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HOUSE . . . . . No. 4742

House bill No. 4725, as changed by the committee on Bills in the Third Reading, and as amended and passed to be engrossed by the House. July 11, 2018.

The Commonwealth of Massachusetts

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

An Act for prevention and access to appropriate care and treatment of addiction.

Whereas, The deferred operation of this act would tend to defeat its purpose, which is to bolster forthwith the commonwealth's efforts to mitigate the effects of the ongoing opioid crisis in Massachusetts, 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 6 of the General Laws is hereby amended by adding the following section:-

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

(b) (1) The commission shall consist of 17 members, as follows: the secretary of health and human services or a designee, who shall serve as the chair; the commissioner of mental health or a designee; the commissioner of public health or a designee; the chief justice of the trial

court or a designee; the house chair of the joint committee on mental health, substance use and recovery; the senate chair of the joint committee on mental health, substance use and recovery; 1 person appointed by the speaker of the house; 1 person appointed by the senate president; and 1 representative from each of the following 9 organizations: the Association for Behavioral Healthcare, Inc.; the Massachusetts Association of Community Health Workers, Inc.; the Massachusetts Association for Mental Health, Inc.; the Massachusetts Organization for Addiction Recovery, Inc.; the Massachusetts Public Health Association; the Massachusetts Society for the Prevention of Cruelty to Children; the National Alliance on Mental Illness of Massachusetts, Inc.; the Social-Emotional Learning Alliance for Massachusetts, Inc.; and the Freedman Center at William James College.

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

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

(d) The commission shall:

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

(2) consult with the secretary of health and human services on grants from the Community-Based Behavioral Health Promotion and Prevention Trust Fund established in section 35EEE of chapter 10;

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

(4) make recommendations to the legislature that: (i) promote behavioral health and prevention issues at the universal, selective and indicated levels; (ii) strengthen community or state-level promotion and prevention systems; and (iii) reduce healthcare and other public costs through evidence-based promotion and prevention; provided that the commission may use state and local prevalence and cost data to ensure commission recommendations are data-informed and address risks at the universal, selective and indicated levels of prevention;

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

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

(e) The commission shall file an annual report, on or before March 1, with the joint committee on health care financing and the joint committee on mental health, substance use and recovery on its activities and any recommendations. The commission shall monitor the implementation of its recommendations and update recommendations to reflect current science and evidence-based practice.

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

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

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

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

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

SECTION 4. Chapter 10 of the General Laws is hereby amended by inserting after section 35DDD the following section:-

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

(b) The fund shall be administered by the secretary of health and human services who, in consultation with the community-based behavioral health promotion and prevention commission established in section 219 of chapter 6, shall issue grants from the fund to:

(1) community organizations to establish or support evidence-based and evidence-informed programs for children and young adults. The community organizations may include, but not be limited to, public and private agencies, community coalitions and other entities that offer resources or support to children or young adults. A community organization or coalition may include more than one community; and

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

(1) programs that educate children and young adults on addiction, substance misuse and other risky behaviors and that identify and support children and young adults at risk for alcohol or substance misuse;

(2) programs that use evidence-based or evidence-informed prevention programs, early detection protocols and policies, risk assessment tools or counseling in a community setting;

(3) support for underserved populations of children and young adults including, but not limited to, children with multiple adverse childhood experiences;

(4) programs that offer culturally and linguistically competent services that meet the needs of the population to be served; and

(5) programs that employ the science of prevention, including, but not limited to, consideration of population health, risk and protective factors, social determinants of health, health equity, adverse childhood experiences and trauma-informed care.

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

(e) The secretary shall file an annual report on its activities, on or before March 1, with the joint committee on health care financing and the joint committee on mental health, substance use and recovery.

SECTION 5. Subsection (a) of section 13 of chapter 13 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out the last sentence and inserting in place thereof the following sentence:- The composition of the board shall be as follows: 11 registered nurses; 2 licensed practical nurses; 1 physician registered pursuant to chapter 112; 1 pharmacist registered under section 24 of chapter 112; and 2 consumers.

SECTION 6. Subsection (c) of said section 13 of said chapter 13, as so appearing, is hereby amended by striking out clause (1) and inserting in place thereof the following paragraph:-

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

SECTION 7. Said subsection (c) of said section 13 of said chapter 13, as so appearing, is hereby further amended by adding the following 2 clauses:-

(5) one registered nurse currently providing direct care to patients with substance use disorders; and

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

SECTION 8. Said section 13 of said chapter 13, as so appearing, is hereby amended by striking out subsection (d) and inserting in place thereof the following subsection:-

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

SECTION 9. Section 13 of chapter 17 of the General Laws, as so appearing, is hereby amended by striking out, in line 2, the figure “16” and inserting in place thereof the following figure:- 18.

SECTION 10. Said section 13 of said chapter 17, as so appearing, is hereby further amended by striking out, in line 5, the figure “13” and inserting in place thereof the following figure:- 14.

SECTION 11. Said section 13 of said chapter 17, as so appearing, is hereby further amended by inserting after the word “designee”, in line 5, the second time it appears, the following words:- ; the director of the department of industrial accidents or a designee.

SECTION 12. Said section 13 of said chapter 17, as so appearing, is hereby further amended by inserting after the word “pain”, in line 12, the following words:- ; 1 representative of a Massachusetts labor organization.

SECTION 13. Subsection (b) of said section 13 of said chapter 17, as so appearing, is hereby amended by inserting after the first paragraph the following paragraph:-

The commission shall prepare a drug formulary of clinically appropriate opioids for use in the treatment of patients with workers’ compensation claims. In establishing the formulary the commission shall consult with the department of industrial accidents established in chapter 152.

The formulary shall be based on well-documented, evidence-based methodology. The commission shall include as part of the formulary a complete list of opioids that are approved for payment under chapter 152 and any specific payment, prescribing or dispensing controls associated with drugs on the list. The formulary shall include all drugs approved by the United States Food and Drug Administration for the treatment of opioid use disorder.

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

SECTION 15. Said section 2 of said chapter 18C, as so appearing, is hereby further amended by inserting after the word “families”, in line 17, the following words:-

; and

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

SECTION 16. Section 19 of chapter 19 of the General Laws, as so appearing, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

(a) The department shall issue for a term of 2 years, and may renew for like terms, a license, subject to revocation by it for cause, to any private, county or municipal facility or department or unit of any such facility which offers to the public inpatient psychiatric, residential or day care services and is represented as providing treatment of persons who are mentally ill and which is deemed by it to be responsible and suitable to meet applicable licensure standards and requirements, set forth in regulations of the department, except that: (1) the department may issue a license to those facilities providing care but not treatment of persons who are mentally ill,

and (2) licensing by the department is not required where such residential or day care treatment is provided within an institution or facility licensed by the department of public health pursuant to chapter 111 unless such services are provided on an involuntary basis. Whether or not a license is issued under clause (1), the department shall make regulations for the operation of such facilities. The department may issue a provisional license where a facility, department or unit has not previously operated, or is operating but is temporarily unable to meet applicable standards and requirements. No original license, as defined in subsection (i), shall be issued to establish or maintain a facility, department or unit subject to licensure under this section, unless there is determination by the department, in accordance with its regulations, that there is need for such a facility, department or unit. The department may grant the type of license that it deems suitable for the facility, department or unit. The department shall fix reasonable fees for licenses and renewal thereof. In order to be licensed by the department under this section, a facility, department or unit shall provide services to commonwealth residents with public health insurance on a non-discriminatory basis and shall report their payer mix to the department on a quarterly basis.

SECTION 17. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out, in line 20, the word "ward" and inserting in place thereof the following word:- unit.

SECTION 18. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out subsection (c) and inserting in place thereof the following subsection:-

(c) Each facility, department and unit licensed by the department shall be subject to the supervision, visitation and inspection of the department. The department shall inspect each

facility, department or unit prior to granting or renewing a license pursuant to this section. The department shall establish regulations to administer licensing standards and to provide operational standards for such facilities, departments or units, including, but not limited to, the standards or criteria an applicant shall meet to demonstrate the need for an original license; provided, however, that such standards or criteria shall be reviewed by the department every 2 years and shall be limited to the health needs of persons who are mentally ill in the commonwealth, including underserved populations, and the demonstrated ability and history of a prospective licensee to meet the needs of such persons.

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

SECTION 19. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out, in line 44, the word "ward" and inserting in place thereof the following words:-

unit, including the denial or conditional issuance of an original license if an application does not meet the department's standards or criteria for demonstrating need.

SECTION 20. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out subsections (e) to (g), inclusive, and inserting in place there of the following 5 subsections:-

(e) The department may conduct surveys and investigations to enforce compliance with this section and any rule or regulation promulgated pursuant to this section. The department may examine the books and accounts of any facility, department or unit if it deems such examination necessary for the purposes of this section. If the department finds upon inspection, or through information in its possession, that a facility, department or unit licensed by the department is not in compliance with a requirement established under this section, the department may order the facility, department or unit to correct such deficiency by providing the facility, department or unit a deficiency notice in writing of each deficiency. In such notice, the department shall specify a reasonable time, not to exceed 60 days after receipt thereof, by which time the facility, department or unit shall remedy or correct each deficiency cited therein; provided, that, in the case of any deficiency which, in the opinion of the department, is not capable of correction within 60 days, the department shall require only that the facility, department or unit submit a written plan for correction of the deficiency in a reasonable manner. The department may modify any nonconforming plan, upon notice in writing to the facility, department or unit. Within 7 days of receipt, the affected facility, department or unit may file a written request with the department for administrative reconsideration of the order or any portion thereof.

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

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

(f) No facility, department or unit, for which a license is required under subsection (a), shall provide inpatient, residential or day care services for the treatment or care of persons who are mentally ill, unless it has obtained a license under this section. The superior court sitting in equity shall have jurisdiction, upon petition of the department, to restrain any violation of this section or to take such other action as equity and justice may require. Whoever violates this

section shall be punished for the first offense by a fine of not more than $500 and for subsequent offenses by a fine of not more than $1,000 or by imprisonment for not more than 2 years.

(g) No patient shall be commercially exploited. No patient shall be photographed, interviewed or exposed to public view without the express written consent of the patient or of the patient's legal guardian.

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

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

SECTION 20A. Said chapter 19 of the General Laws, as so appearing, is hereby amended by inserting after section 24 the following section:-

Section 25. (a) Subject to appropriation, within the department of mental health, there shall be a Center for Police Training in Crisis Intervention, in this section hereinafter referred to as the center. The center shall serve as a source for cost-effective, evidence-based mental health and substance use crisis response training programs for municipal police and other public safety personnel throughout the commonwealth. The center shall conduct activities as the advisory council, pursuant to subsection (e), directs, which shall include: (i) supporting the establishment and availability of community policing and behavioral health training curricula for law

enforcement personnel, particularly in interventions that provide alternatives to arrest and incarceration; (ii) serving as a clearinghouse for best practices in police interactions with individuals suffering from mental illness and substance use disorders; (iii) developing and implementing crisis intervention training curricula for all veteran and new recruit officers; (iv) providing technical assistance to cities and towns by establishing collaborative partnerships between law enforcement and human services providers that maximize referrals to treatment services; and (v) establishing metrics for success and evaluation of outcomes of these programs.

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

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

percentage of the municipality's police sergeants, lieutenants and other officers who directly oversee patrol officers who have received the center's recommended training and the percentage of the municipality's patrol officers who have received the center's recommended training.

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

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

(d) The center shall publish an annual report including: (i) narrative and statistical information about training demand, delivery, cost and identified service gaps during the prior year; (ii) the effectiveness of the services delivered during the prior year; (iii) the communities that participated in the training; (iv) the number of officers, and their ranks, that participated in the training; (v) the progress each municipality has made in reaching the goals described in subsection (c)(3), including the percentage of each municipality's police sergeants, lieutenants and other officers who directly oversee patrol officers who have received the center's recommended training, and the percentage of each municipality's patrol officers who have received the center's recommended training; and (vi) a review of research analyzed or conducted

during the prior year. The center shall submit the annual report by February 1st to the governor, the secretary of health and human services, the commissioner of mental health, the secretary of public safety and security, the clerks of the senate and the house of representatives, the joint committee on mental health, substance use and recovery, the joint committee on public safety and homeland security and the senate and the house committees on ways and means.

(e) There shall be a community policing and behavioral health advisory council, in this section called the council, consisting of 13 members: the secretary of health and human services or the secretary's designee, and the secretary of public safety and security or the secretary's designee who shall serve as co-chairs of the council; the commissioner of the department of mental health or the commissioner's designee; the commissioner of the department of public health or the commissioner's designee; the house chair of the joint committee on mental health, substance use and recovery; the senate chair of the joint committee on mental health, substance use and recovery; the executive director of the municipal police training committee or the director's designee; a representative of a mental health consumer advocacy group, as appointed by the secretary of health and human services; two community members who are consumers of behavioral health services, appointed by the secretary of health and human services; and three municipal police chiefs to be selected by the executive director of the Massachusetts Chiefs of Police Association, which shall include one police chief or commanding officer employed by a community with fewer than 10,000 residents; one police chief or commanding officer employed by a community with 10,000 or more residents and fewer than 60,000 residents; and one police chief or commanding officer employed by a community with 60,000 or more residents. Members of the council shall be appointed for a term of three years, and may be reappointed for consecutive three-year terms. Non-governmental council members shall serve without

compensation, but each member shall be reimbursed by the commonwealth for all expenses incurred in the performance of their official duties.

The council shall advise the chairs in directing the activities of the center consistent with subsection (c), and shall receive ongoing reports from the center concerning its activities. The council shall solicit public comment in the area of community policing and behavioral health, and in so doing may convene public hearings throughout the commonwealth. The council shall hold not less than 2 meetings per year and may convene special meetings at the call of the chair or a majority of the council.

SECTION 21. Section 17M of chapter 32A of the General Laws, as so appearing, is hereby amended by striking out, in line 3, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 22. Section 17N of said chapter 32A, as so appearing, is hereby amended by striking out, in line 31, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 23. Said chapter 32A is hereby further amended by inserting after section 17O the following section:-

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

SECTION 24. Section 1 of chapter 94C of the General Laws is hereby amended by inserting after the definition of "Drug paraphernalia", as so appearing, the following definition:-

“Electronic prescription”, a lawful order from a practitioner for a drug or device for a specific patient that is generated on an electronic prescribing system that meets federal requirements for electronic prescriptions for controlled substances, and is transmitted electronically to a pharmacy designated by the patient without alteration of the prescription information, except that third-party intermediaries may act as conduits to route the prescription from the prescriber to the pharmacist; provided however, that electronic prescription shall not include an order for medication, which is dispensed for immediate administration to the ultimate user; provided further, the electronic prescription shall be received by the pharmacy on an electronic system that meets federal requirements for electronic prescriptions. For the purposes of this chapter, a prescription generated on an electronic system that is printed out or transmitted via facsimile is not considered an electronic prescription.

SECTION 25. Section 8 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “oral”, in line 60, the following word:- , electronic.

SECTION 26. Section 17 of said chapter 94C, as so appearing, is hereby amended by striking out, in line 2, the words “the written prescription of” and inserting in place thereof the following words:- an electronic prescription from.

SECTION 27. Said section 17 of said chapter 94C, as so appearing, is hereby further amended, by striking out subsection (b) and inserting in place thereof the following subsection:-

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

SECTION 28. Said section 17 of said chapter 94C, as so appearing, is hereby further amended, by striking out, in line 11, the words “a written or oral prescription of” and inserting in place thereof the following words:- an electronic prescription from.

SECTION 29. Section 18 of said chapter 94C, as so appearing, is hereby amended by striking out subsection (d¾) and inserting in place thereof the following subsection:-

(d¾) A pharmacist filling a prescription for a schedule II substance shall, if requested by the patient, dispense the prescribed substance in a lesser quantity than indicated on the prescription. The remaining portion may be filled upon patient request in accordance with federal law; provided however, that only the same pharmacy that originally dispensed the lesser quantity may dispense the remaining portion. Upon an initial partial dispensing of a prescription or a subsequent dispensing of a remaining portion, the pharmacist or the pharmacist’s designee shall make a notation in the patient's record maintained by the pharmacy, which shall be accessible to the prescribing practitioner by request, indicating that the prescription was partially filled and the quantity dispensed. The initial partial dispensing of a prescription filled pursuant to subsection (d) or (d1/2) shall be filled within 5 days of the prescription issue date. The remaining portion pursuant to this subsection must be filled within 30 days of the prescription issue date.

SECTION 30. Said chapter 94C is hereby further amended by striking out section 19B, as so appearing, and inserting in place thereof the following section:-

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

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

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

(d) A pharmacist dispensing an opioid antagonist shall annually report to the department the number of opioid antagonist doses dispensed. Reports shall not identify an individual patient, shall be confidential and shall not constitute a public record as defined in clause twenty-sixth of

section 7 of chapter 4. The department shall publish an annual report that includes aggregate information about the dispensing of opioid antagonists in the commonwealth.

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

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

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

SECTION 31. Subsection (c) of section 20 of said chapter 94C, as so appearing, is hereby amended by striking out the first and second sentences and inserting in place thereof the following 2 sentences:- Whenever a practitioner prescribes a controlled substance by oral prescription, such individual shall cause an electronic prescription for the prescribed controlled substance to be delivered to the dispensing pharmacy within 2 days; provided that if such individual has received an exception from using an electronic prescription from the

commissioner pursuant to subsection (h) of section 23, they shall within a period of not more than 7 days or such shorter period that is required by federal law cause a written prescription for the prescribed controlled substance to be delivered to the dispensing pharmacy. The written prescription may be delivered to the pharmacy in person or by mail, but shall be postmarked within 7 days or such shorter period that is required by federal law. When an electronic or written prescription is issued pursuant to this subsection, the practitioner shall indicate on the electronic or written prescription that such prescription is being issued to document an oral prescription.

SECTION 31A. Section 21 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “written”, in line 1, the following words:-, electronic.

SECTION 31B. Said section 21 of said chapter 94C, as so appearing, is hereby further amended by inserting after the word “oral”, in line 28, the following words:-, electronic.

SECTION 32. Section 22 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “written”, in line 2, the following words:- or electronic.

SECTION 33. Said section 22 of chapter 94C of the General Laws, as so appearing , is hereby further amended by striking out, in line 21, the words “recommended full quantity indicated” and inserting in place thereof the words:- full prescribed quantity.

SECTION 34. Section 23 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “written”, in lines 1 and 6, in each instance, the following words:- or electronic.

SECTION 35. Said section 23 of said chapter 94C, as so appearing, is hereby further amended by striking out subsection (b) and inserting in place thereof the following subsection:-

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

SECTION 36. Said section 23 of said chapter 94C, as so appearing, is hereby further amended by striking out subsections (g) and (h) and inserting in place thereof the following 3 subsections:-

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

(h) The commissioner, through regulation, shall establish exceptions to section 17 and subsection (g) authorizing the limited use of a written and oral prescription where appropriate. Said exceptions shall be limited to:

(1) prescriptions that are issued by veterinarians;

(2) prescriptions that are issued or dispensed in circumstances where electronic prescribing is not available due to temporary technological or electrical failure;

(3) a time limited waiver process for practitioners who demonstrate economic hardship, technological limitations that are not reasonably within the control of the practitioner or other exceptional circumstances; and

(4) prescriptions that are issued or dispensed in emergency situations defined by the commissioner pursuant to section 17.

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

SECTION 37. Subsection (c) of section 24A of said chapter 94C, as so appearing, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-

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

licensure by the board of registration in pharmacy, under section 24A of chapter 112. The department shall also study the feasibility and value of expanding the prescription monitoring program to include schedule VI prescription drugs.

SECTION 38. Said section 24A of said chapter 94C, as so appearing, is hereby amended by striking out subsection (g) and inserting in place thereof the following subsection:- (g) The department may provide data from the prescription monitoring program to practitioners in accordance with this section; provided, however, that practitioners shall be able to access the data directly through a secure electronic medical record or other similar secure software or information systems that enables automated query and retrieval of prescription monitoring program data to a practitioner. This data may be used for the purpose of diagnosis, treatment and coordinating care to the practitioners' patients only, unless otherwise permitted by this section. Any such secure software or information system must identify the registered participant on whose behalf the prescription monitoring program was accessed. The department may enter into data use agreements to allow summary prescription monitoring program data to be securely retained in the patient's medical record as a clinical note associated with a clinical encounter; provided, however, that prescription monitoring program data shall not be retained separately from said clinical note; and provided further, that no such agreement shall allow for prescription monitoring program data to be used for purposes inconsistent with this section.

SECTION 39. Said section 24A of said chapter 94C, as so appearing, is hereby further amended by adding the following subsection:- (m) The department may enter into agreements to permit health care facilities to integrate secure software or information systems into their

electronic medical records for the purpose of using prescription monitoring program data to perform data analysis, compilation, or visualization, for purposes of diagnosis, treatment and coordinating care of the practitioner's patient. Any such secure software or information system shall be bound to comply with requirements established by the department to ensure the security and confidentiality of any data transferred.

SECTION 40. Chapter 111 of the General Laws is hereby amended by inserting after section 25J the following section:-

Section 25J ½. Every acute care hospital, as defined in section 25B, that provides emergency services in an emergency department, and every satellite emergency facility as defined in section 51½, shall maintain, as part of their emergency services, protocols and capacity to provide appropriate, evidence-based interventions prior to discharge that reduce the risk of subsequent harm and fatality following an opioid-related overdose.

Every acute care hospital that provides emergency services in an emergency department or satellite emergency facility shall maintain hospital institutional protocols and the capacity to possess, dispense, administer and prescribe opioid agonist treatment and offer such treatment to patients who present in an acute care hospital emergency department or a satellite emergency facility for care and treatment of an opioid-related overdose; provided, that such treatment shall occur whenever it is recommended by the treating healthcare provider and agreed to by the patient. Every hospital emergency department and satellite emergency facility shall demonstrate compliance with applicable training and waiver requirements established by the federal drug enforcement agency and the substance abuse and mental health services administration relative

to prescribing opioid agonist treatment, and compliance with federal enforcement agency regulations relative to administering or dispensing of narcotic drugs.

Prior to discharge, any patient who is administered or prescribed opioid agonist treatment in an emergency department or satellite emergency facility shall be directly connected to an appropriate treatment site to continue said treatment.

SECTION 41. Section 51½ of said chapter 111, as appearing in the 2016 Official Edition, is hereby amended by striking out, in lines 18, 35, 36, 50, 56, 73, 78, and 94, the word "abuse" and inserting in place thereof, in each instance, the following words:- use disorder.

SECTION 42. Subsection (a) of said section 51½ of said chapter 111, as so appearing, is hereby amended by striking out the definition of "Licensed mental health professional" and inserting in place thereof the following definition:-

"Licensed mental health professional", a licensed physician who specializes in the practice of psychiatry or addiction medicine, a licensed psychologist, a licensed independent clinical social worker, a licensed certified social worker, a licensed mental health counselor, a licensed psychiatric clinical nurse specialist, a licensed alcohol and drug counselor I as defined in section 1 of chapter 111J or any other professional with appropriate privileges at the facility to diagnose a substance use disorder.

SECTION 43. Said section 51½ of said chapter 111, as so appearing, is hereby further amended by inserting after the word "program", in line 20, the following words:- , by a licensed mental health professional.

SECTION 44. Said section 51½ of said chapter 111, as so appearing, is hereby further amended by striking out subsection (c) and inserting in place thereof the following subsection:-

(c) After a substance use disorder evaluation has been completed pursuant to subsection (b), a patient may consent to treatment, which may occur within the acute-care hospital or satellite emergency facility, if appropriate services are available, and may include induction to medication-assisted treatment. If the hospital or satellite emergency facility is unable to provide such services, the hospital or satellite emergency facility shall refer the patient to an appropriate and available hospital or treatment provider. Medical necessity for further treatment shall be determined by the treating clinician and noted in the patient's medical record.

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

SECTION 45. Said section 51½ of said chapter 111, as so appearing, is hereby further amended by striking out subsection (g) and inserting in place thereof the following subsection:-

(g) Upon discharge of a patient who experienced an opiate-related overdose, the acute-care hospital, satellite emergency facility or emergency service program shall record the opiate-related overdose and substance use disorder evaluation in the patient's electronic medical record

which shall be directly accessible by other healthcare providers and facilities consistent with federal and state privacy requirements through a secure electronic medical record, health information exchange, or other similar software or information systems for the purposes of (i) improving ease of access and utilization of such data for treatment or diagnosis; (ii) supporting integration of such data within the electronic health records of a healthcare provider for purposes of treatment or diagnosis; or (iii) allowing healthcare providers and their vendors to maintain such data for the purposes of compiling and visualizing such data within the electronic health records of a healthcare provider that supports treatment or diagnosis.

SECTION 46. Said section 51½ of chapter 111, as so appearing, is hereby further amended by striking out, in line 97, the w ords "and substance abuse" and inserting in place thereof the following words:- , substance use and recovery.

SECTION 47. Section 1 of chapter 111E of the General Laws is hereby amended by inserting after the definition of "Assignment", as so appearing, the following definition:-

"Commissioner", the commissioner of public health.

SECTION 48. Said section 1 of said chapter 111E is hereby further amended by inserting after the definition of "Independent addiction specialist", inserted by section 63 of chapter 69 of the acts of 2018, the following definition:-

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

SECTION 49. Section 7 of said chapter 111E, as appearing in the 2016 Official Edition, is hereby amended by striking out, in lines 1, 10, 13, 26, 27, 33, 39, 44, 50, 75, 77 and 80, each time it appears, the word " division" and inserting in place thereof, in each instance, the following word:- department.

SECTION 50. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by inserting after the word "requirements", in line 8, the following words:- , set forth in regulations of the department.

SECTION 51. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in lines 17 and 18, the words "but such standards and requirements shall concern only" and inserting in place thereof the following words:- which shall include, but shall not be limited to.

SECTION 52. The fourth sentence of the first paragraph of said section 7 of said chapter 111E, as so appearing, is hereby amended by striking out clauses (1) to (6), inclusive, and inserting in place thereof the following 8 clauses:-

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

(2) misrepresentations as to the treatment to be afforded patients at a facility;

(3) licensing fees;

(4) procedures for making and approving license applications;

(5) the services and treatment provided by programs;

(6) certification of capability of self-preservation;

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

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

SECTION 53. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in lines 26 and 27, the words “from time to time, on request,”.

SECTION 54. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in lines 28 to 32, inclusive, the words “reasonably require for the purposes of this section, and any licensee or other person operating a private facility who fails to furnish any such data, statistics, schedules or information as requested, or who files fraudulent returns thereof, shall be punished by a fine of not more than five hundred dollars” and inserting in place thereof the following word:- require.

SECTION 55. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in line 42, the second time it appears, the word “or”.

SECTION 56. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in line 43, the figure “10” and inserting in place thereof the following words:- 10; or

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

SECTION 57. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in line 49, the word "director" and inserting in place thereof the following word:- commissioner.

SECTION 58. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out the fifth, sixth and seventh paragraphs and inserting in place thereof the following 5 paragraphs:-

The department may conduct surveys and investigations to enforce compliance with this section and any rule or regulation promulgated pursuant to this chapter. If the department finds upon inspection, or through information in its possession, that a facility is not in compliance with a requirement established under this chapter, the department may order the facility to correct such violation by issuing a corrective action order, which shall provide the facility notice in writing of each violation. In such notice, the department shall specify a reasonable time, not to exceed 60 days after receipt thereof, by which time the facility shall remedy or correct each violation cited therein; provided, that, in the case of any violation which, in the opinion of the department, is not capable of correction within 60 days, the department shall require only that the facility submit a written plan for correction of the violation in a reasonable manner. The department may modify any nonconforming plan upon notice in writing to the facility. Within 7 days of receipt, the affected facility may file a written request with the department for administrative reconsideration of the order or any portion thereof.

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

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

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

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

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

SECTION 59. Section 10H of chapter 118E of the General Laws, inserted by section 19 of chapter 258 of the acts of 2014, is hereby amended by striking out, in line 55, the word "abuse" and inserting in place thereof the following words:- use disorder.

SECTION 60. Said chapter 118E is hereby further amended by inserting after section 10K, inserted by section 2 of chapter 120 of the acts of 2017, the following section:-

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

SECTION 61. Section 47FF of chapter 175 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out, in line 3, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 62. Section 47GG of said chapter 175, as so appearing, is hereby amended by striking out, in line 33, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 63. Said chapter 175 is hereby further amended by inserting after section 47II the following section:-

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

SECTION 64. Section 8HH of chapter 176A of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out, in line 3, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 65. Section 8II of said chapter 176A, as so appearing, is hereby amended by striking out, in line 32, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 66. Said chapter 176A of the General Laws is hereby further amended by inserting after section 8KK the following section:-

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

SECTION 67. Section 4HH of chapter 176B of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out, in line 3, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 68. Section 4II of said chapter 176B, as so appearing, is hereby amended by striking out, in line 31, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 69. Said chapter 176B is hereby further amended by inserting after section 4KK the following section:-

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

including but not limited to co-payments, if said person fills the remaining portion of the prescription.

SECTION 70. Section 4Z of chapter 176G of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out, in line 3, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 71. Section 4AA of said chapter 176G, as so appearing, is hereby amended by striking out, in line 30, the word “abuse” and inserting in place thereof the following words:- use disorder.

SECTION 72. Said chapter 176G is hereby further amended by inserting after section 4CC the following section:-

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

SECTION 73. Notwithstanding any other general or special law to the contrary, for the initial implementation of section 25J½ of chapter 111 of the General Laws, the commissioner of public health shall consult with a stakeholder group of provider representatives in the development of licensure regulations.

SECTION 74. (a) There shall be a special commission established pursuant to section 2A of chapter 4 of the General Laws to review and make recommendations regarding recovery coaching in the commonwealth. The commission shall review training opportunities for recovery coaches, recommend standards that should apply when credentialing a recovery coach, including whether recovery coaches should be required to register with a board, and gather all relevant data related to recovery coaches, including, but not limited to: (i) the total number of recovery coaches in the commonwealth; (ii) the number of people receiving compensation as recovery coaches in the commonwealth; (iii) the average and median compensation for a recovery coach; (iv) the average and median caseload for a recovery coach; and (v) the projected need for certified recovery coach services. The commission shall develop recommendations for a streamlined process to certify recovery coaches and adequate protections to ensure unauthorized individuals are not engaging in the practice of recovery coaching.

(b) The commission shall consist of 13 members: the secretary of health and human services or the secretary's designee, who shall serve as chair; the commissioner of the department of public health or the commissioner's designee; the house chair of the joint committee on mental health, substance use and recovery; the senate chair of the joint committee on mental health, substance use and recovery; 1 representative from the Massachusetts Association of Health Plans; 1 representative from the Massachusetts Psychiatric Society; 1 representative from Blue Cross Blue Shield of Massachusetts; 1 representative from the Massachusetts Organization for Addiction Recovery; and 5 persons who shall be appointed by the secretary of health and human services: 1 of whom shall represent a community provider who employs recovery coaches, 1 of whom shall represent a hospital that employs recovery

coaches, 1 of whom shall have expertise in training recovery coaches, 1 of whom shall currently be employed as a recovery coach and 1 of whom shall be a consumer of recovery coach services.

(c) The commission may hold public meetings and fact-finding hearings as it considers necessary. The commission shall file the report of its study, including recommendations for legislation, with the clerks of the house of representatives and the senate no later than 1 year after the date of the first meeting of the commission; provided, however, that the commission may, at the discretion of the chair, make a draft report available to the public for comment before filing the final version.

SECTION 75. (a) There shall be a commission to review, make recommendations and report on non-opioid and non-pharmacological pain management strategies. The commission shall: (i) develop a plan for insurers to provide adequate coverage and access to non-pharmacological pain management treatment administered by health care providers licensed by the commonwealth; and (ii) develop reasonable standards by which to assess provider networks and patient utilization of evidence-based treatment for pain management.

(b) The commission shall be comprised of 11 members: the commissioner of public health or a designee, who shall serve as chair; a representative from the Center for Health Information and Analysis; the director of Medicaid or their designee; and 1 representative from each of the following 8 organizations: the Massachusetts Association for Health Plans; Blue Cross Blue Shield Massachusetts; the Massachusetts Pain Initiative; the Acupuncture Society of Massachusetts; the American Physical Therapy Association of Massachusetts; the Massachusetts Chiropractic Society, Inc.; the Massachusetts Medical Society; and Alosa Health. The commission may hold public meetings and fact-finding hearings as it considers necessary.

(c) The commission may establish advisory committees to assist its work. The commission shall file the report of its study, including recommendations for legislation, with the clerks of the house of representatives and the senate no later than 1 year after the effective date of this act; provided, however, that the commission may, at the discretion of the chair, make a draft report available to the public for comment before filing the final version.

SECTION 76. (a) There shall be a special commission established pursuant to section 2A of chapter 4 of the General Laws to study and make recommendations regarding the use of medication-assisted treatment for opioid use disorder in the commonwealth, including methadone, buprenorphine and injectable long-acting naltrexone.

(b) The commission shall: (i) create aggregate demographic and geographic profiles of individuals who use medication-assisted treatment; (ii) examine the availability of and barriers to accessing medication-assisted treatment, including federal, state and local laws and regulations; (iii) determine the current utilization of, and projected need for, medication-assisted treatment in inpatient and outpatient settings, including, but not limited to, inpatient and residential substance use treatment facilities, inpatient psychiatric settings, pharmacy settings, mobile settings and primary care settings; (iv) identify ways to expand access to medication-assisted treatment in both inpatient and outpatient settings; (v) identify ways to encourage practitioners to seek waivers to administer buprenorphine to treat patients with opioid use disorder; (vi) study the availability of and concurrent use of behavioral health therapy for individuals receiving medication-assisted treatment; and (vii) study other related matters.

(c) The commission shall consist of 13 members: the commissioner of public health or a designee, who shall serve as chair; the executive director of the health policy commission or a

designee; the director of Medicaid or a designee; the house chair of the joint committee on mental health, substance use, and recovery; the senate chair on mental health, substance use, and recovery; and 1 representative of each of the following 8 organizations: the Massachusetts Medical Society; the Massachusetts Health & Hospital Association; the Association for Behavioral Healthcare; the Massachusetts Association of Behavioral Health Systems; the Massachusetts Association of Health Plans; Blue Cross Blue Shield of Massachusetts; the Massachusetts Pharmacists Association; and the Massachusetts Organization for Addiction Recovery.

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

SECTION 76A. There shall be a commission established pursuant to section 2A of chapter 4 of the General Laws to study the efficacy of involuntary inpatient treatment for non-court involved individuals diagnosed with substance use disorder. The commission shall review: (i) medical literature and expert opinions on the long-term relapse rates of individuals diagnosed with substance use disorder following involuntary inpatient treatment including (a) the differences in outcomes for coerced and non-coerced patients and (b) any potential increased risk of an individual suffering a fatal overdose following a period of involuntary treatment; (ii) medical literature on length of time necessary for detoxification of opioids and recommended time following detoxification to begin medication-assisted treatment; (iii) the legal implications of holding a non-court involved individual who is diagnosed with substance use disorder but is no longer under the influence of substances; (iv) whether the current capacity, including acute treatment services, clinical stabilization services, transitional support services and recovery

homes, is sufficient to treat individuals seeking voluntary treatment for substance use disorder; (v) the availability of other treatments for substance use disorder, including those treatments used in less restrictive settings; and (vi) the effectiveness of the existing involuntary commitment procedures pursuant to section 35 of chapter 123 of the General Laws at reducing long-term relapse rates.

The commission shall consist of: the house and senate chairs of the committee on mental health, substance use and recovery, who shall serve as co-chairs; the house and senate chairs of the committee on judiciary; the minority leader of the house, or a designee; the minority leader of the senate, or a designee; the secretary of the office of health and human services, or a designee; the chief justice of the trial court, or a designee; the commissioner of the department of public health, or a designee; the commissioner of the department of mental health, or a designee; an addiction expert with experience in federal and state policy on substance use disorder; and one from each of the following: Massachusetts Organization for Addiction Recovery; the Massachusetts Health & Hospital Association; the Massachusetts Medical Society; Massachusetts Psychiatric Society; Massachusetts College of Emergency Physicians; the Association for Behavioral Healthcare; the Massachusetts Association of Behavioral Health Systems; the American Civil Liberties Union of Massachusetts; the Committee for Public Counsel Services; the Massachusetts Association of Advanced Practice Psychiatric Nurses; the Massachusetts Society of Addiction Medicine; and Boston Health Care for the Homeless Program. The commission shall file recommendations, including any proposed legislation, with the clerks of the house of representatives and the senate not later July 1, 2019.

SECTION 76B. (a) There shall be a commission to review and make recommendations about appropriate prescribing practices related to the most common oral and maxillofacial

surgical procedures, which shall include the removal of wisdom teeth. The commission shall engage with drug manufacturers to create a pre-packaged product such as a blister pack or z-pack to be used in connection with common oral and maxillofacial surgical procedures that will provide patients with an appropriate, standard post-procedure dosage and quantity of commonly prescribed drugs.

(b) The commission shall be comprised of: the commissioner of public health or a designee, who shall serve as chair, a representative from the Massachusetts Dental Society, and 5 persons who shall be appointed by the commissioner of public health: 1 of whom shall be an oral surgeon; 1 of whom shall be a nurse with expertise in maxillofacial surgical procedures; 1 of whom shall represent a dental school; and 2 of whom shall have expertise in pain management.

(c) The commission shall file its recommendations, including any recommendations for legislation, with the clerks of the senate and the house of representatives 18 months from the effective date of this act.

SECTION 77. (a) For the purposes of this section, the following words shall have the following meanings:-

"Informed consent", consent to treatment that is: (a) voluntarily given by the patient; (b) recorded on a consent form signed by the patient; and (c) given after a written and verbal explanation of the following information: (i) the nature of federal Food and Drug Administration-approved medication used in substance use disorder treatment, including benefits and risks, and the benefits and risks of not receiving treatment; (ii) the distinction between detoxification and maintenance, and the availability of short-term detoxification treatment; (iii) the approximate length of each type of treatment; (iv) a clear statement of the goals of each type

of treatment, and the tasks necessary to reach those goals; (v) the need for the patient to inform the prescribing physician or advanced practice nurse of medical conditions and medications that the patient is currently taking; (vi) acknowledgement that the patient may withdraw voluntarily from treatment and discontinue use of medications; (vii) the options available to both the patient and the program as a result of either a voluntary or involuntary termination, including medically supervised withdrawal; and (viii) for persons who may become pregnant, acknowledgement of the benefits and risks of treatment during pregnancy, and the importance of informing the prescribing physician or advanced practice nurse if said person is or becomes pregnant. No incentives, rewards or punishments shall be used to encourage or discourage a patient's decision to receive treatment, except the information provided in this definition.

"Medication-assisted treatment", treatment for substance use disorder provided to a prisoner that: (i) is provided with informed consent; (ii) is determined to be medically necessary by a physician or advanced practice nurse; (iii) involves the use of medication that is approved by the federal Food and Drug Administration for treatment of substance use disorder and is included in the MassHealth drug list; (iv) includes counseling and behavioral therapy; and (v) is offered in accordance with a treatment plan that is reviewed every 90 days by a physician or advanced practice nurse.

Qualified addiction specialist," a treatment provider who is a physician licensed by the board of registration of medicine, a licensed advanced practice registered nurse or a licensed physician assistant, and who has a minimum of 6 months experience treating individuals with substance use disorder or is a licensed DATA-waiver practitioner under the federal Comprehensive Addiction and Recovery Act of 2016, Public Law 114-198.

(b) The commissioner of correction, in consultation with the commissioner of public health, shall establish a 2 year pilot program to provide medication-assisted treatment for the treatment of substance use disorder in correctional facilities. The commissioner of correction, in consultation with the commissioner of public health, shall develop criteria for the selection of state prisons to participate in a pilot program and shall select six state prisons for participation in the pilot program; provided however, that all selected facilities shall make such treatment available to inmates who were receiving medication for opioid addiction immediately preceding incarceration; provided further, that three of the facilities selected shall be required to make such treatment available to eligible inmates who were not receiving medication for opioid addiction immediately preceding incarceration; provided further, that the Massachusetts Alcohol and Substance Abuse Center shall be selected as one of the three facilities required to make treatment available to eligible inmates who were not receiving medication for opioid addiction immediately preceding incarceration.

Selected facilities shall maintain or provide for the capacity to possess, dispense and administer all drugs approved by the federal Food and Drug Administration for use in medication-assisted treatment for substance use disorder, and shall make such treatment available to any inmate who was receiving medication for opioid addiction immediately preceding incarceration; provided however, that facilities selected shall not be required to maintain or provide an opioid substitution therapy that is not included in the MassHealth drug list and is not a MassHealth covered benefit.

Selected facilities shall ensure that each inmate who is receiving medication-assisted treatment for opioid addiction continues the treatment unless the inmate voluntarily discontinues the treatment or unless the inmate’s treating provider who shall be a qualified addiction

specialist, determines that treatment is no longer medically necessary. Facilities selected to make medication-assisted treatment available to eligible inmates who were not receiving medication for opioid addiction immediately preceding incarceration shall make such treatment available to any person for whom such treatment is determined to be medically appropriate by a qualified addiction specialist.

Selected facilities shall ensure access to a qualified addiction specialist who is a licensed DATA-waiver practitioner under the federal Comprehensive Addiction and Recovery Act of 2016, Public Law 114-198.

Treatment established under this section shall include behavioral health counseling for individuals diagnosed with substance use disorder, and said counseling services shall be consistent with current therapeutic standards for these therapies in a community setting.

Not later than March 1, 2019, and on or before March 1 of each subsequent year that the pilot program is in place, selected facilities shall report to the commissioner of correction the following information: (i) the cost of the pilot program to the facility; (ii) the type and prevalence of medication-assisted treatments provided through the pilot program; (iii) the number of inmates who continued to receive the same medication as they received prior to incarceration; (iv) the number of inmates who voluntarily discontinued medication that they received prior to incarceration; (v) the number of inmates who discontinued the medication that they received prior to incarceration due to a determination by an addiction specialist; (vi) a review of the facility's practices related to medication-assisted treatment prior to inclusion in the pilot program; and (vii) any other information determined necessary by the department of correction,

in consultation with the department of public health, related to the administration of the pilot program.

The department of correction, in consultation with the department of public health, shall provide a report of the findings collected from selected facilities to the chairs of the joint committee on mental health, substance use and recovery and the house and senate committees on ways and means not later than December 31 of each year that the pilot program is in place detailing: (i) the cost of the pilot program in the prior year; (ii) the type and prevalence of medication assisted-treatments provided through the pilot program; (iii) a summary of changes to facility practices concerning medication-assisted treatment related to the pilot program; and (iv) the aggregated results of: (A) the number of inmates who continued to receive the same medication as they received prior to incarceration; (B) the number of inmates who voluntarily discontinued the medication that they received prior to incarceration; and (C) the number of inmates who discontinued medication that they received prior to incarceration based on a determination that it was no longer medically necessary.

At the completion of the pilot program, the department of correction and the department of public health shall provide a final report that includes a plan for the initiation and maintenance of medication-assisted treatment programs in all state and county correctional facilities, the types of protocols for technical assistance that may be required by the department of public health and the estimated costs to the chairs of the joint committee on mental health, substance use and recovery and the house and senate committees on ways and means not later than April 30 of the following year. The report shall also include: (a) rates of relapse after release for individuals who received medication-assisted treatment through the pilot program; (b) rates of recidivism for individuals who received medication-assisted treatment through the pilot program; (c) rates of

death by overdose for individuals who received medication-assisted treatment through the pilot program; (d) the cost of the pilot program; and (e) the projected cost associated with expanding the pilot program to additional state and county correctional institutions.

SECTION 78. When developing the program pursuant to section 16AA of chapter 6A of the General Laws, the executive office of health and human services shall consider the following: (i) how to most effectively adapt the program model of the Massachusetts Child Psychiatry Access Program, established pursuant to section 16A of chapter 19 of the General Laws, for substance use disorder consultation services; (ii) program structure, including whether to use regionally based teams; (iii) the necessity of a needs assessment; (iv) outreach methods to educate and engage providers and health insurance carriers; (v) program metrics to gauge program usage and efficacy in expanding access to appropriate substance use disorder services; and (vi) program costs.

SECTION 79. Sections 24 to 28, inclusive, 31, 32, and 34 to36, inclusive, shall take effect on January 1, 2020.

SECTION 80. Sections 74 to 76, inclusive, are hereby repealed.

SECTION 81. Section 80 shall take effect on January 1, 2021.

SECTION 82. Said section 24A of said chapter 94C, as so appearing, is hereby further amended by striking out clause (4) of subsection (f) and inserting in place thereof the following clause:-

(4) local, state and federal law enforcement or prosecutorial officials working with the executive office of public safety engaged in the administration, investigation or enforcement of

the laws governing prescription drugs; provided, however, that the data request is in connection with a bona fide specific controlled substance or additional drug-related investigation and accompanied by a probable cause warrant issued pursuant to chapter 276;

And striking out clause (6) of subsection (f) and inserting in place thereof the following clause:

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

SECTION 83. Section 27 of chapter 94C of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out after the word “commonwealth” the words: “, but only to persons who have attained the age of 18 years and”; and further moves to amend said section by striking out the second sentence in its entirety; and further moves to amend section 32I of said chapter by striking out in (d) the words: “to persons over the age of 18 pursuant to section 27.

SECTION 84. Notwithstanding any special or general law there shall be a special commission to study the alternatives and develop recommendations to broaden the availability of naloxone without prescription, including but not limited to recommendations on the standing order process, the collaborative practice agreement process, and/or legislative recommendations.

The special commission shall consist of: the secretary of health and human services or their designee, who shall serve as chair; the commissioner of the division of insurance or their designee; three members to be appointed by the governor, which shall include: one person who is

a prescribing physician, one person who is a stakeholder within a retail pharmacy company, and one member of the general citizenry impacted by the opiate epidemic; two members of the house of representatives, one of whom to be appointed by the minority leader; two members of the senate, one of whom to be appointed by the minority leader; the director of the board of pharmacy or their designee; the director of the bureau of substance abuse services or their designee; provided, however, that the first meeting of the commission shall take place not later than January 1, 2019.

The special commission shall submit its recommendations, together with drafts of any legislation, to the clerks of the house of representative and the senate, the chairs of the joint committee on mental health and substance abuse not later than May 1, 2019.

SECTION 85. Paragraph (2) of subsection (b) of section 3 of chapter 175H is hereby amended by inserting at the end thereof the following:- or for any prescription drug that is an opiate, as defined in section 1 of chapter 94C, placed by the commissioner of public health on Schedule II, pursuant to subsection (a) of section 2 of said chapter 94C.

SECTION 86. Subject to appropriation, the health policy commission, in consultation with the department of public health, shall create and administer an early childhood investment opportunity grant program for programs to support and care for families with substance exposed newborns, including the study of long-term effects of neonatal abstinence syndrome on children up to the age of 18. The program shall support a model that includes both medical services and traditionally non-reimbursed services and may support services provided in clinic settings or in-home visits. The commission shall report to the joint committee on mental health, substance use and recovery and the house and senate committees on ways and means not later than 12 months

following completion of the grant program on the results of the programs and the findings of the study on the long-term effects of neonatal abstinence syndrome, including their effectiveness, efficiency, and sustainability.