

**SENATE . . . . . No. 2774**

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The Commonwealth of Massachusetts



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LIEUTENANT GOVERNOR

*March 15, 2022*

To the Honorable Senate and House of Representatives,

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

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

**Investing in Primary Care and Behavioral Health**

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

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

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

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

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

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

- Providers and insurers, including MassHealth, will be required to increase spending on behavioral health and primary care by 30% over three years.
- Calendar year 2019 spending will serve as the baseline; provider and insurer performance against the target will be based on expenditures through calendar year 2024.
- The legislation does not prescribe how providers and insurers must achieve the target, instead leaving decision-making to the discretion of the individual provider and insurer organization.
- Providers and insurers will be required to report their progress on an annual basis through existing processes overseen by the Center for Health Information Analysis (CHIA) and the Health Policy Commission (HPC).
- Providers and insurers that do not meet the 30% increase target will be referred to the HPC for review and may be subject to a performance improvement plan which may require

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

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

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

#### Managing Health Care Cost Drivers that Impact Consumers

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

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

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

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

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

#### Improving Access to High Quality, Coordinated Care

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

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

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

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

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

Respectfully submitted,

Charles D. Baker,  
*Governor*

# SENATE . . . . . No. 2774

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

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## The Commonwealth of Massachusetts

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

An Act investing in the future of our health.

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

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

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

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

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

34 of health and human services and the joint committee on health care financing not later than May  
35 31 of each year with the first report due in the year following the effective date of this section.

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

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

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

58 (d) No later than July 31 of each year, the secretary of health and human services in  
59 consultation with the commissioner of the division of insurance, may establish an aligned  
60 measure set to be used by carriers offering health plans that are subject to chapter 32A or chapter  
61 176O in contracts with health care providers that incorporate quality measures into the payment  
62 terms, and carriers shall use such aligned measure set for assigning tiers to health care providers  
63 in tiered network plans pursuant to section 11 of chapter 176J. The aligned measure set shall  
64 designate: (i) core measures that shall be used in contracts between payers, including carriers,  
65 and health care providers, including provider organizations and accountable care organizations,  
66 which incorporate quality measures into payment terms; and (ii) non-core measures that may be  
67 used in such contracts. In establishing the aligned measure set, the secretary of health and human  
68 services may consider factors including but not limited to quality improvement priorities for the  
69 Commonwealth, quality measurement innovation, data collection methodology, and measure  
70 feasibility.

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

74 “Aggregate baseline expenditures”, the sum of all primary care and behavioral health  
75 expenditures, as defined by the center, in the commonwealth in the calendar year preceding the  
76 3-year period to which the aggregate target applies; provided, however, that aggregate baseline  
77 expenditures shall initially be calculated using calendar year 2019.



78           “Aggregate primary care and behavioral health expenditure target”, hereinafter “the  
79 aggregate target”, the targeted percentage change in total expenditures on primary care and  
80 behavioral health in the commonwealth from aggregate baseline expenditures.

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

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

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

90           “Primary care and behavioral health expenditure target”, hereinafter “the target”, the  
91 targeted percentage change in expenditures on primary care and behavioral health by or  
92 attributed to an individual health care entity compared to the entity’s baseline expenditures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

243 (5) any other factors the commission considers relevant.

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



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

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

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

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

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

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

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

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

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

292 commission; (iii) failed to implement the performance improvement plan in good faith; or (iv)  
293 knowingly failed to provide information required by this section to the commission or that  
294 knowingly falsifies the same, the commission may assess a civil penalty to the health care entity  
295 of not more than \$500,000. A civil penalty assessed under this subsection shall be deposited into  
296 the Primary Care and Behavioral Health Equity Trust Fund established pursuant to section  
297 2TTTTT of chapter 29. The commission shall seek to promote compliance with this section and  
298 shall only impose a civil penalty as a last resort.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

466 shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter  
467 66.

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

470 Section 25. (a) The center shall analyze data on Massachusetts drug utilization and  
471 spending, including but not limited to data reported under Sections 10 and 10A. Annually, the  
472 center shall refer drugs to the health policy commission for review under section 8B of chapter  
473 6D that meet any of the following criteria: (i) a current average annual gross cost per utilizer for  
474 public and private health care payers in Massachusetts of greater than \$50,000; (ii) a biosimilar  
475 drug that has a launch wholesale acquisition cost that is not at least 15 per cent lower than the  
476 referenced brand biologic at the time the biosimilar is launched; or (iii) among the 25 drugs  
477 determined by the center to have the most impact on health care spending in the most recent year  
478 of available data, based upon utilization, price, utilization and price growth, patient cost sharing  
479 amounts, net spending and other factors as determined by the center. The center shall provide  
480 notice of the referral to the manufacturer of the drug.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

545 SECTION 23. Chapter 26 of the General Laws is hereby amended by striking out section  
546 8K and inserting in place thereof the following section:-

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

551 4M of chapter 176G of the General Laws, in regard to any carrier licensed under chapters 175,  
552 176A, 176B and 176G.

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

563 (c) As part of its annual review of health insurance carriers' compliance with state and  
564 federal mental health parity provisions, the commissioner of insurance shall require health  
565 insurance carriers licensed or authorized to do business under chapters 175, 176A, 176B and  
566 176G to submit utilization reports that document the number of requests, approvals, denials and  
567 denial appeals for covered behavioral health services and the number of requests, approvals,  
568 denials and denial appeals for covered non-behavioral health services, and the number of  
569 approved covered out-of-network services for behavioral health services and the number of  
570 approved covered out-of-network services for covered non-behavioral health services. In  
571 creating guidance for these reports, the division of insurance shall specify that information be  
572 broken down by region and behavioral health service category and shall use this information as

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

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

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

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



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

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

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

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

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

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

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

629           (b) There shall be credited to the fund an amount equal to: (i) any revenues under Section  
630 9817 of the American Rescue Plan Act of 2021, Pub. L. No. 117-2 designated for the purposes  
631 described in subsection (a); (ii) any federal financial participation revenues claimed and received  
632 by the commonwealth for eligible expenditures made from the fund; (iii) any appropriations or  
633 other money authorized by the general court and specifically designated to be credited to the  
634 fund; (iv) interest earned on any money in the fund; and (v) any other grants, premiums, gifts,  
635 reimbursements, or other contributions received by the commonwealth from any source for or in  
636 support of for the purposes described in subsection (a).

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

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

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

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

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

655 SECTION 26. The General Laws are hereby further amended by inserting after chapter  
656 63D, as inserted by chapter 69 of the acts of 2021, the following chapter:-

657 Chapter 63E

658 PENALTY ON DRUG MANUFACTURERS FOR EXCESSIVE PRICE INCREASES

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

661 “Commissioner”, the commissioner of revenue.

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

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

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

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

673 “Person”, any natural person or legal entity.

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

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

677 “Reference price”, the price of a drug on the reference date, or in the case of any drug  
678 first commercially marketed in the United States after the reference date, the price of the drug on  
679 the date when first marketed in the United States.

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

688 “Unit”, the lowest dispensable amount of a drug.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

784 rules and regulations adopted pursuant hereto shall be punished by a fine of not more than  
785 \$1,000 per occurrence.

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

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

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

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

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

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

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

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

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

826 (f) The department may promulgate regulations necessary to implement this section and  
827 impose penalties for non-compliance consistent with the department’s authority to regulate  
828 health care providers. A health care provider that violates any provision of this section or the  
829 rules and regulations adopted pursuant hereto shall be punished by a fine of not more than  
830 \$1,000 per occurrence. In addition to any penalties for noncompliance that may be established by  
831 the department, a violation of this section shall be an unfair trade practice under chapter 93A.

832 SECTION 33. Section 52 of said chapter 111 of the General Laws , as appearing in the  
833 2020 Official Edition, is hereby amended by striking out the definition of “Clinic” and inserting  
834 in place thereof the following definition:-

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

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

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

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

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

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

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

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

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

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

883 (e) A health care provider shall determine if it participates in a patient's health benefit  
884 plan prior to said patient's admission, procedure or service for conditions that are not emergency  
885 medical conditions as defined in section 1 of chapter 176O. If the health care provider does not  
886 participate in the patient's health benefit plan and the admission, procedure or service was  
887 scheduled more than 7 days in advance of the admission, procedure or service, such provider  
888 shall notify the patient verbally and in writing of that fact not less than 7 days before the  
889 scheduled admission, procedure or service. If the health care provider does not participate in the  
890 patient's health benefit plan and the admission, procedure or service was scheduled less than 7  
891 days in advance of the admission, procedure or service, such provider shall notify the patient  
892 verbally of that fact not less than 2 days before the scheduled admission, procedure or service or

893 as soon as is practicable before the scheduled admission, procedure or service, with written  
894 notice of that fact to be provided upon the patient’s arrival at the scheduled admission, procedure  
895 or service. If a health care provider that does not participate in the patient’s health benefit plan  
896 fails to provide the required notifications under this subsection, or if the provider is rendering  
897 unforeseen out-of-network services, as defined in subsection (a) of section 30 of chapter 176O,  
898 the provider shall not bill the insured except for any applicable copayment, coinsurance or  
899 deductible that would be payable if the insured received the service from a participating health  
900 care provider under the terms of the insured’s health benefit plan. Nothing in this subsection  
901 shall relieve a health care provider from the requirements under subsections (b) to (d), inclusive.

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

904 Section 5O. (a) For purposes of this chapter “telehealth” shall mean the use of  
905 synchronous or asynchronous audio, video, electronic media or other telecommunications  
906 technology, including, but not limited to: (i) interactive audio-video technology; (ii) remote  
907 patient monitoring devices; (iii) audio-only telephone; and (iv) online adaptive interviews, for  
908 the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring of a  
909 patient’s physical health, oral health, mental health or substance use disorder condition.

910 (b) A Physician licensed pursuant to this chapter may provide healthcare services to a  
911 patient via telehealth from any location within Massachusetts or outside Massachusetts, provided  
912 that the following conditions are met: (i) the patient is physically located in Massachusetts at the  
913 time the healthcare services are provided; (ii) the location from which the physician provides the  
914 services does not compromise patient confidentiality and privacy; and (iii) the location from

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

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

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

926 SECTION 38. Said chapter 112 of the General Laws is hereby further amended by  
927 striking out section 9E and inserting in place thereof the following section:-

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

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

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



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

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

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

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

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

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

954 SECTION 39. Section 9F of said chapter 112 of the General Laws, as appearing in the  
955 2020 Official Edition, is hereby amended by striking out the third paragraph and inserting in  
956 place thereof the following paragraph:-

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

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

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

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

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

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

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

978 SECTION 43. Section 43A of said chapter 112 of the General Laws, as appearing in the  
979 2020 Official Edition, is hereby amended by inserting after the definition of “Appropriate  
980 supervision” the following 2 definitions:-

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

983 “Collaborative management agreement”, a written agreement that complies with section  
984 51B between a dental therapist and a supervising dentist, as defined in section 43A, who holds a  
985 valid license issued pursuant to section 45, who agrees to provide the appropriate level of  
986 communication and consultation with a licensed dental therapist to ensure patient health and  
987 safety.

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

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

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

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

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

1000 SECTION 47. Section 51 of said chapter 112 of the General Laws, as appearing in the  
1001 2020 Official Edition, is hereby amended by striking out, in line 17, the word “revoked” and  
1002 inserting in place thereof the following words:- null and void.

1003 SECTION 48. Section 51½ of said chapter 112, as so appearing, is hereby amended by  
1004 striking out, in line 10, the word “revoked” and inserting in place thereof the following words:-  
1005 null and void.

1006 SECTION 49. Said section 51½ of said chapter 112, as so appearing, is hereby further  
1007 amended by inserting, in lines 18 and 32, after the word “dentist”, both times it appears, the  
1008 following words:- , or a licensed dental therapist to the extent provided in section 51B.

1009 SECTION 50. Said section 51½ of said chapter 112, as so appearing, is hereby further  
1010 amended by inserting after the word “practice” in line 79, the following words:- , or a dental  
1011 therapist licensed under section 51B.

1012 SECTION 51. Said chapter 112 of the General Laws is hereby further amended by  
1013 inserting after section 51A the following section:-

1014 Section 51B. (a) Any person of good moral character, 19 years old or over, who: (i) is a  
1015 graduate of a master’s level dental therapist education program that includes both dental therapy

1016 and dental hygiene education, or an equivalent combination of both dental therapy education and  
1017 dental hygiene education, if all education programs are accredited by the Commission on Dental  
1018 Accreditation; (ii) passes a comprehensive, competency-based clinical examination that is  
1019 approved by the board and administered by a recognized national or regional dental testing  
1020 service that administers testing for dentists and other dental professionals or equivalent  
1021 examination administered by another entity approved by the board; and (iii) obtains a policy of  
1022 professional liability insurance and shows proof of such insurance as required by rules and  
1023 regulations shall, upon payment of a fee to be determined annually by the secretary of  
1024 administration and finance under the provision of section 3B of chapter 7, be registered as a  
1025 dental therapist and be given a certificate to practice in this capacity. A licensed dental therapist  
1026 shall have practiced under the direct supervision of a supervising dentist for a minimum of 2  
1027 years or 2,500 hours, whichever is longer, before practicing under general supervision pursuant  
1028 to a collaborative management agreement. Dental therapists licensed under this section shall  
1029 renew licensure biennially, on a date determined by the board, upon application and payment of  
1030 a fee, as determined by the secretary of administration and finance under section 3B of chapter 7.  
1031 Upon receipt of a license pursuant to section 45, any certificate issued hereunder shall be null  
1032 and void.

1033 Notwithstanding section 43A, as used in this section and in any rules and regulations  
1034 promulgated by the board or the department of health to implement this section, “general  
1035 supervision” shall mean supervision of procedures and services based on a written collaborative  
1036 management agreement between a licensed dentist and a licensed dental therapist but not  
1037 requiring a prior exam or diagnosis by a supervising dentist or the physical presence of a

1038 supervising dentist during the performance of those procedures and services unless required by  
1039 the supervising dentist in the collaborative management agreement.

1040 (b) Any person who has met the requirements to be registered as a dental therapist under  
1041 any provision of this section may also be registered as a dental hygienist and be given a  
1042 certificate to practice in this capacity.

1043 (c) Dental therapists educated in the commonwealth must graduate from a master's level  
1044 dental therapy education program that is accredited by the Commission on Dental Accreditation  
1045 provided by a post-secondary institution accredited by the New England Association of Schools  
1046 and Colleges, Inc. All dental therapy educational programs in the commonwealth must include at  
1047 least one licensed dentist as an instructor. The board shall provide guidance for any educational  
1048 entity or institution that may operate all or some portion of a master's level program, or may  
1049 collaborate with other educational entities, including but not limited to universities, colleges,  
1050 community colleges, and technical colleges, to operate all or some portion of a master's level  
1051 program. The board may also provide guidance to develop mechanisms to award advanced  
1052 standing to students who have completed coursework at other educational programs accredited  
1053 by the Commission on Dental Accreditation. All education programs must prepare students to  
1054 perform all procedures and services within the dental therapy scope of practice as set forth in this  
1055 section.

1056 The educational curriculum for a dental therapist educated in the commonwealth shall  
1057 include training on serving patients with special needs including, but not limited to, people with  
1058 developmental disabilities including autism spectrum disorders, mental illness, cognitive

1059 impairment, complex medical problems, or significant physical limitations, and the vulnerable  
1060 elderly.

1061 Not later than January 1, 2024, the board shall approve a comprehensive, competency  
1062 based clinical dental therapy examination that includes assessment of technical competency in  
1063 performing the procedures and services within the scope of practice as set forth in this section, to  
1064 be administered by a recognized national or regional dental testing service that administers  
1065 testing for dentists and other dental professionals. The examination shall be comparable to the  
1066 examination given to applicants for a dental license but only for the limited scope of dental  
1067 services in the dental therapy scope of practice as set forth in this section.

1068 (d) The board shall grant a dental therapy license by examination to an applicant, upon  
1069 payment of a fee as determined under subsection (a), provided the applicant is of good moral  
1070 character and has: (i) met the eligibility requirements as defined by the board; (ii) submitted  
1071 documentation to the board of a passing score on a comprehensive, competency-based clinical  
1072 examination or combination of examinations that includes both dental therapy and dental  
1073 hygiene components and are approved by the board and administered by a recognized national or  
1074 regional dental testing service that administers testing for dentists and other dental professionals;  
1075 and (iii) submitted to the board documentation of a passing score on the Massachusetts Dental  
1076 Ethics and Jurisprudence Examination or any other successor examination. An applicant failing  
1077 to pass the examination shall be entitled to re-examination pursuant to the rules and guidelines  
1078 established by the Commission on Dental Competency Assessments (formerly NERB), for which  
1079 the applicant shall pay a fee determined annually by the secretary of administration and finance  
1080 under the provision of section 3B of chapter 7.

1081           The board shall require as a condition of granting or renewing authorization in dental  
1082 therapy, that the dental therapist apply to participate in the medical assistance program  
1083 administered by the secretary of health and human services in accordance with chapter 118E and  
1084 Title XIX of the Social Security Act and any federal demonstration or waiver relating to such  
1085 medical assistance program for the limited purposes of ordering and referring services covered  
1086 under such program, provided that regulations governing such limited participation are  
1087 promulgated under said chapter 118E. A dental therapist practicing in a dental therapist role who  
1088 chooses to participate in such medical assistance program as a provider of services shall be  
1089 deemed to have fulfilled this requirement.

1090           The board shall grant a license by credentials, without further professional examination,  
1091 to a dental therapist licensed in another jurisdiction, upon payment of a fee as determined under  
1092 subsection (a), provided the applicant is of good moral character and has: (i) met the eligibility  
1093 requirements as defined by the board; (ii) furnished the board with satisfactory proof of  
1094 graduation from an education program or combination of education programs providing both  
1095 dental therapy and dental hygiene education that meets the standards of the Commission on  
1096 Dental Accreditation, provided, however, that an applicant who graduated from a dental therapy  
1097 education program established before the Commission on Dental Accreditation established a  
1098 dental therapy accreditation program is eligible notwithstanding the lack of accreditation of the  
1099 program at the time the education was received; (iii) submitted documentation of a passing score  
1100 on a dental therapy examination administered by another state or testing agency that is  
1101 substantially equivalent to the board-approved dental therapy examination for dental therapists as  
1102 defined in this section; (iv) submitted documentation of a passing score on the Massachusetts  
1103 Dental Ethics and Jurisprudence Examination or any other successor examination; and (v)



1104 submitted documentation of completion of 2 years or 2,500 hours, whichever is longer, of  
1105 practice. If such practice requirement is not met, a dental therapist shall be required to complete  
1106 the remaining hours or years, whichever is longer, under direct supervision in the commonwealth  
1107 prior to practicing under general supervision.

1108 (e) Pursuant to a collaborative management agreement, a dental therapist licensed and  
1109 registered by the board may perform: (i) all acts of a public health dental hygienist as set forth in  
1110 regulations of the board and (ii) all acts in the Commission on Dental Accreditation's dental  
1111 therapy standards. Dental therapists shall have the authority to perform an oral evaluation and  
1112 assessment of dental disease and formulate an individualized treatment plan as authorized by the  
1113 supervising dentist in the collaborative management agreement. A dental therapist may dispense  
1114 and administer the following medications within the parameters of the collaborative management  
1115 agreement and with the authorization of the supervising dentist: non-narcotic analgesics, anti-  
1116 inflammatories and antibiotics. The authority to dispense and administer shall extend only to the  
1117 categories of drugs identified in this paragraph and may be further limited by the collaborative  
1118 management agreement. A dental therapist is prohibited from dispensing or administering  
1119 narcotic analgesics. A dental therapist may oversee not more than 2 dental hygienists and 2  
1120 dental assistants, but shall not oversee public health dental hygienists.

1121 After entering into a collaborative management agreement with a supervising dentist,  
1122 dental therapists shall practice under direct supervision for not less than 2,500 clinical hours or  
1123 two years, whichever is longer. After completing 2,500 clinical hours or two years, whichever is  
1124 longer, of practice under direct supervision, dental therapists are authorized to perform all  
1125 procedures and services listed in the Commission on Dental Accreditation's dental therapy  
1126 standards and all procedures and services within the scope of a public health dental hygienist, as

1127 set forth in regulations by the board, under general supervision if authorized by a supervising  
1128 dentist pursuant to a written collaborative agreement. In addition, the following procedures,  
1129 referred to in this section as advanced procedures, may be performed under direct supervision: (i)  
1130 preparation and placement of direct restoration in primary and permanent teeth; (ii) fabrication  
1131 and placement of single-tooth temporary crowns; (iii) preparation and placement of preformed  
1132 crowns on primary teeth; (iv) indirect and direct pulp capping on permanent teeth; (v) indirect  
1133 pulp capping on primary teeth; and (vi) simple extractions of erupted primary teeth, provided  
1134 however that the advanced procedures may be performed under general supervision if authorized  
1135 by the board pursuant to subsection (f) of this section.

1136 Pursuant to a collaborative management agreement, a dental therapist may provide  
1137 procedures and services permitted under general supervision when the supervising dentist is not  
1138 on-site and has not previously examined or diagnosed the patient provided the supervising  
1139 dentist is available for consultation and supervision if needed through telehealth, as that term is  
1140 defined in section 4P of chapter 111 or by other means of communication. If the supervising  
1141 dentist will not be available, arrangements shall be made for another licensed dentist to be  
1142 available to provide timely consultation and supervision. A dental therapist may not operate  
1143 independently of, and may not practice or treat any patients without, a supervising dentist. A  
1144 dental therapist is prohibited from practicing without entering into a collaborative management  
1145 agreement with a supervising dentist.

1146 (f) By January 1, 2024, the department of public health in consultation with the board and  
1147 any other entity they deem appropriate, shall begin an evaluation assessing the impact of dental  
1148 therapists practicing under general supervision in Massachusetts and the rest of the United States,  
1149 specifically on: (i) dental therapists' progress in expanding access to safe and effective dental

1150 services for vulnerable populations including, at a minimum, Medicaid beneficiaries and  
1151 individuals who are underserved as defined in this section; (ii) an appropriate geographic  
1152 distance limitation between the dental therapist and supervising dentist that permits the dental  
1153 therapist to expand access to vulnerable populations including, at a minimum, Medicaid  
1154 beneficiaries and individuals who are underserved as defined in this section; and (iii) the number  
1155 of dental hygienists and dental assistants a dental therapist may oversee.

1156 Not before January 1, 2025, and no later than December 1, 2026, the department in  
1157 consultation with the board and any other entity they deem appropriate, shall make a  
1158 recommendation, based on its assessment of whether dental therapists should be authorized to  
1159 perform one or more of the advanced procedures, as defined in subsection (e) under general  
1160 supervision pursuant to a collaborative management agreement. The department shall also make  
1161 a recommendation on an appropriate geographic distance limitation between the dental therapist  
1162 and supervising dentist that permits the dental therapist to expand access to vulnerable  
1163 populations including, at a minimum, Medicaid beneficiaries and individuals who are  
1164 underserved as defined in this section. After the department completes its assessment and  
1165 submits its recommendations to the board, the board shall make a determination, with  
1166 consideration to how authorizing general supervision will expand access to safe and effective  
1167 dental services for vulnerable populations including, at a minimum, Medicaid beneficiaries and  
1168 individuals who are underserved as defined in this section, whether to authorize performance of  
1169 one or more of the procedures as identified in subsection (e), under general supervision pursuant  
1170 to a collaborative management agreement.

1171 Should the board, in consultation with the department and any other appropriate entity,  
1172 determine that dental therapists shall have the authority to perform one or more of the procedures

1173 and services as identified in subsection (e) in their scope of practice under general supervision,  
1174 then the board shall establish regulations no later than six months following the recommendation,  
1175 authorizing dental therapists to perform one or more procedures as identified in subsection (e)  
1176 under general supervision pursuant to a collaborative management agreement after receiving  
1177 advanced practice certification.

1178           The board shall grant advanced practice certification for a dental therapist licensed and  
1179 registered by the board to perform all services within the authorized scope of practice under  
1180 general supervision pursuant to a collaborative management agreement if the dental therapist  
1181 provides documentation of completion of at least two years or 2,500 hours, whichever is longer,  
1182 of direct supervision pursuant to subsection (a) of this section, payment of a fee to be determined  
1183 annually by the secretary of administration and finance under the provision of section 3B of  
1184 chapter 7, and satisfying any other criteria established by regulation adopted by the board as  
1185 authorized in this section.

1186           Should the board determine that dental therapists shall continue to perform one or more  
1187 of the advanced procedures under direct supervision, the department, in consultation with the  
1188 board, shall re-evaluate annually the impact of dental therapists practicing under general  
1189 supervision in Massachusetts and the rest of the United States, and the board shall annually  
1190 reassess whether to authorize general supervision for the advanced procedures in order to  
1191 improve dental therapists' progress in expanding access to safe and effective dental services for  
1192 vulnerable populations including, at a minimum, Medicaid beneficiaries and individuals who are  
1193 underserved as defined in this section.

1194 (g) The board shall establish appropriate guidelines for a written collaborative  
1195 management agreement. A collaborative management agreement shall be signed and maintained  
1196 by the supervising dentist and the dental therapist and shall be submitted annually to the board.  
1197 The agreement may be updated as necessary. The agreement shall serve as standing orders from  
1198 the supervising dentist and shall address: (i) practice settings; (ii) any limitation on services  
1199 established by the supervising dentist; (iii) the level of supervision required for various services  
1200 or treatment settings; (iv) patient populations that may be served; (v) practice protocols; (vi)  
1201 record keeping; (vii) managing medical emergencies; (viii) quality assurance; (ix) administering  
1202 and dispensing medications; (x) geographic distance limitations; (xi) oversight of dental  
1203 hygienists and dental assistants; and (xii) referrals for services outside of the dental therapy  
1204 scope of practice. The collaborative management agreement shall include specific protocols to  
1205 govern situations in which the dental therapist encounters a patient who requires treatment that  
1206 exceeds the authorized scope of practice of the dental therapist. The supervising dentist is  
1207 responsible for directly providing, or arranging for another dentist or specialist within an  
1208 accessible geographic distance to provide, any necessary additional services outside of the dental  
1209 therapy scope of practice needed by the patient. A supervising dentist may have a collaborative  
1210 management agreement with not more than 3 dental therapists at the same time. Not more than 2  
1211 of such dental therapists may practice under general supervision with certification to perform one  
1212 or more of the advanced procedures. A practice or organization with more than one practice  
1213 location listed under the same business name may not employ more than 6 dental therapists,  
1214 provided, however, that this requirement shall not apply if such an organization or practice is a  
1215 federally qualified health center or look-alike, a community health center, a non-profit practice

1216 or organization, or a public health setting, which for purposes of this section shall be as defined  
1217 by 234 CMR 2.02, or as otherwise permitted by the board.

1218 (h) No medical malpractice insurer shall refuse primary medical malpractice insurance  
1219 coverage to a licensed dentist on the basis of whether they entered into a collaborative  
1220 management agreement with a dental therapist or public health dental hygienist. A dental  
1221 therapist may not bill separately for services rendered; the services of the dental therapist are the  
1222 services of the supervising dentist and shall be billed as such.

1223 (i) Not less than 50 per cent of the patient panel of a dental therapist, as determined in  
1224 each calendar year, shall consist of patients who receive coverage through MassHealth or its  
1225 contracted health insurers, health plans, health maintenance organizations, behavioral health  
1226 management firms, and third-party administrators under contract to a MassHealth managed care  
1227 organization or primary care clinician plan; or are considered underserved provided, however,  
1228 that this requirement shall not apply if the dental therapist is operating in a federally qualified  
1229 health center or look-alike, community-health center, non-profit practice or organization, or other  
1230 public health setting as defined by the board by regulation, or as otherwise permitted by the  
1231 board. As used in this section, “underserved” means individuals who: (i) receive, or are eligible  
1232 to receive, benefits through MassHealth or its contracted health insurers, health plans, health  
1233 maintenance organizations, behavioral health management firms, and third-party administrators  
1234 under contract to a MassHealth managed care organization or primary care clinician plan; (ii)  
1235 receive, or are eligible to receive, Social Security Disability Benefits (SSDI), Supplemental  
1236 Security Income (SSI), and/or Massachusetts State Supplement Program (SSP); (iii) live in a  
1237 dental health professional shortage area (DPSA) as designated by the U.S. Department of Health  
1238 and Human Services; (iv) reside in a nursing home, skilled nursing facility, veterans home, or

1239 long-term care facility; (v) receive dental services at a public health setting as defined by the  
1240 board by regulation; (vi) receive benefits, or are eligible to receive benefits, through plans sold  
1241 by the connector; (viii) receive benefits, or are eligible to receive benefits, through the Indian  
1242 Health Service, tribal or urban Indian organizations, or through the Contract Health Service  
1243 Program; (ix) receive benefits, or are eligible to receive benefits, through the Department of  
1244 Veterans Affairs or other organization serving veterans; (x) are elderly and have trouble  
1245 accessing dental care due to mobility or transportation challenges; (xi) meet the Commission on  
1246 Dental Accreditation’s definition of people with special needs; (xii) are uninsured and living at  
1247 305 per cent of the Federal Poverty Level; or (xiii) as otherwise permitted by the board.

1248           An employer of a dental therapist shall submit quarterly reports to the board that provide  
1249 information concerning the makeup of the dental therapist’s patient panel, including the  
1250 percentage of individuals who are underserved in the patient panel. No later than January 1,  
1251 2024, the secretary of health and human services may establish by regulation penalties for  
1252 employers who fail to meet the requirements pertaining to the percentage of individuals who are  
1253 underserved in the dental therapist’s patient panel.

1254           (j) Not later than January 1, 2024, the board, in consultation with the department shall  
1255 establish regulations to implement the provisions of this section for the licensure and practice of  
1256 dental therapy including

1257           (k) Not later than January 1, 2024, the board, in consultation with the department shall  
1258 establish regulations to implement the provisions of this section for the licensure and practice of  
1259 dental therapy to protect the public health, safety and welfare, including but without limitation

1260 guidelines for collaborative management agreements, continuing education requirements, license  
1261 renewal, standards of conduct and the investigation of complaints, and disciplinary actions.

1262 SECTION 52. Said chapter 112 of the General Laws is hereby further amended by  
1263 adding the following 3 sections:-

1264 Section 290. (a) The following words as used in sections 290 to 292, inclusive, unless the  
1265 context otherwise requires, shall have the following meanings:--

1266 “Board”, the board of registration of peer workers, established under section 110 of  
1267 chapter 13.

1268 “Certified Peer Worker”, an individual who is authorized to practice by the board under  
1269 this chapter and who uses shared understanding, respect and mutual empowerment to help others  
1270 become and stay engaged in the process of recovery from a mental health or substance use  
1271 disorder.

1272 “Lived experience”, the experience of addiction and recovery from a substance use  
1273 disorder and/or the experience of and recovery from a mental health disorder.

1274 (b) The board shall have the following powers and duties:

1275 (1) to promulgate regulations and adopt such rules as are necessary to regulate certified  
1276 peer workers, including, but not limited to, the following roles: family partner, young adult peer  
1277 mentor, peer specialist, older adult peer specialist, peer recovery coach, and addictions recovery  
1278 coach.



1279 (2) to receive, review, approve or disapprove initial applications, renewals and  
1280 reinstatement requests and to issue those authorizations to provide services as a certified peer  
1281 worker;

1282 (3) to establish administrative procedures for processing applications submitted under  
1283 clause (2) and to hire or appoint such agents as are appropriate for processing applications;

1284 (4) to retain records of its actions and proceedings in accordance with public records  
1285 laws;

1286 (5) to establish specifications for the authorized training of certified peer workers;  
1287 provided, that the specifications shall require individuals to have lived experience and  
1288 demonstrate at least 2 years of sustained recovery; provided further, that the lived experience  
1289 requirement may be waived for individuals who were credentialed by other certification bodies  
1290 before the establishment of the board;

1291 (6) to define by regulation the appropriate standards for education, core competencies,  
1292 and experience necessary to qualify as a certified peer worker, including, but not limited to,  
1293 continuing professional education requirements; provided, that the board shall consider any  
1294 standards contained within peer worker training programs established by the department of  
1295 public health; provided further, that a waiver may be considered for individuals who already  
1296 possess a certification or who have passed other competency evaluations;

1297 (7) to establish an ethical code of conduct for peer roles authorized to practice by the  
1298 board; provided, that the board shall consider any codes of conduct for peer worker training  
1299 programs established by the department of public health;

1300 (8) to establish standards of supervision for certified peer workers; provided, that the  
1301 board shall consider standards contained within peer worker training programs established by the  
1302 department of public health;

1303 (9) to fine, censure, revoke, suspend or deny a certified peer worker authorization to  
1304 practice, place on probation, reprimand or otherwise discipline a certified peer worker for  
1305 violations of the code of ethics or the rules of the board;

1306 (10) to summarily suspend a certified peer worker who poses an imminent danger to the  
1307 public; provided, that the certified peer worker shall be afforded a hearing within 7 business days  
1308 to determine whether the summary action is warranted; and

1309 (11) to perform other functions and duties as may be required to carry out this section.

1310 Section 291. An application to be a certified peer worker, under section 290, shall be  
1311 made on forms approved by the board, signed under the penalties of perjury by the person  
1312 certifying the information contained therein and accompanied by the required fee. The fee shall  
1313 be determined by the secretary of administration and finance under section 3B of chapter 7. A  
1314 certified peer worker applicant shall furnish satisfactory proof that the applicant is at least 18  
1315 years of age, and has met all the education, training, experience, ethical, and certification  
1316 requirements and qualifications as established by the board.

1317 The board, in consultation with the department of public health, shall determine the  
1318 renewal cycle and renewal period for authorization to practice as a certified peer worker. A peer  
1319 worker authorized to practice under this chapter shall apply to the board for a renewal not later  
1320 than the expiration date, as determined by the board, unless earlier revoked, suspended or  
1321 canceled as a result of a disciplinary proceeding. As a condition for renewal under this section,

1322 the board may require satisfactory proof that the peer worker has successfully completed the  
1323 required number of hours of continuing education in courses or programs approved by the board  
1324 or has complied with such other requirements or equivalent requirements as approved by the  
1325 board. Upon satisfactory compliance with the requirements and successful completion of the  
1326 continuing education requirements, the board shall issue a renewal. The board may provide for  
1327 the late renewal that has lapsed and may require payment of a late fee. Each renewal application  
1328 submitted to the board shall be accompanied by a fee as determined by the secretary of  
1329 administration and finance under section 3B of chapter 7.

1330           Section 292. No person filing a complaint alleging a violation of law or of the regulations  
1331 of the board, reporting information pursuant to such laws or regulations or assisting the board at  
1332 its request in any manner in discharging its duties and functions shall be liable in any cause of  
1333 action arising out of the board's receipt of such information or assistance, if the person making  
1334 the complaint, or reporting or providing such information or assistance, does so in good faith and  
1335 without malice.

1336           SECTION 53. The General Laws are hereby further amended by inserting after chapter  
1337 112A the following chapter:-

1338           Chapter 112B

1339           INTERSTATE MEDICAL LICENSURE COMPACT

1340           Section 1. In order to strengthen access to health care, and in recognition of the advances  
1341 in the delivery of health care, the member states of the Interstate Medical Licensure Compact  
1342 have allied in common purpose to develop a comprehensive process that complements the  
1343 existing licensing and regulatory authority of state medical boards, provides a streamlined

1344 process that allows physicians to become licensed in multiple states, thereby enhancing the  
1345 portability of a medical license and ensuring the safety of patients. The compact creates another  
1346 pathway for licensure and does not otherwise change a state’s existing Medical Practice Act. The  
1347 compact also adopts the prevailing standard for licensure and affirms that the practice of  
1348 medicine occurs where the patient is located at the time of the physician-patient encounter, and  
1349 therefore, requires the physician to be under the jurisdiction of the state medical board where the  
1350 patient is located. State medical boards that participate in the compact retain the jurisdiction to  
1351 impose an adverse action against a license to practice medicine in that state issued to a physician  
1352 through the procedures in the compact.

1353           Section 2. As used in this chapter, the following words shall have the following  
1354 meanings:

1355           “Bylaws,” those bylaws established by the Interstate Commission pursuant to section 11.

1356           “Commissioner,” the voting representative appointed by each member board pursuant to  
1357 section 11.

1358           “Conviction,” a finding by a court that an individual is guilty of a criminal offense  
1359 through adjudication, or entry of a plea of guilt or no contest to the charge by the offender.  
1360 Evidence of an entry of a conviction of a criminal offense by the court shall be considered final  
1361 for purposes of disciplinary action by a member board.

1362           “Expedited License,” a full and unrestricted medical license granted by a member state to  
1363 an eligible physician through the process set forth in the compact.

1364           “Interstate Commission,” the interstate commission created pursuant to section 11.

1365 “License,” authorization by a member state for a physician to engage in the practice of  
1366 medicine, which would be unlawful without authorization.

1367 “Medical Practice Act,” laws and regulations governing the practice of allopathic and  
1368 osteopathic medicine within a member state.

1369 “Member Board,” a state agency in a member state that acts in the sovereign interests of  
1370 the state by protecting the public through licensure, regulation, and education of physicians as  
1371 directed by the state government.

1372 “Member State,” a state that has enacted the compact.

1373 “Practice of Medicine,” that clinical prevention, diagnosis, or treatment of human  
1374 disease, injury, or condition requiring a physician to obtain and maintain a license in compliance  
1375 with the Medical Practice Act of a member state.

1376 “Physician,” any person who (i) is a graduate of a medical school accredited by the  
1377 Liaison Committee on Medical Education, the Commission on Osteopathic College  
1378 Accreditation, or a medical school listed in the International Medical Education Directory or its  
1379 equivalent; (ii) passed each component of the United State Medical Licensing Examination  
1380 (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA)  
1381 within three attempts, or any of its predecessor examinations accepted by a state medical board  
1382 as an equivalent examination for licensure purposes; (iii) successfully completed graduate  
1383 medical education approved by the Accreditation Council for Graduate Medical Education or the  
1384 American Osteopathic Association; (iv) holds specialty certification or a time-unlimited specialty  
1385 certificate recognized by the American Board of Medical Specialties or the American  
1386 Osteopathic Association’s Bureau of Osteopathic Specialists; (v) possesses a full and

1387 unrestricted license to engage in the practice of medicine issued by a member board; (vi) has  
1388 never been convicted, received adjudication, deferred adjudication, community supervision, or  
1389 deferred disposition for any offense by a court of appropriate jurisdiction; (vii) has never held a  
1390 license authorizing the practice of medicine subjected to discipline by a licensing agency in any  
1391 state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related  
1392 to a license; (viii) has never had a controlled substance license or permit suspended or revoked  
1393 by a state or the United States Drug Enforcement Administration; and (ix) is not under active  
1394 investigation by a licensing agency or law enforcement authority in any state, federal, or foreign  
1395 jurisdiction.

1396 “Offense,” a felony, gross misdemeanor, or crime of moral turpitude.

1397 “Rule,” a written statement by the Interstate Commission promulgated pursuant to section  
1398 12 of the compact that is of general applicability, implements, interprets, or prescribes a policy or  
1399 provision of the compact, or an organizational, procedural, or practice requirement of the  
1400 Interstate Commission, and has the force and effect of statutory law in a member state, and  
1401 includes the amendment, repeal, or suspension of an existing rule.

1402 “State,” any state, commonwealth, district, or territory of the United States.

1403 “State of Principal License,” a member state where a physician holds a license to practice  
1404 medicine and which has been designated as such by the physician for purposes of registration  
1405 and participation in the compact.

1406 Section 3. (a) A physician must meet the eligibility requirements as defined in subsection  
1407 (k) of section 2 to receive an expedited license under the terms and provisions of the compact.

1408 (b) A physician who does not meet the requirements of subsection (k) of section 2 may  
1409 obtain a license to practice medicine in a member state if the individual complies with all laws  
1410 and requirements, other than the compact, relating to the issuance of a license to practice  
1411 medicine in that state.

1412 Section 4. (a) A physician shall designate a member state as the state of principal license  
1413 for purposes of registration for expedited licensure through the compact if the physician  
1414 possesses a full and unrestricted license to practice medicine in that state, and the state is:

1415 (1) The state of principal residence for the physician, or

1416 (2) The state where at least 25 per cent of the practice of medicine occurs, or

1417 (3) The location of the physician's employer, or

1418 (4) If no state qualifies under clause (1), clause (2), or clause (3), the state designated as  
1419 state of residence for purpose of federal income tax.

1420 (b) A physician may redesignate a member state as state of principal license at any time,  
1421 as long as the state meets the requirements of subsection (a).

1422 (c) The Interstate Commission is authorized to develop rules to facilitate redesignation of  
1423 another member state as the state of principal license.

1424 Section 5. (a) A physician seeking licensure through the compact shall file an application  
1425 for an expedited license with the member board of the state selected by the physician as the state  
1426 of principal license.

1427 (b) Upon receipt of an application for an expedited license, the member board within the  
1428 state selected as the state of principal license shall evaluate whether the physician is eligible for  
1429 expedited licensure and issue a letter of qualification, verifying or denying the physician's  
1430 eligibility, to the Interstate Commission.

1431 (1) Static qualifications, which include verification of medical education, graduate  
1432 medical education, results of any medical or licensing examination, and other qualifications as  
1433 determined by the Interstate Commission through rule, shall not be subject to additional primary  
1434 source verification where already primary source verified by the state of principal license.

1435 (2) The member board within the state selected as the state of principal license shall, in  
1436 the course of verifying eligibility, perform a criminal background check of an applicant,  
1437 including the use of the results of fingerprint or other biometric data checks compliant with the  
1438 requirements of the Federal Bureau of Investigation, with the exception of federal employees  
1439 who have suitability determination in accordance with 5 C.F.R. §731.202.

1440 (3) Appeal on the determination of eligibility shall be made to the member state where  
1441 the application was filed and shall be subject to the law of that state.

1442 (c) Upon verification in subsection (b), physicians eligible for an expedited license shall  
1443 complete the registration process established by the Interstate Commission to receive a license in  
1444 a member state selected pursuant to subsection (a), including the payment of any applicable fees.

1445 (d) After receiving verification of eligibility under subsection (b) and any fees under  
1446 subsection (c), a member board shall issue an expedited license to the physician. This license  
1447 shall authorize the physician to practice medicine in the issuing state consistent with the Medical



1448 Practice Act and all applicable laws and regulations of the issuing member board and member  
1449 state.

1450 (e) An expedited license shall be valid for a period consistent with the licensure period in  
1451 the member state and in the same manner as required for other physicians holding a full and  
1452 unrestricted license within the member state.

1453 (f) An expedited license obtained through the compact shall be terminated if a physician  
1454 fails to maintain a license in the state of principal licensure for a non-disciplinary reason, without  
1455 redesignation of a new state of principal licensure.

1456 (g) The Interstate Commission is authorized to develop rules regarding the application  
1457 process, including payment of any applicable fees, and the issuance of an expedited license.

1458 Section 6. (a) A member state issuing an expedited license authorizing the practice of  
1459 medicine in that state may impose a fee for a license issued or renewed through the compact.

1460 (b) The Interstate Commission is authorized to develop rules regarding fees for expedited  
1461 licenses.

1462 Section 7. (a) A physician seeking to renew an expedited license granted in a member  
1463 state shall complete a renewal process with the Interstate Commission if the physician:

1464 (1) Maintains a full and unrestricted license in a state of principal license;

1465 (2) Has not been convicted, received adjudication, deferred adjudication, community  
1466 supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

1467 (3) Has not had a license authorizing the practice of medicine subject to discipline by a  
1468 licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-  
1469 payment of fees related to a license; and

1470 (4) Has not had a controlled substance license or permit suspended or revoked by a state  
1471 or the United States Drug Enforcement Administration.

1472 (b) Physicians shall comply with all continuing professional development or continuing  
1473 medical education requirements for renewal of a license issued by a member state.

1474 (c) The Interstate Commission shall collect any renewal fees charged for the renewal of a  
1475 license and distribute the fees to the applicable member board.

1476 (d) Upon receipt of any renewal fees collected in subsection (c), a member board shall  
1477 renew the physician's license.

1478 (e) Physician information collected by the Interstate Commission during the renewal  
1479 process will be distributed to all member boards.

1480 (f) The Interstate Commission is authorized to develop rules to address renewal of  
1481 licenses obtained through the compact.

1482 Section 8. (a) The Interstate Commission shall establish a database of all physicians  
1483 licensed, or who have applied for licensure, under Section 5.

1484 (b) Notwithstanding any other provision of law, member boards shall report to the  
1485 Interstate Commission any public action or complaints against a licensed physician who has  
1486 applied or received an expedited license through the compact.

1487 (c) Member boards shall report disciplinary or investigatory information determined as  
1488 necessary and proper by rule of the Interstate Commission.

1489 (d) Member boards may report any non-public complaint, disciplinary, or investigatory  
1490 information not required by subsection (c) to the Interstate Commission.

1491 (e) Member boards shall share complaint or disciplinary information about a physician  
1492 upon request of another member board.

1493 (f) All information provided to the Interstate Commission or distributed by member  
1494 boards shall be confidential, filed under seal, and used only for investigatory or disciplinary  
1495 matters.

1496 (g) The Interstate Commission is authorized to develop rules for mandated or  
1497 discretionary sharing of information by member boards.

1498 Section 9. (a) Licensure and disciplinary records of physicians are deemed investigative.

1499 (b) In addition to the authority granted to a member board by its respective Medical  
1500 Practice Act or other applicable state law, a member board may participate with other member  
1501 boards in joint investigations of physicians licensed by the member boards.

1502 (c) A subpoena issued by a member state shall be enforceable in other member states.

1503 (d) Member boards may share any investigative, litigation, or compliance materials in  
1504 furtherance of any joint or individual investigation initiate under the compact.

1505 (e) Any member state may investigate actual or alleged violations of the statutes  
1506 authorizing the practice of medicine in any other member state in which a physician holds a  
1507 license to practice medicine.

1508 Section 10. (a) Any disciplinary action taken by any member board against a physician  
1509 licensed through the compact shall be deemed unprofessional conduct which may be subject to  
1510 discipline by other member boards, in addition to any violation of the Medical Practice Act or  
1511 regulations in that state.

1512 (b) If a license granted to a physician by the member board in the state of principal  
1513 license is revoked, surrendered or relinquished in lieu of discipline, or suspended, then all  
1514 licenses issued to the physician by member boards shall automatically be placed, without further  
1515 action necessary by any member board, on the same status. If the member board in the state of  
1516 principal license subsequently reinstates the physician's license, a license issued to the physician  
1517 by any other member board shall remain encumbered until that respective member board takes  
1518 action to reinstate the license in a manner consistent with the Medical Practice Act of that state.

1519 (c) If disciplinary action is taken against a physician by a member board not in the state  
1520 of principal license, any other member board may deem the action conclusive as to matter of law  
1521 and fact decided, and:

1522 (1) Impose the same or lesser sanction(s) against the physician so long as such sanctions  
1523 are consistent with the Medical Practice Act of that state; or

1524 (2) Pursue separate disciplinary action against the physician under its respective Medical  
1525 Practice Act, regardless of the action taken in other member states.

1526 (d) If a license granted to a physician by a member board is revoked, surrendered or  
1527 relinquished in lieu of discipline, or suspended, then any licenses issued to the physician by any  
1528 other member board or boards shall be suspended, automatically and immediately without  
1529 further action necessary by the other member boards, for 90 days upon entry of the order by the  
1530 disciplining board, to permit the member boards to investigate the basis for the action under the  
1531 Medical Practice Act of that state. A member board may terminate the automatic suspension of  
1532 the license it issued prior to the completion of the 90 day suspension period in a manner  
1533 consistent with the Medical Practice Act of that state.

1534 Section 11. (a) The member states hereby create the “Interstate Medical Licensure  
1535 Compact Commission”.

1536 (b) The purpose of the Interstate Commission is the administration of the Interstate  
1537 Medical Licensure Compact, which is a discretionary state function.

1538 (c) The Interstate Commission shall be a body corporate and joint agency of the member  
1539 states and shall have all the responsibilities, powers, and duties set forth in the compact, and such  
1540 additional powers as may be conferred upon it by a subsequent concurrent action of the  
1541 respective legislatures of the member states in accordance with the terms of the compact.

1542 (d) The Interstate Commission shall consist of two voting representatives appointed by  
1543 each member state who shall serve as commissioners. In states where allopathic and osteopathic  
1544 physicians are regulated by separate member boards, or if the licensing and disciplinary authority  
1545 is split between separate member boards, or if the licensing and disciplinary authority is split  
1546 between multiple member boards within a member state, the member state shall appoint one  
1547 representative from each member board. A commissioner shall be a:

- 1548 (1) An allopathic or osteopathic physician appointed to a member board;
- 1549 (2) An executive director, executive secretary, or similar executive of a member board; or
- 1550 (3) A member of the public appointed to a member board.

1551 (e) The Interstate Commission shall meet at least once each calendar year. A portion of  
1552 this meeting shall be a business meeting to address such matters as may properly come before the  
1553 Commission, including the election of officers. The chairperson may call additional meetings  
1554 and shall call for a meeting upon the request of a majority of the member states.

1555 (f) The bylaws may provide for meetings of the Interstate Commission to be conducted  
1556 by telecommunication or electronic communication.

1557 (g) Each commissioner participating at a meeting of the Interstate Commission is entitled  
1558 to one vote. A majority of commissioners shall constitute a quorum for the transaction of  
1559 business, unless a larger quorum is required by the bylaws of the Interstate Commission. A  
1560 Commission shall not delegate a vote to another commissioner. In the absence of its  
1561 commissioner, a member state may delegate voting authority for a specified meeting to another  
1562 person from that state who shall meet the requirements of subsection (d).

1563 (h) The Interstate Commission shall provide public notice of all meetings and all  
1564 meetings shall be open to the public. The Interstate Commission may close a meeting, in full or  
1565 in portion, where it determines by a two-thirds vote of the commissioners present that an open  
1566 meeting would be likely to:

1567 (1) Relate solely to the internal personnel practice and procedures of the Interstate  
1568 Commission;

- 1569 (2) Discuss matters specifically exempted from disclosure by federal statute;
- 1570 (3) Discuss trade secrets, commercial, or financial information that is privileged or  
1571 confidential;
- 1572 (4) Involve accusing a person of a crime, or formally censuring a person;
- 1573 (5) Discuss information of a personal nature where disclosure would constitute a clearly  
1574 unwarranted invasion of personal privacy;
- 1575 (6) Discuss investigative records compiled for law enforcement purposes; or
- 1576 (7) Specifically relate to the participation in a civil action or other legal proceeding.
- 1577 (i) The Interstate Commission shall keep minutes which shall fully describe all matters  
1578 discussed in a meeting and shall provide a full and accurate summary of actions taken, including  
1579 record of any roll call votes.
- 1580 (j) The Interstate Commission shall make its information and official records, to the  
1581 extent not otherwise designated in the compact or by its rules, available to the public for  
1582 inspection.
- 1583 (k) The Interstate Commission shall establish an executive committee, which shall  
1584 include officers, members, and others as determined by the bylaws. The executive committee  
1585 shall have the power to act on behalf of the Interstate Commission, with the exception of  
1586 rulemaking, during periods when the Interstate Commission is not in session. When acting on  
1587 behalf of the Interstate Commission, the executive committee shall oversee the administration of  
1588 the compact including enforcement and compliance with the provisions of the compact, its  
1589 bylaws and rules, and other such duties as necessary.

1590 (l) The Interstate Commission shall establish other committees for governance and  
1591 administration of the compact.

1592 Section 12. The Interstate Commission shall have the following powers and duties:

1593 (i) Oversee and maintain the administration of the compact;

1594 (ii) Promulgate rules which shall be binding to the extent and in the manner provided for  
1595 in the compact;

1596 (iii) Issue, upon the request of a member state or member board, advisory opinions  
1597 concerning the meaning or interpretation of the compact, its bylaws, rules, and actions;

1598 (iv) Enforce compliance with compact provisions, the rules promulgated by the Interstate  
1599 Commission, and the bylaws, using all necessary and proper means, including but not limited to  
1600 the use of judicial process;

1601 (v) Establish and appoint committees including, but not limited to, an executive  
1602 committee as required by section 11, which shall have the power to act on behalf of the Interstate  
1603 Commission in carrying out its powers and duties;

1604 (vi) Pay, or provide for the payment of the expenses related to the establishment,  
1605 organization, and ongoing activities of the Interstate Commission;

1606 (vii) Establish and maintain one or more offices;

1607 (viii) Borrow, accept, hire, or contract for services of personnel;

1608 (ix) Purchase and maintain insurance and bonds;



1609 (x) Employ an executive director who shall have such powers to employ, select or  
1610 appoint employees, agents, or consultants, and to determine their qualifications, define their  
1611 duties, and fix their compensation;

1612 (xi) Establish personnel policies and programs relating to conflicts of interest, rates of  
1613 compensation, and qualifications of personnel;

1614 (xii) Accept donations and grants of money, equipment, supplies, materials, and services  
1615 and to receive, utilize, and dispose of it in a manner consistent with the conflict of interest  
1616 policies established by the Interstate Commission;

1617 (xiii) Lease, purchase, accept contributions or donations of, or otherwise to own, hold,  
1618 improve or use, any property, real, personal, or mixed;

1619 (xiv) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of  
1620 any property, real, personal, or mixed;

1621 (xv) Establish a budget and make expenditures;

1622 (xvi) Adopt a seal and bylaws governing the management and operation of the Interstate  
1623 Commission;

1624 (xvii) Report annually to the legislatures and governors of the member states concerning  
1625 the activities of the Interstate Commission during the preceding year. Such reports shall also  
1626 include reports of financial audits and any recommendations that may have been adopted by the  
1627 Interstate Commission;

1628 (xviii) Coordinate education, training, and public awareness regarding the compact, its  
1629 implementation, and its operation;

- 1630           (xix) Maintain records in accordance with the bylaws;
- 1631           (xx) Seek and obtain trademarks, copyrights, and patents; and
- 1632           (xxi) Perform such functions as may be necessary or appropriate to achieve the purpose
- 1633 of the compact.

1634           Section 13. (a) The Interstate Commission may levy on and collect an annual assessment

1635 from each member state to cover the cost of the operations and activities of the Interstate

1636 Commission and its staff. The total assessment must be sufficient to cover the annual budget

1637 approved each year for which revenue is not provided by other sources. The aggregate annual

1638 assessment amount shall be allocated upon a formula to be determined by the Interstate

1639 Commission, which shall promulgate a rule binding upon all member states.

1640           (b) The Interstate Commission shall not incur obligations of any kind prior to securing

1641 the funds adequate to meet the same.

1642           (c) The Interstate Commission shall not pledge the credit of any of the member states,

1643 except by, and with the authority of, the member state.

1644           (d) The Interstate Commission shall be subject to a yearly financial audit conducted by a

1645 certified or licensed accountant and the report of the audit shall be included in the annual report

1646 of the Interstate Commission.

1647           Section 14. (a) The Interstate Commission shall, by a majority of Commissioners present

1648 and voting, adopt bylaws to govern its conduct as may be necessary or appropriate to carry out

1649 the purposes of the compact within 12 months of the first Interstate Commission meeting.

1650 (b) The Interstate Commission shall elect or appoint annually from among its  
1651 Commissioners a chairperson, a vice-chairperson, and a treasurer, each of whom shall have such  
1652 authority and duties as may be specified in the bylaws. The chairperson, or in the chairperson's  
1653 absence or disability, the vice-chairperson, shall preside at all meetings of the Interstate  
1654 Commission.

1655 (c) Officers selected in subsection (b) shall serve without remuneration for the Interstate  
1656 Commission.

1657 (d) The officers and employees of the Interstate Commission shall be immune from suit  
1658 and liability, either personally or in their official capacity, for a claim for damage to or loss of  
1659 property or personal injury or other civil liability caused or arising out of, or relating to, an actual  
1660 or alleged act, error, or omission that occurred, or that such person had a reasonable basis for  
1661 believing occurred, within the scope of Interstate Commission employment, duties, or  
1662 responsibilities; provided that such person shall not be protected from suit or liability for  
1663 damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of  
1664 such person.

1665 (e) The liability of the executive director and employees of the Interstate Commission or  
1666 representatives of the Interstate Commission, acting within the scope of such person's  
1667 employment or duties for acts, errors, or omissions occurring within such person's state, may not  
1668 exceed the limits of liability set forth under the constitution and laws of that state for state  
1669 officials, employees, and agents. The Interstate Commission is considered to be an  
1670 instrumentality of the states for the purpose of any such action. Nothing in this subsection shall

1671 be construed to protect such person from suit or liability for damage, loss, injury, or liability  
1672 caused by the intentional or willful and wanton misconduct of such person.

1673 (f) The Interstate Commission shall defend the executive director, its employees, and  
1674 subject to the approval of the attorney general or other appropriate legal counsel of the member  
1675 state represented by an Interstate Commission representative, shall defend such Interstate  
1676 Commission representative in any civil action seeking to impose liability arising out of an actual  
1677 or alleged act, error or omission that occurred within the scope of Interstate Commission  
1678 employment, duties or responsibilities, or that the defendant had a reasonable basis for believing  
1679 occurred within the scope of Interstate Commission employment, duties, or responsibilities,  
1680 provided that the actual or alleged act, error, or omission did not result from intentional or willful  
1681 and wanton misconduct on the part of such person.

1682 (g) To the extent not covered by the state involved, member state, or the Interstate  
1683 Commission, the representatives or employees of the Interstate Commission shall be held  
1684 harmless in the amount of a settlement or judgement, including attorney's fees and costs,  
1685 obtained against such persons arising out of an actual or alleged act, error, or omission that  
1686 occurred within the scope of the Interstate Commission employment, duties, or responsibilities,  
1687 or that such persons had a reasonable basis for believing occurred within the scope of Interstate  
1688 Commission employment, duties, or responsibilities, provided that the actual or alleged act,  
1689 error, or omission did not result from intentional or willful and wanton misconduct on the part of  
1690 such person.

1691 Section 15. (a) The Interstate Commission shall promulgate reasonable rules in order to  
1692 effectively and efficiently achieve the purpose of the compact. Notwithstanding the foregoing, in

1693 the event the Interstate Commission exercises its rulemaking authority in a manner that is beyond  
1694 the scope of the purposes of the compact, or the powers granted hereunder, then such an action  
1695 by the Interstate Commission shall be invalid and have no force or effect.

1696 (b) Rules deemed appropriate for the operations of the Interstate Commission shall be  
1697 made pursuant to a rulemaking process that substantially conforms to the “Model State  
1698 Administrative Procedure Act” of 2010, and subsequent amendments thereto.

1699 (c) Not later than 30 days after a rule is promulgated, any person may file a petition for  
1700 judicial review of the rule in the United States District Court for the District of Columbia or the  
1701 federal district where the Interstate Commission has its principal offices, provided that the filing  
1702 of such a petition shall not stay or otherwise prevent the rule from becoming effective unless the  
1703 court finds that the petitioner has a substantial likelihood of success. The court shall give  
1704 deference to the actions of the Interstate Commission consistent with applicable law and shall not  
1705 find the rule to be unlawful if the rule represents a reasonable exercise of the authority granted to  
1706 the Interstate Commission.

1707 Section 16. (a) The executive, legislative, and judicial branches of state government in  
1708 each member state shall enforce the compact and shall take all actions necessary and appropriate  
1709 to effectuate the compact’s purposes and intent. The provisions of the compact and the rules  
1710 promulgated hereunder shall have standing as statutory law but shall not override existing state  
1711 authority to regulate the practice of medicine.

1712 (b) All courts shall take judicial notice of the compact and the rules in any judicial or  
1713 administrative proceeding in a member state pertaining to the subject matter of the compact  
1714 which may affect the powers, responsibilities or actions of the Interstate Commission.

1715 (c) The Interstate Commission shall be entitled to receive all services of process in any  
1716 such proceeding, and shall have standing to intervene in the proceeding for all purposes. Failure  
1717 to provide service of process to the Interstate Commission shall render a judgment or order void  
1718 as to the Interstate Commission, the compact, or promulgated rules.

1719 Section 17. (a) The Interstate Commission, in the reasonable exercise of its discretion,  
1720 shall enforce the provisions and rules of the compact.

1721 (b) The Interstate Commission may, by majority vote of the Commissioners, initiate legal  
1722 action in the United States Court for the District of Columbia, or, at the discretion of the  
1723 Interstate Commission, in the federal district where the Interstate Commission has its principal  
1724 offices, to enforce compliance with the provisions of the compact, and its promulgated rules and  
1725 bylaws, against a member state in default. The relief sought may including both injunctive relief  
1726 and damages. In the event judicial enforcement is necessary, the prevailing party shall be  
1727 awarded all costs of such litigation including reasonable attorney's fees.

1728 (c) The remedies herein shall not be the exclusive remedies of the Interstate Commission.  
1729 The Interstate Commission may avail itself of any other remedies available under state law or  
1730 regulation of a profession.

1731 Section 18. (a) The grounds for default include, but are not limited to, failure of a  
1732 member state to perform such obligations or responsibilities imposed upon it by the compact, or  
1733 the rules and bylaws of the Interstate Commission promulgated under the compact.

1734 (b) If the Interstate Commission determines that a member state has defaulted in the  
1735 performance of its obligations or responsibilities under the compact, or the bylaws or  
1736 promulgated rules, the Interstate Commission shall:

1737 (1) Provide written notice to the defaulting state and other member states, of the nature of  
1738 the default, the means of curing the default, and any action taken by the Interstate Commission.  
1739 The Interstate Commission shall specify the conditions by which the defaulting state must cure  
1740 its default; and

1741 (2) Provide remedial training and specific technical assistance regarding the default.

1742 (c) If the defaulting state fails to cure the default, the defaulting state shall be terminated  
1743 from the compact upon an affirmative vote of a majority of the Commissioners and all rights,  
1744 privileges, and benefits conferred by the compact shall terminate on the effective date of  
1745 termination. A cure of the default does not relieve the offending state of obligations or liabilities  
1746 incurred during the period of the default.

1747 (d) Termination of membership in the compact shall be imposed only after all other  
1748 means of securing compliance have been exhausted. Notice of intent to terminate shall be given  
1749 by the Interstate Commission to the governor, the majority and minority leaders of the defaulting  
1750 state's legislature, and each of the member states.

1751 (e) The Interstate Commission shall establish rules and procedures to address licenses and  
1752 physicians that are materially impacted by the termination of a member state, or the withdrawal  
1753 of a member state.

1754 (f) The member state which has been terminated is responsible for all due, obligations,  
1755 and liabilities incurred through the effective date of termination including obligations, the  
1756 performance of which extends beyond the effective date of termination.

1757 (g) The Interstate Commission shall not bear any costs relating to any state that has been  
1758 found to be in default or which has been terminated from the compact, unless otherwise mutually  
1759 agreed upon in writing between the Interstate Commission and the defaulting state.

1760 (h) The defaulting state may appeal the action of the Interstate Commission by  
1761 petitioning the United States District Court for the District of Columbia or the federal district  
1762 where the Interstate Commission has its principal offices. The prevailing party shall be awarded  
1763 all costs of such litigation including reasonable attorney's fees.

1764 Section 19. (a) The Interstate Commission shall attempt, upon the request of a member  
1765 state, to resolve disputes which are subject to the compact and which may arise among member  
1766 states or member boards.

1767 (b) The Interstate Commission shall promulgate rules providing for both mediation and  
1768 binding dispute resolution as appropriate.

1769 Section 20. (a) Any state is eligible to become a member of the compact.

1770 (b) The compact shall become effective and binding upon legislative enactment of the  
1771 compact into law by no less than 7 states. Thereafter, it shall become effective and binding on a  
1772 state upon enactment of the compact into law by that state.

1773 (c) The governors of non-member states, or their designees, shall be invited to participate  
1774 in the activities of the Interstate Commission on a non-voting basis prior to adoption of the  
1775 compact by all states.

1776 (d) The Interstate Commission may propose amendments to the compact for enactment  
1777 by the member states. No amendment shall become effective and binding upon the Interstate



1778 Commission and the member states unless and until it is enacted into law by unanimous consent  
1779 of the member states.

1780 Section 21. (a) Once effective, the compact shall continue in force and remain binding  
1781 upon each and every member state; provided that a member state may withdraw from the  
1782 compact by specifically repealing the statute which enacted the compact into law.

1783 (b) Withdrawal from the compact shall be by the enactment of a statute repealing the  
1784 same, but shall not take effect until 1 year after the effective date of such statute and until written  
1785 notice of the withdrawal has been given by the withdrawing state to the governor of each other  
1786 member state.

1787 (c) The withdrawing state shall immediately notify the chairperson of the Interstate  
1788 Commission in writing upon the introduction of legislation repealing the compact in the  
1789 withdrawing state.

1790 (d) The Interstate Commission shall notify the other member states of the withdrawing  
1791 state's intent to withdraw within 60 days of its receipt of notice provided under subsection (c).

1792 (e) The withdrawing state is responsible for all dues, obligations and liabilities incurred  
1793 through the effective date of withdrawal, including obligations, the performance of which extend  
1794 beyond the effective date of withdrawal.

1795 (f) Reinstatement following withdrawal of a member state shall occur upon the  
1796 withdrawing date reenacting the compact or upon such later date as determined by the Interstate  
1797 Commission.

1798 (g) The Interstate Commission is authorized to develop rules to address the impact of the  
1799 withdrawal of a member state on licenses granted in other member states to physicians who  
1800 designated the withdrawing member state as the state of principal license.

1801 Section 22. (a) The compact shall dissolve effective upon the date of the withdrawal or  
1802 default of the member state which reduces the membership of the compact to 1 member state.

1803 (b) Upon the dissolution of the compact, the compact becomes null and void and shall be  
1804 of no further force or effect, and the business and affairs of the Interstate Commission shall be  
1805 concluded, and surplus funds shall be distributed in accordance with the bylaws.

1806 Section 23. (a) The provisions of the compact shall be severable, and if any phrase,  
1807 clause, sentence, or provision is deemed unenforceable, the remaining provisions of the compact  
1808 shall be enforceable.

1809 (b) The provisions of the compact shall be liberally construed to effectuate its purposes.

1810 (c) Nothing in the compact shall be construed to prohibit the applicability of other  
1811 interstate compacts to which the member states are members.

1812 Section 24. (a) Nothing herein prevents the enforcement of any other law of a member  
1813 state that is not inconsistent with the compact.

1814 (b) All laws in a member state in conflict with the compact are superseded to the extent  
1815 of the conflict.

1816 (c) All lawful actions of the Interstate Commission, including all rules and bylaws  
1817 promulgated by the Commission, are binding upon the member states.

1818 (d) All agreements between the Interstate Commission and the member states are binding  
1819 in accordance with their terms.

1820 (e) In the event any provision of the compact exceeds the constitutional limits imposed on  
1821 the legislature of any member state, such provision shall be ineffective to the extent of the  
1822 conflict with the constitutional provision in question in that member state.

1823 Section 25. (a) The executive director of the board of registration in medicine, or the  
1824 board executive director's designee, shall be the administrator of compact for the  
1825 commonwealth.

1826 (b) The board of registration in medicine shall adopt regulations in the same manner as  
1827 all other with states legally joining in the compact and may adopt additional regulations as  
1828 necessary to implement the provisions of this chapter.

1829 (c) The board of registration in medicine may take disciplinary action against the practice  
1830 privilege of a physician practicing in the commonwealth under a license issued by party state.  
1831 The board's disciplinary action may be based on disciplinary action against the physician's  
1832 license taken by the physician's home state.

1833 (d) In reporting information to the coordinated licensure information system under  
1834 section 8 of this chapter related to the compact, the board of registration in medicine may  
1835 disclose personally identifiable information about the physician, including social security  
1836 number.

1837 (e) Nothing in this chapter, nor the entrance of the commonwealth into the Interstate  
1838 Medical Licensure compact shall be construed to supersede existing labor laws.

1839 (f) The commonwealth, its officers and employees, and the board of registration in  
1840 medicine and its agents who act in accordance with the provisions of this chapter shall not be  
1841 liable on account of any act or omission in good faith while engaged in the performance of their  
1842 duties under this chapter. Good faith shall not include willful misconduct, gross negligence, or  
1843 recklessness.

1844 Section 26. As part of the licensure and background check process for a multistate license  
1845 and to determine the suitability of an applicant for multistate licensure, the board of registration  
1846 in medicine, prior to issuing any multistate license, shall conduct a fingerprint-based check of the  
1847 state and national criminal history databases, as authorized by 28 CFR 20.33 and Public Law 92-  
1848 544.

1849 Fingerprints shall be submitted to the identification section of the department of state  
1850 police for a state criminal history check and forwarded to the Federal Bureau of Investigation for  
1851 a national criminal history check, according to the policies and procedures established by the  
1852 state identification section and by the department of criminal justice information services.  
1853 Fingerprint submissions may be retained by the Federal Bureau of Investigation, the state  
1854 identification section and the department of criminal justice information services for requests  
1855 submitted by the board of registration in medicine as authorized under this section to ensure the  
1856 continued suitability of these individuals for licensure. The department of criminal justice  
1857 information services may disseminate the results of the state and national criminal background  
1858 checks to the executive director of the board of registration in medicine and authorized staff of  
1859 the board.

1860 All applicants shall pay a fee to be established by the secretary of administration and  
1861 finance, in consultation with the secretary of public safety, to offset the costs of operating and  
1862 administering a fingerprint-based criminal background check system. The secretary of  
1863 administration and finance, in consultation with the secretary of public safety, may increase the  
1864 fee accordingly if the Federal Bureau of Investigation increases its fingerprint background check  
1865 service fee. Any fees collected from fingerprinting activity under this chapter shall be deposited  
1866 into the Fingerprint-Based Background Check Trust Fund, established in section 2HHHH of  
1867 chapter 29.

1868 The board of registration in medicine may receive all criminal offender record  
1869 information and the results of checks of state and national criminal history databases under said  
1870 Public Law 92-544. When the board of registration in medicine obtains the results of checks of  
1871 state and national criminal history databases, it shall treat the information according to sections  
1872 167 to 178, inclusive, of chapter 6 and the regulations thereunder regarding criminal offender  
1873 record information.

1874 Notwithstanding subsections 9 and 9 1/2 of section 4 of chapter 151B, if the board of  
1875 registration in medicine receives criminal record information from the state or national  
1876 fingerprint-based criminal background checks that includes no disposition or is otherwise  
1877 incomplete, the agency head may request that an applicant for licensure provide additional  
1878 information regarding the results of the criminal background checks to assist the agency head in  
1879 determining the applicant's suitability for licensure.

1880 SECTION 54. Chapter 118I of the General is hereby amended by striking out the chapter  
1881 and inserting in place thereof the following chapter:-

1882 Chapter 118I

1883 HEALTH INFORMATION EXCHANGE

1884 Section 1. As used in this chapter, the following words shall, unless the context clearly  
1885 requires otherwise, have the following meanings:

1886 “Council”, the health information technology council established under section 2.

1887 “Electronic health record”, an electronic record of patient health information generated  
1888 by 1 or more encounters in any care delivery setting.

1889 “Executive office”, the executive office of health and human services.

1890 “Health care entity”, a payer, health care provider or provider organization.

1891 “Health care provider”, a provider of medical or health services or any other person or  
1892 organization that furnishes, bills or is paid for health care service delivery in the normal course  
1893 of business.

1894 “Health information exchange”, transmission of health care-related data among health  
1895 care entities of personal health records aligning with national standards; the reliable and secure  
1896 transfer of data among diverse systems and access to and retrieval of data.

1897 “Office of the National Coordinator” or “ONC”, the Office of the National Coordinator  
1898 for Health Information Technology within the United States Department of Health and Human  
1899 Services.

1900 “Payer”, any entity, other than an individual, that pays providers for the provision of  
1901 health care services; provided, that “payer” shall include both governmental and private entities;  
1902 provided further, that “payer” shall not include ERISA plans.

1903 “Provider organization”, any corporation, partnership, business trust, association or  
1904 organized group of persons, which is in the business of health care delivery or management,  
1905 whether incorporated or not that represents 1 or more health care providers in contracting with  
1906 carriers for the payments of health care services; provided, that “provider organization” shall  
1907 include, but not be limited to, physician organizations, physician-hospital organizations,  
1908 independent practice associations, provider networks, accountable care organizations and any  
1909 other organization that contracts with carriers for payment for health care services.

1910 “Statewide health information exchange”, health information exchange established,  
1911 operated, facilitated or funded by a governmental entity or entities in the commonwealth.

1912 Section 2. (a) There shall be a health information technology council within the executive  
1913 office of health and human services. The council shall advise the executive office on design,  
1914 implementation, operation and use of statewide health information exchange.

1915 (b) The council shall consist of the following 21 members: the secretary of health and  
1916 human services or a designee, who shall serve as the chair; the secretary of administration and  
1917 finance or designee; the executive director of the health policy commission or a designee; the  
1918 executive director of the center for health information analysis or a designee; the director of the  
1919 Massachusetts eHealth Institute or a designee; the secretary of housing and economic  
1920 development or a designee; the director of the office of Medicaid or a designee; and 14 members  
1921 who shall be appointed by the governor, of whom at least 1 shall be an expert in health

1922 information technology; 1 shall be an expert in law and health policy; 1 shall be an expert in  
1923 health information privacy and security; 1 shall be from an academic medical center; 1 shall be  
1924 from a community hospital; 1 shall be from a community health center; 1 shall be from a long  
1925 term care facility; 1 shall be a from large physician group practice; 1 shall be from a small  
1926 physician group practice; 1 shall be a registered nurse; 1 shall be from a behavioral health,  
1927 substance abuse disorder or mental health services organization; 1 shall represent health  
1928 insurance carriers; and 2 additional members shall have experience or expertise in health  
1929 information technology. The council may consult with all relevant parties, public or private, in  
1930 exercising its duties under this section, including persons with expertise and experience in the  
1931 development and dissemination of electronic health records systems, and the implementation of  
1932 electronic health record systems by small physician groups or ambulatory care providers, as well  
1933 as persons representing organizations within the commonwealth interested in and affected by the  
1934 development of networks and electronic health records systems, including, but not limited to,  
1935 persons representing local public health agencies, licensed hospitals and other licensed facilities  
1936 and providers, private purchasers, the medical and nursing professions, physicians and health  
1937 insurers, the state quality improvement organization, academic and research institutions,  
1938 consumer advisory organizations with expertise in health information technology and other  
1939 stakeholders as identified by the secretary of health and human services. Appointed members of  
1940 the council shall serve for terms of 2 years or until a successor is appointed. Members shall be  
1941 eligible to be reappointed and shall serve without compensation.

1942 (c) Chapter 268A shall apply to all council members, except that the council may  
1943 purchase from, sell to, borrow from, contract with or otherwise deal with any organization in  
1944 which any council member is in anyway interested or involved; provided, however, that such



1945 interest or involvement shall be disclosed in advance to the council and recorded in the minutes  
1946 of the proceedings of the council; and provided, further, that no member shall be considered to  
1947 have violated section 4 of said chapter 268A because of the member's receipt of usual and  
1948 regular compensation from such member's employer during the time in which the member  
1949 participates in the activities of the council.

1950           Section 3. (a) The executive office shall establish, operate, facilitate, or fund statewide  
1951 health information exchange among health care entities, including, but not limited to, improving  
1952 interoperability among health care entities and requiring the exchange of minimum standardized  
1953 health data requirements.

1954           (b) The executive office may:

1955           (i) conduct procurements and enter into contracts for the purchase, dissemination,  
1956 development of hardware and software, in connection with the implementation of statewide  
1957 health information exchange; and

1958           (ii) in consultation with the council, oversee the development, dissemination,  
1959 implementation and operation of statewide health information exchange including any modules,  
1960 applications, interfaces or other technology infrastructure for statewide health information  
1961 exchange.

1962           (c) In carrying out this chapter, the executive office may undertake any activities  
1963 necessary to implement the powers and duties under this chapter, which may include issuing  
1964 implementing regulations and the adoption of policies consistent with those adopted by the  
1965 Office of the National Coordinator for Health Information Technology of the United States  
1966 Department of Health and Human Services; provided, however, that nothing herein shall be

1967 construed to limit the executive office’s ability to advance interoperability and other health  
1968 information technology beyond such federal standards, including without limitation any  
1969 applicable meaningful use standards.

1970           Section 4. Every patient shall have electronic access to such patient’s health records. The  
1971 executive office shall ensure that each patient will have secure electronic access to such patient’s  
1972 electronic health records with each of such patient’s health care providers.

1973           Section 5. All health care entities in the commonwealth shall participate in statewide  
1974 health information exchange; provided that all health care providers shall implement fully  
1975 interoperable electronic records systems necessary to participate in statewide health information  
1976 exchange activities, as defined by the executive office; and further provided that all payers shall  
1977 implement electronic claims management systems that can send and receive member claims and  
1978 health data with health care providers to participate in statewide health information exchange  
1979 activities, as defined by the executive office. The executive office shall issue regulations  
1980 requiring that statewide health information exchange, the associated electronic records systems  
1981 and electronic claims management systems, comply with all state and federal privacy  
1982 requirements, including those imposed by the Health Insurance Portability and Accountability  
1983 Act of 1996, P.L. 104–191, the American Recovery and Reinvestment Act of 2009, P.L. 111–5,  
1984 42 C.F.R. §§ 2.11 et seq. and 45 C.F.R. §§ 160, 162 and 164.

1985           Section 6. The executive office shall prescribe by regulation penalties for non-compliance  
1986 by health care entities with the requirements of this chapter provided, however, that the executive  
1987 office may waive penalties for good cause. Penalties collected under this section shall be

1988 deposited into the Health Information Technology Trust Fund, established in section 10 of  
1989 chapter 35RR.

1990           Section 7. In the event of an unauthorized access to or disclosure of individually  
1991 identifiable patient health information by or through a health care entity or a vendor contracted  
1992 through services of a health care entity as participants of statewide health information exchange,  
1993 the health care entity or vendor shall comply with the requirements of chapter 93H and in any  
1994 event shall: (i) report the conditions of such unauthorized access or disclosure as required by the  
1995 executive office; and (ii) provide notice, as defined in section 1 of chapter 93H, as soon as  
1996 practicable, but not later than 10 business days after such unauthorized access or disclosure, to  
1997 any person whose patient health information may have been compromised as a result of such  
1998 unauthorized access or disclosure, and shall report the conditions of such unauthorized access or  
1999 disclosure, and further shall concurrently provide a copy of such report to the executive office.  
2000 Any unauthorized access or disclosures shall be punishable by the civil penalties under section  
2001 10.

2002           Section 8. Patients shall have the choice to opt-out of having their health data disclosed  
2003 for electronic health information exchange activities that are owned and operated or contracted  
2004 by the Commonwealth.

2005           Section 9. The executive office shall pursue and maximize all opportunities to qualify for  
2006 federal financial participation under the matching grant program established under the Health  
2007 Information Technology for Economic and Clinical Health Act of the American Recovery and  
2008 Reinvestment Act of 2009, P.L. 111-5.

2009           Section 10. The executive office may require participant fees from health care entities  
2010 that use health information exchange services. Participant fees collected under this section shall  
2011 be deposited into the Health Information Technology Trust Fund, as established by section 35RR  
2012 of chapter 10, or its successor trust fund. Nonpayment or late payment of fees may subject health  
2013 care entities to fines or penalties as determined by the executive office. The executive office shall  
2014 promulgate regulations to assess fair and reasonable fines or penalties.

2015           Section 11. The council shall file an annual report, not later than April 1, with the joint  
2016 committee on health care financing, the joint committee on economic development and emerging  
2017 technologies, the house and senate committees on ways and means and the clerks of the house  
2018 and senate concerning the activities of the council in general and, in particular, describing the  
2019 progress to date in developing statewide health information exchange and recommending such  
2020 further legislative action as it deems appropriate.

2021           Section 12. Unauthorized access to or disclosure of individually identifiable patient  
2022 health information shall be subject to fines or penalties as determined by the executive office.  
2023 The executive office shall promulgate regulations to assess fair and reasonable fines or penalties.

2024           Section 13. Cybersecurity-based documentation, including but not limited to security  
2025 audit reports, provided to the executive office shall be exempt from disclosure under clause  
2026 Twenty-sixth of section 7 of chapter 4 and chapter 66.

2027           SECTION 55. Subsection (i) of section 47B of chapter 175 of the General Laws, as  
2028 appearing in the 2020 Official Edition, is hereby amended by striking out the second paragraph  
2029 and inserting in place thereof the following paragraph:-

2030 For the purposes of this section, “licensed mental health professional” shall mean a  
2031 licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a  
2032 licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse  
2033 mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1  
2034 of chapter 111J, a licensed marriage and family therapist within the lawful scope of practice for  
2035 such therapist, or a clinician practicing under the supervision of licensed professional, and  
2036 working towards licensure, in a clinic licensed under chapter 111.

2037 SECTION 56. Section 1 of chapter 175H of the General Laws , as so appearing, is hereby  
2038 amended by inserting after the definition of “Health care insurer”, the following definition:-

2039 “Impermissible facility fee,” a facility fee, as defined in section 51L of chapter 111, that  
2040 is not charged, billed or collected in accordance with paragraphs (b) or (c) of said section 51L of  
2041 said chapter 111.

2042 SECTION 57. Said section 1 of said chapter 175H, as so appearing, is hereby further  
2043 amended by adding the following definition:-

2044 “Surprise bill,” a bill received by an insured for unforeseen out-of-network services, as  
2045 defined in section 30 of chapter 176O.

2046 SECTION 58. Said chapter 175H of the General Laws is hereby further amended by  
2047 striking out sections 5 and 6 and inserting in place thereof the following 3 sections:-

2048 Section 5. The attorney general may conduct an investigation of an alleged violation of  
2049 this chapter and may commence a proceeding pursuant to section 4. Additionally, the attorney  
2050 general has the authority to initiate a civil action under this chapter. When the attorney general

2051 has determined that a provider has violated this chapter, the attorney general shall notify the  
2052 department of public health, the department of mental health, the board of registration in  
2053 medicine or any other relevant licensing authorities, of that determination. Those licensing  
2054 authorities may, upon their own investigation or upon notification from the attorney general that  
2055 a provider licensed by that authority has violated this section, impose penalties for non-  
2056 compliance consistent with their authority to regulate those providers.

2057           Section 6. A person who receives a health care benefit or payment from a health care  
2058 corporation or health care insurer or other person or entity, which such person knows that he or  
2059 she is not entitled to receive or be paid, or a person who knowingly presents or causes to be  
2060 presented with fraudulent intent a claim which contains a false statement, including but not  
2061 limited to a payment or false statement regarding an impermissible facility fee shall be liable to  
2062 the health care corporation or health care insurer or other person or entity for the full amount of  
2063 the benefit or payment made, and for reasonable attorneys' fees and costs, inclusive of costs of  
2064 investigation. A health care corporation or health care insurer or other injured person or entity  
2065 may bring a civil action under this chapter in the superior court department of the trial court.

2066           Section 6A. A person who receives a health care benefit or payment from a health care  
2067 corporation or health care insurer or other person or entity, shall not be permitted to forward a  
2068 surprise bill to a person covered under an insured health plan. A person who violates this section  
2069 shall be liable to the health care corporation or health care insurer or other person or entity for  
2070 penalties and for reasonable attorneys' fees and costs, inclusive of costs of investigation. A  
2071 health care corporation or health care insurer or other injured person or entity may bring a civil  
2072 action under this chapter in the superior court department of the trial court.

2073 SECTION 59. The General Laws are hereby further amended by inserting after chapter  
2074 175M the following chapter:-

2075 Chapter 175N

2076 PHARMACY BENEFIT MANAGERS

2077 Section 1. As used in this chapter the following words shall, have the following meanings  
2078 unless the context clearly requires otherwise:

2079 “Carrier,” an insurer licensed or otherwise authorized to transact accident or health  
2080 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter  
2081 176A; a nonprofit medical service corporation organized under chapter 176B; a health  
2082 maintenance organization organized under chapter 176G; and an organization entering into a  
2083 preferred provider arrangement under chapter 176I, but not including an employer purchasing  
2084 coverage or acting on behalf of its employees or the employees of or more subsidiaries or  
2085 affiliated corporations of the employer; provided, however, that, unless otherwise noted,  
2086 “carrier” shall not include any entity to the extent it offers a policy, certificate or contract that  
2087 provides coverage solely for dental care services or vision care services.

2088 “Center”, the center for health information and analysis established in chapter 12C.

2089 “Commissioner”, the commissioner of insurance.

2090 “Division”, the division of insurance.

2091 “Health benefit plan,” a policy, contract, certificate or agreement entered into, offered or  
2092 issued by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health  
2093 care services.

2094 “Pharmacy Benefit Manager,” any person, business or entity, however organized, that  
2095 administers, either directly or through subsidiaries, pharmacy benefit services for prescription  
2096 drugs and devices on behalf of health benefit plan sponsors, including, but not limited to, self-  
2097 insured employers, insurance companies and labor unions; provided however, that “pharmacy  
2098 benefit services” shall include, but not be limited to, formulary administration; drug benefit  
2099 design; pharmacy network contracting; pharmacy claims processing; mail and specialty drug  
2100 pharmacy services; and cost containment, clinical, safety and adherence programs for pharmacy  
2101 services; provided, further, that a health benefit plan that does not contract with a pharmacy  
2102 benefit manager shall be considered a pharmacy benefit manager.

2103 Section 2. (a) A person or organization shall not establish or operate as a pharmacy  
2104 benefit manager to administer prescription drug benefits or services for a carrier’s health benefit  
2105 plans in the commonwealth without obtaining certification from the commissioner pursuant to  
2106 this section nor shall a carrier contract with an uncertified pharmacy benefit manager.

2107 (b) The commissioner shall promulgate regulations regarding pharmacy benefit managers  
2108 that shall (i) establish the certification, application, standards and reporting requirements of  
2109 pharmacy benefit managers and (ii) establish requirements for carriers to contract with certified  
2110 pharmacy benefit managers.

2111 (c) The commissioner shall charge pharmacy benefit manager application and renewal  
2112 fees in the amount of \$1,000.

2113 (d) An entity certified as a pharmacy benefit manager shall be required to submit data and  
2114 reporting information to the center, including information associated with discounts, retained  
2115 rebates and earned margins on payments to pharmacy providers on behalf of health plans,



2116 according to standards and methods specified by the center pursuant to section 10A of chapter  
2117 12C.

2118 (d) Certification obtained under this section is valid for a period of 2 years and may be  
2119 renewed. Certification is not transferable.

2120 (e) A pharmacy benefit manager shall report to the division material changes to the  
2121 information contained in its application, certified by an officer of the pharmacy benefit manager,  
2122 within 30 days of such changes.

2123 Section 3. (a) The commissioner may make an examination of the affairs of a pharmacy  
2124 benefit manager when the commissioner deems prudent but not less frequently than once every 3  
2125 years. The focus of the examination shall be to ensure that a pharmacy benefit manager is  
2126 fulfilling its responsibilities under contracts with carriers licensed under chapters 175, 176A,  
2127 176B, or 176G. The examination shall be conducted according to the procedures set forth in  
2128 subsection (6) of section 4 of chapter 175.

2129 (b) The commissioner, a deputy or an examiner may conduct an on-site examination of  
2130 each pharmacy benefit manager in the commonwealth to thoroughly inspect and examine its  
2131 affairs.

2132 (c) The charge for each such examination shall be determined annually according to the  
2133 procedures set forth in subsection (6) of section 4 of chapter 175.

2134 (d) Not later than 60 days following completion of the examination, the examiner in  
2135 charge shall file with the commissioner a verified written report of examination under oath.  
2136 Upon receipt of the verified report, the commissioner shall transmit the report to the pharmacy

2137 benefit manager examined with a notice which shall afford the pharmacy benefit manager  
2138 examined a reasonable opportunity of not more than 30 days to make a written submission or  
2139 rebuttal with respect to any matters contained in the examination report. Within 30 days of the  
2140 end of the period allowed for the receipt of written submissions or rebuttals, the commissioner  
2141 shall consider and review the reports together with any written submissions or rebuttals and any  
2142 relevant portions of the examiner's work papers and enter an order:

2143 (i) adopting the examination report as filed with modifications or corrections and, if the  
2144 examination report reveals that the pharmacy benefit manager is operating in violation of this  
2145 section or any regulation or prior order of the commissioner, the commissioner may order the  
2146 pharmacy benefit manager to take any action the commissioner considers necessary and  
2147 appropriate to cure such violation;

2148 (ii) rejecting the examination report with directions to examiners to reopen the  
2149 examination for the purposes of obtaining additional data, documentation or information and re-  
2150 filing pursuant to the above provisions; or

2151 (iii) calling for an investigatory hearing with no less than 20 days notice to the pharmacy  
2152 benefit manager for purposes of obtaining additional documentation, data, information and  
2153 testimony.

2154 (e) Notwithstanding any general or special law to the contrary, including clause Twenty-  
2155 sixth of section 7 of chapter 4 and chapter 66, the records of any such audit, examination or other  
2156 inspection and the information contained in the records, reports or books of any pharmacy  
2157 benefit manager examined pursuant to this section shall be confidential and open only to the  
2158 inspection of the commissioner, or the examiners and assistants. Access to such confidential

2159 material may be granted by the commissioner to law enforcement officials of the commonwealth  
2160 or any other state or agency of the federal government at any time, provided that the agency or  
2161 office receiving the information agrees in writing to keep such material confidential. Nothing  
2162 herein shall be construed to prohibit the required production of such records, and information  
2163 contained in the reports of such company or organization before any court of the commonwealth  
2164 or any master or auditor appointed by any such court, in any criminal or civil proceeding,  
2165 affecting such pharmacy benefit manager, its officers, partners, directors or employees. The final  
2166 report of any such audit, examination or any other inspection by or on behalf of the division of  
2167 insurance shall be a public record.

2168           Section 4. A pharmacy benefit manager shall be required to submit to periodic audits by a  
2169 carrier licensed under chapters 175, 176A, 176B, or 176G, if the pharmacy benefit manager has  
2170 entered into a contract with the carrier to provide pharmacy benefits to the carrier or its  
2171 members. The commissioner may direct or provide specifications for such audits.

2172           Section 5. (a) The division may suspend, revoke, or place on probation a pharmacy  
2173 benefit manager certification if the pharmacy benefit manager:

2174           (1) has engaged in fraudulent activity that constitutes a violation of state or federal law;

2175           (2) is the subject of consumer complaints received and verified by the division that  
2176 present a substantial risk of harm to the health, safety and interests of consumers;

2177           (3) fails to pay an application fee;

2178           (4) fails to comply with reporting requirements of the center under section 10A of chapter  
2179 12C;

2180 (5) appears upon examination to be unable to fulfill its contractual obligations; or

2181 (6) fails to comply with a requirement set forth in this section.

2182 (b) The commissioner shall notify the pharmacy benefit manager and advise, in writing,  
2183 of the reason for any suspension or any refusal to issue or non-renew a certificate under this  
2184 chapter. A copy of the notice shall be forwarded to the center. The applicant or pharmacy benefit  
2185 manager may make written demand upon the commissioner within 30 days of receipt of such  
2186 notification for a hearing before the commissioner to determine the reasonableness of the  
2187 commissioner's action. The hearing shall be held pursuant to chapter 30A.

2188 (c) The commissioner shall not suspend or cancel a certificate unless the commissioner  
2189 has first afforded the pharmacy benefit manager an opportunity for a hearing pursuant to chapter  
2190 30A.

2191 Section 7. (a) A pharmacy benefits manager under contract with a carrier, shall comply  
2192 with the provisions of section 30 of chapter 176O.

2193 SECTION 60. Subsection (i) of section 8A of chapter 176A of the General Laws, as  
2194 appearing in the 2020 Official Edition, is hereby amended by striking out the second paragraph  
2195 and inserting in place thereof the following paragraph:-

2196 For the purposes of this section, "licensed mental health professional" shall mean a  
2197 licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a  
2198 licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse  
2199 mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1  
2200 of chapter 111J, a licensed marriage and family therapist within the lawful scope of practice for

2201 such therapist, or a clinician practicing under the supervision of licensed professional, and  
2202 working towards licensure, in a clinic licensed under chapter 111.

2203 SECTION 61. Subsection (i) of section 4A of chapter 176B of the General Laws, as so  
2204 appearing, is hereby amended by striking out the second paragraph and inserting in place thereof  
2205 the following paragraph:-

2206 For the purposes of this section, “licensed mental health professional” shall mean a  
2207 licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a  
2208 licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse  
2209 mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1  
2210 of chapter 111J, a licensed marriage and family therapist within the lawful scope of practice for  
2211 such therapist, or a clinician practicing under the supervision of licensed professional, and  
2212 working towards licensure, in a clinic licensed under chapter 111.

2213 SECTION 62. Subsection (i) of section 4M of chapter 176G of the General Laws, as so  
2214 appearing, is hereby amended by striking out the second paragraph and inserting in place thereof  
2215 the following paragraph:-

2216 For the purposes of this section, “licensed mental health professional” shall mean a  
2217 licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a  
2218 licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse  
2219 mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1  
2220 of chapter 111J, a licensed marriage and family therapist within the lawful scope of practice for  
2221 such therapist, or a clinician practicing under the supervision of licensed professional, and  
2222 working towards licensure, in a clinic licensed under chapter 111.

2223 SECTION 63. Paragraph (1) of subsection (a) of section 4 of chapter 176J of the General  
2224 Laws, as so appearing, is hereby amended by striking out, in line 1, the words, “Every carrier  
2225 shall make available” and inserting in place thereof the following words:- “Every carrier shall  
2226 maintain a website on which it will display every available plan and shall offer.”

2227 SECTION 64. Subsection (b) of said section 4 of said chapter 176J, as so appearing, is  
2228 hereby amended by striking out paragraph (4).

2229 SECTION 65. Section 6 of said chapter 176J, as so appearing, is hereby amended by  
2230 striking out subsection (c) and inserting in place thereof the following subsection:-

2231 (c) Notwithstanding any general or special law to the contrary, carriers offering small  
2232 group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or  
2233 176G, shall file small group product base rates and any changes to small group rating factors that  
2234 are to be effective on January 1 of each year, on or before July 1 of the preceding year. The  
2235 commissioner shall approve, modify or disapprove any proposed changes to base rates; provided,  
2236 however, that the commissioner shall only modify or disapprove any proposed changes to base  
2237 rates that are excessive, inadequate or unreasonable in relation to the benefits charged. The  
2238 commissioner shall disapprove any change to small group rating factors that is discriminatory or  
2239 not actuarially sound. The commissioner shall require carriers licensed under chapters 175,  
2240 176A, 176B or 176G to file information annually on price increases negotiated with providers  
2241 participating in their health insurance plans. Rates of reimbursement or rating factors included in  
2242 the rate filing materials submitted for review by the division shall be deemed confidential and  
2243 exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 and chapter 66;  
2244 provided, however, that the commissioner shall provide information on provider price increases

2245 annually to the center for health information and analysis and the health policy commission; and  
2246 provided further that any information received under this section by the center for health  
2247 information and analysis and the health policy commission shall be held confidential but may be  
2248 used in the aggregate or summary form in reports. The commissioner shall adopt regulations to  
2249 carry out this section.

2250 SECTION 66. Said chapter 176J of the General Laws is hereby further amended by  
2251 striking out section 11 and inserting in place thereof the following section:-

2252 Section 11. (a) A carrier that offers a health benefit plan that: (i) provides or arranges for  
2253 the delivery of health care services through a closed network of health care providers; and (ii) as  
2254 of the close of any preceding calendar year, has a combined total of 5,000 or more eligible  
2255 individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans  
2256 sold, issued, delivered, made effective or renewed to qualified small businesses or eligible  
2257 individuals, shall offer to all eligible individuals and small businesses in at least 2 geographic  
2258 areas at least 1 high-value health plan from each of the following categories:

2259 (A) a reduced or selective network of providers;

2260 (B) a plan in which providers are tiered and member cost sharing is based on the tier  
2261 placement of the provider;

2262 (C) a plan in which an enrollee's premium varies based on the primary care provider  
2263 selected at the time of enrollment; or

2264 (D) other innovative plans designed by the carrier and approved by the commissioner,  
2265 including, but not limited to: (1) plans that base plan reimbursement on a benchmark

2266 reimbursement level such as a level tied to Medicare reimbursement; (2) plans with clear rewards  
2267 for receiving care from lower-cost providers; (3) products that are developed for specific  
2268 geographic regions; (4) products that establish pricing based on their inclusion in an employer's  
2269 value-driven defined contribution offering; (5) plans with significant benefit differentials  
2270 between tiers in a tiered benefit product; and (6) site of service products where services may only  
2271 be available from certain network providers or at certain locations based on the medical necessity  
2272 of the service.

2273           Carriers shall establish a base premium rate discount of at least 20 per cent for the plan  
2274 offered pursuant to this section compared to the base premium of the carrier's most actuarially  
2275 similar plan with the carrier's non-selective or non-tiered network of providers. The savings may  
2276 be achieved by means including, but not limited to: (i) the exclusion of providers with similar or  
2277 lower quality based on the quality measure set, as determined according to section 16CC of  
2278 chapter 6A, with higher health status adjusted total medical expenses or relative prices, as  
2279 determined under section 10 of chapter 12C; or (ii) increased member cost-sharing for members  
2280 who utilize providers for non-emergency services with similar or lower quality based on the  
2281 quality measure set, as determined according to section 16CC of chapter 6A, and with higher  
2282 health status adjusted total medical expenses or relative prices, as determined under said section  
2283 10 of said chapter 12C.

2284           The commissioner may apply waivers to the base premium rate discount determined by  
2285 the commissioner under this section to carriers who receive 80 per cent or more of their incomes  
2286 from government programs or the subsidized ConnectorCare Program sponsored by the  
2287 Commonwealth Health Insurance Connector Authority or which have service areas which do not  
2288 include either Suffolk or Middlesex counties and who were first admitted to do business by the



2289 division of insurance on January 1, 1986, as health maintenance organizations under chapter  
2290 176G.

2291 (b) A tiered network plan shall only include variations in member cost-sharing between  
2292 provider tiers which are reasonable in relation to the premium charged and ensure adequate  
2293 access to covered services. Carriers shall tier providers based on quality performance as  
2294 measured by the quality measure set and by cost performance as measured by health status  
2295 adjusted total medical expenses and relative prices. Where applicable quality measures are not  
2296 available, tiering may be based solely on health status adjusted total medical expenses or relative  
2297 prices or both.

2298 The commissioner shall promulgate regulations requiring the uniform reporting of  
2299 information for all products subject to this section, including, but not limited to, for tiered  
2300 network plans requiring at least 90 days before the proposed effective date of any tiered network  
2301 plan or any modification in the tiering methodology for any existing tiered network plan, the  
2302 reporting of a detailed description of the methodology used for tiering providers, including: the  
2303 statistical basis for tiering; a list of providers to be tiered at each member cost-sharing level; a  
2304 description of how the methodology and resulting tiers will be communicated to each network  
2305 provider, eligible individuals and small groups; and a description of the appeals process a  
2306 provider may pursue to challenge the assigned tier level.

2307 (c) The commissioner shall determine network adequacy for a tiered network plan based  
2308 on the availability of sufficient network providers in the carrier's overall network of providers.

2309 (d) The commissioner shall determine network adequacy for a selective network plan  
2310 based on the availability of sufficient network providers in the carrier's selective network. When

2311 medically necessary, carriers shall provide access to out-of-network providers for covered  
2312 services, including those outside the plan's service area.

2313 (e) In determining network adequacy under this section, the commissioner may take into  
2314 consideration factors such as the location of providers participating in the plan and employers or  
2315 members that enroll in the plan, the range of services provided by providers in the plan and plan  
2316 benefits that recognize and provide for extraordinary medical needs of members that may not be  
2317 adequately dealt with by the providers within the plan network.

2318 (f) Carriers may: (i) reclassify provider tiers; and (ii) determine provider participation in  
2319 selective and tiered plans not more than once per calendar year except that carriers may  
2320 reclassify providers from a higher cost tier to a lower cost tier or add providers to a selective  
2321 network at any time. If the carrier reclassifies provider tiers or providers participating in a  
2322 selective plan during the course of an account year, the carrier shall provide affected members of  
2323 the account with information regarding the plan changes at least 30 days before the changes take  
2324 effect. Carriers shall provide information on their websites about any tiered or selective plan,  
2325 including but not limited to, the providers participating in the plan, the selection criteria for those  
2326 providers and where applicable, the tier in which each provider is classified.

2327 (g) Carriers shall develop informational materials that explain the value of high-value  
2328 products and how high-value products provide appropriate access to care. Such high-value  
2329 products shall be promoted along with a carrier's other products, and consumers shall be  
2330 informed that the number of network providers may be different, but that the high-value products  
2331 meet regulatory standards to provide adequate access to appropriate health care systems and to  
2332 out-of-network care if not available within the network.

2333 (h) The division of insurance shall report specific findings and legislative  
2334 recommendations for all products subject to this section, including the following: (1) the  
2335 utilization trends of eligible employers and eligible individuals enrolled in plans offered under  
2336 this section; (2) the extent to which tiered product offerings have reduced health care costs for  
2337 patients and employers; (3) the effects that tiered product offerings have on patient education  
2338 relating to health care costs and quality; (4) the effects that tiered product offerings have on  
2339 patient utilization of local hospitals and the resulting impact on overall state health care costs,  
2340 including the state's compliance with the health care cost growth benchmark established under  
2341 section 9 of chapter 6D; (5) opportunities to incentivize tiered product offerings for both health  
2342 systems and employers. The report shall also include the number of members enrolled by plan  
2343 type, aggregate demographic, geographic information on all members and the average direct  
2344 premium claims incurred, as defined in section 6, for selective and tiered network products  
2345 compared to non-selective and non-tiered products. The report shall be submitted to clerks of the  
2346 house of representatives and the senate, the senate and house committees on ways and means and  
2347 the joint committee on health care financing.

2348 SECTION 67. Section 2 of chapter 176O of the General Laws, as appearing in the 2020  
2349 Official Edition, is hereby amended by inserting, after subsection (d) the following subsection:-

2350 (d ½) A carrier that contracts with a pharmacy benefit manager shall (i) be responsible for  
2351 coordinating an audit, at least once per year, of the operations of the pharmacy benefit manager  
2352 to ensure compliance with the provisions of this chapter and to examine the pricing and rebates  
2353 applicable to prescription drugs that are provided to the carrier's covered persons; and (ii) require  
2354 that the pharmacies with which the pharmacy benefit manager contracts have systems in place to  
2355 ensure that the insured, at the point of sale for any prescription, is charged the lower of: the

2356 applicable cost sharing amount under the terms of the insured's health benefit plan; the pharmacy  
2357 benefits manager's contracted rate of payment to the pharmacy for the prescription drug; or the  
2358 retail price of the prescription drug if purchased without insurance.

2359 SECTION 68. Subsection (a) of section 6 of said chapter 176O, as so appearing, is  
2360 hereby further amended by striking out paragraph (4) and inserting in place thereof the following  
2361 paragraph:-

2362 (4) the locations where, and the manner in which, health care services and other benefits  
2363 may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or  
2364 service that is a medically necessary covered benefit is not available to an insured within the  
2365 carrier's network, the carrier shall cover the out-of-network admission, procedure or service and  
2366 the insured will not be responsible to pay more than the amount which would be required for  
2367 similar admissions, procedures or services offered within the carrier's network; (ii) an  
2368 explanation that whenever a location is part of the carrier's network, that the carrier shall cover  
2369 medically necessary covered benefits delivered at that location and the insured shall not be  
2370 responsible to pay more than the amount required for network services even if part of the  
2371 medically necessary covered benefits are performed by out-of-network providers, in accordance  
2372 with subsection (b) of section 30; and (iii) a summary description of the insured's telehealth  
2373 coverage and access to telehealth services, including, but not limited to, behavioral health  
2374 services, chronic disease management and primary care services via telehealth, as well as the  
2375 telecommunications technology available to access telehealth services.

2376 SECTION 69. Said subsection (a) of said section 6 of said chapter 176O, as so appearing,  
2377 is hereby further amended by striking out paragraph (8) and inserting in place thereof the  
2378 following paragraph:-

2379 (8) a summary description of the procedure, if any, for out-of-network referrals and any  
2380 additional charge for utilizing out-of-network providers, and a description of the protections  
2381 related to unforeseen out-of-network services detailed in this chapter.

2382 SECTION 70. Section 9A of said chapter 176O, as so appearing, is hereby further  
2383 amended by striking out subsection (a) and inserting in place thereof the following subsection:-

2384 (a)(i) limits the ability of the carrier to introduce or modify a select network plan or tiered  
2385 network plan by granting the health care provider a guaranteed right of participation; (ii) requires  
2386 the carrier to place all members of a provider group, whether local practice groups or facilities, in  
2387 the same tier of a tiered network plan; (iii) requires the carrier to include all members of a  
2388 provider group, whether local practice groups or facilities, in a select network plan on an all-or-  
2389 nothing basis.

2390 SECTION 71. Subsection (i) of section 27 of said chapter 176O, as so appearing, is  
2391 hereby amended by adding the following sentence:-

2392 The common summary of payments form shall include, but not be limited to, protections  
2393 related to unforeseen out-of-network services.

2394 SECTION 72. Said chapter 176O of the General Laws is hereby further amended by  
2395 adding the following 3 sections:-

2396 Section 30. (a) As used in this section, “unforeseen out-of-network services” shall mean  
2397 the following: (1) health care services rendered by an out-of-network provider for emergency  
2398 medical conditions or any associated admission or care resulting from an emergency medical  
2399 condition; (2) non-emergency health care services rendered by an out-of-network provider at an  
2400 in-network facility, including but not limited to: (i) services for emergency medicine,  
2401 anesthesiology, pathology, radiology, or neonatology, or services rendered by assistant surgeons,  
2402 hospitalists, and intensivists; (ii) health care services rendered by an out-of-network provider  
2403 without the insured’s advanced knowledge, pursuant to the requirements set forth in subsections  
2404 (b) through (e) of section 228 of chapter 111; (iii) health care services provided by an out-of-  
2405 network provider if there is no in-network provider who can furnish such health care service at  
2406 such facility; or (iv) health care services rendered by an out-of-network provider, including an  
2407 out-of-network laboratory, radiologist, or pathologist, where the health care services were  
2408 referred, or an insured’s specimen was sent, by a participating provider to an out-of-network  
2409 provider; or (v) unforeseen health care services that arise at the time health care services are  
2410 rendered that must necessarily be rendered by an out-of-network provider; provided, however  
2411 that “unforeseen out-of-network services” shall not include a service received by an insured for  
2412 health care services when a participating provider is available and the insured knowingly,  
2413 voluntarily and specifically elects to obtain services from an out-of-network provider.

2414 (b) Consistent with subsection (e) of section 228 of chapter 111, if an insured receives  
2415 unforeseen out-of-network services, the insured shall only be required to pay the applicable  
2416 coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for  
2417 such health care services if the services were rendered by a participating provider. Payments  
2418 made by an insured pursuant to this section shall count towards any in-network deductible or

2419 out-of-pocket maximum pursuant to the terms and conditions of an insured's health benefit plan.  
2420 Pursuant to subsection (e) of section 228 of chapter 111, an out-of-network provider shall not bill  
2421 the insured in excess of the applicable coinsurance, copayment, deductibles or other out-of-  
2422 pocket expenses that would be imposed for such health care services if rendered by a  
2423 participating provider.

2424 (c) If an insured receives unforeseen out-of-network services, benefits provided by a  
2425 carrier that the insured receives for such services shall be assigned to the out-of-network  
2426 provider, and shall require no action on the part of the insured. Once the benefit is assigned as  
2427 provided in this subsection, any payment paid by the carrier shall be paid directly to the out-of-  
2428 network provider, and the carrier shall provide the out-of-network provider with a written  
2429 remittance of payment that specifies the payment and the amount of any applicable coinsurance,  
2430 copayment, deductible, or other out-of-pocket expense owed by the insured.

2431 (d) When an out-of-network provider renders unforeseen out-of-network services to an  
2432 insured, in accordance with subsection (c) the carrier shall pay the out-of-network provider  
2433 directly in the amount of the carrier's median in-network rate for the health care services, as  
2434 further defined in regulation pursuant to subsection (g), minus any member cost-sharing in the  
2435 form of the applicable coinsurance, copayment or deductible. Such regulation shall include the  
2436 appropriate calculation of the carrier's median in-network rate including but not limited to the  
2437 following instances when an out-of-network provider renders unforeseen out-of-network  
2438 services: (i) the out-of-network provider contracts with a carrier to participate in the carrier's  
2439 network but does not contract with the carrier for the specific health benefit plan in which an  
2440 insured is enrolled, (ii) the out-of-network provider and carrier have more than 1 contract for  
2441 health benefit plans; (iii) the out-of-network provider does not contract with the carrier to

2442 participate in any of the carrier's network plans, policies, contracts, or other arrangements; and  
2443 (iv) there is insufficient information to calculate the carrier's median in-network rate.

2444 (e) With respect to an entity providing or administering a self-funded health benefit plan  
2445 governed by the provisions of the federal Employee Retirement Income Security Act of 1974, 29  
2446 U.S.C. § 1001 et seq. and its plan members, this section shall only apply if the plan elects to be  
2447 subject to the provisions of this section. To elect to be subject to the provisions of this section,  
2448 the self-funded health benefit plan shall provide notice to the division on an annual basis, in a  
2449 form and manner prescribed by the division, attesting to the plan's participation and agreeing to  
2450 be bound by the provisions of this section. The self-funded health benefit plan shall amend the  
2451 health benefit plan, coverage policies, contracts and any other plan documents to reflect that the  
2452 benefits of this section shall apply to the plan's members.

2453 (f) In a form and manner to be prescribed by the division, carriers shall indicate to  
2454 insureds that the plan is subject to these provisions. In the case of self-funded health benefit  
2455 plans that elect to be subject to this section pursuant to subsection (e), the plan shall indicate that  
2456 it is self-funded and has elected to be subject to these provisions.

2457 (g) In consultation with the health policy commission and the center for health  
2458 information and analysis, the commissioner shall promulgate regulations to implement this  
2459 section.

2460 (h) This section shall not be construed to require a carrier to cover health care services  
2461 not required by law or by the terms and conditions of an insured's health benefit plan.

2462 Section 31. (a) As used in this section, "facility fee" shall have the meaning as provided  
2463 in section 51L of chapter 111.



2464 (b) A carrier shall not provide reimbursement for a facility fee for a service for which a  
2465 facility fee is prohibited pursuant to section 51L of chapter 111.

2466 (c) Nothing in this section shall be construed to prohibit a carrier from restricting the  
2467 reimbursement of facility fees beyond the limitations set forth in section 51L of chapter 111.

2468 Section 32. (a) A carrier, or a pharmacy benefits manager under contract with a carrier,  
2469 shall use a single maximum allowable cost list to establish the maximum amount to be paid by a  
2470 health plan to a pharmacy provider for a generic drug or a brand-name drug that has at least one  
2471 generic alternative available. A carrier, or a pharmacy benefits manager under contract with a  
2472 carrier, shall use the same maximum allowable cost list for each pharmacy provider.

2473 (b) A maximum allowable cost may be set for a prescription drug, or a prescription drug  
2474 may be allowed to continue on a maximum allowable cost list, only if that prescription drug: (i)  
2475 is rated as “A” or “B” in the most recent version of the United States Food and Drug  
2476 Administration’s “Approved Drug Products with Therapeutic Equivalence Evaluations,” also  
2477 known as “the Orange Book,” or an equivalent rating from a successor publication, or is rated as  
2478 “NR” or “NA” or a similar rating by a nationally recognized pricing reference; and (ii) is  
2479 available for purchase in Massachusetts from a national or regional wholesale distributor by  
2480 pharmacies having a contract with the pharmacy benefits manager.

2481 (c) A carrier, or a pharmacy benefits manager under contract with a carrier, shall establish  
2482 a process for removing a prescription drug from a maximum allowable cost list or modifying a  
2483 maximum allowable cost for a prescription drug in a timely manner to reflect changes to such  
2484 costs and the availability of the drug in the national marketplace.

2485 (d) With regard to a pharmacy with which the carrier, or the pharmacy benefits manager  
2486 under contract with a carrier, has entered into a contract, a carrier, or a pharmacy benefits  
2487 manager under contract with a carrier, shall: (i) upon request, disclose the sources used to  
2488 establish the maximum allowable costs; (ii) provide a process for a pharmacy to readily obtain  
2489 the maximum allowable payment available to that pharmacy under a maximum allowable cost  
2490 list; and (iii) at least once every 7 business days, review and update maximum allowable cost list  
2491 information to reflect any modification of the maximum allowable payment available to a  
2492 pharmacy under a maximum allowable cost list used by the carrier or the pharmacy benefits  
2493 manager under contract with a carrier.

2494 SECTION 73. Notwithstanding any general or special law to the contrary, the secretary  
2495 of health and human services may expend from the Health Information Technology Trust Fund,  
2496 established pursuant to section 35RR of chapter 10 of the General Laws, any grants, premiums,  
2497 gifts, reimbursements, or other contributions received by the commonwealth for the purposes  
2498 described in subsection (a) of the Portable Order for Life Sustaining Treatment Trust Fund,  
2499 established under section 2UUUUU of chapter 29 of the General Laws, provided that any grants,  
2500 premiums, gifts, reimbursements, or other contributions received by the commonwealth for said  
2501 purposes remaining in the Health Information Technology Trust Fund as of the effective date of  
2502 this act shall be transferred to the Portable Order for Life Sustaining Treatment Trust Fund.

2503 SECTION 74. Notwithstanding any general or special law to the contrary, the division of  
2504 insurance shall develop a 3-year pilot program to permit at least 1 but no more than 6 small  
2505 business group purchasing cooperatives, as defined in section 1 of chapter 176J of the General  
2506 Laws, to be considered a large employer for the purposes of accessing affordable health  
2507 insurance coverage options. The total number of covered lives for all approved group purchasing

2508 cooperatives, in the aggregate, participating in this pilot program shall not exceed 85,000  
2509 covered lives. The division shall develop guidelines that shall include but not be limited to: (i)  
2510 ways to reduce premiums for members of small business group purchasing cooperatives and  
2511 their employees; (ii) any waiver of statutory or regulatory requirements to effectuate the pilot  
2512 program; and (iii) requirements for small business group purchasing cooperative participatory  
2513 wellness programming. The pilot program shall be implemented no later than 1 year from the  
2514 effective date of this act.

2515 Not later than 6 months after the conclusion of the pilot program, the division of  
2516 insurance shall issue a report including but not limited to the following information: (i) the  
2517 number of persons covered under this option for each year of the pilot program; (ii) the  
2518 availability of coverage offered over the span of the pilot program; (iii) an analysis of impact that  
2519 the pilot program has on the affordability of health coverage for the participating members and  
2520 their employees and whether there is any demonstrable impact on the merged market; and (iv)  
2521 recommendations regarding making the pilot program permanent.

2522 SECTION 75. Notwithstanding any general or special law to the contrary, the health  
2523 policy commission, in consultation with the center for health information and analysis and the  
2524 division of insurance, shall develop a report and make recommendations to retain or modify the  
2525 out-of-network payment amount established in subsection (d) of section 30 of chapter 176O of  
2526 the General Laws. The report shall include, but not be limited to, an examination of the impact of  
2527 the payment amount for out-of-network providers on: (i) provider participation in insurance  
2528 products, including tiered and limited network products; (ii) provider financial stability; (iii)  
2529 provider price variation; (iv) overall costs; (v) health care quality, (vi) patient access (vii) any  
2530 other factors that the commission determines to be in the public interest. Not later than 3 years

2531 following the effective date of said section 30 of said chapter 176O, the commission shall submit  
2532 its report to the joint committee on health care financing and the house and senate committees on  
2533 ways and means.

2534 SECTION 76. The commissioner of insurance shall promulgate regulations to implement  
2535 chapter 175N of the General Laws, as inserted by section 59, not later than 1 year after the  
2536 effective date of this act.

2537 SECTION 77. To implement chapter 63E of the General Laws, as inserted by section 26,  
2538 the commissioner of revenue shall promulgate regulations or other guidance regarding the  
2539 reporting and payment of the penalty as soon as practicable after the effective date of this act.

2540 SECTION 78. Notwithstanding any general or special law to the contrary, in making  
2541 initial appointments to the board of registration of certified peer workers established in section  
2542 21, the governor shall appoint 12 members, 4 of whom shall be appointed for a term of 1 year, 4  
2543 of whom shall be appointed for a term of 2 years, and 4 of whom shall be appointed for a term of  
2544 3 years. The governor shall make all initial appointments no later than January 1, 2023.

2545 SECTION 79. Chapter 63E of the General Laws, as inserted by section 26, shall apply to  
2546 sales commencing on or after the effective date of this act.

2547 SECTION 80. Section 54 shall take effect on July 1, 2023.