

SENATE No. 2796

Senate, June 25, 2020– Text of the Senate Bill Putting Patients First (being the text of Senate, No. 2769, printed as amended)

The Commonwealth of Massachusetts

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

An Act Putting Patients First.

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

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

3 Section 16A. (a) The commission shall, upon consideration of advice or any other
4 pertinent evidence, recommend the noncontracted commercial rate for emergency services and
5 the noncontracted commercial rate for nonemergency services, as defined in section 1 of chapter
6 176O. The noncontracted commercial rate for emergency services and the noncontracted
7 commercial rate for nonemergency services shall be in effect for a term of 5 years and shall
8 apply to payments under clauses (ii) and (iv) of paragraph (1) of subsection (a) of section 29 of
9 said chapter 176O.

10 (b) In recommending rates, the commission shall consider:

11 (i) existing contracted rates by public and private payers and the appropriateness of those
12 rates for covering the cost of care;

13 (ii) the impact of each rate on: (A) patient access to health care services by geographic
14 location; (B) the growth of total health care expenditures; (C) encouraging in-network
15 participation by health care providers; (D) financial stability of health care providers and
16 systems; (E) insurance premiums; and (F) provider price variation;

17 (iii) utilization of the rates by self-insured health plans;

18 (iv) ease of transparency in calculating the rates and ease of administration by health care
19 providers and carriers;

20 (v) the advisability of establishing a process for providers or payers to dispute the
21 accuracy or appropriateness of a rate;

22 (vi) best practices in other states; and

23 (vii) any other factor that the commission deems relevant.

24 In developing its recommendations, the commission shall determine that the
25 recommended rates do not have a negative impact on the delivery of care by health care
26 providers predominately serving communities that experience health disparities as a result of
27 race, ethnicity, socioeconomic status or other status as determined by the commission. The
28 commission shall not issue its recommendations for the noncontracted commercial rate for
29 emergency services and the noncontracted commercial rate for nonemergency services without
30 the approval of the board established under subsection (b) of section 2.

31 (c) Prior to recommending the rates, the commission shall hold a public hearing. The
32 hearing shall examine current rates paid for in-network and out-of-network services and the
33 impact of those rates on the operation of the health care delivery system and determine, based on

34 the provided testimony, information and data, an appropriate noncontracted commercial rate for
35 emergency services and an appropriate noncontracted commercial rate for nonemergency
36 services consistent with subsection (b). The commission shall provide notice to the public and
37 division of insurance of the hearing not less than 45 days before the date of the hearing and the
38 division may participate in the hearing. The commission shall identify as witnesses for the public
39 hearing a representative sample of providers, provider organizations, payers and other interested
40 parties as the commission may determine. Any interested party may testify at the hearing.

41 (d) If the board approves the recommended rates pursuant to subsection (b), the
42 commission shall submit the recommended rates to the division of insurance. Not later than 45
43 days after the recommended rates have been submitted, the division may hold a public hearing
44 on the recommended rates. The division shall provide public notice of the hearing not less than 7
45 days before the date of the hearing. The division shall identify as witnesses for the public hearing
46 a representative sample of providers, provider organizations, payers and other interested parties
47 as the division may determine. Any interested party may testify at the hearing. Not later than 7
48 days after the division's public hearing, the division shall accept and implement the
49 commission's recommended rates or the division may reject the commission's recommended
50 rates; provided, however, that if the division rejects the commission's recommended rates, the
51 division shall, within 20 days of the division's rejection, report in writing to the commission, the
52 clerks of the senate and house of representatives and the joint committee on health care financing
53 the reasons for the division's rejection. Within 30 days of receipt of the division's rejection of
54 the commission's recommended rates, the commission shall recommend amended rates based on
55 the division's written rejection. If the division takes no action to accept or reject the
56 commission's recommended rates, the recommended rates shall automatically take effect as the

57 noncontracted commercial rate for emergency services and noncontracted commercial rate for
58 nonemergency services 30 days after the commission submitted said rates to the division and
59 shall be in effect for the applicable 5-year term.

60 (e) The commission shall conduct a review of established rates in the fourth year of the
61 rates' operation. The commission shall hold a public hearing under subsection (c) in said fourth
62 year and recommend rates consistent with this section to be effective for the next 5-year term.

63 (f) The noncontracted commercial rate for emergency services and the noncontracted
64 commercial rate for nonemergency services established under subsection (d) shall be calculated
65 by the center for health information and analysis as provided in section 25 of chapter 12C.

66 SECTION 2. Chapter 12C of the General Laws is hereby amended by adding the
67 following section:-

68 Section 25. The center shall calculate the noncontracted commercial rate for emergency
69 services and the noncontracted commercial rate for nonemergency services established under
70 subsection (d) of section 16A of chapter 6D. The center may contract with a nonprofit
71 organization with expertise in independent analysis of payment rates for health care services to
72 assist the center in calculating the noncontracted commercial rate for emergency services and the
73 noncontracted commercial rate for nonemergency services; provided, however, that such
74 organization shall not be affiliated with a health carrier or a health care provider.

75 SECTION 3. Chapter 32A of the General Laws is hereby amended by adding the
76 following section:-

77 Section 30. (a) For the purposes of this section, “telehealth” shall mean the use of
78 synchronous or asynchronous audio, video, electronic media or other telecommunications
79 technology, including, but not limited to, text messaging, application-based communications and
80 online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing,
81 treating or monitoring a patient’s physical, oral, mental health or substance use disorder
82 condition; provided, however, that “telehealth” may include text-only email when it occurs for
83 the purpose of patient management in the context of a pre-existing physician-patient relationship.

84 (b) Coverage offered by the commission to an active or retired employee of the
85 commonwealth insured under the group insurance commission shall provide coverage for health
86 care services via telehealth by a contracted health care provider; provided, however, that the
87 commission, or its carriers or other contracted entities providing health benefits, shall not meet
88 network adequacy through significant reliance on telehealth providers and shall not be
89 considered to have an adequate network if patients are not able to access appropriate in-person
90 services in a timely manner upon request. Health care services delivered via telehealth shall be
91 covered to the same extent as if they were provided via in-person consultation or delivery.
92 Coverage shall not be limited to services delivered by third-party providers.

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

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

104 (e) Coverage for telehealth services may include a deductible, copayment or coinsurance
105 requirement for a health care service provided via telehealth as long as the deductible,
106 copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable
107 to an in-person consultation or in-person delivery of services.

108 (f) Health care services provided by telehealth shall conform to the standards of care
109 applicable to the telehealth provider's profession. Such services shall also conform to applicable
110 federal and state health information privacy and security standards as well as standards for
111 informed consent.

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

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

119 SECTION 5. Said section 1 of said chapter 94C, as so appearing, is hereby further
120 amended by striking out, in line 290, the words "a practitioner, registered nurse, or practical

121 nurse” and inserting in place thereof the following words:- an individual who is authorized to
122 administer such medication under this chapter.

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

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

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

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

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

140 SECTION 8. Said section 1 of said chapter 94C, as so appearing, is hereby further
141 amended by striking out, in lines 367 and 368, the words “a practitioner, registered nurse or

142 licensed practical nurse” and inserting in place thereof the following words:- an individual who
143 is authorized to administer such medication under this chapter.

144 SECTION 9. Section 7 of said chapter 94C, as so appearing, is hereby amended by
145 inserting after the word “nurse”, in line 80, the second time it appears, the following words:- , a
146 licensed dental therapist under the supervision of a practitioner for the purposes of administering
147 analgesics, anti-inflammatories and antibiotics.

148 SECTION 10. Said section 7 of said chapter 94C, as so appearing, is hereby further
149 amended by inserting after the word “podiatrist”, in line 122, the following words:- , nurse
150 practitioner, nurse anesthetist, psychiatric nurse mental health clinical specialist.

151 SECTION 11. Said section 7 of said chapter 94C, as so appearing, is hereby further
152 amended by inserting after the word “podiatrist,” in lines 125 and 126, the following words:-
153 nurse practitioner, nurse anesthetist, psychiatric nurse mental health clinical specialist.

154 SECTION 12. Subsection (g) of said section 7 of said chapter 94C, as so appearing, is
155 hereby amended by striking out the second paragraph.

156 SECTION 13. Said subsection (g) of said section 7 of said chapter 94C, as so appearing,
157 is hereby further amended by striking out the last paragraph.

158 SECTION 14. Said section 7 of said chapter 94C, as so appearing, is hereby further
159 amended by striking out, in line 213, the words “and 66B” and inserting in place thereof the
160 following words:- , 66B and 66C.

161 SECTION 15. Section 9 of said chapter 94C, as so appearing, is hereby amended by
162 inserting after the word “podiatrist”, in line 1, the following words:- , nurse practitioner, nurse
163 anesthetist, psychiatric nurse mental health clinical specialist.

164 SECTION 16. Said section 9 of said chapter 94C, as so appearing, is hereby further
165 amended by striking out, in line 2, the words “and 66B” and inserting in place thereof the
166 following words:- , 66B and 66C.

167 SECTION 17. Said section 9 of said chapter 94C, as so appearing, is hereby further
168 amended by striking out, in lines 3 to 5, inclusive, the words “, nurse practitioner and psychiatric
169 nurse mental health clinical specialist as limited by subsection (g) of said section 7 and section
170 80E of said chapter 112”.

171 SECTION 18. Said section 9 of said chapter 94C, as so appearing, is hereby further
172 amended by striking out, in lines 8 and 9, the words “, nurse anesthetist, as limited by subsection
173 (g) of said section 7 and section 80H of said chapter 112”.

174 SECTION 19. Subsection (a) of said section 9 of said chapter 94C, as so appearing, is
175 hereby amended by adding the following paragraph:-

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

179 SECTION 20. Said section 9 of said chapter 94C, as so appearing, is hereby further
180 amended by inserting after the word “nurse-midwifery”, in line 32, the following words:- ,
181 advanced practice nursing.

182 SECTION 21. Said section 9 of said chapter 94C, as so appearing, is hereby further
183 amended by inserting after the word “podiatrist”, in lines 72 and 80, each time it appears, the
184 following word:- , optometrist.

185 SECTION 22. Subsection (c) of said section 9 of said chapter 94C, as so appearing, is
186 hereby amended by adding the following paragraph:-

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

190 SECTION 23. Said section 9 of said chapter 94C, as so appearing, is hereby further
191 amended by inserting after the word “practitioner”, in lines 100 and 107, each time it appears,
192 the following words:- , nurse anesthetist, psychiatric nurse mental health clinical specialist.

193 SECTION 24. Section 18 of said chapter 94C, as so appearing, is hereby amended by
194 striking out, in lines 10, 39, 72, 115 and 116, the words “to practice medicine” and inserting in
195 place thereof, in each instance, the following words:- and authorized to engage in prescriptive
196 practice.

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

200 SECTION 26. Said section 18 of said chapter 94C, as so appearing, is hereby further
201 amended by striking out, in lines 27, 54 and 55 and 88, the word “medicine”.

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

205 SECTION 28. Said chapter 111 is hereby further amended by striking out section 228, as
206 so appearing, and inserting in place thereof the following section:-

207 Section 228. (a) For the purposes of this section, the following word shall have the
208 following meaning unless the context clearly requires otherwise:

209 “Allowed amount”, the contractually agreed-upon maximum amount paid by a carrier to
210 a health care provider for a health care service provided to an insured.

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

222 (2) If the health care provider is participating in the patient’s or prospective patient’s
223 health benefit plan, the health care provider shall, at the time of scheduling the admission,

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

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

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

249 (c) A health care provider referring a patient to another provider shall disclose: (i) if the
250 provider to whom the patient is being referred is part of or represented by the same provider
251 organization as used in section 11 of chapter 6D; (ii) the possibility that the provider to whom
252 the patient is being referred is not participating in the patient's health benefit plan and that if the
253 provider is out-of-network under the terms of the patient's health benefit plan then any out-of-
254 network applicable rates under such health benefit plan may apply and that the patient has the
255 opportunity to verify whether the provider participates in the patient's health benefit plan prior to
256 making an appointment or agreeing to use the services of said provider; and (iii) sufficient
257 information about the referred provider for the patient to obtain additional information about the
258 provider's network status under the patient's health plan and any applicable out-of-pocket costs
259 for services sought from the referred provider pursuant to section 23 of chapter 176O.

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

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

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

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

290 SECTION 29. Chapter 112 of the General Laws is hereby amended by striking out
291 section 13, as so appearing, and inserting in place thereof the following section:-

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

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

296 (c) Sections 13 to 18, inclusive, shall not apply to surgeons of the United States army,
297 United States navy or of the United States Public Health Service or to physicians registered in
298 the commonwealth.

299 SECTION 30. Section 43A of said chapter 112, as so appearing, is hereby amended by
300 inserting after the definition of “Appropriate supervision” the following 2 definitions:-

301 “Board”, the board of registration in dentistry established under section 19 of chapter 13
302 or a committee or subcommittee of the board.

303 “Collaborative management agreement”, a written agreement that complies with section
304 51B between a local, state or federal government agency or institution or a licensed dentist and a
305 dental therapist outlining the procedures, services, responsibilities and limitations of the
306 therapist.

307 SECTION 31. Said section 43A of said chapter 112, as so appearing, is hereby further
308 amended by inserting after the definition of “Dental supervision” the following definition:-

309 “Dental therapist”, a person who: (i) is registered by the board to practice as a dental
310 therapist pursuant to section 51B and as a dental hygienist pursuant to section 51; and (ii)
311 provides oral health care services pursuant to said section 51B.

312 SECTION 32. Said section 43A of said chapter 112, as so appearing, is hereby further
313 amended by adding the following definition:-

314 “Supervising dentist”, a dentist licensed in the commonwealth pursuant to section 45 who
315 enters into a collaborative management agreement with a dental therapist.

316 SECTION 33. Section 51½ of said chapter 112, as so appearing, is hereby amended by
317 inserting after the word “dentist” in lines 53 and 75, in each instance, the following words:- , a
318 licensed dental therapist to the extent provided in section 51B.

319 SECTION 34. Said section 51½ of said chapter 112, as so appearing, is hereby further
320 amended by inserting after the word “practice”, in line 78, the following words:- , a dental
321 therapist licensed under section 51B.

322 SECTION 35. Said chapter 112 is hereby further amended by inserting after section 51A
323 the following section:-

324 Section 51B. (a) As used in this section, the following words shall have the following
325 meanings unless the context clearly requires otherwise:

326 “Advanced procedures”, the following services performed under direct supervision: (i)
327 preparation and placement of direct restoration in primary and permanent teeth; (ii) fabrication
328 and placement of single-tooth temporary crowns; (iii) preparation and placement of preformed
329 crowns on primary teeth; (iv) indirect and direct pulp capping on permanent teeth; (v) indirect
330 pulp capping on primary teeth; and (vi) simple extractions of erupted primary teeth; provided,
331 however, that “advanced procedures” may be performed under general supervision if authorized
332 by the board pursuant to subsection (f).

333 “General supervision”, notwithstanding section 43A, supervision of procedures and
334 services based on a written collaborative management agreement between a licensed dentist and
335 a licensed dental therapist; provided, however, that “general supervision” shall not require a prior
336 exam or diagnosis by a supervising dentist or the physical presence of a supervising dentist
337 during the performance of those procedures and services unless required by the supervising
338 dentist in the collaborative management agreement.

339 “Individuals who are underserved”, individuals who: (i) qualify for benefits through
340 MassHealth or its contracted health insurers, health plans, health maintenance organizations,
341 behavioral health management firms and third-party administrators under contract to a
342 MassHealth managed care organization or primary care clinician plan; (ii) qualify for federal
343 Social Security Disability Benefits, federal Supplemental Security Income or state
344 supplementary payments; (iii) reside in a dental health professional shortage area as designated
345 by the United States Department of Health and Human Services; (iv) reside in a nursing home,
346 skilled nursing facility, veterans home or long-term care facility; (v) receive dental services in a
347 public health setting as defined by the board by regulation; (vi) qualify to receive benefits
348 through plans sold by the commonwealth health insurance connector; (viii) qualify to receive
349 benefits through the federal Indian Health Service, tribal or urban Indian organizations or the
350 federal Contract Health Service Program; (ix) qualify to receive benefits through the department
351 of veterans’ services or other organizations serving veterans; (x) are elderly and have trouble
352 accessing dental care due to mobility or transportation challenges; (xi) meet the Commission on
353 Dental Accreditation’s definition of people with special needs; (xii) are uninsured and living at
354 305 per cent of the federal poverty level; or (xiii) meet other eligibility criteria established by the
355 board.

356 (b) A person of good moral character shall be registered as a dental therapist if the
357 person: (i) is a graduate of a master's level dental therapist education program that includes both
358 dental therapy and dental hygiene education, or an equivalent combination of both dental therapy
359 education and dental hygiene education, if all education programs: (A) are accredited by the
360 Commission on Dental Accreditation and provided by a post-secondary institution accredited by
361 the New England Association of Schools and Colleges, Inc. or an equivalent accrediting body, or
362 (B) otherwise meet criteria established by the board; (ii) passes a comprehensive, competency-
363 based clinical examination approved by the board and administered by a recognized national or
364 regional dental testing service that administers testing for dentists and other dental professionals
365 or an equivalent examination administered by another entity approved by the board; (iii) obtains
366 a policy of professional liability insurance and shows proof of such insurance as required by
367 rules and regulations promulgated by the board; and (iv) pays a fee determined annually by the
368 secretary of administration and finance under section 3B of chapter 7.

369 A person who has met the requirements to be registered as a dental therapist under this
370 section may also be registered as a dental hygienist.

371 (c) A dental therapy educational program offered in the commonwealth shall have at least
372 1 instructor who is a licensed dentist. The board shall provide guidance for any educational entity
373 or institution that may operate all or some portion of a master's level program or may collaborate
374 with other educational entities, including, but not limited to, universities, colleges, community
375 colleges and technical colleges, to operate all or some portion of a master's level program. The
376 board may also provide guidance to award advanced standing to students who have completed
377 coursework at other educational programs accredited by the Commission on Dental
378 Accreditation or another program that meets criteria established by the board. An educational

379 program shall prepare students to perform all procedures and services, including advanced
380 procedures under general supervision, under this section.

381 Dental therapist educational curriculum offered in the commonwealth shall include, but
382 not be limited to, training related to serving patients with targeted dental care needs because of
383 developmental disability, including an autism spectrum disorder, mental illness, cognitive
384 disability, complex medical needs or significant physical disability or because of dental needs
385 specific to aging adults.

386 (d) The board shall grant a dental therapy license by examination to an applicant of good
387 moral character who: (i) meets the eligibility requirements as defined by the board; (ii) submits
388 documentation to the board of a passing score on a comprehensive, competency-based clinical
389 examination or combination of examinations that include both dental therapy and dental hygiene
390 components and are approved by the board and administered by a recognized national or regional
391 dental testing service that administers testing for dentists and other dental professionals; and (iii)
392 submits to the board documentation of a passing score on the Massachusetts Dental Ethics and
393 Jurisprudence Examination or a successor examination. An applicant failing to pass the
394 examination shall be entitled to re-examination pursuant to the rules and guidelines established
395 by the Commission on Dental Competency Assessments.

396 A licensed dental therapist shall have practiced under the direct supervision of a
397 supervising dentist for not less than 2 years or 2,500 hours, whichever is longer, before
398 practicing under general supervision pursuant to a collaborative management agreement;
399 provided, however, that direct supervision shall be provided pursuant to a collaborative
400 management agreement. A dental therapist license shall be active for a period of 2 years and

401 eligible for renewal for a subsequent 2-year period; provided, however, that upon receipt of a
402 license under section 45, a dental therapy license granted under this section shall be void.

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

412 The board shall grant a license by credentials, without further professional examination,
413 to a dental therapist licensed in another jurisdiction if the applicant is of good moral character
414 and has: (i) met the eligibility requirements as defined by the board; (ii) furnished the board with
415 satisfactory proof of graduation from an education program or combination of education
416 programs providing both dental therapy and dental hygiene education that meets the standards of
417 the Commission on Dental Accreditation; provided, however, that an applicant who graduated
418 from a dental therapy education program established before the Commission on Dental
419 Accreditation established a dental therapy accreditation program is eligible notwithstanding the
420 lack of accreditation of the program at the time the education was received; (iii) submitted
421 documentation of a passing score on a dental therapy examination administered by another state
422 or testing agency that is substantially equivalent to the board-approved dental therapy
423 examination for dental therapists as defined in this section; (iv) submitted documentation of a

424 passing score on the Massachusetts Dental Ethics and Jurisprudence Examination or a successor
425 examination; and (v) submitted documentation of completion of 2 years or 2,500 hours,
426 whichever is longer, of practice; provided, however, that if such practice requirement is not met,
427 a dental therapist shall complete the remaining hours or years, whichever is longer, under direct
428 supervision in the commonwealth before practicing under general supervision.

429 (e) Pursuant to a collaborative management agreement, a dental therapist licensed and
430 registered by the board may perform: (i) all acts of a public health dental hygienist as set forth in
431 regulations of the board under general supervision; (ii) all acts in the Commission on Dental
432 Accreditation's dental therapy standards under general supervision; and (iii) advanced
433 procedures.

434 A dental therapist, as authorized in a collaborative management agreement, may: (i)
435 perform an oral evaluation and assessment of dental disease and formulate an individualized
436 treatment plan; and (ii) dispense and administer, unless further limited by a collaborative
437 management agreement, non-narcotic analgesics, anti-inflammatories and antibiotics. A dental
438 therapist shall not dispense or administer narcotic analgesics. A dental therapist shall not oversee
439 more than 2 dental hygienists and 2 dental assistants; provided, however, a dental therapist shall
440 not oversee a public health dental hygienist.

441 Pursuant to a collaborative management agreement, a dental therapist may provide
442 procedures and services permitted under general supervision when the supervising dentist is not
443 on-site and has not previously examined or diagnosed the patient provided the supervising
444 dentist is available for consultation and supervision as needed through either telemedicine, as
445 defined in section 47CC of chapter 175, or by other means of communication. Arrangements

446 shall be made in a collaborative management agreement for another licensed dentist to be
447 available to provide timely consultation and supervision if the supervising dentist is unavailable.
448 A dental therapist shall not operate independently of a supervising dentist and shall not practice
449 or treat any patients without a supervising dentist or a collaborative management agreement with
450 a supervising dentist.

451 (f) The department, in consultation with the board, shall regularly review and
452 recommend: (i) whether a dental therapist may be authorized to perform 1 or more advanced
453 procedures under general supervision pursuant to a collaborative management agreement; and
454 (ii) appropriate geographic distance limitations between a dental therapist and supervising dentist
455 to increase access to dental therapist services by populations including, but not limited to,
456 Medicaid beneficiaries and individuals who are underserved. The department shall submit its
457 recommendation to the board and if the board authorizes the performance of 1 or more advanced
458 procedure under general supervision pursuant to a collaborative management agreement after
459 receiving advanced practice certification, the board shall promulgate regulations implementing
460 the authorization of the advanced procedure not later than 6 months from the determination.

461 The board shall grant advanced practice certification for a dental therapist licensed and
462 registered by the board to perform all services and procedures within the authorized scope of
463 practice under general supervision pursuant to a collaborative management agreement if the
464 dental therapist provides documentation of completion of the required supervised practice hours
465 pursuant to subsection (b) and satisfies any other criteria established by regulation promulgated
466 by the board as authorized in this section.

467 (g) A collaborative management agreement shall be signed and maintained by the
468 supervising dentist and the dental therapist and may be updated as necessary. The agreement
469 shall serve as standing orders from the supervising dentist and shall address: (i) practice settings;
470 (ii) any limitation on services established by the supervising dentist; (iii) the level of supervision
471 required for various services or treatment settings; (iv) patient populations that may be served;
472 (v) practice protocols; (vi) record keeping; (vii) managing medical emergencies; (viii) quality
473 assurance; (ix) administering and dispensing medications; (x) geographic distance limitations;
474 (xi) oversight of dental hygienists and dental assistants; and (xii) referrals for services outside of
475 the dental therapy scope of practice.

476 The collaborative management agreement shall include specific protocols if a dental
477 therapist encounters a patient who requires treatment that exceeds the authorized scope of the
478 collaborative management agreement. The supervising dentist shall be responsible for directly
479 providing, or arranging for another dentist or specialist within an accessible geographic distance
480 to provide, any necessary additional services outside of the collaborative management
481 agreement. A supervising dentist shall not have a collaborative management agreement with
482 more than 3 dental therapists at the same time. Not more than 2 such dental therapists may
483 practice under general supervision with certification to perform 1 or more advanced procedures.
484 A practice or organization with more than 1 practice location listed under the same business
485 name shall not employ more than 6 dental therapists; provided, however, that this requirement
486 shall not apply if such an organization or practice is a federally-qualified health center or look-
487 alike, a community health center, a non-profit practice or organization or a public health setting
488 as defined in regulations promulgated by the board of registration in dentistry or as otherwise
489 permitted by the board.

490 Each collaborative management agreement shall be filed with the board when it is first
491 entered into by a supervising dentist and dental therapist and biennially thereafter. The board
492 shall establish guidelines for collaborative management agreements.

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

498 (i) Not less than 50 per cent of the patient panel of a dental therapist, as determined in
499 each calendar year, shall consist of individuals who are underserved as defined in this section;
500 provided, however, that this requirement shall not apply if the dental therapist is operating in a
501 federally-qualified health center or look-alike, community-health center, non-profit practice or
502 organization or other public health setting as defined by the board by regulation or as otherwise
503 permitted by the board.

504 A dental therapist's employer shall submit quarterly reports on the makeup of the dental
505 therapist's patient panel.

506 (j) The board, in consultation with the department, shall establish regulations to
507 implement the provisions of this section.

508 SECTION 36. Said chapter 112 is hereby further amended by striking out section 66, as
509 appearing in the 2018 Official Edition, and inserting in place thereof the following section:-

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

518 SECTION 37. Section 66B of said chapter 112, as so appearing, is hereby amended by
519 striking out, in line 31, the following words:- , except glaucoma.

520 SECTION 38. Said chapter 112 is hereby further amended by inserting after section 66B
521 the following section:-

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

532 pharmaceutical agents administered by subdermal injection, intramuscular injection, intravenous
533 injection, subcutaneous injection, intraocular injection or retrobulbar injection; or (D) an opioid
534 substance or drug product.

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

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

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

549 SECTION 39. Said chapter 112 is hereby further amended by inserting after section 68B
550 the following section:-

551 Section 68C. (a) The board of registration in optometry shall administer an examination
552 to permit the use and prescription of therapeutic pharmaceutical agents as authorized in section
553 66C. The examination shall: (i) be held in conjunction with examinations provided for in

554 sections 68, 68A and 68B; and (ii) include any portion of the examination administered by the
555 National Board of Examiners in Optometry or other appropriate examination covering the
556 subject matter of therapeutic pharmaceutical agents as authorized in said section 66C. The board
557 may administer a single examination to measure the qualifications necessary under said sections
558 68, 68A, 68B and this section. The board shall qualify optometrists to use and prescribe
559 therapeutic pharmaceutical agents in accordance with said sections 68, 68A, 68B and this
560 section.

561 (b) Examination for the use and prescription of therapeutic pharmaceutical agents placed
562 in schedules III, IV, V and VI under section 2 of chapter 94C and defined in section 66C shall,
563 upon application, be open to an optometrist registered under section 68, 68A or 68B and to any
564 person who meets the qualifications for examination under said sections 68, 68A and 68B. An
565 applicant registered as an optometrist under said sections 68, 68A or 68B shall: (i) be registered
566 pursuant to subsection (h) of section 7 of said chapter 94C to use or prescribe pharmaceutical
567 agents for the purpose of diagnosing or treating glaucoma and other ocular abnormalities of the
568 human eye and adjacent tissue; and (ii) furnish to the board of registration in optometry evidence
569 of the satisfactory completion of 40 hours of didactic education and 20 hours of supervised
570 clinical education relating to the use and prescription of therapeutic pharmaceutical agents under
571 said section 66C; provided, however, that such education shall: (A) be administered by the
572 Massachusetts Society of Optometrists, Inc.; (B) be accredited by a college of optometry or
573 medicine; and (C) meet the guidelines and requirements of the board of registration in
574 optometry. The board of registration in optometry shall provide to each successful applicant a
575 certificate of qualification in the use and prescription of all therapeutic pharmaceutical agents as

576 authorized under said section 66C and shall forward to the department of public health notice of
577 such certification for each successful applicant.

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

587 (d) A licensed optometrist who has completed a postgraduate residency program
588 approved by the Accreditation Council on Optometric Education of the American Optometric
589 Association may submit an affidavit to the board of registration in optometry from the licensed
590 optometrist's residency supervisor or the director of residencies at the affiliated college of
591 optometry attesting that the optometrist has completed an equivalent level of instruction and
592 supervision and the board may accept the evidence in order to satisfy any of the requirements of
593 this section.

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

598 SECTION 40. Section 80B of said chapter 112, as appearing in the 2018 Official Edition,
599 is hereby amended by inserting after the word “practitioners”, in line 12, the following words:- ,
600 nurse anesthetists.

601 SECTION 41. Said section 80B of said chapter 112, as so appearing, is hereby further
602 amended by striking out the seventh paragraph and inserting in place thereof the following
603 paragraph:-

604 The board shall promulgate advanced practice nursing regulations that govern the
605 provision of advanced practice nursing services and related care including, but not limited to, the
606 ordering and interpreting of tests, the ordering and evaluation of treatment and the use of
607 therapeutics.

608 SECTION 42. Said section 80B of said chapter 112, as so appearing, is hereby further
609 amended by striking out, in lines 64 and 65, the words “in the ordering of tests, therapeutics and
610 the prescribing of medications,”.

611 SECTION 43. Said chapter 112 is hereby further amended by striking out section 80E, as
612 so appearing, and inserting in place thereof the following section:-

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

620 include the name of the supervising nurse practitioner who has independent practice authority,
621 the supervising psychiatric nurse mental health clinical specialist who has independent practice
622 authority or the supervising physician with whom the nurse practitioner or psychiatric nurse
623 mental health clinical specialist developed and signed mutually agreed upon guidelines.

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

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

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

640 SECTION 44. Said chapter 112 is hereby further amended by striking out section 80H, as
641 so appearing, and inserting in place thereof the following section:-

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

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

661 The board may allow a nurse anesthetist to exercise such independent practice authority
662 upon satisfactory demonstration of alternative professional experience if the board determines
663 that the nurse anesthetist has a demonstrated record of safe prescribing and good conduct

664 consistent with professional licensure obligations required by each jurisdiction in which the
665 nurse anesthetist has been licensed.

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

667 SECTION 45. Section 80I of said chapter 112, as so appearing, is hereby amended by
668 striking out the second and third sentences.

669 SECTION 46. Said chapter 112 is hereby further amended by inserting after section 80I
670 the following 2 sections:-

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

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

684 SECTION 47. The definition of “core competencies” in section 259 of said chapter 112,
685 as appearing in the 2018 Official Edition, is hereby amended by striking out clauses (h) and (i)
686 and inserting in place thereof the following 3 clauses:-

687 (h) community capacity building;

688 (i) writing and technical communication skills; and

689 (j) oral health education.

690 SECTION 48. The second paragraph of section 260 of said chapter 112, as so appearing,
691 is hereby amended by adding the following sentence:- As a condition for licensure or renewal of
692 licensure, the board shall require community health workers to receive education or training in
693 oral health.

694 SECTION 49. Chapter 118E of the General Laws is hereby amended by adding the
695 following section:-

696 Section 79. (a) For the purposes of this section, “telehealth” shall mean the use of
697 synchronous or asynchronous audio, video, electronic media or other telecommunications
698 technology, including, but not limited to, text messaging, application-based communications and
699 online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing,
700 treating or monitoring a patient’s physical, oral, mental health or substance use disorder
701 condition; provided, however, that “telehealth” may include text-only email when it occurs for
702 the purpose of patient management in the context of a pre-existing physician-patient relationship.

703 (b) The division and its contracted health insurers, health plans, health maintenance
704 organizations, behavioral health management firms and third-party administrators under contract

705 to a Medicaid managed care organization, accountable care organization or primary care
706 clinician plan shall provide coverage for health care services provided via telehealth by a
707 contracted provider; provided, however, that Medicaid contracted health insurers, health plans,
708 health maintenance organizations, behavioral health management firms and third-party
709 administrators under contract to a Medicaid managed care organization or primary care clinician
710 plan shall not meet network adequacy through significant reliance on telehealth providers and
711 shall not be considered to have an adequate network if patients are not able to access appropriate
712 in-person services in a timely manner upon request. Health care services delivered via telehealth
713 shall be covered to the same extent as if they were provided via in-person consultation or
714 delivery. Coverage shall not be limited to services delivered by third-party providers.

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

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

728 (e) A contract that provides coverage for telehealth services may include a deductible,
729 copayment or coinsurance requirement for a health care service provided via telehealth as long as
730 the deductible, copayment or coinsurance does not exceed the deductible, copayment or
731 coinsurance applicable to an in-person consultation or in-person delivery of services.

732 (f) Health care services provided by telehealth shall conform to the standards of care
733 applicable to the telehealth provider's profession. Such services shall also conform to applicable
734 federal and state health information privacy and security standards as well as standards for
735 informed consent.

736 SECTION 50. Chapter 123 of the General Laws is hereby amended by striking out
737 section 11, as appearing in the 2018 Official Edition, and inserting in place thereof the following
738 section:-

739 Section 11. Any person retained in a facility under the provisions of paragraph (a) of
740 section 10 shall be free to leave such facility at any time, and a parent or guardian who requested
741 the admission of such person may withdraw such person at any time, upon giving written notice
742 to the superintendent. The superintendent may restrict the right to leave or withdraw to normal
743 working hours and weekdays and, in the superintendent's discretion, may require persons or the
744 parent or guardian of a person to give 3 days written notice of their intention to leave or
745 withdraw. If a person or their parent or guardian is required to give 3 days notice of intention to
746 leave or withdraw, an examination of the person may be conducted to determine their clinical
747 progress, their suitability for discharge and to investigate other aspects of their case, including
748 their legal competency and their family, home or community situation, in the interest of
749 discharging them from the facility. The person may be retained at the facility beyond the

750 expiration of the 3-day notice period if prior to the expiration of the 3-day notice period the
751 superintendent files with the district court a petition for the commitment of the person at the
752 facility. Before accepting an application for voluntary admission where the superintendent may
753 require 3 days written notice of intention to leave or withdraw, the admitting or treating
754 physician or qualified advanced practice registered nurse shall assess the person's capacity to
755 understand that: (i) the person is agreeing to stay or remain at the hospital; (ii) the person is
756 agreeing to accept treatment; (iii) the person is required to provide the facility with 3 days
757 written advance notice of the person's intention to leave the facility; and (iv) the facility may
758 petition a court for an extended commitment of the person and that the person may be held at the
759 facility until the petition is heard by the court. If the physician or qualified advanced practice
760 registered nurse determines that the person lacks the capacity to understand these facts and
761 consequences of hospitalization, the application shall not be accepted.

762 SECTION 51. Said chapter 123 is hereby further amended by striking out section 12, as
763 so appearing, and inserting in place thereof the following section:-

764 Section 12. (a) A physician who is licensed pursuant to section 2 of chapter 112, an
765 advanced practice registered nurse authorized to practice as such under regulations promulgated
766 pursuant to section 80B of said chapter 112, a qualified psychologist licensed pursuant to
767 sections 118 to 129, inclusive, of said chapter 112 or a licensed independent clinical social
768 worker licensed pursuant to sections 130 to 137, inclusive, of said chapter 112 who, after
769 examining a person, has reason to believe that failure to hospitalize such person would create a
770 likelihood of serious harm by reason of mental illness may restrain or authorize the restraint of
771 such person and apply for the hospitalization of such person for a 3-day period at a public facility
772 or at a private facility authorized for such purposes by the department. If an examination is not

773 possible because of the emergency nature of the case and because of the refusal of the person to
774 consent to such examination, the physician, qualified psychologist, qualified advanced practice
775 registered nurse or licensed independent clinical social worker on the basis of the facts and
776 circumstances may determine that hospitalization is necessary and may therefore apply. In an
777 emergency situation, if a physician, qualified psychologist, qualified advanced practice
778 registered nurse or licensed independent clinical social worker is not available, a police officer
779 who believes that failure to hospitalize a person would create a likelihood of serious harm by
780 reason of mental illness may restrain such person and apply for the hospitalization of such person
781 for a 3-day period at a public facility or a private facility authorized for such purpose by the
782 department. An application for hospitalization shall state the reasons for the restraint of such
783 person and any other relevant information that may assist the admitting physician or qualified
784 advanced practice registered nurse. Whenever practicable, prior to transporting such person, the
785 applicant shall telephone or otherwise communicate with a facility to describe the circumstances
786 and known clinical history and to determine whether the facility is the proper facility to receive
787 such person and to give notice of any restraint to be used and to determine whether such restraint
788 is necessary.

789 (b) Only if the application for hospitalization under this section is made by a physician or
790 a qualified advanced practice registered nurse specifically designated to have the authority to
791 admit to a facility in accordance with the regulations of the department shall such person be
792 admitted to the facility immediately after reception. If the application is made by someone other
793 than a designated physician or a qualified advanced practice registered nurse such person shall be
794 given a psychiatric examination by a designated physician or a qualified advanced practice
795 registered nurse immediately after reception at such facility. If the physician or a qualified

796 advanced practice registered nurse determines that failure to hospitalize such person would
797 create a likelihood of serious harm by reason of mental illness, the physician or qualified
798 advanced practice registered nurse may admit such person to the facility for care and treatment.
799 Upon admission of a person under this subsection, the facility shall inform the person that it
800 shall, upon such person's request, notify the committee for public counsel services of the name
801 and location of the person admitted. The committee for public counsel services shall immediately
802 appoint an attorney who shall meet with the person. If the appointed attorney determines that the
803 person voluntarily and knowingly waives the right to be represented, is presently represented or
804 will be represented by another attorney, the appointed attorney shall so notify the committee for
805 public counsel services, which shall withdraw the appointment.

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

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

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

820 (e) Any person may make an application to a district court justice or a justice of the
821 juvenile court department for a 3-day commitment to a facility of a person with a mental illness
822 if the failure to confine said person would cause a likelihood of serious harm. The court shall
823 appoint counsel to represent said person. After hearing such evidence as the court may consider
824 sufficient, a district court justice or a justice of the juvenile court department may issue a warrant
825 for the apprehension and appearance before the court of the alleged person with a mental illness
826 if in the court's judgment the condition or conduct of such person makes such action necessary
827 or proper. Following apprehension, the court shall have the person examined by a physician or a
828 qualified advanced practice registered nurse designated to have the authority to admit to a facility
829 or examined by a qualified psychologist in accordance with the regulations of the department. If
830 the physician, qualified advanced practice registered nurse or qualified psychologist reports that
831 the failure to hospitalize the person would create a likelihood of serious harm by reason of
832 mental illness, the court may order the person committed to a facility for a period not to exceed 3
833 days; provided, however, that the superintendent may discharge said person at any time within
834 the 3 day period. The periods of time prescribed or allowed under this section shall be computed
835 pursuant to Rule 6 of the Massachusetts Rules of Civil Procedure.

836 SECTION 52. Said chapter 123 is hereby further amended by striking out section 21, as
837 so appearing, and inserting in place thereof the following section:-

838 Section 21. Any person who transports a person with a mental illness to or from a facility
839 for any purpose authorized under this chapter shall not use any restraint that is unnecessary for

840 the safety of the person being transported or other persons likely to come in contact with said
841 person.

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

845 Restraint of a person with a mental illness may only be used in cases of emergency, such
846 as the occurrence of, or serious threat of, extreme violence, personal injury or attempted suicide;
847 provided, however, that written authorization for such restraint is given by the superintendent or
848 director of the facility or by a physician or qualified advanced practice registered nurse
849 designated by the superintendent or director for this purpose who is present at the time of the
850 emergency or if the superintendent, director, designated physician or designated qualified
851 advanced practice registered nurse is not present at the time of the emergency, non-chemical
852 means of restraint may be used for a period of not more than 1 hour; provided further, that within
853 1 hour the person in restraint shall be examined by the superintendent, director, designated
854 physician or designated qualified advanced practice registered nurse; and provided further, that if
855 the examination has not occurred within 1 hour, the patient may be restrained for an additional
856 period of not more than 1 hour until such examination is conducted and the superintendent,
857 director, designated physician or designated qualified advanced practice registered nurse shall
858 attach to the restraint form a written report as to why the examination was not completed by the
859 end of the first hour of restraint.

860 Any minor placed in restraint shall be examined within 15 minutes of the order for
861 restraint by a physician or qualified advanced practice registered nurse or, if a physician or

862 qualified advanced practice registered nurse is not available, by a registered nurse or a certified
863 physician assistant; provided, however, that said minor shall be examined by a physician or
864 qualified advanced practice registered nurse within 1 hour of the order for restraint. A physician
865 or qualified advanced practice registered nurse or, if a physician or qualified advanced practice
866 registered nurse is not available, a registered nurse or a certified physician assistant, shall review
867 the restraint order by personal examination of the minor or consultation with ward staff attending
868 the minor every hour thereafter.

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

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

885 facility and shall forward a copy of said report on a monthly basis to the human rights committee
886 or the body designated by the commissioner of mental health.

887 No order for restraint for an individual shall be valid for a period of more than 3 hours
888 beyond which time it may be renewed upon personal examination by the superintendent,
889 director, designated physician or designated qualified advanced practice registered nurse or, for
890 adults, by a registered nurse or a certified physician assistant; provided, however, that no adult
891 shall be restrained for more than 6 hours beyond which time an order may be renewed only upon
892 personal examination by a physician or qualified advanced practice registered nurse. The reason
893 for the original use of restraint, the reason for its continuation after each renewal and the reason
894 for its cessation shall be noted upon the restraining form by the superintendent or director or
895 designated physician or, when applicable, by the registered nurse or certified physician or
896 qualified advanced practice registered nurse assistant at the time of each occurrence.

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

905 No person shall be kept in restraint without a person in attendance specially trained to
906 understand, assist and afford therapy to the person in restraint. The person may be in attendance

907 immediately outside the room in full view of the patient when an individual is being secluded
908 without mechanical restraint; provided, however, that in emergency situations when a person
909 specially trained is not available, an adult may be kept in restraint unattended for a period not to
910 exceed 2 hours. In that event, the person kept in restraints shall be observed at least every 5
911 minutes; provided, further, that the superintendent, director, designated physician or designated
912 qualified advanced practice registered nurse shall attach to the restraint form a written report as
913 to why the specially trained attendant was not available. The maintenance of any adult in
914 restraint for more than 8 hours in any 24-hour period shall be authorized by the superintendent or
915 facility director or the person specifically designated to act in the absence of the superintendent
916 or facility director; provided, however, that when such restraint is authorized in the absence of
917 the superintendent or facility director, such authorization shall be reviewed by the superintendent
918 or facility director upon the return of the superintendent or facility director.

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

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

926 A copy of the restraint form and any such attachments shall become part of the chart of
927 the patient. Copies of all restraint forms and attachments shall be sent to the commissioner of
928 mental health, or, with respect to Bridgewater state hospital to the commissioner of correction,

929 who shall review and sign them within 30 days and statistical records shall be kept thereof for
930 each facility, including Bridgewater state hospital, and each designated physician or qualified
931 advanced practice registered nurse. Furthermore, such reports, excluding personally identifiable
932 patient identification, shall be made available to the general public at the department's central
933 office, or, with respect to Bridgewater state hospital at the department of correction's central
934 office.

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

938 SECTION 53. Said chapter 123 is hereby further amended by striking out section 22, as
939 so appearing, and inserting in place thereof the following section:-

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

947 SECTION 54. Chapter 175 of the General Laws is hereby amended by inserting after
948 section 47BB the following section:-

949 Section 47CC. (a) For the purposes of this section, "telehealth" shall mean the use of
950 synchronous or asynchronous audio, video, electronic media or other telecommunications

951 technology, including, but not limited to, text messaging, application-based communications and
952 online adaptive interviews, for the purposes of evaluating, diagnosing, consulting, prescribing,
953 treating or monitoring a patient’s physical, oral, mental health or substance use disorder
954 condition; provided, however, that “telehealth” may include text-only email when it occurs for
955 the purpose of patient management in the context of a pre-existing physician-patient relationship.

956 (b) An individual policy of accident and sickness insurance issued under section 108 that
957 provides hospital expense and surgical expense insurance and any group blanket or general
958 policy of accident and sickness insurance issued under section 110 that provides hospital expense
959 and surgical expense insurance that is issued or renewed within or without the commonwealth
960 shall provide coverage for health care services delivered via telehealth by a contracted health
961 care provider; provided, however, that an insurer shall not meet network adequacy through
962 significant reliance on telehealth providers and shall not be considered to have an adequate
963 network if patients are not able to access appropriate in-person services in a timely manner upon
964 request. Health care services delivered via telehealth shall be covered to the same extent as if
965 they were provided via in-person consultation or delivery. Coverage shall not be limited to
966 services delivered by third-party providers.

967 (c) Coverage may include utilization review, including preauthorization, to determine the
968 appropriateness of telehealth as a means of delivering a health care service; provided, however,
969 that the determination shall be made in the same manner as if the service was delivered in
970 person. A policy, contract, agreement, plan or certificate of insurance issued, delivered or
971 renewed within the commonwealth shall not be required to reimburse a health care provider for a
972 health care service that is not a covered benefit under the plan or reimburse a health care

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

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

979 (e) A policy, contract, agreement, plan or certificate of insurance issued, delivered or
980 renewed within the commonwealth that provides coverage for telehealth services may include a
981 deductible, copayment or coinsurance requirement for a health care service provided via
982 telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible,
983 copayment or coinsurance applicable to an in-person consultation or in-person delivery of
984 services.

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

989 SECTION 55. Chapter 176A of the General Laws is hereby amended by adding the
990 following section:-

991 Section 38. (a) For purposes of this section, "telehealth" shall mean the use of
992 synchronous or asynchronous audio, video, electronic media or other telecommunications
993 technology, including, but not limited to, text messaging, application-based communications and
994 online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing,

995 treating or monitoring a patient’s physical, oral, mental health or substance use disorder
996 condition; provided, however, that “telehealth” may include text-only email when it occurs for
997 the purpose of patient management in the context of a pre-existing physician-patient relationship.

998 (b) A contract between a subscriber and a nonprofit hospital service corporation under an
999 individual or group hospital service plan shall provide coverage for health care services delivered
1000 via telehealth by a contracted health care provider; provided, however, that an insurer shall not
1001 meet network adequacy through significant reliance on telehealth providers and shall not be
1002 considered to have an adequate network if patients are not able to access appropriate in-person
1003 services in a timely manner upon request. Health care services delivered via telehealth shall be
1004 covered to the same extent as if they were provided via in-person consultation or delivery.
1005 Coverage shall not be limited to services delivered by third-party providers.

1006 (c) Coverage may include utilization review, including preauthorization, to determine the
1007 appropriateness of telehealth as a means of delivering a health care service; provided, however,
1008 that the determination shall be made as if the service was delivered in person. A carrier shall not
1009 be required to reimburse a health care provider for a health care service that is not a covered
1010 benefit under the plan or reimburse a health care provider not contracted under the plan except as
1011 provided for under clause (i) of paragraph (4) of subsection (a) of section 6 of chapter 176O.

1012 (d) A health care provider shall not be required to document a barrier to an in-person
1013 visit, nor shall the type of setting where telehealth is provided be limited for health care services
1014 provided through telehealth; provided, however, that a patient may decline receiving services via
1015 telehealth in order to receive in-person services.

1016 (e) Coverage for telehealth services may include a provision for a deductible, copayment
1017 or coinsurance requirement for a health care service provided via telehealth as long as the
1018 deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance
1019 applicable to an in-person consultation or in-person delivery of services.

1020 (f) Health care services provided via telehealth shall conform to the standards of care
1021 applicable to the telehealth provider's profession. Such services shall also conform to applicable
1022 federal and state health information privacy and security standards as well as standards for
1023 informed consent.

1024 SECTION 56. Chapter 176B of the General Laws is hereby amended by adding the
1025 following section:-

1026 Section 25. (a) For the purposes of this section, "telehealth" shall mean the use of
1027 synchronous or asynchronous audio, video, electronic media or other telecommunications
1028 technology, including, but not limited to, text messaging, application-based communications and
1029 online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing,
1030 treating or monitoring a patient's physical, oral, mental health or substance use disorder
1031 condition; provided, however, that "telehealth" may include text-only email when it occurs for
1032 the purpose of patient management in the context of a pre-existing physician-patient relationship.

1033 (b) A contract between a subscriber and a medical service corporation shall provide
1034 coverage for health care services delivered via telehealth by a contracted health care provider;
1035 provided, however, that an insurer shall not meet network adequacy through significant reliance
1036 on telehealth providers and shall not be considered to have an adequate network if patients are
1037 not able to access appropriate in-person services in a timely manner upon request. Health care

1038 services delivered via telehealth shall be covered to the same extent as if they were provided via
1039 in-person consultation or delivery. Coverage shall not be limited to services delivered by third-
1040 party providers.

1041 (c) Coverage may include utilization review, including preauthorization, to determine the
1042 appropriateness of telehealth as a means of delivering a health care service; provided, however,
1043 that the determination shall be made as if the service was delivered in person. A carrier shall not
1044 be required to reimburse a health care provider for a health care service that is not a covered
1045 benefit under the plan or reimburse a health care provider not contracted under the plan except as
1046 provided for under clause (i) of paragraph (4) of subsection (a) of section 6 of chapter 176O.

1047 (d) A health care provider shall not be required to document a barrier to an in-person
1048 visit, nor shall the type of setting where telehealth is provided be limited for health care services
1049 provided through telehealth; provided, however, that a patient may decline receiving services via
1050 telehealth in order to receive in-person services.

1051 (e) A contract that provides coverage for telehealth services may contain a provision for a
1052 deductible, copayment or coinsurance requirement for a health care service provided via
1053 telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible,
1054 copayment or coinsurance applicable to an in-person consultation or in-person delivery of
1055 services.

1056 (f) Health care services provided by telehealth shall conform to the standards of care
1057 applicable to the telehealth provider's profession. Such services shall also conform to applicable
1058 federal and state health information privacy and security standards as well as standards for
1059 informed consent.

1060 SECTION 57. Chapter 176G of the General Laws is hereby amended by adding the
1061 following section:-

1062 Section 33. (a) For the purposes of this section, “telehealth” shall mean the use of
1063 synchronous and asynchronous audio, video, electronic media or other telecommunications
1064 technology, including, but not limited to, text messaging, application-based communications and
1065 online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing,
1066 treating or monitoring a patient’s physical, oral, mental health or substance use disorder
1067 condition; provided, however, that “telehealth” may include text-only email when it occurs for
1068 the purpose of patient management in the context of a pre-existing physician-patient relationship.

1069 (b) A contract between a member and a health maintenance organization shall provide
1070 coverage for health care services delivered via telehealth by a contracted health care provider;
1071 provided, however, that an insurer shall not meet network adequacy through significant reliance
1072 on telehealth providers and shall not be considered to have an adequate network if patients are
1073 not able to access appropriate in-person services in a timely manner upon request. Health care
1074 services delivered via telehealth shall be covered to the same extent as if they were provided via
1075 in-person consultation or delivery. Coverage shall not be limited to services delivered by third-
1076 party providers.

1077 (c) A carrier may undertake utilization review, including preauthorization, to determine
1078 the appropriateness of telehealth as a means of delivering a health care service; provided,
1079 however, that the determination shall be made as if the service was delivered in person. A carrier
1080 shall not be required to reimburse a health care provider for a health care service that is not a
1081 covered benefit under the plan or reimburse a health care provider not contracted under the plan

1082 except as provided for under clause (i) of paragraph (4) of subsection (a) of section 6 of chapter
1083 176O.

1084 (d) A health care provider shall not be required to document a barrier to an in-person
1085 visit, nor shall the type of setting where telehealth is provided be limited for health care services
1086 provided via telehealth; provided, however, that a patient may decline receiving services via
1087 telehealth in order to receive in-person services.

1088 (e) A contract that provides coverage for telehealth services may contain a provision for a
1089 deductible, copayment or coinsurance requirement for a health care service provided through
1090 telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible,
1091 copayment or coinsurance applicable to an in-person consultation or in-person delivery of
1092 services.

1093 (f) Health care services provided by telehealth shall conform to the standards of care
1094 applicable to the telehealth provider's profession. Such services shall also conform to applicable
1095 federal and state health information privacy and security standards as well as standards for
1096 informed consent.

1097 SECTION 58. Chapter 176I of the General Laws is hereby amended by adding the
1098 following section:-

1099 Section 13. (a) For the purposes of this section, "telehealth" shall mean the use of
1100 synchronous or asynchronous audio, video, electronic media or other telecommunications
1101 technology, including, but not limited to, text messaging, application-based communications and
1102 online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing,
1103 treating or monitoring a patient's physical, oral, mental health or substance use disorder

1104 condition; provided, however, that “telehealth” may include text-only email when it occurs for
1105 the purpose of patient management in the context of a pre-existing physician-patient relationship.

1106 (b) A preferred provider contract between a covered person and an organization shall
1107 provide coverage for health care services delivered via telehealth by a contracted health care
1108 provider; provided, however, that an insurer shall not meet network adequacy through significant
1109 reliance on telehealth providers and shall not be considered to have an adequate network if
1110 patients are not able to access appropriate in-person services in a timely manner upon request.
1111 Health care services delivered via telehealth shall be covered to the same extent as if they were
1112 provided via in-person consultation or delivery. Coverage shall not be limited to services
1113 delivered by third-party providers.

1114 (c) An organization may undertake utilization review, including preauthorization, to
1115 determine the appropriateness of telehealth as a means of delivering a health care service;
1116 provided, however, that the determination shall be made as if the service was delivered in person.
1117 An organization shall not be required to reimburse a health care provider for a health care service
1118 that is not a covered benefit under the plan nor reimburse a health care provider not contracted
1119 under the plan except as provided for under clause (i) of paragraph (4) of subsection (a) of
1120 section 6 of chapter 176O.

1121 (d) A health care provider shall not be required to document a barrier to an in-person
1122 visit, nor shall the type of setting where telehealth is provided be limited for health care services
1123 provided through telehealth; provided, however, that a patient may decline receiving services via
1124 telehealth in order to receive in-person services.

1125 (e) A preferred provider contract that provides coverage for telehealth services may
1126 contain a provision for a deductible, copayment or coinsurance requirement for a health care
1127 service provided via telehealth as long as the deductible, copayment or coinsurance does not
1128 exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-
1129 person delivery of services.

1130 (f) Health care services provided via telehealth shall conform to the standards of care
1131 applicable to the telehealth provider's profession. Such services shall also conform to applicable
1132 federal and state health information privacy and security standards as well as standards for
1133 informed consent.

1134 SECTION 59. Section 1 of chapter 176O of the General Laws, as appearing in the 2018
1135 Official Edition, is hereby amended by inserting after the definition of "Downside risk" the
1136 following definition:-

1137 "Emergency health care services", health care services rendered to an insured
1138 experiencing an emergency medical condition.

1139 SECTION 60. Said section 1 of said chapter 176O, as so appearing, is hereby further
1140 amended by inserting after the definition of "Incentive plan" the following definition:-

1141 "In-network contracted rate", the rate contracted between an insured's carrier and a
1142 network health care provider for the reimbursement of health care services delivered by that
1143 health care provider to the insured.

1144 SECTION 61. Said section 1 of said chapter 176O, as so appearing, is hereby further
1145 amended by inserting after the definition of "Network" the following 3 definitions:-

1146 “Noncontracted commercial rate for emergency services”, the amount set pursuant to
1147 section 16A of chapter 6D and used to determine the rate of payment to a health care provider for
1148 the provision of emergency health care services to an insured when the health care provider is
1149 not in the carrier’s network; provided, however, that “noncontracted commercial rate for
1150 emergency services” shall not include emergency health care services that are provided by a
1151 person or entity licensed by the department of public health pursuant to section 6 of chapter
1152 111C to establish or maintain an ambulance service.

1153 “Noncontracted commercial rate for nonemergency services”, the amount set pursuant to
1154 section 16A of chapter 6D and used to determine the rate of payment to a health care provider for
1155 the provision of nonemergency health care services to an insured when the health care provider
1156 is not in the carrier’s network.

1157 “Nonemergency health care services”, health care services rendered to an insured
1158 experiencing a condition other than an emergency medical condition.

1159 SECTION 62. Subsection (a) of section 6 of said chapter 176O, as so appearing, is
1160 hereby amended by striking out clause (8) and inserting in place thereof the following clause:-

1161 (8) a summary description of the procedure, if any, for out-of-network referrals and any
1162 additional charge for utilizing out-of-network providers and a description of the out-of-network
1163 consumer protections, including the prohibition on certain billing practices under this chapter.

1164 SECTION 63. Section 23 of said chapter 176O, as so appearing, is hereby amended by
1165 inserting after the word “time”, in line 3, the following words:- , the network status of an
1166 identified health care provider.

1167 SECTION 64. Subsection (a) of section 27 of said chapter 176O, as so appearing, is
1168 hereby amended by adding the following sentence:-

1169 The common summary of payments form shall include a description of the out-of-
1170 network consumer protections, including the prohibition on certain billing practices, under this
1171 chapter.

1172 SECTION 65. Said chapter 176O is hereby further amended by adding the following
1173 section:-

1174 Section 29. (a)(1) A carrier shall reimburse a health care provider as follows:

1175 (i) where the health care provider is a member of an insured's carrier's network but not a
1176 participating provider in the insured's health benefit plan and the health care provider has
1177 delivered health care services to the insured to treat an emergency medical condition, the carrier
1178 shall pay that provider the in-network contracted rate for each delivered service; provided,
1179 however, that such payment shall constitute payment in full to that health care provider and the
1180 provider shall not bill the insured except for any applicable copayment, coinsurance or
1181 deductible that would be owed if the insured received such service or services from a
1182 participating health care provider under the terms of the insured's health benefit plan;

1183 (ii) where the health care provider is not a member of an insured's carrier's network and
1184 the health care provider has delivered health care services to the insured to treat an emergency
1185 medical condition, the carrier shall pay that provider the noncontracted commercial rate for
1186 emergency services for each delivered service; provided, however, that such payment shall
1187 constitute payment in full to the health care provider and the provider shall not bill the insured
1188 except for any applicable copayment, coinsurance or deductible that would be owed if the

1189 insured received such service or services from a participating health care provider under the
1190 terms of the insured's health benefit plan;

1191 (iii) where the health care provider is a member of an insured's carrier's network but not
1192 a participating provider in the insured's health benefit plan and the health care provider has
1193 delivered nonemergency health care services to the insured and a participating provider in the
1194 insured's health benefit plan is unavailable or the health care provider renders those
1195 nonemergency health care services without proper notice to the insured as described in section
1196 228 of chapter 111, the carrier shall pay that provider the in-network contracted rate for each
1197 delivered service; provided, however, that such payment shall constitute payment in full to the
1198 health care provider and the provider shall not bill the insured except for any applicable
1199 copayment, coinsurance or deductible that would be owed if the insured received such service
1200 from a participating health care provider under the terms of the insured's health benefit plan; and

1201 (iv) where the health care provider is not a member of an insured's carrier's network and
1202 the health care provider has delivered nonemergency services to the insured and a participating
1203 provider in the insured's health benefit plan is unavailable or the health care provider renders
1204 those nonemergency health care services without proper notice to the insured as described in
1205 section 228 of chapter 111, the carrier shall pay the provider the noncontracted commercial rate
1206 for nonemergency services for each delivered service; provided, however, that such payment
1207 shall constitute payment in full to the health care provider and the provider shall not bill the
1208 insured except for any applicable copayment, coinsurance or deductible that would be owed if
1209 the insured received such service or services from a participating health care provider under the
1210 terms of the insured's health benefit plan.

1211 (2) It shall be an unfair and deceptive act or practice in violation of section 2 of chapter
1212 93A for any health care provider or carrier to request payment from an enrollee, other than the
1213 applicable coinsurance, copayment, deductible or other out-of-pocket expense, for the services
1214 described in paragraph (1).

1215 (b) Nothing in this section shall require a carrier to pay for health care services delivered
1216 to an insured that are not covered benefits under the terms of the insured's health benefit plan.

1217 (c) Nothing in this section shall require a carrier to pay for nonemergency health care
1218 services delivered to an insured if the insured had a reasonable opportunity to choose to have the
1219 service performed by a network provider participating in the insured's health benefit plan.
1220 Evidence that an insured had a reasonable opportunity to choose to have the service performed
1221 by a network provider may include, but not be limited to, a written acknowledgement submitted
1222 with any claim for reimbursement from the carrier that: (i) is signed by the insured; and (ii) was
1223 provided by the health care provider to the insured before the delivery of nonemergency health
1224 care services and provided the insured a reasonable amount of time to seek health care services
1225 from a participating provider in the insured's health benefit plan.

1226 (d) With respect to an entity providing or administering a self-funded health benefit plan
1227 governed by the provisions of the federal Employee Retirement Income Security Act of 1974, 29
1228 U.S.C. § 1001 et seq. and its plan members, this section shall only apply if the plan elects to be
1229 subject to the provisions of this section. To elect to be subject to the provisions of this section,
1230 the self-funded health benefit plan shall provide notice to the division on an annual basis, in a
1231 form and manner prescribed by the division, attesting to the plan's participation and agreeing to
1232 be bound by the provisions of this section. The self-funded health benefit plan shall amend the

1233 health benefit plan, coverage policies, contracts and any other plan documents to reflect that the
1234 benefits of this section shall apply to the plan's members.

1235 (e) In a form and manner to be prescribed by the division, carriers shall indicate to
1236 insureds that the plan is subject to these provisions. In the case of self-funded health benefit
1237 plans that elect to be subject to this section pursuant to subsection (d), the plan shall indicate to
1238 its members that it is self-funded and has elected to be subject to these provisions.

1239 (f) The commissioner shall promulgate regulations that are necessary to implement this
1240 section.

1241 (g) The attorney general shall have the authority to conduct investigations of alleged
1242 violations of this section pursuant to section 5 of chapter 175H or section 6 of chapter 93A. The
1243 attorney general may enforce this section by bringing an action pursuant to section 4 or said
1244 section 5 of said chapter 175H or section 4 of said chapter 93A.

1245 SECTION 66. Section 79L of chapter 233 of the General Laws, as appearing in the 2018
1246 Official Edition, is hereby amended by inserting after the word "dentist", in line 12, the
1247 following words:- , dental therapist.

1248 SECTION 67. (a) Notwithstanding any general or special law to the contrary, the health
1249 policy commission shall, in collaboration with the center for health information and analysis,
1250 conduct an analysis of and issue a report on the effects of the COVID-19 pandemic on the
1251 commonwealth's health care delivery system, including on the accessibility, quality, and cost of
1252 health care services and the financial position of health care entities in the short-term, and the
1253 implications of those effects on long-term policy considerations. In developing the report, the
1254 commission shall seek input from the executive office of health and human services, other state

1255 agencies, health care providers and payers, public health and economic experts, patients and
1256 caregivers, and a range of diverse stakeholders including those disproportionately impacted by
1257 COVID-19 or social determinants of health.

1258 (b) The report shall include: (i) an assessment and detailed description of the essential
1259 components of a robust health care system and the distribution of services and resources
1260 necessary to deliver high-quality care, from birth to death, to all residents in the commonwealth,
1261 including, but not limited to, the appropriate level of personal protective equipment at health care
1262 facilities to ensure the health of facility personnel and patients, and eliminate health care
1263 disparities due to economic, geographic, racial, or other factors; (ii) an inventory and description
1264 of the location, distribution, nature, and sustainability of all health care services and resources in
1265 the commonwealth serving residents from birth to death; (iii) an analysis of the impact of
1266 COVID-19 on the health care workforce and on health care provider efforts to plan and invest in
1267 worker readiness, including, but not limited to, the engagement of the workforce; (iv) an
1268 examination of the closures of services classified as essential by the department of public health
1269 or other relevant agency, the impact that the loss of such essential services have had on access to
1270 and the quality of health care services to the communities affected by the closure of such
1271 essential services and the efficacy of existing standards and requirements intended to maintain
1272 such essential services; and (v) in consultation with the office of health equity in the department
1273 of public health, an analysis of health care disparities that exist in the commonwealth due to
1274 economic, geographic, racial, or other factors.

1275 The health care system resource inventory compiled under this subsection and all related
1276 information shall be maintained in a form accessible and usable by the general public on its
1277 website and shall constitute a public record; provided, however, that any item of information that

1278 is confidential or privileged in nature or under any other law shall not be regarded as a public
1279 record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

1280 (c) To assist in its development of the report, the commission may review any data or
1281 findings collected under chapter 93 of the acts of 2020 through an interagency agreement with
1282 the department of public health.

1283 (d) The commission shall submit an initial report to the clerks of the senate and house of
1284 representatives, the senate and house committees on ways and means, the joint committee on
1285 health care financing, the joint committee on public health and the joint committee on mental
1286 health, substance use and recovery not later than November 1, 2020. The commission shall
1287 submit a final report to the clerks of the senate and the house of representatives, the senate and
1288 house committees on ways and means, the joint committee on health care financing, the joint
1289 committee on public health and the joint committee on mental health, substance use and recovery
1290 not later than July 1, 2021.

1291 SECTION 68. Notwithstanding any general or special law to the contrary, the department
1292 of public health and the office of consumer affairs and business regulation shall allow licensees
1293 to obtain proxy credentialing and privileging for telehealth services with other health care
1294 providers as defined in section 1 of chapter 111 of the General Laws or facilities that comply
1295 with the federal Centers for Medicare & Medicaid Services' conditions of participation for
1296 telehealth services.

1297 For the purposes of this section, "telehealth" shall mean the use of synchronous or
1298 asynchronous audio, video, electronic media or other telecommunications technology, including,
1299 but not limited to, text messaging, application-based communications and online adaptive

1300 interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or
1301 monitoring a patient’s physical, oral, mental health or substance use disorder condition;
1302 provided, however, that “telehealth” may include text-only email when it occurs for the purpose
1303 of patient management in the context of a pre-existing physician-patient relationship.

1304 SECTION 69. The board of registration in dentistry shall approve a comprehensive,
1305 competency based clinical dental therapy examination that includes assessment of technical
1306 competency in performing the procedures and services within the scope of practice as set forth in
1307 section 51B of chapter 112 of the General Laws, to be administered by a recognized national or
1308 regional dental testing service that administers testing for dentists and other dental professionals.
1309 The examination shall be comparable to the examination given to applicants for a dental license
1310 but only for the limited scope of dental services in the dental therapy scope of practice as set
1311 forth in said section 51B of said chapter 112.

1312 SECTION 70. Notwithstanding any general or special law to the contrary, the department
1313 of public health, in consultation with the health policy commission and the center for health
1314 information and analysis, shall perform a 5-year longitudinal evaluation of the impact of dental
1315 therapists, registered to practice under section 51B of chapter 112 of the General Laws, on
1316 patient safety, cost-effectiveness and access to dental services.

1317 The department shall collect, analyze and evaluate data at the start of the evaluation and
1318 annually thereafter, including, but not limited to the: (i) number of new and total licensed dental
1319 therapists in the commonwealth, broken down by practice setting; (ii) number of new and total
1320 adult patients served by dental therapists and the number of new and total pediatric patients
1321 served by dental therapists, broken down by geographic location and type of insurance coverage;

1322 (iii) impact on wait times for dental services; (iv) impact on patient travel time and expense; (v)
1323 impact on emergency room usage for dental care; (vi) impact on costs for dental services; (vii)
1324 most commonly performed procedures and services by dental therapists; (viii) level of patient
1325 satisfaction; and (ix) a review on the impact of dental therapists on the overall quality of oral
1326 health care delivered to patients.

1327 The department shall file an interim 3-year report not later than January 1, 2025 and a
1328 final 3-year report not later than January 1, 2027 broken down by calendar year. The reports shall
1329 be filed with the clerks of the senate and house of representatives, the joint committee on public
1330 health, the joint committee on health care financing and the house and senate committees on
1331 ways and means.

1332 SECTION 71. For the purposes of section 30 of chapter 32A, section 79 of chapter 118E,
1333 section 47CC of chapter 175, section 38 of chapter 176A, section 25 of chapter 176B, section 33
1334 of chapter 176G and section 13 of chapter 176I of the General Laws, network adequacy may be
1335 met through significant reliance on telehealth providers until the termination of the governor's
1336 March 10, 2020 declaration of a state of emergency.

1337 SECTION 72. Notwithstanding any general or special law to the contrary, the health
1338 policy commission, in consultation with the center for health information and analysis, shall
1339 report on the use of telehealth services in the commonwealth and the effect of telehealth on
1340 health care access and system cost.

1341 The report shall include, but not be limited to: (i) the number of telehealth services
1342 provided by type of service, provider and provider organization and payer; (ii) an analysis of the
1343 use of telehealth services by patient demographics, geographic region and type of service; (iii) an

1344 analysis of the impact of payer coverage and payment rate of telehealth services on patient
1345 access to and cost of care by patient demographics, geographic region and type of service; (iv)
1346 total health care expenditures on telehealth services by type of service and type of
1347 telecommunication technology used; (v) an assessment of the appropriate scope of coverage
1348 requirements for telehealth services provided through various synchronous or asynchronous
1349 audio, video, electronic media and other telecommunications technology, provided, however,
1350 that the assessment shall consider the effect of coverage requirements on access to quality care,
1351 with special consideration for populations with limited access to technology, and the effect of
1352 coverage requirements on increasing health care expenditures and appropriate utilization; (vi) the
1353 estimated impact of the use and coverage of telehealth services on health care utilization and
1354 total health care expenditures in the commonwealth, including the impact on insurance
1355 premiums; (vii) any barriers to increased use of telehealth services, including cost and
1356 availability of technology infrastructure, including access to broadband internet and cellular
1357 telephone service, for patients and health care providers, cost and availability of technology
1358 infrastructure for patients, equity in access for low-income patients, patient choice of providers
1359 offering telehealth services, provider reimbursement amounts and method of payment and other
1360 payer, patient or provider financial incentives that may reduce the availability of telehealth
1361 services; (viii) the estimated aggregate savings or additional costs of telehealth rate requirements
1362 on total health care expenditures and on health care access in the commonwealth; (ix)
1363 recommendations on ways to expand the use of telehealth services including, but not limited to,
1364 the safe and appropriate provision of telehealth services by health care professionals licensed and
1365 residing in other states; (x) an analysis of any impact of pre-authorization or other utilization
1366 management tools on access to care via telehealth and recommendations for appropriate

1367 limitations on those tools to ensure access to care; and (xi) recommendations on appropriate
1368 reimbursement rates for services provided via telehealth compared to comparable in-person
1369 services in order to maximize health care access and public health outcomes and limit health care
1370 cost growth; provided, however, that data on the use of telehealth services and related effect on
1371 access and cost shall differentiate between telehealth services used while the governor's March
1372 10, 2020 declaration of a state of emergency was in effect and telehealth services used after the
1373 termination of the governor's March 10, 2020 declaration of a state of emergency.

1374 The report, along with a suggested plan to implement its recommendations, in order to
1375 maximize access, quality of care and cost savings shall be submitted to the joint committee on
1376 health care financing and the house and senate committees on ways and means not later than
1377 December 31, 2022; provided, however, that not later than December 31, 2021, the commission
1378 shall present an interim estimate of the fiscal impact of telehealth use in the commonwealth.

1379 SECTION 73. Notwithstanding any general or special law to the contrary, the group
1380 insurance commission under chapter 32A of the General Laws, the division of medical assistance
1381 under chapter 118E of the General Laws, insurance companies organized under chapter 175 of
1382 the General Laws, hospital service corporations organized under chapter 176A of the General
1383 Laws, medical service corporations organized under chapter 176B of the General Laws, health
1384 maintenance organizations organized under chapter 176G of the General Laws and preferred
1385 provider organizations organized under chapter 176I of the General Laws shall ensure that rates
1386 of payment for in-network providers for telehealth services provided pursuant to section 30 of
1387 said chapter 32A, section 79 of said chapter 118E, section 47CC of said chapter 175, section 38
1388 of said chapter 176A, section 25 of said chapter 176B, section 33 of said chapter 176G and

1389 section 13 of said chapter 176I are not less than the rate of payment for the same service
1390 delivered via in-person methods.

1391 SECTION 74. Section 73 is hereby repealed.

1392 SECTION 75. Notwithstanding any general or special law to the contrary, the health
1393 policy commission shall provide its recommended noncontracted commercial rate for emergency
1394 services and the noncontracted commercial rate for nonemergency services under section 16A of
1395 chapter 6D of the General Laws not later than May 1, 2021.

1396 SECTION 76. Section 65 shall take effect 1 year from the effective date of this act.

1397 SECTION 77. The first paragraph of subsection (f) and subsections (i) and (j) of section
1398 51B of chapter 112 of the General Laws and section 69 shall take effect on January 1, 2022.

1399 SECTION 78. The second paragraph of subsection (f) of section 51B of chapter 112 of
1400 the General Laws shall take effect on December 1, 2024.

1401 SECTION 79. Section 74 shall take effect on July 31, 2022.