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November 14, 2017

To the Honorable Senate and House of Representatives:

I am filing for your consideration a bill entitled “An Act Relative to Combatting Addiction, Accessing Treatment, Reducing Prescriptions, and Enhancing Prevention.”

This legislation continues our commitment to mitigate the impacts of the ongoing opioid addiction crisis in Massachusetts. One of the major first steps in this effort was the enactment of Chapter 52 of the Acts of 2016, an Act Relative to Substance Use, Treatment, Education and Prevention (the STEP Act), which created important new tools for expanding treatment for people who suffer from opioid addiction, reducing the overuse of prescription opioids in the Commonwealth, and improving education for young people, educators, and medical professionals on the risks of opioid misuse. Today, eighteen months later, we are seeing early signs of progress in fighting this terrible epidemic, and we know much more about what works in the fight. The legislation I am filing today builds upon the foundational work of the STEP Act and continues the Commonwealth’s comprehensive approach to addressing the problem of opioid addiction.

Improving Access to Treatment

The first priority of this legislation is to ensure that people who are suffering from opioid addiction receive the specialized treatment they need. The STEP Act introduced a requirement that medical staff in an emergency department conduct a substance abuse evaluation and provide information on addiction treatment for any patient treated for an opioid overdose. This bill aims to improve the effectiveness of these consultations by expanding the range of medical professionals authorized to perform the evaluation and by requiring that the emergency department affirmatively connect the patient with the appropriate level of care.

The bill also permits medical professionals or police officers to authorize the transport of a patient to a substance use treatment facility for emergency assessment and treatment when the patient presents a risk of serious harm due to addiction and the patient will not agree to voluntary treatment. A treatment facility receiving a patient transported under this provision would then be required to attempt to engage the patient in voluntary treatment for a period of up to 72 hours. In cases where a patient poses an immediate risk of harm but remains unable to engage in voluntary treatment, medical professionals at the treatment facility would be required to petition a court to

commit the patient for involuntary treatment under section 35 of chapter 123, the existing civil commitment statute. Other provisions in the bill call for the development of a set of consistent, state-wide standards for the medical evaluation of any person who is the subject of a section 35 petition and the inclusion of medical professionals other than physicians among the persons who are authorized to initiate a court petition for commitment under the statute.

In order to ensure that the right kind of treatment facilities will be available to serve every patient who needs treatment, the legislation enhances the oversight authority of the Department of Mental Health (DMH) and the Department of Public Health's Bureau of Substance Addiction Services (DPH/BSAS), the two agencies that license facilities that provide treatment for addiction and mental illness. Under the legislation, before licensing new treatment programs or approving the transfer of license for an existing program, DMH and DPH/BSAS will require that a facility demonstrate that it provides the range and quality of services necessary to meet the current critical treatment needs of the Commonwealth's patients. One important component of the evaluation will be a requirement that these facilities make treatment available to patients with public health insurance on the same basis as patients with private insurance.

The bill recognizes the important role that recovery coaches play in successful long-term addiction treatment by creating a commission to recommend standards for establishing a professional credential for recovery coaches as an important step toward formalizing the role of recovery coaches in the regimen of long-term addiction treatment.

Even now, years into the opioid crisis, there is still far too little high quality data guiding decision making about the most effective forms of treatment for addiction. To address this gap, the bill creates a commission to review evidence-based treatment approaches to substance use disorders and mental health conditions. The bill directs the commission to produce findings in 180 days to help insurers and patients to identify the most effective addiction and mental health treatments offered across the full range of licensed behavioral health clinician specialties so that each patient can find the specific treatment that best meets the patient's needs.

Finally, the bill increases access to naloxone—a front-line treatment for overdoses—by directing the Department of Public Health to issue a state-wide standing order that will authorize every pharmacy in the Commonwealth to dispense naloxone. The bill also encourages broader use of naloxone by guaranteeing that practitioners who prescribe and pharmacists who dispense naloxone in good faith will be protected from criminal or civil liability.

Preventing Opioid Misuse

The Commonwealth has seen a 29% decline in opioid prescriptions since the STEP Act introduced new tools to monitor and limit the use of opioid prescriptions. This legislation introduces a number of initiatives aimed at continuing this positive, downward trend.

In order to reduce fraud and drug diversion and improve tracking and data collection, the bill mandates that by 2020 all prescribers must convert to secure electronic prescriptions and cease the use of oral and paper prescriptions when prescribing regulated drugs.

The STEP Act introduced a 7-day limit on initial prescriptions for opioids and enforced accountability by requiring practitioners to use the Commonwealth's Prescription Monitoring Program (PMP) before issuing any prescription for opioids. The bill creates a commission to develop standards for the Department of Public Health to apply in referring prescribers to professional licensing organizations for potential disciplinary action when they do not check the PMP as required by law or violate the 7-day rule or other legal or professional standards limiting the prescribing of opioids. The bill also creates a commission that will develop recommendations on appropriate prescribing practices for the most common oral and advanced dental procedures including recommendations on approving the use of standardized, pre-packaged doses of commonly issued prescription drugs to reduce the likelihood of over-prescribing.

We know that, for too many people, an opioid prescription issued to treat a serious injury can put them at risk of developing an addiction. To address this danger, the bill authorizes the Department of Industrial Accidents, which administers the Commonwealth's workers compensation insurance program, to develop an approved drug formulary to regulate the use of opioids in treating workplace injuries. Following a change in Federal law, the bill also improves on the "partial fill" provision of the STEP Act so that patients will now be able to receive a portion of their full opioid prescription without invalidating the remainder of it. More patients may choose the "partial fill" option if they know they can go back to the same pharmacy within 30 days to fill the rest of the prescription if needed.

Expanding Educational Efforts

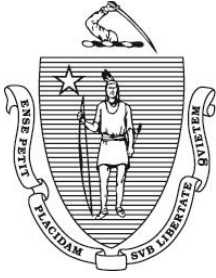
In the long run, our ability to meaningfully reduce the problem of opioid addiction will depend on better and wider education about the larger problem of substance misuse. The STEP Act introduced requirements that every school district in the Commonwealth develop effective substance use prevention and misuse education programming and that schools adopt an individualized assessment tool to screen students for substance use disorders.

This legislation creates a trust fund to help finance the expansion of educational and intervention programs, to support the development of information systems that can help identify students at risk and track outcomes, and to support the implementation of new, school-based models for coordinated support of students in need. I intend to include a request for an appropriation of \$2 million in the fiscal year 2019 budget to provide a first year of funding to the trust.

I urge your prompt enactment of this legislation.

Sincerely,

Charles D. Baker
Governor



The Commonwealth of Massachusetts

IN THE YEAR TWO THOUSAND AND SEVENTEEN

AN ACT RELATIVE TO COMBATTING ADDICTION, ACCESSING TREATMENT, REDUCING PRESCRIPTIONS, AND ENHANCING PREVENTION

Whereas, the deferred operation of this act would tend to defeat its purpose, which is to continue the Commonwealth's efforts to mitigate of the effects of the ongoing opioid crisis in Massachusetts, 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. Chapter 10 of the General Laws is hereby amended by inserting after section 35DDD the following section:-

Section 35EEE. There shall be established and set up on the books of the commonwealth a Safe and Supportive Schools Trust Fund for the purpose of supporting school-based programs that educate children and young persons on addiction, substance misuse and other risky behaviors, and that identify and support children and young persons at risk. The fund shall be administered by the secretary of education, in consultation with the secretary of health and human services, who shall use the fund to provide grants to public elementary, middle, and secondary schools and to public colleges and universities to support the expansion of educational and intervention programs meeting the purposes of the fund. The secretary may

use the fund for necessary and reasonable administrative and personnel costs related to administering the grants. Such expenditures may not exceed, in one fiscal year, 5 per cent of the total amount deposited into the fund during that fiscal year.

The fund shall consist of revenue from appropriations or other money authorized by the general court and specifically designated to be credited to the fund, and revenue from private sources including, but not limited to, grants, gifts and donations received by the commonwealth that are specifically designated to be credited to the fund. Amounts credited to the fund shall not be subject to further appropriation and any money remaining in the fund at the end of a fiscal year shall not revert to the General Fund.

SECTION 2. Subsection (c) of section 13 of chapter 13 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by striking out the first clause and inserting in place thereof the following clause:-

(1) 3 representatives with expertise in nursing education, one from each of the three most common levels of nursing education whose graduates are eligible to write nursing licensure examinations;

SECTION 3. Said subsection (c) of said section 13 of said chapter 13, as so appearing, is hereby further amended by adding following clause:-

(5) 1 registered nurse with expertise in substance use disorder.

SECTION 4. Section 19 of chapter 19 of the General Laws, as so appearing, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

(a) The department shall issue for a term of two years, and may renew for like terms, a license, subject to revocation by it for cause, to any private, county or municipal facility or department or unit of any such facility which offers to the public inpatient psychiatric, residential or day care services and is represented as providing treatment of persons who are mentally ill and which is deemed by it to be responsible and suitable to meet applicable licensure standards and requirements, set forth in regulations of the department, except that: (1) the department may license those facilities providing care but not treatment of persons who are mentally ill, and (2) licensing by the department is not required where such residential or day care treatment is provided within an institution or facility licensed by the department of public health

under the provisions of chapter one hundred and eleven unless such services are provided on an involuntary basis. The department may issue a provisional license where a facility has not previously operated, or is operating but is temporarily unable to meet applicable standards and requirements. No original license, as defined in subsection (i), shall be issued to establish or maintain an inpatient facility subject to licensure under this section, unless there is determination by the department, in accordance with its regulations, that there is need for such a facility. Whether or not a license is issued under clause (1), the department shall make regulations for the operation of such facilities. The department may grant the type of license that it deems suitable for the facility, department or unit. The department shall fix reasonable fees for licenses and renewal thereof.

SECTION 5. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out, in line 20, the word "ward" and inserting in place thereof the following word:- unit.

SECTION 6. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out subsection (c) and inserting in place thereof the following subsection:-

(c) Each facility, department or unit licensed by the department shall be subject to the supervision, visitation and inspection of the department. The department shall establish regulations to administer licensing standards and to provide operational standards for such facilities, departments or units, including, but not limited to, the standards or criteria an applicant shall meet to demonstrate the need for an original license. In order to be licensed by the department under this section, a facility shall provide services to commonwealth residents with public health insurance on a non-discriminatory basis.

The regulations shall provide that no facility, department or unit shall discriminate against an individual, qualified within the scope of the individual's license, when considering or acting on an application of a licensed independent clinical social worker for staff membership or clinical privileges. The regulations shall further provide that each application shall be considered solely on the basis of the applicant's education, training, current competence and experience. Each facility, department or unit shall establish, in consultation with the director of social work or, if none, a consulting licensed independent clinical

social worker, the specific standards, criteria and procedures to admit an applicant for staff membership and clinical privileges. Such standards shall be available to the department upon request.

SECTION 7. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out, in line 44, the word “ward” and inserting in place thereof the following words:- unit; provided, however, that the department may deny or condition the issuance of an original license if an application does not meet the department’s standards or criteria for demonstrating need.

SECTION 8. Said section 19 of said chapter 19, as so appearing, is hereby further amended by striking out subsections (e) through (g), inclusive, and inserting in place thereof the following 5 subsections:-

(e) The department may conduct surveys and investigations to enforce compliance with this section and any rule or regulation promulgated under this section. The department may examine the books and accounts of any facility if it deems such examination necessary for the purposes of this section. If the department finds upon inspection, or through information in its possession, that a facility, department or unit licensed by the department is not in compliance with a requirement established under this section, the department may order the facility, department or unit to correct such deficiency by providing the facility notice in writing of each deficiency. The notice shall specify a reasonable time, not to exceed 60 days after receipt thereof, by which time the facility, department or unit shall remedy or correct each deficiency cited therein; provided, that, in the case of any deficiency which, in the opinion of the department, is not capable of correction within 60 days, the department shall require only that the facility, department or unit submit a written plan for correction for the deficiency in a reasonable manner. The department may modify any nonconforming plan, upon notice in writing to the facility. Within 7 days of receipt, the affected facility, department or unit may file a written request with the department for administrative reconsideration of the order or any portion thereof.

Nothing in this section shall be construed to prohibit the department from enforcing a rule, regulation, or corrective action order, administratively or in court, without first affording formal opportunity to make

correction, or to seek administrative reconsideration under this section, where, in the opinion of the department, the violation of such rule or regulation jeopardizes the health or safety of patients or the public or seriously limits the capacity of facility to provide adequate care, or where the violation of such rule or regulation is the second or subsequent such violation occurring during a period of twelve full months.

Failure to remedy or correct a cited deficiency by the date specified in the written notice or failure to remedy or correct a cited deficiency by the date specified in a plan for correction, as accepted or modified by the department, shall be cause for license revocation or a civil fine imposed upon the facility. The civil fine shall not exceed \$1,000 per deficiency for each day the deficiency continues to exist beyond the date prescribed for correction. The department may pursue either remedy or both or such other sanction as the department may impose administratively upon the facility, department or unit.

(f) No facility, department or unit, for which a license is required under paragraph (a), shall provide inpatient, residential or day care services for the treatment or care of persons who are mentally ill, unless it has obtained a license under this section. The superior court sitting in equity shall have jurisdiction, upon petition of the department, to restrain any violation of the provisions of this section or to take such other action as equity and justice may require. Whoever violates this section shall be punished for the first offense by a fine of not more than \$500 and for subsequent offenses by a fine of not more than \$1,000 or by imprisonment for not more than 2 years.

(g) No patient shall be commercially exploited. No patient shall be photographed, interviewed or exposed to public view without the express written consent of the patient or of the patient's legal guardian.

(h) Notwithstanding paragraphs (a) to (g), inclusive, any child care center, family child care home, family child care system, family foster care or group care facility as defined in section 1A of chapter 15D, shall not be subject to this section.

(i) As used in this section, "original license" shall mean a license, including a provisional license, issued to an inpatient facility not previously licensed; or a license issued to an existing inpatient facility, in

which there has been a change in ownership or location or a change in class of license or specialize service as provided in regulations of the department.”

SECTION 9. Section 1 of chapter 94C of the General Laws, as so appearing, is hereby amended by inserting after the definition of "Drug paraphernalia" the following definition:-

“Electronic prescription”, a lawful order from a prescriber for a drug or device for a specific patient that is generated on an electronic prescribing system that meets federal requirements for electronic prescriptions for controlled substances, and is transmitted electronically to a pharmacy designated by the patient without alteration of the prescription information, except that third-party intermediaries may act as conduits to route the prescription from the prescriber to the pharmacist; provided, however, that “electronic prescription” shall not include an order for medication which is dispensed for immediate administration to the ultimate user. The electronic prescription must be received by the pharmacy on an electronic system that meets federal requirements for electronic prescriptions. A prescription generated on an electronic system that is printed out or transmitted via facsimile is not considered an electronic prescription.

SECTION 10. Section 8 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “oral”, in line 60, the following words:- “, electronic”.

SECTION 11. Section 17 of said chapter 94C, as so appearing, is hereby amended by striking out, in line 2, the words “the written prescription of” and inserting in place thereof the following words:- “an electronic prescription from”.

SECTION 12. Said section 17 of said chapter 94C, as so appearing, is hereby further amended, by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) In emergency situations, as defined by the commissioner, a schedule II substance may be dispensed upon written prescription or oral prescription in accordance with section 20 and department regulations.

SECTION 13. Said section 17 of said chapter 94C, as so appearing, is hereby further amended, by striking out, in line 11, the words “a written or oral prescription of” and inserting in place thereof the following word:- “an electronic prescription from”.

SECTION 14. Section 18 of said chapter 94C is hereby amended by striking out subsection (d³/₄), as inserted by section 21 of chapter 52 of the acts of 2016, and inserting in place thereof the following subsection:-

(d³/₄) A pharmacist filling a prescription for a schedule II substance shall, if requested by the patient, dispense the prescribed substance in a lesser quantity than indicated on the prescription. The remaining portion may be filled upon patient request in accordance with federal law; provided, however, that only the same pharmacy that originally dispensed the lesser quantity may dispense the remaining portion. Upon an initial partial dispensing of a prescription or a subsequent dispensing of a remaining portion, the pharmacist or the pharmacist's designee shall make a notation in the patient's record maintained by the pharmacy, which shall be accessible to the prescribing practitioner by request, indicating that the prescription was partially filled and the quantity dispensed.

SECTION 15. Section 18B of said chapter 94C, as inserted by section 23 of chapter 52 of the acts of 2016, is hereby amended by striking out the words "and in the prescription drug monitoring program established in section 24A".

SECTION 16. Said Chapter 94C, as so appearing, is hereby amended by striking out section 19B and inserting in place thereof the following section:-

Section 19B. As used in this section and unless the context clearly requires otherwise, "opioid antagonist" shall mean naloxone or any other drug approved by the United States Food and Drug Administration as a competitive narcotic antagonist used in the reversal of overdoses caused by opioids.

(a) The department shall ensure that a statewide standing order is issued to authorize the dispensing of an opioid antagonist in the commonwealth by any licensed pharmacist. The statewide standing order shall include, but shall not be limited to, written, standardized procedures or protocols for the dispensing of an opioid antagonist by a licensed pharmacist. Notwithstanding any general or special law to the contrary, the commissioner, or a physician designated by the commissioner who is registered to distribute or dispense a controlled substance in the course of professional practice pursuant to section 7, may issue a

statewide standing order that may be used for a licensed pharmacist to dispense an opioid antagonist under this section.

(b) Notwithstanding any general or special law to the contrary, a licensed pharmacist may dispense an opioid antagonist in accordance with the statewide standing order issued under subsection (a). A pharmacist dispensing an opioid antagonist shall annually report to the department the number of times the pharmacist dispenses an opioid antagonist. Reports shall not identify an individual patient, shall be confidential and shall not constitute a public record as defined in clause Twenty-sixth of section 7 of chapter 4. Except for an act of gross negligence or willful misconduct, a pharmacist who, acting in good faith, dispenses an opioid antagonist shall not be subject to any criminal or civil liability or any professional disciplinary action by the board of registration in pharmacy related to the use or administration of an opioid antagonist.

(c) Except for an act of gross negligence or willful misconduct, the commissioner or physician who issues the statewide standing order under subsection (a) and any practitioner who, acting in good faith, directly or through the standing order, prescribes or dispenses an opioid antagonist shall not be subject to any criminal or civil liability or any professional disciplinary action.

(d) A person acting in good faith may receive a prescription for an opioid antagonist, possess an opioid antagonist and administer an opioid antagonist to an individual appearing to experience an opioid-related overdose. A person who, acting in good faith, administers an opioid antagonist to an individual appearing to experience an opioid-related overdose shall not, as a result of the person's acts or omissions, be subject to any criminal or civil liability or any professional disciplinary action. The immunity in section 34A of this chapter also shall apply to a person administering an opioid antagonist pursuant to this section.

(e) The department, the board of registration in medicine and the board of registration in pharmacy shall adopt regulations to implement this section.

SECTION 17. Subsection (c) of section 20 of said chapter 94C, as so appearing, is hereby amended by striking out the first and second sentences and inserting in place thereof the following 2 sentences:-

Whenever a practitioner, certified nurse practitioner, certified registered nurse anesthetist, nurse midwife, psychiatric clinical nurse specialist, or physician assistant dispenses a controlled substance by oral prescription, such individual shall, within a period of not more than 7 days or such shorter period that is required by federal law cause an electronic or written prescription for the prescribed controlled substance to be delivered to the dispensing pharmacy. The written prescription may be delivered to the pharmacy in person or by mail, but shall be postmarked within 7 days or such shorter period that is required by federal law.

SECTION 18. Section 22 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “written”, in line 2, the following words:- or electronic.

SECTION 19. Section 23 of said chapter 94C, as so appearing, is hereby amended by inserting after the word “written”, in lines 1 and 6, in each instance, the following words:- or electronic.

SECTION 20. Said section 23 of said chapter 94C, as so appearing, is hereby further amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) A written or electronic prescription for a controlled substance in schedule II shall not be refilled.

Written prescriptions for a controlled substance in schedule II shall be kept in a separate file.

SECTION 21. Said section 23 of said chapter 94C, as so appearing, is hereby further amended by striking out subsections (g) and (h) and inserting in place thereof the following 3 subsections:-

(g) Prescribers shall issue an electronic prescription for all controlled substances and medical devices.

The department of public health shall promulgate regulations setting forth standards for electronic prescriptions.

(h) The commissioner, through regulation, shall establish exceptions to section 17 and subsection (g) authorizing the limited use of a written and oral prescription where appropriate. Said exceptions shall include, but shall not be limited to:

(1) prescriptions that are issued by veterinarians;

(2) prescriptions that are issued or dispensed in circumstances where electronic prescribing is not available due to temporary technological or electrical failure;

(3) a time limited waiver process for practitioners who demonstrate economic hardship, technological limitations that are not reasonably within the control of the practitioner, or other exceptional circumstance;

(4) instances where it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the patient's medical condition;

(i) All written prescriptions shall be written in ink, indelible pencil or by other means on a tamper resistant form consistent with federal requirements for Medicaid and signed by the prescriber.

SECTION 22. Section 24A of said chapter 94C, as so appearing, is hereby amended by striking out subsection (g) and inserting in place thereof the following subsection:- (g) The department may provide data from the prescription monitoring program to practitioners in accordance with this section; provided, however, that practitioners shall be able to access the data directly through a secure electronic medical record or other similar secure software or information systems. This data may be used for the purpose of providing medical or pharmaceutical care to the practitioners' patients only, unless otherwise permitted by this section. Any such secure software or information system must identify the registered participant on whose behalf the prescription monitoring program was accessed.

SECTION 23. Said section 24A of said chapter 94C, as so appearing, is hereby further amended by adding the following subsection:-

(m) The department may enter into agreements to permit health care facilities to integrate secure software or information systems into their electronic medical records for the purpose of using prescription monitoring program data to perform data analysis, compilation, or visualization, in order to provide medical or pharmaceutical care to individual patients. Any such secure software or information system shall be bound to comply with requirements established by the department to ensure the security and confidentiality of any data transferred.

SECTION 24: Subsection (a) of section 51½ of chapter 111, inserted by section 32 of chapter 52 of the acts of 2016, is hereby amended by striking out the definition of “Licensed mental health professional” and inserting in place thereof the following definition:-

“Licensed mental health professional”, a licensed physician who specializes in the practice of psychiatry or addiction medicine, a licensed psychologist, a licensed social worker, a licensed mental health counselor, a licensed psychiatric clinical nurse specialist, a licensed alcohol and drug counselor I as defined in section 1 of chapter 111J, a healthcare provider defined in section 1 of chapter 111 whose scope of practice allows such evaluations pursuant to medical staff policies and practice or other professional authorized by the department through regulation.

SECTION 25: Said section 51½ of said chapter 111, as so appearing, is hereby further amended by inserting after the word “program”, in line 20, the following words:- whose staff meet the criteria of a licensed mental health professional.

SECTION 26: Subsection (c) of said section 51½ of said chapter 111, as so appearing, is hereby amended by striking out subsection (c) and inserting in place thereof the following subsection:-

(c) After a substance abuse evaluation has been completed pursuant to subsection (b) treatment may occur within the acute-care hospital or satellite emergency facility, if appropriate services are available, which may include induction to medication assisted treatment. If the hospital or satellite emergency facility is unable to provide such services, the hospital or satellite emergency facility shall refer the patient to an appropriate and available hospital or treatment provider. Medical necessity for further treatment shall be determined by the treating clinician and noted in the patient’s medical record.

If a patient refuses further treatment after the evaluation is complete, and is otherwise medically stable, the hospital or satellite emergency facility may initiate discharge proceedings; provided, however, if the patient is in need of and agrees to further treatment following discharge pursuant to the substance abuse evaluation, then the hospital shall directly connect the patient with a community based program prior to

discharge or within a reasonable time following discharge when the community based program is available.

SECTION 27: Subsection (g) of said section 51½ of said chapter 111, as so appearing, is hereby amended by striking out subsection (g) and inserting in place thereof the following subsection:-

(g) Upon discharge of a patient who experienced an opiate-related overdose, the acute-care hospital, satellite emergency facility, or emergency service program shall record the opiate-related overdose and substance abuse evaluation in the patient's electronic medical record which shall be directly accessible by other healthcare providers and facilities consistent with federal and state privacy requirements through a secure electronic medical record, health information exchange, or other similar software or information systems for the purposes of (i) improving ease of access and utilization of such data for treatment or diagnosis; (ii) supporting integration of such data within the electronic health records of a healthcare provider for purposes of treatment or 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.

SECTION 28. Section 1 of chapter 111E of the General Laws, as so appearing, is hereby amended by inserting after the definition of "Independent physician" the following definition:-

"Original license", a license, including a provisional license, issued to a facility not previously licensed; or a license issued to an existing facility, in which there has been a change in ownership or location.

SECTION 29. Section 7 of said chapter 111E, as so appearing, is hereby amended by striking out, in lines 1, 10, 13, 26, 27, 33, 39, 44, 50, 75, 77, and 80, the word "division" and inserting in place thereof, in each instance, the following word:- department.

SECTION 30. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by inserting after the word "requirements", in line 8, the following words:- , set forth in regulations of the department.

SECTION 31. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in lines 17 and 18, the words “but such standards and requirements shall concern only” and inserting in place thereof the following words:- which shall include, but shall not be limited to.

SECTION 32. The first paragraph of said section 7 of said chapter 111E, as so appearing, is hereby further amended by adding the following 2 clauses:-

(7) a requirement that the facility provide services to commonwealth residents with public health insurance on a non-discriminatory basis, and

(8) the standards or criteria a facility shall meet to demonstrate the need for an original license.

SECTION 33. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in lines 26 and 27, the words “from time to time, on request,”.

SECTION 34. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out, in lines 28 to 32, inclusive, the words “reasonably require for the purposes of this section, and any licensee or other person operating a private facility who fails to furnish any such data, statistics, schedules or information as requested, or who files fraudulent returns thereof, shall be punished by a fine of not more than five hundred dollars” and inserting in place thereof the following words:- require.

SECTION 35. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by inserting after the number “10”, in line 43, the following words:- ; provided however, that the department may, in its discretion, deny or condition the issuance of an original license if an application does not meet the department’s standards or criteria for demonstrating need.

SECTION 36. Said section 7 of said chapter 111E, as so appearing, is hereby further amended by striking out paragraph 5 to 7, inclusive, and inserting in place thereof the following 4 paragraphs:-
No person, partnership, corporation, society, association, or other agency, or entity of any kind, other than a licensed general hospital, a department, agency or institution of the federal government, the commonwealth or any political subdivision thereof, shall operate a facility without a license and no department, agency or institution of the commonwealth or any political subdivision thereof shall operate a facility without approval from the department pursuant to this section.

The department may conduct surveys and investigations to enforce compliance with this section and any rule or regulation. Whenever the department finds upon inspection, or through information in its possession, that a facility is not in compliance with a requirement established under this chapter, the department may order the facility to correct such deficiency by providing the facility notice in writing of each violation. In such notice, the department shall specify a reasonable time, not to exceed 60 days after receipt thereof, by which time the facility shall remedy or correct each violation cited therein; provided, that, in the case of any violation which, in the opinion of the department, is not capable of correction within 60 days, the department shall require only that the facility submit a written plan for correction of the violation in a reasonable manner. The department may modify any nonconforming plan upon notice in writing to the facility. Within 7 days of receipt, the affected facility may file a written request with the department for administrative reconsideration of the order or any portion thereof

Failure to remedy or correct a cited violation by the date specified in a written notice, or failure to remedy or correct a cited violation by the date specified in a plan for correction as accepted or modified by the department, shall be cause for license revocation or a civil fine imposed upon the facility by the department. Such civil fine shall not exceed \$1,000 per deficiency for each day the deficiency continues to exist beyond the date prescribed for correction. The department may pursue either remedy or both or such other sanction as the department may impose administratively upon the facility.

Upon petition of the department, the superior court shall have jurisdiction in equity to restrain any violation of this section and to take such other action as equity and justice may require to enforce its provisions.

Each facility shall be subject to visitation and inspection by the department to enforce compliance with this chapter and any rule or regulation issued thereunder. The department shall inspect each facility prior

to granting or renewing a license or approval. The department may examine the books and accounts of any facility if it deems such examination necessary for the purposes of this section.

SECTION 37. Section 35 of chapter 123 of the General Laws, as so appearing, is hereby amended by inserting after the word guardian, in line 18, the following words:- , medical professional, as defined by the department in regulation.

SECTION 38. Chapter 123 of the General Laws is hereby amended by inserting after section 35 the following 2 sections:-

Section 35A. (a) A clinical professional, who, after examining a person, has reason to believe that failure to commit such person for treatment would create a likelihood of serious harm by reason of an alcohol or substance use disorder may restrain or authorize the restraint of such person for transportation to an appropriate treatment facility authorized for such purposes by the department of public health or the department of mental health. For the purposes of this section, the term “clinical professional” shall include a physician who is licensed pursuant to section 2 of chapter 112 or qualified psychiatric nurse mental health clinical specialist authorized to practice as such under regulations promulgated pursuant to section 80B of said chapter 112 or a qualified psychologist licensed pursuant to sections 118 to 129, inclusive, of said chapter 112, or a licensed independent clinical social worker licensed pursuant to sections 130 to 137, inclusive, of chapter 112; provided, however, that the department may through regulation identify other persons who because of training and credentials shall be included within the definition of “clinical professional.”

If an examination is not possible because of the emergency nature of the case or because of the refusal of the person to consent to such examination, the clinical professional on the basis of the facts and circumstances may determine that treatment is necessary and may restrain or authorize the restraint of such person for transportation to an appropriate treatment facility authorized for such purposes by the department of public health or the department of mental health through regulation.

If a clinical professional is not available, a police officer who believes that failure to treat a person would create a likelihood of serious harm by reason of an alcohol or substance use disorder may restrain or authorize the restraint of such person for transportation to an appropriate treatment facility authorized for such purposes by the department of public health or the department of mental health through regulation.

The clinical professional or police officer shall communicate to the facility receiving a person transported under this section the reasons for the restraint of such person and any other relevant information which may assist the admitting clinician. Whenever practicable, prior to transporting such person, the clinical professional or police officer shall telephone or otherwise communicate with a facility to describe the circumstances and known clinical history and to determine whether the facility is the proper facility to receive such person and also to give notice of any restraint to be used and to determine whether such restraint is necessary.

(b) Only if the transportation for treatment under this section is authorized by a physician specifically designated to have the authority to admit to a facility in accordance with the regulations of the department of mental health or department of public health shall the person be admitted to the facility immediately after the person's reception. If the application is made by someone other than a designated physician, the person shall be given an examination by a physician within a reasonable amount of time after the person's reception at such facility. If the physician determines that failure to treat the person would create a likelihood of serious harm by reason of an alcohol or substance use disorder the physician may admit the person to the facility for care and treatment for up to 72 hours, during which time, staff of the substance use treatment facility shall attempt to engage the individual in voluntary treatment.

Upon admission of a person under this subsection, the facility shall inform the person that, upon the person's request, the facility will notify the committee for public counsel services of the name and location of the person admitted. The committee for public counsel services shall forthwith appoint an

attorney who shall meet with the person. If the appointed attorney determines that the person voluntarily and knowingly waives the right to be represented or is presently represented or will be represented by another attorney, the appointed attorney shall so notify the committee for public counsel services, which shall withdraw the appointment.

Any person admitted under this subsection who has reason to believe that such admission is the result of an abuse or misuse of this subsection, may request, or request through counsel an emergency hearing in the juvenile court or district court in whose jurisdiction the facility is located, and unless a delay is requested by the person or through counsel, the juvenile court or district court shall hold such hearing on the day the request is filed with the court or not later than the next business day. The superintendent of the facility, if he or she seeks to retain the person for treatment, shall at the time of the hearing file a petition for commitment under section 35.

(c) No person shall be admitted to a facility under this section unless the person, or if the person is a minor, the person's parent or guardian, is first given an opportunity to apply for voluntary admission under section 35B.

(d) A person shall be discharged at the end of the 72-hour period unless the person has consented to treatment under section 35B. If the superintendent determines that the failure to provide continued treatment to the person would create a likelihood of serious harm by reason of an alcohol or substance use disorder, the superintendent shall file a petition under section 35 prior to discharge.

(e) Except for an act of gross negligence or willful misconduct, a police officer or a clinical professional who, acting in good faith does not transport or authorize the transport of an individual to receive treatment under subsection (a) shall not be subject to any criminal or civil liability for failure to transport an individual under this section.

(f) The department, in coordination with the department of public health, shall promulgate regulations to implement this section and section 35B.

Section 35B. (a) Pursuant to regulations on admission procedures, the superintendent of a facility may receive and treat on a voluntary basis any person who has been transported under subsection (a) of section 35A; provided, that the person is in need of care and treatment for an alcohol or substance use disorder; and provided further, that the admitting facility is suitable for such care and treatment and approved or licensed by the department of public health or the department of mental health. An application for voluntary treatment may be made by a person who has attained the age of 16 or by a parent or guardian of a person under the age of 18 years. Prior to accepting an application for a voluntary admission, the superintendent shall afford the person making the application the opportunity for consultation with an attorney, or with a person who is working under the supervision of an attorney, concerning the legal effect of a voluntary admission. The superintendent may discharge any person admitted under this subsection at any time the superintendent deems the discharge in the best interest of the person; provided, however, that if a parent made the application for admission, 14 days' notice shall be given to the parent prior to discharge.

(b) A person admitted to a facility under subsection (a) shall be free to leave such facility at any time, and any parent who requested the admission of such person may withdraw such person at any time, upon giving written notice to the superintendent; provided, however, that the superintendent may restrict the right to leave or withdraw to normal working hours and weekdays and, in the superintendent's discretion, may require the person or the person's parent to give 3 days' written notice of his or her intention to leave or withdraw. If a person or the person's parent provides a notice of intention to leave or withdraw, the superintendent may require an examination of the person to determine the person's clinical progress, the person's suitability for discharge and to investigate other aspects of the person's case including the

person's legal competency and family, home or community situation. If the superintendent determines that the failure to provide continued treatment would create a likelihood of serious harm by reason of an alcohol or substance use disorder the superintendent shall file a petition under section 35.

Before accepting an application for voluntary admission where the superintendent may require 3 days written notice of intention to leave or withdraw, the admitting or treating physician shall assess the person's capacity to understand that: (i) the person is agreeing to stay or remain at the facility; (ii) the person is agreeing to accept treatment; (iii) the person may be required to provide the facility with 3 days written advance notice of the person's intention to leave the facility; and (iv) the facility may petition a court for an extended commitment under section 35. If the physician determines that the person lacks the capacity to understand these facts and consequences, the application for voluntary admission shall not be accepted except where a parent or guardian who has applied for voluntary admission on behalf of a minor.

SECTION 39. Chapter 152 of the General Laws is hereby amended by inserting after section 13 the following section:-

Section 13 ½. The department shall establish a formulary of clinically appropriate medications, including opioids and related medications, and shall promulgate regulations for the administration of this formulary. In establishing the formulary the department shall consult with the health care services board and the drug formulary commission established in section 13 of chapter 17 of the General Laws. The formulary shall be based on well-documented, evidence-based methodology, and the department shall include as part of the formulary a complete list of medications that are approved for payment under this chapter, and any specific payment, prescribing, or dispensing controls associated with drugs on the list. The department shall review and update, if necessary, the formulary at least once every 2 years.

SECTION 40. There shall be a commission to review and make recommendations regarding the standards that should apply when credentialing a recovery coach, including, whether recovery coaches should be required to register with a board.

The commission shall be comprised of: the secretary of health and human services or a designee, who shall serve as chair; the commissioner of public health or a designee; and 7 persons who shall be appointed by the secretary of health and human services, 1 of whom shall have expertise in training recovery coaches, 1 of whom shall be a community provider who employs recovery coaches; 1 of whom shall represent a hospital who employs recovery coaches; 1 of whom shall be a family member to an individual with a substance use disorder; 1 of whom shall have lived experience with addiction; 1 of whom shall represent payers; and 1 of whom shall currently be employed as a recovery coach.

The commission shall file its recommendations, if any, together with any recommendations for legislation, with the clerks of the senate and the house of representatives 1 year from the effective date of this act.

SECTION 41. There shall be a commission to review and make recommendations regarding the appropriate standards and criteria that shall be used by the department of public health to refer prescribers, who are suspected of violating the 7-day opioid prescribing limit, under section 19D of chapter 94C of the General Laws, overprescribing opioids to patients and failing to check the prescription monitoring program in accordance with section 24A of said chapter 94C, to their respective board of registration for disciplinary action. The commission shall identify appropriate exceptions to the referral process. The commission shall also make recommendations about appropriate dosing standards for opioid prescriptions, which may include recommendations on appropriate morphine equivalent dosages. Said dosing standards shall be made available to the public.

The commission shall be comprised of: the commissioner of public health or a designee, who shall serve as chair and 10 persons who shall be appointed by the secretary of health and human services, 1 of whom shall represent the board of registration in medicine, 1 of whom shall represent the board of registration in dentistry, 1 of whom shall represent the board of registration in nursing, 1 of whom shall represent the

board of registration of physician assistants, 1 of whom shall have expertise in pain management; 1 of whom shall have expertise in the treatment of addictions, and 4 of whom shall have expertise in prescribing opioids in accordance with best practices.

The commission shall file its recommendations together with any recommendations for legislation, with the clerks of the senate and the house of representatives within 180 days of the effective date of this act.

Upon completion of the report, the department of public health shall issue guidance to prescribers about how it will implement the recommendations of the commission and shall begin making referrals for discipline within 6 months of issuing said guidance.

SECTION 42. There shall be a commission to review and make recommendations about appropriate prescribing practices related to the most common oral and maxillofacial surgical procedures, which shall include the removal of wisdom teeth. The commission shall engage with drug manufacturers to create a pre-packaged product such as a blister pack or z-pack to be used in connection with common oral and maxillofacial surgical procedures that will provide patients with an appropriate, standard post-procedure dosage and quantity of commonly prescribed drugs.

The commission shall be comprised of: the commissioner of public health or a designee, who shall serve as chair, a representative from the Massachusetts Dental Society, and 5 persons who shall be appointed by the governor, 1 of whom shall be an oral surgeon, 1 of whom shall be a nurse with expertise in maxillofacial surgical procedures, 1 of whom shall represent a dental school, 2 of whom shall have expertise in pain management.

The commission shall file its recommendations, including any recommendations for legislation, with the clerks of the senate and the house of representatives 18 months from the effective date of this act.

SECTION 43. There shall be a commission to review evidence based treatment for individuals with a substance use disorder, mental illness or co-occurring substance use disorder and mental illness. The commission shall create a taxonomy of licensed behavioral health clinician specialties, which may be used by insurance carriers to develop a provider network. The commission shall recommend a process that may be used by carriers to validate a licensed behavioral health clinician's specialty.

The commission shall be comprised of: the secretary of health and human services or a designee, who shall serve as chair; the commissioner of insurance or a designee; the executive director of the group insurance commission or a designee; and 7 persons who shall be appointed by the secretary of health and human services: 1 of whom shall have expertise in the treatment of individuals with a substance use disorder; 1 of whom shall have expertise in the treatment of individuals with a mental illness; 2 of whom shall represent payers; 1 of whom shall be a licensed behavioral health clinician; and 2 of whom shall be a family member to an individual with a substance use disorder or mental illness. The secretary may appoint additional members who have expertise that will aid the commission in producing its recommendations.

The commission shall file a report of its findings and recommendations together with any proposed legislation with the clerks of the senate and the house of representatives 180 days from the effective date of this act.

SECTION 44: The Executive Office of Health and Human Services, in coordination with the Trial Court, shall convene an advisory committee of healthcare providers and provider associations, which shall evaluate and develop a consistent statewide standard for the medical review of individuals who are involuntarily committed due to an alcohol or substance use disorder pursuant to section 35 of chapter 123 of the general laws, including but not limited to developing: (1) a standardized form and criteria for releasing medical information, which can be used in a commitment hearing under section 35 of chapter 123 of the general laws, that is in compliance with federal and state privacy requirements; and

(2) criteria and guidance to medical staff about filing a petition under section 35 of chapter 123 of the general laws.

SECTION 45. Sections 9 through 13, inclusive, 17 through 21, inclusive, and 38 shall take effect on January 1, 2020.

SECTION 46. Sections 40 to 44, inclusive, are hereby repealed.

SECTION 47. Section 46 shall take effect on January 1, 2021.