians, creating a new mid-level dental therapist license, standardizing urgent care services, and improving access to telemedicine.

As part of the effort to remedy a critical shortage in the health care workforce, I also once again urge the Legislature to pass language I have filed in a separate bill which would allow Massachusetts to join a multi-state nursing licensure compact. The health care bill I signed in 2021 charged the Health Policy Commission (HPC) with conducting a study on whether it would be beneficial to Massachusetts to join this compact, and the HPC concluded that it would be.

Promoting increased access to vital health care services is more important than ever and will ensure the Commonwealth is prepared to meet the evolving needs of our population. Many of the reforms we have proposed will also reduce costs – including to patients and small businesses – while maintaining the quality of care the people of Massachusetts deserve.

These reforms are critical and I look forward to working with the Legislature to once again enact comprehensive, nation-leading health care reform legislation.

Respectfully submitted,

Charles D. Baker,
Governor

SENATE . . . . . No. 2774

Senate, March 17, 2022 -- Message from His Excellency the Governor recommending legislation investing in the future of our health.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Second General Court
(2021-2022)

An Act investing in the future of our health.

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

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

SECTION 1. Chapter 6A of the General Laws is hereby amended by inserting after section 16CC the following section:-

Section 16DD. (a) There shall be a task force to make recommendations on aligned measures of health care provider quality and health system performance to ensure consistency in the use of quality measures in contracts between payers, including carriers, and health care providers in the commonwealth, ensure consistency in methods for evaluating providers for tiered network products, reduce administrative burden, improve transparency for consumers, improve health system monitoring and oversight by relevant state agencies, and improve quality and equity of care. Through September 2023, the members of the task force shall be the members of the existing EOHHS Quality Measurement Taskforce. After September 30, 2023, the task force shall include the following members: the secretary of health and human services or a

designee, who shall serve as chair; the following individuals, or their designees: the commissioner of public health, the commissioner of mental health, the executive director of the center for health information and analysis, the executive director of the health policy commission, the executive director of the group insurance commission, the assistant secretary for MassHealth, and the commissioner of insurance; and at a minimum, 14 members who shall be appointed by the governor, 1 of whom shall be a representative of a provider trade association, 1 of whom shall be a representative of a medical society, 1 of whom shall be a behavioral health provider, 1 of whom shall be a long-term services and supports provider, 1 of whom shall be a representative of a community health center serving the Medicaid population, 1 of whom shall be a representative of a Medicaid managed care organization, 1 of whom shall be a representative of a Medicaid-contracted accountable care organization, 1 of whom shall be a representative of a commercial managed care organization, 1 of whom shall be a representative for persons with complex health conditions, 1 of whom shall be a representative for consumers, 1 of whom shall be a representative of a hospital, at least 1 of whom shall be an academic with expertise in health care quality measurement, 1 of whom shall be a representative of an employer with experience in health care quality measurement and 1 of whom shall be a representative with subject matter expertise in or experience with health equity. Members appointed to the task force shall have experience with and expertise in health care quality measurement. The task force shall convene annually, with its first meeting occurring not later than January 15, 2023 and shall meet not less than monthly thereafter or as determined necessary by the chair of the task force. The task force shall submit an annual report with its recommendations, including any changes or updates to aligned measures of health care provider quality and health system performance, to the secretary

of health and human services and the joint committee on health care financing not later than May 31 of each year with the first report due in the year following the effective date of this section.

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

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

oral health providers, and other types of providers and measures applicable to different patient populations.

(d) No later than July 31 of each year, the secretary of health and human services in consultation with the commissioner of the division of insurance, may establish an aligned measure set to be used by carriers offering health plans that are subject to chapter 32A or chapter 176O in contracts with health care providers that incorporate quality measures into the payment terms, and carriers shall use such aligned measure set for assigning tiers to health care providers in tiered network plans pursuant to section 11 of chapter 176J. The aligned measure set shall designate: (i) core measures that shall be used in contracts between payers, including carriers, and health care providers, including provider organizations and accountable care organizations, which incorporate quality measures into payment terms; and (ii) non-core measures that may be used in such contracts. In establishing the aligned measure set, the secretary of health and human services may consider factors including but not limited to quality improvement priorities for the Commonwealth, quality measurement innovation, data collection methodology, and measure feasibility.

SECTION 2. Section 1 of chapter 6D of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after the definition of "After-hours care" the following 2 definitions:-

"Aggregate baseline expenditures", the sum of all primary care and behavioral health expenditures, as defined by the center, in the commonwealth in the calendar year preceding the 3-year period to which the aggregate target applies; provided, however, that aggregate baseline expenditures shall initially be calculated using calendar year 2019.

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

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

"Baseline expenditures", the sum of all primary care and behavioral health expenditures, as defined by the center, by or attributed to an individual health care entity in the calendar year preceding the 3-year period to which the target applies; provided, however, that baseline expenditures shall initially be calculated using calendar year 2019.

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

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

SECTION 5. Subsection (d) of section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 32, the words "and (xi)" and inserting in place thereof the following words:- (xi) 1 or more representatives of pharmaceutical or biopharmaceutical companies doing business in the commonwealth or trade groups thereof; (xii) 1 or more pharmacy benefit managers or trade groups thereof; and (xiii).

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

Section 8B. (a) For the purposes of this section, "Manufacturer" shall mean an entity that manufactures a pharmaceutical drug.

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

(1) A schedule of the drug's wholesale acquisition cost increases over the previous 5 calendar years;

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

(3) A written, narrative description, suitable for public release, of factors that contributed to reported changes in wholesale acquisition cost during the previous 5 calendar years; and

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

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

(c) A manufacturer of a drug for which the commission has received a referral from the center under subsection (b) of section 24 of chapter 12C shall comply with the requirements set

forth in this section; provided that the commission may select or prioritize a subset of the referred drugs for the commission's review.

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

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

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

third party in reaching its determination regarding the proposed value or the reasonableness of the drug pricing.

(g) If the commission relies upon a third party to provide cost-effectiveness analysis or research related to the proposed value, such analysis or research shall also provide, without limitation (i) a description of the methodologies and models used by the third party in its analysis; (ii) any assumptions and potential limitations of research findings in the context of the results; and (iii) outcomes for affected subpopulations that utilize the drug.

(h) Not later than 60 days after receiving information from the manufacturer, as required under subsections (b) or (e), the commission shall issue a determination on whether the manufacturer's pricing of a drug is unreasonable or excessive in relation to the commission's proposed value of the drug. Following the determination, the commission shall issue recommendations on measures to reduce the cost of the drug and to improve the affordability of the drug for patients. Recommendations may include, but not be limited to: (i) an alternative purchasing plan or value-based payment methodology; (ii) a bulk purchasing program; (iii) changes to co-pay, deductibles, coinsurance or other cost-sharing requirements; or (iv) a reinsurance program to subsidize the cost of the eligible drug. The commission shall make its determination and recommendations public and shall post them on its website and shall provide them to private and public health care payers.

(i) If the manufacturer fails to timely comply with the commission's request for records under subsections (b) or (e), or otherwise knowingly obstructs the commission's ability to issue its determination under subsection (h), including, but not limited to, providing incomplete, false or misleading information, the commission may assess a civil penalty to a manufacturer of not

more than $500,000. A civil penalty assessed under this subsection shall be deposited into the Payment Reform Fund established pursuant to section 100 of chapter 194 of the acts of 2011. The commission shall seek to promote compliance with this section and shall only impose a civil penalty on the manufacturer as a last resort.

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

SECTION 7. Said chapter 6D of the General Laws is hereby further amended by inserting after section 9 the following section:-

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

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

(1) For the 3-year period ending with calendar year 2024, the aggregate target shall be equal to a 30 per cent increase above aggregate baseline expenditures and the target shall be equal to a 30 per cent increase above baseline expenditures.

(2) For calendar years 2025 and beyond, the commission may modify the target and aggregate target, to be effective for a 3-year period provided that the target and aggregate target shall be approved by a two-thirds vote of the board not later than December 31 of the final calendar year of the preceding 3-year period. If the commission does not act to establish an updated target and aggregate target pursuant to this subsection, the target shall be equal to a 30

per cent increase above baseline expenditures, and the aggregate target shall be equal to a 30 per cent increase above aggregate baseline expenditures until such time as the commission acts to modify the target and aggregate target. If the commission modifies the target and aggregate target, the modification shall not take effect until the 3-year period beginning with the next full calendar year.

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

SECTION 8. Said chapter 6D of the General Laws is hereby further amended by inserting after section 10 the following section:-

Section 10A. (a) For the purposes of this section, "health care entity" shall mean a clinic, hospital, ambulatory surgical center, physician organization, accountable care organization or payer; provided, however, that physician contracting units with a patient panel of 15,000 or

fewer, or which represents providers who collectively receive less than $25,000,000 in annual net patient service revenue from carriers shall be exempt.

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

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

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

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

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

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

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

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

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

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

(5) any other factors the commission considers relevant.

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

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

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

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

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

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

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

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

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

(o) If the commission determines that a health care entity has: (i) willfully neglected to file a performance improvement plan with the commission by the time required in subsection (g); (ii) failed to file an acceptable performance improvement plan in good faith with the

commission; (iii) failed to implement the performance improvement plan in good faith; or (iv) knowingly failed to provide information required by this section to the commission or that knowingly falsifies the same, the commission may assess a civil penalty to the health care entity of not more than $500,000. A civil penalty assessed under this subsection shall be deposited into the Primary Care and Behavioral Health Equity Trust Fund established pursuant to section 2TTTTT of chapter 29. The commission shall seek to promote compliance with this section and shall only impose a civil penalty as a last resort.

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

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

SECTION 9. Section 35RR of chapter 10 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by striking out the second and third sentences and inserting in place thereof the following 2 sentences:- There shall be credited to the fund revenues from federal reimbursements under Title XIX or Title XXI of the Social Security Act and applicable waivers thereof, the Health Information Technology for Economic and Clinical Health Act, Title XIII of Division A and Title IV of Division B of Pub. L. No. 111-5 and any other federal reimbursements, grants, premiums, participant fees pursuant to section 10 of chapter 118I, gifts or other contributions from any source received for or in support of the commonwealth's Health Insurance Exchange/Integrated Eligibility System, the health care provider incentive payment program and for the promotion of electronic health record adoption, and the health information exchange in the commonwealth. The secretary of health and human services shall be the fund's

trustee and shall expend the fund, without further appropriation, for costs associated with the development, maintenance and administration of the Health Insurance Exchange/Integrated Eligibility System, the health information exchange program, incentive payments to eligible MassHealth health care providers for the adoption, implementation, upgrade or meaningful use of certified electronic health record technology and to support the planning, implementation and operating costs of administering these payments.

SECTION 10. Subsection (b) of section 10 of chapter 12C of the General Laws, as so appearing, is hereby amended by striking out, in line 55, the word “and”.

SECTION 11. Said subsection (b) of said section 10 of said chapter 12C is hereby further amended by adding the following words:- ; (12) information about prescription drug utilization and spending for all covered drugs, including for generic drugs, brand-name drugs, and specialty drugs provided in an outpatient setting or sold in a retail setting, including but not limited to information sufficient to show (i) highest utilization drugs, (ii) drugs with the greatest increases in utilization, (iii) drugs that are most impactful on plan spending, net of rebates, and (iv) drugs with the highest year-over-year price increases, net of rebates; and (13) information on claims and non-claims based payments to providers for the provision of primary care and behavioral health, including mental health and substance use disorder, services, as defined by the center.

SECTION 12. Subsection (c) of said section 10 of said chapter 12C, as so appearing, is hereby amended by striking out, in line 91, the words “()” and inserting in place thereof the following words:- (10).

SECTION 13. Said subsection (c) of said section 10 of said chapter 12C, as so appearing, is hereby further amended by striking out, in line 99, the word “and”.

SECTION 14. Said subsection (c) of said section 10 of said chapter 12C, as so appearing, is hereby further amended by adding the following words:- ; (12) information, to the extent permissible under 42 U.S.C. 1396r-8(b)(3)(D), about prescription drug utilization and spending for all covered drugs, including for generic drugs, brand-name drugs, and specialty drugs provided in an outpatient setting or sold in a retail setting, including but not limited to information sufficient to show (i) highest utilization drugs, (ii) drugs with the greatest increases in utilization, (iii) drugs that are most impactful on plan spending, net of rebates, and (iv) drugs with the highest year-over-year price increases, net of rebates; and (13) information on claims and non-claims based payments to providers for the provision of primary care and behavioral health, including mental health and substance use disorder services, as defined by the center.

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

Section 10A. (a) The center shall promulgate regulations necessary to ensure the uniform annual reporting of information from pharmacy benefit managers certified under chapter 175N, including but not limited to information on: (1) prices charged to payers on average by pharmacy benefits managers for select prescription drug products, net of any rebate, discounts, fees or other payments from the manufacturer to the pharmacy benefits manager and from the pharmacy benefits manager to the manufacturer; (2) payments received by pharmacy benefit managers by payers related to drugs provided to Massachusetts residents; (3) payments made by pharmacy benefit managers to pharmacies related to drugs provided to Massachusetts residents; (4) rebates received by pharmacy benefit managers from drug manufacturers related to drugs provided to Massachusetts residents; (5) rebates paid by pharmacy benefit managers to payers related to drugs provided to Massachusetts residents; (6) other payments made or received by pharmacy

benefit managers by payers or pharmacies, including but not limited to administrative or performance-based payments, related to doing business in Massachusetts; (7) other rebates paid to or received by pharmacy benefit managers by drug manufacturers or payers related to doing business in Massachusetts; (8) information about prescription drug utilization and spending for all covered drugs, including for generic drugs, brand-name drugs, and specialty drugs provided in an outpatient setting or sold in a retail setting, including but not limited to information sufficient to show: (i) highest utilization drugs; (ii) drugs with the greatest increases in utilization; (iii) drugs that are most impactful on plan spending, net of rebates; and (iv) drugs with the highest year-over-year price increases, net of rebates; and (9) any other information specified by the center.

(b) The center shall analyze the information and data collected under subsection (a) and shall publish an annual report summarizing, at minimum, the information collected under subsection (a) and comparing the information as it relates to each pharmacy benefit manager certified under chapter 175N with respect to drugs provided to Massachusetts residents.

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

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

SECTION 17. Section 16 of said chapter 12C, as appearing in the 2020 Official Edition, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

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

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

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

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

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

The center shall publish the aggregate baseline expenditures starting in the 2023 annual report.

The center, in consultation with the commission, shall hold a public hearing and adopt or amend rules and regulations establishing the methodology for calculating baseline and subsequent years' expenditures for individual health care entities within 90 days of the effective date.

The center, in consultation with the commission, shall determine the baseline expenditures for individual health care entities and shall report to each health care entity its respective baseline expenditures by not less than thirty days before publishing the results.

SECTION 18. Said chapter 12C of the General Laws is hereby further amended by striking out section 18 and inserting in place thereof the following section:-

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

(1) Contribution to health care spending growth, including but not limited to spending levels and growth as measured by health status adjusted total medical expenses is considered excessive and who threaten the ability of the state to meet the health care cost growth benchmark established by the health policy commission under section 9 of chapter 6D;

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

(3) Data is not submitted to the center in a proper, timely, or complete manner.

The center shall confidentially provide a list of the payers, providers, or provider organizations to the health policy commission such that the commission may pursue further action under sections 10 and 10A of chapter 6D. Confidential referrals under this section shall not preclude the center from using its authority under section 11 .

SECTION 19. Said chapter 12C is hereby further amended by inserting after section 21A the following section:-

Section 21B. The center, in consultation with the health policy commission, shall investigate and analyze trends relative to the health care workforce in the commonwealth, including how it is changing over time, the supply of and demand for workers, demographic characteristics of the workforce including race, ethnicity, language, and age, geographic variations, job satisfaction, retention, and turnover, and other issues affecting the commonwealth’s healthcare workforce and the resulting impact such workforce issues have on health care access, equity, and disparities. Except as specifically provided otherwise by the center or under this chapter, health care workforce data collected by the center under this section

shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66.

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

Section 25. (a) The center shall analyze data on Massachusetts drug utilization and spending, including but not limited to data reported under Sections 10 and 10A. Annually, the center shall refer drugs to the health policy commission for review under section 8B of chapter 6D that meet any of the following criteria: (i) a current average annual gross cost per utilizer for public and private health care payers in Massachusetts of greater than $50,000; (ii) a biosimilar drug that has a launch wholesale acquisition cost that is not at least 15 per cent lower than the referenced brand biologic at the time the biosimilar is launched; or (iii) among the 25 drugs determined by the center to have the most impact on health care spending in the most recent year of available data, based upon utilization, price, utilization and price growth, patient cost sharing amounts, net spending and other factors as determined by the center. The center shall provide notice of the referral to the manufacturer of the drug.

(b) Not later than May 1, the center shall publish an annual report detailing, at minimum, each drug referred to the health policy commission under subsection (a).

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

SECTION 21. Chapter 13 of the General Laws is hereby amended by adding the following section:-

Section 110. (a) There shall be, within the department of public health, a board of registration of certified peer workers which shall consist of the following: the commissioner of public health or a designee; the commissioner of mental health or a designee; the director of the office of Medicaid or a designee; and 12 persons appointed by the governor, 1 of whom shall be a peer recovery coach, 1 of whom shall be a family partner, 1 of whom shall be a young adult peer mentor, 1 of whom shall be a certified peer specialist, 1 of whom shall be a certified addictions recovery coach, 1 of whom shall be a certified older adult peer specialist, 1 of whom shall be a family member to an individual with a mental health or substance use disorder, 1 of whom shall be a peer supervisor or educator, 1 of whom shall be a licensed health care provider specializing in mental health or substance use disorder, and 3 of whom have received peer services for 1 or more years. Members of the board shall be residents of the commonwealth.

(b) Each member of the board shall serve for a term of 3 years. Upon the expiration of a term of office, a member shall continue to serve until a successor has been appointed. A member shall not serve for more than 2 consecutive terms.

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

(d) The board shall, at its first meeting and annually thereafter, organize by electing from its membership a chair, a vice-chair and a secretary. Those officers shall serve until their successors are elected. The first meeting of the board shall take place no less than 2 years after the effective date of this section.

(e) The board shall meet at least 4 times annually and may hold additional meetings at the call of the chair or at such times as may be determined by the board. Board members shall serve

without compensation but shall be reimbursed for actual and reasonable expenses incurred in the performance of their duties.

SECTION 22. Chapter 19A of the General Laws is hereby amended by adding the following section:-

Section 44. (a) To facilitate the effective and efficient use of portable medical orders across care settings, the department shall, notwithstanding any general or special law to the contrary, develop, implement, and administer a program governing the statewide use of Portable Orders for Life Sustaining Treatment (POLST) in Massachusetts. The POLST program shall transition from the use of Medical Orders for Life-Sustaining treatment (MOLST) to the national POLST model. The department shall consult with the department of public health and the executive office of health and human services in the development and implementation of the POLST program.

(b) Any patient information submitted to or held by the POLST program shall be kept confidential and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 and chapter 66 and shall be governed by the provisions of chapter 66A.

(c) The department may develop, implement, and administer a secure electronic system as part of the POLST program. The electronic POLST (ePOLST) system shall be a secure electronic database or other similar secure software or information system that enables automated query and retrieval of POLST program information by a health care professional. The department shall promulgate regulations governing the protection of and access to POLST information.

(d) The department shall establish and maintain procedures to ensure that POLST patient information that may be collected, recorded, transmitted and maintained is not disclosed to persons except as provided for in regulations promulgated in accordance with this chapter.

(e) The department may contract with another agency or private vendor, as necessary, to ensure the effective operation of ePOLST. Any such contractor shall be bound to comply with, at a minimum, the provisions regarding confidentiality of POLST program information and the regulations promulgated in accordance with this chapter.

(f) The department may enter into reciprocal agreements with other states that have compatible ePOLST systems to facilitate access to POLST program information.

(g) The secretary may establish an advisory committee to provide advice regarding POLST program issues, including but not limited to, appropriate user training, policies governing the use of POLST, and aspects of program implementation to facilitate the effective and efficient use of portable medical orders across care settings.

(h) The department shall promulgate regulations necessary to implement the requirements of this chapter.

SECTION 23. Chapter 26 of the General Laws is hereby amended by striking out section 8K and inserting in place thereof the following section:-

(a) The commissioner of insurance may implement and enforce applicable provisions of the federal Mental Health Parity and Addiction Equity Act, section 511 of Public Law 110–343, and applicable state mental health parity laws, including section 22 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and

4M of chapter 176G of the General Laws, in regard to any carrier licensed under chapters 175, 176A, 176B and 176G.

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

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

part of its evaluation of whether a health carrier's provider network is adequate to provide access to covered behavioral health services.

SECTION 24. Chapter 29 of the General Laws is hereby amended by inserting after section 2QQQQQ, as inserted by section 17 of chapter 24 of the acts of 2021, the following 2 sections:-

Section 2TTTTT. (a) There shall be a Primary Care and Behavioral Health Equity Trust Fund. The secretary of health and human services shall be the trustee of the fund and shall expend money in the fund to make payments to providers or care organizations under contract with the executive office of health and human services to provide MassHealth services pursuant to an approved state plan or federal waiver. There shall be credited to the fund: (i) an amount equal to the total receipts deposited each quarter in the General Fund from the penalty on drug manufacturers for excessive price increases established under chapter 63E; (ii) any revenue from appropriations or other money authorized by the general court and specifically designated to be credited to the fund; (iii) other money from public and private sources, including gifts, grants and donations; and (iv) interest earned on any money in the fund. Amounts credited to the fund shall be expended without further appropriation.

(b) Except as provided in subsection (d) or with the written approval of the secretary of administration and finance, money in the fund may be expended for Medicaid payments under an approved state plan or federal waiver; provided, however, that all payments from the fund shall be: (i) subject to the availability of federal financial participation; (ii) made only under federally-approved payment methods; (iii) consistent with federal funding requirements and all applicable federal payment limits as determined by the secretary of health and human services; and (iv)

subject to the terms and conditions of applicable agreements between providers or care organizations and the executive office of health and human services. To accommodate timing discrepancies between the receipt of revenue and related expenditures, the comptroller may certify for payment amounts not to exceed the most recent revenue estimates as certified by the secretary to be transferred, credited or deposited under this section. Money remaining in the fund at the end of a fiscal year shall not revert to the General Fund.

(c) The secretary of health and human services shall annually expend money in the fund for payments to qualifying providers or care organizations under contract with the executive office of health and human services, provided that such payments shall support payments for primary care and behavioral health services.

(d) The secretary of health and human services may annually expend up to $15,000,000 for payments to qualifying providers for the purpose of funding projects designed to advance health equity within local communities within the commonwealth, as determined by the secretary, provided that the secretary shall prioritize payments to primary care and behavioral health providers with a high public payer mix located in underserved communities, also as determined by the secretary. The secretary of health and human services may structure such payments as grants, and need not maximize federal financial participation on such payments.

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

(f) Not later than October 15 of each fiscal year, the secretary of health and human services shall file a report with the joint committee on health care finance and the house and

senate committees on ways and means detailing the allocation of the expenditures from the fund during the prior fiscal year.

Section 2UUUUU. (a) There shall be established and set up on the books of the commonwealth a separate fund to be known as the Portable Order for Life Sustaining Treatment Trust Fund. The secretary of health and human services shall be the trustee of the fund and shall expend the fund to: (i) develop, implement and operate a program governing the statewide use of a Portable Order for Life Sustaining Treatment (POLST) program administered by the department of elder affairs; (ii) support the transition from the use of the Medical Order for Life Sustaining Treatment (MOLST) program in the department of public health to the POLST program in the department of elder affairs; (iii) develop, implement and operate a statewide electronic POLST (ePOLST) program administered by the department of elder affairs; and (iv) provide for any other program purpose related to the transition from MOLST to POLST, or the establishment, maintenance or operation of the POLST or ePOLST program.

(b) There shall be credited to the fund an amount equal to: (i) any revenues under Section 9817 of the American Rescue Plan Act of 2021, Pub. L. No. 117-2 designated for the purposes described in subsection (a); (ii) any federal financial participation revenues claimed and received by the commonwealth for eligible expenditures made from the fund; (iii) any appropriations or other money authorized by the general court and specifically designated to be credited to the fund; (iv) interest earned on any money in the fund; and (v) any other grants, premiums, gifts, reimbursements, or other contributions received by the commonwealth from any source for or in support of for the purposes described in subsection (a).

(c) Amounts credited to the fund may be expended without further appropriation. For the purpose of accommodating timing discrepancies between the receipt of revenues and related expenditures, the fund may incur expenses, and the comptroller shall certify for payment, amounts not to exceed the most recent revenue estimate as certified by the secretary of elder affairs, as reported in the state accounting system. Any moneys remaining in the fund at the end of a fiscal year shall not revert to the General Fund and shall be available for expenditure in a subsequent fiscal year.

SECTION 25. Chapter 32A of the General Laws is hereby amended by adding the following section:-

Section 31. (a) As used in this section, “facility fee” and “health care provider” shall have the same meanings as provided in section 51L of chapter 111.

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

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

SECTION 26. The General Laws are hereby further amended by inserting after chapter 63D, as inserted by chapter 69 of the acts of 2021, the following chapter:-

Chapter 63E

PENALTY ON DRUG MANUFACTURERS FOR EXCESSIVE PRICE INCREASES

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

“Commissioner”, the commissioner of revenue.

“Core consumer price index”, the consumer price index for all urban consumers (CPI-U): U.S. city average, for all Items less food and energy, as reported by the U.S. Bureau of Labor Statistics.

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

“Excessive price,” the price of a drug that exceeds the sum of the reference price of that drug plus the three -year average of the core consumer price index, as measured on January 1 of the current calendar year.

“Excessive price increase”, the amount by which the price of a drug exceeds the sum of the reference price of that drug plus the three -year average of the core consumer price index, as measured on January 1 of the current calendar year.

“Person”, any natural person or legal entity.

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

“Reference date”, January 1 of the calendar year prior to the current calendar year.

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

"Related party", an entity is a related party with respect to a person if that entity (i) belongs to the same affiliated group as that person under section 1504 of the Internal Revenue Code provided that the term 50 percent shall be substituted for the term 80 percent each time it appears in said section 1504, (ii) has a relationship with that person that is specified in subsections (b) and (c) of section 267 of the Internal Revenue Code, or (iii) is otherwise under common ownership and control with regard to that person; provided that all references to the Internal Revenue Code in this definition refer to the Internal Revenue Code as amended and in effect for the taxable year.

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

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

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

penalty amounts on the return for the tax period during which such units are ultimately dispensed or administered.

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

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

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

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

Section 7. To the extent that a person subject to penalty under section 2 fails to pay amounts due under this chapter, a related party of such person that directly or indirectly

distributes in the commonwealth any drug whose sales are subject to this chapter shall be jointly and severally liable for the penalty due.

Section 8. The commissioner may promulgate regulations for the implementation of this chapter.

SECTION 27. Paragraph (4) of subsection (d) of section 7 of chapter 94C of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting, in line 80, after the words “licensed practical nurse” the following words:- or a licensed dental therapist under the supervision of a practitioner for the purposes of administering analgesics, anti-inflammatories and antibiotics.

SECTION 28. Subsection (g) of said section 7 of said chapter 94C, as so appearing, is hereby amended by striking out the third paragraph and inserting in place thereof the following paragraph:-

The commissioner shall promulgate regulations which provide for the registration of physician assistants to issue written prescriptions for patients pursuant to guidelines mutually developed and agreed upon by one or more supervising or collaborating physicians and the physician assistant. Prior to promulgating such regulations, the commissioner shall consult with the board of registration of physician assistants, and the board of registration in medicine with regard to those schedules of controlled substances for which physician assistants may be registered to issue written prescriptions therefor.

SECTION 29. Subsection (a) of section 9 of said chapter 94C, as so appearing, is hereby amended by adding the following paragraph:-

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

SECTION 30. Subsection (c) of said section 9 of said chapter 94C, as so appearing, is hereby amended by adding the following paragraph:-

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

SECTION 31. Chapter 111 of the General Laws is hereby amended by inserting after section 51½ the following section:-

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

SECTION 32. Said chapter 111 of the General Laws is hereby further amended by inserting after section 51K the following 2 sections:-

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

"Campus", a hospital's main buildings, the physical area immediately adjacent to a hospital's main buildings and other areas and structures that are not strictly contiguous to the

main buildings but are located within 250 yards of the main buildings or other area that has been determined by the Centers for Medicare and Medicaid Services to be part of a hospital's campus.

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

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

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

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

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

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

(d) The department may promulgate regulations necessary to implement this section and impose penalties for non-compliance consistent with the department's authority to regulate health care providers. A health care provider that violates any provision of this section or the

rules and regulations adopted pursuant hereto shall be punished by a fine of not more than $1,000 per occurrence.

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

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

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

(c) A facility at which facility fees for services are charged, billed, or collected shall clearly identify itself as being associated with a hospital, including by stating the name of the

hospital that owns or operates the location in its signage, marketing materials, Internet web sites, and stationery.

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

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

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

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

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

SECTION 33. Section 52 of said chapter 111 of the General Laws , as appearing in the 2020 Official Edition, is hereby amended by striking out the definition of "Clinic" and inserting in place thereof the following definition:-

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

institution. For purposes of this section, clinic shall include any entity meeting the definition of urgent care clinic that is conducted by a hospital licensed under section 51, but shall not include a clinic that does not meet the definition of an urgent care clinic conducted by a hospital licensed under section 51 or any clinic conducted by the federal government or the commonwealth.

SECTION 34. Said section 52 of said chapter 111 of the General Laws, as so appearing, is hereby further amended by adding the following 2 definitions:-

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

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

SECTION 35. Said chapter 111 of the General Laws is hereby further amended by inserting after said section 52 the following section:-

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

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

The department may impose a fine of up to $10,000 on a person or entity that advertises, announces, establishes, or maintains an urgent care clinic without a license granted by the department. The department may impose a fine of not more than $10,000 on a licensed urgent care clinic that violates this section or any rule or regulation promulgated hereunder. Each day during which a violation continues shall constitute a separate offense. The department may conduct surveys and investigations to enforce compliance with this section.

SECTION 36. Section 228 of said chapter 111 of the General Laws, as so appearing, is hereby amended by striking out subsection (e) and inserting in place thereof the following subsection:-

(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, or if the provider is rendering unforeseen out-of-network services, as defined in subsection (a) of section 30 of chapter 176O, 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.

SECTION 37. Chapter 112 of the General Laws is hereby amended by striking out section 5O, and inserting in place thereof the following section:-

Section 5O. (a) For purposes of this chapter "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) A Physician licensed pursuant to this chapter may provide healthcare services to a patient via telehealth from any location within Massachusetts or outside Massachusetts, provided that the following conditions are met: (i) the patient is physically located in Massachusetts at the time the healthcare services are provided; (ii) the location from which the physician provides the services does not compromise patient confidentiality and privacy; and (iii) the location from

which the physician provides the services does not exceed restrictions placed on the physician's specific license, including but not limited to, restrictions set by the hospital, institution, clinic or program in which a physician licensed pursuant to section 9 of this chapter has been appointed.

(c) Health care services provided via telehealth shall conform to the standards of care applicable to services rendered in person and shall also conform to applicable federal and state health information privacy and security standards as well as standards for informed consent.

(d) 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 from 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 38. Said chapter 112 of the General Laws is hereby further amended by striking out section 9E and inserting in place thereof the following section:-

Section 9E. Notwithstanding any other provisions of law, a physician assistant may perform medical services when such services are rendered:

(a) under the supervision of or in collaboration with a registered physician or physicians. Such collaboration or supervision shall be continuous but shall not require the personal presence of the registered physician or physicians;

(b) in accordance with the level of the physician assistant's professional training and experience as determined by a supervising or collaborative physician;

(c) in private practice, in group practices or in health care facilities, consistent with any applicable bylaws and policies of such facilities.

Physician assistants may perform medical services of a general nature and may order tests and therapeutics in assisting physicians.

A physician assistant may order therapeutics and tests and issue written prescriptions for patients subject to the provisions of paragraph (g) of section 7 of chapter 94C.

If a physician assistant is employed by a physician or group of physicians, the assistant shall be the legal responsibility of the employing physician or physicians. The legal responsibility of such assistant shall remain that of the employing physician or physicians at all times when the assistant aids in the care and treatment of patients in health care facilities.

If a physician assistant is employed by a health care facility, the legal responsibility for his actions and omissions shall be that of the employing facility. Such physician assistants shall be supervised by or work in collaboration with registered physicians. Such physician assistants employed by health care facilities shall not be utilized as the sole medical personnel in charge of emergency or outpatient services or any other clinical service where a physician is not regularly available.

Notwithstanding any other provisions of law, a physician assistant trainee may perform medical services when such services are rendered within the scope of a program approved under section 9K.

SECTION 39. Section 9F of said chapter 112 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by striking out the third paragraph and inserting in place thereof the following paragraph:-

The board shall adopt, amend and rescind such rules and regulations, not inconsistent with other provisions of the General Laws, as it deems necessary to carry out the provisions of this chapter. The board may, in consultation with the board of registration in medicine, and consistent with the authority of the board of registration in medicine over the supervising and collaborating physicians and the practice of medicine, adopt rules and regulations governing the practice and employment of physician assistants in order to promote the public health, safety and welfare.

SECTION 40. The third paragraph of section 9I of said chapter 112, as so appearing, is hereby amended by striking out the last sentence.

SECTION 41. The fourth paragraph of said section 9I of said chapter 112, as so appearing, is hereby further amended by striking out the last sentence.

SECTION 42. Said chapter 112 of the General Laws is hereby further amended by striking out section 13 and inserting in place thereof the following section:-

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

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

(c) The provisions of this section to section 18, inclusive, shall not apply to surgeons of the United States army, United States navy or of the United States Public Health Service or to physicians registered in the commonwealth.

SECTION 43. Section 43A of said chapter 112 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after the definition of "Appropriate supervision" the following 2 definitions:-

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

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

SECTION 44. Said section 43A of said chapter 112, as so appearing, is hereby further amended by inserting after the definition of "Dental hygienist" the following 2 definitions:-

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

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

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

SECTION 46. Section 46 of said chapter 112 of the General Laws is hereby repealed.

SECTION 47. Section 51 of said chapter 112 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by striking out, in line 17, the word “revoked” and inserting in place thereof the following words:- null and void.

SECTION 48. Section 51½ of said chapter 112, as so appearing, is hereby amended by striking out, in line 10, the word “revoked” and inserting in place thereof the following words:- null and void.

SECTION 49. Said section 51½ of said chapter 112, as so appearing, is hereby further amended by inserting, in lines 18 and 32, after the word “dentist”, both times it appears, the following words:- , or a licensed dental therapist to the extent provided in section 51B.

SECTION 50. Said section 51½ of said chapter 112, as so appearing, is hereby further amended by inserting after the word “practice” in line 79, the following words:- , or a dental therapist licensed under section 51B.

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

Section 51B. (a) Any person of good moral character, 19 years old or over, who: (i) is a graduate of a master’s level dental therapist education program that includes both dental therapy

and dental hygiene education, or an equivalent combination of both dental therapy education and dental hygiene education, if all education programs are accredited by the Commission on Dental Accreditation; (ii) passes a comprehensive, competency-based clinical examination that is approved by the board and administered by a recognized national or regional dental testing service that administers testing for dentists and other dental professionals or equivalent examination administered by another entity approved by the board; and (iii) obtains a policy of professional liability insurance and shows proof of such insurance as required by rules and regulations shall, upon payment of a fee to be determined annually by the secretary of administration and finance under the provision of section 3B of chapter 7, be registered as a dental therapist and be given a certificate to practice in this capacity. A licensed dental therapist shall have practiced under the direct supervision of a supervising dentist for a minimum of 2 years or 2,500 hours, whichever is longer, before practicing under general supervision pursuant to a collaborative management agreement. Dental therapists licensed under this section shall renew licensure biennially, on a date determined by the board, upon application and payment of a fee, as determined by the secretary of administration and finance under section 3B of chapter 7. Upon receipt of a license pursuant to section 45, any certificate issued hereunder shall be null and void.

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

supervising dentist during the performance of those procedures and services unless required by the supervising dentist in the collaborative management agreement.

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

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

The educational curriculum for a dental therapist educated in the commonwealth shall include training on serving patients with special needs including, but not limited to, people with developmental disabilities including autism spectrum disorders, mental illness, cognitive

impairment, complex medical problems, or significant physical limitations, and the vulnerable elderly.

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

(d) The board shall grant a dental therapy license by examination to an applicant, upon payment of a fee as determined under subsection (a), provided the applicant is of good moral character and has: (i) met the eligibility requirements as defined by the board; (ii) submitted documentation to the board of a passing score on a comprehensive, competency-based clinical examination or combination of examinations that includes both dental therapy and dental hygiene components and are approved by the board and administered by a recognized national or regional dental testing service that administers testing for dentists and other dental professionals; and (iii) submitted to the board documentation of a passing score on the Massachusetts Dental Ethics and Jurisprudence Examination or any other successor examination. An applicant failing to pass the examination shall be entitled to re-examination pursuant to the rules and guidelines established by the Commission on Dental Competency Assessments (formerly NERB), for which the applicant shall pay a fee determined annually by the secretary of administration and finance under the provision of section 3B of chapter 7.

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

The board shall grant a license by credentials, without further professional examination, to a dental therapist licensed in another jurisdiction, upon payment of a fee as determined under subsection (a), provided the applicant is of good moral character and has: (i) met the eligibility requirements as defined by the board; (ii) furnished the board with satisfactory proof of graduation from an education program or combination of education programs providing both dental therapy and dental hygiene education that meets the standards of the Commission on Dental Accreditation, provided, however, that an applicant who graduated from a dental therapy education program established before the Commission on Dental Accreditation established a dental therapy accreditation program is eligible notwithstanding the lack of accreditation of the program at the time the education was received; (iii) submitted documentation of a passing score on a dental therapy examination administered by another state or testing agency that is substantially equivalent to the board-approved dental therapy examination for dental therapists as defined in this section; (iv) submitted documentation of a passing score on the Massachusetts Dental Ethics and Jurisprudence Examination or any other successor examination; and (v)

submitted documentation of completion of 2 years or 2,500 hours, whichever is longer, of practice. If such practice requirement is not met, a dental therapist shall be required to complete the remaining hours or years, whichever is longer, under direct supervision in the commonwealth prior to practicing under general supervision.

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

After entering into a collaborative management agreement with a supervising dentist, dental therapists shall practice under direct supervision for not less than 2,500 clinical hours or two years, whichever is longer. After completing 2,500 clinical hours or two years, whichever is longer, of practice under direct supervision, dental therapists are authorized to perform all procedures and services listed in the Commission on Dental Accreditation's dental therapy standards and all procedures and services within the scope of a public health dental hygienist, as

set forth in regulations by the board, under general supervision if authorized by a supervising dentist pursuant to a written collaborative agreement. In addition, the following procedures, referred to in this section as advanced procedures, may be performed under direct supervision: (i) preparation and placement of direct restoration in primary and permanent teeth; (ii) fabrication and placement of single-tooth temporary crowns; (iii) preparation and placement of preformed crowns on primary teeth; (iv) indirect and direct pulp capping on permanent teeth; (v) indirect pulp capping on primary teeth; and (vi) simple extractions of erupted primary teeth, provided however that the advanced procedures may be performed under general supervision if authorized by the board pursuant to subsection (f) of this section.

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

(f) By January 1, 2024, the department of public health in consultation with the board and any other entity they deem appropriate, shall begin an evaluation assessing the impact of dental therapists practicing under general supervision in Massachusetts and the rest of the United States, specifically on: (i) dental therapists' progress in expanding access to safe and effective dental

services for vulnerable populations including, at a minimum, Medicaid beneficiaries and individuals who are underserved as defined in this section; (ii) an appropriate geographic distance limitation between the dental therapist and supervising dentist that permits the dental therapist to expand access to vulnerable populations including, at a minimum, Medicaid beneficiaries and individuals who are underserved as defined in this section; and (iii) the number of dental hygienists and dental assistants a dental therapist may oversee.

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

Should the board, in consultation with the department and any other appropriate entity, determine that dental therapists shall have the authority to perform one or more of the procedures

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

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

Should the board determine that dental therapists shall continue to perform one or more of the advanced procedures under direct supervision, the department, in consultation with the board, shall re-evaluate annually the impact of dental therapists practicing under general supervision in Massachusetts and the rest of the United States, and the board shall annually reassess whether to authorize general supervision for the advanced procedures in order to improve dental therapists' progress in expanding access to safe and effective dental services for vulnerable populations including, at a minimum, Medicaid beneficiaries and individuals who are underserved as defined in this section.

(g) The board shall establish appropriate guidelines for a written collaborative management agreement. A collaborative management agreement shall be signed and maintained by the supervising dentist and the dental therapist and shall be submitted annually to the board. The agreement may be updated as necessary. The agreement shall serve as standing orders from the supervising dentist and shall address: (i) practice settings; (ii) any limitation on services established by the supervising dentist; (iii) the level of supervision required for various services or treatment settings; (iv) patient populations that may be served; (v) practice protocols; (vi) record keeping; (vii) managing medical emergencies; (viii) quality assurance; (ix) administering and dispensing medications; (x) geographic distance limitations; (xi) oversight of dental hygienists and dental assistants; and (xii) referrals for services outside of the dental therapy scope of practice. The collaborative management agreement shall include specific protocols to govern situations in which the dental therapist encounters a patient who requires treatment that exceeds the authorized scope of practice of the dental therapist. The supervising dentist is responsible for directly providing, or arranging for another dentist or specialist within an accessible geographic distance to provide, any necessary additional services outside of the dental therapy scope of practice needed by the patient. A supervising dentist may have a collaborative management agreement with not more than 3 dental therapists at the same time. Not more than 2 of such dental therapists may practice under general supervision with certification to perform one or more of the advanced procedures. A practice or organization with more than one practice location listed under the same business name may not employ more than 6 dental therapists, provided, however, that this requirement shall not apply if such an organization or practice is a federally qualified health center or look-alike, a community health center, a non-profit practice

or organization, or a public health setting, which for purposes of this section shall be as defined by 234 CMR 2.02, or as otherwise permitted by the board.

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

(i) Not less than 50 per cent of the patient panel of a dental therapist, as determined in each calendar year, shall consist of patients who receive coverage through MassHealth or its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms, and third-party administrators under contract to a MassHealth managed care organization or primary care clinician plan; or are considered underserved provided, however, that this requirement shall not apply if the dental therapist is operating in a federally qualified health center or look-alike, community-health center, non-profit practice or organization, or other public health setting as defined by the board by regulation, or as otherwise permitted by the board. As used in this section, “underserved” means individuals who: (i) receive, or are eligible to receive, benefits through MassHealth or its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms, and third-party administrators under contract to a MassHealth managed care organization or primary care clinician plan; (ii) receive, or are eligible to receive, Social Security Disability Benefits (SSDI), Supplemental Security Income (SSI), and/or Massachusetts State Supplement Program (SSP); (iii) live in a dental health professional shortage area (DPSA) as designated by the U.S. Department of Health and Human Services; (iv) reside in a nursing home, skilled nursing facility, veterans home, or

long-term care facility; (v) receive dental services at a public health setting as defined by the board by regulation; (vi) receive benefits, or are eligible to receive benefits, through plans sold by the connector; (viii) receive benefits, or are eligible to receive benefits, through the Indian Health Service, tribal or urban Indian organizations, or through the Contract Health Service Program; (ix) receive benefits, or are eligible to receive benefits, through the Department of Veterans Affairs or other organization serving veterans; (x) are elderly and have trouble accessing dental care due to mobility or transportation challenges; (xi) meet the Commission on Dental Accreditation's definition of people with special needs; (xii) are uninsured and living at 305 per cent of the Federal Poverty Level; or (xiii) as otherwise permitted by the board.

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

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

(k) Not later than January 1, 2024, the board, in consultation with the department shall establish regulations to implement the provisions of this section for the licensure and practice of dental therapy to protect the public health, safety and welfare, including but without limitation

guidelines for collaborative management agreements, continuing education requirements, license renewal, standards of conduct and the investigation of complaints, and disciplinary actions.

SECTION 52. Said chapter 112 of the General Laws is hereby further amended by adding the following 3 sections:-

Section 290. (a) The following words as used in sections 290 to 292, inclusive, unless the context otherwise requires, shall have the following meanings:--

“Board”, the board of registration of peer workers, established under section 110 of chapter 13.

“Certified Peer Worker”, an individual who is authorized to practice by the board under this chapter and who uses shared understanding, respect and mutual empowerment to help others become and stay engaged in the process of recovery from a mental health or substance use disorder.

“Lived experience”, the experience of addiction and recovery from a substance use disorder and/or the experience of and recovery from a mental health disorder.

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

(1) to promulgate regulations and adopt such rules as are necessary to regulate certified peer workers, including, but not limited to, the following roles: family partner, young adult peer mentor, peer specialist, older adult peer specialist, peer recovery coach, and addictions recovery coach.

(2) to receive, review, approve or disapprove initial applications, renewals and reinstatement requests and to issue those authorizations to provide services as a certified peer worker;

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

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

(5) to establish specifications for the authorized training of certified peer workers; provided, that the specifications shall require individuals to have lived experience and demonstrate at least 2 years of sustained recovery; provided further, that the lived experience requirement may be waived for individuals who were credentialed by other certification bodies before the establishment of the board;

(6) to define by regulation the appropriate standards for education, core competencies, and experience necessary to qualify as a certified peer worker, including, but not limited to, continuing professional education requirements; provided, that the board shall consider any standards contained within peer worker training programs established by the department of public health; provided further, that a waiver may be considered for individuals who already possess a certification or who have passed other competency evaluations;

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

(8) to establish standards of supervision for certified peer workers; provided, that the board shall consider standards contained within peer worker training programs established by the department of public health;

(9) to fine, censure, revoke, suspend or deny a certified peer worker authorization to practice, place on probation, reprimand or otherwise discipline a certified peer worker for violations of the code of ethics or the rules of the board;

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

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

Section 291. An application to be a certified peer worker, under section 290, shall be made on forms approved by the board, signed under the penalties of perjury by the person certifying the information contained therein and accompanied by the required fee. The fee shall be determined by the secretary of administration and finance under section 3B of chapter 7. A certified peer worker applicant shall furnish satisfactory proof that the applicant is at least 18 years of age, and has met all the education, training, experience, ethical, and certification requirements and qualifications as established by the board.

The board, in consultation with the department of public health, shall determine the renewal cycle and renewal period for authorization to practice as a certified peer worker. A peer worker authorized to practice under this chapter shall apply to the board for a renewal not later than the expiration date, as determined by the board, unless earlier revoked, suspended or canceled as a result of a disciplinary proceeding. As a condition for renewal under this section,

the board may require satisfactory proof that the peer worker has successfully completed the required number of hours of continuing education in courses or programs approved by the board or has complied with such other requirements or equivalent requirements as approved by the board. Upon satisfactory compliance with the requirements and successful completion of the continuing education requirements, the board shall issue a renewal. The board may provide for the late renewal that has lapsed and may require payment of a late fee. Each renewal application submitted to the board shall be accompanied by a fee as determined by the secretary of administration and finance under section 3B of chapter 7.

Section 292. No person filing a complaint alleging a violation of law or of the regulations of the board, reporting information pursuant to such laws or regulations or assisting the board at its request in any manner in discharging its duties and functions shall be liable in any cause of action arising out of the board's receipt of such information or assistance, if the person making the complaint, or reporting or providing such information or assistance, does so in good faith and without malice.

SECTION 53. The General Laws are hereby further amended by inserting after chapter 112A the following chapter:-

Chapter 112B

INTERSTATE MEDICAL LICENSURE COMPACT

Section 1. In order to strengthen access to health care, and in recognition of the advances in the delivery of health care, the member states of the Interstate Medical Licensure Compact have allied in common purpose to develop a comprehensive process that complements the existing licensing and regulatory authority of state medical boards, provides a streamlined

process that allows physicians to become licensed in multiple states, thereby enhancing the portability of a medical license and ensuring the safety of patients. The compact creates another pathway for licensure and does not otherwise change a state's existing Medical Practice Act. The compact also adopts the prevailing standard for licensure and affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located. State medical boards that participate in the compact retain the jurisdiction to impose an adverse action against a license to practice medicine in that state issued to a physician through the procedures in the compact.

Section 2. As used in this chapter, the following words shall have the following meanings:

"Bylaws," those bylaws established by the Interstate Commission pursuant to section 11.

"Commissioner," the voting representative appointed by each member board pursuant to section 11.

"Conviction," a finding by a court that an individual is guilty of a criminal offense through adjudication, or entry of a plea of guilt or no contest to the charge by the offender. Evidence of an entry of a conviction of a criminal offense by the court shall be considered final for purposes of disciplinary action by a member board.

"Expedited License," a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the compact.

"Interstate Commission," the interstate commission created pursuant to section 11.

"License," authorization by a member state for a physician to engage in the practice of medicine, which would be unlawful without authorization.

"Medical Practice Act," laws and regulations governing the practice of allopathic and osteopathic medicine within a member state.

"Member Board," a state agency in a member state that acts in the sovereign interests of the state by protecting the public through licensure, regulation, and education of physicians as directed by the state government.

"Member State," a state that has enacted the compact.

"Practice of Medicine," that clinical prevention, diagnosis, or treatment of human disease, injury, or condition requiring a physician to obtain and maintain a license in compliance with the Medical Practice Act of a member state.

"Physician," any person who (i) is a graduate of a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent; (ii) passed each component of the United State Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes; (iii) successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association; (iv) holds specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists; (v) possesses a full and

unrestricted license to engage in the practice of medicine issued by a member board; (vi) has never been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction; (vii) has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license; (viii) has never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and (ix) is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

"Offense," a felony, gross misdemeanor, or crime of moral turpitude.

"Rule," a written statement by the Interstate Commission promulgated pursuant to section 12 of the compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the compact, or an organizational, procedural, or practice requirement of the Interstate Commission, and has the force and effect of statutory law in a member state, and includes the amendment, repeal, or suspension of an existing rule.

"State," any state, commonwealth, district, or territory of the United States.

"State of Principal License," a member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the compact.

Section 3. (a) A physician must meet the eligibility requirements as defined in subsection (k) of section 2 to receive an expedited license under the terms and provisions of the compact.

(b) A physician who does not meet the requirements of subsection (k) of section 2 may obtain a license to practice medicine in a member state if the individual complies with all laws and requirements, other than the compact, relating to the issuance of a license to practice medicine in that state.

Section 4. (a) A physician shall designate a member state as the state of principal license for purposes of registration for expedited licensure through the compact if the physician possesses a full and unrestricted license to practice medicine in that state, and the state is:

(1) The state of principal residence for the physician, or

(2) The state where at least 25 per cent of the practice of medicine occurs, or

(3) The location of the physician's employer, or

(4) If no state qualifies under clause (1), clause (2), or clause (3), the state designated as state of residence for purpose of federal income tax.

(b) A physician may redesignate a member state as state of principal license at any time, as long as the state meets the requirements of subsection (a).

(c) The Interstate Commission is authorized to develop rules to facilitate redesignation of another member state as the state of principal license.

Section 5. (a) A physician seeking licensure through the compact shall file an application for an expedited license with the member board of the state selected by the physician as the state of principal license.

(b) Upon receipt of an application for an expedited license, the member board within the state selected as the state of principal license shall evaluate whether the physician is eligible for expedited licensure and issue a letter of qualification, verifying or denying the physician's eligibility, to the Interstate Commission.

(1) Static qualifications, which include verification of medical education, graduate medical education, results of any medical or licensing examination, and other qualifications as determined by the Interstate Commission through rule, shall not be subject to additional primary source verification where already primary source verified by the state of principal license.

(2) The member board within the state selected as the state of principal license shall, in the course of verifying eligibility, perform a criminal background check of an applicant, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation, with the exception of federal employees who have suitability determination in accordance with 5 C.F.R. §731.202.

(3) Appeal on the determination of eligibility shall be made to the member state where the application was filed and shall be subject to the law of that state.

(c) Upon verification in subsection (b), physicians eligible for an expedited license shall complete the registration process established by the Interstate Commission to receive a license in a member state selected pursuant to subsection (a), including the payment of any applicable fees.

(d) After receiving verification of eligibility under subsection (b) and any fees under subsection (c), a member board shall issue an expedited license to the physician. This license shall authorize the physician to practice medicine in the issuing state consistent with the Medical

Practice Act and all applicable laws and regulations of the issuing member board and member state.

(e) An expedited license shall be valid for a period consistent with the licensure period in the member state and in the same manner as required for other physicians holding a full and unrestricted license within the member state.

(f) An expedited license obtained through the compact shall be terminated if a physician fails to maintain a license in the state of principal licensure for a non-disciplinary reason, without redesignation of a new state of principal licensure.

(g) The Interstate Commission is authorized to develop rules regarding the application process, including payment of any applicable fees, and the issuance of an expedited license.

Section 6. (a) A member state issuing an expedited license authorizing the practice of medicine in that state may impose a fee for a license issued or renewed through the compact.

(b) The Interstate Commission is authorized to develop rules regarding fees for expedited licenses.

Section 7. (a) A physician seeking to renew an expedited license granted in a member state shall complete a renewal process with the Interstate Commission if the physician:

(1) Maintains a full and unrestricted license in a state of principal license;

(2) Has not been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(3) Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license; and

(4) Has not had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration.

(b) Physicians shall comply with all continuing professional development or continuing medical education requirements for renewal of a license issued by a member state.

(c) The Interstate Commission shall collect any renewal fees charged for the renewal of a license and distribute the fees to the applicable member board.

(d) Upon receipt of any renewal fees collected in subsection (c), a member board shall renew the physician's license.

(e) Physician information collected by the Interstate Commission during the renewal process will be distributed to all member boards.

(f) The Interstate Commission is authorized to develop rules to address renewal of licenses obtained through the compact.

Section 8. (a) The Interstate Commission shall establish a database of all physicians licensed, or who have applied for licensure, under Section 5.

(b) Notwithstanding any other provision of law, member boards shall report to the Interstate Commission any public action or complaints against a licensed physician who has applied or received an expedited license through the compact.

(c) Member boards shall report disciplinary or investigatory information determined as necessary and proper by rule of the Interstate Commission.

(d) Member boards may report any non-public complaint, disciplinary, or investigatory information not required by subsection (c) to the Interstate Commission.

(e) Member boards shall share complaint or disciplinary information about a physician upon request of another member board.

(f) All information provided to the Interstate Commission or distributed by member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters.

(g) The Interstate Commission is authorized to develop rules for mandated or discretionary sharing of information by member boards.

Section 9. (a) Licensure and disciplinary records of physicians are deemed investigative.

(b) In addition to the authority granted to a member board by its respective Medical Practice Act or other applicable state law, a member board may participate with other member boards in joint investigations of physicians licensed by the member boards.

(c) A subpoena issued by a member state shall be enforceable in other member states.

(d) Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiate under the compact.

(e) Any member state may investigate actual or alleged violations of the statutes authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine.

Section 10. (a) Any disciplinary action taken by any member board against a physician licensed through the compact shall be deemed unprofessional conduct which may be subject to discipline by other member boards, in addition to any violation of the Medical Practice Act or regulations in that state.

(b) If a license granted to a physician by the member board in the state of principal license is revoked, surrendered or relinquished in lieu of discipline, or suspended, then all licenses issued to the physician by member boards shall automatically be placed, without further action necessary by any member board, on the same status. If the member board in the state of principal license subsequently reinstates the physician's license, a license issued to the physician by any other member board shall remain encumbered until that respective member board takes action to reinstate the license in a manner consistent with the Medical Practice Act of that state.

(c) If disciplinary action is taken against a physician by a member board not in the state of principal license, any other member board may deem the action conclusive as to matter of law and fact decided, and:

(1) Impose the same or lesser sanction(s) against the physician so long as such sanctions are consistent with the Medical Practice Act of that state; or

(2) Pursue separate disciplinary action against the physician under its respective Medical Practice Act, regardless of the action taken in other member states.

(d) If a license granted to a physician by a member board is revoked, surrendered or relinquished in lieu of discipline, or suspended, then any licenses issued to the physician by any other member board or boards shall be suspended, automatically and immediately without further action necessary by the other member boards, for 90 days upon entry of the order by the disciplining board, to permit the member boards to investigate the basis for the action under the Medical Practice Act of that state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the 90 day suspension period in a manner consistent with the Medical Practice Act of that state.

Section 11. (a) The member states hereby create the “Interstate Medical Licensure Compact Commission”.

(b) The purpose of the Interstate Commission is the administration of the Interstate Medical Licensure Compact, which is a discretionary state function.

(c) The Interstate Commission shall be a body corporate and joint agency of the member states and shall have all the responsibilities, powers, and duties set forth in the compact, and such additional powers as may be conferred upon it by a subsequent concurrent action of the respective legislatures of the member states in accordance with the terms of the compact.

(d) The Interstate Commission shall consist of two voting representatives appointed by each member state who shall serve as commissioners. In states where allopathic and osteopathic physicians are regulated by separate member boards, or if the licensing and disciplinary authority is split between separate member boards, or if the licensing and disciplinary authority is split between multiple member boards within a member state, the member state shall appoint one representative from each member board. A commissioner shall be a:

(1) An allopathic or osteopathic physician appointed to a member board;

(2) An executive director, executive secretary, or similar executive of a member board; or

(3) A member of the public appointed to a member board.

(e) The Interstate Commission shall meet at least once each calendar year. A portion of this meeting shall be a business meeting to address such matters as may properly come before the Commission, including the election of officers. The chairperson may call additional meetings and shall call for a meeting upon the request of a majority of the member states.

(f) The bylaws may provide for meetings of the Interstate Commission to be conducted by telecommunication or electronic communication.

(g) Each commissioner participating at a meeting of the Interstate Commission is entitled to one vote. A majority of commissioners shall constitute a quorum for the transaction of business, unless a larger quorum is required by the bylaws of the Interstate Commission. A Commission shall not delegate a vote to another commissioner. In the absence of its commissioner, a member state may delegate voting authority for a specified meeting to another person from that state who shall meet the requirements of subsection (d).

(h) The Interstate Commission shall provide public notice of all meetings and all meetings shall be open to the public. The Interstate Commission may close a meeting, in full or in portion, where it determines by a two-thirds vote of the commissioners present that an open meeting would be likely to:

(1) Relate solely to the internal personnel practice and procedures of the Interstate Commission;

(2) Discuss matters specifically exempted from disclosure by federal statute;

(3) Discuss trade secrets, commercial, or financial information that is privileged or confidential;

(4) Involve accusing a person of a crime, or formally censuring a person;

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

(6) Discuss investigative records compiled for law enforcement purposes; or

(7) Specifically relate to the participation in a civil action or other legal proceeding.

(i) The Interstate Commission shall keep minutes which shall fully describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, including record of any roll call votes.

(j) The Interstate Commission shall make its information and official records, to the extent not otherwise designated in the compact or by its rules, available to the public for inspection.

(k) The Interstate Commission shall establish an executive committee, which shall include officers, members, and others as determined by the bylaws. The executive committee shall have the power to act on behalf of the Interstate Commission, with the exception of rulemaking, during periods when the Interstate Commission is not in session. When acting on behalf of the Interstate Commission, the executive committee shall oversee the administration of the compact including enforcement and compliance with the provisions of the compact, its bylaws and rules, and other such duties as necessary.

(l) The Interstate Commission shall establish other committees for governance and administration of the compact.

Section 12. The Interstate Commission shall have the following powers and duties:

(i) Oversee and maintain the administration of the compact;

(ii) Promulgate rules which shall be binding to the extent and in the manner provided for in the compact;

(iii) Issue, upon the request of a member state or member board, advisory opinions concerning the meaning or interpretation of the compact, its bylaws, rules, and actions;

(iv) Enforce compliance with compact provisions, the rules promulgated by the Interstate Commission, and the bylaws, using all necessary and proper means, including but not limited to the use of judicial process;

(v) Establish and appoint committees including, but not limited to, an executive committee as required by section 11, which shall have the power to act on behalf of the Interstate Commission in carrying out its powers and duties;

(vi) Pay, or provide for the payment of the expenses related to the establishment, organization, and ongoing activities of the Interstate Commission;

(vii) Establish and maintain one or more offices;

(viii) Borrow, accept, hire, or contract for services of personnel;

(ix) Purchase and maintain insurance and bonds;

(x) Employ an executive director who shall have such powers to employ, select or appoint employees, agents, or consultants, and to determine their qualifications, define their duties, and fix their compensation;

(xi) Establish personnel policies and programs relating to conflicts of interest, rates of compensation, and qualifications of personnel;

(xii) Accept donations and grants of money, equipment, supplies, materials, and services and to receive, utilize, and dispose of it in a manner consistent with the conflict of interest policies established by the Interstate Commission;

(xiii) Lease, purchase, accept contributions or donations of, or otherwise to own, hold, improve or use, any property, real, personal, or mixed;

(xiv) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(xv) Establish a budget and make expenditures;

(xvi) Adopt a seal and bylaws governing the management and operation of the Interstate Commission;

(xvii) Report annually to the legislatures and governors of the member states concerning the activities of the Interstate Commission during the preceding year. Such reports shall also include reports of financial audits and any recommendations that may have been adopted by the Interstate Commission;

(xviii) Coordinate education, training, and public awareness regarding the compact, its implementation, and its operation;

(xix) Maintain records in accordance with the bylaws;

(xx) Seek and obtain trademarks, copyrights, and patents; and

(xxi) Perform such functions as may be necessary or appropriate to achieve the purpose of the compact.

Section 13. (a) The Interstate Commission may levy on and collect an annual assessment from each member state to cover the cost of the operations and activities of the Interstate Commission and its staff. The total assessment must be sufficient to cover the annual budget approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated upon a formula to be determined by the Interstate Commission, which shall promulgate a rule binding upon all member states.

(b) The Interstate Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same.

(c) The Interstate Commission shall not pledge the credit of any of the member states, except by, and with the authority of, the member state.

(d) The Interstate Commission shall be subject to a yearly financial audit conducted by a certified or licensed accountant and the report of the audit shall be included in the annual report of the Interstate Commission.

Section 14. (a) The Interstate Commission shall, by a majority of Commissioners present and voting, adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes of the compact within 12 months of the first Interstate Commission meeting.

(b) The Interstate Commission shall elect or appoint annually from among its Commissioners a chairperson, a vice-chairperson, and a treasurer, each of whom shall have such authority and duties as may be specified in the bylaws. The chairperson, or in the chairperson's absence or disability, the vice-chairperson, shall preside at all meetings of the Interstate Commission.

(c) Officers selected in subsection (b) shall serve without remuneration for the Interstate Commission.

(d) The officers and employees of the Interstate Commission shall be immune from suit and liability, either personally or in their official capacity, for a claim for damage to or loss of property or personal injury or other civil liability caused or arising out of, or relating to, an actual or alleged act, error, or omission that occurred, or that such person had a reasonable basis for believing occurred, within the scope of Interstate Commission employment, duties, or responsibilities; provided that such person shall not be protected from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(e) The liability of the executive director and employees of the Interstate Commission or representatives of the Interstate Commission, acting within the scope of such person's employment or duties for acts, errors, or omissions occurring within such person's state, may not exceed the limits of liability set forth under the constitution and laws of that state for state officials, employees, and agents. The Interstate Commission is considered to be an instrumentality of the states for the purpose of any such action. Nothing in this subsection shall

be construed to protect such person from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(f) The Interstate Commission shall defend the executive director, its employees, and subject to the approval of the attorney general or other appropriate legal counsel of the member state represented by an Interstate Commission representative, shall defend such Interstate Commission representative in any civil action seeking to impose liability arising out of an actual or alleged act, error or omission that occurred within the scope of Interstate Commission employment, duties or responsibilities, or that the defendant had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such person.

(g) To the extent not covered by the state involved, member state, or the Interstate Commission, the representatives or employees of the Interstate Commission shall be held harmless in the amount of a settlement or judgement, including attorney's fees and costs, obtained against such persons arising out of an actual or alleged act, error, or omission that occurred within the scope of the Interstate Commission employment, duties, or responsibilities, or that such persons had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such person.

Section 15. (a) The Interstate Commission shall promulgate reasonable rules in order to effectively and efficiently achieve the purpose of the compact. Notwithstanding the foregoing, in

the event the Interstate Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the compact, or the powers granted hereunder, then such an action by the Interstate Commission shall be invalid and have no force or effect.

(b) Rules deemed appropriate for the operations of the Interstate Commission shall be made pursuant to a rulemaking process that substantially conforms to the "Model State Administrative Procedure Act" of 2010, and subsequent amendments thereto.

(c) Not later than 30 days after a rule is promulgated, any person may file a petition for judicial review of the rule in the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices, provided that the filing of such a petition shall not stay or otherwise prevent the rule from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Interstate Commission consistent with applicable law and shall not find the rule to be unlawful if the rule represents a reasonable exercise of the authority granted to the Interstate Commission.

Section 16. (a) The executive, legislative, and judicial branches of state government in each member state shall enforce the compact and shall take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provisions of the compact and the rules promulgated hereunder shall have standing as statutory law but shall not override existing state authority to regulate the practice of medicine.

(b) All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the compact which may affect the powers, responsibilities or actions of the Interstate Commission.

(c) The Interstate Commission shall be entitled to receive all services of process in any such proceeding, and shall have standing to intervene in the proceeding for all purposes. Failure to provide service of process to the Interstate Commission shall render a judgment or order void as to the Interstate Commission, the compact, or promulgated rules.

Section 17. (a) The Interstate Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of the compact.

(b) The Interstate Commission may, by majority vote of the Commissioners, initiate legal action in the United States Court for the District of Columbia, or, at the discretion of the Interstate Commission, in the federal district where the Interstate Commission has its principal offices, to enforce compliance with the provisions of the compact, and its promulgated rules and bylaws, against a member state in default. The relief sought may including both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation including reasonable attorney's fees.

(c) The remedies herein shall not be the exclusive remedies of the Interstate Commission. The Interstate Commission may avail itself of any other remedies available under state law or regulation of a profession.

Section 18. (a) The grounds for default include, but are not limited to, failure of a member state to perform such obligations or responsibilities imposed upon it by the compact, or the rules and bylaws of the Interstate Commission promulgated under the compact.

(b) If the Interstate Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact, or the bylaws or promulgated rules, the Interstate Commission shall:

(1) Provide written notice to the defaulting state and other member states, of the nature of the default, the means of curing the default, and any action taken by the Interstate Commission. The Interstate Commission shall specify the conditions by which the defaulting state must cure its default; and

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

(c) If the defaulting state fails to cure the default, the defaulting state shall be terminated from the compact upon an affirmative vote of a majority of the Commissioners and all rights, privileges, and benefits conferred by the compact shall terminate on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of the default.

(d) Termination of membership in the compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to terminate shall be given by the Interstate Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

(e) The Interstate Commission shall establish rules and procedures to address licenses and physicians that are materially impacted by the termination of a member state, or the withdrawal of a member state.

(f) The member state which has been terminated is responsible for all due, obligations, and liabilities incurred through the effective date of termination including obligations, the performance of which extends beyond the effective date of termination.

(g) The Interstate Commission shall not bear any costs relating to any state that has been found to be in default or which has been terminated from the compact, unless otherwise mutually agreed upon in writing between the Interstate Commission and the defaulting state.

(h) The defaulting state may appeal the action of the Interstate Commission by petitioning the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation including reasonable attorney's fees.

Section 19. (a) The Interstate Commission shall attempt, upon the request of a member state, to resolve disputes which are subject to the compact and which may arise among member states or member boards.

(b) The Interstate Commission shall promulgate rules providing for both mediation and binding dispute resolution as appropriate.

Section 20. (a) Any state is eligible to become a member of the compact.

(b) The compact shall become effective and binding upon legislative enactment of the compact into law by no less than 7 states. Thereafter, it shall become effective and binding on a state upon enactment of the compact into law by that state.

(c) The governors of non-member states, or their designees, shall be invited to participate in the activities of the Interstate Commission on a non-voting basis prior to adoption of the compact by all states.

(d) The Interstate Commission may propose amendments to the compact for enactment by the member states. No amendment shall become effective and binding upon the Interstate

Commission and the member states unless and until it is enacted into law by unanimous consent of the member states.

Section 21. (a) Once effective, the compact shall continue in force and remain binding upon each and every member state; provided that a member state may withdraw from the compact by specifically repealing the statute which enacted the compact into law.

(b) Withdrawal from the compact shall be by the enactment of a statute repealing the same, but shall not take effect until 1 year after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the governor of each other member state.

(c) The withdrawing state shall immediately notify the chairperson of the Interstate Commission in writing upon the introduction of legislation repealing the compact in the withdrawing state.

(d) The Interstate Commission shall notify the other member states of the withdrawing state's intent to withdraw within 60 days of its receipt of notice provided under subsection (c).

(e) The withdrawing state is responsible for all dues, obligations and liabilities incurred through the effective date of withdrawal, including obligations, the performance of which extend beyond the effective date of withdrawal.

(f) Reinstatement following withdrawal of a member state shall occur upon the withdrawing date reenacting the compact or upon such later date as determined by the Interstate Commission.

(g) The Interstate Commission is authorized to develop rules to address the impact of the withdrawal of a member state on licenses granted in other member states to physicians who designated the withdrawing member state as the state of principal license.

Section 22. (a) The compact shall dissolve effective upon the date of the withdrawal or default of the member state which reduces the membership of the compact to 1 member state.

(b) Upon the dissolution of the compact, the compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Interstate Commission shall be concluded, and surplus funds shall be distributed in accordance with the bylaws.

Section 23. (a) The provisions of the compact shall be severable, and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the compact shall be enforceable.

(b) The provisions of the compact shall be liberally construed to effectuate its purposes.

(c) Nothing in the compact shall be construed to prohibit the applicability of other interstate compacts to which the member states are members.

Section 24. (a) Nothing herein prevents the enforcement of any other law of a member state that is not inconsistent with the compact.

(b) All laws in a member state in conflict with the compact are superseded to the extent of the conflict.

(c) All lawful actions of the Interstate Commission, including all rules and bylaws promulgated by the Commission, are binding upon the member states.

(d) All agreements between the Interstate Commission and the member states are binding in accordance with their terms.

(e) In the event any provision of the compact exceeds the constitutional limits imposed on the legislature of any member state, such provision shall be ineffective to the extent of the conflict with the constitutional provision in question in that member state.

Section 25. (a) The executive director of the board of registration in medicine, or the board executive director's designee, shall be the administrator of compact for the commonwealth.

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

(c) The board of registration in medicine may take disciplinary action against the practice privilege of a physician practicing in the commonwealth under a license issued by party state. The board's disciplinary action may be based on disciplinary action against the physician's license taken by the physician's home state.

(d) In reporting information to the coordinated licensure information system under section 8 of this chapter related to the compact, the board of registration in medicine may disclose personally identifiable information about the physician, including social security number.

(e) Nothing in this chapter, nor the entrance of the commonwealth into the Interstate Medical Licensure compact shall be construed to supersede existing labor laws.

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

Section 26. As part of the licensure and background check process for a multistate license and to determine the suitability of an applicant for multistate licensure, the board of registration in medicine, prior to issuing any multistate license, shall conduct a fingerprint-based check of the state and national criminal history databases, as authorized by 28 CFR 20.33 and Public Law 92-544.

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

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

The board of registration in medicine may receive all criminal offender record information and the results of checks of state and national criminal history databases under said Public Law 92-544. When the board of registration in medicine obtains the results of checks of state and national criminal history databases, it shall treat the information according to sections 167 to 178, inclusive, of chapter 6 and the regulations thereunder regarding criminal offender record information.

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

SECTION 54. Chapter 118I of the General is hereby amended by striking out the chapter and inserting in place thereof the following chapter:-

Chapter 118I

HEALTH INFORMATION EXCHANGE

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

“Council”, the health information technology council established under section 2.

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

“Executive office”, the executive office of health and human services.

“Health care entity”, a payer, health care provider or provider organization.

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

“Health information exchange”, transmission of health care-related data among health care entities of personal health records aligning with national standards; the reliable and secure transfer of data among diverse systems and access to and retrieval of data.

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

"Payer", any entity, other than an individual, that pays providers for the provision of health care services; provided, that "payer" shall include both governmental and private entities; provided further, that "payer" shall not include ERISA plans.

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

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

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

(b) The council shall consist of the following 21 members: the secretary of health and human services or a designee, who shall serve as the chair; the secretary of administration and finance or designee; the executive director of the health policy commission or a designee; the executive director of the center for health information analysis or a designee; the director of the Massachusetts eHealth Institute or a designee; the secretary of housing and economic development or a designee; the director of the office of Medicaid or a designee; and 14 members who shall be appointed by the governor, of whom at least 1 shall be an expert in health

information technology; 1 shall be an expert in law and health policy; 1 shall be an expert in health information privacy and security; 1 shall be from an academic medical center; 1 shall be from a community hospital; 1 shall be from a community health center; 1 shall be from a long term care facility; 1 shall be a from large physician group practice; 1 shall be from a small physician group practice; 1 shall be a registered nurse; 1 shall be from a behavioral health, substance abuse disorder or mental health services organization; 1 shall represent health insurance carriers; and 2 additional members shall have experience or expertise in health information technology. The council may consult with all relevant parties, public or private, in exercising its duties under this section, including persons with expertise and experience in the development and dissemination of electronic health records systems, and the implementation of electronic health record systems by small physician groups or ambulatory care providers, as well as persons representing organizations within the commonwealth interested in and affected by the development of networks and electronic health records systems, including, but not limited to, persons representing local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, physicians and health insurers, the state quality improvement organization, academic and research institutions, consumer advisory organizations with expertise in health information technology and other stakeholders as identified by the secretary of health and human services. Appointed members of the council shall serve for terms of 2 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation.

(c) Chapter 268A shall apply to all council members, except that the council may purchase from, sell to, borrow from, contract with or otherwise deal with any organization in which any council member is in anyway interested or involved; provided, however, that such

interest or involvement shall be disclosed in advance to the council and recorded in the minutes of the proceedings of the council; and provided, further, that no member shall be considered to have violated section 4 of said chapter 268A because of the member's receipt of usual and regular compensation from such member's employer during the time in which the member participates in the activities of the council.

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

(b) The executive office may:

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

(ii) in consultation with the council, oversee the development, dissemination, implementation and operation of statewide health information exchange including any modules, applications, interfaces or other technology infrastructure for statewide health information exchange.

(c) In carrying out this chapter, the executive office may undertake any activities necessary to implement the powers and duties under this chapter, which may include issuing implementing regulations and the adoption of policies consistent with those adopted by the Office of the National Coordinator for Health Information Technology of the United States Department of Health and Human Services; provided, however, that nothing herein shall be

construed to limit the executive office's ability to advance interoperability and other health information technology beyond such federal standards, including without limitation any applicable meaningful use standards.

Section 4. Every patient shall have electronic access to such patient's health records. The executive office shall ensure that each patient will have secure electronic access to such patient's electronic health records with each of such patient's health care providers.

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

Section 6. The executive office shall prescribe by regulation penalties for non-compliance by health care entities with the requirements of this chapter provided, however, that the executive office may waive penalties for good cause. Penalties collected under this section shall be

deposited into the Health Information Technology Trust Fund, established in section 10 of chapter 35RR.

Section 7. In the event of an unauthorized access to or disclosure of individually identifiable patient health information by or through a health care entity or a vendor contracted through services of a health care entity as participants of statewide health information exchange, the health care entity or vendor shall comply with the requirements of chapter 93H and in any event shall: (i) report the conditions of such unauthorized access or disclosure as required by the executive office; and (ii) provide notice, as defined in section 1 of chapter 93H, as soon as practicable, but not later than 10 business days after such unauthorized access or disclosure, to any person whose patient health information may have been compromised as a result of such unauthorized access or disclosure, and shall report the conditions of such unauthorized access or disclosure, and further shall concurrently provide a copy of such report to the executive office. Any unauthorized access or disclosures shall be punishable by the civil penalties under section 10.

Section 8. Patients shall have the choice to opt-out of having their health data disclosed for electronic health information exchange activities that are owned and operated or contracted by the Commonwealth.

Section 9. The executive office shall pursue and maximize all opportunities to qualify for federal financial participation under the matching grant program established under the Health Information Technology for Economic and Clinical Health Act of the American Recovery and Reinvestment Act of 2009, P.L. 111–5.

Section 10. The executive office may require participant fees from health care entities that use health information exchange services. Participant fees collected under this section shall be deposited into the Health Information Technology Trust Fund, as established by section 35RR of chapter 10, or its successor trust fund. Nonpayment or late payment of fees may subject health care entities to fines or penalties as determined by the executive office. The executive office shall promulgate regulations to assess fair and reasonable fines or penalties.

Section 11. The council shall file an annual report, not later than April 1, with the joint committee on health care financing, the joint committee on economic development and emerging technologies, the house and senate committees on ways and means and the clerks of the house and senate concerning the activities of the council in general and, in particular, describing the progress to date in developing statewide health information exchange and recommending such further legislative action as it deems appropriate.

Section 12. Unauthorized access to or disclosure of individually identifiable patient health information shall be subject to fines or penalties as determined by the executive office. The executive office shall promulgate regulations to assess fair and reasonable fines or penalties.

Section 13. Cybersecurity-based documentation, including but not limited to security audit reports, provided to the executive office shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 and chapter 66.

SECTION 55. Subsection (i) of section 47B of chapter 175 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-

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

SECTION 56. Section 1 of chapter 175H of the General Laws , as so appearing, is hereby amended by inserting after the definition of “Health care insurer”, the following definition:-

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

SECTION 57. Said section 1 of said chapter 175H, as so appearing, is hereby further amended by adding the following definition:-

“Surprise bill,” a bill received by an insured for unforeseen out-of-network services, as defined in section 30 of chapter 176O.

SECTION 58. Said chapter 175H of the General Laws is hereby further amended by striking out sections 5 and 6 and inserting in place thereof the following 3 sections:-

Section 5. The attorney general may conduct an investigation of an alleged violation of this chapter and may commence a proceeding pursuant to section 4. Additionally, the attorney general has the authority to initiate a civil action under this chapter. When the attorney general

has determined that a provider has violated this chapter, the attorney general shall notify the department of public health, the department of mental health, the board of registration in medicine or any other relevant licensing authorities, of that determination. Those licensing authorities may, upon their own investigation or upon notification from the attorney general that a provider licensed by that authority has violated this section, impose penalties for non-compliance consistent with their authority to regulate those providers.

Section 6. A person who receives a health care benefit or payment from a health care corporation or health care insurer or other person or entity, which such person knows that he or she is not entitled to receive or be paid, or a person who knowingly presents or causes to be presented with fraudulent intent a claim which contains a false statement, including but not limited to a payment or false statement regarding an impermissible facility fee shall be liable to the health care corporation or health care insurer or other person or entity for the full amount of the benefit or payment made, and for reasonable attorneys' fees and costs, inclusive of costs of investigation. A health care corporation or health care insurer or other injured person or entity may bring a civil action under this chapter in the superior court department of the trial court.

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

SECTION 59. The General Laws are hereby further amended by inserting after chapter 175M the following chapter:-

Chapter 175N

PHARMACY BENEFIT MANAGERS

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

"Carrier," an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; and an organization entering into a preferred provider arrangement under chapter 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of or more subsidiaries or affiliated corporations of the employer; provided, however, that, unless otherwise noted, "carrier" shall not include any entity to the extent it offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services.

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

"Commissioner", the commissioner of insurance.

"Division", the division of insurance.

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

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

Section 2. (a) A person or organization shall not establish or operate as a pharmacy benefit manager to administer prescription drug benefits or services for a carrier's health benefit plans in the commonwealth without obtaining certification from the commissioner pursuant to this section nor shall a carrier contract with an uncertified pharmacy benefit manager.

(b) The commissioner shall promulgate regulations regarding pharmacy benefit managers that shall (i) establish the certification, application, standards and reporting requirements of pharmacy benefit managers and (ii) establish requirements for carriers to contract with certified pharmacy benefit managers.

(c) The commissioner shall charge pharmacy benefit manager application and renewal fees in the amount of $1,000.

(d) An entity certified as a pharmacy benefit manager shall be required to submit data and reporting information to the center, including information associated with discounts, retained rebates and earned margins on payments to pharmacy providers on behalf of health plans,

according to standards and methods specified by the center pursuant to section 10A of chapter 12C.

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

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

Section 3. (a) The commissioner may make an examination of the affairs of a pharmacy benefit manager when the commissioner deems prudent but not less frequently than once every 3 years. The focus of the examination shall be to ensure that a pharmacy benefit manager is fulfilling its responsibilities under contracts with carriers licensed under chapters 175, 176A, 176B, or 176G. The examination shall be conducted according to the procedures set forth in subsection (6) of section 4 of chapter 175.

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

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

(d) Not later than 60 days following completion of the examination, the examiner in charge shall file with the commissioner a verified written report of examination under oath. Upon receipt of the verified report, the commissioner shall transmit the report to the pharmacy

benefit manager examined with a notice which shall afford the pharmacy benefit manager examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report. Within 30 days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall consider and review the reports together with any written submissions or rebuttals and any relevant portions of the examiner's work papers and enter an order:

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

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

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

(e) Notwithstanding any general or special law to the contrary, including clause Twenty-sixth of section 7 of chapter 4 and chapter 66, the records of any such audit, examination or other inspection and the information contained in the records, reports or books of any pharmacy benefit manager examined pursuant to this section shall be confidential and open only to the inspection of the commissioner, or the examiners and assistants. Access to such confidential

material may be granted by the commissioner to law enforcement officials of the commonwealth or any other state or agency of the federal government at any time, provided that the agency or office receiving the information agrees in writing to keep such material confidential. Nothing herein shall be construed to prohibit the required production of such records, and information contained in the reports of such company or organization before any court of the commonwealth or any master or auditor appointed by any such court, in any criminal or civil proceeding, affecting such pharmacy benefit manager, its officers, partners, directors or employees. The final report of any such audit, examination or any other inspection by or on behalf of the division of insurance shall be a public record.

Section 4. A pharmacy benefit manager shall be required to submit to periodic audits by a carrier licensed under chapters 175, 176A, 176B, or 176G, if the pharmacy benefit manager has entered into a contract with the carrier to provide pharmacy benefits to the carrier or its members. The commissioner may direct or provide specifications for such audits.

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

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

(2) is the subject of consumer complaints received and verified by the division that present a substantial risk of harm to the health, safety and interests of consumers;

(3) fails to pay an application fee;

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

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

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

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

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

Section 7. (a) A pharmacy benefits manager under contract with a carrier, shall comply with the provisions of section 30 of chapter 176O.

SECTION 60. Subsection (i) of section 8A of chapter 176A of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-

For the purposes of this section, "licensed mental health professional" shall mean a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J, a licensed marriage and family therapist within the lawful scope of practice for

such therapist, or a clinician practicing under the supervision of licensed professional, and working towards licensure, in a clinic licensed under chapter 111.

SECTION 61. Subsection (i) of section 4A of chapter 176B of the General Laws, as so appearing, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-

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

SECTION 62. Subsection (i) of section 4M of chapter 176G of the General Laws, as so appearing, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-

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

SECTION 63. Paragraph (1) of subsection (a) of section 4 of chapter 176J of the General Laws, as so appearing, is hereby amended by striking out, in line 1, the words, “Every carrier shall make available” and inserting in place thereof the following words:- “Every carrier shall maintain a website on which it will display every available plan and shall offer.”

SECTION 64. Subsection (b) of said section 4 of said chapter 176J, as so appearing, is hereby amended by striking out paragraph (4).

SECTION 65. Section 6 of said chapter 176J, as so appearing, is hereby amended by striking out subsection (c) and inserting in place thereof the following subsection:-

(c) Notwithstanding any general or special law to the contrary, carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or 176G, shall file small group product base rates and any changes to small group rating factors that are to be effective on January 1 of each year, on or before July 1 of the preceding year. The commissioner shall approve, modify or disapprove any proposed changes to base rates; provided, however, that the commissioner shall only modify or disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged. The commissioner shall disapprove any change to small group rating factors that is discriminatory or not actuarially sound. The commissioner shall require carriers licensed under chapters 175, 176A, 176B or 176G to file information annually on price increases negotiated with providers participating in their health insurance plans. Rates of reimbursement or rating factors included in the rate filing materials submitted for review by the division shall be deemed confidential and exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 and chapter 66; provided, however, that the commissioner shall provide information on provider price increases

annually to the center for health information and analysis and the health policy commission; and provided further that any information received under this section by the center for health information and analysis and the health policy commission shall be held confidential but may be used in the aggregate or summary form in reports. The commissioner shall adopt regulations to carry out this section.

SECTION 66. Said chapter 176J of the General Laws is hereby further amended by striking out section 11 and inserting in place thereof the following section:-

Section 11. (a) A carrier that offers a health benefit plan that: (i) provides or arranges for the delivery of health care services through a closed network of health care providers; and (ii) as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals, shall offer to all eligible individuals and small businesses in at least 2 geographic areas at least 1 high-value health plan from each of the following categories:

(A) a reduced or selective network of providers;

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

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

(D) other innovative plans designed by the carrier and approved by the commissioner, including, but not limited to: (1) plans that base plan reimbursement on a benchmark

reimbursement level such as a level tied to Medicare reimbursement; (2) plans with clear rewards for receiving care from lower-cost providers; (3) products that are developed for specific geographic regions; (4) products that establish pricing based on their inclusion in an employer's value-driven defined contribution offering; (5) plans with significant benefit differentials between tiers in a tiered benefit product; and (6) site of service products where services may only be available from certain network providers or at certain locations based on the medical necessity of the service.

Carriers shall establish a base premium rate discount of at least 20 per cent for the plan offered pursuant to this section compared to the base premium of the carrier's most actuarially similar plan with the carrier's non-selective or non-tiered network of providers. The savings may be achieved by means including, but not limited to: (i) the exclusion of providers with similar or lower quality based on the quality measure set, as determined according to section 16CC of chapter 6A, with higher health status adjusted total medical expenses or relative prices, as determined under section 10 of chapter 12C; or (ii) increased member cost-sharing for members who utilize providers for non-emergency services with similar or lower quality based on the quality measure set, as determined according to section 16CC of chapter 6A, and with higher health status adjusted total medical expenses or relative prices, as determined under said section 10 of said chapter 12C.

The commissioner may apply waivers to the base premium rate discount determined by the commissioner under this section to carriers who receive 80 per cent or more of their incomes from government programs or the subsidized ConnectorCare Program sponsored by the Commonwealth Health Insurance Connector Authority or which have service areas which do not include either Suffolk or Middlesex counties and who were first admitted to do business by the

division of insurance on January 1, 1986, as health maintenance organizations under chapter 176G.

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

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

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

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

medically necessary, carriers shall provide access to out-of-network providers for covered services, including those outside the plan's service area.

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

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

(g) Carriers shall develop informational materials that explain the value of high-value products and how high-value products provide appropriate access to care. Such high-value products shall be promoted along with a carrier's other products, and consumers shall be informed that the number of network providers may be different, but that the high-value products meet regulatory standards to provide adequate access to appropriate health care systems and to out-of-network care if not available within the network.

(h) The division of insurance shall report specific findings and legislative recommendations for all products subject to this section, including the following: (1) the utilization trends of eligible employers and eligible individuals enrolled in plans offered under this section; (2) the extent to which tiered product offerings have reduced health care costs for patients and employers; (3) the effects that tiered product offerings have on patient education relating to health care costs and quality; (4) the effects that tiered product offerings have on patient utilization of local hospitals and the resulting impact on overall state health care costs, including the state's compliance with the health care cost growth benchmark established under section 9 of chapter 6D; (5) opportunities to incentivize tiered product offerings for both health systems and employers. The report shall also include the number of members enrolled by plan type, aggregate demographic, geographic information on all members and the average direct premium claims incurred, as defined in section 6, for selective and tiered network products compared to non-selective and non-tiered products. The report shall be submitted to clerks of the house of representatives and the senate, the senate and house committees on ways and means and the joint committee on health care financing.

SECTION 67. Section 2 of chapter 176O of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting, after subsection (d) the following subsection:-

(d ½) A carrier that contracts with a pharmacy benefit manager shall (i) be responsible for coordinating an audit, at least once per year, of the operations of the pharmacy benefit manager to ensure compliance with the provisions of this chapter and to examine the pricing and rebates applicable to prescription drugs that are provided to the carrier's covered persons; and (ii) require that the pharmacies with which the pharmacy benefit manager contracts have systems in place to ensure that the insured, at the point of sale for any prescription, is charged the lower of: the

applicable cost sharing amount under the terms of the insured's health benefit plan; the pharmacy benefits manager's contracted rate of payment to the pharmacy for the prescription drug; or the retail price of the prescription drug if purchased without insurance.

SECTION 68. Subsection (a) of section 6 of said chapter 176O, as so appearing, is hereby further amended by striking out paragraph (4) and inserting in place thereof the following paragraph:-

(4) the locations where, and the manner in which, health care services and other benefits may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to an insured within the carrier's network, the carrier shall cover the out-of-network admission, procedure or service and the insured will not be responsible to pay more than the amount which would be required for similar admissions, procedures or services offered within the carrier's network; (ii) an explanation that whenever a location is part of the carrier's network, that the carrier shall cover medically necessary covered benefits delivered at that location and the insured shall not be responsible to pay more than the amount required for network services even if part of the medically necessary covered benefits are performed by out-of-network providers, in accordance with subsection (b) of section 30; 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 69. Said subsection (a) of said section 6 of said chapter 176O, as so appearing, is hereby further amended by striking out paragraph (8) and inserting in place thereof the following paragraph:-

(8) a summary description of the procedure, if any, for out-of-network referrals and any additional charge for utilizing out-of-network providers, and a description of the protections related to unforeseen out-of-network services detailed in this chapter.

SECTION 70. Section 9A of said chapter 176O, as so appearing, is hereby further amended by striking out subsection (a) and inserting in place thereof the following subsection:-

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

SECTION 71. Subsection (i) of section 27 of said chapter 176O, as so appearing, is hereby amended by adding the following sentence:-

The common summary of payments form shall include, but not be limited to, protections related to unforeseen out-of-network services.

SECTION 72. Said chapter 176O of the General Laws is hereby further amended by adding the following 3 sections:-

Section 30. (a) As used in this section, “unforeseen out-of-network services” shall mean the following: (1) health care services rendered by an out-of-network provider for emergency medical conditions or any associated admission or care resulting from an emergency medical condition; (2) non-emergency health care services rendered by an out-of-network provider at an in-network facility, including but not limited to: (i) services for emergency medicine, anesthesiology, pathology, radiology, or neonatology, or services rendered by assistant surgeons, hospitalists, and intensivists; (ii) health care services rendered by an out-of-network provider without the insured’s advanced knowledge, pursuant to the requirements set forth in subsections (b) through (e) of section 228 of chapter 111; (iii) health care services provided by an out-of-network provider if there is no in-network provider who can furnish such health care service at such facility; or (iv) health care services rendered by an out-of-network provider, including an out-of-network laboratory, radiologist, or pathologist, where the health care services were referred, or an insured’s specimen was sent, by a participating provider to an out-of-network provider; or (v) unforeseen health care services that arise at the time health care services are rendered that must necessarily be rendered by an out-of-network provider; provided, however that “unforeseen out-of-network services” shall not include a service received by an insured for health care services when a participating provider is available and the insured knowingly, voluntarily and specifically elects to obtain services from an out-of-network provider.

(b) Consistent with subsection (e) of section 228 of chapter 111, if an insured receives unforeseen out-of-network services, the insured shall only be required to pay the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for such health care services if the services were rendered by a participating provider. Payments made by an insured pursuant to this section shall count towards any in-network deductible or

out-of-pocket maximum pursuant to the terms and conditions of an insured's health benefit plan. Pursuant to subsection (e) of section 228 of chapter 111, an out-of-network provider shall not bill the insured in excess of the applicable coinsurance, copayment, deductibles or other out-of-pocket expenses that would be imposed for such health care services if rendered by a participating provider.

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

(d) When an out-of-network provider renders unforeseen out-of-network services to an insured, in accordance with subsection (c) the carrier shall pay the out-of-network provider directly in the amount of the carrier's median in-network rate for the health care services, as further defined in regulation pursuant to subsection (g), minus any member cost-sharing in the form of the applicable coinsurance, copayment or deductible. Such regulation shall include the appropriate calculation of the carrier's median in-network rate including but not limited to the following instances when an out-of-network provider renders unforeseen out-of-network services: (i) the out-of-network provider contracts with a carrier to participate in the carrier's network but does not contract with the carrier for the specific health benefit plan in which an insured is enrolled, (ii) the out-of-network provider and carrier have more than 1 contract for health benefit plans; (iii) the out-of-network provider does not contract with the carrier to

participate in any of the carrier's network plans, policies, contracts, or other arrangements; and (iv) there is insufficient information to calculate the carrier's median in-network rate.

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

(f) In a form and manner to be prescribed by the division, carriers shall indicate to insureds that the plan is subject to these provisions. In the case of self-funded health benefit plans that elect to be subject to this section pursuant to subsection (e), the plan shall indicate that it is self-funded and has elected to be subject to these provisions.

(g) In consultation with the health policy commission and the center for health information and analysis, the commissioner shall promulgate regulations to implement this section.

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

Section 31. (a) As used in this section, "facility fee" shall have the meaning as provided in section 51L of chapter 111.

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

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

Section 32. (a) A carrier, or a pharmacy benefits manager under contract with a carrier, shall use a single maximum allowable cost list to establish the maximum amount to be paid by a health plan to a pharmacy provider for a generic drug or a brand-name drug that has at least one generic alternative available. A carrier, or a pharmacy benefits manager under contract with a carrier, shall use the same maximum allowable cost list for each pharmacy provider.

(b) A maximum allowable cost may be set for a prescription drug, or a prescription drug may be allowed to continue on a maximum allowable cost list, only if that prescription drug: (i) is rated as "A" or "B" in the most recent version of the United States Food and Drug Administration's "Approved Drug Products with Therapeutic Equivalence Evaluations," also known as "the Orange Book," or an equivalent rating from a successor publication, or is rated as "NR" or "NA" or a similar rating by a nationally recognized pricing reference; and (ii) is available for purchase in Massachusetts from a national or regional wholesale distributor by pharmacies having a contract with the pharmacy benefits manager.

(c) A carrier, or a pharmacy benefits manager under contract with a carrier, shall establish a process for removing a prescription drug from a maximum allowable cost list or modifying a maximum allowable cost for a prescription drug in a timely manner to reflect changes to such costs and the availability of the drug in the national marketplace.

(d) With regard to a pharmacy with which the carrier, or the pharmacy benefits manager under contract with a carrier, has entered into a contract, a carrier, or a pharmacy benefits manager under contract with a carrier, shall: (i) upon request, disclose the sources used to establish the maximum allowable costs; (ii) provide a process for a pharmacy to readily obtain the maximum allowable payment available to that pharmacy under a maximum allowable cost list; and (iii) at least once every 7 business days, review and update maximum allowable cost list information to reflect any modification of the maximum allowable payment available to a pharmacy under a maximum allowable cost list used by the carrier or the pharmacy benefits manager under contract with a carrier.

SECTION 73. Notwithstanding any general or special law to the contrary, the secretary of health and human services may expend from the Health Information Technology Trust Fund, established pursuant to section 35RR of chapter 10 of the General Laws, any grants, premiums, gifts, reimbursements, or other contributions received by the commonwealth for the purposes described in subsection (a) of the Portable Order for Life Sustaining Treatment Trust Fund, established under section 2UUUUU of chapter 29 of the General Laws, provided that any grants, premiums, gifts, reimbursements, or other contributions received by the commonwealth for said purposes remaining in the Health Information Technology Trust Fund as of the effective date of this act shall be transferred to the Portable Order for Life Sustaining Treatment Trust Fund.

SECTION 74. Notwithstanding any general or special law to the contrary, the division of insurance shall develop a 3-year pilot program to permit at least 1 but no more than 6 small business group purchasing cooperatives, as defined in section 1 of chapter 176J of the General Laws, to be considered a large employer for the purposes of accessing affordable health insurance coverage options. The total number of covered lives for all approved group purchasing

cooperatives, in the aggregate, participating in this pilot program shall not exceed 85,000 covered lives. The division shall develop guidelines that shall include but not be limited to: (i) ways to reduce premiums for members of small business group purchasing cooperatives and their employees; (ii) any waiver of statutory or regulatory requirements to effectuate the pilot program; and (iii) requirements for small business group purchasing cooperative participatory wellness programming. The pilot program shall be implemented no later than 1 year from the effective date of this act.

Not later than 6 months after the conclusion of the pilot program, the division of insurance shall issue a report including but not limited to the following information: (i) the number of persons covered under this option for each year of the pilot program; (ii) the availability of coverage offered over the span of the pilot program; (iii) an analysis of impact that the pilot program has on the affordability of health coverage for the participating members and their employees and whether there is any demonstrable impact on the merged market; and (iv) recommendations regarding making the pilot program permanent.

SECTION 75. Notwithstanding any general or special law to the contrary, the health policy commission, in consultation with the center for health information and analysis and the division of insurance, shall develop a report and make recommendations to retain or modify the out-of-network payment amount established in subsection (d) of section 30 of chapter 176O of the General Laws. The report shall include, but not be limited to, an examination of the impact of the payment amount for out-of-network providers on: (i) provider participation in insurance products, including tiered and limited network products; (ii) provider financial stability; (iii) provider price variation; (iv) overall costs; (v) health care quality, (vi) patient access (vii) any other factors that the commission determines to be in the public interest. Not later than 3 years

following the effective date of said section 30 of said chapter 176O, the commission shall submit its report to the joint committee on health care financing and the house and senate committees on ways and means.

SECTION 76. The commissioner of insurance shall promulgate regulations to implement chapter 175N of the General Laws, as inserted by section 59, not later than 1 year after the effective date of this act.

SECTION 77. To implement chapter 63E of the General Laws, as inserted by section 26, the commissioner of revenue shall promulgate regulations or other guidance regarding the reporting and payment of the penalty as soon as practicable after the effective date of this act.

SECTION 78. Notwithstanding any general or special law to the contrary, in making initial appointments to the board of registration of certified peer workers established in section 21, the governor shall appoint 12 members, 4 of whom shall be appointed for a term of 1 year, 4 of whom shall be appointed for a term of 2 years, and 4 of whom shall be appointed for a term of 3 years. The governor shall make all initial appointments no later than January 1, 2023.

SECTION 79. Chapter 63E of the General Laws, as inserted by section 26, shall apply to sales commencing on or after the effective date of this act.

SECTION 80. Section 54 shall take effect on July 1, 2023.