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HOUSE . . . . . No. 4758

House bill No. 4743, as change by the House committee on Bills in the Third Reading, and as amended and passed to be engrossed by the House. June 13, 2024.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Third General Court
(2023-2024)

An Act relative to treatments and coverage for substance use disorder and recovery coach licensure.

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

SECTION A1. Chapter 32A of the General Laws is hereby amended by striking out section 17Q and inserting in place thereof the following section:-

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

(b) No such coverage offered by the commission shall, relative to pain management services identified by the commission pursuant to subsection (a), require a member to obtain a preauthorization for non-medication, non-surgical treatment modalities that include restorative

therapies, behavioral health approaches or integrative health therapies, including acupuncture, chiropractic treatments, massage and movement therapies.

(c)(1) The plan pursuant to subsection (a) shall be subject to review by the division of insurance. In its review, the division shall consider the adequacy of access to a broad spectrum of pain management services and any policies that may create unduly preferential coverage to prescribing opioids without other pain management modalities.

(2) Any coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission shall not establish utilization controls, including preauthorization or step therapy requirements, for clinically appropriate non-opioid drugs approved by the federal Food and Drug Administration for the treatment or management of pain that are more restrictive or extensive than the least restrictive or extensive utilization controls applicable to any clinically appropriate opioid drug.

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

SECTION 1. Said chapter 32A is hereby further amended by inserting after section 17S the following 2 sections:-

Section 17T. (a) Any coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission shall provide coverage for prescribed or dispensed opioid antagonists, as defined in section 19B of chapter 94C and used in the reversal of overdoses caused by opioids, which shall be deemed medically

necessary and shall not require prior authorization; provided, however, that a prescription from a health care practitioner shall not be required for coverage of opioid antagonists. An opioid antagonist used in the reversal of overdoses caused by opioids shall not be subject to any deductible, coinsurance, copayments or out-of-pocket limits; provided, however, that cost-sharing shall be required if the applicable plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(b) The commission shall provide coverage for an opioid antagonist used in the reversal of overdoses caused by opioids as a medical benefit when dispensed by the health care facility in which the opioid antagonist was prescribed and shall provide coverage as a pharmacy benefit for an opioid antagonist used in the reversal of overdoses caused by opioids dispensed by a pharmacist, including an opioid antagonist dispensed pursuant to section 19B of chapter 94C; provided, however, that the rate to be reimbursed under the medical benefit shall not exceed the commission's average in-network pharmacy benefit rate and the health care facility shall not balance bill the patient.

Section 17U. (a) The commission shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage for the provision of services by a recovery coach licensed or otherwise authorized to practice pursuant to chapter 111J, irrespective of the setting in which the services are provided; provided, that such services shall be within the lawful scope of practice of a recovery coach. The contractual rate for these services shall be not less than the prevailing MassHealth rate for recovery coach services. The benefits in this section shall not be subject to any deductible, coinsurance, copayments or out-of-pocket limits; provided, however, that cost-sharing shall be required if the applicable plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status as a result

of the prohibition on cost-sharing for the service. Recovery coach services shall be deemed medically necessary and shall not require prior authorization.

SECTION 2. Chapter 18 of chapter 94C of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out subsection (e) and inserting in place thereof the following subsection:-

(e) Practitioners who prescribe controlled substances, except veterinarians, shall be required, as a prerequisite to obtaining or renewing their professional licenses, to complete appropriate training relative to: (i) effective pain management including, but not limited to: (A) appropriate, available non-opioid alternatives for the treatment of pain; (B) the advantages and disadvantages of the use of non-opioid treatment alternatives, considering a patient's risk of substance misuse; and (C) the options for referring or prescribing appropriate non-opioid treatment alternatives based on the practitioner's clinical judgment and following generally accepted clinical guidelines, taking into consideration the preference and consent of the patient and the educational information described in section 21; (ii) the risks of misuse and addiction associated with opioid medication; (iii) the identification of patients at risk for substance misuse; (iv) counseling patients about the side effects, risks, addictive nature and proper storage and disposal of prescription medications; (v) the appropriate prescription quantities for prescription medications that have an increased risk of misuse and addiction, including a patient's option to fill a prescription for a schedule II controlled substance in a lesser quantity than indicated on the prescription pursuant to subsection (d¾); and (vi) opioid antagonists, overdose prevention treatments and information to advise patients on both the use of and ways to access opioid antagonists and overdose prevention treatments. The boards of registration for each professional license that require this training shall, in consultation with the department, relevant stakeholders

and experts in the treatment and management of acute and chronic pain, develop the standards for appropriate training programs. For the purposes of this section, non-opioid treatment alternatives shall include, but shall not be limited to, medications, restorative therapies, interventional procedures, behavioral health approaches and complementary and integrative treatments.

SECTION 3. Said chapter 94C is hereby further amended by striking out section 19C and inserting in place thereof the following section:-

Section 19C. The board of registration in pharmacy shall promulgate regulations requiring pharmacies located in areas with high incidents of opiate overdose, as determined by the board in consultation with the department, to maintain a continuous supply of opioid antagonists, as defined in section 19B; provided, that the continuous supply of opioid antagonists shall include opioid antagonists that are approved by the federal Food and Drug Administration to be sold over the counter without a prescription; provided further, that such pharmacies shall notify the department if the supply or stock of opioid antagonist doses is insufficient to enable compliance with maintaining a continuous supply of opioid antagonists.

SECTION 4. Said chapter 94C is hereby further amended by inserting after section 19D the following section:-

Section 19D½. (a) For the purposes of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Opioid antagonist", as defined in section 19B.

"Substance use disorder treatment facility", a facility licensed or approved by the department to offer treatment for substance use disorder, including, but not limited to: (i) withdrawal management services; (ii) clinical stabilization services; (iii) transitional support services; (iv) residential support services; (v) community behavioral health center services; (vi) office-based opioid or addiction treatment services; or (vii) outpatient substance use disorder services.

(b) Upon discharge of a patient from a substance use disorder treatment facility, the facility shall educate the patient on the use of opioid antagonists and dispense not less than 2 doses of an opioid antagonist to the patient or a legal guardian.

(c) The commissioner may promulgate rules and regulations necessary to implement this section.

SECTION 5. Section 21 of said chapter 94C, as appearing in the 2022 Official Edition, is hereby amended by striking out the third paragraph and inserting in place thereof the following paragraph:-

The department, in consultation with relevant stakeholders and experts in the treatment and management of acute and chronic pain, and based in part on the Pain Management Best Practices Inter-Agency Task Force Report issued by the United States Department of Health and Human Services, shall produce and distribute either in written or electronic form to pharmacies, not including institutional pharmacies, pamphlets for consumers relative to narcotic drugs, specifically opiates, that include educational information related to: (i) pain management and the use and availability of non-opioid alternatives for the treatment of acute and chronic pain, including, but not limited to: (A) information on available non-opioid alternatives for the

treatment of pain, including non-opioid medications and non-pharmacological therapies; and (B) the advantages and disadvantages of the use of such non-opioid treatment alternatives; (ii) the consumer's option to fill a prescription for a schedule II controlled substance in a lesser quantity than indicated on the prescription pursuant to subsection (d¾) of section 18; (iii) misuse and abuse by adults and children; (iv) the risk of dependency and addiction; (v) proper storage and disposal; (vi) addiction support and treatment resources; (vii) the telephone helpline operated by the bureau of substance addiction services established in section 18 of chapter 17; (viii) risks of unintended overdoses associated with prescription opioid use, including, but not limited to: (A) mixing any opioid with respiratory depressants, including, but not limited to, alcohol, benzodiazepines and stimulants; and (B) changes in personal tolerance levels for persons with a history of overdose; and (ix) risk reduction measures to prevent, respond to and reverse an opioid overdose. A pharmacist shall distribute the pamphlet when dispensing a narcotic or controlled substance contained in schedule II or III; provided, however, that pharmacists shall not be required to distribute the pamphlet if: (i) the patient is receiving outpatient palliative care pursuant to section 227 of chapter 111; (ii) the patient is a resident of a long-term care facility; or (iii) the narcotic or controlled substance is prescribed for use in the treatment of substance use disorder or opioid dependence. For the purposes of this section, non-opioid treatment alternatives shall include, but shall not be limited to, medications, restorative therapies, interventional procedures, behavioral health approaches and complementary and integrative treatments.

SECTION 6. Said chapter 94C is hereby further amended by inserting after section 34A the following section:-

Section 34A½. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Drug testing services", the use of testing equipment to identify or analyze the strength, effectiveness or purity of a controlled substance prior to its injection, inhalation or ingestion by another person to determine whether the controlled substance contains chemicals, toxic substances or hazardous compounds.

"Testing equipment", including, but not limited to: fentanyl test strips, colorimetric reagents, high-performance liquid chromatography, gas chromatography and mass spectrometry.

(b)(1) A person acting in good faith and within the scope of their role providing or assisting in the provision of harm reduction services as an owner, employee, intern, volunteer or third-party contractor of an entity providing harm reduction services may provide or assist in drug testing services to an individual to ensure that a controlled substance in the possession of the individual and exclusively for that individual's personal use does not contain dangerous chemicals, toxic substances or hazardous compounds likely to cause an accidental overdose.

(2) A person acting in good faith and within the scope of their role providing or assisting in the provision of harm reduction services as an owner, employee, intern, volunteer or third-party contractor of an entity providing harm reduction services who provides or assists in the provision of drug testing services pursuant to this section shall not be charged or prosecuted pursuant to sections 32I, 34 or 40.

(3) A person acting in good faith and within the scope of their role providing or assisting in the provision of harm reduction services as an owner, employee, intern, volunteer or third-party contractor of an entity providing harm reduction services who provides or assists in drug testing services pursuant to this section shall: (i) not be held civilly liable for drug testing services unless for gross negligence or willful misconduct in the execution of the drug testing

services; and (ii) not be subject to any criminal or civil liability or any professional disciplinary action; provided, however, that this section shall not apply to acts of gross negligence or willful or wanton misconduct.

(c) An individual acting in good faith who seeks drug testing services of a controlled substance in their possession and intended exclusively for their personal use from a person acting in good faith and within the scope of their role providing, or assisting in the provision of, harm reduction services as an owner, employee, intern, volunteer or third-party contractor of an entity providing harm reduction services shall not be charged or prosecuted pursuant to sections 32I, 34 or 40 while on the premises where the drug testing services are conducted.

SECTION 7. Section 25J½ of chapter 111 of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by inserting after the first paragraph the following paragraph:-

Upon discharge of a patient from an acute care hospital or satellite emergency facility who has: (i) a history of or is actively using opioids; (ii) been diagnosed with opioid use disorder; or (iii) experienced an opioid-related overdose, the acute care hospital or satellite emergency facility shall educate the patient on the use of opioid antagonists, as defined in section 19B of chapter 94C, and prescribe or dispense not less than 2 doses of an opioid antagonist to the patient or a legal guardian and notify the patient's primary care physician or preferred care provider, if known and in consultation with the patient, of the prescribed or dispensed opioid antagonist.

SECTION 8. Said chapter 111, as so appearing, is hereby amended by inserting after section 110C the following section:-

Section 110D. (a) The department shall collect and provide data to the department of children and families and the office of the child advocate on all births of infants affected by prenatal substance exposure in a form and manner consistent with any requirements of the federal Child Abuse Prevention and Treatment Act; provided, that said data shall not include personally identifiable information.

(b) Annually, not later than April 1, the department, in consultation with the department of children and families and the office of the child advocate, shall file with the clerks of the house of representatives and the senate, the house and senate committees on ways and means, the joint committee on children, families and person with disabilities and the joint committee on mental health, substance use and recovery a report, along with any recommendations, examining the prevalence of births of infants identified as affected by prenatal substance exposure or fetal alcohol spectrum disorder, including, but not limited to: (i) any gaps in services for perinatal patients or such infants; (ii) an examination of child abuse and neglect reports related to an infant's prenatal exposure to substances, including those that were ultimately screened out by the department of children and families; (iii) an examination of child abuse and neglect reports made pursuant to section 51A of chapter 119 related to an infant's prenatal exposure to substances; and (iv) any recommended changes, including legislative or regulatory changes, that may be necessary to ensure the ongoing health, safety and wellbeing of perinatal patients and infants. If applicable, the department, in consultation with the department of children and families and the office of the child advocate, shall provide recommendations to address disparate impacts of the safety and wellbeing of infants identified as affected by prenatal substance exposure or fetal alcohol spectrum disorder.

SECTION 9. Section 7 of chapter 111E of the General Laws, as so appearing, is hereby amended by inserting after the word “basis”, in line 28, the following words:- , as determined by the department to be consistent with section 4 of chapter 151B and sufficient to ensure the needs of such residents are met and such residents have adequate access to such a facility,.

SECTION 10. The General Laws are hereby amended by striking out chapter 111J and inserting in place thereof the following chapter:-

CHAPTER 111J

ALCOHOL AND DRUG COUNSELORS; RECOVERY COACHES.

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

“Applicant”, an individual seeking licensure under this chapter.

“Approved continuing education”, continuing education approved by the department, including research and training programs, college and university courses, in-service training programs, seminars and conferences designed to maintain and enhance the skills of licensees.

“Approved program”, a program approved by the department for the education and training of licensees.

“Approved work experience”, supervised work experience, approved by the department, in the practice area for which an applicant seeks licensure.

“Department”, the department of public health.

“Licensee”, an individual who is licensed under this chapter.

"Licensed alcohol and drug counselor I", a person licensed by the department to conduct an independent practice of alcohol and drug counseling and to provide supervision to other alcohol and drug counselors. A licensed alcohol and drug counselor I shall have: (i) received a master's or doctoral degree in behavioral sciences, which included a supervised counseling practicum that meets the requirements established by the department or such equivalent educational credits as may be established by the department; (ii) at least 3 years of approved work experience; and (iii) passed a licensing examination approved by the department.

"Licensed alcohol and drug counselor II", a person licensed by the department to practice alcohol and drug counseling under clinical supervision. A licensed alcohol and drug counselor II shall have: (i) completed an approved program of education, which included a supervised counseling practicum that meets the requirements established by the department or such equivalent educational credits as may be established by the department; (ii) at least 3 years of approved work experience; and (iii) passed a licensing examination approved by the department.

"Licensed recovery coach", a person with lived experience who is licensed by the department to practice recovery coaching using shared understanding, respect and mutual empowerment to help others become and stay engaged in the process of recovery from a substance use disorder. A licensed recovery coach shall: (i) have completed an approved program of education, including approved work experience that meets the requirements established by the department; (ii) demonstrate at least 2 years of sustained recovery; and (iii) have met all education, training and experience requirements and qualifications as established by the department.

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

Section 2. (a) The department shall establish and administer a program for the licensure of alcohol and drug counselors and recovery coaches. The department shall: (i) establish the licensure requirements for licensed alcohol and drug counselors practicing in the commonwealth; (ii) establish the licensure requirements for licensed recovery coaches practicing in the commonwealth; (iii) evaluate the qualifications of applicants for licensure; (iv) supervise licensing examinations, where applicable; (v) establish and collect fees for licensing and examination, where applicable; (vi) grant and issue licenses to applicants who satisfy the department's requirements for licensure; (vii) establish continuing education requirements; (viii) investigate complaints; (ix) take appropriate disciplinary action to protect the public health, safety and welfare; and (x) perform other functions and duties as may be necessary to carry out this chapter.

(b) The department shall establish requirements for licensed alcohol and drug counselors I and licensed alcohol and drug counselors II and may establish other reasonable classifications for alcohol and drug counselors as it finds necessary and appropriate, taking into consideration different levels of education, training and work experience.

(c) The department shall establish requirements for licensed recovery coaches, including, but not limited to, establishing an ethical code of conduct for recovery coaches, and may establish other reasonable classifications for recovery coaches as it finds necessary and appropriate, taking into consideration different levels of education, training and work experience.

(d) The department shall approve and issue certificates of approval of programs for the training of alcohol and drug counselors. The department shall maintain a list of approved programs and a current roster of persons serving as licensed alcohol and drug counselors in the commonwealth.

(e) The department shall approve and issue certificates of approval of programs for the training of recovery coaches. The department shall maintain a list of approved programs and a current roster of persons serving as licensed recovery coaches in the commonwealth.

(f) The department shall promulgate rules and regulations as it deems necessary to implement the provisions of this chapter, including, but not limited to, rules and regulations establishing the educational and professional requirements for licensing individuals under this chapter, establishing fees for licensing and examination, where applicable, and governing the practice and employment of licensees to promote the public health, safety and welfare.

Section 3. (a) Each applicant shall furnish the department with proof of satisfactory completion of the educational, training and experience requirements for licensure, including completion of an approved program and approved work experience and proof of having passed any licensing examinations required by the department; provided, that the department may establish additional requirements for licensure and exemptions by regulation.

(b) A licensee shall apply biennially to the department for license renewal. A licensee seeking license renewal shall submit proof of having successfully completed the requirements for approved continuing education as may be established by the department.

(c) Applications for licenses and renewals thereof shall be submitted in accordance with procedures established by the department. The department may establish fees for license applications or renewals.

Section 4. (a) Except as otherwise provided for in this chapter or by regulation of the department, persons not licensed or otherwise exempt from licensing shall not hold themselves out as a licensed recovery coach and shall not use the title, initials, abbreviations, insignia or description of a licensed recovery coach or practice or attempt to practice recovery coaching unless otherwise authorized by law or rule or regulation of the department. Whoever engages in any such unauthorized action shall be subject to a fine of not less than $500. The department may bring a petition in superior court to enjoin such action or any other violation of this chapter or a regulation of the department.

(b) The following individuals pursuing a recovery coach license who meet the requirements for licensed recovery coach applicants as set forth in this chapter or in rules or regulations of the department may practice without a license in order to obtain the requisite hours of supervised work experience needed to obtain such license:

(i) an educational psychologist, marriage and family therapist, alcohol and drug counselor, mental health counselor, nurse practitioner, occupational therapist, physician, physician assistant, practical nurse, psychologist, registered nurse, rehabilitation counselor or social worker;

(ii) an employee or other agent of a recognized academic institution or employee assistance program or a federal, state, county or local government institution, program, agency or facility or school committee, school district, school board or board of regents while performing

recovery coach duties solely for the respective entity or under the jurisdiction and supervision of such entity; and

(iii) an employee of a program or facility approved or licensed by the department pursuant to chapters 111B and 111E; provided, however, that such individual shall perform recovery coaching solely within or under the jurisdiction and supervision of such program or facility.

(c) Nothing in this section shall be construed to prevent members of peer groups or self-help groups from performing peer counseling or self-help activities that may be included within the practice recovery coaching; provided, however, that no members of peer groups or self-help groups who are not so credentialed shall use a title stating or implying that such person is a licensed recovery coach.

Section 5. (a) Except as otherwise provided for in this chapter or by regulation, a person who is not licensed or is otherwise exempt from licensing shall not hold themself out as a licensed alcohol and drug counselor and shall not use the title, initials or description of a licensed alcohol and drug counselor or practice or attempt to practice alcohol and drug counseling. Whoever engages in any such unauthorized action shall be subject to a fine of not less than $500. The department may bring a petition in superior court to enjoin such action or any other violation of this chapter or a regulation of the department.

(b) The following individuals shall be exempt from the licensing requirements for alcohol and drug counseling under this chapter:

(i) an educational psychologist, marriage and family therapist, mental health counselor, nurse practitioner, occupational therapist, physician, physician assistant, practical nurse, psychologist, registered nurse, rehabilitation counselor and social worker;

(ii) an employee or other agent of a recognized academic institution or employee assistance program or a federal, state, county or local government institution, program, agency or facility or school committee, school district, school board or board of regents while performing alcohol and drug counseling duties solely for the respective entity or under the jurisdiction of such entity; provided, however, that a license pursuant to this chapter need not be a requirement for employment in any state, county or municipal agency; and

(iii) an employee of a treatment program or facility licensed or approved by the department pursuant to chapters 111B and 111E; provided, however, that such individual shall perform alcohol and drug counseling solely within or under the jurisdiction of such program or facility.

(c) Nothing in this section shall be construed to prevent qualified members of other professions, including attorneys, Christian Science practitioners or members of the clergy, from providing alcohol or drug counseling consistent with accepted standards of their respective professions; provided, however, that no such person shall use a title stating or implying that such person is a licensed alcohol and drug counselor.

(d) Nothing in this section shall be construed to prevent members of peer groups or self-help groups from performing peer group or self-help activities; provided, however, that no such person shall use a title stating or implying that such person is a licensed alcohol and drug counselor.

Section 6. (a) The department shall establish procedures for consumers to file written complaints regarding an individual licensed under this chapter. The department shall investigate all complaints relating to the proper practice of a person holding a license under this chapter and all complaints relating to any violation of this chapter or regulation of the department.

(b) The department may conduct an adjudicatory proceeding pursuant to chapter 30A, but shall not have the power to issue, vacate, modify or enforce subpoenas pursuant to section 12 of said chapter 30A. The department may, after a hearing pursuant to said chapter 30A, deny, refuse renewal, revoke, limit or suspend a license or otherwise discipline a licensee; provided, however, the department may suspend the license of a licensee who poses an imminent danger to the public; provided further, that the licensee shall be afforded a hearing within 7 business days to determine whether the action is warranted; and provided further, that the department shall conduct its proceedings in accordance with the provisions of this chapter and said chapter 30A. Grounds for denial, refusal to renew, revocation, limitation, suspension or other discipline shall include the following:

(i) fraud or misrepresentation in obtaining a license;

(ii) criminal conduct which the department determines to be of such a nature as to render such person unfit to practice as licensed as evidenced by criminal proceedings resulting in a conviction, guilty plea or plea of nolo contendere or an admission of sufficient facts;

(iii) violation of any law or rule or regulation of the department governing the practice of the licensee;

(iv) violation of ethical standards which the department determines to be of such a nature as to render such person unfit to practice as a licensee; or

(v) other just and sufficient cause that the department determines would render a person unfit to practice as a licensee.

(c) Where denial, refusal to renew, revocation or suspension is based solely on the failure of the licensee to timely file an application or pay prescribed fees or to maintain insurance coverage as required by law or regulation, the department may act without first granting the applicant or licensee a hearing.

Section 7. (a) Examinations for licensure, where applicable, shall be conducted at least twice per year at times and places designated by the department. Examinations for licensure, where applicable, shall be written; provided, however, that portions thereof may be conducted orally. A person who has failed an examination may be admitted to the next subsequent examination.

(b) The department may accept, in lieu of its own examination, a current certificate of any recognized certifying body issued on the basis of an examination satisfactory to the department; provided, however, that the standards of such body shall be at least as stringent as those established by the department.

Section 8. (a) The department may issue a license without examination to an applicant who meets the requirements for licensure established by the department if such applicant is licensed or certified in alcohol and drug counseling or in recovery coaching or a comparable field in another state wherein the requirements for licensure shall be determined by the department to be equivalent to or in excess of the requirements of this chapter.

(b) The department may authorize an alcohol and drug counselor or a recovery coach to practice by reciprocity.

(c) The department shall promulgate rules and regulations as may be necessary to implement this section.

Section 9. (a) There shall be a recovery coach advisory council within the department to assist and support the department in carrying out this chapter by planning, guiding and coordinating the components of the practice of recovery coaching; provided, that the council may advise the department on other such matters related to the practice of repractice of alcohol and drug counseling and the inclusion of people with lived experience in guiding such practices.

(b) The advisory council shall consist of the following members: the director of the bureau of substance addiction services, or a designee, who shall serve as chair; and 7 members appointed by the secretary of health and human services, 4 of whom shall be employed as recovery coaches, recovery coach supervisors or recovery coach educators and shall be, to the extent possible, representative of the demographic diversity of the commonwealth, including, but not limited to, diversity in race, ethnicity, gender, gender identity, sexual orientation, age, disability, geographical region, workplace and history of involvement with the criminal legal system, 1 of whom shall be a representative of the Massachusetts Board of Substance Abuse Counselor Certification, 1 of whom shall represent a health plan and 1 of whom shall be a person with lived experience who has received or is receiving recovery coaching services. Members of the advisory council shall be residents of the commonwealth.

Section 10. The bureau of substance addiction services shall establish a comprehensive peer support program to provide mentorship, technical assistance and support resources for the wellbeing of recovery coaches, including, but not limited to, peer support specialists, peer recovery coaches and recovery support navigators. The program shall include, but shall not be

limited to: (i) a network for peer-to-peer trainings, education, mentorship, counseling and support; (ii) educational and other clinical support materials; (iii) technical assistance for licensure, certification, credentialing and other employment and practice requirements; and (iv) billing technical assistance for organizations that employ recovery coaches.

SECTION 10A. Chapter 112 of the General Laws is hereby amended by inserting after section 52G the following section:-

Section 52H. (a) For the purpose of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Board", the board of registration in dentistry established in section 19 of chapter 13.

"Continuing care", guidance, support, toxicology collection and accountability through a formal monitoring contract concurrent with or following an evaluation and treatment process.

"Peer review committee", a committee of healthcare providers which evaluates or improves the quality of health care rendered by providers of health care services and evaluates and assists health care providers impaired or allegedly impaired by reason of alcohol, drugs, physical disability, mental instability or otherwise.

"Substantive non-compliance", a pattern of non-compliance or dishonesty in continuing care monitoring or an episode of non-compliance which could place patients at risk.

(b)(1) The board is hereby authorized and directed to offer a remediation program for dentists and dental hygienists.

(2) The board shall select 1 or more providers to serve as designated remediation programs.

(3) The board shall establish: (i) criteria for the acceptance, denial or termination of registered dentists and dental hygienists in the program; and (ii) an outreach program to identify registered dentists and dental hygienists who may have a substance use disorder and to provide education about the remediation program.

(4) No member of the board shall be employed by or volunteer for the program.

(c)(1) A remediation program shall serve as a voluntary alternative to traditional disciplinary actions. Any registered dentist or dental hygienist in the commonwealth may request to participate in the program.

(2) To be eligible for designation, a remediation program shall have demonstrable experience in the field of substance use disorder and shall employ a licensed mental health professional with experience in the treatment of substance use disorders.

(3) The remediation program shall have the following duties and responsibilities: (i) to evaluate registered dentists and dental hygienists who request to participate in the program for admission into the program; (ii) to agree to accept referrals from the board; (iii) to review and designate treatment facilities and assessment services to which participants may be referred; (iv) to receive and review information concerning a participant in the program; (v) to disclose to the board aggregate data on compliance-based on ongoing recovery documentation; (vi) to provide each participant, through contracted agreements, with an individualized remediation plan according to guidelines developed through collaboration between the board and the remediation

program with regards to requirements for supervision; (vii) to provide information to dentists or dental hygienists who request to participate in the program; and (viii) to establish an outreach program to identify registered dentists and dental hygienists who may have a substance use or other mental health disorder, and to provide education about the remediation program.

(4) A registered dentist or dental hygienist who requests to participate in the remediation program shall agree to cooperate with the individualized remediation plan recommended by the remediation program. The remediation program may report to the board the name and license number of a registered dentist or dental hygienist who fails to comply with an individualized remediation plan.

(5) After the remediation program, in its discretion, has determined that a registered dentist or dental hygienist has successfully completed an individualized remediation plan through the program, the board shall seal all records pertaining to the participation of the registered dentist or dental hygienist in the program. No record shall be sealed sooner than 5 years from the participant's date of entry into the program. All board and remediation program records of a participant's involvement in the program shall be kept confidential and shall not be subject to discovery or subpoena in any civil, criminal, legislative or administrative proceeding without the prior written consent of the participant.

(6) The designated remediation programs shall be confidential and shall offer a means of recovery and rehabilitation without the loss of a license by providing access to early identification, intervention, evaluation, monitoring, referral to appropriate intervention programs and treatment services, and earned advocacy, when appropriate, of licensees with potentially impairing illness, ideally prior to functional impairment.

(7) In accordance with peer review law, proceedings, reports and records of the remediation program shall be confidential pursuant to section 240. Such records shall not to be disclosed, and shall not subject to subpoena or discovery, and shall not be introduced into evidence in any judicial or administrative proceeding, subject to paragraph (4) and (5).

(8) No employee or volunteer member of the remediation program who is licensed to practice by the department of public health division of professional licensure or by the board shall have had any type of disciplinary or enforcement action taken against them by their respective licensing board, during the 5 years preceding their appointment to the program.

SECTION 11. Chapter 118E of the General Laws is hereby amended by inserting after section 10Q the following 2 sections:-

Section 10R. The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization, accountable care organization or primary care clinician plan shall provide coverage for prescribed or dispensed opioid antagonists, as defined in section 19B of chapter 94C, which shall be deemed medically necessary and shall not require prior authorization; provided, however, that a prescription from a health care practitioner shall not be required for coverage of opioid antagonists. An opioid antagonist shall not be subject to any deductible, coinsurance, copayments or out-of-pocket limits; provided, however, that cost-sharing shall be required if the applicable plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(b) The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators shall provide coverage for an opioid antagonist as a medical benefit when dispensed by the health care facility in which the opioid antagonist was prescribed and shall provide coverage as a pharmacy benefit for an opioid antagonist dispensed by a pharmacist, including an opioid antagonist dispensed pursuant to section 19B of chapter 94C.

Section 10S. The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization, accountable care organization or primary care clinician plan shall provide coverage for the provision of services by a recovery coach licensed or otherwise authorized to practice pursuant to chapter 111J, irrespective of the setting in which these services are provided; provided, that such services shall be within the lawful scope of practice of a recovery coach. The benefits in this section shall not be subject to any deductible, coinsurance, copayments or out-of-pocket limits. Recovery coach services shall be deemed medically necessary and shall not require prior authorization.

SECTION 11A. Section 35 of chapter 123 of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by inserting after the definition of "Facility" the following definition:-

"Secured facility", any public or private facility that provides care and treatment for a person with alcohol or substance use disorder located within a correctional facility funded, controlled, or administered by a county sheriff, or a private facility that provides a comparable level of security.

SECTION 11B. Said section 35 of chapter 123, as so appearing, is hereby amended by striking out the fourth, fifth and six paragraphs and inserting in place thereof the following paragraphs:-

The secretary of health and human services shall ensure an adequate supply of suitable beds for the treatment of alcohol or substance use disorders at facilities licensed or approved by the department of public health or the department of mental health for persons ordered to be committed under this section.

If the department of public health informs the court that there are no such suitable facilities or if the court makes a specific finding that the only appropriate setting for treatment for the person is a secure facility, then the person may be committed to a secure facility licensed or approved by the department of public health or the department of mental health; provided further, that such secure facilities shall be geographically distributed so as to provide access to treatment in all regions of the commonwealth.

A person committed under this section shall, upon release, be encouraged to consent to further treatment and shall be allowed voluntarily to remain in the facility for such purpose. The department of public health shall maintain a roster of public and private facilities available, together with the number of beds currently available and the level of security at each facility, for the care and treatment of alcohol use disorder and substance use disorder and shall make the roster available to the trial court.

SECTION 12. Subsection (a) of section 51A of chapter 119 of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by striking out the first paragraph and inserting in place thereof the following paragraph:-

A mandated reporter shall immediately communicate with the department orally and shall, within 48 hours, file a written report with the department detailing suspected abuse or neglect if, in their professional capacity, they have reasonable cause to believe that a child is: (i) suffering physical or emotional injury resulting from abuse inflicted upon them which causes harm or substantial risk of harm to the child's health or welfare including, but not limited to, sexual abuse; (ii) suffering physical or emotional injury resulting from neglect including, but not limited to, malnutrition; (iii) a sexually exploited child; or (iv) a human trafficking victim, as defined by section 20M of chapter 233.

SECTION 13. Section 1 of chapter 151B of the General Laws, as so appearing, is hereby amended by striking out subsection 17 and inserting in place thereof the following subsection:-

17. The term "handicap" means: (a) a physical or mental impairment which substantially limits 1 or more major life activities of a person; (b) a record of having such impairment; (c) being regarded as having such impairment; or (d) the lawful possession and clinically appropriate taking of any medication that is: (i) approved by the federal Food and Drug Administration for the treatment of an opioid-related substance use disorder, including, but not limited to, an opioid agonist or a partial opioid agonist and used for the treatment of an opioid-related substance use disorder; (ii) obtained directly or pursuant to a valid prescription or order from a practitioner, as defined in section 1 of chapter 94C; (iii) determined to be medically necessary by a practitioner while acting in the course of professional practice; and (iv) offered in accordance with a treatment plan that is reviewed by a practitioner at a frequency consistent with appropriate clinical standards. The term handicap shall not include current, illegal use of a controlled substance, as defined in said section 1 of said chapter 94C. For the purposes of this subsection, the words "clinically appropriate" shall mean the taking of a prescribed medication

for the treatment of an opioid-related substance use disorder when such drug is medically indicated and intake is proportioned to the medical need.

SECTION 13A. Chapter 175 of the General Laws is hereby amended by striking out section 47KK and inserting in place thereof the following section:-

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

(b) No such policy, contract, agreement, plan or certificate of insurance shall, relative to pain management services identified by the carrier pursuant to subsection (a), require a member to obtain a preauthorization for non-medication, non-surgical treatment modalities that include restorative therapies, behavioral health approaches or integrative health therapies, including acupuncture, chiropractic treatments, massage and movement therapies.

(c)(1) The plan pursuant to subsection (a) shall be subject to approval and shall be a component of carrier accreditation by the division of insurance pursuant to section 2 of chapter 176O. In its review, the division shall consider the adequacy of access to a broad spectrum of pain management services and any carrier policies that may create unduly preferential coverage to prescribing opioids without other pain management modalities.

(2) No policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth, which is considered creditable coverage under said section 1 of said chapter 111M, shall establish utilization controls, including preauthorization or step therapy requirements, for clinically appropriate non-opioid drugs approved by the federal Food and Drug Administration for the treatment or management of pain, that are more restrictive or extensive than the least restrictive or extensive utilization controls applicable to any clinically appropriate opioid drug.

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

SECTION 14. Said chapter 175 is hereby further amended by inserting after section 47UU the following 2 sections:-

Section 47VV. 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 coverage for prescribed or dispensed opioid antagonists, as defined in section 19B of chapter 94C and used in the reversal of overdoses caused by opioids, which shall be deemed medically necessary and shall not require prior authorization; provided, however, that a prescription from a health care practitioner shall not be required for coverage of opioid antagonists. An opioid antagonist used in the reversal of overdoses caused by opioids shall not be subject to any deductible, coinsurance, copayments or out-of-pocket limits; provided, however, that cost-sharing shall be required if the applicable plan is governed by the

federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(b) The policy, contract, agreement, plan or certificate of insurance shall provide coverage for an opioid antagonist used in the reversal of overdoses caused by opioids as a medical benefit when dispensed by the health care facility in which the opioid antagonist was prescribed and shall provide coverage as a pharmacy benefit for an opioid antagonist used in the reversal of overdoses caused by opioids dispensed by a pharmacist, including an opioid antagonist dispensed pursuant to section 19B of chapter 94C; provided, however, that the rate to be reimbursed under the medical benefit shall not exceed the carrier's average in-network pharmacy benefit rate and the health care facility shall not balance bill the patient.

Section 47WW. 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 coverage for the provision of services by a recovery coach licensed or otherwise authorized to practice under chapter 111J, irrespective of the setting in which these services are provided; provided, that such services shall be within the lawful scope of practice of a recovery coach. The contractual rate for these services shall be no less than the prevailing MassHealth rate for recovery coach services. The benefits in this section shall not be subject to any deductible, coinsurance, copayments or out-of-pocket limits; provided, however, that cost-sharing shall be required if the applicable plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service. Recovery coach services shall be deemed medically necessary and shall not require prior authorization.

SECTION 15. Said chapter 175 is hereby further amended by inserting after section 122A the following section:-

Section 122B. (a) No insurer authorized to issue policies on the lives of persons in the commonwealth shall make a distinction or otherwise discriminate between persons, reject an applicant, cancel a policy or demand or require a higher rate of premium for reasons based solely upon an applicant or insured having or had a prescription for, purchased or otherwise possessed an opioid antagonist, as defined in section 19B of chapter 94C.

(b) A violation of this section shall constitute an unfair method of competition or unfair and deceptive act or practice pursuant to chapters 93A and 176D.

SECTION 15A. Chapter 176A of the General Laws is hereby amended by striking out section 8MM and inserting in place thereof the following section:-

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

(b) No such contract shall, relative to pain management services identified by the carrier pursuant to subsection (a), require a member to obtain a preauthorization for non-medication, non-surgical treatment modalities that include restorative therapies, behavioral health approaches

or integrative health therapies, including acupuncture, chiropractic treatments, massage, and movement therapies.

(c)(1) The plan pursuant to subsection (a) shall be subject to approval and shall be a component of carrier accreditation by the division of insurance pursuant to section 2 of chapter 176O. In its review, the division shall consider the adequacy of access to a broad spectrum of pain management services and any carrier policies that may create unduly preferential coverage to prescribing opioids without other pain management modalities.

(2) No contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall establish utilization controls, including preauthorization or step therapy requirements, for clinically appropriate non-opioid drugs approved by the federal Food and Drug Administration for the treatment or management of pain, that are more restrictive or extensive than the least restrictive or extensive utilization controls applicable to any clinically appropriate opioid drug.

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

SECTION 16. Said chapter 176A is hereby further amended by inserting after section 8VV the following 2 sections:-

Section 8WW. Any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall provide coverage for prescribed or dispensed opioid antagonists, as defined

in section 19B of chapter 94C and used in the reversal of overdoses caused by opioids, which shall be deemed medically necessary and shall not require prior authorization; provided, however, that a prescription from a health care practitioner shall not be required for coverage of opioid antagonists. An opioid antagonist used in the reversal of overdoses caused by opioids shall not be subject to any deductible, coinsurance, copayments or out-of-pocket limits; provided, however, that cost-sharing shall be required if the applicable plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(b) Such contract shall provide coverage for an opioid antagonist used in the reversal of overdoses caused by opioids as a medical benefit when dispensed by the health care facility in which the opioid antagonist was prescribed and shall provide coverage as a pharmacy benefit for an opioid antagonist used in the reversal of overdoses caused by opioids dispensed by a pharmacist, including an opioid antagonist dispensed pursuant to section 19B of chapter 94C; provided, however, that the rate to be reimbursed under the medical benefit shall not exceed the carrier's average in-network pharmacy benefit rate and the health care facility shall not balance bill the patient.

Section 8XX. Any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall provide coverage for the provision of services by a recovery coach licensed or otherwise authorized to practice under chapter 111J, irrespective of the setting in which these services are provided; provided, that such services shall be within the lawful scope of practice of a recovery coach. The contractual rate for these services shall be no less than the prevailing MassHealth rate for recovery coach services. The benefits in this section shall not be subject to any deductible,

coinsurance, copayments or out-of-pocket limits; provided, however, that cost-sharing shall be required if the applicable plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service. Recovery coach services shall be deemed medically necessary and shall not require prior authorization.

SECTION 16A. Chapter 176B of the General Laws is hereby amended by striking out section 4MM and inserting in place thereof the following section:-

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

(b) No such subscription certificate shall, relative to pain management services identified by the carrier pursuant to subsection (a), require a member to obtain a preauthorization for non-medication, non-surgical treatment modalities that include restorative therapies, behavioral health approaches or integrative health therapies, including acupuncture, chiropractic treatments, massage, and movement therapies.

(c)(1) The plan pursuant to subsection (a) shall be subject to approval and shall be a component of carrier accreditation by the division of insurance pursuant to section 2 of chapter 176O. In its review, the division shall consider the adequacy of access to a broad spectrum of pain management services and any carrier policies that may create unduly preferential coverage to prescribing opioids without other pain management modalities.

(2) No subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall establish utilization controls, including preauthorization or step therapy requirements, for clinically appropriate non-opioid drugs approved by the federal Food and Drug Administration for the treatment or management of pain, that are more restrictive or extensive than the least restrictive or extensive utilization controls applicable to any clinically appropriate opioid drug.

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

SECTION 17. Said chapter 176B is hereby further amended by inserting after section 4VV the following 2 sections:-

Section 4WW. Any subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth, shall provide coverage for prescribed or dispensed opioid antagonists, as defined in section 19B of chapter 94C and used in the reversal of overdoses caused by opioids, which shall be deemed medically necessary and shall not require prior authorization; provided, however, that a prescription from a health care practitioner shall not be required for coverage of opioid antagonists. An opioid antagonist used in the reversal of overdoses caused by opioids shall not be subject to any deductible, coinsurance, copayments or out-of-pocket limits; provided, however, that cost-sharing shall be required if the applicable plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(b) The policy, contract, agreement, plan or certificate of insurance shall provide coverage for an opioid antagonist used in the reversal of overdoses caused by opioids as a medical benefit when dispensed by the health care facility in which the opioid antagonist was prescribed and shall provide coverage as a pharmacy benefit for an opioid antagonist used in the reversal of overdoses caused by opioids dispensed by a pharmacist, including an opioid antagonist dispensed pursuant to section 19B of chapter 94C; provided, however, that the rate to be reimbursed under the medical benefit shall not exceed the carrier's average in-network pharmacy benefit rate and the health care facility shall not balance bill the patient.

Section 4XX. Any subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall provide coverage for the provision of services by a recovery coach licensed or otherwise authorized to practice under chapter 111J, irrespective of the setting in which these services are provided; provided, that such services shall be within the lawful scope of practice of a recovery coach. The contractual rate for these services shall be no less than the prevailing MassHealth rate for recovery coach services. The benefits in this section shall not be subject to any deductible, coinsurance, copayments or out-of-pocket limits; provided, however, that cost-sharing shall be required if the applicable plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service. Recovery coach services shall be deemed medically necessary and shall not require prior authorization.

SECTION 17A. Chapter 176G of the General Laws is hereby amended by striking out section 4EE and inserting in place thereof the following section:-

Section 4EE. (a) Any individual or group health maintenance contract that is issued or renewed within or without the commonwealth shall develop a plan to provide adequate coverage and access to a broad spectrum of pain management services, including, but not limited to, non-medication, non-surgical treatment modalities and non-opioid medication treatment options that serve as alternatives to opioid prescribing, in accordance with guidelines developed by the division of insurance.

(b) No such contract shall, relative to pain management services identified by the carrier pursuant to subsection (a), require a member to obtain a preauthorization for non-medication, non-surgical treatment modalities that include restorative therapies, behavioral health approaches or integrative health therapies, including acupuncture, chiropractic treatments, massage, and movement therapies.

(c)(1) The plan pursuant to subsection (a) shall be subject to approval and shall be a component of carrier accreditation by the division of insurance pursuant to section 2 of chapter 176O. In its review, the division shall consider the adequacy of access to a broad spectrum of pain management services and any carrier policies that may create unduly preferential coverage to prescribing opioids without other pain management modalities.

(2) No individual or group health maintenance contract that is issued or renewed within or without the commonwealth shall establish utilization controls, including preauthorization or step therapy requirements, for clinically appropriate non-opioid drugs approved by the federal Food and Drug Administration for the treatment or management of pain, that are more restrictive or extensive than the least restrictive or extensive utilization controls applicable to any clinically appropriate opioid drug.

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

SECTION 18. Said chapter 176G is hereby further amended by inserting after section 4NN the following 2 sections:-

Section 4OO. An individual or group health maintenance contract that is issued or renewed within or without the commonwealth shall provide coverage for prescribed or dispensed opioid antagonists, as defined in section 19B of chapter 94C and used in the reversal of overdoses caused by opioids, which shall be deemed medically necessary and shall not require prior authorization; provided, however, that a prescription from a health care practitioner shall not be required for coverage of opioid antagonists. An opioid antagonist used in the reversal of overdoses caused by opioids shall not be subject to any deductible, coinsurance, copayments or out-of-pocket limits; provided, however, that cost-sharing shall be required if the applicable plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

(b) The individual or group health maintenance contract shall provide coverage for an opioid antagonist used in the reversal of overdoses caused by opioids as a medical benefit when dispensed by the health care facility in which the opioid antagonist was prescribed and shall provide coverage as a pharmacy benefit for an opioid antagonist used in the reversal of overdoses caused by opioids dispensed by a pharmacist, including an opioid antagonist dispensed pursuant to section 19B of chapter 94C; provided, however, that the rate to be

reimbursed under the medical benefit shall not exceed the carrier's average in-network pharmacy benefit rate and the health care facility shall not balance bill the patient.

Section 4PP. An individual or group health maintenance contract that is issued or renewed within or without the commonwealth shall provide coverage for the provision of services by a recovery coach licensed or otherwise authorized to practice under chapter 111J, irrespective of the setting in which these services are provided; provided, that such services shall be within the lawful scope of practice of a recovery coach. The contractual rate for these services shall be no less than the prevailing MassHealth rate for recovery coach services. The benefits in this section shall not be subject to any deductible, coinsurance, copayments or out-of-pocket limits; provided, however, that cost-sharing shall be required if the applicable plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service. Recovery coach services shall be deemed medically necessary and shall not require prior authorization.

SECTION 18A. (a) Notwithstanding any general or special law to the contrary, the Massachusetts alcohol and substance abuse center, hereinafter referred to as the center, shall be considered a security facility under section 35 of chapter 123 of the General Laws for the purposes of commitments under said section 35 until the conditions under subsection (b) are satisfied.

(b) The secretary of health and human services shall develop a plan to end operations at the center as a facility accepting persons committed for treatment for alcohol or substance use disorder by not later than December 31, 2026; provided, however, that persons may continue to be committed to the center under said section 35 of said chapter 123 until the department of

public health and department of mental health have licensed and approved suitable facilities with a total bed capacity equal to the center. Such facilities shall be geographically distributed so as to provide access to treatment in all regions of the commonwealth.

(c) The secretary shall submit the plan required under subsection (b) to the clerks of the senate and house of representatives and to the joint committee on mental health, substance abuse and recovery not later than 180 days after the effective date of this act. The secretary shall submit interim reports quarterly detailing the progress towards ending operations at the center to the clerks of the senate and house of representatives and to the joint committee on mental health, substance abuse and recovery. The quarterly reports shall include, but shall not be limited to following: (i) a census of persons being treated at the center; (ii) the number of persons transferred from the center to other facilities licensed by the department of public health or department of mental health; (iii) the location and bed capacity of each newly licensed facility; (iv) the type of facility and location of newly committed persons under section 35 of chapter 123 of the General Laws; and (v) the anticipated fiscal impact, if any, of complying with this section.

SECTION 19. (a) The department of children and families, in consultation with the department of public health and the office of the child advocate, shall promulgate regulations or issue further guidance for the requirements of health care providers involved in the delivery or care of infants identified as being affected by prenatal substance exposure or fetal alcohol spectrum disorder. The regulations or guidance shall include, but shall not be limited to: (i) factors for determining instances in which prenatal substance exposure from a medication prescribed by a licensed health care provider require filing a report pursuant to section 51A of chapter 119 of the General Laws; provided, that an indication of prenatal substance exposure shall not solely meet the requirements of said section 51A of said chapter 119; and (ii) the roles

and responsibilities of health care providers and staff who care for perinatal patients or newborns pursuant to 42 U.S.C. § 5106a(b)(2)(B)(ii) and in accordance with the federal Child Abuse Prevention and Treatment Act, 42 U.S.C. § 5101 et seq. and 42 U.S.C. § 5116 et seq., as amended from time to time.

(b) Such regulations or guidance shall: (i) reflect current accepted standards of health care and substance use treatment practices; (ii) conform to the reporting requirements under the federal Child Abuse Prevention and Treatment Act, 42 U.S.C. § 5101 et seq. and 42 U.S.C. § 5116 et seq., as amended from time to time; and (iii) to the extent possible, reduce racial disparities in maternal and child health care, reports of suspected child abuse or neglect under said section 51A of said chapter 119 or the number of patients identified for plans of safe care pursuant to the federal Child Abuse Prevention and Treatment Act, 42 U.S.C. § 5101 et seq. and 42 U.S.C. § 5116 et seq., as amended from time to time.

(c) Such regulations or guidance shall be developed with input from relevant stakeholders, including, but not limited to: (i) medical professional associations and health care providers with expertise in the provision of care to pregnant people; (ii) individuals who have lived experience of seeking or receiving behavioral health services or treatment prior to, during and after pregnancy; (iii) professional associations and organizations with expertise in prenatal substance exposure, perinatal and child health, treatment of substance use disorder and racial equity in access to health care; and (iv) behavioral health professionals with expertise in providing culturally-competent care.

SECTION 20. The bureau of substance addiction services within the department of public health shall conduct a comprehensive review of barriers to certification, credentialing and

other employment and practice requirements of recovery coaches, including, but not limited to, peer support specialists, peer recovery coaches and recovery support navigators, and issue a report on its findings. The report shall include, but shall not be limited to: (i) cost barriers for individuals with lived experience, including, but not limited to, application and examination fees for initial certification and credentialing; (ii) cost barriers to certification and credentialing renewals; (iii) cost and reimbursement barriers for hospitals and clinics licensed under chapter 111 of the General Laws and other employers to hire, train and retain recovery coaches, including, but not limited to, peer support specialists, peer recovery coaches and recovery support navigators; (iv) eligibility requirements for certification and credentialing; (v) access to training programs and resources; and (vi) any additional barriers to obtaining and maintaining authorization to practice recovery coaching. The report shall also include recommendations to address said barriers. The bureau shall submit a copy of the report to the secretary of health and human services, the clerks of the house of representatives and the senate and the joint committee on mental health, substance use and recovery within 90 days of the effective date of this act.

SECTION 20A. (a) The bureau of substance addiction services within the department of public health shall review and study the disparate impacts and disparities of substance use disorder, overdoses, overdose deaths and clinical outcomes for members of historically marginalized communities, including, but not limited to, impacts based on race, ethnicity, language, gender, gender identity, sexual orientation, age, disability and other social determinants of health identified by the bureau.

(b) The bureau shall: (i) review current data and trends regarding substance use and overdose rates, disparities in treatment access and corresponding causes within historically marginalized communities; (ii) evaluate the effectiveness of current treatment interventions

within historically marginalized communities; (iii) identify barriers to accessing treatment, including, but not limited to, access to necessary resources, education and access to appropriate care and interventions; and (iv) identify evidence-based strategies to reduce overdose deaths and improve access, treatment and education within historically marginalized communities.

(c) Not later than June 30, 2025, the bureau shall submit a report of its findings and any recommendations, including any legislative or regulatory changes that may be necessary to carry out any recommendations, to the clerks of the house of representatives and the senate, the joint committee on mental health, substance use and recovery and the joint committee on racial equity, civil rights, and inclusion.

SECTION 20B. (a) For the purposes of this section, the words “administrative discharge” shall mean the termination of treatment of a patient determined by a health care provider to have a substance use disorder and related treatment needs despite a lack of clinical improvement in the patient due to a violation of an administrative rule of a licensed substance use disorder treatment program.

(b) The bureau of substance addiction services within the department of public health shall study the circumstances and effects of administrative discharges of patients from substance use disorder treatment programs licensed under sections 6 and 6A of chapter 111B of the General Laws or section 7 of chapter 111E of the General Laws or programs established pursuant to sections 24 and 24D of chapter 90.

(b) The bureau shall examine: (i) standards used by substance use disorder treatment programs in determining when an administrative discharge is appropriate, including, but not limited to, any standard criteria, methodology or graduated sanctions based on staff and patient

safety and the level of treatment and severity of the symptoms of the patient; (ii) options for patients following an administrative discharge from a substance use disorder treatment program, including, but not limited to, any programs or resources available to a patient and the frequency that such options are provided to said patients; and (iii) the applicability, availability and effectiveness of the regulations relative to the coordination of care and management of discharge planning for an administrative discharge pursuant to 105 CMR 164 and section 19 of chapter 17 of the General Laws.

(c) Not later than December 31, 2025, the bureau shall submit its findings and any recommendations, including any legislative or regulatory changes that may be necessary to implement any recommendations, with the clerks of the house of representatives and senate, the house and senate committees on ways and means and the joint committee on mental health, substance use and recovery.

SECTION 21. (a) The department of public health may issue a recovery coach license to an applicant who: (i) is practicing in the commonwealth as a recovery coach as of the effective date of this act; and (ii) applies for licensure within 1 year of the effective date of this act. The lived experience requirement pursuant to section 1 of chapter 111J of the General Laws, as inserted by section 10, shall be waived for applicants who were credentialed by the Massachusetts Board of Substance Abuse Counselor Certification prior to the effective date of this act.

(b) The department of public health shall issue a temporary recovery coach license to an applicant who has received a Certified Addictions Recovery Coach certification, issued by the Massachusetts Board of Substance Abuse Counselor Certification and provides satisfactory proof

for any test or examination that may be required for licensure; provided, that no temporary license shall be valid for more than 2 years. The applicants eligible for a temporary license shall meet all other qualifications and requirements for licensure as determined by the department of public health.

(c) The department of public health shall promulgate rules or regulations for the implementation of this section.

SECTION 21A. (a) There is hereby established a special commission to study and make recommendations on ways to address the public health and safety concerns posed by the proliferation of xylazine as an additive to illicit drugs such as fentanyl.

(b) The commission shall consist of the following 13 members: the chairs of the joint committee on mental health, substance use, and recovery, who shall serve as co-chairs; 1 member appointed by the speaker of the house of representatives; 1 member appointed by the minority leader of the house of representatives; 1 member appointed by the senate president; 1 member appointed by the minority leader of the senate; the secretary of health and human services, or their designee; the commissioner of public health, or their designee; the commissioner of mental health, or their designee; the secretary of public safety and security, or their designee; 1 member who is a representative of the bureau of substance addiction services within the department of public health; 1 member who is a representative of the Massachusetts Veterinary Medical Association; and 1 member appointed by the governor who shall be a registered nurse or licensed physician with experience in treating patients for substance use disorder.

(c) The commission shall consider: (i) best practices to regulate and oversee the production and distribution of xylazine to ensure that it is used solely for its intended purpose as an animal tranquilizer administered by licensed veterinarians and not for human consumption; (ii) whether xylazine should be classified as a controlled substance and appropriate penalties for its illegal production and distribution; (iii) the availability of effective outreach and treatment programs for patients who have been exposed to xylazine and ways to address any gaps in available programs and services; and (iv) any other considerations determined to be relevant by the commission.

(d) The commission shall file a report and its recommendations, including any legislation necessary to implement the recommendations, with the clerks of the house of representatives and the senate not later than June 30, 2025.

SECTION 22. No person shall be found to have violated section 4 of chapter 111J of the General Laws, as inserted by section 10, until 6 months after the department of public health first issues a recovery coach license pursuant to said section 4 of said chapter 111J.

SECTION 23. Not later than 18 months after the effective date of this act, the initial report consistent with the report required pursuant to section 110D of chapter 111 of the General Laws, as inserted by section 8, shall be filed by the department of public health, in consultation with the department of children and families and the office of the child advocate, with the clerks of the house of representatives and the senate, the house and senate committees on ways and means, the joint committee on children, families and person with disabilities and the joint committee on mental health, substance use and recovery examining the prevalence of births of

infants identified as being affected by prenatal substance exposure or fetal alcohol spectrum disorder.

SECTION 23A. All commission members pursuant to section 21A shall be appointed within 30 days of the effective date of this act.