



MASSACHUSETTS
Health & Hospital
ASSOCIATION

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STATE LEGISLATIVE PRIORITIES

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HB991/ SB612

An Act Advancing & Expanding Access to Telemedicine Services

Rep. Tom Golden (D-Lowell) / Sen. Jason Lewis (D-Winchester)

Referred to the Joint Committee on Financial Services

Bill Summary

This legislation will: establish coverage parity for telemedicine services across all payers – including MassHealth and the GIC; enable proxy credentialing for telemedicine providers in a manner that is consistent with federal regulations; and include a flexible definition of telemedicine that recognizes and covers both interactive and asynchronous (store and forward) technologies. The legislation is supported by the tMED Coalition whose members include MHA and more than 30 healthcare provider, consumer, and technology organizations.

Bill Text

SECTION 1. Chapter 32A of the General Laws, as appearing in the 2016 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; provided, that a carrier shall not meet network adequacy through significant reliance on telemedicine providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner, upon request. 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 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 prior to utilizing telemedicine, nor shall the type of setting where such telemedicine is provided be limited; provided further, a patient may decline receiving services via telemedicine in order to receive in person services and shall not incur costs that exceed the deductible, copayment or co-insurance applicable for the same services provided via telemedicine. 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 evaluation, diagnosis, consultation, prescribing, and

treatment of a patient's medical, oral, mental health and substance use disorder condition 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 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. Said regulations shall direct healthcare providers to provide information to patients about follow-up health care services that are available to the patient; this requirement may be fulfilled through the use of a website identifying available services in the community. 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 evaluation, diagnosis, consultation, prescribing, and treatment of a patient's medical, oral, mental health, and substance use disorder condition 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 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 13C12. 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; provided, however, that 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 a Medicaid accountable care organization shall not meet network adequacy through significant reliance on telemedicine providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner, upon request. 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 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 prior to utilizing telemedicine, nor shall the type of setting where such telemedicine is provided be limited; provided further, a patient may decline receiving services via telemedicine in order to receive in person services and shall not incur costs that exceed the deductible, copayment or co-insurance applicable for the same services provided via telemedicine. 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 evaluation, diagnosis, consultation, prescribing, and treatment of a patient's medical, oral, mental health, and substance use disorder condition 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; provided however, that an insurer shall not meet network adequacy through significant reliance on telemedicine providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner, upon request. 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 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 prior to utilizing telemedicine, nor shall the type of setting where such telemedicine is provided be limited; provided further, a patient may decline receiving services via telemedicine in order to receive in person services and shall not incur costs that exceed the deductible, copayment or co-insurance applicable for the same services provided via telemedicine. 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 evaluation, diagnosis, consultation, prescribing, and treatment of a patient's medical, oral, mental health, and substance use disorder condition 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; provided, however, that the corporation shall not meet network adequacy through significant reliance on telemedicine providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-

person services in a timely manner, upon request. 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 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 prior to utilizing telemedicine, nor shall the type of setting where such telemedicine is provided be limited; provided further, a patient may decline receiving services via telemedicine in order to receive in person services and shall not incur costs that exceed the deductible, copayment or coinsurance applicable for the same services provided via telemedicine. 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 evaluation, diagnosis, consultation, prescribing, and treatment of a patient's medical, oral, mental health and substance use disorder condition 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; provided, however, that the medical service corporation shall not meet network adequacy through significant reliance on telemedicine providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner, upon request. 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 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 prior to utilizing telemedicine, nor shall the type of setting where such telemedicine is provided be limited; provided further, a patient may decline receiving services via telemedicine in order to receive in person services and shall not incur costs that exceed the deductible, copayment or co-insurance applicable for the same services provided via telemedicine. 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 evaluation, diagnosis, consultation, prescribing, and treatment of a patient's medical, oral, mental health and substance use disorder condition 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; provided however, a carrier shall not meet network adequacy through significant reliance on telemedicine providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner, upon request. 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 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 prior to utilizing telemedicine, nor shall the type of setting where such telemedicine is provided be limited; provided further, a patient may decline receiving services via telemedicine in order to receive in person services and shall not incur costs that exceed the deductible, copayment or co-insurance applicable for the same services provided via telemedicine. 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, evaluation, consultation, prescribing, and treatment of a patient's medical, oral, mental health and substance use disorder condition 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; provided, however, an organization shall not meet network adequacy through significant reliance on telemedicine providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner, upon request.

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 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; provided further, a patient may decline receiving services via telemedicine in order to receive in person services and shall not incur costs that exceed the deductible, copayment or co-insurance applicable for the same services provided via telemedicine. 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 evaluation, diagnosis, consultation, prescribing, and treatment of a patient's medical, oral, mental health and substance use disorder condition 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 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. Said regulations shall direct healthcare providers to provide information to patients about follow-up health care services that are available to the patient; this requirement may be fulfilled through the use of a website identifying available services in the community. 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 evaluation, diagnosis, consultation, prescribing, and treatment of a patient's medical, oral, mental health and substance use disorder condition 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. Notwithstanding any general or special law to the contrary, the Division of Insurance and the Executive Office of Health and Human Services shall annually issue a joint

report with data collected from carriers as well as 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 Medicaid accountable care organizations which indicates the percentage of services provided through telemedicine to patients by: (1) modality, including in-person visits and telemedicine visits; (2) provider specialty; and (3) patient age. Said report shall be publicly available and delivered to the joint committee on health care financing, the joint committee on mental health, substance use and recovery, the joint committee on public health, the clerk of the house of representatives, and the clerk of the Senate not later than January 1, 2021, and annually thereafter for the next 5 years.

SECTION 11. The provisions of this Act shall be effective for all contracts which are entered into, renewed, or amended one year after its effective date.

HB1944/SB103

An Act Relative to the Nurse Licensure Compact in Massachusetts

Rep. Kay Khan (D-Newton) / Sen. Joe Boncore (D-Winthrop)

HB1944 referred to the Joint Committee on Public Health

SB103 referred to the Joint Committee on Consumer Protection & Professional Licensure

Bill Summary

This bill authorizes the commonwealth to join 31 other states that have adopted the national Nurse Licensure 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.

Bill Text

An Act relative to nurse licensure compact in Massachusetts.

Whereas, 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;

Whereas, Violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public;

Whereas, 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;

Whereas, New practice modalities and technology make compliance with individual state nurse licensure laws difficult and complex;

Whereas, The current system of duplicative licensure for nurses practicing in multiple states is cumbersome and redundant for both nurses and states; and

Whereas, Uniformity of nurse licensure requirements throughout the states promotes public safety and public health benefits.

The deferred operation of this act would tend to defeat its purposes, which are to facilitate the states' responsibility to protect the public's health and safety, ensure and encourage the cooperation of party states in the areas of nurse licensure and regulation; facilitate the exchange of information between party states in the areas of nurse regulation, investigation and adverse actions, promote compliance with the laws governing the practice of nursing in each jurisdiction, 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, decrease redundancies in the consideration and issuance of nurse licenses, and provide opportunities for interstate

practice by nurses who meet uniform licensure requirements, therefore, it is hereby declared to be an emergency law, necessary for the immediate preservation of the public convenience.

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

SECTION 1. Subsection (c) of section 14 of chapter 13 of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the words “chapter one hundred and twelve,” the following words:- chapter one hundred and twelve A,

SECTION 2. Section 79 of chapter 112 of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by adding the following two sentences:-

The board may assess a licensed nurse a penalty of not more than \$2,000 for each violation of regulations promulgated pursuant to this section and for each violation of any general law that governs the practice of nursing. The board, through regulation, shall ensure that any fine levied is commensurate with the severity of the violation.

SECTION 3. The General Laws are hereby amended by inserting after chapter 112 the following new chapter:-

Chapter 112A. Nurse Licensure Compact

Section 1. Definitions

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

“Adverse action”, 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.

“Alternative program”, a non-disciplinary monitoring program approved by a licensing board.

“Compact” or “Nurse Licensure Compact”, the legally binding agreement between party states as adopted by the National Council of State Boards of Nursing Nurse Licensure Compact in its Final Version dated May 4, 2015, and entered into by the commonwealth in accordance with this chapter.

“Coordinated licensure information system”, 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.

“Current significant investigative information”, (i) 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 (ii) 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.

“Encumbrance”, a revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing imposed by a licensing board.

“Home state”, the party state which is the nurse’s primary state of residence.

“Interstate commission”, the Interstate Commission of Nurse Licensure Compact Administrators as established in section 6 of this chapter.

“Licensing board”, a party state’s regulatory body responsible for issuing nurse licenses.

“Multistate license”, a license to practice as a registered nurse or a licensed practical/vocational nurse issued by a home state licensing board that authorizes the licensed nurse to practice in all party states under a multistate licensure privilege.

“Multistate licensure privilege”, a legal authorization associated with a multistate license permitting the practice of nursing as either a registered nurse or as a licensed practical/vocational nurse in a remote state.

“Nurse”, registered nurse or a licensed practical/vocational nurse, as those terms are defined by each party state’s practice laws.

“Party state”, the commonwealth and any other state that has adopted this Compact.

“Remote state”, a party state other than the home state.

“Single-state license”, 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.

“State”, a state, territory or possession of the United States and the District of Columbia.

“State practice laws”, a party state’s laws, rules and regulations that govern the practice of nursing, define the scope of nursing practice, and establish 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 2. General Provisions and Jurisdictions

(a) A multistate license to practice as a nurse 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 or as a licensed practical/vocational nurse (, 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;

(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 requirements under section 2 to obtain a multistate license from a new home state.

(2) A nurse who fails to satisfy the multistate licensure requirements in in section 2 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.

Section 3. 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.

(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 interstate 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 4. 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.

(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 5. 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 interstate 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;

(3) Information related to alternative program participation; and

(4) Other information that may facilitate the administration of this Compact, as determined by interstate commission rules.

(i) The Compact administrator of a party state shall provide all investigative documents and information requested by another party state.

Section 6. 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 interstate commission is an instrumentality of the party states.

(2) Venue is proper, and judicial proceedings by or against the interstate commission shall be brought solely and exclusively, in a court of competent jurisdiction where the principal office of the interstate commission is located. The interstate 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 interstate 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 interstate 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 interstate 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 interstate 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 section 7.

(5) The interstate commission may convene in a closed, nonpublic meeting if the interstate 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 interstate 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;

(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 interstate 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 interstate commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The interstate 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 interstate commission or order of a court of competent jurisdiction.

(c) The interstate 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 interstate 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 interstate commission;

(3) Providing reasonable procedures for calling and conducting meetings of the interstate 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 interstate 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 interstate 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 interstate commission;

(5) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the interstate 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 interstate commission; and

(6) Providing a mechanism for winding up the operations of the interstate 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 interstate commission shall publish its bylaws and rules, and any amendments thereto, in a convenient form on the website of the interstate commission.

(e) The interstate commission shall maintain its financial records in accordance with the bylaws.

(f) The interstate commission shall meet and take such actions as are consistent with the provisions of this Compact and the bylaws.

(g) The interstate 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 interstate 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 interstate 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 interstate 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 interstate 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 interstate commission

(1) The interstate commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization and ongoing activities.

(2) The interstate 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 interstate commission, which shall promulgate a rule that is binding upon all party states.

(3) The interstate commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the interstate commission pledge the credit of any of the party states, except by, and with the authority of, such party state.

(4) The interstate commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the interstate commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the interstate 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 interstate commission.

(i) Qualified Immunity, Defense and Indemnification

(1) The administrators, officers, executive director, employees and representatives of the interstate 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 interstate 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 interstate commission shall defend any administrator, officer, executive director, employee or representative of the interstate 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 interstate 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 interstate 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 interstate commission shall indemnify and hold harmless any administrator, officer, executive director, employee or representative of the interstate 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 interstate commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of interstate 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 7. Rulemaking

(a) The interstate commission shall exercise its rulemaking powers pursuant to the criteria set forth in this section 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.

(b) Rules or amendments to the rules shall be adopted at a regular or special meeting of the interstate commission.

(c) Prior to promulgation and adoption of a final rule or rules by the interstate commission, and at least sixty (60) days in advance of the meeting at which the rule will be considered and voted upon, the interstate commission shall file a notice of proposed rulemaking:

(1) On the website of the interstate 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 interstate commission of their intention to attend the public hearing and any written comments.

(e) Prior to adoption of a proposed rule, the interstate commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

(f) The interstate commission shall grant an opportunity for a public hearing before it adopts a rule or amendment.

(g) The interstate 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 interstate commission at hearings required by this section.

(h) If no one appears at the public hearing, the interstate 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 interstate commission shall consider all written and oral comments received.

(j) The interstate 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 interstate 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 interstate 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.

(l) The interstate 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 interstate 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 interstate 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 interstate commission.

Section 8. 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 interstate commission shall be entitled to receive service of process in any proceeding that may affect the powers, responsibilities or actions of the interstate 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 interstate commission shall render a judgment or order void as to the interstate commission, this Compact or promulgated rules.

(b) Default, Technical Assistance and Termination

(1) If the interstate commission determines that a party state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the interstate 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 interstate 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 interstate 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 interstate 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 interstate commission and the defaulting state.

(6) The defaulting state may appeal the action of the interstate commission by petitioning the U.S. District Court for the District of Columbia or the federal district in which the interstate commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(c) Dispute Resolution

(1) Upon request by a party state, the interstate commission shall attempt to resolve disputes related to the Compact that arise among party states and between party and non-party states.

(2) The interstate commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes, as appropriate.

(3) In the event the interstate 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 interstate commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this Compact.

(2) By majority vote, the interstate commission may initiate legal action in the U.S. District Court for the District of Columbia or the federal district in which the interstate 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 interstate commission. The interstate commission may pursue any other remedies available under federal or state law.

Section 9. 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.

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

Section 10. 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 11. 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 12. The board of registration in nursing shall adopt regulations in the same manner as all other with states legally joining in the Compact and may adopt additional regulations as necessary to implement the provisions of this chapter.

Section 13. 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 14. 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 party state. The board's disciplinary action may be based on disciplinary action against the nurse's license taken by the nurse's home state.

Section 15. 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 16. Nothing in this chapter, nor the entrance of Massachusetts into the Nurse Licensure Compact shall be construed to supersede existing labor laws.

Section 17. 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 18. As part of the licensure and background check process for a multistate license and to determine the suitability of an applicant for multistate licensure, the board of registration in 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. Fingerprint submissions may be retained by the Federal Bureau of Investigation, the state identification section and the department of criminal justice information services for requests submitted by the board of registration in nursing as authorized under this section to ensure the continued suitability of these individuals for licensure. The department of criminal justice information services may disseminate the results of the state and national criminal background checks to the executive director of the board of registration in nursing and authorized staff of the board.

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 board of registration in 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 board of registration in 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.

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

SECTION 4. 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.

SECTION 5. The effective date of the commonwealth's entry into the Nurse Licensure Compact shall be one year from the effective date of this act. Prior to said effective date, the board of registration in nursing may take such actions as are necessary to implement chapter 112A of the General Laws and effectuate entry into the Nurse Licensure Compact.

HB1976 / SB1093

An Act Requiring Health Care Facilities to Develop & Implement Programs to Prevent Workplace Violence

Rep. Michael Moran (D-Boston) / Sen. Jason Lewis (D-Winchester)

HB1976 referred to the Joint Committee on Public Health

SB1093 referred to the Joint Committee on Labor & Workforce Development

Bill Summary

Modeled on legislation that was reported favorably by the Labor & Workforce Development Committee last session, this bill requires: DPH to develop statewide standards for evaluating and addressing security risks within hospitals and then monitor facility compliance with the new statewide standards; heightens penalties for assaults on healthcare providers; supports employees as they address legal proceedings related to incidents of violence; and seeks to identify and increase awareness of potential risks to workers

Bill Text

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

SECTION 1. Chapter 111 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after section 237, the following new section:-

Section 237. (a) As used in this section, the following words shall have the following meanings:-

“Employee”, an individual employed by a health care facility as defined in this section.

“Health care facility”, a hospital as defined under Section 51 of Chapter 111 of the Massachusetts General Laws.

“Workplace Violence”, any attempted or actual harmful or unpermitted touching of another person that results in injury and occurs on a work site.

(b) Notwithstanding any general or special law to the contrary, within 6 months of the date of enactment, the department shall develop statewide standards for evaluating and addressing known security risks at health care facilities. Such standards shall be based on existing state laws and regulations as well as national accreditation and professional association standards for health care facilities for the purpose of ensuring consistency in the development of and annual

review of internal operations preventing known risks. These standards shall include, but not be limited to: working in public settings; guarding or maintaining property or possessions; working in high-crime areas; working late night or early morning hours; working alone or in small numbers; uncontrolled public access to the workplace; working in public areas where people are in crisis; working in areas where patients or residents may exhibit violent behavior; and working in areas with known security problems. In developing such standards, the department shall convene and consult with an advisory committee comprised of health care facilities, including but not limited to, leadership, staff nurses and facility directors. Following development of the statewide standards, each healthcare facility shall be required to provide a summary of its operational policy that complies with the standards and includes a description of: i) the development of security risk identification; ii) engagement with employees on potential risks; iii) evaluation of incidents that have occurred; and iv) periodic reassessments of programs and policies. Such summaries shall be submitted to the department within six months after the advisory committee promulgates its standards, and shall be updated when a health care facility makes a substantive change to its operational policy for security risk assessment.

(c) The health care facility shall develop and implement a program to minimize the danger of workplace violence to employees based on the statewide standards developed pursuant to subsection (b), which shall include appropriate employee training and a system for the ongoing reporting and monitoring of incidents and situations involving violence or the risk of violence. Employee training shall include, in addition to all employer training program policies, methods of reporting to appropriate public safety officials, bodies or agencies and processes necessary for the filing of criminal charges. Each health care facility shall develop a written violence prevention plan setting forth the facility's workplace violence prevention plan. The health care facility shall make the plan available on site to each employee and allow any of its employees to

review the plan on site upon request. The health care facility shall provide the plan to a labor organization that represents employees at the health care employer.

(d) Each health care facility shall designate a senior manager responsible for the development and support of an in-house crisis response team for employee-victims of workplace violence.

Said team shall implement an assaulted staff action program that includes, but is not limited to, group crisis interventions, individual crisis counseling, staff victims' support groups, employee victims' family crisis intervention, peer-help or professional referrals.

(e) The commissioner of public health shall adopt rules and regulations necessary to implement the purposes of this act. The rules and regulations shall include such guidelines as the commissioner deems appropriate regarding workplace violence prevention programs required pursuant to this act, and related reporting and monitoring systems and employee training.

SECTION 2. Section 13I of Chapter 265 of the General Laws as appearing in the 2016

Official Edition, is hereby amended by replacing the entire section with the following language:-

Whoever commits an assault or an assault and battery on an emergency medical technician, an ambulance operator, an ambulance attendant or a health care provider as defined in section 1 of chapter 111 of the general laws, while the technician, operator, attendant or provider is in the course of employment at the time of such assault or assault and battery, shall be punished by imprisonment in state prison for not more than five years or imprisonment in a jail or house of correction for not less than 90 days nor more than 2 and one-half years or by a fine of not less than \$500 nor more than \$5,000, or any combination of said fines and imprisonment.

Any emergency medical technician, ambulance operator, ambulance attendant or a health care provider as defined in section 1 of chapter 111, who is the victim of assault or assault and battery in the line of duty shall be given the option of providing either the individual's home address, the address of the health care facility where the assault or assault and battery occurred, the address of a labor organization who is representing the employee, if so requested by the employee, or by requesting a judge to impound the individual's home address. In

instances where the address of the health care facility or labor organization is used, said facility or labor organization shall ensure that the individual receives any documents pertaining to the assault or assault and battery by the next business day of receipt by said facility or labor organization. The health care facility or labor organization shall demonstrate that it has provided any and all documentation by obtaining an acknowledgement of receipt from the individual.

SECTION 3. Each health care facility shall report every six months all incidents of assault and assault and battery under Section 237 of Chapter 111 and Section 13I of Chapter 265 of the General Laws, as appearing in the 2016 Official Edition, to the department of public health and the office of the district attorney. The department of public health shall make an annual public report using aggregated

statewide data of reported incidents of assault and assault and battery under Section 237 of Chapter 111 and Section 13I of Chapter 265.

SECTION 4. Chapter 265 of the General Laws as so appearing, is hereby amended after Section 13I by inserting at the end the following sections:-

Section 13I 1/2. (a) For purposes of this section, the following words shall have the following meanings, unless the context clearly indicates otherwise:

“Employee”, an individual employed by a health care facility as defined in this section.

“Health care facility”, a hospital as defined under Section 51 of Chapter 111 of the Massachusetts General Laws

(b) A health care facility shall permit an employee to take unpaid leave from work if: (i) the employee is a victim of assault or assault and battery which occurred in the line of duty; and (ii) the employee is using the leave from work to: seek or obtain victim services or legal assistance; obtain a protective order from a court; appear in court or before a grand jury; or meet with a district attorney.

(c) An employee seeking leave from work under this section shall provide appropriate advance notice of the leave to the health care facility as required by the facility's leave policy.

(d) A health care facility may require an employee to provide documentation evidencing that the employee has been a victim of assault or assault and battery sustained in the line of duty and that the leave taken is consistent with the conditions of clauses (i) and (ii).

(e) If an unscheduled absence occurs, the health care facility shall not take any negative action against the employee if the employee, within 30 days from the unauthorized absence or within 30 days from the last unauthorized absence in the instance of consecutive days of unauthorized absences, provides documentation that the unscheduled absence meets the criteria of clauses (i) and (ii).

(f) An employee shall provide such documentation to the health care facility within a reasonable period after the health care facility requests documentation relative to the employee's absence.

(g) All information related to the employee's leave under this section shall be kept confidential by the health care facility and shall not be disclosed, except to the extent that disclosure is: (i) requested or consented to, in writing, by the employee; (ii) ordered to be released by a court of competent jurisdiction; (iii) otherwise required by applicable federal or state law; (iv) required in the course of an investigation authorized by law enforcement, including, but not limited to, an investigation by the attorney general; or (v) necessary to protect the safety of the employee or others employed at the facility.

(h) An employee seeking leave under this section shall not have to exhaust all annual leave, vacation leave, personal leave or sick leave available to the employee, prior to requesting or taking leave under this section.

(i) No health care facility shall coerce, interfere with, restrain or deny the exercise of, or any attempt to exercise, any rights provided under this section or to make leave requested or taken hereunder contingent upon whether or not the victim maintains contact with the alleged abuser.

(j) No health care facility shall discharge or in any other manner discriminate against an employee for exercising the employee's rights under this section. The taking of leave under this section shall not result in the loss of any employment benefit accrued prior to the date on which

the leave taken under this section commenced. Upon the employee's return from such leave, the employee shall be entitled to restoration to the employee's original job or to an equivalent position.

(k) The attorney general shall enforce this section and may seek injunctive relief or other equitable relief to enforce this section.

(l) Health care facilities shall notify each employee of the rights and responsibilities provided by this section including those related to notification requirements and confidentiality.

(m) This section shall not be construed to exempt a health care facility from complying with chapter 258B, section 14B of chapter 268 or any other general or special law or to limit the rights of any employee under said chapter 258B, said section 14B of chapter 268 or any other general or special law.

SECTION 5. Notwithstanding any general or special law or rule or regulation to the contrary, within 6 months of the date of enactment, the executive office of health and human services shall coordinate with the executive office of public safety and security to develop regulations that would allow healthcare providers, as defined in section 1 of chapter 111 of the general laws, to be able to access reports on individuals maintained by agencies within each executive office as well as other public safety and law enforcement officials through a secure electronic medical record, health information exchange, or other similar software or information systems connected to healthcare providers for the purposes of: (i) improving ease of access and utilization of such data for treatment and diagnosis;(ii) supporting integration of such data within the electronic health records of a healthcare provider for purposes of treatment of diagnosis; or, (iii) allowing healthcare providers and their vendors to maintain such data for the purposes of compiling and visualizing such data within the electronic health records of a healthcare provider that supports treatment or diagnosis. Such regulations shall further allow the sharing of such information between healthcare providers consistent with federal and state privacy requirements through a

secure electronic medical record, health information exchange, or other similar software or information systems.

SB1147/HB1737

An Act Establishing a Behavioral Health Workforce Commission

Sen. Cindy Friedman (D-Arlington) and Rep. Liz Malia (D-Boston)

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

Bill Summary

Massachusetts is facing a shortage of behavioral healthcare providers, particularly psychiatrists and nurses that specialize in behavioral health. This shortage results in an inability to fully open units and facilities for lack of necessary behavioral healthcare professionals, difficulty in recruiting staff for existing inpatient and community-based services, and, ultimately, delays in care for individuals seeking behavioral healthcare. This legislation would create a Behavioral Health Workforce Commission composed of state officials, as well as provider and consumer groups to study workforce needs, identify reasons for shortages in inpatient and community-based settings, and make recommendations to address the shortages.

Bill Text

An Act relative to a behavioral health workforce commission

SECTION 1. There shall be a behavioral health workforce commission to study the workforce needs of the behavioral health system in the commonwealth and to identify reasons for behavioral health workforce shortages, including, but not limited to, shortages in inpatient and community-based settings.

The commission shall issue a report that shall include : (1) an assessment of the current behavioral health workforce, workforce needs and workforce shortages by service type, settings and geography; (2) barriers to increasing the workforce in any identified shortage areas; (3) the impact of commercial and public behavioral health wage rates on the ability to recruit and retain behavioral health providers; and (4) recommendations and best practices proven to have the most impact on addressing behavioral health workforce shortages. In preparing the report, the commission shall look at the efficacy of: (i) expanding and funding mechanisms for loan forgiveness and scholarship programs for all providers in the behavioral health field, regardless of whether they practice in a health professional shortage area; (ii) the inclusion of behavioral health curriculum earlier in medical, nursing, and other educational programs; (iii) expanding

slots at associates and bachelors level registered nurse programs and(vi) creating programs to encourage registered nurses to work in psychiatric settings, including internships and fellowships in psychiatric nursing; (v) increasing the number of psychiatric clinical sites for nursing students; (vi) increasing training for behavioral health providers to treat severe mental illness and substance use disorders; (vii) expanding the scope of practice for psychiatric nurse mental health clinical specialists and psychiatric nurse practitioners in inpatient settings by allowing all providers to work at the top of their license; and (viii) any other recommendations relevant to addressing behavioral health workforce shortages.

The commission shall consist of 23 members: the secretary of health and human services or a designee, who shall serve as chair; the commissioner of mental health or a designee; the commissioner of public health or a designee; the director of the office of Medicaid or a designee, the commissioner of the department of higher education or a designee; and 1 representative from each of the following organizations: the Massachusetts Psychiatric Society, the Massachusetts Medical Society, the Massachusetts Association of Advanced Practice Psychiatric Nurses, the Massachusetts chapter of the National Association of Social Workers, the Massachusetts Psychological Association, the Massachusetts Society of Addiction Medicine, the American Nurses Association Massachusetts, the Organization of Nurse Leaders, the Massachusetts Health and Hospital Association, the Association of Behavioral Healthcare, the Massachusetts Association of Behavioral Health Systems, the Massachusetts League of Community Health Centers, the Massachusetts Organization for Addiction Recovery, the Massachusetts Association for Mental Health, the National Alliance on Mental Illness of Massachusetts, the Children's Mental Health Campaign, the Massachusetts Association of Health Plans, and the Blue Cross Blue Shield of Massachusetts.

The commission shall file a report on its findings and recommendations, together with any recommendations for legislation, with the clerks of the house of representatives and the

senate and with the chairs of the joint committee on mental health, substance use and recovery
no later than 1 year from the effective date of this act.

SB1709/HB2529

An Act to Promote Healthy Alternatives to Sugary Drinks

Sen. Jason Lewis (D-Winchester) and Rep. Kay Khan (D-Newton)

Referred to the Joint Committee on Revenue

Bill Summary

This legislation will implement a tiered tax on sugar-sweetened beverages based upon sugar content, with proceeds from the tax dedicated to a broad slate of the state's public health priorities.

Bill Text

SECTION 1. The Massachusetts General Laws, as appearing in the 2018 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) "Commissioner" means the commissioner of revenue and his or her authorized agents and employees.

(5) "Commonwealth" means the commonwealth of Massachusetts.

(6) "Consumer" means a person who purchases a sugary drink for consumption and not for sale to another.

(7) "Department" means the department of public health.

(8) "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.

(9) "Fund" means the Children's Health Promotion Fund, established pursuant to section 5.

(10) "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.

(11) "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.

(12) "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.

(13) "Non-nutritive sweetener" means any non-nutritive substance suitable for human consumption that humans perceive as sweet and includes, without limitation, aspartame, acesulfame-K, neotame, saccharin, sucralose and stevia. "Non-nutritive sweetener" excludes sugars. For purposes of this definition, "non-nutritive" means a substance that contains fewer than 5 calories per serving.

(14) "Person" means any natural person, partnership, cooperative association, limited liability company, corporation, personal representative, receiver, trustee, assignee or any other legal entity.

(15) "Place of business" means any place where sugary drinks, syrups or powders are manufactured or received for sale in the commonwealth.

(16) "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.

(17) "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.

(18) "Sale" means the transfer of title or possession for valuable consideration regardless of the manner by which the transfer is completed.

(19) "Sugars" means any monosaccharide or disaccharide nutritive sweetener such as glucose, fructose, lactose, and sucrose. Examples include, without limitation, cane sugar, beet sugar, high-fructose corn syrup, honey, fruit juice concentrate, and other caloric sweeteners. For purposes of this definition, "nutritive" means a substance that contains 5 or more calories per serving.

(20) "Sugary drink" means any nonalcoholic beverage, carbonated or noncarbonated, which is intended for human consumption and contains any added sugars. 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.

(22) "Water", means no-calorie liquid water, which is either non-flavored or flavored without the use of sugars. "Water" may be carbonated (including club soda and seltzer), still, distilled and/or purified.

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 7.5 grams of sugars or less per 12 fluid ounces will not be taxed.

(ii.) Beverages with more than 7.5 grams but less than 30 grams of sugars per 12 fluid ounces will be taxed at a rate of \$0.01 per ounce.

(iii.) Beverages with 30 grams of sugars 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 7.5 grams of sugars or less per 12 fluid ounces, the syrup or powder will not be taxed.

(ii.) If the beverages made from the syrup or powder have more than 7.5 grams but less than 30 grams of sugars per 12 fluid ounces, the syrup or powder will be taxed at a rate equal to \$0.01 per ounce of sugary drink produced from that syrup or powder.

(iii.) If the beverages made from the syrup or powder have 30 grams of sugars or more per 12 fluid ounces, the syrup or powder will be taxed at a rate equal to \$0.02 per ounce 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 Nutrition Facts product label, as required by the Food and Drug Administration, shall be used to determine the amount of sugars per 12 ounces of sugary drink by referencing the "Serving Size" and "Sugars" or "Total Sugars" lines on the label.

(4) 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.

(5) 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.

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-nutritive sweeteners;

(4) Beverages consisting of 100 per cent natural fruit or vegetable juice with no added sugars;

(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 sugars;

(7) Infant formula;

(8) Beverages for medical use;

(9) Water without added sugars.

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 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.

HB1734 / SB1153

An Act to Remove Administrative Barriers to Behavioral Health Services

Rep. Liz Malia (D-Boston) / Sen. John Keenan (D-Quincy)

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

Bill Summary

This bill removes prior authorization requirements for inpatient mental health services within the MassHealth program, so long as the provider notifies MassHealth within 48 hours of the inpatient admission. While this standard has been adopted by the majority of the commercial health insurers in the state, the MassHealth program still requires prior authorization, which has led to increased ED boarding and delayed access to medical necessary care for these patients.

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.

HB1733 / SB1152

An Act to Improve Access to Behavioral Health Services

Rep. Liz Malia (D-Boston) / Sen. John Keenan (D-Quincy)

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

Bill Summary

This legislation directs the MassHealth program to engage with a stakeholder working group to develop a process allowing community-based crisis stabilization service providers, who work with MassHealth patients, to directly admit patients to an inpatient behavioral health facility when medical screening in an emergency department is not required. This new process would reduce emergency department boarding for patients in need of inpatient behavioral health services and would allow patients to better access the care they need without unnecessary delays.

Bill Text

SECTION 1. 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,

substance use and recovery, 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, 2020.

HB1172

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

Rep. David Linsky (D-Natick)

Referred to the Joint Committee on Health Care Financing

Bill Summary

MassHealth recently introduced a policy that limits reimbursements paid from MassHealth Managed Care Organizations (MCOs) to acute care hospitals. With only strictly limited exceptions, MCOs are not permitted to reimburse more than 100% of the MassHealth fee-for-service rates for in-network acute care hospital services. This policy took effect in March 2018.

Separately, the Executive Office of Health and Human Services (EOHHS) has proposed to implement payment limitations for hospitals and physicians in dual-eligible programs such as One Care and Senior Care Options (SCO). Currently, MCOs serving dual-eligible members negotiate payment terms with all healthcare providers. EOHHS has proposed to set a cap that has not yet been determined but is described as a range of 97.55% to 100% of the Medicare priced claim for hospitals, and 88% to 100% for physicians. Medicare is the primary payer of hospital and physician services provided to dual-eligible patients.

These rate-setting policies have the effect of tilting the playing field to the imbalanced favor of the insurers, leaving providers with little ability to negotiate. If a healthcare provider demonstrates added value to a health plan as a key network provider or through its care management efforts, the provider and health plan should be permitted to negotiate and mutually agree to contract terms. There are also additional administrative costs for providers in dealing with health plans that must be factored into reimbursement, including unique billing, prior authorization, reporting, credentialing, and utilization review requirements.

An environment that attracts robust provider and MCO participation through fairness, flexibility, and financial stability will best allow these organizations to meet their common goal of ensuring care is accessible and is delivered effectively to MassHealth enrollees. This bill will require the long-standing free market practice of allowing healthcare providers to freely negotiate with MassHealth MCOs for services. Reimbursement for emergency services provided by hospitals to patients covered by out-of-network MassHealth MCOs could continue to be specified by EOHHS in its contracts with acute care hospitals.

Bill Text

Section 1: Section 12 of Chapter 118E of the general laws, as so appearing, is hereby

amended by inserting the following new clause:

“Reimbursement from managed care organizations that contract with the executive office for hospital and physician services provided to beneficiaries under this chapter shall be subject to negotiation between providers of medical services and managed care organizations and shall

not be limited or determined through contracts between the executive office and managed care organizations, including accountable care organizations and dual-eligible health plans.”

Section 2: Section 13E½ of Chapter 118E of the general laws, as appearing in the 201X official edition, is hereby amended by inserting the following clause at the end of the first paragraph:

“provided further, that acute hospital and non-acute 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, including accountable care organizations and dual-eligible health plans.”

Section 3: Section 13F of Chapter 118E of the general laws, as so appearing, is hereby amended by inserting the following new subsection:

“The executive office shall not, in its contracts with acute hospitals and non-acute 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 including for accountable care organizations and dual-eligible health plans. The office may require hospitals that are not in a managed care organization’s provider network to accept fee-for-service rates established by the office for emergency services only.”

HB1150

An Act to Restore Adequate Funding for Disproportionate Share Hospitals

Rep. Michael Finn (D-West Springfield)

Referred to the Joint Committee on Health Care Financing

Bill Summary

In recognition of the added costs of treating large numbers of low-income patients, the commonwealth provides additional funding for Disproportionate Share Hospitals (DSH). For many years, adjustments were made to the MassHealth reimbursement rates, including adjustments the legislature specified. In recent years, MassHealth has changed this support to a supplemental payment. In FY2019, \$13 million is currently assumed in the MassHealth budget for this purpose.

The supplemental payment process has created uncertainty surrounding when the payments will be made. The MassHealth method includes a year-long lag in issuing the payments as current-year hospital payments are actually funded out of the subsequent state fiscal year budget. The payments also 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, and no payments were made in FY2017.

The current lag in payment relative to the budget year affects the reliability of these payments because they are now dependent on state budgets that have not yet been passed. The prior DSH adjustment to the reimbursement rates allowed the added funding to be incorporated more effectively into patient care delivery and hospital operations. In order to provide the additional support the legislature intends for DSH hospitals, adjustments should be made to the current MassHealth process.

This bill will return the state's DSH funding to the mechanism that was used previously -- an adjustment to the actual hospital reimbursement rate -- thereby improving the reliability of the funding. Whereas in past years the legislature had provided a 5% adjustment for DSH, this language calls for a 2% increase. MHA also recommends that \$12.3 million in additional funding support be provided to disproportionate share hospitals to support behavioral health services, including substance use disorder treatment.

Bill Text

SECTION 1. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall include in its reimbursement rates to disproportionate share hospitals as defined under section 8A of chapter 118E an additional 2 percent to its inpatient

adjudicated payment amount per discharge and an additional 2 percent to its outpatient adjudicated payment amount per episode of care; provider further, the executive office shall provide a supplemental payment of at least \$10,000,000 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.

HB1135

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

Rep. Jennifer Benson (D-Lunenburg)

Referred to the Joint Committee on Health Care Financing

Bill 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 that the Unemployment Assistance Trust Fund contribute at least \$30 million annually to support the Health Safety Net with, 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 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.

HB1157 / SB666

An Act Administering National Standards to Medicaid Medical Necessity Reviews

Rep. Danielle Gregoire / Sen. Nick Collins

Referred to the Joint Committee on Health Care Financing

Bill 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 that clinicians conducting reviews practice in the same clinical services specialty 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 it 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.

HB1142 / SB662

An Act to Cap Liability Related to Hospital Financial Penalties

Rep. Claire Cronin (D-Brockton) / Sen. Michael Brady (D-Brockton)

Referred to the Joint Committee on Health Care Financing

Bill Summary

MassHealth recently changed its preventable readmission penalty methodology for acute care hospitals. Hospitals have serious concerns with the fundamental objective of this penalty, as well as with its process and financial effect on hospitals. Regarding the latter, the new method is highly problematic in that it exposes hospitals to significant financial losses related to hospital inpatient care provided to MassHealth patients. In changing the method, the Executive Office of Health and Human Services (EOHHS) stated it does not intend the changes to produce savings to the state. To ensure that intent is fulfilled, this bill seeks to cap that financial effect related to the new readmission penalty policy so that it is more closely aligned with the previous penalty amounts.

As background, the previous MassHealth readmission penalty applied a reduction to the inpatient reimbursement rate for hospitals that have higher-than-expected rates of preventable readmissions based on prior-year data. This penalty ranged from a fraction of a percent to as high as 4.4% of total inpatient fee-for-service payments for hospital medical services covered under the acute care hospital RFA contract. Under that construct, hospitals could estimate the losses they could expect in a given year. Under the new penalty, MassHealth will phase-in a new method that will potentially deny an entire claim following a post-payment clinical review for certain readmissions to the same hospital within 30 days of discharge. The impact is therefore unknown.

The criteria that will be used in the clinical evaluations are not clear and in many cases are very broad, which potentially can be used subjectively by a reviewer to deny a hospital claim. The criteria, in some cases, also references circumstances that are not directly in the control of the hospital. Responsibility and accountability for readmissions, as with most patient health issues, is shared among hospitals, ambulatory care providers, long-term care/post-acute care institutions, community service organizations, payers including MassHealth, patients themselves, and patients' families.

The new readmission penalty is also now considered an overpayment and subject to recovery under the MassHealth regulations. These recoveries may be appealed to MassHealth; however, the current process is administratively burdensome and suffers from a multi-year backlog. As we expect these preventable readmission determinations to be very questionable, a more expedited process will be needed for these cases so the financial exposure is not indefinite.

While many of the technical details of the penalty will be addressed with MassHealth and hospitals, it is important that hospitals are not harmed unfairly by this new penalty. Hospitals

are already significantly underpaid for services provided to MassHealth patients and penalties that result in the full denial of a claim further greatly reduce the financial support needed to care for MassHealth patients. This bill provides necessary guardrails on a questionable payment penalty policy in order to avoid an undefined hospital payment reduction related to MassHealth patients requiring inpatient medical care.

Bill Text:

Section 1: Subsection (b) of Section 13F of Chapter 118E of the general laws, as appearing in the 2016 official edition, is hereby amended by inserting the following new paragraph at the end thereof:

In its contracts with acute hospitals, the executive office and any third party under contract with the executive office to provide medical benefits for medical assistance recipients under Title XIX, shall limit any financial penalty related to potentially preventable readmissions to no more than 4.4 percent of a hospital's total annual inpatient payments covered under said contract. Furthermore, total penalties across all acute hospitals shall not exceed the penalty amount assessed in hospital rate year 2018. Notwithstanding the provisions of section 38 of this chapter, any appeal regarding an overpayment recovery for potentially preventable readmissions which is not adjudicated by the executive office or its third party contractors within 180 days that the provider submits a timely claim for an adjudicatory hearing shall be nullified and any payment recoveries made by the executive office or a third party contractor shall be repaid to the hospital.

HB976

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

Rep. Carole Fiola (D-Fall River)

Referred to the Joint Committee on Financial Services

Bill Summary

“Consumer-directed” health insurance plans are more prevalent under the Affordable Care Act (ACA) as employers increasingly shift healthcare 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 \$3,500 for an individual (with out-of-pocket maximums in 2019 of \$7,900) and \$7,000 for a family (with \$15,800 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: patients’ 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 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

(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.

HB1146

An Act Regarding Shared Responsibility for Funding of Health Care

Oversight Agencies

Rep. Michael Day (D-Stoneham)

Referred to the Joint Committee on Health Care Financing

Bill 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 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 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 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”.

HB971

An Act Relative to Insurance Coverage of Mobile Integrated Health

Rep. Michael Finn (D-West Springfield)

Referred to the Joint Committee on Financial Services

Bill Summary

This legislation would disallow public and private health plans from refusing to cover healthcare services on the basis that they were delivered by a state-approved mobile integrated health (MIH) program, and requires that said services be covered to the same extent as they would have had they been provided in a healthcare facility

Bill Text

SECTION 1. Chapter 32A of the General Laws is hereby amended by inserting after section 17O the following section:-

Section 17P. The group insurance commission and any carrier as defined in section 1 of chapter 176O 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 medical, behavioral or health care services solely on the basis that those services were delivered by a health care provider, as defined in section 1 of chapter 111O, participating in a mobile integrated health care program approved by the department of public health pursuant to chapter 111O. Medical, behavioral or health care services delivered by way of an approved mobile integrated health care program shall be covered to the same extent as if they were provided in a health care facility, as defined in section 1 of chapter 111O, and the rates of payments for otherwise covered services shall not be reduced on the grounds that those services were delivered by a health care provider participating in an approved mobile integrated health care program. A contract that provides coverage for care delivered may contain a provision for a deductible, copayment or coinsurance requirement for a service provided by a health care provider participating in an approved mobile integrated health care program as long

as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to delivery of the same services within a health care facility.

SECTION 2. Chapter 118E of the General Laws, as so appearing, is hereby amended by inserting after section 10J the following section:-

Section 10K. 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, the Medicaid primary care clinician plan, or an accountable care organization shall not decline to provide coverage for medical, behavioral or health care services solely on the basis that those services were delivered by a health care provider, as defined in section 1 of chapter 111O, participating in a mobile integrated health care program approved by the department of public health pursuant to chapter 111O. Medical, behavioral or health care services delivered by way of an approved mobile integrated health care program shall be covered to the same extent as if they were provided in a health care facility, as defined in section 1 of chapter 111O, and the rates of payments for otherwise covered services shall not be reduced on the grounds that those services were delivered by a health care provider participating in an approved mobile integrated health care program. A contract that provides coverage for care delivered may contain a provision for a deductible, copayment or coinsurance requirement for a service provided by a health care provider participating in an approved mobile integrated health care program as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to delivery of the same services within a health care facility.

SECTION 3. Chapter 175 of the General Laws, as so appearing, 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, shall not decline to provide coverage for medical, behavioral or health care services solely on the basis that those services were delivered by a health care provider, as defined in section 1 of chapter 111O, participating in a mobile integrated health care program approved by the department of public health pursuant to chapter 111O. Medical, behavioral or health care services delivered by way of an approved mobile integrated health care program shall be covered to the same extent as if they were provided in a health care facility, as defined in section 1 of chapter 111O, and the rates of payments for otherwise covered services shall not be reduced on the grounds that those services were delivered by a health care provider participating in an approved mobile integrated health care program. A contract that provides coverage for care delivered may contain a provision for a deductible, copayment or coinsurance requirement for a service provided by a health care provider participating in an approved mobile integrated health care program as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to delivery of the same services within a health care facility.

SECTION 4. Chapter 176A of the General Laws, as so appearing, 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 not decline to provide coverage for medical, behavioral or health care services delivered by a health care provider, as defined in section 1 of chapter 111O, participating in a mobile integrated health care program approved by the department of public health pursuant to chapter 111O. Medical, behavioral or health care services delivered by way of an approved mobile integrated health care program shall be covered to the same extent as if they were provided in a health care facility, as defined in section 1 of chapter 111O, and the rates of payments for

otherwise covered services shall not be reduced on the grounds that those services were delivered by a health care provider participating in an approved mobile integrated health care program. A contract that provides coverage for care delivered may contain a provision for a deductible, copayment or coinsurance requirement for a service provided by a health care provider participating in an approved mobile integrated health care program as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to delivery of the same services within a health care facility.

SECTION 5. Chapter 176B of the General Laws, as so appearing, 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 not decline to provide coverage for medical, behavioral or health care services delivered by a health care provider, as defined in section 1 of chapter 111O, participating in a mobile integrated health care program approved by the department of public health pursuant to chapter 111O. Medical, behavioral or health care services delivered by way of an approved mobile integrated health care program shall be covered to the same extent as if they were provided in a health care facility, as defined in section 1 of chapter 111O, and the rates of payments for otherwise covered services shall not be reduced on the grounds that those services were delivered by a health care provider participating in an approved mobile integrated health care program. A contract that provides coverage for care delivered may contain a provision for a deductible, copayment or coinsurance requirement for a service provided by a health care provider participating in an approved mobile integrated health care program as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to delivery of the same services within a health care facility.

SECTION 6. Chapter 176G of the General Laws, as so appearing, is hereby amended by inserting after section 4CC the following section:-

Section 4DD. Any individual or group health maintenance contract that is issued or renewed shall not decline to provide coverage for medical, behavioral or health care services delivered by a health care provider, as defined in section 1 of chapter 111O, participating in a mobile integrated health care program approved by the department of public health pursuant to chapter 111O. Medical, behavioral, or health care services delivered by way of an approved mobile integrated health care program shall be covered to the same extent as if they were provided in a health care facility, as defined in section 1 of chapter 111O, and the rates of payments for otherwise covered services shall not be reduced on the grounds that those services were delivered by a health care provider participating in an approved mobile integrated health care program. A contract that provides coverage for care delivered may contain a provision for a deductible, copayment or coinsurance requirement for a service provided by a health care provider participating in an approved mobile integrated health care program as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to delivery of the same services within a health care facility.

SECTION 6. Chapter 176I of the General Laws, as so appearing, is hereby amended by inserting after section 12 the following section:-

Section 13. An organization entering into a preferred provider contract shall not decline to provide coverage for medical, behavioral or health care services delivered by a health care provider, as defined in section 1 of chapter 111O, participating in a mobile integrated health care program approved by the department of public health pursuant to chapter 111O. Medical, behavioral, or health care services delivered by way of an approved mobile integrated health care program shall be covered to the same extent as if they were provided in a health care

facility, as defined in section 1 of chapter 111O, and the rates of payments for otherwise covered services shall not be reduced on the grounds that those services were delivered by a health care provider participating in an approved mobile integrated health care program. A contract that provides coverage for care delivered may contain a provision for a deductible, copayment or coinsurance requirement for a service provided by a health care provider participating in an approved mobile integrated health care program as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to delivery of the same services within a health care facility.

HB1072

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

Rep. David Nangle (D-Lowell)

Referred to the Joint Committee on Financial Services

Bill 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.

SB564

An Act Relative to Health Insurer Reserve Requirements

Sen. Julian Cyr (D-Truro)

Referred to the Joint Committee on Financial Services

Bill 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 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) 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

(ii) 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.

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;

(vii) realized capital gains and losses;

(viii) net income;

(ix) accumulated surplus;

(x) accumulated reserves;

(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) risk-based capital ratio, based on a formula developed by the National Association of Insurance Commissioners;

(xiii) financial administration expenses, including underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;

(xiv) marketing and sales expenses, including advertising, member relations, member enrollment expenses;

(xv) distributions expenses, including commissions, producers, broker and benefit consultant expenses;

(xvi) claims operations expenses, including adjudication, appeals, settlements and expenses associated with paying claims;

(xvii) medical administration expenses, including disease management, utilization review and medical management expenses;

(xviii) network operational expenses, including contracting, hospital and physician relations and medical policy procedures;

(xix) charitable expenses, including any contributions to tax-exempt foundations and community benefits;

(xx) board, bureau or association fees;

(xxi) any miscellaneous expenses described in detail by expense, including an expense not included in (i) to (xix), inclusive;

(xxii) payroll expenses and the number of employees on the carrier's payroll;

(xxiii) taxes, if any, paid by the carrier to the federal government or to the commonwealth;

(xxiv) any capital investments or write downs in investments in related or unrelated organizations;

(xxv) intercompany transfers with subsidiary organizations;

(xxvi) any changes in reserves for unpaid claims and any other contingent liabilities; and

(xxvii) 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;

(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.

SB700

An Act Providing Financial Transparency for Patients Receiving Care at Hospital-Based Outpatient Facilities

Sen. Jason Lewis (D-Winchester)

Referred to the Joint Committee on Health Care Financing

Bill Summary

MHA supports providing complete transparency of patient financial obligations for services provided at hospital outpatient departments. In particular, hospitals believe that patients should be informed and fully understand those circumstances when a separate facility fee may be applied to a procedure or service. Hospital outpatient departments and hospital-based entities are required by Medicare to inform the patient and the public that a specific location is part of the main hospital and may therefore be billed as a hospital.

This legislation establishes statewide transparency requirements that are consistent with Medicare standards (42 CFR 413.65). Under this bill, any hospital-based outpatient provider, prior to the delivery of non-emergency healthcare services, will be required to inform a patient that: it is licensed as part of the hospital and the patient may receive a separate facility fee charge that is in addition to and separate from the professional fee charged by the provider; that the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility; and how the patient can find out information on the potential financial liability for the known services that may be provided through the hospital or the patient's insurance carrier, along with information that the actual liability may change depending on the actual services provided.

Bill Text

SECTION 1. Chapter 111 of the General Laws is hereby amended by inserting the following:

Section 228A. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Facility fee", a fee charged or billed for outpatient hospital services provided in a hospital-based facility that is intended to cover the cost of the hospital operational expenses; which is separate and distinct from a professional fee.

“Hospital-based facility”, a provider of health care services, including but not limited to a department of a provider, a remote location of a hospital, or a satellite facility that meets the requirements of 42 C.F.R. § 413.65.

(a) Prior to the delivery of non-emergency services, a hospital-based facility that charges or bills a facility fee for services shall inform the patient that: 1) it is licensed as part of the hospital and the patient may receive a separate charge that is in addition to and separate from the professional fee charged by the provider; 2) the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility; and 3) information on how the patient can obtain financial liability for the known services through the hospital or the patient’s insurance carrier, along with information that the actual liability may change depending on the actual services provided. This information shall be provided in written form before the delivery of services.

(b) If a hospital or health system designates a location as a hospital-based facility, the facility shall clearly identify the facility as being hospital-based, including by stating the name of the hospital or health system in the facility’s signage, marketing materials, Internet web sites and stationery and by posting notices in designated locations accessible to and visible by patients in a manner proscribed by the commissioner.

(c) The commissioner may promulgate regulations that are necessary to implement this section.

SB153

An Act to Ensure Timely Physician Licensure

Sen. Adam Hinds (D-Pittsfield)

Referred to the Joint Committee on Consumer Protection & Professional Licensure

Bill Summary

Filed by the Mass. Association of Behavioral Health Systems, this legislation would require the Board of Registration in Medicine (BORIM) to implement administrative processes to ensure that full applications are reviewed and processed within 90 days from the date of submission, including for registration of qualified physicians, who have been licensed to practice in another state. It would also require BORIM to issue a temporary license to any physician whose renewal application has not been reviewed within 90 days to allow for hospitals to complete their internal credentialing processes.

Bill Text

SECTION 1. Section 2 of chapter 112 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended in the first paragraph by inserting after the second sentence the following sentence:--

The board shall implement administrative procedures to ensure that applications for registration, including registration of qualified physicians who have been licensed or registered upon a written examination in another state pursuant to paragraph 3 of this section, are reviewed and processed within 90 days from the date of submission.

SECTION 2. Said section 2 of chapter 112, as so appearing, is hereby further amended by inserting after the sixth paragraph the following paragraph:--

If the board has not made a determination on a physician's application for renewal of the certificate of registration within 90 days from the date of submission of a complete renewal application, the board shall issue a temporary registration to the physician so that the physician can complete the internal hospital credentialing and privileging process at the hospital at which the physician is employed or at the hospital at which the physician will be employed.

HB913 / SB610

An Act to Increase Consumer Transparency about Insurance Provider Networks

Rep. Christine Barber (D-Somerville) / Sen. Jason Lewis (D-Winchester)

Referred to the Joint Committee on Financial Services

Bill Summary

Families and individuals seeking care in Massachusetts sometimes face difficulty finding providers through their health plan's provider directory that are accepting new patients. This bill would establish a task force, chaired by the Division of Insurance (DOI), to make recommendations for improving the accuracy of provider directories. DOI would then issue regulations based on the task force recommendations to ensure consistency across carriers. This language is supported by the MassCollaborative, a voluntary coalition of payers and providers led by MHA, the Massachusetts Medical Society, the Massachusetts Association of Health Plans, and Blue Cross Blue Shield MA, in addition to Health Care For All, and the Children's Mental Health Campaign.

Bill Text

SECTION 1.

Chapter 176O of the General Laws is hereby amended by inserting after section 27 the following sections:-

Section 28. (a) A carrier shall ensure the accuracy of the information concerning each provider listed in the carrier's provider directories for each network plan and shall review and update the entire provider directory for each network plan. In making the directory available electronically in a searchable format, the carrier shall ensure that the general public is able to view all of the current health care providers for a network plan through a clearly identifiable link or tab and without creating or accessing an account, entering a policy or contract number, providing other identifying information, or demonstrating coverage or an interest in obtaining coverage with the network plan. Thereafter, the carrier shall update each online network plan provider directory at least monthly, or more frequently, if required by state or federal law or regulations promulgated

by the commissioner pursuant to Section 29(j), when informed of and upon confirmation by the plan of any of the following:

- (1) A contracting provider is no longer accepting new patients for that network plan, or an individual provider within a provider group is no longer accepting new patients.
 - (2) A provider or provider group is no longer under contract for a particular network plan.
 - (3) A provider's practice location or other information required under this section has changed.
 - (4) Upon completion of the investigation described in paragraph (a)(4), a change is necessary based on an enrollee complaint that a provider was not accepting new patients, was otherwise not available, or whose contact information was listed incorrectly.
 - (5) A provider has retired or otherwise has ceased to practice.
 - (6) Any other information that affects the content or accuracy of the provider directory or directories.
- (b) A provider directory shall not list or include information on a provider that is not currently under contract with the network plan.
- (c) A carrier shall periodically audit its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request.
- (d) A carrier shall provide a print copy, or a print copy of the requested directory information, of a current provider directory upon request of an insured or a prospective insured. The printed copy of the provider directory or directories shall be provided to the requester by mail postmarked no later than five business days following the date of the request and may be limited to the geographic region in which the requester resides or works or intends to reside or work.

(e) The carrier shall include in both its electronic and print directories a dedicated customer service email address and telephone number or electronic link that insureds, providers and the general public may use to notify the carrier of inaccurate provider directory information. This information shall be disclosed prominently in the directory or directories and on the carrier's web site. The carrier shall be required to investigate reports of inaccuracies within 30 days of notice and modify the directories in accordance with any findings within 30 days of such findings.

(f) The provider directory or directories shall inform enrollees and potential enrollees that they are entitled to: (A) language interpreter services, at no cost to the enrollee; and (B) full and equal access to covered services as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency, including how to obtain interpretation and translation services.

(g) The carrier shall include a disclosure in the print directory that the information included in the directory is accurate as of the date of printing and that insureds or prospective insureds should consult the carrier's electronic provider directory on its website or call a specified customer service telephone number to obtain the most current provider directory information.

(h) The carrier shall update its printed provider directory or directories at least annually, or more frequently, if required by federal law or regulations promulgated by the commissioner.

Section 29. (a) The division shall establish a task force to develop recommendations to ensure the current and accurate electronic posting of carrier provider directories in a searchable format for each of the carriers' network plans available for viewing by the general public.

(b) The task force shall consist of the commissioner of insurance or a designee, who shall serve as chair, and 12 members: one of whom shall be a representative of the Massachusetts

Association of Health Plans, one of whom shall be a representative of Blue Cross Blue Shield MA, one of whom shall be a representative of the Massachusetts Health and Hospital Association, one of whom shall be a representative of the Massachusetts Medical Society, one of whom shall be a representative of Healthcare Administrative Solutions, Inc., one of whom shall be a representative of the Children's Mental Health Campaign, one of whom shall be a representative of the Massachusetts Association for Mental Health, and five members chosen by the commissioner: one of whom shall have expertise in the treatment of individuals with substance use disorder, one of whom shall have expertise in the treatment of individuals with a mental illness, one of whom shall be from a health consumer advocacy organization, one of whom shall be a consumer representative, and one of whom shall be a representative from an employer group. The task force shall have the ability to form workgroups to develop the recommendations defined in subsection (a).

(c) The recommendations shall include measures for ensuring the accuracy of information concerning each provider listed in the carrier's provider directories for each network plan. The task force shall develop recommendations that establish substantially similar processes and time frames for health care providers included in a carrier's network to provide information to the carrier, and substantially similar processes and timeframes for carriers to include such information in their provider directories, regarding the following:

(1) when a contracting provider is no longer accepting new patients for that network plan and when a contracting provider is resuming acceptance of new patients, or an individual provider within a provider group is no longer accepting new patients and when an individual provider within a provider group is resuming acceptance of new patients;

(2) when a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient, the provider may direct the enrollee or potential

enrollee to the carrier for additional assistance in finding a provider and shall inform the carrier immediately if they have not done so already that the provider is not accepting new patients;

(3) when a provider is no longer under contract for a particular network plan;

(4) when a provider's practice location or other information required under this section has changed;

(5) for health care professionals: (i) name; (ii) contact information; (iii) gender; (iv) participating office location(s); (v) specialty, if applicable; (vi) clinical and developmental areas of expertise; (vii) populations of interest; (viii) licensure and board certification(s); (ix) medical group affiliations, if applicable; (x) facility affiliations, if applicable; (xi) participating facility affiliations, if applicable; (xii) languages spoken other than English, if applicable; (xiii) whether accepting new patients; and (xiv) information on access for people with disabilities, including but not limited to structural accessibility and presence of accessible examination and diagnostic equipment;

(6) for hospitals: (i) hospital name; (ii) hospital type; (iii) participating hospital location and telephone number; (iv) hospital accreditation status; (7) for facilities, other than hospitals, by type: (i) facility name; (ii) facility type; (iii) types of services performed; (iv) participating facility location(s) and telephone number; and

(7) Any other information that affects the content or accuracy of the provider directory or directories.

(d) The task force shall develop recommendations for carriers to include information in the provider directory that identifies the tier level for each specific provider, hospital or other type of facility in the network, when applicable.

(e) The task force shall develop recommendations for carriers to include in the provider directories substantially similar language to assist insureds with understanding and searching for behavioral health specialty providers.

(f) The task force shall consider the feasibility of carriers making updates to each online network plan provider directory in real time when health care providers included in a carrier's network provide information to the carrier pursuant to subsection (c).

(g) The task force shall consider measures to address circumstances when an insured reasonably relies upon materially inaccurate information contained in a carrier's provider directory.

(h) The task force shall develop recommendations for measures carriers shall take to ensure the accuracy of the information concerning each provider listed in the carrier's provider directories for each network plan based on the information provided to the carriers by network providers, as described in paragraph (c), including but not limited to periodic testing to ensure that the public interface of the directories accurately reflects the provider network, as required by state and federal laws and regulations.

(i) The task force shall recommend appropriate timelines for completion of its recommendations.

(j) The commissioner shall file the task force's recommendations, including any proposed regulations, with the joint committee on health care financing not later than June 30, 2019.

(k) The commissioner shall promulgate regulations pursuant to section 28 and the recommendations of the task force no later than three months following the commissioner's filing under subsection (j).

(l) The commissioner shall conduct quarterly implementation progress reports, which shall be available to the public, commencing on September 1, 2019 and continuing until the task force recommendations under subsection (j) are fully implemented.

SECTION 2. Carriers shall ensure the accuracy of the information pursuant to the regulations issued by the commissioner of insurance pursuant to section 29 of chapter 176O of the general laws for each network plan no later than January 1, 2020.

HB1126/SB1685

An Act to Ensure Affordable Health Connector Coverage

Rep. Ruth Balser (D-Newton), Sen. Pat Jehlen (D-Somerville)

HB1126 referred to the Joint Committee on Health Care Financing;

SB1685 referred to the Joint Committee on Revenue

BILL SUMMARY

Using a combination of federal and state funding, the ConnectorCare program provides subsidies to low and moderate-income Massachusetts residents to help them pay for health insurance purchased through the Health Connector. ConnectorCare has its roots in the Commonwealth Care program established in the landmark 2006 Massachusetts health reform law, which became the model for the Affordable Care Act (ACA).

BILL TEXT

SECTION 1. Section 2000 of chapter 29 of the Massachusetts General Laws is hereby amended by striking out the second paragraph, as appearing in the 2016 Official Edition, and inserting in place thereof the following paragraph:-

Section 2000. There shall be credited to the trust fund: (a) employer medical assistance contributions under section 189 of chapter 149; (b) all revenue from surcharges imposed under section 18 of chapter 176Q; (c) any transfers from the Health Safety Net Trust Fund established in section 66 of chapter 118E; (d) revenues deposited from penalties collected under chapter 111M; and (e) any revenue from appropriations or other monies authorized by the general court and specifically designated to be credited to the fund. Amounts credited to the fund shall be expended without further appropriation for programs administered by the commonwealth health insurance connector authority pursuant to chapter 176Q that are designed to increase health coverage for residents of the commonwealth. A sufficient portion of money from the fund shall be designated to ensure affordable premiums and cost-sharing for enrollees with income at or below 300 per cent of the federal poverty guidelines, who are eligible for premium assistance payments and point-of-service cost-sharing subsidies pursuant to section 3 of chapter 176Q of the General Laws. Money from the fund may 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. Not later than January 1, the comptroller shall report an update of revenues for the current fiscal year and prepare estimates of revenues to be credited to the fund in the subsequent fiscal year. The comptroller shall file this report with the secretary of administration and finance, the secretary of health and human services, the joint committee on health care financing and the house and senate committees on ways and means. To accommodate timing discrepancies between the receipt of revenue and related expenditures, the comptroller may certify for payment amounts not to exceed the most recent estimate of revenues as certified by the secretary of administration and finance to be deposited under this section. A full accounting of revenue credited to the fund and transfers and expenditures out of the fund shall be reported at least annually to the board of the commonwealth health insurance connector authority established under section 2 of chapter 176Q. Monies remaining in the fund at the end of a fiscal year shall not revert to the General Fund and shall be used solely as designated in this section; provided, however, that the comptroller shall report the amount remaining in the fund at the end of each fiscal year to the house and senate committees on ways and means.

SECTION 2. Section 3 of chapter 176Q of the Massachusetts General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out the 14th paragraph and inserting in place thereof the following paragraph:-

“(14) develop criteria for plans sold through the connector that are eligible for premium assistance payments or cost sharing subsidies, taking into consideration affordability of premiums and cost-sharing and a reasonable choice of health benefit plans in each area; provided further than an enrollee with household income that does not exceed 100 per cent of the federal poverty level shall have available to them at least two health benefit plans with no premium contribution and copayments shall not exceed the highest copayments required of enrollees in the MassHealth program with household income that does not exceed 100 per cent of the federal poverty level; provided further that enrollees with income between 100 and 150 per cent of the federal poverty guidelines shall have available to them at least one health benefit plan with no premium contribution. If the health benefit plans submitted through the Seal of Approval process pursuant to section 10 of this chapter do not permit such choice of health benefit plans at a reasonable cost to the Commonwealth, the board may seek additional participation of health benefit plans in conjunction with the Division of Insurance pursuant to section 3(b) of chapter 176J of the General Laws or take other measures to facilitate reasonable access to health benefit plans up to and including establishing contracts under subsection v of this section or seeking a waiver under subsection x of this section.

HB1153 / SB679

An Act Relative to Newborn Enrollment in MassHealth

Rep. Sean Garballey (D-Arlington) / Sen. Sal DiDomenico (D-Everett)

Bill Summary

Traditionally, for MassHealth and commercial insurers, newborns are attributed to their mother's health insurance plan at birth. For a baby born to a mother who is enrolled in MassHealth, the newborn is often auto-assigned to that mother's health plan, which may be a Managed Care Organization (MCO), Accountable Care Organization (ACO), or the Primary Care Clinician (PCC) plan. Often, this health plan may not include the baby's new pediatrician. Since ACOs were launched on March 1, 2018, there is a reasonable likelihood that the newborn is expected to be in a different ACO than the mother, since ACO attribution is based on the patient's primary care provider (PCP). This requires a proactive step by the parent to place the newborn into the appropriate ACO and, until that happens, it can create significant confusions for parents and billing problems for pediatricians. In order to ensure that newborn well-child visits happen in a seamless and timely fashion with the parent's preferred provider, newborns born to a mother enrolled in MassHealth should be enrolled into MassHealth fee-for-service for a limited period of time. This legislation will require that the first 45 days of MassHealth eligibility for newborns be managed under the fee-for-service program. On day 46, the newborns would be enrolled into MassHealth managed care offerings, including MCOs, ACOs, and the PCC plan – either the plan that was proactively chosen by the parents or through current MassHealth auto-assignment rules if no plan is chosen.

Bill Text

Section 1. Chapter 118E of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after section 9F the following new section:

Section 9G. Newborn enrollment

(a) In the case of a newborn(s) born to a mother who is covered by MassHealth at the time of birth and who will be required to enroll in managed care, the newborn(s) shall initially be enrolled in MassHealth fee-for-service from the date of birth until a parent or guardian selects a managed care plan, provided that if no such selection is made during the first forty -five days of life, on day forty-six, the newborn may be assigned to a managed care plan by the Secretary

who shall give preference to assigning the infant to the same managed care plan as that of other children in the household or of either parent or guardian.