



MASSACHUSETTS
Health & Hospital
ASSOCIATION

2017

2018

STATE LEGISLATIVE PRIORITIES
PROMOTING COST-EFFECTIVE,
AFFORDABLE HEALTHCARE

MASSACHUSETTS HEALTH & HOSPITAL ASSOCIATION

2017-2018 STATE LEGISLATIVE PRIORITIES

PROMOTING COST-EFFECTIVE, AFFORDABLE HEALTHCARE

The pages that follow highlight legislation that the Massachusetts Health & Hospital Association (MHA) has identified as priorities for the 2017-2018 state legislative session. The majority of these bills have been filed on behalf of MHA. Others, as indicated in the bill summaries, have been developed by allied healthcare organizations or specific legislators.

These bills all advance cost-effective, affordable healthcare by promoting access and quality while seeking to eliminate unnecessary costs. A key focus is placed on access to behavioral health and substance use disorder services, telemedicine, coverage and innovation in the MassHealth and other insurer programs, administrative simplification and cost reduction, and quality and patient safety and improving public health.

These legislative filings are consistent with the sweeping reform efforts now underway in Massachusetts. This ambitious agenda will help ensure the continued delivery of safe, high-quality healthcare to all those living in the commonwealth.

On behalf of the entire staff at MHA, we wish to thank our membership for providing input and guidance in the development of this legislative package and to commend these bills to legislators for their consideration and support. MHA looks forward to working with all who support the hospital community's mission of caring for patients and communities, and maintaining a strong, committed workforce able to reform the Massachusetts healthcare system in a sensible and long-lasting way.

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BEHAVIORAL HEALTH & SUBSTANCE USE DISORDERS

HB2404

An Act to Improve Access to Behavioral Health Services

(filed jointly by Rep. Malia/Sen. Keenan)

Referred to the Joint Committee on Mental Health, Substance Use & Recovery

SUMMARY

This legislation seeks to improve behavioral health services for MassHealth patients by streamlining administrative barriers to accessing inpatient and community-based care, as well as creating a statewide sequential intercept model for early intervention and treatment and developing a centralized list of available services to assist providers, payers and those in the criminal justice system in coordinating care. Specifically, the bill will do the following:

1. Section 1 –Amends the MassHealth statute by requiring all Medicaid programs to cover inpatient behavioral health services without requiring a prior authorization. All private and Medicare coverage options provide access to inpatient behavioral health services without a prior authorization requirement, thus this bill would implement true mental health parity.
2. Section 2 - Expands the ability of community-based crisis stabilization services who are directly working with patients to determine if an admission is appropriate from the community – instead of going through a hospital Emergency Department and thus reducing emergency department boarding.
3. Section 3 – Directs EOHHS and the trial court to develop a statewide sequential intercept model to identify opportunities for early intervention and treatment for those with co-occurring mental health and substance use disorders in the criminal justice system to improve care coordination and collaboration, identify gaps in services, and prioritize action steps to develop best practices for improving access to mental health and substance use disorder treatment services. It further requires the state to analyze and maintain a database of current behavioral health providers (inpatient, outpatient, and community-based) and the payer networks they participate in to assist with care coordination for patients with behavioral health needs.

BILL TEXT

SECTION 1. Section 19 of Chapter 118E, as appearing in the 2014 Official Edition, is hereby amended by adding after the first paragraph, the following new paragraph:-

“The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract to a Medicaid managed care organization or primary care clinician plan shall not require preauthorization or prior authorization before obtaining medically necessary mental health services within an inpatient psychiatric facility licensed by the Department of Mental Health; provided that the facility shall provide the division or its contractors notification of admission within 48 hours of admission; provided further, that utilization review procedures may be initiated after 48 hours of admission; and provided further, that Emergency Service Program teams, so-called, as contracted through MassHealth to conduct behavioral health screenings, shall not be considered a preauthorization or prior authorization requirement pursuant to any admission under this section. Medical necessity shall be determined by the treating healthcare provider and noted in the member’s medical record.”

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDERS

SECTION 2. Notwithstanding any general or special law, rule or regulation to the contrary, the Office of Medicaid shall develop a streamlined process to enhance the current community-based behavioral health screening process and direct Medicaid contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract to a Medicaid managed care organization or the Medicaid primary care clinician plans to allow admission to inpatient behavioral health services from a community-based setting where a patient is presenting with a behavioral health condition that requires such admission but does not require a medical screening examination in an emergency department. Said process shall be developed after consultation with a working group that includes representatives from the Association for Behavioral Healthcare, Massachusetts College of Emergency Physicians, Massachusetts Psychiatric Society, Massachusetts Health and Hospital Association, National Alliance on Mental Illness, the Massachusetts Association of Behavioral Health Systems, and all applicable carriers that cover such services. The Office of Medicaid shall file a report on the status of the working group, progress of the streamlined process, and, if necessary, legislative recommendations with the clerks of the senate and house of representatives, the house and senate chairs of the joint committee on mental health and substance abuse, the joint committee on public health, the joint committee on health care financing and the house and senate committees on ways and means no later than six months after the first meeting of the working group. A report of the final implemented streamlined process shall be filed with said committees no later than July 31, 2019.

SECTION 3: Notwithstanding any general or special law to the contrary, the secretary of the Executive Office of Health and Human Services, or a designee, in conjunction with the chief justice of the Trial Court, or a designee, shall develop a statewide sequential intercept model to identify opportunities for early intervention and treatment for those with serious mental illness and co-occurring mental health and substance use disorders in the criminal justice system in order to improve coordination and collaboration, identify gaps in services, and prioritize action steps to develop best practices for improving access to mental health and substance use disorder treatment services in the commonwealth. The Secretary and Chief Justice shall develop the model in coordination with a working group consisting of representatives from the Association of Behavioral Healthcare, Massachusetts College of Emergency Physicians, Massachusetts Psychiatric Society, Massachusetts Health and Hospital Association, National Alliance on Mental Illness, the Massachusetts Association of Behavioral Health Systems, Blue Cross Blue Shield of Massachusetts, the Massachusetts Association of Health Plans, the Massachusetts Department of Correction, the Massachusetts Sheriffs' Association and other criminal justice reform advocacy groups as designated by the Secretary and Chief Justice. Based on the results of the completed sequential intercept model, the Secretary, or a designee, shall further develop and manage a statewide database for providers, the office of Medicaid, carriers, sheriffs, corrections facilities, and the trial courts that provides up-to-date information on: 1) existing inpatient, outpatient, and community-based mental health and substance use disorder providers by location; 2) the types of services provided at each location; and 3) the commercial insurance, Medicaid or other forms of benefit coverage available for each service at each location. Such database may be incorporated as part of an existing website or provider-based forum for communicating access to mental health and substance use disorder services. The database should be completed and available to healthcare providers and carriers for care management purposes, including the ability to develop a process to allow for such data to be transmitted to a provider's electronic medical record through a Health Information Exchange platform or care coordination tool no later than January 1, 2019.

SB1099/ HB2180

An Act Relative to Patient Choice to Promote Prescription Safety

(Sen. Keenan/Rep. Malia)

SB1099 referred to the Joint Committee on Mental Health, Substance Use & Recovery

HB2180 referred to the Joint Committee on Financial Services

SUMMARY

“Partial-fill” prescriptions help patients balance the need to relieve pain with the imperative to reduce the excess number of pills dispensed that go unused, by allowing patients to choose a partial filling of their prescription according to their specific needs. Should patients require additional pain relief, patients can return to the pharmacy to fill the remaining portion of their prescription. The ability of clinicians to write “partial-fill” prescriptions is known to help reduce the amount of unused pain medicines sitting in medicine cabinets and limiting the number of drugs that can be diverted to other uses. Estimates from the U.S. Centers for Disease Control indicate that the majority of individuals – up to 70 percent – who misuse or abuse pain medications get them from prescriptions written for friends or family – a practice more commonly described as “diversion”, and furthermore that those who begin abusing prescription drugs are 40 times more likely to become addicted to heroin.

Although there was language included in last year’s substance use, treatment, education and prevention law (Ch. 52), the full intent of the “partial fill” provision was curtailed due to ambiguity in federal code on this subject. Due to the advocacy of the Mass. Congressional delegation, the recently passed federal Comprehensive Addiction and Recovery Act clears this ambiguity, and explicitly allows states to pass legislation for partial-fill opioid prescriptions. This legislation would allow for the ability of practitioners in Massachusetts to appropriately implement “partial fill” for schedule II opioid prescriptions.

BILL TEXT

SECTION 1. Section 18 of said chapter 94C is hereby amended by striking subsection (d^{3/4}) as inserted by section 21 of chapter 52 of the acts of 2016, and inserting in place thereof the following subsection:-

(d⁴) A registered pharmacist filling a prescription for an opioid substance in schedule II of section 3 shall, if requested by the patient, dispense the prescribed substance in a lesser quantity than indicated on the prescription. Within a reasonable time following a reduction in quantity, but not to exceed 7 days, the pharmacist or a designee shall notify the prescribing practitioner of the reduction and of the amount actually dispensed. The notification shall be conveyed by a notation in the interoperable electronic health record of the patient as defined by section 1 of chapter 118I or, if the pharmacist does not have the ability to make a notation in the patient’s interoperable electronic health record, by facsimile or electronic transmission to the prescribing practitioner. A prescription filled in a lesser quantity pursuant to this subsection shall be considered a partial fill and the remaining portion may be filled according to federal regulations applicable to partially filled prescriptions; provided, however, that the fill of the remaining portion shall occur at the pharmacy that initially dispensed the partial fill. Nothing in this subsection shall be interpreted to conflict with or supersede any other requirement established in this section for a prescription of a narcotic substance or any requirements or conditions for drug substitutions established in chapter 112.

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDERS

SECTION 2. The second paragraph of section 21A of said chapter 94C, as appearing in the 2014 Official Edition, is hereby amended by adding the following sentence:- A pharmacist or a pharmacist's designee shall notify any person who presents for filling a prescription for an opiate contained in schedule II of section 3 that the person may choose to receive a lesser quantity of the prescribed substance than the quantity indicated on the prescription in accordance with subsection (d3/4) of section 18.

SECTION 3. Section 22 of said chapter 94C, as amended by chapter 52 of the acts of 2016, is hereby further amended by striking, in subsection (c), the words "recommended full quantity indicated" and inserting in place thereof the words:- "full prescribed quantity"

SECTION 4. Chapter 175 of the General Laws, as amended by chapter 233 of the acts of 2016, is hereby amended by inserting after section 47II the following section:-

Section 47JJ. Any policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth, which is considered creditable coverage under section 1 of chapter 111M, shall provide, for any covered drug that is a narcotic substance contained in schedule II of section 3 of chapter 94C and that is subject to cost sharing, a schedule that allows for adjustments and reductions in the cost sharing when a person requests a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C.

SECTION 5. Chapter 176A of the General Laws, as amended by chapter 233 of the acts of 2016, is hereby amended by inserting after section 8KK the following section:-

Section 8LL. Any contract between a subscriber and the corporation under an individual or group hospital service plan which is delivered, issued or renewed within the commonwealth shall provide, for any covered drug that is a narcotic substance contained in schedule II of section 3 of chapter 94C and that is subject to cost sharing, a schedule that allows for adjustments and reductions in the cost sharing when a person requests a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C.

SECTION 6. Chapter 176B of the General Laws, as amended by chapter 233 of the acts of 2016, is hereby amended by inserting after section 4KK the following section:-

Section 4LL. Any subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall provide, for any covered drug that is a narcotic substance contained in schedule II of section 3 of chapter 94C and that is subject to cost sharing, a schedule that allows for adjustments and reductions in the cost sharing when a person requests a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C.

SECTION 7. Chapter 176G of the General Laws, as amended by chapter 233 of the acts of 2016, is hereby amended by inserting after section 4CC the following section:-

Section 4DD. An individual or group health maintenance contract that is issued or renewed shall provide, for any covered drug that is a narcotic substance contained in schedule II of section 3 of chapter 94C and that is subject to cost sharing, a schedule that allows for adjustments and reductions in the cost sharing when a person requests a prescription filled in a lesser quantity pursuant to section 18 of said chapter 94C.

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDERS

HB2469 / SB1214

An Act to Enhance Access to Prescription Information and Overdose Reporting for Care Coordination

(Rep. Malia/Sen. Lesser)

Referred to the Joint Committee on Public Health

SUMMARY

This legislation will ensure that entities such as the MHA Pre-Manage ED initiative can access Massachusetts Prescription Awareness Tool (MassPAT) data for healthcare diagnosis, treatment and coordination purposes. It also seeks to maintain essential state and regional reporting from the state on fatal and non-fatal opioid overdoses beyond its current 2017 sunset.

- Section 1: Ensures that provider entities and their vendors that provide Health Information Exchange Platforms or care management tools (such MHA's Pre-Manage ED initiative) are able to access, integrate and maintain MassPAT data for the purposes of compiling and visualizing such data within the electronic health records of a healthcare provider that supports diagnosis, treatment and care coordination.
- Sections 2/3: Extends the time frame that the state's Department of Public Health must provide a statewide opioid overdose report, which sunsets in 2016, to run through 2020. The goal is to ensure that prescribers and facilities can access opioid overdose information for statewide or regional planning purposes.

BILL TEXT

SECTION 1. Section 24A of Chapter 94C of the general laws, as so appearing, is hereby amended by striking subsection (g) and inserting in place thereof the following:

(g) The department may, at its initiative, provide data from the prescription monitoring program to practitioners in accordance with section 24; provided, however, that healthcare providers, as defined in Section 1 of Chapter 111, shall be able to access the data directly through a secure electronic medical record, health information exchange, or other similar software or information systems connected to the prescription monitoring program for the purposes of: (i) improving ease of access and utilization of such data for treatment, diagnosis, or healthcare operations; (ii) supporting integration of such data within the electronic health records of a healthcare provider for purposes of treatment, diagnosis, or healthcare operations; or, (iii) allowing healthcare providers and their vendors to maintain such data for the purposes of compiling and visualizing such data within the electronic health records of a healthcare provider that supports treatment, diagnosis, or healthcare operations.

SECTION 2. Section 1 of Chapter 55 of the Acts of 2015, as most recently amended by Section 136 of Chapter 133 of the Acts of 2016, is hereby further amended by striking out the first paragraph and inserting in place thereof the following paragraph:

Notwithstanding any general or special law to the contrary, the secretary of health and human services, in collaboration with the department of public health, shall conduct or provide for an examination of the prescribing and treatment history, including court-ordered treatment or treatment within the criminal justice system, of persons in the commonwealth who suffered fatal or nonfatal opiate overdoses in calendar years 2013 to 2020, inclusive. Any report or supplemental reports resulting from this examination shall provide any data in an aggregate and de-identified format.

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDERS

SECTION 3. Section 1 of Chapter 55 of the Acts of 2015, as most recently amended by Section 137 of Chapter 133 of the Acts of 2016, is hereby further amended by striking out the fourth paragraph and inserting in place thereof the following paragraph:

The report, which shall be publicly available, shall be filed with the clerks of the senate and house of representatives, the house and senate chairs of the joint committee on mental health and substance abuse, the joint committee on public health, the joint committee on health care financing and the house and senate committees on ways and means. The secretary of health and human services may publish supplemental reports on the trends identified through its examination; provided, however, that any supplemental report shall be filed not later than July 1, 2021 and shall be filed with the clerks of the senate and house of representatives, the house and senate chairs of the joint committee on mental health and substance abuse, the joint committee on public health, the joint committee on health care financing and the house and senate committees on ways and means.

HB616

An Act Ensuring Protections for Hospitals that Contract with Medicaid Managed Care Organizations

(Rep. Linsky)

Referred to the Joint Committee on Health Care Financing

SUMMARY

In August, MassHealth informed hospitals that it will now limit reimbursements paid from MassHealth MCOs (managed care organizations) to acute care hospitals. With only strictly limited exceptions, MCOs will not be permitted to reimburse more than 105% of the MassHealth fee-for-service rates for in-network acute care hospital services. MassHealth expects the cap to be fully implemented by January 1, 2017. In addition, the 2017 acute care hospital RFA (the contract that hospitals sign with MassHealth to provide services) requires out-of-network acute care hospitals to accept the MassHealth fee-for-service rate for non-emergency services provided to MassHealth MCO members and to also execute a contract with at least one MCO if offered.

According to MassHealth, these MCO policies, when annualized, will result in payment reductions to acute care hospitals that total \$100 million to \$150 million. However, the state will only realize \$22.5 million in budget savings on an annualized basis. As MassHealth capitation rates paid to MCOs already assume 105% of Medicaid hospital fee-for-service rates, the savings for the state will come solely through a 1% reduction in capitation rates, which MassHealth states is worth only approximately \$45 million – half of which is federal revenue.

This bill will reverse these changes by re-establishing the long-standing free market practice of allowing healthcare providers to freely negotiate with MassHealth MCOs for in-network services. Additionally, the bill will prohibit MassHealth policies that seek to mandate limited reimbursement for non-emergency services provided to patients covered by out-of-network MassHealth MCOs.

BILL TEXT

Section 1: Section 13E½ of Chapter 118E of the general laws, as appearing in the 2014 official edition, is hereby amended by inserting the following clause at the end of the first paragraph:

“provided further, that acute care hospital reimbursement from managed care organizations that contract with the executive office shall for health services provided to beneficiaries under this chapter be subject to negotiation between those hospitals and managed care organizations and shall not be limited or determined through contracts between the executive office and managed care organizations.”

Section 2: Subsection (b) of Section 13F of Chapter 118E of the general laws, as so appearing, is hereby amended by inserting at the end of the first paragraph the following new sentence:

“Provided further, the executive office shall not, in its contracts with hospitals or through any other rule or regulation, require hospitals to accept fee-for-service rates established by the office of Medicaid for non-emergency services provided to beneficiaries enrolled in managed care organizations.”

HB2984

An Act to Restore Adequate Funding for Disproportionate Share Hospitals

(Rep. Finn)

Referred to the Joint Committee on Health Care Financing

SUMMARY

This legislation requires MassHealth to restore a 5 percent supplementary adjustment its reimbursement rates for disproportionate share hospitals (DSH). This additional amount is similar to what the legislature had endorsed in both FY2014 and FY2015. In recent years, MassHealth has provided supplemental payments to disproportionate share hospitals. However these payments have not always been fulfilled in their entirety by MassHealth. For example, FY2016 supplemental payments from MassHealth were \$11 million less than what the legislature appropriated in FY2016. In FY2017, no payments will be made as MassHealth has revised the formula for these payments to be based on data that won't be finalized until March 31, 2018. This is despite funding being included in the FY2017 MassHealth budget by the legislature expressly for this purpose. This legislation will return the DSH adjustment to the actual reimbursement rates instead of a year-end supplemental payment which will improve the reliability of the funding and allow these hospitals to factor this needed funding into their current operations. The legislation also directs MassHealth to provide \$12.3 million in supplementary payments for behavioral health services provided by disproportionate share hospitals to MassHealth patients, the same amount provided in FY2015 as directed by the legislature.

BILL TEXT

SECTION 1. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall require Medicaid to annually include in its reimbursement rates to disproportionate share hospitals as defined under section 8A of chapter 118E an additional 5 percent to its inpatient adjudicated payment amount per discharge and an additional 5 percent to its outpatient adjudicated payment amount per episode of care; provider further, the executive office shall require Medicaid to annually provide a supplemental payment of at least \$12,307,769 for inpatient and outpatient behavioral and mental health services provided by disproportionate share hospitals subject to all required federal approvals and the availability of federal financial participation and shall be prioritized for services provided to children and adolescents.

HB595 / SB623

An Act to Address the Financial Sustainability of the Health Safety Net

(Rep. Benson / Sen. Flanagan)

Referred to the Joint Committee on Health Care Financing

SUMMARY

The commonwealth continues to need a strong safety net for uninsured and underinsured Massachusetts residents and the Health Safety Net program is an integral part of protecting these patients. However, the program has in most years operated with a funding shortfall and this financial instability threatens the viability of the program. This bill addresses the financial stability in three ways. First, it reinforces the current statutory requirement of the Unemployment Assistance Trust Fund's contribution to support the Health Safety Net with at least \$30 million annually, which has not been fulfilled in recent years. The bill also protects the federal revenue generated by Health Safety Net spending by dedicating it to the Health Safety Net Trust Fund. Finally, the bill allocates responsibility for any funding shortfall in the program equally among hospitals and surcharge payers. While hospitals and surcharge payers are currently assessed an equal amount to fund the Health Safety Net, currently hospitals alone are solely responsible for any funding shortfall in the program.

BILL TEXT

SECTION 1. Section 2000 of Chapter 29 of the general laws, as appearing in the 2014 official edition, shall be amended by striking the third sentence in the second paragraph in its entirety and inserting in place thereof the following:

Money from the fund shall be transferred to the Health Safety Net Trust Fund, or any successor fund, as necessary to provide payments to acute hospitals and community health centers for reimbursable health services. No less than the amounts in subsection (b) of section 189 of chapter 149 of the general laws shall be annually transferred to the Health Safety Net Trust Fund.

SECTION 2. Section 64 of Chapter 118E of the general laws, as so appearing, shall be amended by inserting the following new definition:

"Supplemental surcharge amount", an amount equal to 50 per cent of the annual revenue shortfall in the Health Safety Net Trust fund as estimated by the health safety net office no later than 60 days after the fund fiscal year end.

SECTION 3. Section 66 of Chapter 118E of the general laws, as so appearing, is here by amended by striking the first sentence in its entirety and inserting in place thereof the following:

The fund shall consist of: (i) all amounts paid by acute hospitals and surcharge payors under sections 67 and 68; (ii) all appropriations for the purpose of payments to acute hospitals or community health centers for health services provided to uninsured and underinsured residents; (iii) any transfers from the Commonwealth Care Trust Fund, established under section 2000 of chapter 29; (iv) all property and securities acquired by and through the use of monies belonging to the fund and all interest thereon; and (v) an amount equal to any federal financial participation revenues claimed and received by the commonwealth for eligible expenditures made from the fund.

SECTION 4. Subsection (a) Section 68 of Chapter 118E of the general laws, as so appearing, shall be amended by inserting the following new words immediately following the phrase “total surcharge amount” in the three places that it so appears in this subsection:

“and the supplemental surcharge amount”

SECTION 5. Section 69 of Chapter 118E of the general laws, as so appearing, shall be amended by striking subsection b in its entirety and inserting in place thereof the following:

(b) By April 1 of the year preceding the start of the fund fiscal year, the office shall, after consultation with the office of Medicaid, and using the best data available, provide an estimate of the projected total reimbursable health services provided by acute hospitals and community health centers and emergency bad debt costs, the total funding available and any projected shortfall after adjusting for reimbursement payments to community health centers. If a shortfall in revenue exists in any fund fiscal year to cover projected costs for reimbursement of health services, the office shall allocate half of that shortfall in a manner that reflects each hospital’s proportional financial requirement for reimbursements from the fund, including, but not limited to, the establishment of a graduated reimbursement system and under any additional regulations promulgated by the office. The remaining half of the shortfall shall be accounted for through a supplemental surcharge amount that is paid in accordance with section 64 and 68.

HB611

An Act Updating MassHealth Reimbursement Rates for Chronic Disease and Rehabilitation Hospitals

(Rep. Honan)

Referred to the Joint Committee on Health Care Financing

SUMMARY

The goal of this legislation is to require MassHealth to provide a more fair and equitable basis for reimbursing chronic disease and rehabilitation hospitals who care for critically and chronically ill patients in need of prolonged care and recovery time unavailable elsewhere. These facilities are an essential component of the integrated and efficient health care delivery system that is the basis of the Massachusetts' health care reform effort. However, MassHealth currently uses outdated cost data from 2003 to set the reimbursement rates for these post-acute care hospitals. This artificially reduces the reimbursement for these facilities and threatens the future of post-acute care hospitals and our evolving integrated care delivery system. This bill would ensure that the MassHealth program relies upon a more recent and appropriate base year of FY2012 when calculating inpatient rates for post-acute care hospitals.

BILL TEXT

SECTION 1: Notwithstanding any general or special law to the contrary, for services provided on or after October 1, 2017, the Office of Medicaid shall update the chronic disease and rehabilitation hospitals inpatient per diem reimbursement rates using operating and capital cost information for each hospital based on data no earlier than fiscal year 2012, in addition to other customary payment rate adjustments to chronic disease and rehabilitation inpatient hospital reimbursement methodologies.

HB614

An Act Administering National Standards to Medicaid Medical Necessity Reviews

(Rep. Kulik)

Referred to the Joint Committee on Health Care Financing

SUMMARY

This bill ensures that the Office of Medicaid complies with review guidelines established by the Massachusetts Patients' Bill of Rights, as well as requiring clinicians conducting reviews to be practicing in the same specialty of the clinical services that are the subject of an adverse determination. The Patients' Bill of Rights required that the determination of coverage for clinical services should be done by a clinician in the same specialty as the provider who treated the patient. Similar standards, however, have never been adopted by the MassHealth program, which often sends out letters to patients without any explanation as to why they made an adverse determination. This results in unnecessary administrative expenses for both the state and the provider community. Patients and healthcare providers should receive information from MassHealth when cases are denied so that providers can work to update their clinical and operational practices to prevent such denials for patients in the future.

BILL TEXT

SECTION 1. Section 8 of chapter 118E of the General Laws, as appearing in the 2014 Official Edition, is hereby amended in line 3 by inserting after the words "meaning:" the following definitions:

"Adverse determination", a determination from a clinical peer reviewer, based upon a concurrent and retrospective medical review of information provided by a healthcare provider, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

"Clinical peer reviewer", a physician or other health care professional, other than the physician or other health care professional who made the initial decision, who holds a non-restricted license from the appropriate professional licensing board in the commonwealth, a current board certification from a specialty board approved by the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists from the major areas of clinical services or, for non-physician health care professionals, the recognized professional board for their specialty, who also actively practices in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and whose compensation does not directly or indirectly depend upon the quantity, type or cost of the services that such person approves or denies.

SECTION 2. Section 51 of said chapter 118E, as so appearing, is hereby amended by inserting after the first paragraph the following new paragraph:

Upon making an adverse determination regarding an admission, continued inpatient stay, or the availability of any other health care services or procedure, the division shall provide a written notification of the adverse determination that shall include a substantive clinical justification that is consistent with generally accepted principles of professional medical

practice, and shall, at a minimum: (1) identify the specific information upon which the adverse determination was based; (2) discuss the medical assistance recipient's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons based on national evidence based medical standards and criteria that such medical evidence fails to meet a national evidence based medical standard and criteria; (3) specify any alternative treatment option offered by the division, if any; and (4) reference and include applicable clinical practice guidelines and review criteria used in making the adverse determination. The division shall give a provider treating a medical assistance recipient an opportunity to seek reconsideration of an adverse determination. Said reconsideration process shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if said reviewer cannot be available within one working day. If the adverse determination is not reversed by the reconsideration process, nothing in the paragraph shall prevent the provider from pursuing the claim through the division's appeal process.

HB592 / SB630

An Act Restoring Affordable Health Connector Coverage

(Rep. Balsler/Sen. Jehlen)

Referred to the Joint Committee on Health Care Financing

SUMMARY

The state's ConnectorCare program provides subsidies to help lower income Massachusetts residents pay for health insurance through the Health Connector. Recent ConnectorCare premium increases and the likely repeal of key provisions of the Affordable Care Act (ACA) reduces the availability of affordable health coverage options and puts the ConnectorCare program at risk. This legislation ensures the continuation of ConnectorCare and, in particular, protects members from drastic premium and cost-sharing increases. Without these protections, the state risks people dropping coverage, going without necessary care, falling into debt, and unraveling the coverage gains that the state has made under both the Massachusetts health reform law and the ACA.

BILL TEXT

SECTION 1. Section 9 of chapter 118E of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by inserting after the word "office.", in line 45, the following:-

"Enrollees with a household income that does not exceed 100 per cent of the federal poverty guidelines shall only be responsible for copayments equal to those required of enrollees in the MassHealth program. No other deductible, cost sharing or premium shall apply to these enrollees. Enrollees with income that does not exceed 150 per cent of said guidelines shall have available to them at least one plan with no premium contribution."

SECTION 2. Section 3 of chapter 176Q of the General Laws, as so appearing, is hereby amended by striking out clause (b) and inserting in place thereof the following clause:-

"(b) to determine each applicant's eligibility for purchasing insurance offered by the connector, and to establish eligibility criteria and determine eligibility for premium assistance payments or point of service cost-sharing subsidies for applicants at or below 300 per cent of the federal poverty guidelines, provided that individuals receiving premium assistance payments or point-of-service cost-sharing subsidies whose household income does not exceed 100 per cent of the federal poverty guidelines shall only be responsible for copayments equal to those required of enrollees in the MassHealth program, and no other premium, deductible or cost-sharing shall apply to these enrollees; provided further that individuals receiving premium assistance or point-of-service cost-sharing subsidies with income that does not exceed 150 per cent of said guidelines shall have available to them at least one plan with no premium contribution; provided further that for individuals not described above receiving premium assistance payments or point-of-service cost-sharing subsidies whose household income does not exceed 300 per cent of the federal poverty guidelines, premium contributions shall be on a sliding scale based on income; provided further, that premiums shall not exceed those at levels established in the enrollee premium contribution schedule for 2016, with adjustments by a reasonable inflation factor; provided further that plans offered to individuals whose household income exceeds 100 per cent of the federal poverty guidelines but does not exceed 200 per cent of the federal poverty guidelines shall meet 97 percent actuarial value, provided further that plans offered to individuals whose household income exceeds 200 per cent of the federal poverty guidelines but does not exceed 300 per cent of the federal poverty guidelines shall meet 95 percent actuarial value."

TELEMEDICINE

HB578/SB549

An Act Advancing and Expanding Access to Telemedicine Services

(Rep. Scibak / Sen. Lewis)

Referred to the Joint Committee on Financial Services

SUMMARY

This legislation seeks to ensure that telemedicine shall be covered by all commercial insurers in addition to MassHealth and the GIC in the same manner as an in-person visit. In particular, it states that:

- Health care services delivered by way of telemedicine shall be covered to the same extent as if they were provided via in-person consultation or in-person delivery.
- Rates of payment for otherwise covered services cannot be reduced on the grounds that those services were delivered via telemedicine.
- Co-payments, co-insurances and deductibles cannot exceed the amount of the same co-payments, co-insurances & deductibles for in-person visits.
- Providers will not be required to document a barrier to an in-person visit in order to provide care via telemedicine, nor can the insurer limit the type of setting where telemedicine can be provided.
- Telemedicine is defined as the use of synchronous or asynchronous audio, video or other electronic media for the purpose of diagnosis, consultation, prescribing, and treatment of a patient's physical, oral and mental health that meets applicable health information privacy and security standards similar to those provided during an in-person visit. Telemedicine shall not include audio-only telephone, facsimile machine, but may include online adaptive interviews or text-only e-mail used when it occurs for the purpose of patient management in the context of a pre-existing physician-patient relationship.
- Nothing in these sections shall be interpreted as changing the prevailing standard of care for healthcare services whether delivered in person or through telemedicine. And although not explicitly stated in the text, patients retain all rights to decline care via telemedicine just as they would decline any other treatment under the patients bill of rights and since the prevailing standard of care does not change, the standard for informed consent to treatment is the same as for an in-person visit.

Sections 2 & 9 direct the respective boards of registration for various healthcare providers to promulgate regulations allow licensees to obtain proxy credentialing and privileging for telemedicine services with other healthcare providers or facilities consistent with the federal Medicare Conditions of Participation telemedicine standards.

Additionally, these sections direct that the regulations address the establishment of the provider-patient relationship by requiring that they ensure that providers using telemedicine services conducts such services within a provider to patient relationship which includes the provider agreeing to affirmatively diagnose and treat the patient, or affirmatively agreeing to participate in the patient's diagnosis and treatment. Additionally, the bill directs that the regulations shall allow for the establishment of the provider-patient relationship via telemedicine.

Finally, these sections also make clear that nothing included in these regulations will modify any law or regulation related to licensure requirements for the Massachusetts licensure of providers delivering telemedicine services to consumers in Massachusetts and does not change the prevailing standard of care for healthcare services, whether delivered in-person or through telemedicine.

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BILL TEXT

SECTION 1. Chapter 32A of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by adding at the end the following new section:

Section 28: Notwithstanding any general or special law or rule or regulation to the contrary, the Group Insurance Commission and any carrier, as defined in Section 1 of Chapter 176O of the general laws or other entity which contracts with the Commission to provide health benefits to eligible Employees and Retirees and their eligible dependents, shall not decline to provide coverage for health care services solely on the basis that those services were delivered through the use of telemedicine by a contracted health care provider. Health care services delivered by way of telemedicine shall be covered to the same extent as if they were provided via in-person consultation or in-person delivery, nor shall the rates of payments for otherwise covered services be reduced on the grounds that those services were delivered through telemedicine. A contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of the same health care services. For health care services provided through telemedicine, a health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where such telemedicine is provided be limited. For the purposes of this section, "telemedicine" shall mean the use of synchronous or asynchronous audio, video or other electronic media for the purpose of diagnosis, consultation, prescribing, and treatment of a patient's physical, oral and mental health care that meets applicable health information privacy and security standards similar to those provided during an in-person visit. Telemedicine shall not include audio-only telephone or facsimile machine communications, but may include an online adaptive interview. Telemedicine may also include text only email when it occurs for the purpose of patient management in the context of a pre-existing physician patient relationship. Nothing in this paragraph shall be interpreted as changing the prevailing standard of care for healthcare services whether delivered in person or through telemedicine.

SECTION 2. Section 2 of Chapter 112 of the General Laws, as so appearing, is hereby amended by inserting at the end thereof the following:

Notwithstanding any other provision of this chapter, the board shall promulgate regulations to allow licensees to obtain proxy credentialing and privileging for telemedicine services with other healthcare providers as defined in section 1 of chapter 111 of the general laws or facilities consistent with federal Medicare Conditions of Participation telemedicine standards. Said regulations shall ensure that licensees using telemedicine to provide services are done within a provider to patient relationship which includes the provider agreeing to affirmatively diagnose, treat and prescribe to the patient, or affirmatively agreeing to participate in the patient's diagnosis and treatment. Said regulations shall allow for the establishment of the physician-patient relationship via telemedicine. Such regulations shall be promulgated six months after the effective date of this act. For the purposes of this section, "telemedicine" shall mean the use of synchronous or asynchronous audio, video or other electronic media for the purpose of diagnosis, consultation, prescribing, and treatment of a patient's physical, oral and mental health care that meets applicable health information privacy and security standards similar to those provided during an in-person visit. Telemedicine shall not include audio-only telephone or facsimile machine communications, but may include an online adaptive interview. Telemedicine may also include text only email when it occurs for the purpose of patient management in the context of a pre-existing physician patient relationship. For the purposes of this paragraph, nothing herein shall modify any law or regulation related to the

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requirements for Massachusetts licensure for individual providers delivering services through telemedicine services to consumers in the Commonwealth; provided further, that this paragraph shall not change the prevailing standard of care for healthcare services whether delivered in-person or through telemedicine.

SECTION 3. Chapter 118E of the General Laws, as so appearing, is hereby amended by inserting at the end thereof the following new section:

Section 13C1/2. Notwithstanding any general or special law or rule or regulation to the contrary, the Executive Office of Health and Human Services shall provide coverage under its Medicaid contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract to a Medicaid managed care organization, the Medicaid primary care clinician plan, or an accountable care organization for health care services provided through telemedicine by a contracted provider. Health care services delivered by way of telemedicine shall be covered to the same extent as if they were provided via in-person consultation or in-person delivery, nor shall the rates of payments for otherwise covered services be reduced on the grounds that those services were delivered through telemedicine. A contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of the same health care services. For health care services provided through telemedicine, a health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where such telemedicine is provided be limited. For the purposes of this section, "telemedicine" shall mean the use of synchronous or asynchronous audio, video or other electronic media for the purpose of diagnosis, consultation, prescribing, and treatment of a patient's physical, oral and mental health care that meets applicable health information privacy and security standards similar to those provided during an in-person visit. Telemedicine shall not include audio-only telephone or facsimile machine communications, but may include an online adaptive interview. Telemedicine may also include text only email when it occurs for the purpose of patient management in the context of a pre-existing physician patient relationship. Nothing in this section shall be interpreted as changing the prevailing standard of care for healthcare services whether delivered in person or through telemedicine.

SECTION 4. Section 47BB of chapter 175 of the General Laws, is hereby amended by striking subsections (a)-(d) and adding at the end of the existing paragraph the following new paragraph:

Notwithstanding any general or special law or rule or regulation to the contrary, an insurer shall provide for coverage for health care services under an individual, group, or general policy of accident and sickness insurance to an insured through the use of telemedicine by a contracted health care provider. Health care services delivered by way of telemedicine shall be covered to the same extent as if they were provided via in-person consultation or in-person delivery, nor shall the rates of payments for otherwise covered services be reduced on the grounds that those services were delivered through telemedicine. A contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of the same health care services. For health care services provided through telemedicine, a health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where such telemedicine is provided be limited. For the purposes of this section, "telemedicine" shall mean the

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use of synchronous or asynchronous audio, video or other electronic media for the purpose of diagnosis, consultation, prescribing, and treatment of a patient's physical, oral and mental health care that meets applicable health information privacy and security standards similar to those provided during an in-person visit. Telemedicine shall not include audio-only telephone or facsimile machine communications, but may include an online adaptive interview. Telemedicine may also include text only email when it occurs for the purpose of patient management in the context of a pre-existing physician patient relationship. Nothing in this paragraph shall be interpreted as changing the prevailing standard of care for healthcare services whether delivered in person or through telemedicine.

SECTION 5. Chapter 176A of the General Laws, as so appearing, is hereby amended by inserting at the end thereof the following new section:

Section 38: Notwithstanding any general or special law or rule or regulation to the contrary, any contract between a subscriber and the corporation under an individual or group hospital service plan shall provide for coverage for health care services to a subscriber through the use of telemedicine by a contracted health care provider. Health care services delivered by way of telemedicine shall be covered to the same extent as if they were provided via in-person consultation or in-person delivery, nor shall the rates of payments for otherwise covered services be reduced on the grounds that those services were delivered through telemedicine. A contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of the same health care services. For health care services provided through telemedicine, a health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where such telemedicine is provided be limited. For the purposes of this section, "telemedicine" shall mean the use of synchronous or asynchronous audio, video or other electronic media for the purpose of diagnosis, consultation, prescribing, and treatment of a patient's physical, oral and mental health care that meets applicable health information privacy and security standards similar to those provided during an in-person visit. Telemedicine shall not include audio-only telephone or facsimile machine communications, but may include an online adaptive interview. Telemedicine may also include text only email when it occurs for the purpose of patient management in the context of a pre-existing physician patient relationship. Nothing in this paragraph shall be interpreted as changing the prevailing standard of care for healthcare services whether delivered in person or through telemedicine.

SECTION 6. Chapter 176B of the General Laws, as so appearing, is hereby amended by inserting at the end thereof the following new section:

Section 25: Notwithstanding any general or special law or rule or regulation to the contrary, any contract between a subscriber and the medical service corporation shall provide for coverage for health care services to a subscriber through the use of telemedicine by a contracted health care provider. Health care services delivered by way of telemedicine shall be covered to the same extent as if they were provided via in-person consultation or in-person delivery, nor shall the rates of payments for otherwise covered services be reduced on the grounds that those services were delivered through telemedicine. A contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of the same health care services. For health care services provided through

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telemedicine, a health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where such telemedicine is provided be limited. For the purposes of this section, “telemedicine” shall mean the use of synchronous or asynchronous audio, video or other electronic media for the purpose of diagnosis, consultation, prescribing, and treatment of a patient’s physical, oral and mental health care that meets applicable health information privacy and security standards similar to those provided during an in- person visit. Telemedicine shall not include audio-only telephone or facsimile machine communications, but may include an online adaptive interview. Telemedicine may also include text only email when it occurs for the purpose of patient management in the context of a pre-existing physician patient relationship. Nothing in this section shall be interpreted as changing the prevailing standard of care for healthcare services whether delivered in person or through telemedicine.

SECTION 7. Chapter 176G of the General Laws, as so appearing, is hereby amended by inserting at the end thereof the following new section:

Section 33: Notwithstanding any general or special law or rule or regulation to the contrary, any contract between a member and a carrier shall provide for coverage for health services to a subscriber through the use of telemedicine by a contracted health care provider. Health care services delivered by way of telemedicine shall be covered to the same extent as if they were provided via in-person consultation or in-person delivery, nor shall the rates of payments for otherwise covered services be reduced on the grounds that those services were delivered through telemedicine. A contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of the same health care services. For health care services provided through telemedicine, a health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where such telemedicine is provided be limited. For the purposes of this section, “telemedicine” shall mean the use of synchronous or asynchronous audio, video or other electronic media for the purpose of diagnosis, consultation, prescribing, and treatment of a patient’s physical, oral and mental health care that meets applicable health information privacy and security standards similar to those provided during an in- person visit. Telemedicine shall not include audio-only telephone or facsimile machine communications, but may include an online adaptive interview. Telemedicine may also include text only email when it occurs for the purpose of patient management in the context of a pre-existing physician patient relationship. Nothing in this section shall be interpreted as changing the prevailing standard of care for healthcare services whether delivered in person or through telemedicine.

SECTION 8. Chapter 176I of the General Laws, as so appearing, is hereby amended by inserting at the end thereof the following new section:

Section 13: Notwithstanding any general or special law or rule or regulation to the contrary, any contract between a covered person and an organization shall provide for coverage for health care services to a subscriber through the use of telemedicine by a contracted health care provider. Health care services delivered by way of telemedicine shall be covered to the same extent as if they were provided via in-person consultation or in-person delivery, nor shall the rates of payments for otherwise covered services be reduced on the grounds that those services were delivered through telemedicine. A contract that provides coverage for telemedicine services may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as

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the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation or in-person delivery of the same health care services. For health care services provided through telemedicine, a health care provider shall not be required to document a barrier to an in-person visit, nor shall the type of setting where such telemedicine is provided be limited. For the purposes of this section, "telemedicine" shall mean the use of synchronous or asynchronous audio, video or other electronic media for the purpose of diagnosis, consultation, prescribing, and treatment of a patient's physical, oral and mental health care that meets applicable health information privacy and security standards similar to those provided during an in-person visit. Telemedicine shall not include audio-only telephone or facsimile machine communications, but may include an online adaptive interview. Telemedicine may also include text only email when it occurs for the purpose of patient management in the context of a pre-existing physician patient relationship. Nothing in this section shall be interpreted as changing the prevailing standard of care for healthcare services whether delivered in person or through telemedicine.

SECTION 9. Notwithstanding any general or special law or rule or regulation to the contrary, the Bureau of Health Professions Licensure within the Department of Public Health and the Division of Professional Licensure within the Office of Consumer Affairs and Business Regulation shall, respectively, promulgate regulations to allow licensees to obtain proxy credentialing and privileging for telemedicine services with other healthcare providers as defined in section 1 of chapter 111 of the general laws, allied health professionals as defined in section 23A of chapter 112 of the general laws, and allied mental health or human service professionals as defined in section 163 of chapter 112 of the general laws or facilities consistent with federal Medicare Conditions of Participation telemedicine standards. Said regulations shall ensure that providers using telemedicine to provide services are done within a provider to patient relationship, which includes the provider agreeing to affirmatively diagnose and treat the patient, including prescriptions when appropriate, or affirmatively agreeing to participate in the patient's diagnosis and treatment. Said regulations shall also allow for the establishment of the provider-patient relationship via telemedicine. Such regulations shall be promulgated six months after the effective date of this act. For the purposes of this section, "telemedicine" shall mean the use of synchronous or asynchronous audio, video or other electronic media for the purpose of diagnosis, consultation, prescribing, and treatment of a patient's physical, oral and mental health care that meets applicable health information privacy and security standards similar to those provided during an in-person visit. Telemedicine shall not include audio-only telephone or facsimile machine communications, but may include an online adaptive interview. Telemedicine may also include text only email when it occurs for the purpose of patient management in the context of a pre-existing physician patient relationship. For the purposes of this paragraph, nothing herein shall modify any law or regulation related to the requirements for Massachusetts licensure for individual providers delivering services through telemedicine services to consumers in the Commonwealth; provided further, that this paragraph shall not change the prevailing standard of care for healthcare services whether delivered in-person or through telemedicine.

SECTION 10. The provisions this Act shall be effective for all contracts which are entered into, renewed, or amended one year after its effective date.

ADMINISTRATIVE SIMPLIFICATION & COST REDUCTION

HB523

An Act Relative to Uncollected Co-Pays, Co-Insurance and Deductibles

(Rep. Fiola)

Referred to the Joint Committee on Financial Services

SUMMARY

“Consumer-directed” health insurance plans are more prevalent under the Affordable Care Act (ACA) as employers increasingly shift health care costs to patients with larger deductibles, co-insurance and co-payments. In the ACA, some silver and bronze individual insurance plans have deductibles of up to \$2,000 for an individual (with out-of-pocket maximums of \$6,350) and \$4000 deductibles for a family and (with \$12,700 out of pocket maximums). In the Massachusetts Connector, almost half of enrollees in non-group plans choose these high deductible bronze and silver plans. Similarly, many employer groups have added large deductibles to their insurance plans so that patients must share in the cost of services. The result is that patients end up with large out-of-pocket expenses that they can’t pay and healthcare providers end up with uncollectible bad debt for the patient’s unpaid obligations.

Under current policies, insurers may inform patients to refuse payment at the time of service and similarly instruct providers to wait until a claim is adjudicated before billing a patient. In emergency situations, hospitals may not even know the identity of a patient’s insurer, making it impossible (or illegal under EMTALA requirements) to collect any patient obligations at the time of service. Therefore, the burden of uncollectible patient debt is born entirely by the providers, who must also deal with many issues including: patient confusion about their financial responsibilities; spending considerable time and money trying to collect the patient’s debt; and ultimately, writing-off millions of dollars in bad debt when patients cannot pay the amounts owed. This bill requires carriers, who design and sell these plans, to share accountability with providers for uncollectible patient obligations after insurance. This legislation would require insurers to reimburse healthcare providers 65% of an uncollected co-payment, co-insurance, and/or deductible that exceeds \$250 if the provider does not receive payment after the provider has made reasonable collection efforts. The process for reasonable collection efforts outlined in the bill is similar to the processes that Medicare and the state’s Health Safety Net use, with the 65% reimbursement similar to the Medicare methodology.

BILL TEXT

SECTION 1. Chapter 176O of the General Laws, as appearing in the 2014 official edition, is hereby amended by adding the following new section:

Section 7A. Equitable Funding for Health Care Provider Bad Debt

- a. Notwithstanding any other provision of the general laws to the contrary, a carrier shall reimburse a health care provider no less than sixty-five percent (65%) of each co-payment, co-insurance and/or deductible amount due under an insured’s health benefit plan which are unpaid after reasonable collection efforts have been made by the health care provider pursuant to subsection (c) of this section.
- b. As used in this section, the following words shall have the following meanings: a “co-payment” is defined as a fixed dollar amount that is owed by an insured as required under a health benefit plan for health care services provided and billed by a healthcare provider. A “co-insurance” is defined as a percentage of the allowed amount, after a co-payment, if any, that an insured must pay for covered services received under a health benefit plan for health care services provided and billed by a healthcare provider. A “deductible” is defined as a specific dollar amount

ADMINISTRATIVE SIMPLIFICATION & COST REDUCTION

that an insured must pay for covered services before the carrier's health benefit plan becomes obligated to pay for covered health care services provided and billed by a healthcare provider; such deductible does not include any portion of premiums paid by an insured.

- c. Reimbursement for uncollected co-payment, co-insurance and/or deductible amounts due (each a "claim") under an insured's health benefit plan for covered services rendered shall be deemed an uncollectible bad debt, and a health care provider may submit a request for reimbursement to the carrier under the following conditions:
 1. The claim must be derived from the wholly or partially uncollected co-payment, co-insurance and/or deductible amounts under an insured's health benefit plan;
 2. The reimbursement requested by the health care provider should be for a claim where the co-payment, co-insurance, or deductible amount was at least two hundred and fifty dollars (\$250), and each claim reflected a unique covered service under the health benefit plan per insured;
 3. The health care provider must have made reasonable collection efforts for each claim filed for reimbursement under this section, such efforts including documentation that the claim has remained partially or fully unpaid and is not subject to an on-going payment plan for more than one hundred twenty (120) days from the date the first bill was mailed, which may include such efforts as telephone calls, collection letters, or any other notification method that constitutes a genuine and continuous effort to contact the member, said documentation shall include the date and method of contact;
 4. On or before May 1 of each year, the health care provider shall submit an aggregate request for reimbursement representing all claims that meet the criteria under this section in the prior calendar year. The request for reimbursement shall include documentation of the attempt to collect on the claim(s), the name and identification number of the insured, the date of service, the unpaid co-payment, co-insurance, or deductible, the amount that was collected, if any, and the date and general method of contact with the insured. For the purposes of this section, an insured co-payment, co-insurance, and/or deductible amount due shall be determined based on the date that the service is rendered; provided further that a carrier shall not prohibit reimbursement if the insured is no longer covered by the plan on the date that the request is made.
 5. Nothing in this section shall prevent the carrier from conducting an audit of the request for reimbursement of unpaid co-payment, co-insurance, and/or deductible amounts to verify that the insured was eligible for coverage at the time of service, that the service was a covered health benefit under the applicable health benefit plan, and to verify from the provider's internal log that reasonable efforts were made to contact the insured following the criteria outlined in this section. The carrier must complete any such audit of the submitted report from the health care provider and notify the health care provider of any disputes as to the request for reimbursement within one hundred and twenty (120) days of receipt of the request for reimbursement from the health care provider. The carrier shall pay the health care provider sixty-five percent (65%) of the undisputed amounts as submitted by the health care provider in the request for reimbursement in accordance with this section within 120 days of receipt of such requests from the health care provider. Any dispute regarding contested claims shall be subject to a dispute resolution process applicable to the arrangement between the carrier and the health care provider; and

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6. Any amounts attributable to co-payment, co-insurance, or deductible amount collected by a health care provider after reimbursement has been made by the carrier pursuant to this section shall be recorded by the health care provider and reported as an offset to future submissions to such carrier.
- d. No carrier shall prohibit a health care provider from collecting the amount of the insured's co-payment, co-insurance, and/or deductible, if any, at the time of service.

SECTION 2. The division shall promulgate regulations within ninety (90) days of the effective date of this act that are consistent with the rules developed by the Centers for Medicare & Medicaid Services for reasonable collection efforts required by a health care provider prior to submission of a request of reimbursement to a carrier. Notwithstanding the foregoing, in the event that the division fails to promulgate such regulations, the provisions of section 1 shall be self-implementing, and carriers shall make applicable payments to health care providers in accordance with the provisions of section 1 utilizing the same process adopted by the Centers for Medicare & Medicaid Services' reasonable collection efforts for bad debt, as documented in the most recent Medicare Provider Reimbursement Manual, CMS Pub. 15-1 and 15-2 (HIM-15) in effect within 90 days of the effective date of this Act. The division shall further require each carrier to provide the division an annual report showing the total number and amount of uncollected co-payments, co-insurances, and deductibles that are reimbursed as well as those that are denied. The report shall be made publicly available on the division's website.

ADMINISTRATIVE SIMPLIFICATION & COST REDUCTION

HB603/SB665

An Act Regarding Shared Responsibility for Funding of Health Care Oversight Agencies

(Rep. Day/Sen. Tarr)

Referred to the

SUMMARY

Chapter 224 requires that hospitals, ambulatory surgical centers (ASCs), and health insurers pay for the cost of funding the Center for Health Information and Analysis (CHIA) and the Health Policy Commission (HPC). For CHIA, the funding assessment began in FY2013 with the inception of the agency. For the HPC, hospitals, ASCs, and insurers became responsible for the agency's costs beginning in FY2017. The assessment methodology for both agencies is the same, with hospitals and ASCs responsible for at least 33% of each agency's expenses and insurers responsible for at least 33% of the expenses. The intent of Chapter 224 was that hospitals, ASCs, insurers, and the state government would all share equal responsibility for funding these oversight agencies.

Unfortunately, hospitals/ASCs and insurers each have been made responsible for 50% of the CHIA appropriation and other employee fringe benefits. This cost shift to the healthcare community has been further exacerbated by significant growth in CHIA's administrative expenses. Similarly hospitals/ASCs and insurers each have been made responsible for 50% of the HPC's FY17 appropriation.

This legislation reflects the intent of the Chapter 224 language to fund these agencies so that hospitals, ASCs, insurers, and the commonwealth's general fund share equal responsibility for funding CHIA and HPC (the latter beginning in FY2017) since both agencies serve a broad healthcare mission from which the commonwealth benefits.

BILL TEXT

SECTION 1. Section 6 of Chapter 6D of the General Laws, as appearing in the 2014 Official Edition, is hereby amended in line 5 striking the words "not less than" and inserting in place thereof the words "no more than"; and in line 35, by striking the words "not less than" and inserting in place thereof the words "no more than".

SECTION 2. Section 7 of Chapter 12C of the General Laws, as so appearing, is hereby amended in line 5 by striking the words "not less than" and inserting in place thereof the words "no more than"; and in line 35 by striking the words "not less than" and inserting in place thereof the words "no more than".

ADMINISTRATIVE SIMPLIFICATION & COST REDUCTION

HB2982

An Act Maintaining Confidentiality of Proprietary Information within Health Care Oversight Agencies

(Rep. Brodeur)

Referred to the Joint Committee on Health Care Financing

SUMMARY

While there is a recognized need to provide information to oversight agencies to conduct their due diligence in various healthcare oversight programs, there is also an equivalent need to ensure that proprietary information submitted to these agencies is not made public during a state agency's review of records or data. The legislature recently amended the general laws when it established a standard for maintaining the confidentiality of proprietary information during cost-and-market impact reviews conducted by the Health Policy Commission (HPC). This bill seeks to extend that same level of protection to other confidential data reviews by healthcare oversight agencies, including the Center for Health Information & Analysis, the Division of Insurance and the Department of Public Health.

BILL TEXT

SECTION 1. Subsection (a) of section 11 of Chapter 6D of the General Laws, as appearing in the 2014 Official Edition, is hereby amended in line 10 by adding after the words "collected." the following: -

The commission shall keep confidential all nonpublic data obtained under this section and shall not disclose the data to any person without the consent of the provider or payer that produced the data, except in a preliminary report or final report under this section if the commission believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. The confidential data shall not be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

SECTION 2. Subsection (a) of section 9 of chapter 12C of the General Laws, as so appearing, shall be amended in line 10 by inserting after the words "necessary." the following:-

The center shall keep confidential all nonpublic data obtained under this section and shall not disclose the data to any person without the consent of the provider or payer that produced the data, except in a preliminary report or final report under this section if the center believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. The confidential data shall not be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

SECTION 3: Subsection (h) of section 25C of chapter 111 of the General Laws, as so appearing, shall be amended in line 131 by inserting after the words "commission." the following::-

The department shall keep confidential all nonpublic documentation obtained pursuant to this section and shall not disclose such documentation that is not available publicly to any person, entity, or a party of record, without the consent of the applicant that produced the documentation. Said non-public documentation shall not be a public record and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

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SECTION 4. Subsection (c) of section 3 of chapter 176T of the General Laws, as so appearing, shall be amended in line 20 by inserting after the words “commissioner.” the following:-

The division shall keep confidential all nonpublic information obtained under this section and shall not disclose the information to any person without the consent of the provider or payer that produced the information, except in a preliminary report or final report under this section if the division believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. The confidential information shall not be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

ADMINISTRATIVE SIMPLIFICATION & COST REDUCTION

HB563

An Act to Prevent Inappropriate Denials by Insurers for Medically Necessary Services

(Rep. Nangle)

Referred to the Joint Committee on Financial Services

SUMMARY

This bill would ensure healthcare providers are reimbursed for the delivery of medically necessary services that health insurers cover. It prohibits insurers from denying payment for services solely on the basis of an administrative or technical defect in a claim. It also requires insurers to provide clarification of the reasons for claim denials and allows providers sufficient time to re-submit curative claims. It limits the period for payment retractions by insurers for retroactively-terminated insured individuals to 90 days after the original payment is made when the provider can document that it verified eligibility at the time the services were rendered (mirroring a Group Insurance Commission requirement on insurers). The bill also establishes a 30-day timeframe for insurers to respond to provider appeals for retrospective reviews of medically necessary services. If, upon review by the insurer, the service is deemed to be medically necessary, the insurer must reverse the administrative denial and pay the claim to the healthcare provider.

BILL TEXT

SECTION 1. Section 24B of chapter 175 of the General Laws, as appearing in the 20142014 Official Edition, is hereby amended by inserting after the first paragraph the following paragraph:

A carrier , as defined in section 1 of chapter 176O, shall be required to pay for health care services ordered by the health care provider if (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services follow the carrier's clinical review criteria. Provided however, a claim for treatment of medically necessary services may not be denied if the health care provider follows the carrier's approved method for securing authorization for a covered service for the insured at the time the service was provided. A carrier shall have no more than twelve months after the original payment was received by the provider to recoup a full or partial payment for a claim for services rendered, or to adjust a subsequent payment to reflect a recoupment of a full or partial payment. However, a carrier shall not recoup payments more than ninety days after the original payment was received by a provider for services provided to an insured that the carrier deems ineligible for coverage because the insured was retroactively terminated or retroactively disenrolled for services, provided that the provider can document that it received verification of an insured's eligibility status using the carrier's approved method for verifying eligibility at the time service was provided. Claims may also not be recouped for utilization review purposes if the services were already deemed medically necessary or the manner in which the services were accessed or provided were previously approved by the carrier or its contractor. A carrier which seeks to make an adjustment pursuant to this section shall provide the health care provider with written notice that explains in detail the reasons for the recoupment, identifies each previously paid claim for which a recoupment is sought, and provides the health care provider with thirty days to challenge the request for recoupment. Such written notice shall be made to the health provider not less than thirty days prior to the seeking of a recoupment or the making of an adjustment.

ADMINISTRATIVE SIMPLIFICATION & COST REDUCTION

HB1205

An Act to Implement Consistent Protections for Health Information

(Rep. Parisella)

Referred to the Joint Committee on Public Health

SUMMARY

This bill implements the federal Health Insurance Portability and Accountability Act (HIPAA) privacy protections for accessing and sharing health information between providers and payers within existing state laws. The federal HIPAA requirements allows for the exchange of data between providers and payers in a confidential and secure manner to streamline treatment, payment, and healthcare operations. Unfortunately, state law is silent and, in some cases, may be confusing due to prior case law interpretations. The goal of this bill is to align federal and state standards that would also apply a uniform and consistent set of security and confidentiality criteria for clinicians, hospitals, laboratories, pharmacies, skilled nursing facilities, and health insurers. This bill would ensure that uniform standards for sharing of confidential and highly protected information between providers, including the receipt of test results from referring providers.

BILL TEXT

SECTION 1. Section 12G of Chapter 112 of the General Laws, as appearing in the 2014 official edition, is hereby amended by adding at the end of the section the following new paragraph:-

Notwithstanding any general or special law to the contrary, the protections established under this section also shall apply to any disclosure of information by a physician, a health care facility, as defined in section 9C of this Chapter, or any other medical provider or by an agent of any of the foregoing to another healthcare provider or carrier, as such terms are defined in section 1 of chapter 176O of the general laws, as well as a government program so long as such disclosure is made in connection with the treatment, payment or health care operations, and such disclosure is in compliance with applicable federal privacy laws. The terms treatment, payment and health care operations shall have the same definitions as used in the federal privacy regulations, 45 C.F.R. § 164.501.

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SB520

An Act Relative to Health Insurer Reserve Requirements

(Sen. Donoghue)

Referred to the Joint Committee on Financial Services

SUMMARY

This bill increases transparency and requirements around the amount of risk-based capital (RBC) held by carriers. Currently, the surplus of Massachusetts insurers is higher than both the minimum statutory standards and the minimum RBC standards that the state's Division of Insurance (DOI) uses for monitoring purposes. All of the insurers exceed the 200% Company Action RBC level, some by a factor of two or three. Under this bill, carriers exceeding 600% would be listed publicly on the DOI website and would be required to submit testimony to the DOI on the continued need for additional surplus as well as how the carrier will use the additional surplus to reduce the cost of patient premiums. According to the DOI's 2010 report on insurer surplus and reserves, "There are costs for health plan members, customers and the public if surplus is greater than needed for financial soundness. This is particularly true in Massachusetts, where most of the major health plans are non-profit public charities, and surplus is accumulated through operating profits and investment growth. This means that the accumulation of ever increasing amounts of surplus by insurers comes at the expense of the current affordability of health insurance."

In addition, pursuant to Chapter 224 of the Acts of 2012, many providers will be entering into contracts with alternative payment methodologies that require the providers to accept downside risk. Under these global payment arrangements, the provider is responsible for either the full or partial costs of treating a group of patients that may exceed the contracted or budgeted payment arrangements. Currently, insurers carry reserves as a protection against risk; as some or all of this risk is transferred to providers, MHA believes that a corresponding percentage of reserves should be transferred as well. This bill also require carriers to report to the Division of Insurance (DOI) the percentage of downside risk transferred to each certified risk bearing provider organization. The DOI would establish a formula for determining the percentage of reserves to be transferred on an annual basis.

BILL TEXT

SECTION 1. Chapter 176O of the General Laws, as appearing in the 2014 official edition, is hereby amended by striking out section 21 in its entirety and inserting in place thereof the following new section:

Section 21. (a)(1) Each carrier shall submit an annual comprehensive financial statement to the division detailing carrier costs from the previous calendar year; provided, however, that for the purposes of this subsection, "carrier" shall not include any entity to the extent it offers a policy, certificate or contract that does not qualify as creditable coverage as defined in section 1 of chapter 111M.

The annual comprehensive financial statement shall include all of the information in this section and shall be itemized, where applicable, by:

- (i.) market group size, including individual; small groups of 1 to 5, 6 to 10, 11 to 25 and 26 to 50; large groups of 50 to 100, 101 to 500, 501 to 1000 and greater than 1000; and

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(v.) line of business, including individual, general, blanket or group policy of health, accident or sickness insurance issued by an insurer licensed under chapter 175; a hospital service plan issued by a nonprofit hospital service corporation under chapter 176A; a medical service plan issued by a nonprofit hospital service corporation under chapter 176B; a health maintenance contract issued by a health maintenance organization under chapter 176G; insured health benefit plan that includes a preferred provider arrangement issued under chapter 176I; and group health insurance plans issued by the commission under chapter 32A.

(a) The statement shall include, but shall not be limited to, the following information:

- (i.) direct premiums earned, as defined in chapter 176J; direct claims incurred, as defined in said chapter 176J;
- (ii.) medical loss ratio;
- (iii.) number of members;
- (iv.) number of distinct groups covered;
- (v.) number of lives covered;
- (vi.) realized capital gains and losses;
- (vii.) net income;
- (viii.) accumulated surplus;
- (ix.) accumulated reserves;
- (x.) amount of downside risk, as defined in Chapter 176T section 1, transferred to each certified risk bearing provider organization where the carrier has entered into a contractual agreement that utilizes an alternate payment methodology with downside risk;
- (xi.) risk-based capital ratio, based on a formula developed by the National Association of Insurance Commissioners;
- (xii.) financial administration expenses, including underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;
- (xiii.) marketing and sales expenses, including advertising, member relations, member enrollment expenses;
- (xiv.) distributions expenses, including commissions, producers, broker and benefit consultant expenses;
- (xv.) claims operations expenses, including adjudication, appeals, settlements and expenses associated with paying claims;
- (xvi.) medical administration expenses, including disease management, utilization review and medical management expenses;
- (xvii.) network operational expenses, including contracting, hospital and physician relations and medical policy procedures;
- (xviii.) charitable expenses, including any contributions to tax-exempt foundations and community benefits;
- (xix.) board, bureau or association fees;

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- (xx.) any miscellaneous expenses described in detail by expense, including an expense not included in (i) to (xix), inclusive;
- (xxi.) payroll expenses and the number of employees on the carrier's payroll;
- (xxii.) taxes, if any, paid by the carrier to the federal government or to the commonwealth;
- (xxiii.) any capital investments or write downs in investments in related or unrelated organizations;
- (xxiv.) intercompany transfers with subsidiary organizations;
- (xxv.) any changes in reserves for unpaid claims and any other contingent liabilities; and
- (xxvi.) any other information deemed necessary by the commissioner.

(b)(1) In this subsection, the following words shall have the following meanings:--

"Carrier", an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; and an organization entering into a preferred provider arrangement under chapter 176I; or a third party administrator, a pharmacy benefit manager or other similar entity with claims data, eligibility data, provider files and other information relating to health care provided to residents of the commonwealth and health care provided by health care providers in the commonwealth; provided, however, that "carrier" shall not include any entity to the extent it offers a policy, certificate or contract that does not qualify as creditable coverage as defined in section 1 of chapter 111M; provided, further, that "carrier" shall include an entity that offers a policy, certificate or contract that provides coverage solely for dental care services or visions care services.

"Self-insured customer", a self-insured group for which a carrier provides administrative services.

"Self-insured group", a self-insured or self-funded employer group health plan.

"Third-party administrator", a person who, on behalf of a health insurer or purchaser of health benefits, receives or collects charges, contributions or premiums for, or adjusts or settles claims on or for residents of the commonwealth.

(2.) Any carrier required to report under this section, which provides administrative services to 1 or more self-insured groups shall include, as an appendix to such report, the following information:

- (i.) the number of the carrier's self-insured customers;
- (ii.) the aggregate number of members, as defined in section 1 of chapter 176J, in all of the carrier's self-insured customers;
- (iii.) the aggregate number of lives covered in all of the carrier's self-insured customers;
- (iv.) the aggregate value of direct premiums earned, as defined in said section 1 of said chapter 176J, for all of the carrier's self-insured customers;
- (v.) the aggregate value of direct claims incurred, as defined in said section 1 of said chapter 176J, for all of the carrier's self-insured customers;
- (vi.) the aggregate medical loss ratio, as defined in said section of said chapter 176J, for all of the carrier's self-insured customers;
- (vii.) net income;

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- (viii.) accumulated surplus;
 - (ix.) accumulated reserves;
 - (x.) the percentage of the carrier's self-insured customers that include each of the benefits mandated for health benefit plans under chapters 175, 176A, 176B and 176G;
 - (xi.) amount of downside risk, as defined in Chapter 176T section 1, transferred to each certified risk bearing provider organization where the carrier has entered into a contractual agreement that utilizes an alternate payment methodology with downside risk;
 - (xii.) administrative service fees paid by each of the carrier's self-insured customers; and
 - (xiii.) any other information deemed necessary by the commissioner.
- (c.) A carrier who fails to file this report on or before April 1 shall be assessed a late penalty not to exceed \$100 per day. The division shall make public all of the information collected under this section. The division shall issue an annual summary report to the joint committee on financial services, the joint committee on health care financing and the house and senate committees on ways and means of the annual comprehensive financial statements by May 15. The information shall be exchanged with the center for health information and analysis for use under section 10 of chapter 12C. The division shall, from time to time, require payers to submit the underlying data used in their calculations for audit.
- The commissioner shall adopt regulations to carry out this subsection, including standards and procedures requiring the registration of persons or entities not otherwise licensed or registered by the commissioner, such as third-party administrators, and criteria for the standardized reporting and uniform allocation methodologies among carriers.
- The commissioner shall establish a formula to determine the amount of reserves, allocated on an annual basis, to each risk bearing provider organization by each carrier that has entered into an alternative payment methodology with downside risk. The amount to be allocated shall be based on the proportion of risk that the carrier is shifting to the certified risk bearing provider organization. The Division shall promulgate rules to carry out the provision of this subsection, which shall include reporting of such information as part of its requirements for approval of a risk bearing provider organization under Section 3(c) of Chapter 176T.
- (d.) If, in any year, a carrier reports a risk-based capital ratio on a combined entity basis under subsection (a) that exceeds 600 per cent, the division shall hold a public hearing within 60 days. Each carrier that exceeds 600 per cent shall be publicly listed on the Division's website. The carrier shall submit testimony on its overall financial condition and the continued need for additional surplus. The carrier shall also submit testimony on how, and in what proportion to the total surplus accumulated, the carrier will dedicate additional surplus to reducing the cost of health benefit plans. The division shall review such testimony and issue a final report on the results of the hearing. The Division's report shall be made publicly available on the Division's website.
- (e.) The commissioner may waive specific reporting requirements in this section for classes of carriers for which the commissioner deems such reporting requirements to be inapplicable; provided, however, that the commissioner shall provide written notice, which shall be a public record, of any such waiver to the joint committee on health care financing and the house and senate committees on ways and means.

SECTION 2. The Commissioner of Insurance shall promulgate regulations to enforce the provisions of this Act no later than 90 days after the effective date, which shall be effective for provider contracts which are entered into, renewed, or amended on or after the regulations effective date.

QUALITY & PATIENT SAFETY

HB1188/SB1162

An Act Relative to Nurse Licensure Compact in Massachusetts

(Rep. Khan / Sen. Boncore)

Referred to the Joint Committee on Public Health

SUMMARY

This bill authorizes Massachusetts to join the growing the list of states that have adopted the national Nurse Licensure Compact (NLC). 24 states have joined the Compact, including Maine, Rhode Island, and New Hampshire. The NLC follows the mutual recognition model of nurse licensure that allows a nurse to have one license in his or her state of residency and to practice in other states, subject to each state's practice law and regulation. Adoption of the NLC by the Commonwealth will decrease barriers to nursing care and will help ensure the availability of licensed nurses in the Commonwealth, especially during a disaster or during other times of great need for qualified nursing services. The NLC will also provide for greater nurse mobility and will enhance access to essential data on the nursing workforce.

BILL TEXT

By inserting at the end there of the following new sections:-

SECTION XX. The General Laws, as appearing in the 2014 Official Edition, are hereby amended by inserting after chapter 112 the following new chapter:-

Chapter 112A. Nurse Licensure Compact

Section 1. Notwithstanding any general or special law to the contrary, the "Nurse Licensure Compact" or Compact as adopted by the National Council of State Boards of Nursing Nurse Licensure Compact in its Final Version dated May 4, 2015 is hereby enacted into law. The Massachusetts board of registration in nursing shall adopt regulations in the same manner as all other with states legally joining in the Compact as set forth in this chapter.

Section 2. Findings and Declaration of Purpose

a. The party states find that:

1. The health and safety of the public are affected by the degree of compliance with and the effectiveness of enforcement activities related to state nurse licensure laws;
2. Violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public;
3. The expanded mobility of nurses and the use of advanced communication technologies as part of our nation's health care delivery system require greater coordination and cooperation among states in the areas of nurse licensure and regulation;
4. New practice modalities and technology make compliance with individual state nurse licensure laws difficult and complex;
5. The current system of duplicative licensure for nurses practicing in multiple states is cumbersome and redundant for both nurses and states; and
6. Uniformity of nurse licensure requirements throughout the states promotes public safety and public health benefits.

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b. The general purposes of this Compact are to:

1. Facilitate the states' responsibility to protect the public's health and safety;
2. Ensure and encourage the cooperation of party states in the areas of nurse licensure and regulation;
3. Facilitate the exchange of information between party states in the areas of nurse regulation, investigation and adverse actions;
4. Promote compliance with the laws governing the practice of nursing in each jurisdiction;
5. Invest all party states with the authority to hold a nurse accountable for meeting all state practice laws in the state in which the patient is located at the time care is rendered through the mutual recognition of party state licenses;
6. Decrease redundancies in the consideration and issuance of nurse licenses; and
7. Provide opportunities for interstate practice by nurses who meet uniform licensure requirements.

Section 3. Definitions

As used in this Compact, the following words shall have the following meanings:

- a. "Adverse action", means any administrative, civil, equitable or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against a nurse, including actions against an individual's license or multistate licensure privilege such as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting a nurse's authorization to practice, including issuance of a cease and desist action.
- b. "Alternative program", means a non-disciplinary monitoring program approved by a licensing board.
- c. "Coordinated licensure information system", means an integrated process for collecting, storing and sharing information on nurse licensure and enforcement activities related to nurse licensure laws that is administered by a nonprofit organization composed of and controlled by licensing boards.
- d. "Current significant investigative information", means:
 1. Investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or
 2. Investigative information that indicates that the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond.
- e. "Encumbrance", means a revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing imposed by a licensing board.
- f. "Home state", means the party state which is the nurse's primary state of residence.
- g. "Licensing board", means a party state's regulatory body responsible for issuing nurse licenses.
- h. "Multistate license", means a license to practice as a registered or a licensed practical/vocational nurse (LPN/VN) issued by a home state licensing board that authorizes the licensed nurse to practice in all party states under a multistate licensure privilege.

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- i. “Multistate licensure privilege”, means a legal authorization associated with a multistate license permitting the practice of nursing as either a registered nurse (RN) or LPN/VN in a remote state.
- j. “Nurse”, means RN or LPN/VN, as those terms are defined by each party state’s practice laws.
- k. “Party state”, means any state that has adopted this Compact.
- l. “Remote state”, means a party state, other than the home state.
- m. “Single-state license”, means a nurse license issued by a party state that authorizes practice only within the issuing state and does not include a multistate licensure privilege to practice in any other party state.
- n. “State”, means a state, territory or possession of the United States and the District of Columbia.
- o. “State practice laws”, means a party state’s laws, rules and regulations that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for imposing discipline. “State practice laws” do not include requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

Section 4. General Provisions and Jurisdictions

- a. A multistate license to practice registered or licensed practical/vocational nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a nurse to practice as a registered nurse (RN) or as a licensed practical/vocational nurse (LPN/VN), under a multistate licensure privilege, in each party state.
- b. A state must implement procedures for considering the criminal history records of applicants for initial multistate license or licensure by endorsement. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant’s criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state’s criminal records.
- c. Each party state shall require the following for an applicant to obtain or retain a multistate license in the home state:
 - 1. Meets the home state’s qualifications for licensure or renewal of licensure, as well as, all other applicable state laws;
 - 2. i) Has graduated or is eligible to graduate from a licensing board-approved RN or LPN/VN pre-licensure education program; or ii) Has graduated from a foreign RN or LPN/VN pre-licensure education program that (a) has been approved by the authorized accrediting body in the applicable country and (b) has been verified by an independent credentials review agency to be comparable to a licensing board-approved pre-licensure education program;
 - 3. Has, if a graduate of a foreign pre-licensure education program not taught in English or if English is not the individual’s native language, successfully passed an English proficiency examination that includes the components of reading, speaking, writing and listening;
 - 4. Has successfully passed an NCLEX-RN® or NCLEX-PN® Examination or recognized predecessor, as applicable;
 - 5. Is eligible for or holds an active, unencumbered license;
 - 6. Has submitted, in connection with an application for initial licensure or licensure by endorsement, fingerprints or other biometric data for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state’s criminal records;

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7. Has not been convicted or found guilty, or has entered into an agreed disposition, of a felony offense under applicable state or federal criminal law;
 8. Has not been convicted or found guilty, or has entered into an agreed disposition, of a misdemeanor offense related to the practice of nursing as determined on a case-by-case basis;
 9. Is not currently enrolled in an alternative program;
 10. Is subject to self-disclosure requirements regarding current participation in an alternative program; and
 11. Has a valid United States Social Security number.
- d. All party states shall be authorized, in accordance with existing state due process law, to take adverse action against a nurse's multistate licensure privilege such as revocation, suspension, probation or any other action that affects a nurse's authorization to practice under a multistate licensure privilege, including cease and desist actions. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.
 - e. A nurse practicing in a party state must comply with the state practice laws of the state in which the client is located at the time service is provided. The practice of nursing is not limited to patient care, but shall include all nursing practice as defined by the state practice laws of the party state in which the client is located. The practice of nursing in a party state under a multistate licensure privilege will subject a nurse to the jurisdiction of the licensing board, the courts and the laws of the party state in which the client is located at the time service is provided.
 - f. Individuals not residing in a party state shall continue to be able to apply for a party state's single- state license as provided under the laws of each party state. However, the single-state license granted to these individuals will not be recognized as granting the privilege to practice nursing in any other party state. Nothing in this Compact shall affect the requirements established by a party state for the issuance of a single-state license.
 - g. Any nurse holding a home state multistate license, on the effective date of this Compact, may retain and renew the multistate license issued by the nurse's then-current home state, provided that:
 1. A nurse, who changes primary state of residence after this Compact's effective date, must meet all applicable Article III.c. requirements to obtain a multistate license from a new home state.
 2. A nurse who fails to satisfy the multistate licensure requirements in Article III.c. due to a disqualifying event occurring after this Compact's effective date shall be ineligible to retain or renew a multistate license, and the nurse's multistate license shall be revoked or deactivated in accordance with applicable rules adopted by the Interstate Commission of Nurse Licensure Compact Administrators ("Commission").

Section 5. Application for Licensure in a Party State

- a. Upon application for a multistate license, the licensing board in the issuing party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any encumbrances on any license or multistate licensure privilege held by the applicant, whether any adverse action has been taken against any license or multistate licensure privilege held by the applicant and whether the applicant is currently participating in an alternative program.
- b. A nurse may hold a multistate license, issued by the home state, in only one party state at a time.

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- c. If a nurse changes primary state of residence by moving between two party states, the nurse must apply for licensure in the new home state, and the multistate license issued by the prior home state will be deactivated in accordance with applicable rules adopted by the Commission.
 - 1. The nurse may apply for licensure in advance of a change in primary state of residence.
 - 2. A multistate license shall not be issued by the new home state until the nurse provides satisfactory evidence of a change in primary state of residence to the new home state and satisfies all applicable requirements to obtain a multistate license from the new home state.
- d. If a nurse changes primary state of residence by moving from a party state to a non-party state, the multistate license issued by the prior home state will convert to a single-state license, valid only in the former home state.

Section 6. Additional Authorities Invested in Party State Licensing Boards

- a. In addition to the other powers conferred by state law, a licensing board shall have the authority to:
 - 1. Take adverse action against a nurse's multistate licensure privilege to practice within that party state.
 - i. Only the home state shall have the power to take adverse action against a nurse's license issued by the home state.
 - ii. For purposes of taking adverse action, the home state licensing board shall give the same priority and effect to reported conduct received from a remote state as it would if such conduct had occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action.
 - 2. Issue cease and desist orders or impose an encumbrance on a nurse's authority to practice within that party state.
 - 3. Complete any pending investigations of a nurse who changes primary state of residence during the course of such investigations. The licensing board shall also have the authority to take appropriate action(s) and shall promptly report the conclusions of such investigations to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such actions.
 - 4. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, as well as, the production of evidence. Subpoenas issued by a licensing board in a party state for the attendance and testimony of witnesses or the production of evidence from another party state shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state in which the witnesses or evidence are located.
 - 5. Obtain and submit, for each nurse licensure applicant, fingerprint or other biometric-based information to the Federal Bureau of Investigation for criminal background checks, receive the results of the Federal Bureau of Investigation record search on criminal background checks and use the results in making licensure decisions.
 - 6. If otherwise permitted by state law, recover from the affected nurse the costs of investigations and disposition of cases resulting from any adverse action taken against that nurse.
 - 7. Take adverse action based on the factual findings of the remote state, provided that the licensing board follows its own procedures for taking such adverse action.

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- b. If adverse action is taken by the home state against a nurse's multistate license, the nurse's multistate licensure privilege to practice in all other party states shall be deactivated until all encumbrances have been removed from the multistate license. All home state disciplinary orders that impose adverse action against a nurse's multistate license shall include a statement that the nurse's multistate licensure privilege is deactivated in all party states during the pendency of the order.
- c. Nothing in this Compact shall override a party state's decision that participation in an alternative program may be used in lieu of adverse action. The home state licensing board shall deactivate the multistate licensure privilege under the multistate license of any nurse for the duration of the nurse's participation in an alternative program.

Section 7. Coordinated Licensure Information System and Exchange of Information

- a. All party states shall participate in a coordinated licensure information system of all licensed registered nurses (RNs) and licensed practical/vocational nurses (LPNs/VNs). This system will include information on the licensure and disciplinary history of each nurse, as submitted by party states, to assist in the coordination of nurse licensure and enforcement efforts.
- b. The Commission, in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection and exchange of information under this Compact.
- c. All licensing boards shall promptly report to the coordinated licensure information system any adverse action, any current significant investigative information, denials of applications (with the reasons for such denials) and nurse participation in alternative programs known to the licensing board regardless of whether such participation is deemed nonpublic or confidential under state law.
- d. Current significant investigative information and participation in nonpublic or confidential alternative programs shall be transmitted through the coordinated licensure information system only to party state licensing boards.
- e. Notwithstanding any other provision of law, all party state licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with non-party states or disclosed to other entities or individuals without the express permission of the contributing state.
- f. Any personally identifiable information obtained from the coordinated licensure information system by a party state licensing board shall not be shared with non-party states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.
- g. Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information shall also be expunged from the coordinated licensure information system.
- h. The Compact administrator of each party state shall furnish a uniform data set to the Compact administrator of each other party state, which shall include, at a minimum:
 - 1. Identifying information;
 - 2. Licensure data;

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3. Information related to alternative program participation; and
4. Other information that may facilitate the administration of this Compact, as determined by Commission rules.
 - i. The Compact administrator of a party state shall provide all investigative documents and information requested by another party state.

Section 8. Establishment of the Interstate Commission of Nurse Licensure Compact Administrators

- a. The party states hereby create and establish a joint public entity known as the Interstate Commission of Nurse Licensure Compact Administrators.
 1. The Commission is an instrumentality of the party states.
 2. Venue is proper, and judicial proceedings by or against the Commission shall be brought solely and exclusively, in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.
 3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.
- b. Membership, Voting and Meetings
 1. Each party state shall have and be limited to one administrator. The head of the state licensing board or designee shall be the administrator of this Compact for each party state. Any administrator may be removed or suspended from office as provided by the law of the state from which the Administrator is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the party state in which the vacancy exists.
 2. Each administrator shall be entitled to one (1) vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. An administrator shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for an administrator's participation in meetings by telephone or other means of communication.
 3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws or rules of the commission.
 4. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Article VIII.
 5. The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:
 - i. Noncompliance of a party state with its obligations under this Compact;
 - ii. The employment, compensation, discipline or other personnel matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;
 - iii. Current, threatened or reasonably anticipated litigation;
 - iv. Negotiation of contracts for the purchase or sale of goods, services or real estate;
 - v. Accusing any person of a crime or formally censuring any person;
 - vi. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

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- vii. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
 - viii. Disclosure of investigatory records compiled for law enforcement purposes;
 - ix. Disclosure of information related to any reports prepared by or on behalf of the Commission for the purpose of investigation of compliance with this Compact; or
 - x. Matters specifically exempted from disclosure by federal or state statute.
6. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.
- c. The Commission shall, by a majority vote of the administrators, prescribe bylaws or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of this Compact, including but not limited to:
- 1. Establishing the fiscal year of the Commission;
 - 2. Providing reasonable standards and procedures:
 - i. For the establishment and meetings of other committees; and
 - ii. Governing any general or specific delegation of any authority or function of the Commission;
 - 3. Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the administrators vote to close a meeting in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each administrator, with no proxy votes allowed;
 - 4. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;
 - 5. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any party state, the bylaws shall exclusively govern the personnel policies and programs of the Commission; and
 - 6. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of this Compact after the payment or reserving of all of its debts and obligations;
- d. The Commission shall publish its bylaws and rules, and any amendments thereto, in a convenient form on the website of the Commission.

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- e. The Commission shall maintain its financial records in accordance with the bylaws.
- f. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the bylaws.
- g. The Commission shall have the following powers:
 - 1. To promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all party states;
 - 2. To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any licensing board to sue or be sued under applicable law shall not be affected;
 - 3. To purchase and maintain insurance and bonds;
 - 4. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a party state or nonprofit organizations;
 - 5. To cooperate with other organizations that administer state compacts related to the regulation of nursing, including but not limited to sharing administrative or staff expenses, office space or other resources;
 - 6. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of this Compact, and to establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel and other related personnel matters;
 - 7. To accept any and all appropriate donations, grants and gifts of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall avoid any appearance of impropriety or conflict of interest;
 - 8. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, whether real, personal or mixed; provided that at all times the Commission shall avoid any appearance of impropriety;
 - 9. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, whether real, personal or mixed;
 - 10. To establish a budget and make expenditures;
 - 11. To borrow money;
 - 12. To appoint committees, including advisory committees comprised of administrators, state nursing regulators, state legislators or their representatives, and consumer representatives, and other such interested persons;
 - 13. To provide and receive information from, and to cooperate with, law enforcement agencies;
 - 14. To adopt and use an official seal; and
 - 15. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of nurse licensure and practice.
- h. Financing of the Commission
 - 1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization and ongoing activities.

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2. The Commission may also levy on and collect an annual assessment from each party state to cover the cost of its operations, activities and staff in its annual budget as approved each year. The aggregate annual assessment amount, if any, shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule that is binding upon all party states.
3. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the party states, except by, and with the authority of, such party state.
4. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Commission.

- i. Qualified Immunity, Defense and Indemnification

1. The administrators, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit or liability for any damage, loss, injury or liability caused by the intentional, willful or wanton misconduct of that person.
2. The Commission shall defend any administrator, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further that the actual or alleged act, error or omission did not result from that person's intentional, willful or wanton misconduct.
3. The Commission shall indemnify and hold harmless any administrator, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional, willful or wanton misconduct of that person.

Section 9. Rulemaking

- a. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this Article and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment and shall have the same force and effect as provisions of this Compact.

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- b. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.
- c. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least sixty (60) days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a notice of proposed rulemaking:
 - 1. On the website of the Commission; and
 - 2. On the website of each licensing board or the publication in which each state would otherwise publish proposed rules.
- d. The notice of proposed rulemaking shall include:
 - 1. The proposed time, date and location of the meeting in which the rule will be considered and voted upon;
 - 2. The text of the proposed rule or amendment, and the reason for the proposed rule;
 - 3. A request for comments on the proposed rule from any interested person; and
 - 4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.
- e. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.
- f. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment.
- g. The Commission shall publish the place, time and date of the scheduled public hearing.
 - 1. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing. All hearings will be recorded, and a copy will be made available upon request.
 - 2. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.
- h. If no one appears at the public hearing, the Commission may proceed with promulgation of the proposed rule.
- i. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.
- j. The Commission shall, by majority vote of all administrators, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.
- k. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment or hearing, provided that the usual rulemaking procedures provided in this Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:
 - 1. Meet an imminent threat to public health, safety or welfare;
 - 2. Prevent a loss of Commission or party state funds; or
 - 3. Meet a deadline for the promulgation of an administrative rule that is required by federal law or rule.

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- I. The Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the Commission, prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

Section 10. Oversight, Dispute Resolution and Enforcement

a. Oversight

1. Each party state shall enforce this Compact and take all actions necessary and appropriate to effectuate this Compact's purposes and intent.
2. The Commission shall be entitled to receive service of process in any proceeding that may affect the powers, responsibilities or actions of the Commission, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process in such proceeding to the Commission shall render a judgment or order void as to the Commission, this Compact or promulgated rules.

b. Default, Technical Assistance and Termination

1. If the Commission determines that a party state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:
 - i. Provide written notice to the defaulting state and other party states of the nature of the default, the proposed means of curing the default or any other action to be taken by the Commission; and
 - ii. Provide remedial training and specific technical assistance regarding the default.
2. If a state in default fails to cure the default, the defaulting state's membership in this Compact may be terminated upon an affirmative vote of a majority of the administrators, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.
3. Termination of membership in this Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor of the defaulting state and to the executive officer of the defaulting state's licensing board and each of the party states.
4. A state whose membership in this Compact has been terminated is responsible for all assessments, obligations and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.
5. The Commission shall not bear any costs related to a state that is found to be in default or whose membership in this Compact has been terminated unless agreed upon in writing between the Commission and the defaulting state.
6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district in which the Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorneys' fees.

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c. Dispute Resolution

1. Upon request by a party state, the Commission shall attempt to resolve disputes related to the Compact that arise among party states and between party and non-party states.
2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes, as appropriate.
3. In the event the Commission cannot resolve disputes among party states arising under this Compact:
 - i. The party states may submit the issues in dispute to an arbitration panel, which will be comprised of individuals appointed by the Compact administrator in each of the affected party states and an individual mutually agreed upon by the Compact administrators of all the party states involved in the dispute.
 - ii. The decision of a majority of the arbitrators shall be final and binding.

d. Enforcement

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this Compact.
2. By majority vote, the Commission may initiate legal action in the U.S. District Court for the District of Columbia or the federal district in which the Commission has its principal offices against a party state that is in default to enforce compliance with the provisions of this Compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorneys' fees.
3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

Section 11. Effective Date, Withdrawal and Amendment

- a. This Compact shall become effective and binding on the earlier of the date of legislative enactment of this Compact into law by no less than twenty-six (26) states or December 31, 2018. All party states to this Compact, that also were parties to the prior Nurse Licensure Compact, superseded by this Compact, ("Prior Compact"), shall be deemed to have withdrawn from said Prior Compact within six (6) months after the effective date of this Compact.
- b. Each party state to this Compact shall continue to recognize a nurse's multistate licensure privilege to practice in that party state issued under the Prior Compact until such party state has withdrawn from the Prior Compact.
- c. Any party state may withdraw from this Compact by enacting a statute repealing the same. A party state's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.
- d. A party state's withdrawal or termination shall not affect the continuing requirement of the withdrawing or terminated state's licensing board to report adverse actions and significant investigations occurring prior to the effective date of such withdrawal or termination.
- e. Nothing contained in this Compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a non-party state that is made in accordance with the other provisions of this Compact.
- f. This Compact may be amended by the party states. No amendment to this Compact shall become effective and binding upon the party states unless and until it is enacted into the laws of all party states.

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- g. Representatives of non-party states to this Compact shall be invited to participate in the activities of the Commission, on a nonvoting basis, prior to the adoption of this Compact by all states.

Section 12. Construction and Severability

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable, and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States, or if the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held to be contrary to the constitution of any party state, this Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

Section 13. The executive director of the board of registration in nursing, or the board executive director's designee, shall be the administrator of the Nurse Licensure Compact for the commonwealth.

Section 14. The board of registration in nursing may adopt regulations necessary to implement the provisions of this chapter.

Section 15. The board of registration in nursing may recover from a nurse the costs of investigation and disposition of cases resulting in any adverse disciplinary action taken against that nurse's license or privilege to practice. Funds collected pursuant to this section shall be deposited in the Quality in Health Professions Trust Fund established pursuant to section 35X of chapter 10.

Section 16. The board of registration in nursing may take disciplinary action against the practice privilege of a registered nurse or of a licensed practical/vocational nurse practicing in the commonwealth under a license issued by a state that is a party to the Nurse Licensure Compact. The board's disciplinary action may be based on disciplinary action against the nurse's license taken by the nurse's home state.

Section 17. In reporting information to the coordinated licensure information system under Section 8 of this chapter related to the Nurse Licensure Compact, the board of registration in nursing may disclose personally identifiable information about the nurse, including social security number.

Section 18. Enactment of the Nurse Licensure Compact shall not supersede existing labor laws.

Section 19. The commonwealth, its officers and employees, and the board of registration in nursing and its agents who act in accordance with the provisions of this chapter shall not be liable on account of any act or omission in good faith while engaged in the performance of their duties under this chapter. Good faith shall not include willful misconduct, gross negligence, or recklessness.

SECTION XX. The effective date of entry into the Nurse Licensure Compact for Massachusetts shall be one year from the effective date of the Nurse Licensure Compact. Prior to said effective date, the board of registration in nursing may take such actions as are necessary to effectuate entry into, and implement, the Compact.

SECTION XX. Notwithstanding any general or special law to the contrary, the secretary of administration and finance, following a public hearing, shall increase the fee for obtaining or renewing a license, certificate, registration, permit or authority issued by a board within the department of public health, excluding the board of registration in medicine, as necessary to implement the provisions of the Nurse Licensure Compact. The amount of the increase in fees shall be deposited in the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

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SECTION XX. As part of the licensure and background check process for a multistate license, the Massachusetts Board of Nursing, prior to issuing any multistate license, shall conduct a fingerprint-based check of the state and national criminal history databases, as authorized by 28 CFR 20.33 and Public Law 92-544.

Fingerprints, shall be submitted to the identification section of the department of state police for a state criminal history check and forwarded to the Federal Bureau of Investigation for a national criminal history check, according to the policies and procedures established by the state identification section and by the department of criminal justice information services.

All applicants, shall pay a fee to be established by the secretary of administration and finance, in consultation with the secretary of public safety, to offset the costs of operating and administering a fingerprint-based criminal background check system. The secretary of administration and finance, in consultation with the secretary of public safety, may increase the fee accordingly if the Federal Bureau of Investigation increases its fingerprint background check service fee. Any fees collected from fingerprinting activity under this chapter shall be deposited into the Fingerprint-Based Background Check Trust Fund, established in section 2HHHH of 133 chapter 29.

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

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HB1186

An Act to Promote Patient Care Transparency and Nurse Advancement

(Rep. Khan)

Referred to the Joint Committee on Public Health

SUMMARY

To support transparency of patient care staffing, this bill requires hospitals to report to DPH, on an annual basis, their staffing plans, which shall indicate the team of patient care professionals involved in the direct care for patients for certain units in hospitals. Additionally, such reports will be publically posted on DPH's website. DPH is further directed to develop a process to collect, monitor and evaluate evidence-based, nurse-sensitive, clinical performance measures endorsed by the National Quality Forum that measure how well hospitals prevent pressure ulcers, patient falls, and falls with injury. Such information shall be annually issued to the general public through hospital-specific and aggregated industry trend reporting. This legislation also advances the practice of nursing through the design of academic pathways in support of the goals of the Massachusetts Action Coalition to ensure that 95% of all registered nurses in the Massachusetts workforce have obtained baccalaureate degrees in nursing by 2030.

BILL TEXT

SECTION 1: Chapter 111 of the General Laws is hereby amended by inserting the following new section 232:-

Section 232. For the purposes of this section, the following words shall have the following meanings:

- a. "Hospital", a hospital licensed under section 51 of chapter 111, the teaching hospital of the University of Massachusetts medical school, a private licensed hospital; provided, however, that "hospital" shall not include a hospital or unit classified as either an inpatient rehabilitation facility, an inpatient psychiatric facility, an inpatient substance abuse facility, or a long term care hospital by the federal Centers for Medicare and Medicaid Services, as well as a state-owned and state-operated hospital, or a unit within a state-operated facility.
- b. "Staffing data", the unit level budgeted staffing data for the upcoming fiscal year as well as the unit level actual staffing data for the preceding fiscal year that indicates the team of patient care professionals involved in the direct care of patients for the following units in each hospital: medical, surgical, intensive care units, rehabilitation, behavioral health, skilled nursing care, step down or intermediate care, emergency departments, and such other units as determined by the Department.

A hospital shall submit the staffing data for its fiscal year to the Department on an annual basis. The staffing data shall include, but not be limited to, the following:

- a. consideration and inclusion of patient care professionals who have productive hours with direct patient care responsibilities greater than 50% of their shift who are counted in the staffing matrix and replaced if they call in sick; provided however that such staffing plan shall exclude monitor technicians, students, and sitters/patient observers;
- b. the inclusion of additional different care team members who are available resources to the unit on a given shift (Day, Evening, Night) who support the direct caregivers in providing care to patients and families on the unit; and
- c. in a general narrative form appended to the report, discussion of: the complexity of clinical judgment needed to design and implement a patient's nursing care plan; the varying acuity of patients; the need for specialized equipment and technology; the skill mix of other patient care team members providing or supporting direct

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patient care; patient care team member experience, preparation and involvement in quality improvement activities professional preparation and experience; and the patient centered nursing activities carried out by unit-based staff in the presence of the patient (e.g., medication administration, nursing treatments, nursing rounds, admission/transfer/discharge, patient teaching, patient communication) and nursing activities that occur away from the patient that are related (e.g., coordination of patient care, documentation, treatment planning).

The Department shall post the reports in an electronic format, published on the department website and available to the public.

The Department shall develop a process to collect standardized nursing-sensitive quality measures that are evidence-based, nationally-accepted patient safety quality indicators that shall be consistent with those established pursuant to section 231. Reporting shall be done in the same manner as existing state and federal data reporting requirements. The department shall annually issue to the general public hospital-specific data and aggregated industry trends developed from these reports.

SECTION 2: Notwithstanding any general or special law to the contrary, there shall be a Special Commission on Nursing Education and Experience, which shall be jointly chaired by the commissioner of the Department of Public Health or a designee and the commissioner of the Department of Higher Education or a designee. The commission shall make recommendations necessary to advance the practice of nursing through the design of academic pathways and supports needed to ensure that 66% of licensed registered nurses in the Commonwealth have obtained a minimum of a bachelor's degree or higher in nursing by the year 2020; 85% of licensed registered nurses have obtained a minimum of a bachelor's degree or higher in nursing by 2025; and, 95% of licensed registered nurses have obtained a minimum of a bachelor's degree or higher in nursing by 2030. The Commission shall issue its recommendations no later than January 1, 2018.

In addition to the commissioner of public health and the commissioner of higher education, the commission shall include 15 members: the executive director of the Massachusetts Board of Registration in Nursing or designee; a representative of the Organization of Nurse Leaders of Massachusetts, Rhode island, New Hampshire, and Connecticut; a representative of the Massachusetts Health and Hospital Association; a representative of the Massachusetts Association of Colleges of Nursing; a representative of the Massachusetts/Rhode Island League for Nursing (MARILN); a representative of the Massachusetts Action Coalition included in the Robert Wood Johnson Foundation's Academic Progression in Nursing initiative; a representative of the American Nurses Association Massachusetts; a representative of the Massachusetts Nurses Association; a representative of the Massachusetts Community Colleges Executive Office; a representative of the Association of Independent Colleges and Universities of Massachusetts; a representative of AARP Massachusetts; a representative of a veterans administration hospital; a representative of the Council of Presidents of the Massachusetts State University System; a representative of the Massachusetts Senior Care Association, and a representative of the Home Care Alliance of Massachusetts.

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SB1211 / HB3242

An Act to Review the Quality and Patient Safety of Dispensing Certain Cancer and Chronic Disease Related Drugs (Sen. Keenan / Rep. Hogan)

Referred to the Joint Committee on Public Health

SUMMARY

This legislation follows language sent back by Governor Baker in response to last year's budget that would direct the Health Policy Commission to examine the health care quality and patient safety impacts posed by emerging insurance industry practices requiring the forced "brown-bagging" and "white-bagging" of cancer and chronic-illness related pharmaceuticals.

Recent changes to several health insurer benefit structures now require cancer and chronic disease patients to obtain certain injected or infused medications through a specialty pharmacy. In many cases, these medications are no longer covered by insurance companies unless the patient self-administers the medication; utilizes a visiting nurse; or brings the drug to their health care facility or physician's office to be administered by a clinician – a practice known as "brown-bagging".

Brown-bagging requirements restrict the ability of treating providers to have a complete record of the medications administered to the patient through the patient's medical record, including the expiration date, drug specific lot numbers, documentation of side effects/adverse reactions, medication recalls etc. Of particular concern, many of the infusion drugs simply cannot be safely administered at home because they require preparation by a pharmacist, extensive clinical monitoring and may have serious side effects that require a hospital setting. Medications requiring patient-specific dosages dependent on lab tests performed the same day are also inappropriate for delivery directly to a patient.

Some insurers are also forcing the "white-bagging" of similar medications - a practice where medications are required to be dispensed by a specialty pharmacy and delivered to a hospital, infusion center, pharmacy of physician's office for administration to a specific patient. In many circumstances, insurer-required brown-bagging and white-bagging raises unsettling consequences as both ultimately compromise the integrity of medications.

The integrity of the pharmaceutical supply chain must never be compromised. Because of this, hospitals have many procedures in place to ensure the quality of the medications that are procured, stored, dispensed and administered, including prohibiting the procurement of medications from outside sources and/or patient delivery to the hospital for administration in an outpatient setting. Forced brown-bagging and white-bagging directly contradicts this critical safety protocol and raises troubling legal conflicts related to the state's prohibition of the re-dispensing of pharmaceuticals.

BILL TEXT

SECTION 1. The health policy commission, in consultation with the department of public health and the division of insurance, shall study and analyze health insurance payer practices that require certain categories of drugs, including those that are administered by injection or infusion, to be dispensed by a third-party specialty pharmacy directly to a patient or to a health care provider with the designation that such drugs be used for a specific patient and not for the general use of the provider. The commission shall file a report of its findings, including recommended legislation, with the senate and house committees on ways and means, the joint committee on health care financing and the joint committee on public health not later than January 1, 2018.

QUALITY & PATIENT SAFETY

HB3239

An Act to Improve Access to and Reporting of Pharmacy Services in Hospitals

(Rep. Heroux)

Referred to the Joint Committee on Public Health

SUMMARY

This bill seeks to improve several administrative requirements to improve access to pharmacy based services as part of the care and treatment within a hospital setting. The first part of the bill seeks to implement a collaborative drug therapy management program that would allow a hospital pharmacist to partner with a physician to manage and resolve medication-related problems as well as to make decisions regarding drug prescribing and monitoring during the inpatient stay. The goal is to ensure that the hospital pharmacist is able to develop a shared responsibility with the attending physician to improve patient outcomes, including better assessment of patients, earlier initiation and quicker modification of drug therapies, additional monitoring of patients, and direct administration of drugs. This law would also provide for a technical clarification to the recently enacted compounding law to provide for an exception to submitting an annual list of compounded drugs within a hospital setting to the state. The compounding law was developed to target those drugs that are developed and shipped to locations that are external to the pharmacy to ensure that there is a system to track when there is an adverse event related to a specific drug. However, the law did not take into account that drugs may be compounded during a surgical or other procedure for active inpatient use, during which the patient would be closely monitored by a team of clinicians. Without this technical change, hospitals would be required to develop a detailed reporting process that would use staff time and resources with no impact on monitoring patient safety.

BILL TEXT

SECTION 1. Subsection (a) of Section 24B ½ of chapter 112 of the General laws, as appearing in the 2014 official edition, is hereby amended by inserting after each instance of “supervising physician” the words “, attending physician or attending physician’s designee in the hospital setting”.

SECTION 2. Subpart (1) of subsection (c) of Section 24B ½ of Chapter 112 of the General laws, as so appearing, is hereby amended by adding after the word “designee;” the following “provided, that a patient’s attending physician or attending physician’s designee may refer a patient to a pharmacist practicing under a collaborative practice agreement overseen by a supervising physician whose scope of practice is in that area of medicine;”

SECTION 3. Clause (6) of subsection (a) of Section 39I of Chapter 112 of the general laws is hereby amended by striking the first sentence and inserting in place thereof the following:

All institutional sterile compounding pharmacies shall report to the board, on an annual basis, a list of prescriptions dispensed within and outside of the commonwealth, as well as the volume of these prescriptions, with the exception of prescriptions dispensed to individuals for immediate use while receiving inpatient or outpatient care and treatment in the institution during the year.

QUALITY & PATIENT SAFETY

HB2322/SB1193

An Act Relative to Emergency and Disaster Planning for Health Care Providers

(Rep. Malia / Sen. Eldridge)

HB2322 referred to the Joint Committee on The Judiciary

SB1193 referred to the Joint Committee on Public Health

SUMMARY

This bill would require that, during a state or regional emergency or other emergency situation, there would be a general waiver of liability against healthcare providers to ensure that they are able to appropriate care for patients quickly without undue concern over unwarranted liability issues. With recent natural storms, pandemic concerns and more, it is time that the state developed a process to ensure that providers are able to quickly and effectively care for patients regardless of the setting and without unnecessary concern of legal or administrative sanctions.

BILL TEXT

SECTION 1: Section 12B of chapter 112 of the General Laws is hereby amended by inserting at the end thereof the following new paragraph:-

No health care provider, as defined in section 1 of chapter 111 or a health care provider licensed under chapter 112, shall be further liable in a suit for damages or administrative sanctions as a result of good-faith acts or omissions while engaged in the performance of their duties in rendering emergency care, treatment, advice, or assistance during a federal, state, or local disaster or emergency situation, including but not limited to public health emergencies.

PUBLIC HEALTH/ALLIED EFFORTS

SB1218 / HB2864

An Act to Protect Youth from the Health Risks of Tobacco and Nicotine Addiction

(Sen. Lewis / Rep. McMurtry)

SB1218 referred to the Joint Committee on Public Health

HB2864 referred to the Joint Committee on Education

SUMMARY

Tobacco and nicotine use is the leading cause of preventable illness and premature death in Massachusetts. It costs the state more than \$4 billion annually in healthcare costs. In addition, tobacco consumption results in hundreds of millions of dollars in lost productivity due to illness and premature death. Increasing the age at which individuals can buy cigarettes – or any tobacco product – is a commonsense way to promote population health. Youth are particularly susceptible to nicotine addiction. According to the US Surgeon General, almost 90% of tobacco users become addicted to nicotine before age 21.

These bills seek to directly address the issue of youth smoking addiction. It will increase the age of sale for tobacco-related products from 18 to 21, add e-cigarettes to the smoke-free workplace law, and prohibit sales of tobacco in pharmacies and other healthcare facilities.

A consistent, statewide age limit of 21 for the sale of tobacco is the most appropriate approach to discourage tobacco use and subsequent addiction among the young people of Massachusetts, and thereby decrease smoking, vaping, and other tobacco use overall.

Additionally, this legislation also prohibits the sale of nicotine delivery products – e-cigarettes and their ilk – to anyone under age 21. E-cigarettes are not defined by federal law as tobacco products. This means that they are not regulated by the Food & Drug Administration and have had no safety or efficacy evaluation. This regulatory void means it's appropriate for the state to intervene to protect young people from the effects of these products. The legislation mirrors many of the provisions that the Massachusetts Attorney General has implemented in regulations to prohibit the sale of electronic smoking devices to those under age 18 and protect children from unsafe packaging of liquid nicotine. As more and more youth use tobacco products other than cigarettes, the provisions of this bill will go further to help ensure that any tobacco or new nicotine delivery products stay out of the hands of minors.

Finally this bill also prohibits the sale of tobacco products at healthcare facilities. This is a straight-forward, commonsense restriction. Hospitals strive to improve the health of all patients and we believe that it's counterproductive to the collective mission of hospitals and healthcare providers – including pharmacies – to sell tobacco products where healthcare treatment is offered. Hospitals already have taken the lead on this issue. In fact, more than 75% of MHA members have established completely tobacco-free campuses (prohibiting any use) and several hospitals have joined MHA in establishing employment practices that screen for tobacco use. The hospital community clearly understands the detrimental effects tobacco products have on the health and recovery process of all individuals.

This important legislation will reduce tobacco use and nicotine addiction among youth in order to improve health, save lives, and reduce healthcare costs.

PUBLIC HEALTH/ALLIED EFFORTS

BILL TEXT

SECTION 1. Chapter 71 of the General Laws is hereby amended by striking out section 2A, as appearing in the 2014 Official Edition, and inserting in place thereof the following section:-

Section 2A. No person shall use tobacco products as defined in section 6 of chapter 270 within the school buildings or facilities or on the grounds or school buses of a primary or secondary school, including public and private schools, or at any school-sponsored event. Each school committee or board of trustees shall establish a policy regarding violations of this section. The policy may include, but shall not be limited to, mandatory education classes on the hazards of using tobacco products.

SECTION 2. Section 37H of said chapter 71, as so appearing, is hereby amended by inserting after the word “products”, in line 4, the following words:- , as defined in section 6 of chapter 270.

SECTION 3. Chapter 74 of the General Laws is hereby amended by adding the following section:-

Section 57. No person shall use tobacco products as defined in section 6 of chapter 270 within the school buildings or facilities or on the grounds or school buses of a vocational school or at any school-sponsored event at a vocational school. Each school committee or board of trustees shall establish a policy regarding violations of this section. The policy may include, but shall not be limited to, mandatory education classes on the hazards of using of tobacco products.

SECTION 4. Chapter 94 of the General Laws is hereby amended by striking out section 307C, as appearing in the 2014 Official Edition, and inserting in place thereof the following section:-

Section 307C. The department of public health may, in consultation with the attorney general and the department of revenue, establish regulations for persons engaged in the sale or shipment of tobacco products as defined in section 6 of chapter 270 to prevent the sale or delivery of tobacco products to individuals under 21 years of age.

SECTION 5. Chapter 112 of the General Laws is hereby amended by inserting after section 61 the following section:-

Section 61A. (a) As used in this section, the following words shall have the following meanings unless the context clearly requires otherwise:

“Health care institution”, an individual, partnership, association, corporation or trust or a person or group of persons that:

(i) provides health care services and employs health care providers subject to licensing under this chapter; or (ii) a retail establishment that sells pharmaceutical goods and services and is subject to regulation by the board of registration in pharmacy.

“Retail establishment”, a store that sells goods to the public.

“Tobacco product”, a tobacco product as defined in section 6 of chapter 270.

(b) No health care institution shall sell or authorize the sale of tobacco products within the buildings or facilities or on the grounds of the health care institution. For the purposes of this section, a retail establishment shall be considered a health care institution if it operates at a health care institution or has a health care institution located on or within its premises; provided, however, a retail establishment that provides optician, optometric, hearing aid or audiology services but is not subject to regulation by the board of registration in pharmacy shall not be considered a health care institution.

SECTION 6. Chapter 270 of the General Laws is hereby amended by striking out sections 6 and 6A, as appearing in the

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2014 Official Edition, and inserting in place thereof the following 2 sections:-

Section 6. (a) As used in this section and section 6A, the following words shall have the following meanings unless the context clearly requires otherwise:

“Manufacturer”, a person or entity that manufactures or produces a tobacco product.

“Person”, an individual, firm, fiduciary, partnership, corporation, trust or association, however formed, a club, trustee, agency or receiver.

“Retail establishment”, a physical place of business or a section of a physical place of business where a tobacco product is offered for sale to consumers.

“Retail tobacco store”, an establishment: (i) that is not required to possess a retail food permit;

- ii. whose primary purpose is to sell or offer for sale to consumers, but not for resale, a tobacco product and related paraphernalia in which the sale of other products is merely incidental; (iii) that prohibits the entry of persons under the age of 21; and (iv) that maintains a valid permit for the retail sale of a tobacco product as required to be issued by the appropriate authority in the city or town in which the establishment is located.

“Retailer”, a person or entity that operates a store or premises that offers a tobacco product for sale.

“Tobacco product”, a product containing, made or derived from tobacco or nicotine that is intended for human consumption, whether smoked, chewed, absorbed, dissolved, inhaled, snorted, sniffed or ingested by any other means including, but not limited to: cigarettes, cigars, little cigars, chewing tobacco, pipe tobacco and snuff and electronic cigarettes, electronic cigars, electronic pipes or other similar products that rely on vaporization or aerosolization; provided, however, that ‘tobacco product’ shall include any component, part or accessory of a tobacco product; and provided further, that ‘tobacco product’ shall not include a product that has been approved by the United States Food and Drug Administration for the sale as a tobacco cessation product and is marketed and sold exclusively for the approved purpose.

- b. No person shall sell a tobacco product to a person under the age of 21 or give a tobacco product to a person under the age of 21.
- c. No manufacturer or retailer shall distribute or cause to be distributed a free sample of a tobacco product in a retail or other commercial establishment; provided, however, that this subsection shall not apply to retail tobacco stores and smoking bars as defined in section 22.
- d. A person who violates this section shall be punished by a fine of \$100 for the first offense, \$200 for a second offense and \$300 for a third or subsequent offense.
- e. The department of public health may promulgate regulations to implement this section.

Section 6A. (a) For purposes of this section, “tobacco vending machine”, shall mean an automated or mechanical self-service device which, upon insertion of money or other form of payment, dispenses or creates a tobacco product.

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- b. No person shall use a tobacco vending machine for the commercial distribution of tobacco products or to otherwise sell tobacco products.
- c. A person who sells tobacco rolling papers to a person under the age of 21 shall be punished by a fine of \$25 for the first offense, \$50 for the second offense and \$100 for a third or subsequent offense.

SECTION 6A. Section 7 of said chapter 270, as so appearing, is hereby amended by adding the following paragraph:-

The owner or other person in charge of a shop or other place used to sell any tobacco products at retail shall conspicuously post signage provided by the department of public health that discloses current referral information about smoking cessation which may include, but shall not be limited to, the website of the Massachusetts Tobacco Cessation and Prevention Program (www.makesmokinghistory.org) and the Massachusetts Smokers' Helpline at 1-800-Quit-Now (1-800-784-8669).

SECTION 7. Subsection (a) of section 22 of said chapter 270, as appearing in the 2014 Official Edition, is hereby amended by striking out the definitions of "Smoking or smoke" and "Smoking bar" and inserting in place thereof the following 3 definitions:-

"Smoking", the inhaling, exhaling, burning or carrying of a lighted or heated cigar, cigarette, pipe or other tobacco product or plant product intended for inhalation in any manner or form; provided, however, that "smoking" shall include the use of electronic cigarettes, electronic cigars, electronic pipes or other similar products that rely on vaporization or aerosolization.

"Smoking bar", an establishment that: (i) exclusively occupies an enclosed indoor space and is primarily engaged in the retail sale of tobacco products as defined in section 6 for consumption by customers on the premises; (ii) derives revenue from the sale of food, alcohol or other beverages that is incidental to the sale of a tobacco product and prohibits entry to a person under 21 years of age; (iii) prohibits any food or beverage not sold directly by the business from being consumed on the premises; (iv) maintains a valid permit for the retail sale of a tobacco product as required to be issued by the appropriate authority in the city or town in which the establishment is located; and (v) maintains a valid permit to operate a smoking bar issued by the department of revenue.

"Tobacco product", a tobacco product as defined in section 6.

SECTION 8. Said section 22 of said chapter 270, as so appearing, is hereby further amended by striking out, in lines 90, 276 and 281, the figure "18" and inserting in place thereof, in each instance, the following figure:- 21.

SECTION 9. Said chapter 270 is hereby further amended by adding the following section:-

Section 27. (a) As used in this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"Child-resistant packaging", packaging intended to reduce the risk of children ingesting nicotine that meets the minimum standards as set forth in 15 U.S.C. §§ 1471 to 1476, inclusive, and 16 CFR § 1700 et seq.

"Liquid nicotine container", a package: (i) from which nicotine in a solution or other form is accessible through normal and foreseeable use by a consumer; and (ii) that is used to hold soluble nicotine in any concentration; provided, however, that the term "liquid nicotine container" shall not include a sealed, prefilled and disposable container of nicotine in a solution

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or other form in which such container is inserted directly into an electronic cigarette, electronic nicotine delivery system or other similar product if the nicotine in the container is inaccessible through customary or reasonably foreseeable handling or use, including reasonably foreseeable ingestion or other contact by children, as amended from time to time.

- b. No person shall knowingly sell, distribute or import for sale within the commonwealth:
 - i. a liquid or gel substance containing nicotine unless that product is contained in child-resistant packaging; or
 - ii. a nicotine liquid container unless that container includes child-resistant packaging as part of its design.
- c. A person who violates this section shall be subject to a civil penalty of \$250 for a first violation, \$500 for a second violation and \$1,000 for a third or subsequent violation.
- d. The local board of health, the local department of public health, the local inspection department or equivalent local authority or its agent shall enforce this section through the noncriminal disposition of violations. In the city of Boston, the commissioner of health and the commissioner's authorized agents shall enforce this section through the noncriminal disposition of violations.

SECTION 10. The commissioner of public health may promulgate regulations to restrict the sale of products containing nicotine to individuals under the age of 21; provided, however, that a regulated product shall contain nicotine and be primarily manufactured or used to deliver nicotine to the user. The commissioner shall send a notice of proposed changes, including proposed draft regulations, to the house and senate committees on ways and means and the joint committee on public health at least 90 days before filing draft regulations with the secretary of state.

SECTION 11. On the effective date of this act, a retail establishment that sells tobacco products as those terms are defined in section 6 of chapter 270 of the General Laws shall conspicuously post a notice produced by the department of public health that states the minimum legal sales age to purchase tobacco products. The notice shall include the dates that the minimum age for sale of tobacco products shall go into effect. Retail establishments shall continuously post the notice until January 1, 2019.

SECTION 12. Notwithstanding subsection (b) of section 6 of chapter 270 of the General Laws, the prohibition on sales of tobacco products to persons under the age of 21 shall not prohibit such sales to persons who attained the age of 18 before January 1, 2017.

SECTION 13. The center for health information and analysis, in collaboration with the division of insurance, department of public health, the group insurance commission and the office of Medicaid, shall review the tobacco cessation benefits offered by each health insurance plan and compare the tobacco cessation benefits to the United States Preventive Services Task Force recommendations for best practices for comprehensive tobacco cessation treatment.

SECTION 14. The special commission established in section 206 of chapter 139 of the acts of 2012, and extended by section 24A of chapter 118 of the acts of 2013 is hereby revived and continued. The commission shall file a report of its recommendations to the clerks of the senate and house of representatives, the joint committee on public health, the joint committee on health care financing and the house and senate committees on ways and means not later than December 31, 2017.

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SECTION 15: Nothing in the above sections shall permit the use of or sale and delivery of tobacco products as defined herein in which the use of or sale and delivery of tobacco products is or may hereafter be prohibited by law including, without limitation: any other law or ordinance or by-law, or any fire, health or safety regulation. Nothing in the above sections shall preempt further limitation of the use of or sale and delivery of tobacco products as defined herein by the commonwealth or any department, agency or political subdivision of the commonwealth.

SECTION 16. This act shall take effect on July 1, 2017.

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SB1562 / HB3329

An Act to Promote Healthy Alternatives to Sugary Drinks

(Sen. Lewis / Rep. Khan)

Referred to the Joint Committee on Revenue

SUMMARY

This legislation, filed in conjunction with the American Heart Association and the Massachusetts Health Council, will implement a tiered tax on sugar-sweetened beverages, based upon sugar content, with proceeds from the excise dedicated to a broad slate of the state's public health priorities including the Prevention & Wellness Trust Fund. The bill additionally: prohibits marketing of such beverages in schools; places limitations on such beverages in children's meals at restaurants; requires labels on advertisements for such beverages; and establishes a commission on access to drinking water in public places.

BILL TEXT

SECTION 1. The Massachusetts General Laws, as appearing in the 2014 Official Edition, are hereby amended by inserting after chapter 64N the following new chapter:-

Chapter 64O. SUGARY DRINK TAX

Section 1. Definitions.

- a. For the purposes of this section, the following words shall have the following meanings:
 1. "Beverage for medical use" means a beverage suitable for human consumption and manufactured for use as an oral nutritional therapy for persons who cannot absorb or metabolize dietary nutrients from food or beverages, or for use as an oral rehydration electrolyte solution for infants and children formulated to prevent or treat dehydration due to illness. "Beverage for medical use" shall also mean a "medical food" as defined in section 5(b)(3) of the Orphan Drug Act (21 U.S.C. 360ee(b)(3)); this Act defines medical food as "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation."
"Beverage for medical use" shall not include drinks commonly referred to as "sports drinks" or any other common names that are derivations thereof.
 2. "Bottle" means any closed or sealed container regardless of size or shape, including, without limitation, those made of glass, metal, paper, plastic or any other material or combination of materials.
 3. "Bottled sugary drink" means any sugary drink contained in a bottle that is ready for consumption without further processing such as, without limitation, dilution or carbonation.
 4. "Caloric sweetener" means any caloric substance suitable for human consumption that humans perceive as sweet and includes, without limitation, sucrose, fructose, glucose, fruit juice concentrate or other sugars. "Caloric sweetener" excludes non-caloric sweeteners. For purposes of this definition, "caloric" means a substance which adds calories to the diet of a person who consumes that substance.
 5. "Commissioner" means the commissioner of revenue and his or her authorized agents and employees.

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6. "Commonwealth" means the commonwealth of Massachusetts.
7. "Consumer" means a person who purchases a sugary drink for consumption and not for sale to another.
8. "Department" means the department of public health.
9. "Distributor" means any person, including manufacturers and wholesale dealers, who receives, stores, manufactures, bottles and/or distributes bottled sugary drinks, syrups or powders, for sale to retailers doing business in the commonwealth, whether or not that person also sells such products to consumers.
10. "Fund" means the Children's Health Promotion Fund, established pursuant to section 5.
11. "Milk" means natural liquid milk regardless of animal or plant source or butterfat content; natural milk concentrate, whether or not reconstituted; or dehydrated natural milk, whether or not reconstituted.
12. "Natural fruit juice" means the original liquid resulting from the pressing of fruits, or the liquid resulting from the dilution with water of dehydrated natural fruit juice.
13. "Natural vegetable juice" means the original liquid resulting from the pressing of vegetables, or the liquid resulting from the dilution with water of dehydrated natural vegetable juice.
14. "Non-caloric sweetener" means any non-caloric substance suitable for human consumption that humans perceive as sweet and includes, without limitation, aspartame, acesulfame-K, neotame, saccharin, sucralose and stevia. "Non-caloric sweetener" excludes caloric sweeteners. For purposes of this definition, "non-caloric" means a substance that contains fewer than 5 calories per serving.
15. "Person" means any natural person, partnership, cooperative association, limited liability company, corporation, personal representative, receiver, trustee, assignee or any other legal entity.
16. "Place of business" means any place where sugary drinks, syrups or powders are manufactured or received for sale in the commonwealth.
17. "Powder" means any solid mixture of ingredients used in making, mixing, or compounding sugary drinks by mixing the powder with any one or more other ingredients, including without limitation water, ice, syrup, simple syrup, fruits, vegetables, fruit juice, vegetable juice, carbonation or other gas.
18. "Retailer" means any person who sells or otherwise dispenses in the commonwealth a sugary drink to a consumer whether or not that person is also a distributor as defined in this section.
19. "Sale" means the transfer of title or possession for valuable consideration regardless of the manner by which the transfer is completed.
20. "Sugary drink" means any nonalcoholic beverage, carbonated or noncarbonated, which is intended for human consumption and contains any added caloric sweetener. As used in this definition, "nonalcoholic beverage" means any beverage that contains less than one-half of one percent alcohol per volume.
21. "Syrup" means a liquid mixture of ingredients used in making, mixing, or compounding sugary drinks using one or more other ingredients including, without limitation, water, ice, a powder, simple syrup, fruits, vegetables, fruit juice, vegetable juice, carbonation or other gas.

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22. "Water", means no-calorie, and non-flavored or flavored with natural fruit essence or natural flavor. The source of the water may be artesian, mineral, spring or well. "Water" may be carbonated, still, distilled or purified, including distilled, demineralized, deionized or reverse osmosis.

Section 2. Tax imposed.

- a. There is hereby imposed an excise tax on every distributor for the privilege of selling the products governed by this chapter in the commonwealth, calculated as follows:
1. The tax shall be calculated using the following tiered system.
 - i. Beverages with less than 5 grams of sugar per 12 fluid ounces will not be taxed.
 - ii. Beverages with 5 grams or more but less than 20 grams of sugar per 12 fluid ounces will be taxed at a rate of \$0.01 per ounce.
 - iii. Beverages with 20 grams of sugar or more per 12 fluid ounces will be taxed at a rate of \$0.02 per ounce.
 2. Syrups and powders sold or offered for sale to a retailer for sale in the State to a consumer, either as syrup or powder or as a sugary drink derived from that syrup or powder, are taxable. Syrups and powders shall be taxed using the following tiered system:
 - i. If the beverages made from the syrup or powder have less than 5 grams of sugar per 12 fluid ounces, the syrup or powder will not be taxed.
 - ii. If the beverages made from the syrup or powder have 5 grams or more but less than 20 grams of sugar per 12 fluid ounces, the syrup or powder will be taxed at a rate equal to \$0.01 per ounce for each gallon of sugary drink produced from that syrup or powder.
 - iii. If the beverages made from the syrup or powder have 20 grams of sugar or more per 12 fluid ounces, the syrup or powder will be taxed at a rate equal to \$0.02 per ounce for each gallon of sugary drink produced from that syrup or powder.

For purposes of calculating the tax, the volume of sugary drink produced from syrups or powders shall be the larger of (i) the largest volume resulting from use of the syrups or powders according to any manufacturer's instructions, or (ii) the volume actually produced by the retailer, as reasonably determined by the commissioner;
 3. The tax amounts set forth in this section shall be adjusted annually by the commissioner in proportion with the Consumer Price Index: All Urban Consumers for All Items for the Northeast Region Statistical Area as reported by the United States Bureau of Labor Statistics or any successor to that index.
 4. Manufacturers, bottlers, wholesalers or distributors shall add the amount of the tax imposed by this section to the retail price of sugary drinks.
- b. A retailer who sells bottled sugary drinks, syrups, or powders in the commonwealth to a consumer, on which the tax imposed by this section has not been paid by a distributor, is liable for the tax imposed in subsection (a) at the point of sale to a consumer.
- c. The taxes imposed by this section are in addition to any other taxes that may apply to persons or products subject to this chapter.

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Section 3. Report of Sales and Tax Remittances.

Any distributor or retailer liable for the tax imposed by this chapter shall, on or before the last day of March, June, October, and December of each year, return to the commissioner under oath of a person with legal authority to bind the distributor or retailer, a statement containing his or her name and place of business, the quantity of sugary drinks, syrups and powders subject to the excise tax imposed by this chapter sold or offered for sale in the 3 months immediately preceding the month in which the report is due, and any other information required by the commissioner, along with the tax due.

Section 4. Records of Distributors

Every distributor, and every retailer subject to this chapter, shall maintain for not less than 2 years accurate records, showing all transactions that gave rise, or may have given rise, to tax liability under this chapter. Such records are subject to inspection by the commissioner at all reasonable times during normal business hours.

Section 5. Exemptions.

- a. The following shall be exempt from the tax imposed by this chapter:
 1. Bottled sugary drinks, syrups, and powders sold to the United States Government and American Indian Tribal Governments;
 2. Bottled sugary drinks, syrups, and powders sold by a distributor to another distributor that holds a permit issued pursuant to this chapter if the sales invoice clearly indicates that the sale is exempt. If the sale is to a person who is both a distributor and a retailer, the sale shall also be tax exempt and the tax shall be paid when the purchasing distributor or retailer resells the product to a retailer or a consumer. This exemption does not apply to any other sale to a retailer;
 3. Beverages sweetened solely with non-caloric sweeteners;
 4. Beverages consisting of 100 per cent natural fruit or vegetable juice with no added caloric sweetener;
 5. Beverages in which milk, or soy, rice or similar milk substitute, is the primary ingredient or the first listed ingredient on the label of the beverage;
 6. Coffee or tea without added caloric sweetener;
 7. Infant formula;
 8. Beverages for medical use;
 9. Water without any caloric sweeteners.

Section 6. Unpaid Taxes and Debt.

All taxes imposed under the provisions of this chapter remaining due and unpaid shall constitute a debt to the commonwealth, which may be collected from the person owing same by suit or otherwise.

Section 7. Records of commissioner.

At the end of each month, the auditor of the commonwealth shall carefully check the books and records of the commissioner and his accounts with any bank or banks, and shall verify the amounts collected pursuant to this chapter and paid into the Children's Health Promotion Fund. Any duty herein required of the auditor of the commonwealth may

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be performed by any duly trained clerk in his office, designated by the auditor of the commonwealth for that purpose.

Section 8. Exercise of Powers and Duties.

Whenever in this chapter any reference is made to any power or duty of the commissioner, the reference is construed to mean that the power or duty shall be exercised by the commissioner, under the supervision and direction of the commissioner.

Section 9. Rules and Regulations.

The commissioner is hereby empowered to make such rules and regulations, and provide such procedural measures, in cooperation with the auditor of the commonwealth, as may be reasonably necessary to accomplish the purposes of this chapter.

Section 10. Severability.

If any provision of this chapter, any rule or regulation made under this chapter, or the application of this chapter to any person or circumstance is held invalid by any court of competent jurisdiction, the remainder of the chapter, rule, or regulation, and the application of the provision to other persons or circumstances shall not be affected. The invalidity of any section or sections or parts of any section of this chapter shall not affect the validity of the remainder of the chapter.

SECTION 2. The Massachusetts General Laws, as appearing in the 2014 Official Edition, are hereby amended by inserting after Section 2I of Chapter 111 the following new chapter:-

Section 2J. CHILDRENS HEALTH PROMOTION FUND

- a. There shall be established and set up on the books of the commonwealth a separate fund to be known as the Children's Health Promotion Fund. The department of public health shall administer the fund. The fund shall consist of revenues from the commonwealth generated by the tax imposed by Chapter 64O, section 2. The fund shall be expended first for the implementation, administration, and enforcement of Chapter 64O. Unexpended balances shall be allocated in a proportion to be determined by the department of public health. Qualifying programs funded under Chapter 64O shall include but not be limited to
 - i. Expansion of Mass in Motion as funded in item 4513-1111 of section 2 of chapter 133 of the acts of 2016.
 - ii. Expansion of the Prevention and Wellness Trust Fund established in section 2G of chapter 111.
 - iii. A municipal grant program for the fluoridation of public water supplies.
 - iv. Funding for the department of early education and care to support and promote nutrition programs for preschools, nursery schools, and child care facilities serving low-income communities.
 - v. Development and promotion of educational materials with the intent of educating citizens about the health effects of consuming sugary drinks and to promote the consumption of tap water.
 - vi. A municipal grant program for the creation and improvement of water fountains, improvement of water quality, and increasing water access in schools and municipal parks and facilities.
 - vii. Other evidence-based methods of improving children's health and wellness.

SECTION 3. The second paragraph of Section 1 of Chapter 71 of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by adding the following sentence: -

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- a. The department of elementary and secondary education shall encourage school districts to implement instruction in media literacy skills from the third grade to the twelfth grade, and in any of the core subjects or other subjects, to equip students with skills for accessing, analyzing, evaluating, and creating all types of media. Instruction shall include, but not be limited to, teaching of skills for analyzing and evaluating advertising content for food, beverages, drugs and alcohol.

SECTION 4. Chapter 71 of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by inserting after section 97 the following section:-

Section 98. PROHIBITION OF MARKETING OF SUGARY DRINKS IN SCHOOLS

- a. For the purposes of this section, the following words shall have the following meanings:
 1. "Advertising" means an oral, written or graphic statement or representation, including a company logo or trademark, made for the purpose of promoting the use or sale of a product by the producer, manufacturer, distributor, seller or any other entity with a commercial interest in the product.
 2. "Brand" means a corporate or product name, a business image or a mark, regardless of whether it may legally qualify as a trademark used by a seller or manufacturer to identify goods or services and to distinguish them from competitors' goods.
- b. Except as provided in subsection (c), the department of education shall prohibit at any school within the commonwealth:
 1. The advertising of any beverage that may not be sold on the school campus during the school day or of any corporate brand, unless every beverage product manufactured, sold or distributed under the corporate brand name, or by any of the corporate brand's subsidiaries and affiliated corporations, can be served or sold on the school campus during the school day. Advertising is prohibited on any property or facility owned or leased by the school district or school and used at any time for school-related activities, including, but not limited to, school buildings, athletic fields, facilities, signs, scoreboards, or parking lots, or any school buses or other vehicles, equipment, vending machines, uniforms, educational material or supplies. For purposes of this statute, beverages that may not be sold on the school campus during the school day are those that do not meet the minimum nutrition standards for foods sold outside the school meal programs as set forth by the United States Department of Agriculture under the Healthy, Hunger-Free Kids Act of 2010 and federal regulations implementing the Act [42 U.S.C. section 1779(b)];
 2. the participation in a corporate incentive program that rewards children with free or discounted beverages that may not be sold on the school campus during the school day when they reach certain academic goals; or
 3. the participation in corporate-sponsored programs that provide funds to schools in exchange for consumer purchases of beverages that may not be sold on the school campus during the school day.
- c. The restriction on advertising in subsection (b) shall not apply to
 1. Advertising on broadcast, digital, or print media, unless the media are produced or controlled by the local education agency, school, faculty, or its students;

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2. Advertising on clothing with brand images work on school grounds; or
3. Advertising contained on product packaging.

SECTION 5. Chapter 111 of the General Laws is hereby amended by inserting after section 235 of the following section:-

Section 236. LIMITATION ON BEVERAGES IN CHILDREN'S MEALS

- a. For the purposes of this section, the following words shall have the following meanings:
 1. "Chain restaurant" a retail food establishment that prepares, serves, and vends food directly to the consumer that (a) operates 10 or more establishments in the commonwealth or (b) is a restaurant franchisee where the franchisor and the franchisees of that restaurant together operate 10 or more establishments in the commonwealth.
 2. "Chain restaurant franchisee," an individual, corporation, partnership or other entity, or group of individuals or entities, that operates one or more restaurants in the commonwealth under a franchise agreement with another individual, corporation, partnership or other entity, or group of individuals or entities.
 3. "Chain restaurant franchisor," an individual, corporation, partnership or other entity, or group of individuals or entities, that grants a franchisee the right to operate one or more fast food restaurants in the commonwealth under its trademark or trade name.
 4. "Children's Meal" means a combination of food item or items and a beverage, sold together at a single price, primarily intended for consumption by children.
 5. "Default Beverage" means the beverage automatically included as part of a children's meal, absent a specific request by the purchaser of the children's meal for an alternative beverage.
- b. A chain restaurant may only sell a children's meal if the default beverage is one of the following:
 1. Water, sparkling water or flavored water, with no added natural or artificial sweeteners;
 2. Nonfat or 1 per cent milk or non-dairy milk alternative containing no more than 130 calories per container and/or serving as offered for sale; or
 3. 100 per cent juice, with no added sweeteners, in a serving size of no more than 8 ounces.
- c.
 1. The department of public health and local boards of health acting under the supervision of the department of public health shall implement, administer and enforce this section. The department of public health is hereby authorized to issue all rules and regulations consistent with this section and shall have all necessary powers to carry out the purpose of this section.
 2. All chain restaurants shall report, upon enactment of this chapter and annually, thereafter, to the department of public health whether they offer children's meals and if so, that they understand their obligations under this section. Such reporting must be done on a form prescribed by the department of public health and must be signed by a responsible agent or officer of the chain restaurant in order to confirm that the information provided on the form is accurate and complete. Failure to comply with this subsection shall constitute a violation of this section.

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- d. Restaurants in violation of this section shall for the first offense be punished by a fine of not more than \$100; and for any subsequent offense shall be punished by a fine of not less than \$100 nor more than \$500.

SECTION 6. Chapter 94 of the General Laws is hereby amended by inserting after section 330 the following section:-

Section 331. REQUIRING LABELS ON CERTAIN SUGARY DRINK ADVERTISEMENTS

- a. For the purposes of this section, the following words shall have the following meanings:
 1. "Advertiser" means any person who is any of the following "(a) in the business of manufacturing, distributing, or selling sugary drinks, including without limitation, a retailer; (b) is in the business of placing or installing advertisements, or who provides space for the display of advertisements; or (c) is an agent or contractor of a Person described in (a) or (b) assisting such Person with the manufacture, distribution or sale of sugary drink, the placement or installation of advertisements or the provision of space for advertisements. The term "advertiser" shall not include the employees of a person, including, without limitation, employees of agent or contractors, except that it shall include individuals acting as sole proprietors.
 2. "Sugary drink" is defined as stated in chapter 64O.
 3. "Sugary drink advertisement" means any advertisement, including, without limitation, any logo, that identifies, promotes or markets a sugary drink for sale or use that is any of the following: (a) on a poster, paper or a billboard; (b) in or on a stadium, arena, transit shelter or any other structure; (c) in or on a bus, car, train, pedicab or any other vehicle; or (d) on a wall, or any other surface material.
- b. Any advertiser who posts a sugary drink advertisement shall place on the sugary drink advertisement the following label: "WARNING: Drinking beverages with added sugar(s) contributes to obesity, diabetes, and tooth decay." The word "WARNING" shall appear in capital letters. The Warning shall be enclosed in a rectangular border within the printed advertisement that is the same color as the letters of the Warning and that is the width of the first downstroke of the capital "W" of the word "WARNING." The Warning shall occupy at least 20% of the area of each sugary drink advertisement and the text shall be printed in a size and manner so as to be clearly legible to the intended viewer of the sugary drink advertisement. The text of the warning shall be positioned such that the Warning and the other information on the sugary drink advertisement had the same orientation, such that text in the sugary drink advertisement and the Warning are read in the same direction. The Warning shall be indelibly printed on or permanently affixed to each sugary drink advertisement.
- c. The department of public health shall promulgate regulations related to this section, including, but not limited to, determining reasonable exemptions to this section.
- d. The following shall be exempt from the requirement imposed in this section:
 1. Containers or packages for sugary drinks;
 2. Any menus or handwritten listings or representations of foods or beverages that may be served or ordered for consumption at a retail establishment;
 3. Any display or representation of, or other information about, a sugary drink, including, without limitation, any logo on a vehicle if the vehicle is being used by any person who is in the business of manufacturing, distributing or selling the sugary drink in the performance of such business;
 4. Any other advertisements determined by the department of public health as referenced in subsection (c).

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- e. Advertisers in violation of this section shall for the first offense be punished by a fine of not more than \$100; and for any subsequent offense shall be punished by a fine of not less than \$100 nor more than \$500.

SECTION 7. (a) Notwithstanding any general or special law to the contrary, there shall be established a Special Commission on Access to Drinking Water in Public Places. The Commission shall evaluate the public health benefits of and options for expanding access to drinking water in public places, including but not limited to parks, playgrounds, schools, libraries, other public buildings, bicycle and pedestrian paths, stadiums, arenas, and commercial, cultural and other properties generally open to the public.

- b. The Commission shall consist of 13 members, 1 of whom shall be the commissioner of public health or a designee, who shall serve as chair, 1 of whom shall be the commissioner of elementary and secondary education or a designee, 1 of whom shall be the executive director of the Massachusetts School Building Authority or a designee, 1 of whom shall be the secretary of transportation or a designee, 1 of whom shall be the commissioner of environmental protection or a designee, 1 of whom shall be the commissioner of conservation and recreation or a designee, 1 of whom shall be the administrator of the Board of Building Regulations and Standards or a designee, 1 of whom shall be the executive director of the Massachusetts Water Resources Authority or a designee, 1 of whom shall be a representative of a public health advocacy organization, 1 of whom shall be a representative of a water access advocacy organization, 1 of whom shall be the director of the Prevention Research Center on Nutrition and Physical Activity at Harvard University School of Public Health or a designee.
- c. The Commission shall first convene within 60 days of the effective date of this Act, and not less than bi-monthly thereafter, and shall file a report with the Joint Committee on Public Health no later than 180 days after first convening. The report shall (a) present current scientific evidence on the health and other benefits of adequate water consumption, including but not limited to consumption by school-age children; (b) present currently available data on water consumption among Massachusetts residents by age, place of residence, gender, race, income, and other demographic factors; (c) evaluate current laws, regulations, and policies regarding access to drinking water in public places in Massachusetts; (d) evaluate current obstacles to access to drinking water in public places in Massachusetts; and (e) make recommendations for changes to policies, regulations, and legislation in order to expand access to drinking water in public places in Massachusetts. The commission shall be empowered to hold regular public meetings, fact-finding hearings and other public forums as it considers necessary. Members shall not receive compensation for their services.



MASSACHUSETTS
Health & Hospital
ASSOCIATION

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MHA'S 2017/2018 PRIORITY LEGISLATION PACKAGE

MHA's Priority Legislation Package for the 2017/2018 legislative session includes 23 bills focused on behavioral health and substance use disorders, public coverage programs, telemedicine, administrative simplification and cost reduction, healthcare quality and patient safety, and improving public health.

BEHAVIORAL HEALTH & SUBSTANCE USE DISORDERS

1. *HB2404-An Act to Improve Access to Behavioral Health Services* (jointly, Rep. Malia/Sen. Keenan)
- referred to the Joint Committee on Mental Health, Substance Use & Recovery
This legislation will: require all Medicaid programs to cover inpatient behavioral health services without requiring a prior authorization; direct Medicaid to enable community-based crisis stabilization providers to determine if an inpatient admission is appropriate instead of requiring an ER visit; and require the state to analyze and maintain a database of current behavioral health providers to assist with care coordination.
2. *SB1099/HB2180-An Act Relative to Patient Choice to Promote Prescription Safety* (Sen. Keenan/Rep. Malia)
- SB1099 referred to the Joint Committee on Mental Health, Substance Use & Recovery
- HB2180 referred to the Joint Committee on Financial Services
The recently passed federal Comprehensive Addiction and Recovery Act cleared up federal ambiguity regarding the ability of states to use "partial-fill" for opioid prescriptions. These bills would give Massachusetts practitioners the ability to implement "partial fill" for schedule II opioid prescriptions. Clinicians who write "partial-fill" prescriptions can reduce the amount of unused pain medicines sitting in medicine cabinets and limit the number of drugs that can be diverted to other uses.
3. *HB2469/SB1214-An Act to Enhance Access to Prescription Information and Overdose Reporting for Care Coordination* (Rep. Malia/Sen. Lesser)
- referred to the Joint Committee on Public Health
This legislation will: ensure entities such as the MHA Pre-Manage ED initiative can access Massachusetts Prescription Awareness Tool (MassPAT) data effectively for healthcare diagnosis, treatment and coordination purposes; and maintains essential state and regional reporting on fatal and non-fatal opioid overdoses beyond its current 2017 sunset.

MASSHEALTH/HEALTH SAFETY NET/CONNECTORCARE

4. *HB616-An Act Ensuring Protections for Hospitals that Contract with Medicaid Managed Care Organizations* (Rep. Linsky)
- referred to the Joint Committee on Health Care Financing

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This bill will reestablish the long-standing free market practice of allowing healthcare providers to freely negotiate with MassHealth MCOs for in-network services and will prohibit MassHealth policies that seek to mandate limited reimbursement for non-emergency services provided to patients covered by out-of-network MassHealth MCOs.

5. *HB2984-An Act to Restore Adequate Funding for Disproportionate Share Hospitals* (Rep. Finn)

- referred to the Joint Committee on Health Care Financing

This bill will restore the elimination of Disproportionate Share Hospital Payments in the MassHealth program by requiring MassHealth to restore a 5 percent supplementary adjustment to its reimbursement rates for disproportionate share hospitals (DSH) and directing MassHealth to provide \$12.3 million in supplementary payments for behavioral health services provided by disproportionate share hospitals to MassHealth patients.

6. *HB595/SB623-An Act to Address the Financial Stability of the Health Safety Net* (Rep. Benson/Sen. Flanagan)

- referred to the Joint Committee on Health Care Financing

This legislation seeks to enhance the foundations that support the Health Safety Net (HSN) Trust Fund by: reinforcing the current requirement to transfer \$30 million in funding from the Unemployment Assistance Trust Fund to the Health Safety Net, which has not been fulfilled in recent years; dedicating federal Health Safety Net matching revenues to the HSN Trust Fund instead of the general fund; and allocating the responsibility for HSN shortfalls equally between hospitals and surcharge payers. The shortfall is currently the sole responsibility of hospitals.

7. *HB611-An Act Updating MassHealth Reimbursement Rates for Chronic Disease & Rehabilitation Hospitals* (Rep. Honan)

- referred to the Joint Committee on Health Care Financing

This bill will ensure the MassHealth program relies upon a more recent and appropriate base year of FY2012 when calculating inpatient rates for post-acute care hospitals. MassHealth currently uses outdated cost data from 2003 to set the reimbursement rates for these hospitals.

8. *HB614-An Act Administering National Standards to Medicaid Medical Necessity Reviews* (Rep. Kulik)

- referred to the Joint Committee on Health Care Financing

This bill will ensure that the Office of Medicaid complies with the utilization review guidelines established by the Massachusetts Patients' Bill of Rights. This standard requires the adoption of uniform national utilization review criteria (e.g., Interqual) and is followed by Medicare and health insurers. In addition, it requires that clinicians conducting reviews are practicing in the same specialty as the clinical services that are the subject of a review.

9. *HB592/SB630-An Act Restoring Affordable Health Connector Coverage* (Rep. Balser/Sen. Jehlen)

- referred to the Joint Committee on Health Care Financing

Filed in conjunction with the Affordable Care Today!! Coalition, Currently, the state's ConnectorCare program provides subsidies to help lower income Massachusetts residents pay for health insurance through the Health Connector. Recent ConnectorCare premium increases and the likely repeal of key provisions of the Affordable Care Act (ACA) reduces the availability of affordable health coverage options and puts the ConnectorCare program at risk. This legislation ensures the continuation of ConnectorCare and, in particular, protects members from drastic premium and cost-sharing increases. Without these protections, the state risks people dropping coverage, going without necessary care, falling into debt, and unraveling the coverage gains that the state has made under both the Massachusetts health reform law and the ACA.

TELEMEDICINE

10. *HB578/SB630-An Act Advancing and Expanding Access to Telemedicine Services* (Rep. Scibak/Sen. Lewis)

- referred to the Joint Committee on Financial Services

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This legislation will establish both coverage and reimbursement parity for telemedicine services and enable proxy credentialing/privileging for telemedicine that is consistent in a manner that is consistent with federal regulations. This legislation is supported by the tMED Coalition whose members include MHA and more than 27 health care provider, consumer and technology organizations.

ADMINISTRATIVE SIMPLIFICATION & COST REDUCTION

11. *HB523-An Act Relative to Uncollected Co-pays, Co-insurance and Deductibles* (Rep. Fiola)

- referred to the Joint Committee on Financial Services

This bill will ensure shared accountability between insurers and healthcare providers for uncollectible co-payments (those that exceed \$250), co-insurance, and deductibles. It requires insurers to reimburse providers for 65% of the uncollectible amounts if the provider is unable to receive payment after reasonable efforts have been taken. It would establish a process similar to the Medicare program, which reimburses hospitals for 65% of uncollectible patient out-of-pocket expenses.

12. *HB603/SB665-An Act Regarding Shared Responsibility for Funding of Health Care Oversight Agencies* (Rep. Day/Sen. Tarr)

- referred to the Joint Committee on Health Care Financing

This bill will enforce the intent of Chapter 224 by requiring equitable state funding to be dedicated to both the Center for Health Information & Analysis and the Health Policy Commission. Currently, hospitals and health insurers pay for all costs of these two agencies. Under this legislation the state would be required to pay one-third of the cost.

13. *HB2982-An Act Maintaining Confidentiality of Proprietary Information within Health Care Oversight Agencies* (Rep. Brodeur)

- referred to the Joint Committee on Health Care Financing

This bill will extend confidentiality protections to proprietary data submitted by providers to healthcare oversight agencies for various programs. It mirrors language adopted for the confidentiality of proprietary information submitted for market impact reviews.

14. *HB563-An Act to Prevent Inappropriate Denials for Medically Necessary Services* (Rep. Nangle)

- referred to the Joint Committee on Financial Services

This bill includes a number of steps to ensure that health insurers cannot use administrative denials as a way to avoid paying for medically necessary, covered services.

15. *HB1205-An Act to Implement Consistent Protections for Health Information* (Rep. Parisella)

- referred to the Joint Committee on Public Health

This bill implements federal HIPAA protections for accessing and sharing health information between providers, whether through an EMR or the Mass HiWay. Currently there are no specific protections in state law that would allow the sharing of confidential and highly protected information between providers, including the receipt of tests results from referring providers.

16. *SB520-An Act Relative to Health Insurer Reserve Requirements* (Sen. Donoghue)

- referred to the Joint Committee on Financial Services

This bill increases the transparency of risk-based capital held by health insurance companies and establishes a process to require the transfer of a percentage of reserves from insurers to risk-bearing provider organizations.

QUALITY & PATIENT SAFETY

17. *HB1188/SB1162-An Act Relative to Nurse Licensure Compact in Massachusetts* (Rep. Khan/Sen. Boncore)

- referred to the Joint Committee on Public Health

This bill authorizes the commonwealth to join 24 other states that have adopted the national Nurse Licensure

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Compact (NLC).The NLC follows the mutual recognition model of nurse licensure that allows a nurse to have one license in his or her state of residency and to practice in other states, subject to the nurse practice laws and regulations of each state.

18. *HB1186-An Act to Promote Patient Care Transparency and Nurse Advancement* (Rep. Khan)

- referred to the Joint Committee on Public Health

This bill establishes full transparency of patient care staffing and nurse-sensitive outcome measures while advancing the practice of nursing through the design of academic pathways and supports to effectuate the goals of the Massachusetts Action Coalition.

19. *SB1211/HB3242-An Act to Review the Quality and Patient Safety of Dispensing Certain Cancer and Chronic Disease Related Drugs* (Sen. Keenan/Rep. Hogan)

- referred to the Joint Committee on Public Health

This bill requires the Health Policy Commission to investigate the quality and patient safety implications of insurer policies that encourage the re-dispensing and administration of medications by hospitals for cancer and chronic disease patients for drugs that were previously dispensed by a specialty pharmacy.

20. *HB3239-An Act to Improve Access to and Reporting of Pharmacy Services in Hospitals* (Rep. Heroux)

- referred to the Joint Committee on

Filed in conjunction with the Mass. Society of Health System Pharmacists, this bill will expand collaborative drug therapy management for hospital pharmacists and streamline reporting from institutional compounding pharmacies for prescriptions used in hospital settings.

21. *HB2322/SB1193-An Act Relative to Emergency and Disaster Planning for Health Care Providers* (Rep. Malia/Sen. Eldridge)

- *HB2322* referred to the Joint Committee on The Judiciary

- *SB1193* referred to the Joint Committee on Public Health

Filed in conjunction with the Mass. College of Emergency Physicians, this bill would require that, in the situation of a state or regional emergency or other emergency situations, there would be a general waiver of liability against healthcare providers to ensure that providers are able to care for patients quickly without worry about liability concerns.

PUBLIC HEALTH/ALLIED EFFORTS

22. *SB1218/HB2864-An Act to Protect Youth from the Health Risks of Tobacco and Nicotine Addiction* (Sen. Lewis/Rep. McMurtry)

-referred to the Joint Committee on Public Health

Filed in conjunction with the Tobacco Free Mass. Coalition, this legislation will prohibit the sale of all tobacco and e-cigarettes to individuals under the age of 21. It also prohibits the sale of all tobacco and e-cigarettes in pharmacies and other healthcare institutions and responsibly regulates e-cigarettes by prohibiting their use at schools and workplaces.

23. *SB1562/HB3329-An Act to Promote Healthy Alternatives to Sugary Drinks* (Sen. Lewis/Rep. Khan)

- referred to the Joint Committee on Revenue

Filed in conjunction with the American Heart Association & the Massachusetts Health Council, this legislation will implement a tiered tax on sugar-sweetened beverages, based upon sugar content, with proceeds from the excise dedicated to a broad slate of the state's public health priorities, including the Prevention and Wellness Trust Fund. The bill additionally: prohibits marketing of such beverages in schools; places limitations on such beverages in children's meals at restaurants; requires labels on ads for such beverages; and establishes a commission on access to drinking water in public places.



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