

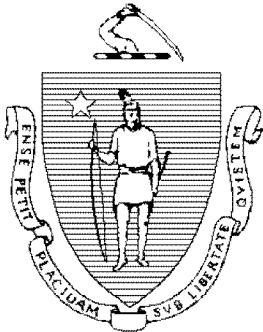
The

Massachusetts

Register

Published by:
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THE COMMONWEALTH OF MASSACHUSETTS
Secretary of the Commonwealth - William Francis Galvin

The Massachusetts Register
TABLE OF CONTENTS

Page

THE GENERAL COURT

Acts and Resolves 1

SECRETARY OF THE COMMONWEALTH

State Register of Historic Places 3

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Administrative Bulletin 26-13: 101 CMR 322.00: Rates for Durable Medical
Equipment, Oxygen and Respiratory Therapy Equipment 5

ADMINISTRATIVE PROCEDURES

Notices of Public Review of Prospective Regulations 9

Cumulative Table 31

Notice of Expiration of Emergency Regulations -

Emergency Regulations -

Permanent Regulations 39

Future Date Effective Regulations -

Notices of Emergency Expiration

There Are No Notices of Emergency Expiration

Emergency Regulations

There Are No Emergency Regulations

Permanent Regulations

105 CMR	Department of Public Health	
270.000	Blood Screening of Newborns for Treatable Diseases and Disorders	39
	<i>Lists mandated screening tests for diseases and disorders with treatments that are known to be more effective if the condition is identified in the newborn period and for which there is a reliable and effective blood screening test that may be administered during the newborn period, and that there is a diagnostic protocol.</i>	
211 CMR	Division of Insurance	
52.00	Managed Care Consumer Protections and Accreditation of Carriers	41
	<i>Provides for health insurance managed care requirements to protect consumers.</i>	
527 CMR	Board of Fire Prevention Regulations	
12.00	Massachusetts Electrical Code - <i>Correction</i>	43
830 CMR	Department of Revenue	
62B.00	Withholding of Taxes on Wages and Declaration of Estimated Income Tax	45
	<i>830 CMR 62B.2.1 contains revisions to incorporate the 4% surtax on income over a certain threshold. Withholding agents must withhold the 4% surtax from payments made to certain individual performers where the aggregate amount of such payments in a given year exceeds the surtax threshold for that year. The amount of tax to withhold is determined based on the calculation methods or tables provided by the Commissioner. 830 CMR 62B.2.3 contains revisions to incorporate the 4% surtax. Motion picture production companies must withhold the 4% surtax from payments made to independent contractors and loan-outs for the production of a motion picture where the annual aggregate amount of such payments exceeds the surtax's threshold.</i>	

980 CMR Energy Facilities Siting Board

17.00 Constructive Approval

47

The 2024 Climate Act (St. 2024, c. 239) requires the Energy Facilities Siting Board (“Siting Board” or “EFSB”) to promulgate regulations to implement the changes to M.G.L. c. 164, §§ 69G through 69J¼, inclusive, §§ 69O and 69P, §§ 69R and 69S, and §§ 69T through 69W, inclusive. As modified, these sections authorize the Siting Board to issue a single consolidated permit that comprises all state, regional, and local permits that a clean energy infrastructure facility would otherwise need to commence construction and operation. The 2024 Climate Act further requires the Siting Board to promulgate 980 CMR 17.00 not later than 3/1/26, and 980 CMR 17.00 will apply to all jurisdictional projects submitted to the Siting Board on and after 7/1/26. St. 2024, c. 239, § 132. 980 CMR 17.00: Constructive Approval, will apply if the Siting Board does not issue a final decision on an Application by the statutory deadline.

Acts 2026

CHAPTER NUMBER	BILL NUMBER	TITLE	DATE
55	H 5384	Making Appropriations for the Fiscal Year 2026 to Provide for Supplementing Certain Existing Appropriations and for Certain Other Activities and Projects.	4/6/2026
56	H 4542	Making the Charter of the City of Chicopee Gender Neutral.	4/10/2026
57	H 2985	Exempting Stephen Justice from the Maximum Age Requirement for Appointment to the Position of Firefighter in the City of Haverhill.	4/10/2026
58	H 2986	Exempting Javier Vargas from the Maximum Age Requirement for the Position of Firefighter in the City of Haverhill.	4/10/2026
59	H 2987	Exempting Brittany Sproule from the Maximum Age Requirement for the Position of Firefighter in the City of Haverhill.	4/10/2026
60	H 2988	Exempting Freddy Castaneda from the Maximum Age Requirement for the Position of Police Officer in the City of Haverhill.	4/10/2026
61	H 4524	Changing the Name of the Board of Selectmen in the Town of Williamsburg to Select Board.	4/10/2026
62	H 4374	Designating a Certain Overpass in the Town of Sandwich as the United States Marine Corps Staff Sergeant Raymond G. Tourville Veterans Memorial Overpass.	4/10/2026
63	H 3213	Authorizing the City of Springfield to Appropriate Funds to Help Certain Residents Meet Their Local Tax Obligations.	4/16/2026
64	S 2859	Amending the Charter of the Town of Sandwich.	4/16/2026
65	H 5350	Modernizing the Commonwealth's Cannabis Laws.	4/19/2026
66	H 4621	Changing the Name of the Board of Selectmen in the Town of Boylston to Select Board.	4/19/2026
67	H 4225	Authorizing the Town of Marblehead to Establish a Means-Tested Senior Citizen Property Tax Exemption.	4/29/2026
68	H 4584	Further Regulating the Appointment of Special Police Officers in the City of Malden.	4/29/2026
69	H 4602	Increasing the Membership of the Select Board in the Town of Monson.	4/29/2026
70	H 4259	Designating the Weider Park Tennis Courts as the Kim O'Connell Tennis Courts.	4/30/2026
71	H 4232	Relative to the Charter of the Town of Fairhaven.	5/4/2026
72	H 4057	Increasing the Membership of the Haverhill Board of Health From 3 Members to 5 Members.	5/8/2026

Acts 2026

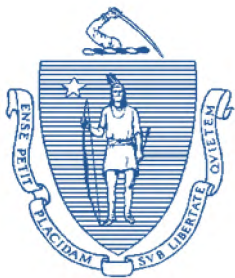
CHAPTER NUMBER	BILL NUMBER	TITLE	DATE
73	S 1859	Providing for the Retirement of Walter L. Guertin, a Former Member of the Fire Department in the City of Attleboro.	5/8/2026
74	H 4399	Amending the Charter of the Town of Middleton.	5/8/2026
75	S 2596	Enabling the Maintenance of Private Roads in the City of Gloucester.	5/8/2026
76	H 2917	Further Regulating Creditable Service for Employees of the Dedham-Westwood Water District.	5/12/2026
77	H 4212	Authorizing the Town of Lancaster to Dissolve Its Animal Control Commission.	5/12/2026
78	H 4717	Setting a Date for the Annual Town Meeting for the Town of Orange.	5/12/2026
79	S 2789	Providing for Recall Elections in the Town of Rutland.	5/13/2026
80	S 2652	Authorizing the City of Taunton to Establish a Separate Billing Rate for Water Supplied to Manufactured Housing Communities.	5/14/2026
81	H 4784	Providing for a Town Administrator in the Town of Hopedale.	5/14/2026
82	H 5245	Establishing a Sick Leave Bank for Courtney Cochran, an Employee of the Department of Children and Families.	5/14/2026
83	S 2544	Regulating the Number of Registered Voters Who May Petition for a Special Town Meeting in the Town of Andover.	5/19/2026
84	H 4842	To Clarify the Organization of the Lexington Housing Assistance Board.	5/19/2026
85	H 4817	Authorizing the Town of Pembroke to Grant an Additional License for the Sale of All Alcoholic Beverages Not to Be Drunk on the Premises.	5/21/2026
86	H 4501	Amending the Town Charter of the Town of Plymouth.	5/21/2026

STATE REGISTER OF HISTORIC PLACES

WEEKS OF: March 29 to May 2, 2026

For further information call the Massachusetts Historical Commission (617-727-8470)

ACTIONS TAKEN UNDER 950 CMR 71.00			
Town/Property/Agency	Finding	Date	
NONE			
ADDITIONAL LISTINGS UNDER 950 CMR 71.00			
Town/Name/Address	Designation	Date	Number of Properties
Boston (Dorchester) Bussey, Capt. John House 1203 Adams St	LL	4/29/2026	1
Easton Josiah Keith House Historic District 479 Bay Rd	LHD	4/13/2026	3
Nantucket Mitchell, Maria Observatory and Astronomical Study 1-3 Vestal St	PR	4/17/2026	1



MAURA T. HEALEY
GOVERNOR

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SECRETARY

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

MIKE LEVINE
UNDERSECRETARY
FOR MASSHEALTH

Administrative Bulletin 26-13

101 CMR 322.00: Rates for Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment

Effective January 1, 2026

Coding Updates for Certain Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment

Summary

In accordance with [101 CMR 322.01\(6\)](#): *Coding Updates and Corrections*, the Executive Office of Health and Human Services (EOHHS) is adding new procedure codes, deleting outdated codes, and updating narratives for certain codes, effective for dates of service on or after January 1, 2026. This bulletin lists specific codes that have been added or deleted or have revised code descriptions, as well as cross-walked codes that identify code splits for applicable codes.

The three cross-walked codes reflect Centers for Medicare & Medicaid Services (CMS) code splits for certain intermittent urinary catheter products. New codes A4295, A4296, and A4297 are cross-walked from existing codes A4351, A4352, and A4353, respectively. To maintain consistent payment rates following the code split, EOHHS is assigning to codes A4295, A4296, and A4297 the same rates as the corresponding existing codes from which they are cross-walked. EOHHS is also retaining the existing codes with revised descriptions, as applicable.

For entirely new codes with associated Medicare fees, payment rates are set at a percentage of prevailing Medicare fees as described in [101 CMR 322.03\(16\)\(a\)](#). For entirely new codes without associated Medicare fees, individual consideration (IC) is applied to establish payment as described in [101 CMR 322.03\(16\)\(b\)](#). For existing codes for which only the description has changed, as described in [101 CMR 322.01\(6\)\(b\)](#), the rates are unchanged. Rates listed in this administrative bulletin apply until EOHHS issues revised rates.

The appearance of a code in the tables below does not constitute authorization for, or approval of, the procedures or services for which rates are determined pursuant to [101 CMR 322.00](#). Governmental units that purchase care are responsible for the definition, authorization, and approval of care to publicly aided individuals.

Added Codes

Code	Description	Rate
A4295	Intermittent urinary catheter; straight tip, hydrophilic coating, each	\$2.10
A4296	Intermittent urinary catheter; coude (curved) tip, hydrophilic coating, each	\$7.45
A4297	Intermittent urinary catheter; hydrophilic coating, with insertion supplies	\$8.11
J0162	Injection, epinephrine (Fresenius), not therapeutically equivalent to J0165, 0.1 mg	\$0.39
J0654	Injection, liothyronine, 1 mcg	IC
J1736	Injection, meloxicam (Delova), 1 mg	IC
J1737	Injection, meloxicam (Azurity), 1 mg	IC
J1837	Injection, posaconazole, 1 mg	\$0.29
J2516	Injection, pentamidine isethionate, 1 mg	\$0.20
J2596	Injection, vasopressin (long grove), not therapeutically equivalent to J2598, 1 unit	\$1.52
J3291	Injection, tranexamic acid in sodium chloride, 5 mg	IC
J3376	Injection, vancomycin HCl (Hikma), not therapeutically equivalent to J3373, 10 mg	\$0.02
J3379	Injection, valproate sodium, 5 mg	\$0.04
J3387	Injection, elivaldogene autotemcel, per treatment	IC
J7528	Mycophenolate mofetil, for suspension, oral, 100 mg	\$0.20
J9184	Injection, gemcitabine hydrochloride (Avyxa), 200 mg	IC
J9256	Injection, nipocalimab-aahu, 3 mg	\$27.83
Q5160	Injection, bevacizumab-nwgd (Jobevne), biosimilar, 10 mg	IC

Deleted Codes

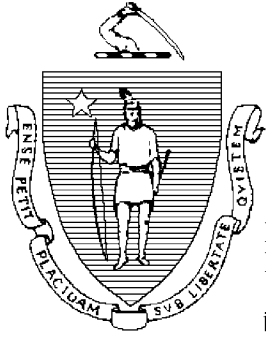
Code	Description
J0172	Injection, aducanumab-avwa, 2 mg
J0190	Injection, biperiden lactate, per 5 mg

Code	Description
J0200	Injection, alatrofloxacin mesylate, 100 mg
J0205	Injection, alglucerase, per 10 units
J0215	Injection, alefacept, 0.5 mg
J0288	Injection, amphotericin b cholesteryl sulfate complex, 10 mg
J0350	Injection, anistreplase, per 30 units
J0365	Injection, aprotonin, 10,000 KIU
J0380	Injection, metaraminol bitartrate, per 10 mg
J0395	Injection, arbutamine HCl, 1 mg
J0710	Injection, cephalirin sodium, up to 1 gm
J0715	Injection, ceftizoxime sodium, per 500 mg
J0795	Injection, corticorelin ovine triflutate, 1 microgram
J0889	Daprodustat, oral, 1 mg, (for ESRD on dialysis)
J1267	Injection, doripenem, 10 mg
J1330	Injection, ergonovine maleate, up to 0.2 mg
J1443	Injection, ferric pyrophosphate citrate solution (triferic), 0.1 mg of iron
J1444	Injection, ferric pyrophosphate citrate powder, 0.1 mg of iron
J1445	Injection, ferric pyrophosphate citrate solution (triferic avnu), 0.1 mg of iron
J1452	Injection, fomivirsen sodium, intraocular, 1.65 mg
J1457	Injection, gallium nitrate, 1 mg
J1562	Injection, immune globulin (vivaglobin), 100 mg
J1620	Injection, gonadorelin hydrochloride, per 100 mcg
J1655	Injection, tinzaparin sodium, 1,000 IU
J1710	Injection, hydrocortisone sodium phosphate, up to 50 mg
J1945	Injection, lepirudin, 50 mg
J2504	Injection, pegademase bovine, 25 IU
J2513	Injection, pentastarch, 10% solution, 100 ml
J2910	Injection, aurothioglucose, up to 50 mg
J2940	Injection, somatrem, 1 mg
J2995	Injection, streptokinase, per 250,000 IU
J3280	Injection, thiethylperazine maleate, up to 10 mg
J3305	Injection, trimetrexate glucuronate, per 25 mg

Code	Description
J3310	Injection, perphenazine, up to 5 mg
J3320	Injection, spectinomycin dihydrochloride, up to 2 gm
J3355	Injection, urofollitropin, 75 IU
J3364	Injection, urokinase, 5,000 IU vial
J3365	Injection, IV, urokinase, 250,000 I.U. vial
J3400	Injection, triflupromazine HCl, up to 20 mg
J7505	Muromonab-cd3, parenteral, 5 mg
J7513	Daclizumab, parenteral, 25 mg
J8562	Fludarabine phosphate, oral, 10 mg
J8650	Nabilone, oral, 1 mg
J9019	Injection, asparaginase (Erwinaze), 1,000 IU
J9020	Injection, asparaginase, not otherwise specified, 10,000 units
J9098	Injection, cytarabine liposome, 10 mg
J9151	Injection, daunorubicin citrate, liposomal formulation, 10 mg
J9165	Injection, diethylstilbestrol diphosphate, 250 mg
J9212	Injection, interferon alfacon-1, recombinant, 1 microgram
J9270	Injection, plicamycin, 2.5 mg
Q0174	Thiethylperazine maleate, 10 mg, oral, FDA-approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen
Q5109	Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg

Revised Code Descriptions

Code	Description
A4351	Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, or silicone elastomer, etc.), each
A4352	Intermittent urinary catheter; coude (curved) tip, with or without coating (Teflon, silicone, or silicone elastomeric, etc.), each



THE COMMONWEALTH OF MASSACHUSETTS

Secretary of the Commonwealth - William Francis Galvin

NOTICES OF PUBLIC REVIEW OF PROSPECTIVE REGULATIONS PUBLISHED IN COMPLIANCE WITH M.G.L. c. 30A, §§ 2 AND 3

June 5, 2026

Health and Human Services,
Executive Office of

101 CMR 358.00

6/17/26 @ 11:00 A.M. Written
testimony accepted until
6/17/26 @ 5:00 P.M.

101 CMR 410.00,
420.00 & 424.00

6/12/26 @ 9:30 A.M. (410.00),
10:30 A.M. (420.00) & 11:30
A.M. (424.00). Written
comments accepted until
6/12/26 by 5:00 P.M.

Center for Health Information
and Analysis

957 CMR 11.00

7/2/26 @ 10:00 A.M. Written
comments accepted until
7/13/26 by 5:00 P.M.

Purchased Services, Bureau of

808 CMR 1.00

6/17/26 @ 1:00 P.M. Written
comments accepted until
6/18/26 by 5:00 P.M.

**Commonwealth of Massachusetts
Executive Office of Health and Human Services**

NOTICE OF PUBLIC HEARING

Under the authority of M.G.L. c. 118E and in accordance with M.G.L. c. 30A, the Executive Office of Health and Human Services (EOHHS) will hold a remote public hearing on Wednesday, June 17, 2026, at 11:00 a.m. on the adoption of amendments to the following regulation.

101 CMR 358.00.00: Rates for Applied Behavior Analysis

The proposed regulation contains rates effective for dates of service on or after December 1, 2026. There is no fiscal impact on cities and towns.

Under M.G.L. Chapter 118E, Section 13D, EOHHS is required to establish and periodically review the rates to be paid by governmental units for non-institutional health care services, including applied behavior analysis (ABA) services provided under MassHealth. ABA services are an array of home- and community-based services for MassHealth members younger than 21 with a diagnosis of autism spectrum disorder or Down syndrome. EOHHS reviewed the rates in 101 CMR 358.00 and proposes to maintain the current rates.

EOHHS is proposing these amendments, subject to federal approval, to ensure that payment rates are consistent with efficiency, economy, and quality of care and to satisfy the requirements of M.G.L. 118E, Sections 13C and 13D. It is estimated that annual aggregate MassHealth expenditures will not change as a result of the proposed amendments. The amendments are not expected to impose new costs on small businesses, and any impact on small business providers will vary based on the volume of services provided.

To register to testify at the hearing and to get instructions on how to join the hearing online, go to mass.gov/service-details/executive-office-of-health-and-human-services-public-hearings. To join the hearing by phone, call (646) 558-8656 and enter meeting ID 935 397 8200# when prompted.

You may also submit written testimony instead of, or in addition to, live testimony. To submit written testimony, please email your testimony to ehs-regulations@mass.gov as an attached Word or PDF document or as text within the body of the email with the name of the regulation in the subject line. All written testimony must include the sender's full name, mailing address, and organization or affiliation, if any. Individuals who are unable to submit testimony by email should mail written testimony to EOHHS, c/o D. Briggs, 100 Hancock Street, 6th Floor, Quincy, MA 02171. Written testimony will be accepted through 5:00 p.m. on June 17, 2026. EOHHS specifically invites comments

as to how the amendments may affect beneficiary access to care for MassHealth-covered services.

To review the current draft of the proposed regulation, go to mass.gov/service-details/executive-office-of-health-and-human-services-public-hearings or request a copy in writing from MassHealth Publications, 100 Hancock Street, 6th Floor, Quincy, MA 02171.

Special accommodation requests may be directed to the Disability Accommodations Ombudsman by email at ADAaccommodations@mass.gov or by phone at (617) 847-3468 (TTY: (617) 847-3788 for people who are deaf, hard of hearing, or speech disabled). Please allow two weeks to schedule sign language interpreters.

EOHHS may adopt a revised version of the proposed regulation taking into account relevant comments and any other practical alternatives that come to its attention.

In case of inclement weather or other emergency, hearing cancellation announcements will be posted on the MassHealth website at mass.gov/service-details/executive-office-of-health-and-human-services-public-hearings.

May 22, 2026

Small Business Impact Statement

(As required by M.G.L. c. 30A §§ 2, 3 & 5)

CMR No and Title: 101 CMR 358.00, Rates for Applied Behavior Analysis

Estimate of the Number of Small Businesses Impacted by the Regulation: There are 197 providers governed by the proposed regulation.

Write Yes or No	Explain Briefly
No	Will small businesses have to create, file, or issue additional reports? No. Small businesses will not have to create, file, or issue additional reports as a result of the proposed amendments to 101 CMR 358.00.
No	Will small businesses have to implement additional recordkeeping procedures? No. Small businesses will not have to implement additional recordkeeping procedures as a result of the proposed amendments to 101 CMR 358.00.
No	Will small businesses have to provide additional administrative oversight? No. Small businesses are not required by 101 CMR 358.00 to provide additional administrative oversight. The proposed regulation establishes the rates to be paid by governmental units for applied behavior analysis (ABA) services.
No	Will small businesses have to hire additional employees in order to comply with the proposed regulation? No. 101 CMR 358.00 does not require small businesses to hire additional employees to comply.
No	Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)? No. Small businesses are not required by 101 CMR 358.00 to hire other employees to comply.
No	Does the regulation require small businesses to purchase a product or make any other capital investments in order to comply with the regulation? No. 101 CMR 358.00 does not require small businesses to purchase any particular product or make any capital investments.
No	Are performance standards more appropriate than design/operational standards to accomplish the regulatory objective? (Performance standards express requirements in terms of outcomes, giving the regulated party flexibility to achieve regulatory objectives and design/operational standards specify exactly what actions regulated parties must take.) No. Performance standards are not more appropriate than design or operational standards to accomplish the regulatory objective of establishing rates for health care services for the Executive Office of Health and Human Services, as the proposed regulation is required by statute under M.G.L. Chapter 118E, Section 13C.
No	Do any other regulations duplicate or conflict with the proposed regulation? No. No other regulations duplicate or conflict with the proposed regulation.
Yes	Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities? Yes. This regulation uniformly requires all providers to periodically file cost data.
No	Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements? No. Regulation 101 CMR 358.00 does not require small businesses to provide educational services to keep up to date with regulatory requirements..
No	Is the regulation likely to <i>deter</i> the formation of small businesses in Massachusetts? No. The proposed regulation is not likely to deter or encourage the formation of small businesses, as it establishes uniform governmental rates of payment for ABA.

Write Yes or No	Explain Briefly
No	<p>Is the regulation likely to <i>encourage</i> the formation of small businesses in Massachusetts?</p> <p>No. The proposed regulation is not likely to deter or encourage the formation of small businesses in Massachusetts, as it establishes uniform governmental rates of payment for ABA.</p>
No	<p>Does the regulation provide for less stringent compliance or reporting requirements for small businesses?</p> <p>No. The proposed regulation does not distinguish between small and other businesses.</p>
No	<p>Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses?</p> <p>No. The proposed regulation does not distinguish between small and other businesses.</p>
No	<p>Did the agency consolidate or simplify compliance or reporting requirements for small businesses?</p> <p>No. The proposed regulation does not distinguish between small and other businesses.</p>
No	<p>Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective?</p> <p>No. Distinguishing between small and other businesses would not be practicable to implement the proposed regulation.</p>
No	<p>Are there alternative regulatory methods that would minimize the adverse impact on small businesses?</p> <p>No. The proposed regulation does not have an adverse impact on small businesses.</p>

**Commonwealth of Massachusetts
Executive Office of Health and Human Services**

NOTICE OF PUBLIC HEARING

Under the authority of M.G.L. c. 118E and in accordance with M.G.L. c. 30A, the Executive Office of Health and Human Services (EOHHS) will hold three remote public hearings on Friday, June 12, 2026, at the respective times listed below, relative to the adoption of amendments to the following regulations.

Pursuant to M.G.L. Chapter 118E, Section 13D (f/k/a Chapter 257 of the Acts of 2008), EOHHS is required to establish and biennially review the rates to be paid by governmental units for social service programs. The proposed amendments update certain rates by a cost adjustment factor (CAF) of 3.00%. The CAF was determined by using baseline and prospective Massachusetts Economic Indicator data from IHS Economics – Fall 2025 Forecast, baseline scenario data. The CAF reflects the period between the rates' base period (calendar year 2026 Q2) and the prospective period of fiscal years 2027 and 2028. The rates for these services have been updated with the weighted average expenses from the FY24 Uniform Financial Statements and Independent Auditor's Reports (UFRs) for services' programmatic costs, where applicable. Staff salaries have been benchmarked to the Massachusetts Bureau of Labor Statistics (BLS) median wages as dated May 2024 at the 53rd percentile. The tax and fringe rate has been benchmarked to 24.97%. This benchmark is derived from the MA Comptrollers' FY25 approved rate less terminal leave and retirement. The administrative allocation has been benchmarked to 12%, consistent with other Chapter 257 programs.

The proposed regulations contain rates effective for dates of service on or after July 1, 2026. There is no fiscal impact on cities and towns.

1. 9:30 a.m.: 101 CMR 410.00: Rates for Competitive Integrated Employment Services

101 CMR 410.00 governs the payment rates for competitive integrated employment services provided to publicly aided individuals by governmental units. These services are purchased by the Massachusetts Commission for the Blind (MCB), MassAbility (MBY), and the Department of Transitional Assistance (DTA).

A new level of retention supports, sustained employment supports, is being introduced by DTA and is supported by the other purchasing agencies. This new service will give the providers more flexibility and options to help attract and retain staffing.

The total annualized cost to state government from the proposed amendments to this regulation is approximately \$2.39 million, which represents an increase of 9.77% over FY25 spending of approximately \$24.48 million. The increase in spending in FY27 will be covered through a combination of the Chapter 257 Reserve Account and the purchasing departments' FY27 budgets.

2. 10:30 a.m.: 101 CMR 420.00: Rates for Adult Long-Term Residential Services

101 CMR 420.00 governs the payment rates for adult long-term residential services provided to publicly aided individuals by governmental units. These services are purchased by the Department of Developmental Services (DDS), the Massachusetts Commission for the Blind (MCB), and MassAbility (MBY).

The geographic regions, now called occupancy rate zones, have been expanded from four areas to five to include a new "Cape and Islands" region that will help agencies and providers service their communities more effectively.

The total annualized cost to state government from the proposed amendments to this regulation is approximately \$188.6 million, which represents an increase of 8.92% over FY25 spending of approximately \$2.11 billion on these services. Of this amount, the estimated annualized cost to DDS is \$185,606,442; the estimated annualized cost to MCB is \$2,017,065; and the estimated annualized cost to MBY is \$957,773. The increase in spending in FY27 will be covered through the Chapter 257 Reserve Account.

3. 11:30 a.m.: 101 CMR 424.00: Rates for Certain Developmental and Support Services

101 CMR 424.00 governs the rates paid by governmental units for certain developmental and support services provided to publicly aided individuals. These services are purchased by the Department of Developmental Services (DDS) and MassAbility (MBY).

At this time, only the rates for corporate representative payee and remote supports and monitoring are being updated.

The total annualized cost to state government from the proposed amendments to this regulation is approximately \$265,446, which represents an increase of 7.03% over FY25 spending of approximately \$3.77 million. The increase in spending in FY27 will be covered through the Chapter 257 Reserve Account.

To register to testify at the hearings and to get instructions on how to join the hearings online, go to www.mass.gov/info-details/executive-office-of-health-and-human-services-public-hearings. To join the hearings by phone, call (646) 558-8656 and enter meeting ID 935 397 8200# when prompted.

You may also submit written testimony instead of, or in addition to, live testimony. To submit written testimony, please email your testimony to ehs-regulations@mass.gov as an attached Word or PDF document or as text within the body of the email with the name of the regulation in the subject line. All written testimony must include the sender's full name, mailing address, and organization or affiliation, if any. Individuals who are unable to submit testimony by email should mail written testimony to EOHHS, c/o D. Briggs, 100 Hancock Street, 6th Floor, Quincy, MA 02171. Written testimony will be accepted through 5:00 p.m. on Friday, June 12, 2026. EOHHS specifically invites comments as to how the amendments may affect beneficiary access to care for MassHealth-covered services.

To review the current drafts of the proposed regulations, go to www.mass.gov/info-details/executive-office-of-health-and-human-services-public-hearings or request a copy in writing from MassHealth Publications, 100 Hancock Street, 6th Floor, Quincy, MA 02171. To view or download related supporting materials, go to www.mass.gov/info-details/proposed-regulations-supporting-materials.

Special accommodation requests may be directed to the Disability Accommodations Ombudsman by email at ADAaccommodations@mass.gov or by phone at (617) 847-3468 (TTY: (617) 847-3788 for people who are deaf, hard of hearing, or speech disabled). Please allow two weeks to schedule sign language interpreters.

EOHHS may adopt a revised version of the proposed regulations taking into account relevant comments and any other practical alternatives that come to its attention.

In case of inclement weather or other emergency, hearing cancellation announcements will be posted on the MassHealth website at www.mass.gov/info-details/executive-office-of-health-and-human-services-public-hearings.

May 22, 2026

Small Business Impact Statement
(As required by M.G.L. c. 30A §§ 2, 3 & 5)

CMR No and Title: 101 CMR 410.00: Rates for Competitive Integrated Employment Services
Estimate of the Number of Small Businesses Impacted by the Regulation: 27

Write Yes or No	Explain Briefly
No	Will small businesses have to create, file, or issue additional reports? No. Small businesses will not have to create, file, or issue additional reports as a result of the proposed amendments to this regulation.
No	Will small businesses have to implement additional recordkeeping procedures? No. Small businesses will not have additional responsibilities to keep records as a result of the proposed amendments to this regulation.
No	Will small businesses have to provide additional administrative oversight? No. Small businesses are not required by this regulation to provide additional administrative oversight as a result of the proposed amendments to this regulation.
No	Will small businesses have to hire additional employees in order to comply with the proposed regulation? No. This regulation does not require small businesses to hire additional employees to remain in compliance.
No	Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)? No. Small businesses are not required by this regulation to hire other professionals.
No	Does the regulation require small businesses to purchase a product or make any other capital investments in order to comply with the regulation? No. This regulation does not require small businesses to purchase any particular product or make any capital investments.
No	Are performance standards more appropriate than design/operational standards to accomplish the regulatory objective? (Performance standards express requirements in terms of outcomes, giving the regulated party flexibility to achieve regulatory objectives and design/operational standards specify exactly what actions regulated parties must take.) No. The regulation is required by statute under M.G.L. Chapter 118E, Section 13D and establishes the rates to be paid by governmental units to providers of certain social service programs.
No	Do any other regulations duplicate or conflict with the proposed regulation? No regulations duplicate or conflict with this regulation.
Yes	Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities? Yes. The regulation requires providers to periodically file cost data to enable EOHHS to develop rates for certain social service programs. The requirement to report cost data to EOHHS is applied uniformly to enable EOHHS to timely develop accurate rates that reflect cost data from all providers.
No	Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements? No. This regulation does not require small businesses to provide educational services to keep up to date with the regulatory requirements.
No	Is the regulation likely to <i>deter</i> the formation of small businesses in Massachusetts?

Write Yes or No	Explain Briefly
	No. The regulation is not likely to deter or encourage the formation of small businesses in Massachusetts as this regulation establishes rates by which providers of certain social service programs are to be paid when services are purchased by governmental units.
No	Is the regulation likely to <i>encourage</i> the formation of small businesses in Massachusetts? No. The regulation is not likely to deter or encourage the formation of small businesses in Massachusetts as this regulation establishes rates by which providers of certain social service programs are to be paid when services are purchased by governmental units.
No	Does the regulation provide for less stringent compliance or reporting requirements for small businesses? No. The regulation contains requirements to report cost data to EOHHS to enable EOHHS to develop rates for certain social services. This cost reporting requirement is applied uniformly to all providers to enable EOHHS to develop accurate rates that reflect cost data from all providers.
No	Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses? No. The regulation contains requirements to report cost data to EOHHS to enable EOHHS to develop rates for certain social services. The time frame for cost reporting is applied uniformly to all providers to enable EOHHS to timely develop accurate rates that reflect cost data from all providers.
No	Did the agency consolidate or simplify compliance or reporting requirements for small businesses? No. The agency did not consolidate or simplify compliance or reporting requirements for small businesses. The requirement to report cost data to EOHHS is applied uniformly to enable EOHHS to timely develop accurate rates that reflect cost data from all providers.
No	Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective? No. The establishment of rates for certain social service providers by regulation is a statutory requirement under M.G.L. Chapter 118E, Section 13D.
No	Are there alternative regulatory methods that would minimize the adverse impact on small businesses? No. The regulation does not have an adverse impact on small businesses. The regulation establishes rates by which certain social service providers are to be paid when services are purchased by governmental units. The establishment of rates for these social services by regulation is a statutory requirement under M.G.L. Chapter 118E, Section 13D.

Small Business Impact Statement
(As required by M.G.L. c. 30A §§ 2, 3 & 5)

CMR No and Title: 101 CMR 420.00: *Rates for Adult Long-Term Residential Services*
Estimate of the Number of Small Businesses Impacted by the Regulation: 200

Write Yes or No	Explain Briefly
No	Will small businesses have to create, file, or issue additional reports? No. Small businesses will not have to create, file, or issue additional reports as a result of the proposed regulation.
No	Will small businesses have to implement additional recordkeeping procedures? No. Small businesses will not have additional responsibilities to keep records as a result of the proposed regulation.
No	Will small businesses have to provide additional administrative oversight? No. Small businesses are not required by this regulation to provide additional administration oversight as a result of the proposed regulation.
No	Will small businesses have to hire additional employees in order to comply with the proposed regulation? No. This regulation does not require small businesses to hire additional employees to remain in compliance.
No	Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)? No. Small businesses are not required by this regulation to hire other professionals.
No	Does the regulation require small businesses to purchase a product or make any other capital investments in order to comply with the regulation? No. This regulation does not require small businesses to purchase any particular product or make any capital investments.
No	Are performance standards more appropriate than design/operational standards to accomplish the regulatory objective? (Performance standards express requirements in terms of outcomes, giving the regulated party flexibility to achieve regulatory objectives and design/operational standards specify exactly what actions regulated parties must take.) No. The regulation is required by statute under M.G.L. Chapter 118E, Section 13D, and establishes the rates to be paid by governmental units to providers of certain social service programs.
No	Do any other regulations duplicate or conflict with the proposed regulation? No regulations duplicate or conflict with this regulation.
Yes	Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities? Yes. The regulation requires providers to periodically file cost data to enable EOHHS to develop rates for certain social service programs. This cost reporting requirement is applied uniformly to all providers to enable EOHHS to develop accurate rates that reflect cost data from all providers.
No	Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements? No. This regulation does not require small businesses to provide educational services to keep up to date with the regulatory requirements.
No	Is the regulation likely to <i>deter</i> the formation of small businesses in Massachusetts?

Write Yes or No	Explain Briefly
	No. The regulation is not likely to deter or encourage the formation of small businesses in Massachusetts as this regulation establishes rates by which providers of certain social service programs are to be paid when services are purchased by governmental units.
No	Is the regulation likely to <i>encourage</i> the formation of small businesses in Massachusetts? No. The regulation is not likely to deter or encourage the formation of small businesses in Massachusetts as this regulation establishes rates by which providers of certain social service programs are to be paid when services are purchased by governmental units.
No	Does the regulation provide for less stringent compliance or reporting requirements for small businesses? No. The regulation contains requirements to report cost data to EOHHS to enable EOHHS to develop rates for certain social services. This cost reporting requirement is applied uniformly to all providers to enable EOHHS to develop accurate rates that reflect cost data from all providers.
No	Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses? No. The regulation contains requirements to report cost data to EOHHS to enable EOHHS to develop rates for certain social services. The time frame for cost reporting is applied uniformly to all providers to enable EOHHS to timely develop accurate rates that reflect cost data from all providers.
No	Did the agency consolidate or simplify compliance or reporting requirements for small businesses? No. The agency did not consolidate or simplify compliance or reporting requirements for small businesses. The requirement to report cost data to EOHHS is applied uniformly to enable EOHHS to timely develop accurate rates that reflect cost data from all providers.
No	Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective? No. The establishment of rates for certain social service providers by regulation is a statutory requirement under M.G.L. Chapter 118E, Section 13D.
No	Are there alternative regulatory methods that would minimize the adverse impact on small businesses? No. The regulation does not have an adverse impact on small businesses. The regulation establishes rates by which certain social service providers are to be paid when services are purchased by governmental units. The establishment of rates for these social services by regulation is a statutory requirement under M.G.L. Chapter 118E, Section 13D.

Small Business Impact Statement
(As required by M.G.L. c. 30A §§ 2, 3 & 5)

CMR No and Title: 101 CMR 424.00: *Rates for Certain Developmental and Support Services*
Estimate of the Number of Small Businesses Impacted by the Regulation: 79

Write Yes or No	Explain Briefly
No	Will small businesses have to create, file, or issue additional reports? No. Small businesses will not have to create, file, or issue additional reports as a result of the proposed regulation.
No	Will small businesses have to implement additional recordkeeping procedures? No. Small businesses will not have additional responsibilities to keep records as a result of the proposed regulation.
No	Will small businesses have to provide additional administrative oversight? No. Small businesses are not required by this regulation to provide additional administration oversight as a result of the proposed regulation.
No	Will small businesses have to hire additional employees in order to comply with the proposed regulation? No. This regulation does not require small businesses to hire additional employees to remain in compliance.
No	Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)? No. Small businesses are not required by this regulation to hire other professionals.
No	Does the regulation require small businesses to purchase a product or make any other capital investments in order to comply with the regulation? No. This regulation does not require small businesses to purchase any particular product or make any capital investments.
No	Are performance standards more appropriate than design/operational standards to accomplish the regulatory objective? (Performance standards express requirements in terms of outcomes, giving the regulated party flexibility to achieve regulatory objectives and design/operational standards specify exactly what actions regulated parties must take.) No. The regulation is required by statute under M.G.L. Chapter 118E, Section 13D, and establishes the rates to be paid by governmental units to providers of certain social service programs.
No	Do any other regulations duplicate or conflict with the proposed regulation? No regulations duplicate or conflict with this regulation.
Yes	Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities? Yes. The regulation requires providers to periodically file cost data to enable EOHHS to develop rates for certain social service programs. This cost reporting requirement is applied uniformly to all providers to enable EOHHS to develop accurate rates that reflect cost data from all providers.
No	Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements? No. This regulation does not require small businesses to provide educational services to keep up to date with the regulatory requirements.
No	Is the regulation likely to <i>deter</i> the formation of small businesses in Massachusetts?

Write Yes or No	Explain Briefly
	No. The regulation is not likely to deter or encourage the formation of small businesses in Massachusetts as this regulation establishes rates by which providers of certain social service programs are to be paid when services are purchased by governmental units.
No	Is the regulation likely to <i>encourage</i> the formation of small businesses in Massachusetts? No. The regulation is not likely to deter or encourage the formation of small businesses in Massachusetts as this regulation establishes rates by which providers of certain social service programs are to be paid when services are purchased by governmental units.
No	Does the regulation provide for less stringent compliance or reporting requirements for small businesses? No. The regulation contains requirements to report cost data to EOHHS to enable EOHHS to develop rates for certain social services. This cost reporting requirement is applied uniformly to all providers to enable EOHHS to develop accurate rates that reflect cost data from all providers.
No	Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses? No. The regulation contains requirements to report cost data to EOHHS to enable EOHHS to develop rates for certain social services. The time frame for cost reporting is applied uniformly to all providers to enable EOHHS to timely develop accurate rates that reflect cost data from all providers.
No	Did the agency consolidate or simplify compliance or reporting requirements for small businesses? No. The agency did not consolidate or simplify compliance or reporting requirements for small businesses. The requirement to report cost data to EOHHS is applied uniformly to enable EOHHS to timely develop accurate rates that reflect cost data from all providers.
No	Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective? No. The establishment of rates for certain social service providers by regulation is a statutory requirement under M.G.L. Chapter 118E, Section 13D.
No	Are there alternative regulatory methods that would minimize the adverse impact on small businesses? No. The regulation does not have an adverse impact on small businesses. The regulation establishes rates by which certain social service providers are to be paid when services are purchased by governmental units. The establishment of rates for these social services by regulation is a statutory requirement under M.G.L. Chapter 118E, Section 13D.



NOTICE OF PUBLIC HEARING

Pursuant to the provisions of M.G.L. c. 12C and in accordance with M.G.L. c. 30A, the Center for Health Information and Analysis (CHIA) will hold a **remote public hearing on Thursday, July 2, 2026 at 10:00 A.M.** relative to the adoption of amendments to the following regulation:

957 CMR 11.00 – REGISTERED PROVIDER ORGANIZATION REPORTING REQUIREMENTS

957 CMR 11.00 governs reporting requirements for Registered Provider Organizations. The proposed amendments to 957 CMR 11.00 add reporting requirements consistent with changes made to M.G.L. c. 12C § 9 by Chapter 343 of the Acts of 2024. The proposed amendments also align the regulation's penalty language with changes made to M.G.L. c. 12C, § 11 by Chapter 343 of the Acts of 2024. Finally, the proposed amendments clarify CHIA's process for providing detailed data reporting specifications to reporting entities.

It is anticipated that entities covered by this regulation will incur no additional administrative costs resulting from the proposed new regulation. The amended regulation will have no fiscal impact on cities and towns and will have no fiscal impact on small businesses.

If you plan to testify at the hearing, CHIA strongly encourages you to register in advance by emailing regulations@chiamass.gov. Individuals may also submit written testimony to the same email address. Please include the name of the regulation in the subject line of your email. All submissions must include the sender's full name, mailing address, and organization or affiliation (if applicable). Individuals who are unable to submit testimony by email should mail written testimony to the Center for Health Information and Analysis, 501 Boylston Street, Suite 5100, Boston, MA 02116. Written testimony must be submitted by 5:00 P.M. on Monday, July 13, 2026. This notice and copies of the proposed regulations may be viewed on CHIA's website at www.chiamass.gov/regulations.

To join the remote hearing online, go to:

<https://us02web.zoom.us/j/88230583797?pwd=Tjs6NRF6eHGOwPX95xfkuhtKmqszJ0.1>, and enter Meeting ID: 882 3058 3797 and Passcode: 108158.

To join the remote hearing by phone, call 1-646-518-9805 or 1-646-558-8656, and enter Meeting ID: 882 3058 3797 and Password: 108158 when prompted.

SMALL BUSINESS IMPACT STATEMENT

In order to accurately predict the impact the adoption, amendment, or repeal of a regulation will have on small businesses, the promulgating authority must conduct a thorough analysis that not only considers the potential effects of the action but also quantifies the costs, if any, associated with each. The questions below are designed to aid promulgating authorities in conducting their analysis.

Agency Submitting Regulation: Center for Health Information and Analysis (“CHIA”).

Subject Matter of Regulation: Registered Provider Organization Reporting Requirements; Monetary Penalties.

Regulation No: 957 C.M.R. 11.00.

Statutory Authority: M.G.L. c. 12C.

Other Agencies Affected: Health Policy Commission and other government agencies.

Other Regulations That May Duplicate or Conflict with the Regulation: None.

Describe the Scope and Objectives of the Regulation: 957 CMR 11.00 governs reporting requirements for Registered Provider Organizations. The proposed amendments to 957 CMR 11.00 add reporting requirements consistent with changes made to M.G.L. c. 12C § 9 by Chapter 343 of the Acts of 2024. The proposed amendments also align the regulation’s penalty language with changes made to M.G.L. c. 12C, § 11 by Chapter 343 of the Acts of 2024. Finally, the proposed amendments clarify CHIA’s process for providing detailed data reporting specifications to reporting entities.

Business Industry(ies) Affected by the Regulation: Health care.

Types of Businesses Included in the Industry(ies): Registered Provider Organizations who are required to submit data to CHIA pursuant to M.G.L. c. 12C, § 9.

Total Number of Small Businesses Included in the Regulated Industry(ies) *Please see the attached guidance documents for assistance determining the total number of small businesses:* None.

Number of Small Businesses Potentially Subject to the Proposed Regulation: None.

Effective Date Used In Cost Estimate: May 22, 2026

Yes	No	<i>*Note: For each question, please answer “yes” or “no” and offer a brief explanation. Please describe any facts, data, views, arguments, or other input from small businesses, organizations or any other sources that were used to quantify the impacts outlined below.</i>
Yes <input type="checkbox"/>	No x	Will small businesses have to create, file, or issue additional reports? No. The proposed regulation will not require small businesses to create, file, or issue additional reports.
Yes <input type="checkbox"/>	No x	Will small businesses have to implement additional recordkeeping procedures? No. The proposed regulation will not require small businesses to implement additional recordkeeping procedures.

Yes <input type="checkbox"/>	No x	Will small businesses have to provide additional administrative oversight? No. The proposed regulation will not require small businesses to provide additional administrative oversight.
Yes <input type="checkbox"/>	No x	Will small businesses have to hire additional employees in order to comply with the proposed regulation? No. The proposed regulation will not require small businesses to hire additional employees in order to comply with the proposed regulation.
Yes <input type="checkbox"/>	No x	Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)? No. The proposed regulation will not require small businesses to hire other professionals.
Yes <input type="checkbox"/>	No x	Does the regulation require small businesses to purchase a product or make any other capital investments in order to comply with the regulation? No. The proposed regulation will not require small businesses to purchase a product or make any other capital investments in order to comply with the regulation.
Yes <input type="checkbox"/>	No x	Are performance standards more appropriate than design standards? No. The proposed regulation creates uniform data reporting standards for each entity in a given category of data submitter to ensure Massachusetts has consistent, comprehensive health care databases.
Yes <input type="checkbox"/>	No x	Does the regulation require small businesses to cooperate with audits, inspections, or other regulatory enforcement activities? No. The proposed regulation will not require small businesses to cooperate with audits, inspections, or other regulatory enforcement activities.
Yes <input type="checkbox"/>	No x	Will the regulation have the effect of creating additional taxes and/or fees for small businesses? No. The proposed regulation will not create additional taxes and/or fees for small businesses.
Yes <input type="checkbox"/>	No x	Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements? No. The proposed regulation will not require small businesses to provide educational services to keep up to date with regulatory requirements.
Yes <input type="checkbox"/>	No x	Is the regulation likely to <i>deter</i> the formation of small businesses in Massachusetts? No. The proposed regulation is not likely to deter the formation of small businesses.
Yes <input type="checkbox"/>	No x	Is the regulation likely to <i>encourage</i> the formation of small businesses in Massachusetts? No. The proposed regulation is not likely to encourage the formation of small businesses.
Yes <input type="checkbox"/>	No x	Can the regulation provide for less stringent compliance or reporting requirements for small businesses? No. The proposed regulation applies uniform reporting requirements to each entity in a given category of data submitter to ensure Massachusetts has consistent, comprehensive health care databases.
Yes <input type="checkbox"/>	No x	Can the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses?

		No. The proposed regulation applies uniform schedules for each entity in a given category of data submitter to ensure Massachusetts has consistent, comprehensive health care databases.
Yes <input type="checkbox"/>	No x	Can the compliance or reporting requirements be consolidated or simplified for small businesses? No. The proposed regulation applies uniform reporting requirements to each entity in a given category of data submitter to ensure Massachusetts has consistent, comprehensive health care databases.
Yes <input type="checkbox"/>	No x	Can performance standards for small businesses replace design or operational standards? No. The proposed regulation creates uniform data reporting standards for each entity in a given category of data submitter to ensure Massachusetts has consistent, comprehensive health care databases.
Yes <input type="checkbox"/>	No x	Are there alternative regulatory methods that would minimize the adverse impact on small businesses? No. The proposed regulation is not expected to have an adverse impact on small businesses.
Yes <input type="checkbox"/>	No x	Were any small businesses or small business organizations contacted during the preparation of this document? If so, please describe. No. The proposed regulation is not expected to affect small businesses.

Mark S. Fine
Assistant Secretary
for Operational Services

Maura Healey, Governor
Kim Driscoll, Lieutenant Governor
Matthew Gorzkowicz, Secretary

NOTICE OF PUBLIC HEARING AND COMMENT PERIOD
808 CMR 1.00 (Compliance, Reporting and Auditing
for Human and Social Services)

Notice is hereby given pursuant to M.G.L. c. 30A, §§ 2, 3 that the Operational Services Division (OSD), *Bureau of Purchased Services* will hold a public hearing and comment period on the proposed amendments to 808 CMR 1.00 (Compliance, Reporting and Auditing for Human and Social Services).

A hybrid public hearing will be held on Wednesday, June 17, 2026, at 1:00 pm in Conference Room E located on the 2nd Floor of One Ashburton Place, Boston, MA 02108 and virtually using this link:

Zoom Link: [Proposed Amendments to 808 CMR 1.00](#)

Both verbal and written testimony may be presented at the public hearing. Written comments will be accepted until 5:00pm on Thursday, June 18, 2026. All written testimony must include the sender's full name, email or mailing address, and organization or affiliation, if any.

Please submit written comments electronically to OSDLegal@mass.gov or via mail to:

The Operational Services Division
One Ashburton Place, Room 1608
Boston, Massachusetts 02108

All written comments submitted to OSD are a public record in their entirety and will be provided in response to a public records request.

A copy of the proposed regulation may be viewed on [OSD's website](#) or obtained from OSD Legal by sending a request via e-mail to OSDLegal@mass.gov.

Initial Small Business Impact Statement

(As required by M.G.L. c.30A, §§ 2, 3 & 5)

Agency: Operational Services Division - *Bureau of Purchased Services*

CMR No: 808 CMR 1.00: Compliance, Reporting and Auditing for Human and Social Services

Estimate of the Number of Small Businesses Impacted by the Regulation: Approximately 50 – There are approximately 1,000 filers, of which the majority are non-profit organizations.

- **Will small businesses have to create, file, or issue additional reports?**

Yes. The regulation currently includes reporting requirements for Departments, Contractors, and Subcontractors. The amendment requires Contractors and Subcontractors, when a price authorization or price adjustment is requested, to report in their property inventory which items are environmentally preferable products (EPP) and must include EPP specifications in procurements for building repair, construction, or renovation and purchase of major appliances.

- **Will small businesses have to implement additional recordkeeping procedures?**

Yes. The regulation currently includes recordkeeping for Departments, Contractors, and Subcontractors. The amendment requires recordkeeping, when a price authorization or price adjustment is requested, to note in their property inventory which items are environmentally preferable products (EPP) and must include EPP specifications in procurements for building repair, construction, or renovation and purchase of major appliances.

- **Will small businesses have to provide additional administrative oversight?**

Yes. Additional oversight will be required for Departments, Contractors, and Subcontractors to ensure that EPP documentation is included when requesting price authorizations for new and reconstructed approved private school programs or price adjustments.

- **Will small businesses have to hire additional employees in order to comply with the proposed regulation?**

No. It is not anticipated that this additional recordkeeping/reporting requirement related to environmentally preferable products will require additional staffing in order to comply.

- **Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)?**

No. It is not anticipated that this additional recordkeeping/reporting requirement related to environmentally preferable products will require professional assistance beyond what is currently required to file a Uniform Financial Report.

- **Does the regulation require small businesses to purchase a product or make any other capital investments in order to comply with the regulation?**

No. It is not anticipated that this additional recordkeeping/reporting requirement related to environmentally preferable products will require small businesses to purchase a product or make capital investments.

- **Are performance standards more appropriate than design/operational standards to accomplish the regulatory objective? (Performance standards express requirements in terms of outcomes,**

giving the regulated party flexibility to achieve regulatory objectives and design/operational standards specify exactly what actions regulated parties must take.)

No. The amendment to the regulations is necessary so that Departments can more readily comply with Executive Order 515: Establishing an Environmental Purchasing Policy, requiring Commonwealth Departments to reduce their impact on the environment and enhance public health by procuring EPPs whenever they are readily available, perform to satisfactory standards, and represent best value to the Commonwealth and Executive Order 594: Leading By Example: Decarbonizing and Minimizing Environmental Impacts of State Government.

- **Do any other regulations duplicate or conflict with the proposed regulation?**

No. There are no duplicative or conflicting regulations. OSD's Bureau of Purchased Services has the authority to issue and amend these regulations pursuant to M.G.L. c. 7, § 22N.

- **Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities?**

Yes. The regulation currently includes provisions authorizing audits for Departments, Contractors, and Subcontractors. The amended regulation does not impose additional audits or inspections. The amended regulation imposes additional requirements related to environmentally preferable products.

- **Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements?**

No. It is not anticipated that this additional recordkeeping/reporting requirement related to environmentally preferable products will require small businesses to provide educational services. OSD will provide training related to this new regulatory requirement.

- **Is the regulation likely to deter the formation of small businesses in Massachusetts?**

No. It is not anticipated that this additional recordkeeping/reporting requirement related to environmentally preferable products will deter the formation of small businesses in Massachusetts.

- **Is the regulation likely to encourage the formation of small businesses in Massachusetts?**

No. It is not anticipated that this additional recordkeeping/reporting requirement related to environmentally preferable products will encourage the formation of small businesses in Massachusetts.

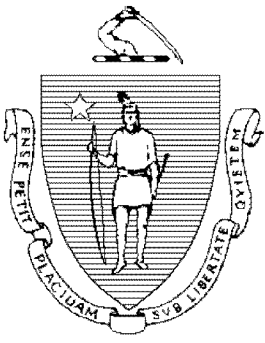
- **Does the regulation provide for less stringent compliance or reporting requirements for small businesses?**

No. The regulation currently includes reporting requirements for Departments, Contractors, and Subcontractors. The amendment requires Contractors and Subcontractors, when a price authorization or price adjustment is requested, to report in their property inventory which items are environmentally preferable products (EPP) and must include EPP specifications in procurements for building repair, construction, or renovation and purchase of major appliances.

- **Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses?**

No. The regulation currently includes reporting requirements for Departments, Contractors, and Subcontractors, including small businesses. The deadlines and schedules for reporting remain unchanged.

- **Did the agency consolidate or simplify compliance or reporting requirements for small businesses?**
No. The regulation currently includes reporting requirements for Departments, Contractors, and Subcontractors, including small businesses.
- **Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective?**
No. The purpose of 801 CMR 21.00 is to provide all Departments with uniform rules and standards governing the Procurement of Commodities or Services, or both, including Human and Social Services for Clients. The amendment to the regulations is necessary so that Departments can more readily comply with Executive Order 515: Establishing an Environmental Purchasing Policy, requiring Commonwealth Departments to reduce their impact on the environment and enhance public health by procuring EPPs whenever they are readily available, perform to satisfactory standards, and represent best value to the Commonwealth and Executive Order 594: Leading By Example: Decarbonizing and Minimizing Environmental Impacts of State Government.
- **Are there alternative regulatory methods that would minimize the adverse impact on small businesses?**
No. The purpose of 801 CMR 21.00 is to provide all Departments with uniform rules and standards governing the Procurement of Commodities or Services, or both, including Human and Social Services for Clients. The amendment to the regulations is necessary so that Departments can more readily comply with Executive Order 515: Establishing an Environmental Purchasing Policy, requiring Commonwealth Departments to reduce their impact on the environment and enhance public health by procuring EPPs whenever they are readily available, perform to satisfactory standards, and represent best value to the Commonwealth and Executive Order 594: Leading By Example: Decarbonizing and Minimizing Environmental Impacts of State Government.



THE COMMONWEALTH OF MASSACHUSETTS
Secretary of the Commonwealth - William Francis Galvin

2026 CUMULATIVE TABLE TO THE MASSACHUSETTS REGISTER
1565 - 1575

The Cumulative Tables lists all regulations and amendments thereto published in the Massachusetts Register during the current year. The Table is published in each Register.

State agencies are listed in the Table as they appear in the Code of Massachusetts Regulations (CMR or Code) in CMR numerical order which is based on the cabinet structure. For example, all Human Service agencies are prefaced by the number "1" and are designated as 101 CMR through 130 CMR.

The Cumulative Tables published in the last issue of previous years will have a listing of all regulations published for that year. These Registers are:

April 6, 1976 - 1977	Register: # 88	Date: 2004	Register: #1016
1978	138	2005	1042
1979	193	2006	1068
1980	241	2007	1094
1981	292	2008	1120
1982	344	2009	1146
1983	396	2010	1172
1984	448	2011	1198
1985	500	2012	1224
1986	546	2013	1250
1987	572	2014	1276
1988	598	2015	1302
1989	624	2016	1329
1990	650	2017	1355
1991	676	2018	1381
1992	702	2019	1407
1993	729	2020	1433
1994	755	2021	1459
1995	871	2022	1485
1996	Supp. # 2 807	2023	1511
1997	833	2024	1537
1998	859	2025	1563
1999	885		
2000	911		
2001	937		
2002	963		
2003	989		

		<u>Issue</u>	<u>Effective Date</u>
101 CMR	Executive Office of Health and Human Services		
204.00	Rates of Payment to Resident Care Facilities		
	- <i>Emergency Refile</i> (MA Reg. # 1563)	1569	12/5/25
	- <i>Compliance</i> (MA Reg. # 1563)	1572	12/5/25
206.00	Standard Payments to Nursing Facilities		
	- <i>Emergency Refile</i> (MA Reg. # 1559)	1564	10/1/25
	. . . . .	1567	2/13/26
307.00	Rates for Psychiatric Day Treatment Center Services	1569	3/13/26
317.00	Rates for Medicine Services - <i>Emergency Refile</i> (MA Reg. # 1561) . .	1567	11/7/25
	. . . . .	1573	5/8/26
322.00	Rates for Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment.	1568	3/1/26
327.00	Rates for Ambulance and Wheelchair Van Services		
	- <i>Emergency Refile</i> (MA Reg. # 1557)	1564	9/26/25
	- <i>Compliance</i> (MA Reg. # 1557)	1570	9/26/25
	- <i>Correction</i> (MA Reg. # 1557)	1571	9/26/25
347.00	Rates for Freestanding Ambulatory Surgery Center Services	1572	4/24/26
349.00	Rates for Early Intervention Program Services		
	- <i>Future Effective Regulation</i>	1565	7/1/26
355.00	Rates for Freestanding Birth Center Services.	1567	2/13/26
414.00	Rates for Family Stabilization Services	1574	5/22/26
416.00	Rates for Clubhouse Services.	1574	5/22/26
417.00	Rates for Certain Elder Care Services	1570	3/27/26
422.00	Rates for General Programs Disability Services	1574	5/22/26
614.00	Health Safety Net Payments and Funding		
	- <i>Emergency Refile</i> (MA Reg. # 1559)	1564	9/30/25
	. . . . .	1569	3/13/26
105 CMR	Department of Public Health		
125.000	Licensing of Radiologic Technologists	1564	1/2/26
	- <i>Correction</i> (MA Reg. # 1564)	1567	1/2/26
270.000	Blood Screening of Newborns for Treatable Diseases and Disorders .	1575	6/5/26
775.000	Certified Medication Aides in Long-term Care Facilities	1567	2/13/26
110 CMR	Department of Children and Families		
2.00	Glossary	1571	4/10/26
7.000	Services - <i>Emergency</i>	1564	12/12/25
	- <i>Compliance</i> (MA Reg. # 1564)	1570	12/12/25
124 CMR	Massachusetts Office for Victim Assistance		
2.00	Compensation for Victims of Violent Crimes		
	- <i>Compliance</i> (MA Reg. # 1554)	1564	8/4/25
	- <i>Correction</i> (MA Reg. # 1564)	1565	8/4/25

		<u>Issue</u>	<u>Effective Date</u>
130 CMR	Division of Medical Assistance		
449.000	Correctional Facility Services - <i>Emergency Refile</i> (MA Reg. # 1561).	1567	11/7/25
	- <i>Emergency Refile</i> (MA Reg. # 1561)	1573	11/7/25
501.000	Health Care Reform: MassHealth: General Policies	1567	2/13/26
502.000	Health Care Reform: MassHealth: The Eligibility Process	1567	2/13/26
503.000	Health Care Reform: MassHealth: Universal Eligibility Requirements	1567	2/13/26
505.000	Health Care Reform: MassHealth: Coverage Types.	1567	2/13/26
506.000	MassHealth: Financial Requirements	1566	1/30/26
	- <i>Correction</i> (MA Reg. # 1566)	1568	1/30/26
515.000	MassHealth: General Policies	1567	2/13/26
516.000	MassHealth: The Eligibility Process	1567	2/13/26
	- <i>Correction</i> (MA Reg. # 1567)	1569	2/13/25
517.000	MassHealth: Universal Eligibility Requirements	1567	2/13/26
519.000	MassHealth: Coverage Types	1567	2/13/26
522.000	MassHealth: Other Division Programs	1567	2/13/26
205 CMR	Massachusetts Gaming Commission		
3.00	Harness Horse Racing - <i>Emergency</i>	1571	3/27/26
101.00	M.G.L. c. 23K Adjudicatory Proceedings	1572	4/24/26
116.00	Persons Required to Be Licensed or Qualified.	1569	3/13/26
133.00	Voluntary Self-exclusion	1574	5/22/26
134.00	Licensing and Registration of Employees, Vendors, Junket Enterprises and Representatives, and Labor Organizations	1572	4/24/26
138.00	Uniform Standards of Accounting Procedures and Internal Controls - <i>Correction</i> (MA Reg. # 1492)	1571	3/9/23
147.00	Uniform Standards of Rules of the Games.	1574	5/22/26
149.00	Race Horse Development Fund	1572	4/24/26
234.00	Sports Wagering Vendors - <i>Compliance</i> (MA Reg. # 1560)	1564	10/24/25
238.00	Additional Uniform Standards of Accounting Procedures and Internal Controls for Sports Wagering.	1569	3/13/26
	- <i>Correction</i> (MA Reg. # 1569)	1571	3/13/26
	. . . . .	1572	4/24/26
239.00	Continuing Disclosure and Reporting Obligations of Sports Wagering Licensees - <i>Correction</i> (MA Reg. # 1558)	1571	10/10/25
	- <i>Correction</i> (MA Reg. # 1558)	1572	10/10/25
247.00	Uniform Standards of Sports Wagering	1572	4/24/26
248.00	Sports Wagering Account Management	1572	4/24/26
250.00	Protection of Minors and Underage Youth from Sports Wagering . . .	1571	4/10/26
211 CMR	Division of Insurance		
52.00	Managed Care Consumer Protections and Accreditation of Carriers. .	1575	6/5/26
157.00	Licensing and Regulation of Pharmacy Benefit Managers	1569	3/13/26

		<i>Issue</i>	<i>Effective Date</i>
220 CMR	Department of Public Utilities		
29.00	Billing Procedures for Residential Rental Property Owners Cited for Violation of the State Sanitary Code 105 CMR 410.200	1568	2/27/26
	- <i>Correction</i> (MA Reg. # 1568)	1569	2/27/26
34.00	Intervenor Support Grant Program	1568	2/27/26
225 CMR	Department of Energy Resources		
29.00	Small Clean Energy Infrastructure Facility Siting and Permitting	1568	2/27/26
250 CMR	Board of Registration of Professional Engineers and Land Surveyors		
2.00	General Provisions, Board Procedures and Definitions	1568	2/27/26
3.00	The Registration Process	1568	2/27/26
5.00	Professional Practice.	1568	2/27/26
7.00	Enforcement and Discipline	1568	2/27/26
266 CMR	Board of Registration of Home Inspectors		
2.00	Definitions	1567	2/13/26
3.00	Procedure for Registration	1567	2/13/26
4.00	Associate Home Inspector Training Program Requirements	1567	2/13/26
6.00	Standards of Practice	1567	2/13/26
11.00	Insurance Requirements for Limited Liability Corporations and Limited Liability Partnerships	1567	2/13/26
301 CMR	Executive Office of Energy and Environmental Affairs		
11.00	MEPA Regulations	1566	1/30/26
41.00	Toxic or Hazardous Substance List - <i>Correction</i> (MA Reg. # 1563). .	1568	12/19/25
309 CMR	Board of Registration of Hazardous Waste Site Cleanup Professionals		
2.00	Introductory Provisions.	1566	1/30/26
3.00	Licensing of Licensed Site Professionals.	1566	1/30/26
4.00	Rules of Professional Conduct	1566	1/30/26
5.00	Advisory Rulings	1566	1/30/26
6.00	Design and Use of Licensed Site Professional's Seal.	1566	1/30/26
7.00	Procedure Governing Disciplinary Proceedings and Other Dispositions	1566	1/30/26
8.00	Administrative Penalty Regulations	1566	1/30/26
9.00	Inactive Status.	1566	1/30/26

		<i>Issue</i>	<i>Effective Date</i>
321 CMR	Division of Fisheries & Wildlife		
3.00	Hunting - Emergency	1564	12/19/25
	- <i>Emergency Correction</i> (MA Reg. # 1564)	1565	12/19/25
	. . . . .	1564	1/2/26
	- <i>Compliance</i> (MA Reg. # 1564)	1571	12/19/25
322 CMR	Division of Marine Fisheries		
4.00	Fishing and Shellfishing Equipment	1566	1/30/26
	. . . . .	1573	5/8/26
6.00	Regulation of Catches - <i>Emergency</i>	1573	4/24/26
	. . . . .	1573	5/8/26
7.00	Permits	1566	1/30/26
	. . . . .	1567	2/13/26
	. . . . .	1573	5/8/26
15.00	Management of Marine Aquaculture	1566	1/30/26
400 CMR	Executive Office of Economic Development		
9.00	Qualified Data Centers	1570	3/27/26
527 CMR	Board of Fire Prevention Regulations		
12.00	Massachusetts Electrical Code	1572	4/24/26
	- <i>Correction</i> (MA Reg. # 1572)	1575	4/24/26
603 CMR	Department of Elementary and Secondary Education\		
7.00	Educator Licensure and Preparation Program Approval	1574	5/22/26
23.00	Student Records	1568	2/27/26
31.00	Certificate of Mastery and State Seal of Biliteracy	1568	2/27/26
606 CMR	Department of Early Education and Care		
10.00	Child Care Financial Assistance	1566	1/30/26
610 CMR	Board of Higher Education		
16.00	Degree Granting Regulation for Pilot Proposals on Innovation	1568	2/27/26
760 CMR	Executive Office of Housing and Livable Communities		
69.00	Starter Home Zoning Districts	1569	3/13/26
76.00	Seasonal Communities	1568	2/27/26

		<u>Issue</u>	<u>Effective Date</u>
801 CMR	Executive Office for Administration and Finance		
4.00	Rates	1567	2/13/26
	.....	1568	2/27/26
807 CMR	Teachers' Retirement Board		
25.00	Interest on Delayed Corrections	1570	3/27/26
815 CMR	Office of the Comptroller		
2.00	State Grants, Federal Grant Awards, Federal Subgrants and Subsidies	1574	5/22/26
3.00	Ready Payment System	1574	5/22/26
4.00	Late Penalty Interest	1574	5/22/26
6.00	Interdepartmental Fiscal Business	1574	5/22/26
8.00	Contingent Fee Contracts for Non-tax Revenue Maximization	1574	5/22/26
9.00	Debt Collection and Intercept	1574	5/22/26
830 CMR	Department of Revenue		
62B.00	Withholding of Taxes on Wages and Declaration of Estimated Income Tax	1575	6/5/26
62C.00	Administrative Provisions Relative to State Taxation - <i>Emergency</i> ..	1568	2/5/26
840 CMR	Public Employee Retirement Administration Commission		
28.00	Electronic Signatures	1573	5/8/26
935 CMR	Cannabis Control Commission		
500.000	Adult Use of Marijuana	1564	1/2/26
	- <i>Correction</i> (MA Reg. # 1564)	1568	1/2/26
	.....	1570	3/27/26
	- <i>Correction</i> (MA Reg. # 1570)	1572	3/27/26
501.000	Medical Use of Marijuana	1564	1/2/26
	- <i>Correction</i> (MA Reg. # 1564)	1565	1/2/26
	- <i>Correction</i> (MA Reg. # 1564)	1568	1/2/26
	.....	1570	3/27/26
	- <i>Correction</i> (MA Reg. #1570)	1572	3/27/26
945 CMR	Office of the Inspector General		
4.00	Owner's Representative for Major Contracts under M.G.L. c. 30, § 39M½	1565	1/16/25
5.00	Owner's Representative for Major Contracts under M.G.L. c. 149A, § 15½	1565	1/16/25

		<i>Issue</i>	<i>Effective Date</i>
957 CMR	Center for Health Information and Analysis		
3.00	Assessment on Certain Health Care Providers and Surcharge Payers - <i>Emergency</i>	1566 1571	1/16/26 4/10/26
4.00	Standard Quality Measure Set	1569	3/13/26
5.00	Health Care Claims, Case Mix and Charge Data Release Procedures .	1568	2/27/26
6.00	Cost Reporting Requirements.	1568	2/27/26
7.00	Nursing Facility Cost Reporting Requirements	1568	2/27/26
9.00	Financial Data Reporting Requirements for Health Care Entities and Affiliated Entities	1565	1/16/26
12.00	Pharmacy Benefit Manager Reporting	1566	1/30/26
958 CMR	Health Policy Commission		
6.00	Registration of Provider Organizations	1573	5/8/26
7.00	Notices of Material Change and Cost and Market Impact Reviews. . .	1573	5/8/26
9.00	Assessment on Certain Health Care Providers and Pharmacy Benefit Managers	1573	5/8/26
960 CMR	Office of the State Treasurer and Receiver General		
6.00	Massachusetts Defined Contribution CORE Plan	1564	1/2/26
961 CMR	State Lottery Commission		
2.00	Rules and Regulations	1567	2/13/26
980 CMR	Energy Facilities Siting Board		
1.00	Rules for the Conduct of Adjudicatory Proceedings	1568	2/27/26
2.00	General Information and Conduct of Board Business	1568	2/27/26
4.00	Freedom of Information; Protection of Trade Secrets	1568	2/27/26
5.00	Environmental Assessment and Environmental Impact Energy Facilities Siting Counsel.	1568	2/27/26
7.00	Long Range Forecasts and Supplements	1568	2/27/26
8.00	Notices to Construct an Oil Facility	1568	2/27/26
11.00	Licensing of Hydropower Generating Facilities.	1568	2/27/26
13.00	Consolidated Permits for Clean Energy Infrastructure Facilities.	1568	2/27/26
14.00	De Novo Adjudications of Consolidated Local Permit Applications. .	1568	2/27/26
15.00	Cumulative Impact Analysis and Standards for Applying Site Suitability Criteria	1573	5/8/26
16.00	Pre-filing Consultation and Engagement Requirements.	1568	2/27/26
17.00	Constructive Approval	1575	6/5/26



THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin
Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **105 CMR 270.000**

CHAPTER TITLE: **Blood Screening of Newborns for Treatable Diseases and Disorders**

AGENCY: **Department of Public Health**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

The purpose of 105 CMR 270 is to list mandated screening tests for diseases and disorders with treatments that are known to be more effective if the condition is identified in the newborn period and for which there is a reliable and effective blood screening test that may be administered during the newborn period, and that there is a diagnostic protocol.

REGULATORY AUTHORITY: **M.G.L. c. 111, s. 3, 4E, 5, 6, 24A and 110A**

AGENCY CONTACT: **James Ballin** PHONE: **617-624-5220**

ADDRESS: **250 Washington Street, 2nd Floor, Boston, MA 02108**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

MA Executive Office of Housing and Livable Communities notified on February 6, 2026
MA Municipal Association notified on February 6, 2026

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **March 16, 2026**

FISCAL EFFECT - Estimate the fiscal effect of the public and private sectors.

For the first and second year: _____

For the first five years: _____

No fiscal effect: **No fiscal effect expected**

SMALL BUSINESS IMPACT - M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.

Date amended small business impact statement was filed: **May 12, 2026**

CODE OF MASSACHUSETTS REGULATIONS INDEX - List key subjects that are relevant to this regulation:
Newborn Screening

PROMULGATION - State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:

Amends 105 CMR 270.000.

ATTESTATION - The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency. ATTEST:

SIGNATURE: _____ SIGNATURE ON FILE _____ DATE: **May 14 2026**

Publication - To be completed by the regulations Division

MASSACHUSETTS REGISTER NUMBER: **1575** DATE: **6/5/26**

EFFECTIVE DATE: **6/5/26**

CODE OF MASSACHUSETTS REGULATIONS

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49 & 50 1281 - 1284.2	49 & 50 1281 - 1284.4

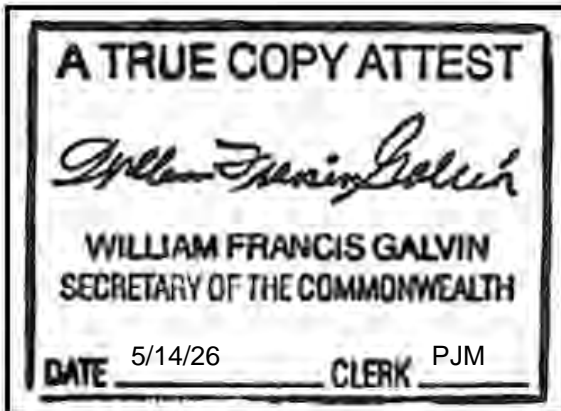


Table of Contents

	<u>Page</u>
105 CMR 225.000: NUTRITION STANDARDS FOR COMPETITIVE FOODS AND BEVERAGES IN PUBLIC SCHOOLS (continued)	
Section 225.100: General Nutrition Standards for Public Schools	1206
Section 225.200: Specific Nutrition Standards for Competitive Foods in Public Schools	1206.1
(105 CMR 226.000 THROUGH 239.000: RESERVED)	1207
105 CMR 240.000: CRITERIA FOR INSURANCE COVERAGE OF BONE MARROW TRANSPLANTS FOR BREAST CANCER PATIENTS	1231
Section 240.001: Purpose	1231
Section 240.002: Authority	1231
Section 240.003: Scope	1231
Section 240.004: Definitions	1231
Section 240.005: Insurance Coverage for Eligible Patients	1232
Section 240.006: Suitable Clinical Trials	1232
Section 240.007: Appeal	1232
Section 240.008: Patient Information and Education	1233
Section 240.009: Advisory Board	1233
(105 CMR 241.000 THROUGH 259.000: RESERVED)	1235
105 CMR 260.000: PROHIBITION AGAINST CERTAIN FISHING IN NEW BEDFORD HARBOR	1261
Section 260.001: Findings and Purpose	1261
Section 260.002: Emergency Promulgation	1261
Section 260.003: Authority	1261
Section 260.004: Adulterated Fish	1261
Section 260.005: Taking and/or Sale of Lobsters, and Certain Fish Prohibited	1261
(105 CMR 261.000 THROUGH 269.000: RESERVED)	1263
105 CMR 270.000: BLOOD SCREENING OF NEWBORNS FOR TREATABLE DISEASES AND DISORDERS	1281
Section 270.001: Purpose	1281
Section 270.004: Definitions	1281
Section 270.005: Newborn Blood Screening Advisory Committee	1283
Section 270.006: Diseases and Disorders Included in Newborn Blood Screening	1283
Section 270.007: Collection and Submission of Newborn Blood Specimens	1284.1
Section 270.008: Newborn Blood Screening Fees	1284.1
Section 270.009: Notification of Newborn Blood Screening Test Results	1284.1
Section 270.010: Follow-up of Newborn Blood Screening	1284.2
Section 270.011: Confidentiality of Newborn Screening Test Results and Information	1284.2
Section 270.012: Storage and Use of Residual Specimens	1284.2
Section 270.013: Severability	1284.3

Table of Contents

	<u>Page</u>
105 CMR 271.000: POSTPARTUM DEPRESSION SCREENING AND REPORTING	1285
Section 271.001: Purpose	1285
Section 271.002: Scope	1285
Section 271.003: Definitions	1285
Section 271.004: Responsibilities of Providers	1286
Section 271.005: Responsibilities of Carriers	1287
Section 271.006: Severability	1287
(105 CMR 272.000 THROUGH 299.000: RESERVED)	1289
105 CMR 300.000: REPORTABLE DISEASES, SURVEILLANCE, AND ISOLATION AND QUARANTINE REQUIREMENTS	1301
Section 300.001: Purpose	1301
Section 300.020: Definitions	1301
Section 300.050: Disease Surveillance and Case Management System	1306
Section 300.100: Diseases Reportable to Local Boards of Health	1306
Section 300.110: Case Reports by Local Boards of Health	1308
Section 300.120: Confidentiality	1308
Section 300.131: Illness Believed to Be Due to Food Consumption	1309
Section 300.132: Illness Believed to Be Transmissible Through Food	1309
Section 300.133: Illness Believed to Be Unusual	1309
Section 300.134: Illness Believed to Be Part of a Suspected or Confirmed Cluster or Outbreak	1309
Section 300.135: Reporting of Pediatric Influenza Deaths, Severe and Unusual Illness Due to Influenza, Cases of Antiviral Treatment or Prophylaxis Failure, and Illness Believed to Be Due to Novel Influenza Viruses	1309
Section 300.136: Reporting of Infection or Suspected Infection Believed to Be Transmitted by a Transfused Blood Product or Transplanted Organ, Tissue or Tissue Product	1310
Section 300.140: Reporting of Animal Diseases with Zoonotic Potential by Veterinarians	1310
Section 300.150: Declaring a Disease or Condition Immediately Reportable, under Surveillance and/or Subject to Isolation and Quarantine: Temporary Reporting, Surveillance and/or Isolation and Quarantine	1310
Section 300.160: Diseases Reportable by Local Boards of Health to the Department	1310
Section 300.170: Laboratory Findings Indicative of Infectious Disease Reportable Directly to the Department by Laboratories	1311
Section 300.171: Reporting of Antimicrobial Resistant Organisms and Cumulative Antibiotic Susceptibility Test Results (Antibiograms)	1312
Section 300.172: Submission of Selected Isolates and Diagnostic Specimens to the State Public Health Laboratory	1313
Section 300.173: Reporting of Certain Negative and Indeterminant Diagnostic Tests Associated with Ascertainment of Infection Status	1314
Section 300.174: Laboratory Findings Indicative of Infectious Disease Reportable Directly to the Department by Point of Care Testing	1314
Section 300.175: Potential Exposures to Certain Infectious Agents in Clinical Laboratories and Research Settings Reportable Directly to the Department	1314
Section 300.180: Diseases Reportable Directly to the Department	1314
Section 300.181: Reporting Work-related Disease Outbreaks	1314.2
Section 300.182: Joint Authority with Department of Labor and Workforce Development	1314.2
Section 300.190: Surveillance and Control of Diseases Dangerous to the Public Health	1314.2
Section 300.191: Access to Medical Records and Other Information	1315

105 CMR 270.000: BLOOD SCREENING OF NEWBORNS FOR TREATABLE DISEASES AND DISORDERS

Section

- 270.001: Purpose
- 270.004: Definitions
- 270.005: Newborn Blood Screening Advisory Committee
- 270.006: Diseases and Disorders Included in Newborn Blood Screening
- 270.007: Collection and Submission of Newborn Blood Specimens
- 270.008: Newborn Blood Screening Fees
- 270.009: Notification of Newborn Blood Screening Test Results
- 270.010: Follow-up of Newborn Blood Screening
- 270.011: Confidentiality of Newborn Screening Test Results and Information
- 270.012: Storage and Use of Residual Specimens
- 270.013: Severability

270.001: Purpose

The purposes of 105 CMR 270.000 are to:

- (A) list those diseases and disorders with treatments that are known to be more effective if the condition is identified in the newborn period and for which there is a reliable and effective blood screening test that may be administered during the newborn period, and that there is a diagnostic protocol; and
- (B) ensure that every newborn is screened for markers of these diseases and disorders; and
- (C) make available Optional Newborn Blood Screening for another set of diseases and disorders with treatments that are thought to be effective if the condition is identified in the newborn period and for which testing shall be offered under an optional protocol to collect critical population-based data on prevalence of these diseases and disorders in the Massachusetts population, their natural history, and the efficacy of screening, diagnostic, and treatment protocols.

270.004: Definitions

Approved Research means a research study that has been approved by the Department and a federally approved Institutional Review Board.

Department means the Department of Public Health or its designated agent.

Diagnostic Evaluation means the clinical evaluation of an individual or the laboratory testing of a clinical specimen from an individual with signs or symptoms or screening indicators of a disease or disorder in order to confirm or rule out the disease or disorder in that individual.

Early Childhood means the period from birth through eight years old.

Health Care Provider means any licensed provider involved in the delivery or care of a person, including but not limited to, obstetricians, gynecologists, certified nurse midwives, certified professional midwives, neonatologists, pediatricians, family medicine physicians, and nurses.

Health Care Provider Attending a Newborn means the Director of Newborn Medicine or other treating physician designated by the hospital of birth/neonatal care unit to care for the newborn, or the physician who certifies the birth of the newborn, or any licensed provider involved in the delivery or care of the newborn including but not limited to, obstetricians, gynecologists, certified nurse midwives, licensed certified professional midwives, neonatologists, pediatricians, family medicine physicians, and nurses.

Infant means any liveborn person who has yet to have had a first year birthday.

270.004: continued

Institutional Review Board (IRB) means an appropriately constituted group that has been formally designated to review and monitor biomedical research involving human subjects in accordance with 45 CFR Part 46.

Mandated Newborn Blood Screening means the required statewide collection and testing of newborn blood specimens from all newborns in Massachusetts and related follow up activities for the benefit of the child tested (subject to religions exemption only) for diseases and disorders for which:

- (1) there is a significant, life-challenging risk of morbidity or mortality to those who have the disease or disorder if they are not treated in the newborn/infant period or early childhood period for certain disorders;
- (2) there is a standard of care screening test that is universally available;
- (3) there is a standard of care diagnostic evaluation that is universally available for all newborns/infants or those in the early childhood period for certain disorders whose newborn screening results warrant such evaluations;
- (4) there is a standard of care treatment that is universally available for the screened newborn/infant or those in the early childhood period with a confirmed diagnosis and that should begin in the newborn/infant period to be beneficial to the screened newborn with a confirmed diagnosis;
- (5) there are resources for and access to treatment and family counseling; and
- (6) the positive health benefits to the screened person outweigh the risks and burdens of screening and treatment.

Newborn means any liveborn infant who is 28 days old or younger.

Newborn Blood Screening Program means the program operated either by the Department or its agent to conduct Mandated and Optional Newborn Blood Screening for the Commonwealth's newborns and newborns receiving healthcare in the Commonwealth.

Newborn Blood Screening Information or Data means the newborn screening test results or any information collected or maintained by the Newborn Blood Screening Program, except a blood specimen, that relates to screening, diagnostic, or treatment information concerning a specific individual.

Optional Newborn Blood Screening means the universal offering of one or more pilot studies to the newborn population.

Pilot Study means a research protocol with an informed consent process approved by the Department's Institutional Review Board that includes statewide testing of newborn blood specimens and related follow up activities offered for those diseases and disorders that do not meet the criteria for Mandated Newborn Blood Screening but are likely, based on an evaluation of additional information to be gained through the pilot study, to have the potential to meet the criteria for mandatory screening and provide a benefit to newborns. Pilot studies provide for the maintenance of specimen identifiers, allowing study results to be linked to, and reported for, specific individuals.

Research means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

Residual Specimen means any dried blood spot collected in accordance with 105 CMR 270.000 that remains following the completion of newborn blood screening and any necessary follow-up for the benefit of the child tested.

Screening Tests means the laboratory testing of clinical specimens from a population of individuals regardless of health status to detect markers or risk factors of a disease or a disorder.

Specimen means a blood sample collected according to Newborn Blood Screening Program guidelines on the filter paper that is provided by the Newborn Blood Screening Program.

270.004: continued

Treatment means an intervention with demonstrated effectiveness to prevent or reduce symptoms or to delay progression of disease that is associated with the diagnosed condition identified in the infant via newborn screening, including, but not limited to interventions that are dietary/nutritional, physical therapy, genetic, cellular, pharmaceutical, surgical, radiological, behavioral, or environmental.

270.005: Newborn Blood Screening Advisory Committee

(A) The Commissioner shall establish a permanent advisory committee to advise the Commissioner on matters pertaining to the Newborn Blood Screening Program including, but not limited to:

- (1) the listing of treatable diseases and disorders that meet the criteria in the definition of "Mandated Newborn Blood Screening" for which newborn blood screening should be mandated;
- (2) the listing of diseases and disorders that meet the criteria in the definition for "Pilot Study" that are offered as Optional Newborn Blood Screening;
- (3) quality assurance and control measures utilized for the operation of the Newborn Blood Screening Program; and
- (4) new and emerging research in newborn screening.

(B) Membership of the committee may include, but not be limited to, parents and other consumers, practicing pediatricians, public health officials, neonatologists, obstetricians, clinicians and researchers specializing in newborn diseases and disorders, clinical geneticists, birth hospital representatives, Newborn Blood Screening Program professionals, medical ethicists, and other experts as needed to represent a variety of related fields such as emerging technologies and health insurance.

(C) The committee shall meet not less than twice per year.

(D) On an annual basis, the Newborn Blood Screening Program shall submit to the committee a report on the quality assurance and control measures utilized for the operation of the Newborn Blood Screening Program and the committee shall review and provide guidance on these measures.

270.006: Diseases and Disorders Included in Newborn Blood Screening

(A) Mandated Newborn Blood Screening. The following diseases and disorders shall be included in mandated newborn screening:

- (1) Inborn Errors of Metabolism.
 - (a) Amino Acid Disorders:
 1. Homocystinuria (HCY);
 2. Maple Syrup Urine Disease (MSUD);
 3. Phenylketonuria (PKU);
 4. Tyrosinemia, Type I (TYR I).
 - (b) Fatty Acid Oxidation Disorders:
 1. Carnitine-Acylcarnitine Translocase Deficiency (CACT);
 2. Carnitine Uptake Defect (CUD);
 3. Long-chain L-3-Hydroxyacyl-CoA Dehydrogenase Deficiency (LCHAD);
 4. Medium-chain Acyl-CoA Dehydrogenase Deficiency (MCAD);
 5. Very long-chain Acyl-CoA Dehydrogenase Deficiency (VLCAD).
 - (c) Organic Acidemias:
 1. Beta-Ketothiolase Deficiency (BKT);
 2. Glutaric Acidemia type I (GAI);
 3. 3-Hydroxy-3-Methylglutaric Aciduria (HMG);
 4. Isovaleric Acidemia (IVA);
 5. Methylmalonic Acidemia: methylmalonyl CoA mutase deficiency (MUT);
 6. Methylmalonic Acidemia: cobalamin A, B (Cbl A,B);
 7. Methylmalonic Acidemia: cobalamin C, D (Cbl C,D);
 8. Propionic Acidemia (PA).

270.006: continued

(d) Urea Cycle Disorders:

1. Argininemia (ARG) aka Arginase Deficiency;
2. Argininosuccinic Aciduria (ASA) aka Argininosuccinate Lyase Deficiency;
3. Carbamylphosphate Synthetase Deficiency (CPS);
4. Citrullinemia, Type I aka Argininosuccinate Synthetase Deficiency (CIT-I);
5. Ornithine Transcarbamylase Deficiency (OTC).

(e) Storage Disorders and Leukodystrophies:

1. Glycogen Storage Disorder-II (GSD-II aka Pompe);
2. Krabbe disease (globoid cell leukodystrophy) (KD) (for specimens received on or after January 1, 2027);
3. Mucopolysaccharidosis type 1 (MPS-I);
4. X-linked adrenoleukodystrophy (X-ALD);
5. Metachromatic leukodystrophy (MLD) (for specimens received on or after July 1, 2027);

(f) Other Disorders of Metabolism:

1. Biotinidase Deficiency (BTD);
2. Galactosemia Classical (GALT);
3. Guanidinoacetate methyltransferase (GAMT) (for specimens received on or after January 1, 2027).

(2) Other Genetic Disorders:(a) Hemoglobin Sickling Disorders including but not limited to:

1. Sickle cell anemia (Hb SS);
2. Hb S/C disease (Hb SC);
3. Hb S/Beta -thalassemia (Hb S/BetaThalassemia).

(b) Cystic Fibrosis (CF);

(c) Severe Combined Immunodeficiency (SCID).

(d) Neuromuscular Disorders:

1. Duchenne Muscular Dystrophy (DMD)
2. Spinal Muscular Atrophy (SMA)

(3) Other Congenital Disorders:(a) Endocrinopathies:

1. Congenital Adrenal Hyperplasia (CAH);
2. Congenital hypothyroidism (CH)

(b) Infectious Diseases:

1. Congenital Toxoplasmosis (TOXO)

(B) Pilot Studies. The Newborn Blood Screening Program shall identify and maintain a list of diseases and disorders that shall be included in the Optional Newborn Blood Screening as Pilot Studies. A current list of diseases and conditions available for optional screening shall be included in the Newborn Screening in Massachusetts brochure provided to parents and guardians and shall be maintained on the web page for the New England Newborn Screening Program

(C) By-product Conditions. Due to the technology used for some screening tests, and tests used to confirm results, and/or the physiology associated with the disorders being tested for, some conditions not listed in 105 CMR 270.006(A) or offered as Pilot Studies pursuant to 105 CMR 270.006(B) may be identified during the screening process. These by-product conditions do not currently meet the criteria for mandated screening or pilot studies. These by-product conditions are listed in the Newborn Blood Screening in Massachusetts brochure provided to parents and guardians and are maintained on the web page for the Newborn Blood Screening Program.

270.007: Collection and Submission of Newborn Blood Specimens

(A) Except as provided in 105 CMR 270.007(C), the health care provider attending a newborn shall ensure that a blood specimen is collected from the newborn between 24 and 48 hours after the birth. If a newborn child is discharged within the first 24 hours after the birth, the health care provider attending a newborn shall ensure that a blood specimen is collected prior to discharge and shall instruct the parents/guardians of the newborn to have a second specimen collected from the newborn within 48 hours of birth, and shall submit to the Newborn Blood Screening Program the contact information of the infant's health care provider. The health care provider of a child after discharge from the birth hospital shall ensure that any repeat specimens requested by the Newborn Blood Screening Program are collected.

(B) The health care provider attending a newborn shall ensure that the blood specimen is collected from the newborn using the filter paper blood collection device provided by the Newborn Blood Screening Program and shall ensure that the specimen is submitted within 24 hours of collection or at next available specimen shipment for delivery to the Newborn Blood Screening Program in accordance with directions provided on the device and other supplemental information that may be provided by the Newborn Blood Screening Program. All information requested must be provided on the form associated with the device.

(C) If any parent or guardian objects to Mandated Newborn Blood Screening, the health care provider attending a newborn shall provide information about the benefits of mandated newborn screening and about the risks to the child from infancy through the early childhood period of refusing mandated newborn screening. A medical interpreter should be provided if necessary. If all of the newborn's parents or guardians with legal custody refuse mandated newborn blood screening based on a conflict with their religious tenets and practices after being provided this information, the health care provider attending a newborn shall not conduct the newborn blood screening required by 105 CMR 270.007(A) and shall document the refusal on a form provided by the Newborn Blood Screening Program. The completed and signed form shall be sent to the Newborn Blood Screening Program and to the newborn's health care provider.

(D) The health care provider attending a newborn shall ensure that a copy of the Newborn Screening in Massachusetts brochure is provided to parents or guardians prior to the collection of blood spots to inform them about the mandated screening tests and the availability of Optional Screening for Pilot Studies as specified in 105 CMR 270.006(B).

(E) The health care provider attending a newborn shall ensure that the consent and documentation procedures, as specified by the Newborn Blood Screening Program, are followed.

270.008: Newborn Blood Screening Fees

The Newborn Blood Screening Program shall bill the hospital of birth, or the parents for out-of-hospital births, a reasonable charge for the services associated with the testing of newborns for those diseases or disorders screened for pursuant to 105 CMR 270.006 and for notification and follow-up to ensure treatment of affected newborns.

270.009: Notification of Newborn Blood Screening Test Results

(A) The Newborn Blood Screening Program shall notify the hospital of birth and the health care provider listed by the hospital on the newborn screening collection device or the health care provider determined to be the infant's health care provider of the results of the newborn blood screening tests as soon as feasible. The infant's health care provider shall notify the parent or guardian of the newborn of the newborn's screening test results.

(B) The Newborn Blood Screening Program shall provide to the health care provider, upon request, the results of all or specified newborn blood screening tests for his or her patient.

270.010: Follow-up of Newborn Blood Screening

For the purposes of quality assurance, quality improvement and ongoing evaluation of the effectiveness of the Newborn Blood Screening Program, including the determination of those disorders and diseases that should be included in the Department's Newborn Blood Screening Program, the health care provider shall report to the Newborn Blood Screening Program, upon request, the following information as soon as possible but no later than 30 days after the request:

- (A) Diagnostic and long term outcomes for all newborns whose newborn screening results warranted diagnostic evaluation for a newborn screening disorder or disease; and
- (B) Any additional relevant information regarding these diagnostic and long term outcomes as specified by the Newborn Blood Screening Program.

270.011: Confidentiality of Newborn Screening Test Results and Information

(A) The Newborn Blood Screening Program shall maintain the confidentiality of testing results generated by the Program and information submitted to the Program for purposes of newborn screening and follow-up of newborn testing.

(B) Other than as required for routine notification of newborn blood testing results or for follow up diagnosis or treatment of an individual as described in 105 CMR 270.009, the Newborn Blood Screening Program shall not disclose newborn screening results or any information or patient identifiers which because of name, identifying number, mark or description can be readily associated with a particular individual or the individual's parents/guardians, or any newborn screening information that could be used in combination with other information to identify an individual, except to:

- (1) that individual;
- (2) the individual's parents or guardians if a minor;
- (3) the personal representative of the individual's estate;
- (4) anyone authorized in writing by that individual or the individual's legal representative;
- (5) authorized Department and Newborn Blood Screening Program personnel;
- (6) authorized staff at other state newborn screening programs responsible for the follow up of the particular newborn;
- (7) anyone authorized to receive such information pursuant to a court order;
- (8) anyone authorized to receive such information by law, including, but not limited to, a state or local child fatality review team pursuant to M.G.L. c. 38, § 2A, at the request of the local district attorney, or the Office of the Chief Medical Examiner pursuant to M.G.L. c. 38, § 4, at the request of the Chief Medical Examiner, or his or her designee, in order to establish the cause and manner of death and identity of the deceased; or
- (9) any researcher approved by the Department to conduct a specific study pursuant to M.G.L. c. 111, § 24A, and when approved by an Institutional Review Board. Newborn screening information or data that could be used to identify an individual shall not be disclosed to a researcher without the written consent of a parent or guardian unless a waiver of consent has been issued from an Institutional Review Board.

(C) All individually identifiable newborn screening information or data shall be considered confidential and shall not be available as a public record under M.G.L. c. 66.

270.012: Storage and Use of Residual Specimens

(A) The Newborn Blood Screening Program is the custodian of Residual Specimens. Residual Specimens shall be retained, stored, used, and destroyed by the Newborn Blood Screening Program only in accordance with 105 CMR 270.000. Residual Specimens shall be retained in a secure environment under the direction of the Newborn Blood Screening Program. The Program shall ensure that no specimen shall be retrieved or shared for any purpose other than authorized uses specified in 105 CMR 270.000.

270.012: continued

(B) The Newborn Blood Screening Program shall retain and use Residual Specimens for a minimum of 15 years and a maximum of 16 years, except upon written request for destruction from all parents or legal guardians of a child, the Newborn Blood Screening Program shall destroy a stored Residual Specimen as soon as practicable, but no later than one year from the receipt of a written request. After 16 years from the date of birth of a child, the newborn screening specimen shall be destroyed.

(C) Residual Specimens shall be used and shared for only the following purposes, subject to specimen availability as determined by the Newborn Blood Screening Program:

(1) Laboratory Quality Assurance, including laboratory quality control, laboratory validation, participation in proficiency testing, and the practice of continuous quality improvements;

(2) Individual or family clinical benefit with individual or parent/guardian authorization in writing;

(3) Individual or family forensic purposes with individual or parent/guardian authorization in writing;

(4) Uses authorized by law including, but not limited to, an investigation of a child death by a state or local child fatality review team pursuant to M.G.L. c. 38, § 2A, at the request of the local district attorney, or by the Office of the Chief Medical Examiner pursuant to M.G.L. c. 38, § 4, at the request of the Chief Medical Examiner, or his or her designee, in order to establish the cause and manner of death and identity of the deceased;

(5) In response to a court order. Upon receipt of a court order, the Newborn Blood Screening Program shall notify the Department and the specimen subject's parent or legal guardian in writing as soon as possible in order to provide an opportunity to object to the order in court; or

(6) Research studies approved by the Department pursuant to M.G.L. c. 111, § 24A and an Institutional Review Board, provided that a Residual Specimen is not provided to a researcher without the written consent of the parent or guardian.

270.013: Severability

The provisions of 105 CMR 270.000 are severable. If any provision or application thereof is held to be invalid by a court of competent jurisdiction, such invalidity will be severed and will not affect the remainder of 105 CMR 270.000.

REGULATORY AUTHORITY

105 CMR 270.000: M.G.L. c. 111, §§ 3, 4E, 5, 6, 24A and 110A.

NON-TEXT PAGE



THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **211 CMR 52.00**

CHAPTER TITLE: **Managed Care Consumer Protections and Accreditation of Carriers**

AGENCY: **Division of Insurance**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

211 CMR 52.00 provides for health insurance managed care requirements to protect consumers.

REGULATORY AUTHORITY: **M.G.L. c. 175, § 24B; c. 176J, § 11; c. 176O, §§ 2 and 17; c. 176R, § 6; and c. 176S, § 6.**

AGENCY CONTACT: **Rebecca Butler** PHONE: **(508)561-4435**

ADDRESS: **Division of Insurance, 1 Federal St., Suite 700, Boston, MA
02110**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

Notice to Local Government Advisory Commission: September 10, 2025

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **February 19, 2026**

FISCAL EFFECT - Estimate the fiscal effect of the public and private sectors.

For the first and second year: minimal

For the first five years: minimal

No fiscal effect: minimal

SMALL BUSINESS IMPACT - M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.

Date amended small business impact statement was filed: April 21, 2026

CODE OF MASSACHUSETTS REGULATIONS INDEX - List key subjects that are relevant to this regulation:

Insurance

Health Insurance Consumer Protection

PROMULGATION - State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:

Amends existing regulation:: 211 CMR 52.00, Managed Care Consumer Protections and Accreditation of Carriers

ATTESTATION - The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency. ATTEST:

SIGNATURE: _____ SIGNATURE ON FILE _____ DATE: May 13 2026

Publication - To be completed by the regulations Division

MASSACHUSETTS REGISTER NUMBER: 1575 DATE: 6/5/26

EFFECTIVE DATE: 6/5/26

CODE OF MASSACHUSETTS REGULATIONS

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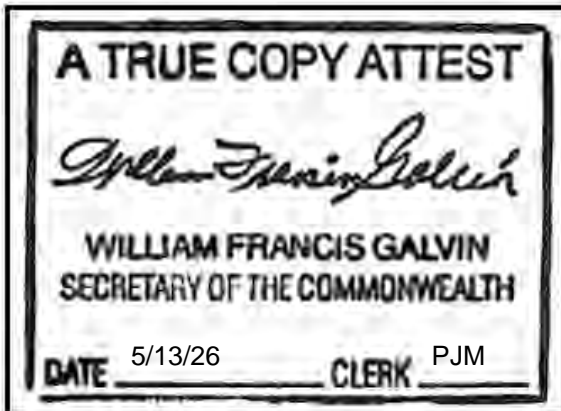


Table of Contents

	<u>Page</u>
211 CMR 41.00: NONGROUP HEALTH INSURANCE RATE AND POLICY FORM FILINGS, REVIEW, AND HEARING PROCEDURES UNDER M.G.L. C. 176M	205
Section 41.01: Purpose, Scope and Authority	205
Section 41.02: Definitions	205
Section 41.03: Geographic Regions for Area Rate Adjustments	211
Section 41.04: Pre-existing Condition Limitations and Waiting Periods	211
Section 41.05: Calculation of Adjusted Composite Rate	212
Section 41.06: Content and Timing of Rate Filings	212.1
Section 41.07: Annual Notice to Insureds	212.3
Section 41.08: Discontinuing a Closed Guaranteed Issue Health Plan or a Closed Plan	412.3
Section 41.09: Content and Timing of Policy Form Filings	212.4
Section 41.10: Review of Policy Forms and Rate Filings and Notification to Carriers	212.5
Section 41.11: Further Review of Closed Issue Health Rate Filing	212.5
Section 41.12: Hearing Request for Disapproved Closed Guaranteed Issue Health Plan Rate Filing	212.6
Section 41.13: General Provisions Governing Rate Proceedings	212.7
Section 41.14: Intervention	212.8
Section 41.15: Responsive Filings	212.9
Section 41.16: Scheduling of Hearing	212.10
Section 41.17: Discovery	212.10
Section 41.18: Pre-hearing Motions and Conferences	212.12
Section 41.19: Conduct of Proceedings	212.13
Section 41.20: Briefs	212.15
Section 41.21: Decision and Order on Closed Guaranteed Issue Health Plan Rate Filing	212.15
Section 41.22: Revised Rate Filings	212.15
Section 41.23: Appeals	212.16
Section 41.24: Severability	212.16
Section 41.98: Appendix A: Adjusted Composite Rate Worksheet	212.17
Section 41.99: Appendix B: Adjusted Composite Rate Worksheet Examples	212.20
211 CMR 42.00: THE FORM AND CONTENTS OF INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE	213
Section 42.01: Purpose	213
Section 42.02: Applicability	213
Section 42.03: Authority	213
Section 42.04: Definitions	213
Section 42.05: Policy Types	214
Section 42.06: Review of Policy Forms and Rate Filings	215
Section 42.07: Loss Ratio Guarantee Filings and Review	217
Section 42.08: Requirements for Replacement	219
Section 42.09: Requirements for Disclosure	219
Section 42.10: Severability	221
Section 42.11: Required Notice for Policy Replacement	222
211 CMR 43.00: HEALTH MAINTENANCE ORGANIZATIONS (HMOs)	229
Section 43.01: Applicability	229
Section 43.02: Definitions	229
Section 43.03: Licensing	231
Section 43.04: Reporting	236
Section 43.05: Deposit Requirements	240
Section 43.06: Net Worth Requirements	241
Section 43.07: Premium Rates	241
Section 43.08: Evidence of Coverage	243
Section 43.09: Agents	243
Section 43.10: Books and Records	243
Section 43.11: Penalties	244
Section 43.12: Health Maintenance Organization Holding Company System Requirements	244
Section 43.13: Severability	244

211 CMR: DIVISION OF INSURANCE

Table of Contents

	<u>Page</u>
211 CMR 44.00: CONFIDENTIALITY OF BIDS SUBMITTED FOR RESTRICTED PHARMACY NETWORK CONTRACTS -- TO FACILITATE THE IMPLEMENTATION OF M.G.L. c. 176D, § 3B	245
Section 44.01: Purpose	245
Section 44.02: Applicability, Scope and Effective Date	245
Section 44.03: Definitions	245
Section 44.04: Bid Disclosure and Confidentiality Requirements	246
Section 44.05: Request for Ruling	246.1
Section 44.06: Notice that a Bid is Public	246.1
Section 44.07: Severability	246.1
 211 CMR 45.00: ESTABLISHMENT OF SERVICE FEE TO INSURANCE PRODUCERS ASSISTING EMPLOYERS IN OBTAINING WORKERS' COMPENSATION INSURANCE	 247
Section 45.01: Authority	247
Section 45.02: Purpose	247
Section 45.03: Eligibility to Receive Service Fee	247
Section 45.04: Amount of Service Fee	247
 (211 CMR 46.00 THROUGH 49.00 RESERVED)	 249
 211 CMR 50.00: CONTINUING EDUCATION FOR INSURANCE PRODUCERS	 281
Section 50.01: Purpose	281
Section 50.02: Definitions	281
Section 50.03: Applicability	281
Section 50.04: Hours of Study	282
Section 50.05: Forms of Submission	282
Section 50.06: Application for Program Credit	282
Section 50.07: Failure to Comply	282
 211 CMR 51.00: PREFERRED PROVIDER HEALTH PLANS AND WORKERS' COMPENSATION PREFERRED PROVIDER ARRANGEMENTS	 283
Section 51.01: Authority	283
Section 51.02: Definitions	283
Section 51.03: Applicability	285
Section 51.04: Approval of Preferred Provider Health Plans and Workers' Compensation Preferred Provider Arrangements	285
Section 51.05: Evidence of Coverage for Insured Preferred Provider Health Plan Coverage	288
Section 51.06: Reporting	288
Section 51.07: Severability	289
 211 CMR 52.00: MANAGED CARE CONSUMER PROTECTIONS AND ACCREDITATION OF CARRIERS	 295
Section 52.01: Applicability	295
Section 52.02: Definitions	295
Section 52.03: Accreditation of Carriers	302.1
Section 52.04: Deemed Accreditation	302.2
Section 52.05: Application for Accreditation	302.2
Section 52.06: Review of Application for Accreditation	302.7
Section 52.07: Utilization Review	302.7
Section 52.08: Quality Management and Improvement	302.13
Section 52.09: Credentialing	302.13

Table of Contents

	<u>Page</u>
211 CMR 52.00: MANAGED CARE CONSUMER PROTECTIONS AND ACCREDITATION OF CARRIERS (continued)	
Section 52.10: Preventive Health Services	302.14
Section 52.11: Provider Contracts	302.14
Section 52.12: Network Adequacy	302.17
Section 52.13: Evidences of Coverage	302.19
Section 52.14: Required Disclosures for Carriers and Behavioral Health Managers	302.24
Section 52.15: Provider Directories	302.27
Section 52.16: Access to Covered Services through Telehealth	302.33
Section 52.17: Material to Be Provided to the Office of Patient Protection	302.34
Section 52.18: Noncompliance with 211 CMR 52.00	302.35
Section 52.19: Severability	302.36
 (211 CMR 53.00: RESERVED)	 302.53
 211 CMR 54.00: PROCEDURE FOR SURRENDER AND NON-RENEWAL OF LICENSES BY INSURERS AUTHORIZED TO WRITE MOTOR VEHICLE INSURANCE	 303
Section 54.01: Purpose and Scope	303
Section 54.02: Applicability	303
Section 54.03: Definitions	303
Section 54.04: Filing Requirements	304
Section 54.05: Review and Approval of Filing	306
Section 54.06: Severability	307
 211 CMR 55.00: DISCLOSURE REQUIREMENTS FOR LIFE INSURANCE POLICIES WITH ACCELERATED BENEFIT PROVISIONS AND ANNUITY CONTRACTS WITH WAIVERS OF SURRENDER CHARGES FOR EARLY WITHDRAWAL OF ANNUITY PROCEEDS IN THE EVENT OF TOTAL AND PERMANENT DISABILITY	 309
Section 55.01: Purpose	309
Section 55.02: Applicability	309
Section 55.03: Authority	309
Section 55.04: Definitions	309
Section 55.05: Minimum Standards	311
Section 55.06: Requirements for Disclosure	313
Section 55.07: Severability	315
Section 55.100: Disclosure Statement Required at the Time of Application for Policy or Contract	316
Section 55.110: Required Disclosure at the Time of Application for Acceleration of Life Insurance Benefits or Early Withdrawal of Annuity Proceeds with a Waiver of Surrender Charge	318

Table of Contents

	<u>Page</u>
211 CMR 56.00: REDUCTIONS IN PREMIUM CHARGES FOR PRIVATE PASSENGER MOTOR VEHICLE INSURANCE FOR INSURED ELECTIONS OF PARTICIPATING REPAIR SHOP ENDORSEMENT PLANS	319
Section 56.01: Scope	319
Section 56.02: Purpose	319
Section 56.03: Definitions	319
Section 56.04: Procedure for Approval of Endorsement and Plans	320
Section 56.05: Participating Repair Shop Endorsement Plans: Required Provisions	320
Section 56.06: Conflicts of Interest	323
Section 56.07: Disclosures to Consumers	323
Section 56.08: Penalties	323
Section 56.09: Severability	324
211 CMR 57.00: RECOGNITION OF THE 2001 CSO MORTALITY TABLE FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NON-FORFEITURE BENEFITS	327
Section 57.01: Purpose	327
Section 57.02: Authority	327
Section 57.03: Definitions	327
Section 57.04: 2001 CSO Mortality Table	327
Section 57.05: Conditions	328
Section 57.06: Applicability of the 2001 CSO Mortality Table to 211 CMR 29.00	328
Section 57.07: Gender Blended Tables	329
Section 57.08: Severability	329
211 CMR 58.00: PERMITTING THE RECOGNITION OF PREFERRED MORTALITY TABLES FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES	331
Section 58.01: Purpose	331
Section 58.02: Authority	331
Section 58.03: Definitions	331
Section 58.04: 2001 CSO Preferred Class Structure Table	332
Section 58.05: Conditions	332
Section 58.06: Severability	333
211 CMR 59: TERM AND UNIVERSAL LIFE INSURANCE RESERVE FINANCING	335
Section 59.01: Purpose and Intent	335
Section 59.02: Applicability	335
Section 59.03: Exemptions from 211 CMR 59.00	335
Section 59.04: Definitions	337
Section 59.05: The Actuarial Method	338
Section 59.06: Requirements Applicable to Covered Policies to Obtain Credit for Reinsurance; Opportunity for Remediation	339
Section 59.07: Prohibition against Avoidance	340
Section 59.08: Severability	341
(211 CMR 60.00 THROUGH 64.00: RESERVED)	343

211 CMR 52.00: MANAGED CARE CONSUMER PROTECTIONS AND ACCREDITATION OF CARRIERS

Section

- 52.01: Applicability
- 52.02: Definitions
- 52.03: Accreditation of Carriers
- 52.04: Deemed Accreditation
- 52.05: Application for Accreditation
- 52.06: Review of Application for Accreditation
- 52.07: Utilization Review
- 52.08: Quality Management and Improvement
- 52.09: Credentialing
- 52.10: Preventive Health Services
- 52.11: Provider Contracts
- 52.12: Network Adequacy
- 52.13: Evidences of Coverage
- 52.14: Required Disclosures for Carriers and Behavioral Health Managers
- 52.15: Provider Directories
- 52.16: Access to Covered Services through Telehealth
- 52.17: Material to Be Provided to the Office of Patient Protection
- 52.18: Noncompliance with 211 CMR 52.00
- 52.19: Severability

52.01: Applicability

211 CMR 52.00 applies to any Carrier that offers for sale, provides or arranges for the provision of a defined set of Health Care Services to Insureds through affiliated and contracting Providers or employs Utilization Review in making decisions about whether services are Covered Benefits under a Health Benefit Plan. A Carrier that provides coverage for Limited Health Services only, that provides specified services through a workers' compensation preferred Provider arrangement, or that does not provide services through a Network or through Participating Providers shall be subject to those requirements of 211 CMR 52.00 as deemed appropriate by the Commissioner in a manner consistent with a duly filed application for Accreditation as outlined in 211 CMR 52.05(2).

Certain requirements of 211 CMR 52.00, as specified, shall also apply to Dental and Vision Carriers. Such provisions are: 211 CMR 52.11(1) through (4); (11); (13); 52.13(2), (3)(a), (c) through (e), (g), (h), (l) through (o); (4) through (10); 52.14(1)(c) and (d); (2), (3) and (7); and 211 CMR 52.17.

A Carrier that delegates to or contracts with another entity, including a Utilization Review Organization, for the performance of some or all of the functions governed by M.G.L. c. 176O and/or 211 CMR 52.00 shall be responsible for ensuring compliance by said entity with the provisions of M.G.L. c. 176O and 211 CMR 52.00.

52.02: Definitions

As used in 211 CMR 52.00, the following words mean:

Accreditation. A written determination by the Bureau of Managed Care of compliance with M.G.L. c. 176O, 211 CMR 52.00 and 958 CMR 3.000: *Health Insurance Consumer Protection*.

Actively Practices. A Health Care Professional who regularly treats or manages patients in a clinical setting.

Administrative Disenrollment. A change in the status of an Insured whereby the Insured remains with the same Carrier but his or her membership may appear under a different identification number. Examples of an Administrative Disenrollment are a change in employers, a move from an individual plan to a spouse's plan, or any similar change that may be recorded by the Carrier as both a disenrollment and an enrollment.

52.02: continued

Adverse Determination. A determination, based upon a review of information provided, by a Carrier or its designated Utilization Review Organization, 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, including a determination that a requested or recommended Health Care Service or treatment is experimental or investigational. An Adverse Determination includes any denial of access to an out-of-Network Provider at an in-Network benefit level where there is an oral or written assertion by an Insured or treating Provider that a Carrier's preferred Provider Network does not have Providers who are able and available to treat the patient's specific condition and the preferred Provider Network is therefore not adequate to deliver the needed benefits at the preferred Provider level.

Alternative Payment Contract. Any contract between a Carrier and a Provider or Provider organization that utilizes alternative payment methodologies, which are methods of payment that are not solely based on fee-for-service reimbursements and that may include, but is not limited to, shared savings arrangements, bundled payments, global payments, and fee-for-service payments that are settled or reconciled with a bundled or global payment.

Ambulatory Review. Utilization Review of Health Care Services performed or provided in an outpatient setting, including, but not limited to, outpatient or ambulatory surgical, diagnostic and therapeutic services provided at any medical, surgical, obstetrical, psychiatric and chemical dependency Facility, as well as other locations such as laboratories, radiology facilities, Provider offices and patient homes.

Application Programming Interface. An electronic interface that enables software applications used by Carriers, Utilization Review Organizations and Providers to communicate with each other to exchange data.

Asynchronous or Asynchronous Telehealth. An exchange of information regarding a patient that does not occur in real time, including but not limited to the secure collection and transmission of a patient's medical information, clinical data clinical images, laboratory results, or a self-reported medical history.

Behavioral Health Manager. A company, organized under the laws of the Commonwealth of Massachusetts or organized under the laws of another state and qualified to do business in the Commonwealth, that has entered into a contractual arrangement with a Carrier to provide or arrange for the provision of behavioral, substance use disorder and mental Health Services to voluntarily enrolled members of the Carrier.

Behavioral Health Services. Care and services for the evaluation, diagnosis, treatment, consultation, prescribing, monitoring or management of mental health, developmental, or substance use disorders. Such care and services may be provided by any Health Care Professional for whom such services are within the scope of licensure for such Health Care Professional. Behavioral Health Services shall also include but not be limited to Partial Hospital Programs and Intensive Outpatient Programs.

Behavioral Health Specialty Care. Behavioral Health Services dedicated to treating particular behavioral health conditions. A behavioral health Provider should be listed as providing specific Behavioral Health Specialty Care when they regularly provide the care.

Bureau of Managed Care or Bureau. The bureau in the Division of Insurance established by M.G.L. c. 176O, § 2.

Capitation. A set payment per patient per unit of time made by a Carrier to a licensed Health Care Professional, Health Care Provider group, or organization that employs or utilizes services of Health Care Professionals to cover a specified set of services and administrative costs without regard to the actual number of services provided.

52.02: continued

Carrier. An insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization organized under M.G.L. c. 176G; and an organization entering into a preferred Provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. Unless otherwise noted, the term "Carrier" shall not include any entity to the extent it offers a policy, certificate, or contract that is not a health benefit plan as defined in M.G.L. c. 176J, § 1.

Case Management. A coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

Chronic Disease Management. Care and services for the management of chronic conditions, including

- (a) conditions, defined by the federal Centers for Medicare and Medicaid Services that include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, cancer, and coronary artery disease;
- (b) congenital anomalies and hereditary conditions; and
- (c) other chronic conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both.

Clean and Complete Credentialing Application. A credentialing application which is appropriately signed and dated by the Provider, and which includes all of the applicable information requested from the Provider by the Carrier.

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 nonrestricted license from the appropriate professional licensing board in Massachusetts, current board certification from a Specialty board approved by the American Board of Medical Specialties or of 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 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.

Clinical Review Criteria. The written screening procedures, decisions, abstracts, clinical protocols and practice guidelines used by a Carrier to determine the Medical Necessity and appropriateness of Health Care Services.

Commissioner. The Commissioner of Insurance, appointed pursuant to M.G.L. c. 26, § 6, or his or her designee.

Complaint.

- (a) any Inquiry made by or on behalf of an Insured to a Carrier or Utilization Review Organization that is not explained or resolved to the Insured's satisfaction within three business Days of the Inquiry;
- (b) any matter concerning an Adverse Determination; or
- (c) in the case of a Carrier or Utilization Review Organization that does not have an internal Inquiry process, a Complaint means any Inquiry.

Concurrent Review. Utilization Review conducted during an Insured's inpatient hospital stay or course of treatment.

Cost Sharing or Cost-sharing. Includes deductibles, coinsurance, copayments, or similar charges required of an Insured, but does not include premiums, balance-billing amounts for out-of-Network Providers, or spending for non-covered Benefits.

Covered Benefits or Benefits. Health Care Services to which an Insured is entitled under the terms of the Health Benefit Plan.

52.02: continued

Days. Calendar days, unless otherwise specified in 211 CMR 52.00; provided, that computation of days specified in 211 CMR 52.00 begins with the first day following the referenced action, and provided further that if the final day of a period specified in 211 CMR 52.00 falls on a Saturday, Sunday or state holiday, the final day of the period will be deemed to occur on the next working day.

Dental Benefit Plan. A policy, contract, certificate or agreement of insurance entered into, offered or issued by a Dental Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for Dental Care Services.

Dental Care Professional. A dentist or other dental care practitioner licensed, accredited or certified to perform specified Dental Services consistent with the law.

Dental Care Provider. A Dental Care Professional or Facility licensed to provide Dental Care Services.

Dental Care Services or Dental Services. Services for the diagnosis, prevention, treatment, cure or relief of a dental condition, illness, injury or disease.

Dental Carrier. An entity that offers a policy, certificate or contract that provides coverage solely for Dental Care Services and is: an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a dental service corporation organized under M.G.L. c. 176E, or an organization entering into a preferred Provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees or one or more subsidiaries or affiliated corporations of the employer, that offers a policy, certificate or contract that provides coverage solely for Dental Care Services.

Discharge Planning. The formal process for determining, prior to discharge from a Facility, the coordination and management of the care that an Insured receives following discharge from a Facility.

Division. The Division of Insurance established pursuant to M.G.L. c. 26, § 1.

Emergency Medical Condition. A medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an Insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Evidence of Coverage. Any certificate, contract or agreement of health insurance including riders, amendments, endorsements and any other supplementary inserts or a summary plan description pursuant to § 104(b)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1024(b), issued to an Insured specifying the Benefits to which the Insured is entitled. For workers' compensation preferred Provider arrangements, the Evidence of Coverage will be considered to be the information annually distributed pursuant to 211 CMR 51.04(3)(i)1. through 3.

Facility. A licensed institution providing Health Care Services or a health care setting including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

Finding of Neglect. A written determination by the Commissioner that a Carrier has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required.

52.02: continued

Grievance. Any oral or written Complaint submitted to the Carrier that has been initiated by an Insured, or on behalf of an Insured with the consent of the Insured, concerning any aspect or action of the Carrier relative to the Insured including, but not limited to, review of Adverse Determinations regarding scope of coverage, denial of services, rescission of coverage, quality of care and administrative operations, in accordance with the requirements of M.G.L. c. 176O and 958 CMR 3.000: *Health Insurance Consumer Protection*.

Health Benefit Plan. A policy, contract, certificate or agreement of insurance entered into, offered or issued by a Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services. Unless otherwise noted, Health Benefit Plan shall not include any policy, certificate, or contract that is not a health benefit plan as defined in M.G.L. c. 176J, § 1.

Health Care Professional. A physician or other health care practitioner licensed, accredited or certified to perform specified Health Services consistent with the law.

Health Care Provider or Provider. A Health Care Professional or Facility.

Health Care Services or Health Services. Services for the evaluation, consultation, prescribing, diagnosis, prevention, treatment, management, cure or relief of a physical, behavioral, substance use disorder or mental health condition, illness, injury or disease.

HMO. A health maintenance organization licensed pursuant to M.G.L. c. 176G.

Incentive Plan. Any compensation arrangement between a Carrier and Health Care Professional or Licensed Health Care Provider Group or organization that employs or utilizes services of one or more licensed Health Care Professionals that may directly or indirectly have the effect of reducing or limiting specific services furnished to Insureds of the organization. Incentive Plan shall not mean contracts that involve general payments such as Capitation payments or shared risk agreements that are made with respect to Health Care Professionals or Providers, or Health Care Professional groups or Provider groups which are made with respect to groups of Insureds if such contracts, which impose risk on such Health Care Professionals or Providers or Health Care Professional groups or Provider groups for the cost of medical care, services and equipment provided or authorized by another Health Care Professional or Provider or by another Health Care Professional group or Provider group, comply with 211 CMR 52.00.

Inquiry. Any communication by or on behalf of an Insured to the Carrier or Utilization Review Organization that has not been the subject of an Adverse Determination and that requests redress of an action, omission or policy of the Carrier.

Insured. An enrollee, covered person, Insured, member, policy holder or subscriber of a Carrier, including a Dental or Vision Carrier, including an individual whose eligibility as an Insured of a Carrier is in dispute or under review, or any other individual whose care may be subject to review by a Utilization Review program or entity as described under the provisions of M.G.L. c. 176O, 211 CMR 52.00 and 958 CMR 3.000: *Health Insurance Consumer Protection*.

Internet Website. Includes, but shall not be limited to, an internet website, an intranet website, a web portal, or electronic mail.

JCAHO. The Joint Commission on Accreditation of Healthcare Organizations.

Licensed Health Care Provider Group. A partnership, association, corporation, individual practice association, or other group that distributes income from the practice among members. An individual practice association is a Licensed Health Care Provider Group only if it is composed of individual Health Care Professionals and has no subcontracts with Licensed Health Care Provider Groups.

Limited Health Services. Pharmaceutical services, and such other services as may be determined by the Commissioner to be Limited Health Services. Limited Health Services shall not include hospital, medical, surgical or emergency services, except as such services are provided in conjunction with the Limited Health Services set forth in the preceding sentence.

52.02: continued

Limited Network Plan. A Limited Network plan as defined in 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks.*

Managed Care Organization or MCO. A Carrier subject to M.G.L. c. 176O.52.02: continued

Material Change. A modification to any of a Carrier's, including a Dental or Vision Carrier's, procedures or documents required by 211 CMR 52.00 that substantially affects the rights or responsibilities of:

- (a) an Insured;
- (b) a Carrier, including a Dental or Vision Carrier; and/or
- (c) a Health, Dental, or Vision Care Provider.

Medical Necessity or Medically Necessary. Health Care Services that are consistent with generally accepted principles of professional medical practice as determined by whether:

- (a) the service is the most appropriate available supply or level of service for the Insured in question considering potential benefits and harms to the individual;
- (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
- (c) for services and interventions not in widespread use, is based on scientific evidence.

National Accreditation Organization. JCAHO, NCQA, URAC or any other national Accreditation entity approved by the Division that accredits Carriers that are subject to the provisions of M.G.L. c. 176O and 211 CMR 52.00.

NCQA. The National Committee for Quality Assurance.

NCQA Standards. The Standards and Guidelines for the Accreditation of Health Plans published annually by the NCQA.

Network or Provider Network. A group of health, Dental or Vision Care Providers who contract with a Carrier, including a Dental or Vision Carrier, or affiliate to provide health, Dental or Vision Care Services to Insureds covered by any or all of the Carrier's, including a Dental or Vision Carrier's or affiliate's, plans, policies, contracts or other arrangements. Network shall not mean those Participating Providers who provide services to subscribers of a nonprofit hospital service corporation organized under M.G.L. c. 176A, or a nonprofit medical service corporation organized under M.G.L. c. 176B.

Nongatekeeper Preferred Provider Plan. An insured preferred Provider plan approved for offer under M.G.L. c. 176I which offers preferred Benefits when a covered person receives care from preferred Network Providers but does not require the Insured to designate a Primary Care Provider to coordinate the delivery of care or receive referrals from the Carrier or any Network Provider as a condition of receiving Benefits at the preferred benefit level.

Nurse Practitioner. A registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under M.G.L. c. 112, § 80B.

Office of Patient Protection. The office within the Health Policy Commission established by M.G.L. c. 6D, § 16, responsible for the administration and enforcement of M.G.L. c. 176O, §§ 13, 14, 15 and 16.

Participating Provider. A Provider who, under a contract with the Carrier, including a Dental or Vision Carrier, or with its contractor or subcontractor, has agreed to provide health, Dental or Vision Care Services to Insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the Carrier, including a Dental or Vision Carrier.

52.02: continued

Pharmacy Benefit Manager. A person, business or other entity, however organized, that directly or through a subsidiary provides Pharmacy Benefit Management Services for prescription drugs and devices on behalf of a Health Benefit Plan sponsor, including but not limited to, a self-insurance plan, labor union or other third-party payer. Beginning January 1, 2026, a Carrier may contract for Pharmacy Benefit Management Services in Massachusetts only with a Pharmacy Benefit Manager licensed by the Division.

Pharmacy Benefit Management Services. Services performed by a Pharmacy Benefit Manager, including:

- (a) negotiating the price of prescription drugs, including negotiating and contracting for direct or indirect rebates, discounts or other price concessions;
- (b) managing any aspects of a prescription drug benefit, including, but not limited to, formulary administration, mail-order pharmacy and specialty drug pharmacy services, clinical, safety and adherence programs for pharmacy service, the processing and payment of claims for prescription drugs, arranging alternative access to or funding for prescription drugs, the performance of drug Utilization Review, the processing of drug Prospective Review requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, controlling the cost of covered prescription drugs and managing or providing data relating to the prescription drug benefit or the provision of services related thereto;
- (c) performance of any administrative, managerial, clinical, pricing, financial, reimbursement, data administration or reporting or billing service related to a Health Benefit Plan's prescription drug benefit; and
- (d) such other services as defined by the Division.

Physician Assistant. A person who is a graduate of an approved program for the training of physician assistants who is supervised by a registered physician in accordance with M.G.L. c. 112, § 9C through 9H and who has passed the Physician Assistant National Certifying Exam or its equivalent.

Preventive Health Services. Any periodic, routine, screening or other services designed for the prevention and early detection of illness that a Carrier is required to provide pursuant to Massachusetts or federal law.

Primary Care Provider. A Health Care Professional qualified to provide general medical care for common health care problems, who supervises, coordinates, prescribes, or otherwise provides or proposes Health Care Services; initiates referrals for Specialty Care; and maintains continuity of care within the scope of his or her practice. A Primary Care Provider may include but not be limited to medical doctors and Nurse Practitioners and Physician Assistants who concentrate in primary care, pediatric primary care, and/or gynecological and reproductive health.

Primary Care Services. Services delivered by a Primary Care Provider.

Prospective Review. Utilization Review conducted prior to an admission or a course of treatment. Prospective Review shall include any pre-authorization and pre-certification requirements of a Carrier or Utilization Review Organization.

Regional Network Plan. A Regional Network Plan as defined in 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*.

Religious Non-medical Provider. A Provider who provides no medical care but who provides only religious non-medical treatment or religious non-medical nursing care.

Retrospective Review. Utilization Review of Medical Necessity that is conducted after services have been provided to a patient. Retrospective Review shall not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

52.02: continued

Same or Similar Specialty. The Health Care Professional has similar credentials and licensure as those who typically provide the treatment in question and has experience treating the same condition that is the subject of the Grievance. Such experience shall extend to the treatment of children in a Grievance involving a child where the age of the patient is relevant to the determination of whether a requested service or supply is Medically Necessary.

Second Opinion. An opportunity or requirement to obtain a clinical evaluation by a Health Care Professional other than the Health Care Professional who made the original recommendation for a proposed Health Service, to assess the clinical necessity and appropriateness of the initial proposed Health Service.

Service Area. The geographical area as approved by the Commissioner within which the Carrier, including a Dental or Vision Carrier, has developed a Network of Providers to afford adequate access to members for covered Health, Dental or Vision Services.

Site of Service Plan. An insured Health Benefit Plan where access to certain specified Network Providers or access to care in certain specified settings may only be available when the Carrier determines that it is medically necessary to receive covered care from these certain Providers or the certain settings. The Utilization Review processes and Medical Necessity criteria used are required to meet the relevant requirements of 211 CMR 52.00 and any requirements as determined by the Commissioner. Whenever a request for services provided by certain specified Network Providers for care at certain specified locations is denied, Carriers with Site of Service Plans are to follow all required protocols for Adverse Determination notices and appeals as required under 211 CMR 52.00.

Specialty or Specialty Care. Healthcare services dedicated to a specific branch of medicine or all healthcare services not considered primary care. Patients can be referred to a specialist by a Primary Care Provider for disease-specific care that requires expert support.

Telehealth. The use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology including, but not limited to:

- (a) interactive audio-video technology;
- (b) remote patient monitoring devices;
- (c) audio-only telephone; and
- (d) online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating, managing, or monitoring of a patient's physical health, oral health, mental health or substance use disorder condition.

Terminally Ill or Terminal Illness. An illness that is likely, within a reasonable degree of medical certainty, to cause one's death within six months, or as otherwise defined in section 1861(dd)(3)(A) of the Social Security Act, 42 U.S.C. § 1395x(dd)(3)(A).

Tiered Network Plan. A Tiered Network Plan as described in 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*.

URAC. The American Accreditation HealthCare Commission/URAC, formerly known as the Utilization Review Accreditation Commission.

Utilization Review. Set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, Health Care Services, procedures or settings. Such techniques may include, but are not limited to, Ambulatory Review, Prospective Review, Second Opinion, certification, Concurrent Review, Case Management, Discharge Planning or Retrospective Review.

Utilization Review Organization. An entity that conducts Utilization Review under contract with or on behalf of a Carrier, but does not include a Carrier performing Utilization Review for its own Health Benefit Plans. A Behavioral Health Manager is considered a Utilization Review Organization. A Pharmacy Benefit Manager may be considered a Utilization Review Organization if it conducts Utilization Review.

52.02: continued

Vision Benefit Plan. A policy, contract, certificate or agreement of insurance entered into, offered or issued by a Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for Vision Care Services.

Vision Care Professional. An ophthalmologist, optometrist or other practitioner licensed, accredited or certified to perform specified Vision Services consistent with the law.

Vision Care Provider. A Vision Care Professional; or a Facility licensed to perform and provide Vision Care Services.

Vision Care Services or Vision Services. Services for the diagnosis, prevention, treatment, cure or relief of a vision condition, illness, injury or disease.

Vision Carrier. An entity that offers a policy, certificate or contract that provides coverage solely for Vision Care Services and is: an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; an optometric service corporation organized under M.G.L. c. 176F, or an organization entering into a preferred Provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, that offers a policy, certificate or contract that provides coverage solely for Vision Care Services.

Visit. A scheduled, urgent, or emergency encounter between a covered patient and a Health Care Professional, whether conducted within the Health Care Professional's office, another physical location or conducted *via* synchronous or Asynchronous Telehealth, to evaluate, diagnose, consult, treat, conduct clinical trials, prescribe, manage or monitor a covered medical, oral health or behavioral health condition. Within a Visit, the Health Care Professional will review patient history, examine the patient's condition, and exercise medical judgment in treating a patient. In the case of Telehealth Visits, a Health Care Professional must receive consent from a patient that the encounter will constitute a Visit and may be subject to Health Benefit Plan Cost-sharing if the Health Care Professional ever seeks reimbursement for the Telehealth encounter from either the patient or the patient's Carrier.

52.03: Accreditation of Carriers

(1) A Carrier must be accredited according to the requirements set forth in 211 CMR 52.00 in order to offer for sale, provide, or arrange for the provision of a defined set of Health Care Services to Insureds through affiliated and contracting Providers or employ Utilization Review in making decisions about whether services are Covered Benefits under a Health Benefit Plan.

(2) Accreditation granted to Carriers pursuant to 211 CMR 52.00 shall remain in effect for up to 24 months until the end of the respective biennial Accreditation period, unless revoked or suspended by the Commissioner.

(3) A Carrier shall be exempt from 211 CMR 52.00 if in the written opinion of the Attorney General, the Commissioner, and the Commissioner of Public Health, the health and safety of health care consumers would be materially jeopardized by requiring Accreditation of the Carrier.

(a) Before publishing a written exemption pursuant to 211 CMR 52.03(3), the Attorney General, the Commissioner, and the Commissioner of Public Health shall jointly hold at least one public hearing at which testimony from interested parties on the subject of the exemption shall be solicited.

(b) A Carrier granted an exemption pursuant to 211 CMR 52.03(3) shall be provisionally accredited and, during such provisional Accreditation, shall be subject to review not less than every four months and shall be subject to those requirements of M.G.L. c. 176O and 211 CMR 52.00 as deemed appropriate by the Commissioner.

(c) Before the end of each four-month period specified in 211 CMR 52.03(3)(b) the Commissioner shall review the Carrier's exemption.

1. If the Bureau determines that the Carrier has met the requirements of 211 CMR 52.00, then the Carrier shall be accredited and the exemption shall expire upon Accreditation.

52.03: continued

2. If the Commissioner determines that the Carrier's exemption should be continued, the Commissioner shall communicate that determination in writing to the Attorney General and the Commissioner of Public Health. Continuation of the exemption shall be granted only upon a written decision by the Commissioner, the Attorney General and the Commissioner of Public Health.

52.04: Deemed Accreditation

(1) A Carrier may apply for deemed Accreditation. A Carrier that applies for deemed Accreditation may be deemed to be in compliance with the standards set forth in 211 CMR 52.00 and may be so accredited by the Bureau if it meets the following requirements:

- (a) It must be accredited by JCAHO, NCQA or URAC;
- (b) It must meet all the requirements set forth in M.G.L. c. 176O, 211 CMR 52.00 and 958 CMR 3.000: *Health Insurance Consumer Protection*; and
- (c) It must have received the ratings specified in 211 CMR 52.05(5)(c) and (d).

(2) For a Carrier that applies for deemed Accreditation:

- (a) If the Carrier meets or exceeds the ratings identified in 211 CMR 52.05(5)(c), the Carrier shall not be further reviewed by the Bureau for compliance with the standards set forth in 211 CMR 52.07 and 52.08 for that applicable period.
- (b) If the Carrier meets or exceeds the ratings identified in 211 CMR 52.05(5)(d), the Carrier shall not be further reviewed by the Bureau for compliance with the standards set forth in 211 CMR 52.09 for that applicable period.

(3) A Carrier shall not be eligible for deemed Accreditation status if the National Accreditation Organization has revoked the Carrier's Accreditation status in the past 24 months or the Accreditation status of an entity that currently contracts with the Carrier to provide services regulated by M.G.L. c. 176O.

(4) A Carrier that has applied for deemed Accreditation and been denied, shall be considered an applicant for Accreditation under 211 CMR 52.05(3) or (4). Denial of a request for deemed Accreditation shall not be eligible for reconsideration under 211 CMR 52.06(5).

(5) If a Carrier has received Accreditation from a National Accreditation Organization, or a subcontracting organization, with whom the Carrier has a written agreement delegating certain services, or has received Accreditation or certification from a National Accreditation Organization, but under standards other than those identified in 211 CMR 52.05(5), the Carrier may submit the documents indicating such Accreditation or certification so that the Division may consider this in developing the scores described in 211 CMR 52.06(1).

52.05: Application for Accreditation

(1) Timing of Application.

- (a) Carriers must submit biennial renewal applications by July 1st for renewals to be effective on November 1st.
- (b) A Carrier seeking initial Accreditation must submit an application at least 90 Days prior to the date on which it intends to offer Health Benefit Plans.

(2) Inapplicability of Accreditation Requirements.

- (a) A Carrier that provides coverage for Limited Health Services only, that does not provide services through a Network or through Participating Providers or for which other requirements set forth in 211 CMR 52.05 are otherwise inapplicable may indicate within its application which of those items are inapplicable to its Health Benefit Plan and provide an explanation of why the Carrier is exempt from each particular requirement.

52.05: continued

(b) A Carrier that provides coverage for specified services through a workers' compensation preferred Provider arrangement may provide evidence of compliance with 211 CMR 51.00: *Preferred Provider Health Plans and Workers' Compensation Preferred Provider Arrangements* and 452 CMR 6.00: *Utilization Review and Quality Assessment* to satisfy the materials required by 211 CMR 52.05(3)(b), (e), (g), (h), (i), (j), (l), and (n). A Carrier that provides coverage for specified services through a workers' compensation preferred Provider arrangement may provide evidence of compliance with 211 CMR 51.00 and 452 CMR 6.00 to satisfy the materials required by 211 CMR 52.05(4)(d) and (g).

(3) Initial Application. Any Carrier seeking initial Accreditation under M.G.L. c. 176O must submit an application that contains at least the materials applicable for Massachusetts described in 211 CMR 52.05(3)(a) through (s) in a format specified by the Commissioner. Any Carrier that contracts with another organization to perform any of the functions specified in 211 CMR 52.00 is responsible for collecting and submitting all of such materials from the contracting organization.

- (a) A filing fee of \$1,000 made payable to the Commonwealth of Massachusetts;
- (b) A complete description of the Carrier's Utilization Review policies and procedures;
- (c) A written attestation by a company officer to the Commissioner that the Utilization Review program of the Carrier or its designee complies with all applicable state and federal laws concerning confidentiality and reporting requirements;
- (d) A copy of the most recent existing survey described in 211 CMR 52.07(13);
- (e) A complete description of the Carrier's internal Grievance procedures consistent with 958 CMR 3.000: *Health Insurance Consumer Protection* and a complete description of the external review process consistent with 958 CMR 3.000: *Health Insurance Consumer Protection*;
- (f) A complete description of the Carrier's process to establish guidelines for Medical Necessity consistent with 958 CMR 3.000: *Health Insurance Consumer Protection*;
- (g) A complete description of the Carrier's quality management and improvement policies and procedures;
- (h) A complete description of the Carrier's credentialing policies and procedures for all Participating Providers;
- (i) A complete description of the Carrier's policies and procedures for providing or arranging for the provision of Preventive Health Services;
- (j) A sample of every Provider contract used by the Carrier or the organization with which the Carrier contracts, unless the Commissioner has requested the Provider contract under 52.05(3)(k);
- (k) All contracts the Carrier has with a subcontracting organization and/or delegated vendor that performs Utilization Review, member services, or pharmacy benefit management on behalf of the Carrier, as well as any Provider contracts requested by the Commissioner;
- (l) A statement that advises the Bureau whether the Carrier has issued new contracts, revised existing contracts, made revisions to fee schedules in any existing contract with a Health Care Professional or Provider or Health Care Professional or Provider group that imposes financial risk on such Health Care Professional or Provider or Health Care Professional or Provider group for the costs of medical care, services or equipment provided or authorized by another Health Care Professional or Health Care Provider. If the Carrier has any such contracts or fee schedules, the Carrier shall identify the contracts in which such arrangement exists and identify the sections of the contracts that comply with 211 CMR 52.11(4);
- (m) A statement that advises the Bureau whether the Carrier has contracts with Providers that places the Provider into a Limited, Regional, or Tiered Network Plan subject to 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*. If the Carrier has any such contract, the Carrier shall identify the contracts in which such arrangements exist and identify the sections of the contracts that comply with 211 CMR 152.05: *Provider Contracts in Limited, Regional and Tiered Provider Network Plans*;
- (n) A complete description of the Carrier's Network adequacy standards, along with an access analysis meeting the requirements of 211 CMR 52.12(2);

52.05: continued

- (o) A copy of every Provider directory used by the Carrier, including a summary description of the insured's Telehealth coverage and access to Telehealth services including, but not limited to, Behavioral Health Services, Chronic Disease Management, and Primary Care Services *via* Telehealth, as well as the telecommunications technology platforms that are available for insureds to use to access Telehealth services;
- (p) Evidence satisfactory to the Commissioner that the Carrier is providing adequate access within its Network to pain management services, including non-opioid and non-pharmaceutical service options;
- (q) Evidence satisfactory to the Commissioner that the Carrier is providing adequate access within its Network to Behavioral Health Services, Chronic Disease Management, and Primary Care Services *via* Telehealth, including the following:
 - 1. Communications for use with Providers that specify the Providers' service and documentation standards necessary in order for Telehealth services to be covered by the Carrier;
 - 2. A statement that restricts covered Telehealth visits to those that are compatible with state/federal privacy standards;
 - 3. A list of the services that will not be covered when provided to a covered person *via* Telehealth, and an explanation for why these services are not covered;
 - 4. An explanation of how and when cost-sharing (copayments, coinsurance, and deductibles) will apply for Telehealth services, and if cost-sharing is waived, a description of the exact circumstances under which the cost-sharing will be waived with a company officer stating how the Carrier intends to reimburse Providers for Telehealth services, including an identification of the billing codes, location codes or other codes that the Carrier intends to use to reimburse Providers for Telehealth services, and the following information for Telehealth services.
 - 5. A statement of how the Carrier intends to reimburse Providers for the following Telehealth services:
 - a. Behavioral Health Services;
 - b. Primary Care Services;
 - c. Chronic Disease Management Services;
 - d. Physical exams, including those that have both Telehealth and in-person components; and
 - 6. When Telehealth may be used for follow-up care, including but not limited to follow-up care provided by Asynchronous Telehealth that may be considered less than a Visit, a description of how the Carrier intends to reimburse Providers for these follow-up Telehealth services;
- (r) The Evidence of Coverage for every product offered by the Carrier;
- (s) A copy of each disclosure described in 211 CMR 52.14, if applicable;
- (t) A written attestation by a company officer that the Carrier has complied with 211 CMR 52.16;
- (u) An explanation of how the Carrier, directly or through any entity that manages or administers mental health or substance use disorder benefits for the Carrier, utilizes a base fee schedule for evaluation and management services for Behavioral Health Providers that is not less than the base fee schedule used for evaluation and management services for Primary Care Providers of the same or similar licensure type and in the same geographic region, and an explanation how the Carrier has established such a base fee schedule for Behavioral Health Providers while not lowering its base fee schedule for Primary Care Providers; and
- (v) Any additional information as deemed necessary by the Commissioner.

(4) Renewal Application. Any Carrier seeking renewal of Accreditation under M.G.L. c. 176O must submit an application that contains at least the materials for Massachusetts described in 211 CMR 52.05(4)(a) through (m) in a format specified by the Commissioner. Any Carrier that contracts with another organization to perform any of the functions specified in 211 CMR 52.00 is responsible for collecting and submitting all of such materials from the contracting organization.

- (a) A filing fee of \$1,000 made payable to the Commonwealth of Massachusetts;
- (b) A written attestation by a company officer to the Commissioner that the Utilization Review Program of the Carrier or its designee complies with all applicable state and federal laws concerning confidentiality and reporting requirements;

52.05: continued

- (c) A copy of the most recent survey described in 211 CMR 52.07(13);
- (d) A copy of the Prospective Review report described in 211 CMR 52.07(12);
- (e) A sample of every Provider contract used by the Carrier or the organization with which the Carrier contracts since the Carrier's most recent Accreditation, unless the Commissioner has requested the Provider contract under 52.05(4)(e);
- (f) All contracts the Carrier has with a subcontracting organization or delegated vendor that performs Utilization Review, medical management, member services, or pharmacy benefits management on behalf of the Carrier, as well as any Provider contracts requested by the Commissioner;
- (g) A statement that advises the Bureau whether the Carrier has issued new contracts, revised existing contracts, made revisions to fee schedules in any existing contract with a Health Care Professional or Provider or Health Care Professional or Provider group that impose financial risk on such Health Care Professional or Provider, or Health Care Professional or Provider group for the costs of medical care, services or equipment provided or authorized by another Health Care Professional or Health Care Provider. If the Carrier has issued or revised any such contracts or revised any fee schedules, the Carrier shall identify the contracts in which such changes were made and identify the sections of the contracts that comply with 211 CMR 52.11(4) and 152.05: *Provider Contracts in Limited, Regional and Tiered Provider Network Plans*;
- (h) A statement that advises the Bureau whether the Carrier has issued new contracts or revised existing contracts with Providers that places the Provider into a limited, regional, or tiered Network subject to 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*. If the Carrier has made any of the specified changes, the Carrier shall identify the contracts in which such changes were made and identify the sections of the contracts that comply with 211 CMR 152.05: *Provider Contracts in Limited, Regional and Tiered Provider Network Plans*;
- (i) Any Material Change made to the Carrier's Network adequacy standards, along with an access analysis meeting the requirements of 211 CMR 52.11(2);
- (j) The Evidence of Coverage for every product offered by the Carrier, and for every product that has Insureds but is no longer offered, which was revised since the Carrier's most recent Accreditation;
- (k) A copy of each Provider directory used by the Carrier, including a summary description of the insured's Telehealth coverage and access to Telehealth services including, but not limited to, Behavioral Health Services, Chronic Disease Management, and Primary Care Services *via* Telehealth, as well as the telecommunications technology platforms that are available for insureds to use to access Telehealth services;
- (l) Material Changes to any of the information contained in 211 CMR 52.05(3)(b), (e), (f), (g), (h), (i), and (s);
- (m) Evidence satisfactory to the Commissioner that the Carrier is providing adequate access within its Network to pain management services, including non-opioid and non-pharmaceutical service options;
- (n) Evidence satisfactory to the Commissioner that the Carrier is providing adequate access within its Network to Behavioral Health Services, Chronic Disease Management, and Primary Care Services *via* Telehealth, including the following:
 1. The communications for use with Providers that specify the Providers' service and documentation standards necessary in order for Telehealth services to be covered by the Carrier;
 2. A statement that restricts covered Telehealth visits to those that are compatible with state/federal privacy standards;
 3. A list of the services that will not be covered when provided to a covered person via Telehealth, and an explanation for why these services are not covered;
 4. An explanation of how and when cost-sharing (copayments, coinsurance, and deductibles) will apply for Telehealth services, and if cost-sharing is waived, a description of the exact circumstances under which the cost-sharing will be waived, with a company officer stating how the Carrier intends to reimburse Providers for Telehealth services, including an identification of the billing codes, location codes or other codes that the Carrier intends to use to reimburse Providers for Telehealth services;
 5. A statement of how the Carrier intends to reimburse Providers for the following Telehealth services:

52.05: continued

- a. Behavioral Health Services;
 - b. Primary Care Services;
 - c. Chronic Disease Management Services; and
- (o) Evidence that the Carrier, directly or through any entity that manages or administers mental health or substance use disorder benefits for the Carrier, utilizes a base fee schedule for evaluation and management services for Behavioral Health Providers that is not less than the base fee schedule used for evaluation and management services for Primary Care Providers of the same or similar licensure type and in the same geographic region, and an explanation how the Carrier has established such a base fee schedule for Behavioral Health Providers while not lowering its base fee schedule for Primary Care Providers;
- (p) A written attestation by a company officer that the Carrier has complied with 211 CMR 52.16; and
- (q) Any additional information as deemed necessary by the Commissioner.
- (5) Application for Deemed Accreditation. A Carrier seeking deemed Accreditation pursuant to 211 CMR 52.04 shall submit an application that contains the materials described in 211 CMR 52.05(5)(a) through (d).
- (a) For initial applicants, the information required by 211 CMR 52.05(3).
 - (b) For renewal applicants, the information required by 211 CMR 52.05(4).
 - (c) Proof in a form satisfactory to the Commissioner that the Carrier has attained:
 1. a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the Accreditation of Managed Care Organizations, in the categories of utilization management, quality management and improvement, and members' rights and responsibilities;
 2. a score equal to or above the rating of "accredited" in the categories of utilization management, Network management, quality management and member protections for the most recent review of health plan standards by URAC; or
 3. for Non-gatekeeper Preferred Provider Plans, a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the Accreditation of preferred Provider organizations, in the categories of utilization management, quality management and improvement, and enrollees' rights and responsibilities.
 4. for Non-gatekeeper Preferred Provider Plans, a score equal to or above the rating of "accredited" in the most recent review of health utilization management standards by URAC and a score equal or above the rating of "accredited" in the categories of Network management, quality management and member protections for the most recent review of health Network standards by URAC.
 - (d) Proof in a form satisfactory to the Commissioner that the Carrier has attained:
 1. a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the Accreditation of Managed Care Organizations, in the category of credentialing and recredentialing;
 2. a score equal to or above the rating of "accredited" in the category of Provider credentialing for the most recent review of health plan standards by URAC; or
 3. for Non-gatekeeper Preferred Provider plans, a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the Accreditation of preferred Provider organizations in the category of credentialing and recredentialing.
 4. for Non-gatekeeper Preferred Provider Plans, a score equal to or above the rating of "accredited" in the category of Provider credentialing for the most recent review of health Network standards by URAC.
- (6) Application to be Reviewed as a Non-gatekeeper Preferred Provider Plan. A Carrier shall submit a statement signed by a corporate officer certifying that none of the Carrier's insured plans require the Insured to designate a Primary Care Provider to coordinate the delivery of care or receive referrals from the Carrier or any Network Provider as a condition of receiving Benefits at the preferred benefit level.
- (7) Material Changes. Carriers shall submit to the Bureau any Material Changes to any of the items under 211 CMR 52.05(3) and (4) at least 30 Days before the effective date of the changes.

52.06: Review of Application for Accreditation

(1) Carriers shall comply with the standards set forth in M.G.L. c. 176O, 211 CMR 52.00; 958 CMR 3.000: *Health Insurance Consumer Protection*; 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*, if applicable; and all other applicable state and federal law.

(a) For all products, a Carrier shall not be accredited unless the Carrier scores 65% or higher of an aggregate of the applicable elements in the NCQA Standards, effective July 1, 2017, or any edition of such standards determined by the Commissioner to be functionally equivalent or appropriate, for the Accreditation of Health Benefit Plans, including health maintenance organizations, gatekeeper preferred Provider plans, and Non-gatekeeper Preferred Provider Plans, in the categories of utilization management, quality management and improvement, and credentialing and recredentialing.

(b) The NCQA Standards, effective July 1, 2017, or any edition of such standards determined by the Commissioner to be functionally equivalent or appropriate, are incorporated by reference into 211 CMR 52.00 to the extent that the NCQA Standards do not conflict with other laws of this Commonwealth. The NCQA Standards can be obtained from the NCQA.

(c) In reviewing the Carrier's application for Accreditation under 211 CMR 52.06, the Carrier may be given credit toward the relevant score for any Accreditation that it received, or which the Carrier's subcontracting organization, with which the Carrier has a written agreement delegating certain services, received, from a National Accreditation Organization for the standards described in 211 CMR 52.07, 52.08 or 52.09.

(2) A Carrier's application will not be considered to be complete until all materials required by M.G.L. c. 176O and 211 CMR 52.00 have been received by the Bureau. A Carrier shall respond to any request for additional information by the Bureau within 15 Days of the date of the Bureau's request. A Carrier that fails to respond in writing to requests within the 15 Days shall be subject to the penalties described in 211 CMR 52.17.

(3) The Bureau may schedule, at the Carrier's expense, on-site surveys of the Carrier's Utilization Review, quality management and improvement, credentialing and Preventive Health Services activities in order to examine records. Any on-site visit shall be scheduled within 15 Days of receipt of a Carrier's complete application.

(4) The Bureau shall notify a Carrier in writing that it is accredited or that its application for Accreditation has been denied. If an Accreditation is denied, the Bureau shall identify those items that require improvement in order to comply with Accreditation standards.

(5) A Carrier may seek reconsideration of a denial of its application for Accreditation.

(a) A Carrier whose application for Accreditation has been denied may make a written request to the Bureau for reconsideration within ten Days of receipt of the Bureau's notice.

(b) The Bureau shall schedule a meeting with the Carrier within ten Days of the receipt of the request for reconsideration to review any additional materials presented by the Carrier.

(c) Following the meeting pursuant to 211 CMR 52.06(5)(b) the Bureau may conduct a second on-site survey at the expense of the Carrier.

(d) The Bureau shall notify a Carrier in writing of the final disposition of its reconsideration.

52.07: Utilization Review

(1) Standards. A Carrier's application will be reviewed for compliance with the applicable NCQA Standards for utilization management. In addition, Carriers shall meet the requirements identified in 211 CMR 52.07(2) through (11). In cases where the standards in 211 CMR 52.07(2) through (11) differ from those in the NCQA Standards, the standards in 211 CMR 52.07(2) through (11) shall apply.

(2) Written Plan. Utilization Review conducted by a Carrier or a Utilization Review Organization shall be conducted pursuant to a written plan, under the supervision of a physician and staffed by appropriately trained and qualified personnel, and shall include a documented process to:

(a) review and evaluate its effectiveness;

52.07: continued

- (b) ensure the consistent application of Utilization Review criteria; and
 - (c) ensure the timeliness of Utilization Review determinations.
- (3) Criteria. A Carrier or Utilization Review Organization shall adopt Utilization Review criteria and conduct all Utilization Review activities pursuant to said criteria.
- (a) The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of Participating Providers, consistent with the development of Medical Necessity criteria consistent with 958 CMR 3.101: *Carrier's Medical Necessity Guidelines*.
 - (b) Utilization Review criteria, including a list of Health Services, supplies and pharmaceuticals requiring preauthorization or Prospective Review, shall be up to date and applied consistently by a Carrier or the Utilization Review Organization and made readily accessible in a searchable electronic format to subscribers, Health Care Providers and the general public on a Carrier's website; provided, however, that a Carrier shall not be required to disclose licensed, proprietary criteria purchased by a Carrier or Utilization Review Organization on its website, but must disclose such criteria to a Provider or subscriber upon request.
 - (c) Any new or amended preauthorization or Prospective Review requirement or restriction shall not be implemented unless the Carrier's publicly accessible website has been updated to clearly reflect the new or amended requirement or restriction and the Carrier has notified Providers at least 60 days prior to the effective date of the new or amended requirement or restriction.
 - (d) Adverse Determinations rendered by a program of Utilization Review, or other denials of requests for Health Services, shall be made by a person licensed in the appropriate Specialty related to such Health Services and, where applicable, by a Provider in the same licensure category as the ordering Provider.
- (4) Initial Determination Regarding a Proposed Admission, Procedure or Service.
- (a) When requiring Prospective Review for Health Services, supplies or pharmaceuticals, a Carrier shall use and accept, or a Carrier shall require and ensure that its Utilization Review Organization uses and accepts, only the Prospective Review forms designated by the Commissioner for the specific types of Health Care Services, supplies and pharmaceuticals identified in the designated forms.
 - (b) If the Carrier fails to use or accept the designated Prospective Review form, or fails to respond within time limitations established under 211 CMR 52.07(4)(c) after receiving all necessary information pursuant to the submission of the designated form under 211 CMR 52.07(4)(a), the Prospective Review request shall be deemed to have been granted. For purposes of 211 CMR 52.07, "necessary information" includes the results of any clinical evaluation that may be required.
 - (c) In addition to any other requirements under applicable law, a Carrier shall make, or a Carrier shall require and ensure that its Utilization Review Organization makes, an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working days of obtaining all necessary information; provided that if additional delay would result in serious jeopardy to the Insured's health or well-being, and the Provider electronically requests Prospective Review and presents documentation to the Carrier or Utilization Review Organization of the potential serious jeopardy to the Insured's health or well-being, a Carrier or its Utilization Review Organization shall make and communicate to the requesting Provider an initial determination not more than 24 hours following the receipt of all necessary information by the Carrier or Utilization Review Organization as applicable.
 - (d) In the case of a determination to approve an admission, procedure or service, the Carrier or Utilization Review Organization shall notify the Provider rendering the service within 24 hours, and shall send written or electronic confirmation of the notification to the Insured and the Provider within two working days thereafter.
 - (e) A Prospective Review authorization for a prescribed Health Service, supply or pharmaceutical shall be valid for at least 90 days or until the end of the benefit year, whichever is earlier. Where an Insured is stable on an evidence-based treatment plan for

52.07: continued

Chronic Disease Management, a Prospective Review authorization for that prescribed Health Service, supply or pharmaceutical shall be valid for the Insured's course of treatment, including for routine dosage adjustments of a pharmaceutical with an existing Prospective Review authorization, so long as the Insured's condition remains stable.

(f) When an Insured enrolls in a Health Benefit Plan, a Prospective Review authorization for a prescribed Health Service, supply or pharmaceutical from the immediate previous health plan will be honored by the new Carrier or Health Benefit Plan for at least 90 days after enrollment; provided that the prescribed Health Service, supply or pharmaceutical is a Covered Benefit under the new Health Benefit Plan.

(g) For an Insured who is stable on a prescribed Health Service, supply or pharmaceutical as determined by a Provider and approved for coverage by the Carrier or its Utilization Review Organization, and where the Health Service, supply or pharmaceutical is then removed from a Health Benefit Plan's formulary or is subject to new coverage restrictions after the Insured's enrollment period has ended, a Carrier shall cover the approved Health Service, supply or pharmaceutical for 90 days or the rest of the benefit year, whichever is shorter.

(h) In the case of an Adverse Determination, the Carrier or the Utilization Review Organization shall notify the Provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the Insured and the Provider within one working day thereafter.

(i) Subject to 211 CMR 52.07(4)(a) through (h), nothing in 211 CMR 52.07(4) shall:

1. require a treating Health Care Provider to obtain information regarding whether a proposed admission, procedure or service is Medically Necessary on behalf of an Insured;
2. restrict the ability of a Carrier or Utilization Review Organization to deny a claim for an admission, procedure or service if the admission, procedure or service was not Medically Necessary, based on information provided at the time of claim; or
3. shall restrict the ability of a Carrier or Utilization Review Organization to deny a claim for an admission, procedure or service if other terms and conditions of coverage are not met at the time of service or time of claim.

(5) Prospective Review for Certain Health Services, Supplies and Pharmaceuticals.

(a) A Carrier or its Utilization Review Organization shall not require Prospective Review for:

1. emergency services that are provided to an Insured for Emergency Medical Conditions, whether provided in or out of Network;
2. inpatient acute care services that are provided to an Insured in Network;
3. post-acute care services that are provided on weekends or holidays to an Insured in Network;
4. urgent care services that are provided to an Insured in Network;
5. Primary Care Services that are provided to an Insured in Network;
6. pharmaceuticals for chronic conditions as identified pursuant to section 47CCC of chapter 175, section 8DDD of chapter 176A, section 4DDD of chapter 176B, and section 4VV of chapter 176G, that are provided to an Insured in Network;
7. Preventive Health Services that are provided to an Insured in Network;
8. vaccinations that are provided to an Insured in Network;
9. abortion and abortion-related care that is provided to an Insured in Network;
10. maternity services that are provided to an Insured in Network;
11. for those Insureds with an already confirmed cancer diagnosis, plain radiography, ultrasound, computed tomography, magnetic resonance imaging, scintigraphy and echocardiogram, used to stage or determine treatment efficacy, that is provided to an Insured in Network;
12. physical therapy, occupational therapy, and speech therapy that are provided to an Insured in Network; and
13. pharmaceuticals for serious persistent mental illness that are provided to an Insured in Network;
14. outpatient substance use disorder services that are provided to an Insured in Network.

52.07: continued

(b) Notwithstanding the foregoing, with regard to services within the categories of post-acute care services provided on weekends or legal holidays, pharmaceuticals for chronic conditions as identified pursuant to section 47CCC of chapter 175, section 8DDD of chapter 176A, section 4DDD of chapter 176B, and section 4VV of chapter 176G, physical therapy, occupational therapy, speech therapy, for those Insureds with an already confirmed cancer diagnosis, plain radiography, ultrasound, computed tomography, magnetic resonance imaging, scintigraphy and echocardiogram, used to stage or determine treatment efficacy, pharmaceuticals for serious persistent mental illness, outpatient substance use disorder services, and Chronic Disease Management pursuant to 211 CMR 52.07(4)(e), if a Carrier experiences and can demonstrate to the Division's satisfaction that there has been a significant increase in the risk-adjusted utilization of a specific Health Services, supplies or pharmaceuticals for two consecutive quarters, the Carrier may submit an application with corresponding supportive data to the Division for consideration of a limited use of Prospective Review requirements for a designated, time-limited period. The notice and website provisions set forth in this regulation shall otherwise apply to the introduction of the new limited period Prospective Review requirements so approved by the Division.

(c) At the discretion of the Commissioner, the Division shall examine the financial, administrative and clinical impacts of maintaining or eliminating Prospective Review for other specific Health Services, supplies, and pharmaceuticals, including the impacts on appropriate or inappropriate use, the extent to which alternative services or benefits that are more expensive or less expensive may exist, the effects on the overall cost, quality of patient care and health equity in the Commonwealth; and the results of any professionally accepted research pertaining thereto. The Division may request public comment, and may contract with an actuary, economist or other technical experts as necessary for this examination.

(6) Concurrent Review. A Carrier or the Utilization Review Organization shall make a Concurrent Review determination within one working day of obtaining all necessary information.

(a) In the case of a determination to approve an extended stay or additional services, the Carrier or Utilization Review Organization shall notify the Provider rendering the service by telephone within one working day, and shall send written or electronic confirmation to the Insured and the Provider within one working day thereafter. A written or electronic notification shall include the number of extended Days or the next review date, the new total number of Days or services approved, and the date of admission or initiation of services.

(b) In the case of an Adverse Determination, the Carrier or Utilization Review Organization shall notify the Provider rendering the service by telephone within 24 hours, and shall send written or electronic notification to the Insured and the Provider within one working Day thereafter.

(c) The service shall be continued without liability to the Insured until the Insured has been notified of the determination.

(7) Written Notice. The written notification of an Adverse Determination shall include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum:

(a) include information about the claim including, if applicable, the date(s) of service, the Health Care Provider(s), the claim amount, and any diagnosis, treatment, and denial code(s) and their corresponding meaning(s);

(b) identify the specific information upon which the Adverse Determination was based shall explain the reason for any denial, including the specific Utilization Review criteria or Benefits provisions used in the determination, and;

(c) discuss the Insured's presenting symptoms or condition, diagnosis and treatment interventions;

(d) explain in a reasonable level of detail the specific reasons such medical evidence fails to meet the relevant medical review criteria;

(e) reference and include, or provide a website link(s) to the specifically applicable, clinical practice guidelines, medical review criteria, or other clinical basis for the Adverse Determination;

52.07: continued

- (f) a description of any additional material or information necessary for the Insured to perfect the claim and an explanation of why such material or information is necessary;
- (g) if the Carrier specifies alternative treatment options which are Covered Benefits, include identification of Providers who are currently accepting new patients;
- (h) prominently explain all appeal rights applicable to the denial, including a clear, concise and complete description of the Carrier's formal internal Grievance process and the procedures for obtaining external review pursuant to 958 CMR 3.000: *Health Insurance Consumer Protection*, and a clear, prominent description of the process for seeking expedited internal review and concurrent expedited internal and external reviews, including applicable timelines, pursuant to 958 CMR 3.000; and a clear and prominent notice of a patient's right to file a Grievance with the with the Office of Patient Protection; and information on how to file a Grievance with the Office of Patient Protection.
- (i) prominently notify the Insured of the availability of, and contact information for, the consumer assistance toll-free number maintained by the Office of Patient Protection, and if applicable, the Massachusetts consumer assistance program; and
- (j) include a statement, prominently displayed on all product/plan materials in at least the languages identified by the Centers for Medicare & Medicaid Services as the top non-English languages in Massachusetts, that clearly indicates how the Insured can request oral interpretation and written translation services from the Carrier consistent with 958 CMR 3.000: *Health Insurance Consumer Protection*.

(8) Reconsideration of an Adverse Determination. A Carrier or Utilization Review Organization shall give a Provider treating an Insured an opportunity to seek reconsideration of an Adverse Determination from a Clinical Peer Reviewer in any case involving an initial determination or a Concurrent Review determination.

- (a) The 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 the reviewer cannot be available within one working day.
- (b) If the Adverse Determination is not reversed by the reconsideration process, the Insured, or the Provider on behalf of the Insured, may pursue the Grievance process established pursuant to 958 CMR 3.000: *Health Insurance Consumer Protection*.
- (c) The reconsideration process allowed pursuant to 211 CMR 52.07(7) shall not be a prerequisite to the internal Grievance process or an expedited appeal required by 958 CMR 3.000: *Health Insurance Consumer Protection*.

(9) Continuity of Care. A Carrier must provide evidence that its policies regarding continuity of care comply with all provisions of 958 CMR 3.000: *Health Insurance Consumer Protection*.

(10) Step Therapy. A Carrier must provide evidence that its protocols regarding step therapy comply with all provisions of section 12A of chapter 176O.

(11) Workers' Compensation Preferred Provider Arrangement. A Carrier that provides specified services through a workers' compensation preferred Provider arrangement shall be deemed to have met the requirements of 211 CMR 52.07, except 211 CMR 52.07(10), if it has met the requirements of 452 CMR 6.00: *Utilization Review and Quality Assessment*.

(12) Prospective Review Submissions.

- (a) A Carrier shall submit a report as part of its biennial managed care accreditation submission under 211 CMR 52.05, signed by the Carrier's medical officer, that presents detailed information about the manner and timing of how the Carrier has reviewed Health Services, supplies and pharmaceuticals, including specific service codes, subject to Prospective Review. The report shall specifically include:
 1. a list of the Health Services, supplies and pharmaceuticals, including specific service codes, subject to Prospective Review as of January 1 of the following year where the Carrier has approved over 98% of all requests in the last available calendar year, including approvals following an appeal of a denial, for that specific service, supply or pharmaceutical and the reasons supporting the continued use of Prospective Review;

52.07: continued

2. a list of the Health Services, supplies and pharmaceuticals, including service codes, for which Prospective Review will no longer be required by the Carrier as of January 1 of the following year and the reasons supporting their discontinued use; and
3. a list of the Health Services, supplies and pharmaceuticals, including service codes, subject to Prospective Review in the last available calendar year, including the number of requests reviewed per item, the number of requests approved, modified, and denied per item, as well as information about denied requests that were appealed and the results of those appeals per item.

(13) Annual Survey. A Carrier shall conduct an annual survey of Insureds to assess satisfaction with access to Primary Care Services, Specialty Care services, ancillary services, hospitalization services, durable medical equipment and other covered Health Services, supplies and pharmaceuticals, including satisfaction with Utilization Review processes used by a Carrier or its Utilization Review Organization.

- (a) The survey shall compare the actual satisfaction of Insureds with projected measures of their satisfaction.
- (b) Carriers that utilize Incentive Plans shall establish mechanisms for monitoring the satisfaction, quality of care and actual utilization compared with projected utilization of Health Care Services of Insureds.
- (c) Carriers shall submit the results of these annual surveys to the Division as part of their biennial managed care accreditation filings under 211 CMR 52.05.

(14) Religious Non-medical Treatment and Providers. Nothing in 211 CMR 52.07 shall be construed to require Health Benefit Plans to use medical professionals or criteria to decide insured access to Religious Non-medical Providers, utilize medical professionals or criteria in making decisions in internal appeals from decisions denying or limiting coverage or care by Religious Non-medical Providers, compel an Insured to undergo a medical examination or test as a condition of receiving coverage for treatment by a Religious Non-medical Provider, or require Health Benefit Plans to exclude Religious Non-medical Providers because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious non-medical treatment or nursing care provided by the Provider.

(15) Application Programming Interface. A Carrier or its Utilization Review Organization may implement and maintain an Application Programming Interface for the automated processing of Prospective Review requests to enable a Provider to: determine whether Prospective Review is required for a Health Service, supply and/or pharmaceutical; identify Prospective Review information and documentation requirements, including any standardized forms; and facilitate the exchange through secure electronic submission of Prospective Review requests and determinations from the Provider's electronic health records or practice management systems.

- (a) Beginning January 1, 2027, if a Carrier or its Utilization Review Organization implements an Application Programming Interface it shall conform with the most appropriate standards, including specifications adopted by the Secretary of the United States Department of Health and Human Services as specified in federal regulations and utilize the appropriate standard in accordance with the federal regulations and the most recent standards and guidance adopted by the United States Department of Health and Human Services to implement said regulations; provided, however, that the Application Programming Interface shall:
 1. support a Health Insurance Portability and Accountability Act-compliant Prospective Review requests and responses, as described in related federal regulations and
 2. communicate the following information about Prospective Review requests:
 - (i) whether the Carrier or its Utilization Review Organization:
 - (A) approves the Prospective Review request and the date or circumstance under which the authorization ends;
 - (B) denies the Prospective Review request; or
 - (C) requests more information; and
 - (ii) if the Carrier or its Utilization Review Organization denies the Prospective Review request, the Carrier or Utilization Review Organization shall include a specific reason for the denial.

52.07: continued

(b) Beginning January 1, 2028, unless otherwise determined by the Commissioner, if a Carrier or its Utilization Review Organization implements and maintains a Prospective Review Application Programming Interface it shall comply with the most recent version of the National Council for Prescription Drug Programs SCRIPT standard or its successor standard, and relevant federal regulations.

(c) A Carrier or its Utilization Review Organization may use financial incentives in order to require a Provider to participate in the implementation of an Application Programming Interface for the automated processing of Prospective Review.

52.08: Quality Management and Improvement

(1) Standards. A Carrier's application will be reviewed for compliance with the applicable NCQA Standards for quality management and improvement.

(2) Workers' Compensation Preferred Provider Arrangements. A Carrier that provides specified services through a workers' compensation preferred Provider arrangement shall be deemed to have met the requirements of 211 CMR 52.08 if it has met the requirements of 452 CMR 6.00: *Utilization Review and Quality Assessment.*

52.09: Credentialing

(1) A Carrier will credential all Health Care Providers according to the NCQA Standards for credentialing and recredentialing, and the Bureau of Managed Care will review a Carrier's credentialing and recredentialing processes that are set forth in the Carrier's application for Accreditation for compliance with the applicable NCQA Standards for credentialing and recredentialing if the Carrier does not have Deemed Accreditation with respect to credentialing and recredentialing.

(2) Credentialing of Health Care Professionals.

(a) A Carrier shall accept, in both electronic and paper form, a Health Care Professional credentialing application that is submitted in an application format specified by the Commissioner. For purposes of 211 CMR 52.09(2), acceptance in electronic form shall mean that a Carrier, at minimum, shall accept a Health Care Professional credentialing application by means of facsimile and electronic mail and may implement an online process for the purpose of processing credentialing applications. For purposes of 211 CMR 52.09(2), Carriers may charge Health Care Professionals a reasonable administrative charge associated with the costs of processing submissions in electronic or paper form that differs from the form used by the majority of Health Care Professionals

(b) Unless there are otherwise binding arrangements between a Carrier and specific Providers holding Carriers to a shorter time standard, a Carrier shall notify a Health Care Professional that a submitted credentialing application is incomplete no later than 20 business days after the Carrier receives the credentialing application.

(c) All Carriers shall complete credentialing of 95% of Health Care Professionals' initial Clean and Complete Credentialing Applications within 60 Days of receipt of the Health Care Professional's Clean and Complete Credentialing Application, and all Carriers shall complete credentialing of 95% of Health Care Professionals' Clean and Complete re-Credentialing Applications within 120 Days of receipt of the Health Care Professional's Clean and Complete re-Credentialing Application, and Carriers shall inform a Health Care Professional within 75 Days of receipt of an initial Clean and Complete Credentialing Application of the status of the application, including, if applicable, the reasons for any delay in the completion of credentialing and a timeline of the expected resolution of the application and, if a Health Care Professional is not credentialed, the reasons that the Health Care Professional is not credentialed.

(3) Nothing in this 211 CMR 52.09 shall be construed to prevent a Carrier from utilizing additional credentialing information in selecting the Providers with which it contracts.

(4) Nothing in this 211 CMR 52.09 shall be construed to require a Carrier to select a Provider as a Participating Provider, even if the Provider meets the Carrier's credentialing criteria.

52.09: continued

- (5) Carriers shall maintain documentation regarding all submissions.
- (6) A Carrier shall not be required to meet the requirements of 211 CMR 52.09 if the Carrier does not provide Benefits through a Network or does not have contracts with Participating Providers.
- (7) A Carrier that provides specified services through a workers' compensation preferred Provider arrangement shall be deemed to have met the requirements of 211 CMR 52.09 if it has met the requirements of 211 CMR 51.00: *Preferred Provider Health Plans and Workers' Compensation Preferred Provider Arrangements* and 452 CMR 6.00: *Utilization Review and Quality Assessment*.
- (8) Nothing in 211 CMR 52.09 shall be construed to prevent a Carrier from implementing timelines that are more stringent than otherwise provided in 211 CMR 52.09.

52.10: Preventive Health Services

- (1) A Carrier's application will be reviewed for compliance with preventive services mandated by applicable law. A Carrier that is not an HMO shall be required to comply with 211 CMR 52.10 only to the extent of those Preventive Health Services mandated by its licensing or enabling statute or by any other applicable state or federal law.
- (2) A Carrier that provides specified services through a workers' compensation preferred Provider arrangement shall not be required to meet the requirements of 211 CMR 52.10.

52.11: Provider Contracts

- (1) Contracts between Carriers and Health Care Providers may include provisions to protect against payments that exceed the maximum allowable amount payable for such service under the applicable payment method, so long as the contracts comply with all Rules for Coordination of Benefits in 211 CMR 38.04(1) and (2).
- (a) Without limiting the generality of this provision, contracts between Carriers and Health Care Providers may include provisions that address the submission of claims for payments or reimbursements for the following inappropriate practices:
1. duplicate billing, which includes the submission of multiple claims for the same service, for the same Insured, by the same Provider or multiple Providers;
 2. overstating or misrepresenting services, including Provider upcoding or submitting separate claims for services or procedures provided as components of a more-comprehensive service for which a single rate of payment is established; and
 3. submitting inappropriate claims under an individual practitioner's provider ID/service location number.
- (2) Contracts between Carriers and Providers shall state that a Carrier shall not refuse to contract with or compensate for covered services an otherwise eligible Health Care Provider solely because such Provider has in good faith:
- (a) communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Carrier's Health Benefit Plans as they relate to the needs of such Provider's patients; or
 - (b) communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the Carrier for services provided to the patient.
- (3) Contracts between Carriers and Providers shall state that the Provider is not required to indemnify the Carrier for any expenses and liabilities including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Carrier based on the Carrier's management decisions, Utilization Review provisions or other policies, guidelines or actions.

52.11: continued

(4) No contract between a Carrier and a Licensed Health Care Provider Group may contain any Incentive Plan that includes a specific payment made to a Health Care Professional as an inducement to reduce, delay or limit specific, Medically Necessary services covered by the health care contract.

(a) Health Care Professionals shall not profit from provision of covered services that are not Medically Necessary or medically appropriate.

(b) Carriers shall not profit from denial or withholding of covered services that are Medically Necessary or medically appropriate.

(c) Nothing in 211 CMR 52.11(3) shall be construed to prohibit contracts that contain Incentive Plans that involve general payments such as Capitation payments or shared risk agreements between Carriers and Providers, so long as such contracts, which impose risk on such Providers for the costs of care, services and equipment provided or authorized by another Health Care Provider, comply with 211 CMR 52.11(4) and 211 CMR 155.00: *Risk-bearing Provider Organizations*.

(d) In the event that a Provider with which a Carrier has a contract makes any decisions about coverage of requested care, then the Carrier remains responsible to ensure compliance with all applicable Utilization Review processes including, but not limited to, Adverse Determination notices that describe rights to appeal Medical Necessity denials.

(5) No Carrier may enter into a new contract, revise the risk arrangements in an existing contract, or revise the fee schedule in an existing contract with a Health Care Provider which imposes financial risk on such Provider for the costs of care, services or equipment provided or authorized by another Provider unless such contract includes specific provisions with respect to the following:

(a) stop loss protection;

(b) minimum patient population size for the Provider group; and

(c) identification of the Health Care Services for which the Provider is at risk.

(6) No Carrier shall enter into an agreement or contract with a Health Care Provider if the agreement or contract contains a provision that:

(a) 1. limits the ability of the Carrier to introduce or modify a Limited, Regional or Tiered Network Plan by granting the Health Care Provider a guaranteed right of participation;

2. requires the Carrier to place all members of a Provider group, whether local practice groups or facilities, in the same tier of a Tiered Network Plan;

3. requires the Carrier to include all members of a Provider group, whether local practice groups or facilities, in a Limited Network Plan on an all-or-nothing basis; or

4. requires a Provider to participate in a new plan subject to 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks* that the Carrier introduces without granting the Provider the right to opt-out of the new plan at least 60 Days before the new plan is submitted to the Commissioner for approval; or

(b) requires or permits the Carrier or the Health Care Provider to alter or terminate a contract or agreement, in whole or in part, to affect parity with an agreement or contract with other Carriers or Health Care Providers or based on a decision to introduce or modify a select Network plan or Tiered Network Plan;

(c) requires or permits the Carrier to make any form of supplemental payment unless each supplemental payment is publicly disclosed to the Commissioner as a condition of Accreditation, including the amount and purpose of each payment and whether or not each payment is included within the Provider's reported relative prices and health status adjusted total medical expenses under M.G.L. c. 12C, § 10;

(d) limits the ability of either the Carrier or the Health Care Provider to disclose the allowed amount and fees of services to an Insured's treating Health Care Provider; or

(e) limits the ability of either the Carrier or the Health Care Provider to disclose out-of-pocket costs to an Insured.

(7) Contracts between Carriers and Health Care Providers shall state that neither the Carrier nor the Provider has the right to terminate the contract without cause.

52.11: continued

(8) Contracts between Carriers and Health Care Providers shall state that a Carrier shall provide a written statement to a Provider of the reason or reasons for such Provider's involuntary disenrollment.

(9) Contracts between Carriers and Health Care Providers shall state that the Carrier shall notify Providers, either by mail or electronically, of modifications in payments, modifications in covered services or modifications in a Carrier's procedures, documents or requirements, including those associated with Utilization Review, quality management and improvement, credentialing and Preventive Health Services, that have a substantial impact on the rights or responsibilities of the Providers, and the effective date of the modifications. The notice shall be provided 60 Days before the effective date of such modification, unless such other date for notice is mutually agreed upon between the Carrier and the Provider.

(10) Contracts between Carriers and Health Care Providers shall state that Providers shall not bill patients for charges for covered services other than for deductibles, copayments, or coinsurance.

(11) Contracts between Carriers and Health Care Providers shall prohibit Health Care Providers from billing patients for nonpayment by the Carrier of amounts owed under the contract due to the insolvency of the Carrier. Contracts shall further state that this requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination.

(12) Contracts between Carriers and Health Care Providers shall require Providers to comply with the Carrier's requirements for Utilization Review, quality management and improvement, credentialing and the delivery of Preventive Health Services.

(13) Contracts between Carriers and Health Care Providers shall require Providers to promptly advise Carriers when their availability to see new patients changes (including when they implement a waitlist) and shall require Carriers to make changes to reflect changes to Provider availability within two business days of receiving notice of a Provider's change in status.

(14) Nothing in 211 CMR 52.11: *Provider Contracts* shall be construed to preclude a Carrier from requiring a Health Care Provider to hold confidential specific compensation terms.

(15) Nothing in 211 CMR 52.11: *Provider Contracts* shall be construed to restrict or limit the rights of Health Benefit Plans to include as Providers Religious Non-medical Providers or to utilize medically based eligibility standards or criteria in deciding Provider status for Religious Non-medical Providers.

(16) For Dental and Vision Benefit Plans, the following provisions regarding the standards for Provider contracts found at 211 CMR 51.11: *Provider Contracts*, shall apply for Dental and Vision Benefits: 211 CMR 52.11(1) through (4) and (11).

(17) Contracts between Carriers and Health Care Providers shall recognize Nurse Practitioners and Physician Assistants as Participating Providers and shall treat services provided by Participating Provider Nurse Practitioners and Physician Assistants to their Insureds in a nondiscriminatory manner for care provided for the purposes of health maintenance, diagnosis and treatment. Such nondiscriminatory treatment shall include, but not be limited to, coverage of Benefits for primary care, intermediate care and inpatient care, including care provided in a hospital, clinic, professional office, home care setting, long-term care setting, mental health or substance abuse program, or any other setting when rendered by a Nurse Practitioner or Physician Assistant who is a Participating Provider and is practicing within the scope of his or her professional license to the extent that such policy or contract currently provides Benefits for identical services rendered by a Provider of healthcare licensed by the Commonwealth.

52.11: continued

(18) Contracts between Carriers and Behavioral Health Service Providers, or between any entity that manages or administers mental health or substance use disorder benefits for the Carrier and Behavioral Health Service Providers, shall require that the Carrier will establish a base fee schedule for evaluation and management services for Behavioral Health Service Providers that is not lower than the base fee schedule used for evaluation and management services for Primary Care Providers of the same of similar licensure type in the same geographic region. For the purposes of this item, the term "base fee schedule" means the minimum rates, typically set forth in fee schedules, paid by the Carrier to an in-Network Health Care Provider who is not paid under an alternative payment arrangement for covered Health Care Services, provided, however, that final rates may be subject to negotiations or adjustments that may result in payments to in-network providers that are different from the base schedule. Carriers are expected to issue contract amendments necessary to implement 211 CMR 52.11(18) by no later than August 10, 2023 and, when implementing 211 CMR 52.11(18), Carriers shall not lower their base fee schedules for Primary Care Providers in order to comply with this item.

(19) Contracts between Carriers and Health Care Providers shall provide clear notice to Providers about a Provider's responsibility to keep appropriate Medical Necessity records for at least six years in the event the Carrier does an audit of records as part of review of any potential fraud, waste, or abuse investigation.

(20) Contracts between Carriers and Health Care Providers shall provide clear notice to Providers about processes to audit a Provider's records retrospectively to question the Medical Necessity of claims or the accuracy of payments made and a Carrier's right to seek repayment of prior-made payments.

(21) Contracts between Carriers and Health Care Providers shall provide clear notice to Providers about timely filing requirements and the processes required by Carriers to consider claims that are submitted beyond those identified timely filing requirements.

52.12: Network Adequacy

(1) A Carrier offering a plan(s) that includes a Network(s) shall maintain such Network(s) such that it is adequate in numbers and types of Providers to assure that all covered services will be accessible to Insureds without unreasonable delay. Adequacy shall be determined in accordance with the requirements of this 211 CMR 52.12, and shall be established by reference to reasonable criteria used by the Carrier, which shall include, but not be limited to, the reasonableness of Cost-sharing in relation to the Benefits provided. In any case where the Carrier has an inadequate number or type of Participating Provider(s) to provide services for a Covered Benefit, the Carrier shall ensure that the Insured receives the Covered Benefit at the same benefit level as if the Benefit was obtained from a Participating Provider, or shall make other arrangements acceptable to the Commissioner.

(2) In accordance with 211 CMR 52.05(3) and (4), a Carrier shall file with the Commissioner an access analysis that meets the requirements of 211 CMR 52.12 for each plan that includes a Network that the Carrier offers in the Commonwealth. The Carrier shall also prepare an access analysis prior to offering a plan that includes a Provider Network, and shall update an existing access analysis whenever the Carrier makes any Material Change to such an existing plan. The access plan shall describe or contain at least the following:

- (a) The Carrier's Network(s);
- (b) A summary of the Carrier's Network adequacy standards;
- (c) The Carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the Network(s) to meet the health care needs of populations that enroll in plans with Provider Networks;
- (d) The Carrier's efforts to address the ability of the Network(s) to meet the needs of Insureds with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, or with disabilities;
- (e) The Carrier's methods for assessing the health care needs of Insureds, including but not limited to the Insureds' needs set forth in 211 CMR 52.12(2)(d), and the Insureds' satisfaction with services in relation to the development of the Network(s);

52.12: continued

- (f) The Carrier's methods for monitoring the ability of Insureds to access services out-of-Network;
- (g) A report developed using a Network accessibility analysis system such as GeoNetworks, which shall include the following, or, for Carriers in a new geographic area(s) or an area(s) that does not currently have Insureds, estimates for the following, as applicable;
1. maps showing the residential location of Insureds in Massachusetts, Primary Care Providers for both adults and children, Specialty Care practitioners, and institutional Providers;
 2. the Carrier's Network adequacy standards;
 3. geographic access tables illustrating the geographic relationship between Providers and Insureds, or for proposed plans or Service Areas, the population according to the Carrier's standards for geographic areas as appropriate for the Carrier's service area, including at a minimum:
 - a. The total number of Insureds, if applicable;
 - b. The total number of Network Primary Care Providers who are accepting new patients;
 - c. The total number of Network Primary Care Providers who are not accepting new patients;
 - d. The total number of Network Health Care Professionals who specialize in the treatment of Behavioral Health and substance use disorders who are accepting new patients;
 - e. The total number of Network Health Care Professionals who specialize in the treatment of Behavioral Health and substance use disorders, but are not accepting new patients;
 - f. The total number of Network Health Care Professionals who specialize in the top five types of Specialty Care by volume of utilization who are accepting new patients and a list of those top five types;
 - g. The total number of Network Health Care Professionals who specialize in the top five types of Specialty Care by volume of utilization who are not accepting new patients and a list of those top five types;
 - h. The total number of Network inpatient hospitals that provide treatment for acute and tertiary care;
 - i. The total number of Network inpatient hospitals that provide treatment for Behavioral Health and substance use disorders;
 - j. The percentage of Insureds meeting the Carrier's standard(s) for access through its Network to Primary Care Providers;
 - k. The percentage of Insureds meeting the Carrier's standard(s) for access through its Network to Behavioral Health and substance use disorder Health Care Professionals Practitioners;
 - l. The percentage of Insureds, meeting the Carrier's standard(s) for access through its Network to Specialty Care Health Care Professionals;
 - m. The percentage of Insureds meeting the Carrier's standard(s) for access through its Network to inpatient Behavioral Health and substance use disorder treatment;
 - n. The percentage of the number of Insureds meeting the Carrier's standard(s) for access through its Network to inpatient acute tertiary care.
- (h) If, at any time, the Carrier becomes aware of changes to the numbers of Health Care Professionals or Providers within its Network that would cause the Carrier to not meet any of its standard(s) for access, then within 30 Days of becoming aware the Carrier will submit a corrective action plan for the Commissioner's review and approval that will identify the steps that the Carrier will take to address the geographic areas where it is not meeting its standard(s) and how the Carrier plans to address access to care in those areas until Network changes are made so that the Carrier can once again satisfy its standard(s) for access to care.
- (i) In tiered Networks and/or other instances where the Commissioner finds that cost-sharing levels could cause inadequate access to Provider types, Carriers shall provide at the Commissioner's request: a Cost-sharing access analysis, illustrating the relationship between Providers at various Cost-sharing levels and Insureds; or, for proposed plans or Service Areas, the relationship between Providers and the population, according to the Carrier's standard, for every city and town. For tiered Networks, the analysis shall indicate the relationship between Providers at each tier and associated Cost-sharing level and Insureds;

52.12: continued

or, for proposed plans or Service Areas, the relationship between Providers and the population, according to the Carrier's standard, for every city and town.

(j) Any other information required by the Commissioner to determine compliance with the provisions of 211 CMR 52.12.

(3) A Carrier shall make its selection standards for Participating Providers available for review by the Commissioner.

52.13: Evidences of Coverage

(1) Evidences of Coverage as to a Carrier. It shall constitute delivery of an Evidence of Coverage if a Carrier chooses to, upon or after enrollment, require the Insured to designate whether the Insured wants to receive an Evidence of Coverage electronically or in writing. If no option is designated, the Evidence of Coverage shall be provided electronically. If the Insured designates written notice, a Carrier shall issue and deliver to at least one adult Insured in the household an Evidence of Coverage. If the Insured designates electronic notice, a Carrier shall refer the Insured to a resource where the information described in such Evidence of Coverage can be accessed including, but not limited to, an Internet Website. In such instance, the Evidence of Coverage must meet the requirements of 211 CMR 52.13(4).

An electronic copy of the Evidence of Coverage shall always be delivered to the group representative in the case of a group policy.

(2) Evidences of Coverage as to Dental and Vision Carriers. Dental and Vision Carriers shall issue and deliver to at least one adult Insured in each household residing in Massachusetts, upon enrollment:

- (a) an Evidence of Coverage;
 - (b) a summary of the information contained in the Evidence of Coverage; or
 - (c) refer the Insured to resources where the information described in such Evidence of Coverage can be accessed, including, but not limited to, an Internet Website.
- Dental and Vision Carriers shall be exempt from the provisions of 211 CMR 52.13(3)(b), (h) through (j), (q) through (x), (z) and (aa).

(3) Evidence of Coverage Requirements. An Evidence of Coverage shall contain a clear, concise and complete statement of all of the information described at 211 CMR 52.13(3)(a) through (aa). In addition, for Limited, Regional and Tiered Network Plans, an Evidence of Coverage shall also contain any information as required by 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*.

- (a) The health, Dental or Vision Care Services and any other Benefits to which the Insured is entitled on a nondiscriminatory basis, including Benefits mandated by state or federal law;
- (b) The prepaid fee which must be paid by or on behalf of the Insured and an explanation of any grace period for the payment of any Health Benefit Plan premium;
- (c) The toll-free telephone number and website established by the Carrier to identify the Network status of an identified health care Provider and present Provider cost and location information and an explanation of the information that an Insured may obtain through such toll-free number and website.
- (d) The limitations on the scope of:
 - 1. Health Care Services and any other Benefits to be provided, including:
 - a. an explanation of any Facility fee, allowed amount, coinsurance, copayment, deductible or other amount that the Insured may be responsible to pay to obtain Covered Benefits from Network or Out-of-Network Providers; and
 - b. an explanation of the information that an Insured may obtain through the toll-free number and website established by the Carrier under 211 CMR 52.14(4).
 - 2. Dental or Vision Care Services and any other Benefits to be provided, including an explanation of any deductible or copayment feature.
- (e) All restrictions relating to preexisting condition limitations or exclusions, or a statement that there are no preexisting condition limitations or exclusions if there are none under the Health, Dental or Vision Benefit Plan;

52.13: continued

- (f) A description of the locations where, and the manner in which, Health, Dental or Vision Care Services and other Benefits may be obtained, and, additionally, for Health Care Services:
1. the method to locate Provider directory information on a Carrier's website and the method to obtain a paper Provider directory;
 2. an explanation that whenever a proposed admission, procedure or covered service that is Medically Necessary is not available to an Insured within the Carrier's Network, the Carrier will cover the out-of-Network admission, procedure or service, and the Insured will not be responsible for paying more than the amount which would be required for a similar admission, procedure or service offered within the Carrier's Network; and
 3. an explanation that whenever a location where Health Care Services are provided is part of a Carrier's Network, the Carrier will cover Medically Necessary covered Benefits delivered at that location, and an explanation that the Insured will not be responsible for paying more than the amount required for Network services delivered at that location even if part of the Medically Necessary Covered Benefits are performed by out-of-Network Provider(s), unless the Insured has a reasonable opportunity to choose to have the service performed by a Network Provider.
- (g) A description of eligibility of coverage for dependents, including a summary description of the procedure by which dependents may be added to the plan;
- (h) The criteria by which an Insured may be disenrolled or denied enrollment. 211 CMR 52.13(3)(h) shall apply to Carriers, including Dental and Vision Carriers.
- (i) The involuntary disenrollment rate among Insureds of the Carrier. 211 CMR 52.13(3)(i) shall apply to Carriers, including Dental and Vision Carriers.
1. For the purposes of 211 CMR 52.13(3)(i), Carriers shall exclude all Administrative Disenrollments, Insureds who are disenrolled because they have moved out of a health plan's Service Area, Insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or Insureds who lose coverage under an employer sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, become disabled, retired or died.
 2. For the purposes of 211 CMR 52.13(3)(i), the term "involuntary disenrollment" means that a Carrier has terminated the coverage of the Insured due to any of the reasons contained in 211 CMR 52.13(3)(j)2. and 3.
- (j) The requirement that an Insured's coverage may be canceled, or its renewal refused may arise only in the circumstances listed in 211 CMR 52.13(3)(j)1. through 5. 211 CMR 52.13(3)(j) shall apply to Carriers, including Dental and Vision Carriers.
1. failure by the Insured or other responsible party to make payments required under the contract;
 2. misrepresentation or fraud on the part of the Insured;
 3. commission of acts of physical or verbal abuse by the Insured which pose a threat to Providers or other Insureds of the Carrier and which are unrelated to the physical or mental condition of the Insured; provided, that the Commissioner prescribes or approves the procedures for the implementation of the provisions of 211 CMR 52.13(3)(i)3.;
 4. relocation of the Insured outside the Service Area of the Carrier; or
 5. non-renewal or cancellation of the group contract through which the Insured receives coverage;
- (k) A description of the Carrier's, including a Dental or Vision Carrier's, method for resolving Insured Inquiries and Complaints. For a Health Benefit Plan, this description shall include a description of the internal Grievance process and the external review process consistent with 958 CMR 3.000: *Health Insurance Consumer Protection*, including a description of the process for seeking expedited internal review and concurrent expedited internal and external reviews pursuant to 958 CMR 3.000;
- (l) A statement telling Insureds how to obtain the report regarding Grievances pursuant to 958 CMR 3.600(1)(d) from the Office of Patient Protection;
- (m) A description of the Office of Patient Protection, including its toll-free telephone number, facsimile number, and Internet Website;
- (n) A summary description of the procedure, if any, for out-of-Network referrals and any additional charge for utilizing out-of-network Providers. 211 CMR 52.13(3)(n) shall apply to Carriers, including Dental and Vision Carriers;

52.13: continued

- (o) A summary description of the Utilization Review procedures and quality assurance programs used by the Carrier, including a Dental or Vision Carrier, including the toll-free telephone number to be established by the Carrier that enables consumers to determine the status or outcome of Utilization Review decisions;
- (p) A statement regarding all products/plans detailing what translator and interpretation services are available to assist Insureds, including that the Carrier will provide, upon request, interpreter and translation services related to administrative procedures. The statement must appear in at least the languages identified by the Centers for Medicare & Medicaid Services as the top non-English languages in Massachusetts, 211 CMR 52.13(3)(p) shall apply to Carriers, including Dental and Vision Carriers.
- (q) A list of prescription drugs excluded from any closed or restricted formulary available to Insureds under the Health Benefit Plan; provided, that the Carrier shall annually disclose any changes in such a formulary, and shall provide a toll-free telephone number to enable consumers to determine whether a particular drug is included in the closed or restricted formulary. A Carrier will be deemed to have met the requirements of 211 CMR 52.13(3)(q) if the Carrier does all of the following:
1. provides a complete list of prescription drugs that are included in any closed or restricted formulary;
 2. clearly states that all other prescription drugs are excluded;
 3. provides a toll-free number that is updated within 48 hours of any change in the closed or restricted formulary to enable Insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary;
 4. provides an Internet Website that is updated as soon as practicable relative to any change in the closed or restricted formulary to enable Insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary; and
 5. clearly states that there shall be no financial penalty for a patient's choice to receive a lesser quantity of any opioid contained in schedule II or III of M.G.L. c. 94C, § 3, and lists each of such schedule II or III drugs.
- (r) A summary description of the procedures followed by the Carrier in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;
- (s) Requirements for continuation of coverage mandated by state and federal law;
- (t) A description of coordination of Benefits consistent with 211 CMR 38.00: *Coordination of Benefits (COB)*;
- (u) A description of coverage for emergency care and a statement that Insureds have the opportunity to obtain Health Care Services for an Emergency Medical Condition, including the option of calling the local pre-hospital emergency medical service system, whenever the Insured is confronted with an Emergency Medical Condition which in the judgment of a prudent layperson would require pre-hospital emergency services;
- (v) If the Carrier offers services through a Network or through Participating Providers, the following statements regarding continued treatment:
1. If the Carrier allows or requires the designation of a Primary Care Provider, a statement that the Carrier will notify an Insured at least 30 Days before the disenrollment of such Insured's Primary Care Provider and shall permit such Insured to continue to be covered for Health Services, consistent with the terms of the Evidence of Coverage, by such Primary Care Provider for at least 30 Days after said Provider is disenrolled, other than disenrollment for quality related reasons or for fraud. The statement shall also include a description of the procedure for choosing an alternative Primary Care Provider.
 2. A statement that the Carrier will allow any female Insured who is in her second or third trimester of pregnancy and whose Provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with said Provider, consistent with the terms of the Evidence of Coverage, for the period up to and including the Insured's first postpartum Visit.
 3. A statement that the Carrier will allow any Insured who is Terminally Ill and whose Provider in connection with said illness is involuntarily disenrolled, other than disenrollment for quality related reasons or for fraud, to continue treatment with said Provider, consistent with the terms of the Evidence of Coverage, until the Insured's death.

52.13: continued

4. A statement that the Carrier will provide coverage for Health Services for up to 30 Days from the effective date of coverage to a new Insured by a Provider who is not a Participating Provider in the Carrier's Network if:
 - a. the Insured's employer only offers the Insured a choice of Carriers in which said Provider is not a Participating Provider; and
 - b. said Provider is providing the Insured with an ongoing course of treatment or is the Insured's Primary Care Provider; and
 - c. With respect to an Insured in her second or third trimester of pregnancy, 211 CMR 52.13(3)(v)4. shall apply to services rendered through the first postpartum Visit. With respect to an Insured with a Terminal Illness, 211 CMR 52.13(3)(v)4. shall apply to services rendered until death;
 5. A Carrier may condition coverage of continued treatment by a Provider under 211 CMR 52.13(3)(v)1. through 4. upon the Provider's agreeing as follows:
 - a. to accept reimbursement from the Carrier at the rates applicable prior to notice of disenrollment as payment in full and not to impose Cost Sharing with respect to the Insured in an amount that would exceed the Cost Sharing that could have been imposed if the Provider had not been disenrolled;
 - b. to adhere to the quality assurance standards of the Carrier and to provide the Carrier with necessary medical information related to the care provided; and
 - c. to adhere to the Carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the Carrier;
 6. Nothing in 211 CMR 52.13(3)(v) shall be construed to require the coverage of Benefits that would not have been covered if the Provider involved remained a Participating Provider;
- (w) If a Carrier requires an Insured to designate a Primary Care Provider, a statement that the Carrier will allow the Primary Care Provider to authorize a standing referral for Specialty health Care provided by a Health Care Provider participating in the Carrier's Network when:
1. the Primary Care Provider determines that such referrals are appropriate;
 2. the Provider of Specialty Care agrees to a treatment plan for the Insured and provides the Primary Care Provider with all necessary clinical and administrative information on a regular basis; and
 3. the Health Care Services to be provided are consistent with the terms of the Evidence of Coverage.
- Nothing in 211 CMR 52.13(3)(v) shall be construed to permit a Provider of Specialty health Care who is the subject of a referral to authorize any further referral of an Insured to any other Provider without the approval of the Insured's Carrier;
- (x) If a Carrier requires an Insured to obtain referrals or Prospective Review from a Primary Care Provider for Specialty Care, a statement that the Carrier will not require an Insured to obtain a referral or Prospective Review from a Primary Care Provider for the following Specialty Care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in such Carrier's Health Care Provider Network and that the Carrier will not require higher copayments, coinsurance, deductibles or additional Cost-Sharing features for such services provided to such Insureds in the absence of a referral from a Primary Care Provider:
1. annual preventive gynecologic health examinations, including any subsequent obstetric or gynecological services determined by such obstetrician, gynecologist, certified nurse midwife or family practitioner to be Medically Necessary as a result of such examination;
 2. maternity care; and
 3. medically necessary evaluations and resultant Health Care Services for acute or emergency gynecological conditions.
- Carriers may establish reasonable requirements for participating obstetricians, gynecologists, certified nurse midwives or family practitioners to communicate with an Insured's Primary Care Provider regarding the Insured's condition, treatment, and need for follow-up care; and nothing in 211 CMR 52.13(3)(x) shall be construed to permit an obstetrician, gynecologist, certified nurse midwife or family practitioner to authorize any further referral of an Insured to any other Provider without the approval of the Insured's Carrier;

52.13: continued

(y) If a Carrier offers a Site of Service Plan, the Carrier must prominently and clearly specify on the cover of the Evidence of Coverage and related promotional materials that care delivered by certain Network Providers or at certain Network locations may only be available when deemed medically necessary for the patient's condition. In addition, prior to offering Site of Service Plans, the Carrier is to provide notice to covered members and to Network Providers prior to the Site of Service Plan being issued or renewed.

(z) A statement that the Carrier will provide coverage of pediatric Specialty Care, including, for the purposes of 211 CMR 52.13(3)(x), mental health care, by persons with recognized expertise in Specialty pediatrics to Insureds requiring such services.

(aa) If a Carrier allows or requires an Insured to designate a Primary Care Provider, a statement that the Carrier shall provide the Insured with an opportunity to select a Participating Provider Nurse Practitioner or a Participating Provider Physician Assistant as a Primary Care Provider or to change his or her Primary Care Provider to a Participating Provider Nurse Practitioner or a Participating Provider Physician Assistant at any time during the Insured's coverage period.

(bb) Evidence that the Carrier will provide coverage on a nondiscriminatory basis for covered services when delivered or arranged for by a Participating Provider Nurse Practitioner or a Participating Provider Physician Assistant. For the purposes of 211 CMR 52.13(3)(bb), nondiscriminatory basis shall mean that a Carrier's plan does not contain any annual or lifetime dollar or unit of service limitation imposed on coverage for the care provided by a Participating Provider Nurse Practitioner or Participating Provider Physician Assistant which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the same services by other Participating Providers, in accordance with M.G.L. c. 176R, § 16(1) and c. 176S, § 1;

(cc) A statement that the Carrier shall be required to pay for Health Care Services ordered by a treating physician or a Primary Care Provider if the Health Services are a Covered Benefit under the Insured's Health Benefit Plan and the Health Services are Medically Necessary.

(4) Internet Websites. If the Carrier, including any Dental or Vision Carrier, refers the Insured to resources where the information described in the Evidence of Coverage can be accessed including, but not limited to, an Internet Website, such Carrier must be able to demonstrate compliance with applicable law, and with the following with respect to the Internet Website:

(a) The Carrier has issued and delivered written notice to the Insured that includes:

1. All necessary information and a clear explanation of the manner by which Insureds can access their specific Evidence of Coverage and any amendments thereto through such Internet Website;
2. A list of the specific information to be furnished by the Carrier through an Internet Website;
3. The significance of such information to the Insured;
4. The Insured's right to receive, free of charge, a paper copy of Evidences of Coverage and any amendments thereto at any time;
5. The manner by which the Insured can exercise the right to receive a paper copy at no cost to the Insured; and
6. A toll free number for the Insured to call with any questions or requests including, but not limited to, a request for the Carrier to provide assistance for the Insured with finding a Provider.

(b) The Carrier has taken reasonable measures to ensure that the information and documents furnished in an Internet Website is substantially the same as that contained in its paper documents. All notice and time requirements applicable to Evidences of Coverage shall apply to information and documents furnished by an Internet Website.

(c) The Carrier has taken reasonable measures to ensure that it furnishes, upon request of the Insured, a paper copy of the Evidence of Coverage and any amendments thereto.

(5) Group Plans. A Carrier, including a Dental and Vision Carrier, shall always deliver at least one Evidence of Coverage to the group representative of a group plan, notwithstanding the provisions of 211 CMR 52.13, 52.14 or 52.15.

52.13: continued

(6) General Notice of Material Changes. A Carrier, including a Dental and Vision Carrier, shall provide to at least one adult Insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, notice of all Material Changes to the Evidence of Coverage.

(7) Advance Notice of Material Modifications. A Carrier, including a Dental or Vision Carrier, shall issue and deliver to at least one adult Insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, prior notice of material modifications in covered services under the Health, Dental or Vision Benefit Plan, at least 60 Days before the effective date of the modifications. Such notices shall include the following:

- (a) any changes in Clinical Review Criteria; and
- (b) a statement of the effect of such changes on the personal liability of the Insured for the cost of any such changes.

(8) Advance Filing of Evidence of Coverage. A Carrier, including a Dental or Vision Carrier, shall submit all Evidences of Coverage to the Bureau at least 30 Days prior to their effective dates.

(9) Dates Required. Every Evidence of Coverage described in 211 CMR 52.13 must contain the effective date, date of issue and, if applicable, expiration date.

(10) Workers' Compensation. A Carrier that provides specified services through a workers' compensation preferred Provider arrangement shall be deemed to have met the requirements of 211 CMR 52.13 if it has met the requirements of 211 CMR 51.00: *Preferred Provider Health Plans and Workers' Compensation Preferred Provider Arrangements* and 452 CMR 6.00: *Utilization Review and Quality Assessment*.

(11) Certain Requirements also Applicable to Evidences of Coverage for Dental and Vision Carriers. The following provisions of 211 CMR 52.13 shall also apply to Evidences of Coverage issued by Dental and Vision Carriers: 211 CMR 52.13(4) through (10).

52.14: Required Disclosures for Carriers and Behavioral Health Managers

(1) A Carrier shall provide to at least one adult Insured in each household upon enrollment, and to a prospective Insured upon request, the following information:

- (a) a statement that physician profiling information, so-called, may be available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts;
- (b) a summary description of the process by which clinical guidelines and Utilization Review criteria are developed;
- (c) the voluntary and involuntary disenrollment rate among Insureds of the Carrier;
 1. For the purposes of 211 CMR 52.14(1)(c), Carriers shall exclude all Administrative Disenrollments, Insureds who are disenrolled because they have moved out of a health plan's Service Area, Insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or Insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, retired or died.
 2. For the purposes of 211 CMR 52.14(1)(c), the term "voluntary disenrollment" means that an Insured has terminated coverage with the Carrier by nonpayment of premium.
 3. For the purposes of 211 CMR 52.14(1)(c), the term "involuntary disenrollment" means that a Carrier has terminated the coverage of the Insured due to any of the reasons contained in 211 CMR 52.13(3)(i)2. and 3.
- (d) a notice to Insureds regarding Emergency Medical Conditions that states all of the following:
 1. that Insureds have the opportunity to obtain Health Care Services for an Emergency Medical Condition, including the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever the Insured is confronted with an Emergency Medical Condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

52.14: continued

2. that no Insured shall in any way be discouraged from using the local pre hospital emergency medical service system, the 911 telephone number, or the local equivalent;
 3. that no Insured will be denied coverage for medical and transportation expenses incurred as a result of such Emergency Medical Condition; and
 4. if the Carrier requires an Insured to contact either the Carrier or its designee or the Primary Care Provider of the Insured within 48 hours of receiving emergency services, that notification already given to the Carrier, designee or Primary Care Provider by the attending emergency Provider shall satisfy that requirement.
- (e) a description of the Office of Patient Protection and a statement that the information specified in 211 CMR 52.16 is available to the Insured or prospective Insured from the Office of Patient Protection; and
- (f) a statement:
1. that an Insured has the right to request referral assistance from a Carrier if the Insured or the Insured's Primary Care Provider has difficulty identifying Medically Necessary services within the Carrier's Network;
 2. that the Carrier, upon request by the Insured, shall identify and confirm the availability of these services directly; and
 3. that the Carrier, if necessary, shall obtain or arrange for Out-of-Network services if they are unavailable within the Network.
- (2) The information required of Carriers by 211 CMR 52.14(1)(a) through (f) may be contained in the Evidence of Coverage and need not be provided in a separate document.
- (3) Every disclosure required of Carriers and described in 211 CMR 52.14(1)(a) through (f) must contain the effective date, date of issue and, if applicable, expiration date.
- (4) A Carrier must maintain a toll-free telephone number and website available to Insureds to present Provider cost information to Insureds that meets the following requirements:
- (a) the Insured may request and obtain the following, in real time:
 1. the estimated or maximum allowed amount or charge for a proposed admission, procedure or service and
 2. the estimated amount the Insured will be responsible to pay for a proposed admission, procedure or service that is a Medically Necessary Covered Benefit, based on the information available to the Carrier at the time the request is made, including any Facility fee, copayment, deductible, coinsurance or other Cost-sharing requirements for any Covered Benefits;
 - (b) notwithstanding anything to the contrary in 211 CMR 52.14(4)(a), the Insured shall not be required to pay more than the disclosed amounts for the Covered Benefits that were actually provided;
 - (c) nothing in 211 CMR 52.14(4) shall prevent a Carrier from imposing Cost-sharing requirements disclosed in the Insured's Evidence of Coverage for unforeseen services that arise out of the proposed admission, procedure or service;
 - (d) the Carrier must alert the Insured that these are estimated costs, and that the actual amount the Insured will be responsible to pay may vary due to unforeseen services that arise out of the proposed admission, procedure or service.
- (5) To provide information to Insureds about the disposition of Provider claims submitted to the Carrier, the Carrier shall issue to Insureds the summary of payments form, as authorized by the Commissioner, and the form shall be issued to the individual Insured rather than to the subscriber, and the form may be issued in paper or through an Internet Website, provided that a Carrier will issue the form by paper upon request by the Insured.
- (6) Carriers shall submit Material Changes to the disclosures required by 211 CMR 52.14 to the Bureau at least 30 Days before their effective dates.
- (7) Carriers shall submit Material Changes to the disclosures required by 211 CMR 52.14(1)(a) through (f) to at least one adult Insured in every household residing in Massachusetts at least once every two years.

52.14: continued

(8) A Carrier that provides specified services through a workers' compensation preferred Provider arrangement shall be deemed to have met the requirements of 211 CMR 52.14 if it has met the requirements of 211 CMR 51.00: *Preferred Provider Health Plans and Workers' Compensation Preferred Provider Arrangements* and 452 CMR 6.00: *Utilization Review and Quality Assessment*.

(9) A Carrier, including a Dental or Vision Carrier, shall provide to a health, Dental or Vision Care Provider, a written reason or reasons for denying the application of any health, Dental, or Vision Care Provider who has applied to be a Participating Provider.

(10) A Carrier for whom a Behavioral Health Manager is administering Behavioral Health Services shall state the name and telephone number of the Behavioral Health Manager on the Carrier's enrollment cards issued in the normal course of business.

(11) A Behavioral Health Manager shall provide the following information to at least one adult Insured in each household covered by their services:

- (a) a notice to the Insured regarding emergency mental Health Services that states:
 - 1. that the Insured may obtain emergency mental Health Services, including the option of calling the local pre-hospital emergency medical service system by dialing the 911 emergency telephone number or its local equivalent, if the Insured has an emergency mental health condition that would be judged by a prudent layperson to require pre-hospital emergency services;
 - 2. that no Insured shall be discouraged from using the local pre-hospital emergency medical service system, the 911 emergency telephone number or its local equivalent;
 - 3. that no Insured shall be denied coverage for medical and transportation expenses incurred as a result of such emergency mental health condition; and
 - 4. if the Behavioral Health Manager requires an Insured to contact either the Behavioral Health Manager, Carrier or Primary Care Provider of the Insured within 48 hours of receiving emergency services, notification already given to the Behavioral Health Manager, Carrier or Primary Care Provider by the attending emergency Provider shall satisfy that requirement;
- (b) a summary of the process by which clinical guidelines and Utilization Review criteria are developed for Behavioral Health Services; and
- (c) a statement that the Office of Patient Protection is available to assist consumers, a description of the Grievance and review processes available to consumers, and relevant contact information to access the Office of Patient Protection and these processes.

(12) The information required of Behavioral Health Managers by 211 CMR 52.14(11) may be contained in the Carrier's Evidence of Coverage and need not be provided in a separate document. Every disclosure described in 211 CMR 52.14(11) shall contain the effective date, date of issue and, if applicable, expiration date.

(13) A Behavioral Health Manager (if applicable) or Carrier shall submit a Material Change to the information required by 211 CMR 52.14(11) to the Bureau at least 30 Days before its effective date and to at least one adult Insured in every household residing in the Commonwealth at least biennially.

(14) A Behavioral Health Manager that provides specified services through a workers' compensation preferred Provider arrangement that meets the requirements of 211 CMR 51.00: *Preferred Provider Health Plans and Workers' Compensation Preferred Provider Arrangements* and 452 CMR 6.00: *Utilization Review and Quality Assessment* shall be considered to comply with 211 CMR 52.14.

(15) A Carrier for whom a Behavioral Health Manager is administering Behavioral Health Services shall be responsible for the Behavioral Health Manager's failure to comply with the requirements of 211 CMR 52.00 in the same manner as if the Carrier failed to comply and shall be subject to the provisions of 211 CMR 52.17.

52.15: Provider Directories

All Provider directory requirements set forth in 211 CMR 52.15 shall be in addition to any applicable Provider directory requirements under 211 CMR 152.08: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks* for insured Health Benefit Plans that use limited, regional or tiered Provider Networks:

(1) Carriers shall establish appropriate systems to collect, store, and maintain detailed information about each Health Care Provider within their Provider Network systems. The systems are to be developed in a manner that facilitates a Health Care Provider's ability to update personal and practice information to the maximum extent feasible. Carriers shall ensure that Provider directories educate persons covered by plans providing services through Networks of Providers about how they may obtain in-Network care from an out-of-Network Provider when an in-Network Provider is not available.

(2) The detailed information that the Carrier is required to collect, store and maintain about Health Care Providers who are a part of the Carrier's Network, shall include at least the following information for each Health Care Provider:

- (a) Health Care Provider's primary Specialty, secondary Specialty (if applicable), tertiary Specialty (if applicable), Behavioral Health sub-Specialty (if applicable)
 - 1. The reporting of a Specialty or sub-Specialty should be based on the Provider's actual training and experience in treatment of this Specialty or sub-Specialty in the past 24 months;
- (b) license type, practice credentials (education, including all relevant licensure(s), professional designations, and relevant certifications, including but not limited to board certifications);
- (c) Health Care Facilities with which a Health Care Provider is affiliated (*e.g.*, where a Provider has admitting privileges);
- (d) if a hospital or Facility, the type of hospital\Facility and its Accreditation status;
- (e) if a non-hospital behavioral health Facility, the standard services as identified by the Commissioner, that are available in the Facility;
- (f) practice group affiliation;
- (g) office locations for a Provider, and for each location whether the individual Provider sees patients in that location:
 - 1. at least once per week;
 - 2. at least once per month; or
 - 3. as a cover/fill-in as needed;
- (h) whether the Health Care Provider is:
 - 1. is available to accept new patients covered by the Carrier;
 - 2. is not accepting new patients covered by the Carrier; or
 - 3. has limited availability to accept new patients covered by the Carrier with a waitlist of 4 weeks of less to schedule an appointment;
- (i) operating hours for each office location, including whether the office is available for evening and weekend appointments;
- (j) main phone number(s) available for members' use in setting up appointments;
- (k) all languages understood and/or spoken by the Health Care Provider;
- (l) whether the setting in which a Provider treats patients is ADA accessible and a description of the accommodations available to address physical, developmental, and intellectual disabilities;
- (m) whether the practice specializes in the treatment of specific genders and identification of those specific genders or gender identities based upon the Provider's actual treatment of members of such populations or groups in the last 24 months;
- (n) any specific age groups treated by the Health Care Provider, if the Provider so chooses;
- (o) any special populations or cultural groups that the Health Care Provider wishes to highlight that the Health Care Provider serves, as well as the Provider's race and nationality, if the Provider so chooses;
- (p) whether the Health Care Provider has conditions to treating a patient, including the following:

52.15: continued

1. requiring a patient to pay a concierge medicine fee, Facility fee, or other administrative fee in order to be treated by the Health Care Provider,
 2. if a Health Care Provider practice requires that the care is limited to hospital or Facility inpatients;
 3. for Health Care Providers who work in clinics or community health centers, requiring that a patient receive other health care at the clinic or community health center; or
 4. for Health Care Providers who work at university or school health centers, requiring that patients are enrolled students in the university or school.
- (q) if a Tiered Network Plan, the Provider's tier, an explanation of how the Carrier identifies the Provider's tier, and the impact of the tier on Cost-sharing under the health plan; and
- (r) which Health Care Providers within a Facility are available for consultation *via* Telehealth and the modalities of Telehealth the Health Care Provider offers to patients or whether the Health Care Provider is available for consultation only *via* Telehealth.
- (3) detailed information that the Carrier is required to display in the Provider directory shall present information about the Health Care Professionals who see patients at each office location identifying whether the Health Care Professional is limiting patients to a subset of the Carrier's members and information according to the following categories:
- a. Health Care Professional sees patients at the location at least once per week;
 - b. Health Care Professional sees patients at the location at least once per month; and
 - c. Health Care Professional sees patients as a cover/fill-in or when needed.
- (4) detailed information that the Carrier is required to display in the Provider directory shall include at least the following information about non-Facility Health Care Providers who are a part of the Carrier's Network:
- (a) Health Care Provider's primary Specialty, secondary Specialty (if applicable), tertiary Specialty (if applicable), Behavioral Health sub-Specialty (if applicable);
 - (b) license type, practice credentials (education, including all relevant licensure(s), professional designations, and relevant certifications including but not limited to board certifications);
 - (c) Health Care Facilities with which a Health Care Provider is affiliated (*e.g.*, where a Provider has admitting privileges);
 - (d) whether the Health Care Provider is:
 1. accepting new patients that are covered by the Carrier
 2. closed to new patients covered by the Carrier; or
 3. accepting new patients but with a waitlist of 4 weeks or less to schedule an appointment);
 - (e) group practice affiliations;
 - (f) office locations for a Provider where the Provider will see patients and for each location whether the Provider sees patients:
 1. at least once per week; or
 2. at least once per month;
 - (g) operating hours for each office location, including whether the office is open for evening and weekend appointments;
 - (h) phone number(s) or other contact information a member may use in setting up an appointment;
 - (i) whether the office at which a Provider treats patients is ADA accessible and a description of the accommodations available to address physical, developmental, and intellectual disabilities;
 - (j) languages spoken by the Health Care Provider;
 - (k) age groups and special populations, genders or cultural groups that the Health Care Provider treats on a regular basis, as well as the Provider's race and nationality, if the Provider so chooses;
 - (l) whether the Health Care Provider requires a patient to pay a concierge medicine, Facility fee, or other administrative fee in order to be treated by the Health Care Provider;
 - (m) if a covered member is in a Tiered Network Plan, the Carrier shall provide access to information that will identify the Provider's tier within the covered members' Tiered Network Plan, an explanation of how the Carrier identifies the Provider's tier, and the impact of the tier on Cost-sharing under the health plan; and

52.15: continued

- (n) whether the Health Care Provider is available for consultation via Telehealth and the modalities of Telehealth the Health Care Provider offers to patients.
- (5) The detailed information that the Carrier is required to display in the Provider directory shall include at least the following information about Facility Health Care Providers who are a part of the Carrier's Network:
- (a) the type of hospital/Facility and its Accreditation status;
 - (b) if a non-hospital behavioral health Facility, the standard services as identified by the Commissioner that are available in the Facility;
 - (c) the main phone number(s) for members to use in contacting the Facility;
 - (d) all languages spoken by Providers within the Facility;
 - (e) whether the office is ADA compliant and list a description of accommodations to address physical and intellectual disabilities;
 - (f) if Facilities are tiered within a Tiered Network Plan, the Provider's tier, an explanation of how the Carrier identifies the Provider's tier, and the impact of the tier on Cost-sharing under the health plan;
 - (g) how the Health Care Provider may be contacted by a patient, including phone numbers and internet portals; and .
 - (h) whether the Facility's practitioners may be available for consultation via Telehealth.
- (6) 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.
- (7) If delivering a paper copy of the Provider directory, a Carrier shall be deemed to have met the requirements of 211 CMR 52.15(1) if the Carrier:
- (a) provides to at least one adult Insured in each household, or in the case of a group policy, to the group representative, at least once per calendar year an addendum, insert, or other update to the Provider directory originally provided under 211 CMR 52.15(1);
 - (b) updates its toll-free number within 48 hours and Internet Website as soon as practicable, or as directed by the Commissioner.
- (8) Every Provider directory described in 211 CMR 52.15 must contain the effective date, date of issue, expiration date, if applicable, and reference to any government-sponsored website(s) providing quality and cost information, as may be designated by the Commissioner.
- (9) A Carrier shall deliver a Provider directory through an Internet Website. A Carrier may also deliver a Provider directory *via* "intranet websites," "electronic mail," and "e-mail". If the Carrier refers an Insured to access directory information through an Internet Website, the Carrier must be able to demonstrate compliance with the following:
- (a) The Carrier shall deliver notice of the Provider directory to at least one adult in the household of each Insured, by direct mail, or by electronic mail if the Insured has agreed to communicate electronically, that includes:
 1. all necessary information and a clear explanation of the manner by which Insureds can access their specific Provider directory through an Internet Website;
 2. a list of the specific information to be furnished by the Carrier through an Internet Website;
 3. the Insured's right to receive, free of charge, a paper copy of the Provider directory at any time;
 4. the manner by which the Insured can exercise the right to receive a paper copy at no cost to the Insured; and
 5. a toll-free number for the Insured to call with any questions or requests and instructions about how the Insured can contact the Carrier if they want assistance in locating an available Provider. The Carrier shall take reasonable measures to ensure that the Provider directory information and documents furnished in an Internet Website are substantially the same as that contained in the Carrier's paper documents.
 - (b) The Carrier takes reasonable measures to ensure that it furnishes, upon request of an individual, a paper copy of the Provider directory.

52.15: continued

(10) A Provider directory that is electronically available shall:

- (a) be in a format which will be searchable by
 - 1. Provider type,
 - 2. Specialty in treating specific populations, if applicable,
 - 3. whether the Provider is accepting new patients/is closed to new patients,
 - 4. language spoken, and
 - 5. distance from a geographic starting point selected by a consumer.;
- (b) shall identify that it is current as of a certain date;
- (c) be accessible to the general public through a clearly identifiable link or tab without requiring the general public to create or access an account, enter a policy or contract number, provide other identifying information, or demonstrate coverage or an interest in obtaining coverage with the Network plan;
- (d) be updated as soon as practicable and not less often than monthly or as directed by the Commissioner; provided, however, that an electronic Network plan Provider directory shall be updated within two business days, or sooner if consistent with federal guidelines, when the Carrier is informed of and upon confirmation that:
 - 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 being under contract for a particular Network plan;
 - 3. a Provider's practice location or other Provider directory information has changed;
 - 4. a Provider has retired or ceased practice; or
 - 5. any other information that affects the content or accuracy of the Provider directory has changed.

(11) A Provider directory shall include a dedicated customer service email address and telephone number and electronic link, set forth prominently in both the directory and on the Carrier's website, to assist with the Provider directory information and to provide information about a Provider's participation in the Carrier's Network, consistent with federal requirements for providing this information. The Provider directory will educate members to notify the Carrier of inaccurate Provider directory information, consistent with federal requirements.

The Carrier shall investigate reports of Provider directory inaccuracies within 30 Days of receiving notice of an inaccuracy, and the Carrier shall modify the Provider directory as soon as practicable, but not longer than 30 Days after finding an inaccuracy. Carrier will establish a dedicated toll-free telephone number or add an option to its existing toll-free number to assist covered persons to schedule an appointment with an available and appropriate Health Care Provider when they are unable to locate or schedule an appointment with a Health Care Provider who is listed in the Carrier's Provider directory information as accepting new patients to treat the patients of a certain age or health condition Specialty.

The Carrier will also contact each of the Health Care Providers who were unavailable to schedule an appointment with the patient in order to understand the reasons that an appointment was not scheduled, and the Carrier shall modify the Provider directory information as necessary to reflect the correct availability of the Health Care Provider to treat conditions and certain age groups. Carriers shall conduct staff training regarding communications about inaccurate Provider information so as to ensure that Provider directory inaccuracies are promptly investigated and corrected. Carriers will maintain files of all such follow-up calls so that they may be reviewed by Division staff upon request.

(12) The Provider directory must contain a list of Health Care Providers in the Carrier's Network available to Insureds residing in Massachusetts, organized by Specialty, location, and distance from a starting point selected by the searching individual, and the directory shall summarize on the Carrier's Internet Website for each such Provider:

- (a) the method used to compensate or reimburse such Provider;
- (b) the Provider price relativity, as defined in and reported under M.G.L. c. 12C, § 10, ;
- (c) the Provider's health status adjusted total medical expenses, as defined in and reported under M.G.L. c. 12C, § 10;

52.15: continued

(d) current measures of the Provider's quality based on measures from the Standard Quality Measure Set, as defined in the regulations promulgated by the Center for Health Information Analysis established by M.G.L. c. 12C, § 2; provided, that the Carrier shall prominently promote Providers based on quality performance as measured by the standard quality measure set and cost performance as measured by health status adjusted total medical expenses and relative prices;

(e) such information about Providers may be provided directly by Carrier or by reference to a third-party source that facilitates comparison of Providers' performance.

(13) Carriers shall display information in the Provider directory about how to access coverage for community-based Behavioral Health Service Providers that provide crisis, urgent care, and stabilization services, including but not limited to mobile crisis intervention and the emergency services program.

(14) Nothing in 211 CMR 52.15(8) shall be construed to require disclosure of the specific details of any financial arrangements between a Carrier and a Provider.

(15) If any specific Providers or type of Providers requested by an Insured are not available in said Network, or are not a covered benefit, or if any Primary Care Provider or Behavioral Health or substance use disorder Health Care Professional is not accepting new patients, such information shall be provided in an easily obtainable manner, including in the Provider directory.

(16) Notwithstanding any general or specific law to the contrary, a Carrier shall ensure that all Participating Provider Nurse Practitioners and Participating Provider Physician Assistants with whom a member can make an appointment are included and displayed in a nondiscriminatory manner in the Carrier's Provider Directory.

(17) Carriers' new and renewing Provider contracts shall require Providers to inform the Carrier promptly when the Provider availability to see new patients changes (including whether they have a waitlist) and Carriers shall prioritize updating directories to reflect these changes within two business days of receiving notice of a Provider's change in status.

(18) Consistent with federal guidelines, Carriers shall contact Providers every 90 days, or as directed by the Commissioner, to remind Providers to check and verify their profiles so that Carriers can certify that the Provider's information is correct. As part of such reminders, Carriers shall educate Providers about the importance of making Provider changes as soon as Provider changes occur so that Carriers may make the appropriate Provider directory updates as soon as possible.

(19) Consistent with federal guidelines, Carriers that have received notice of potentially inaccurate information through a consumer, Provider, or audit and have been unable to validate the accuracy of the listing shall take the following steps:

(a) If the potential inaccuracy relates to the physical address or telephone number of the Provider, the Carrier should either immediately remove the information from the online directory until the information is updated, or designate the information as "unverified" for no longer than 90 days, after which the information must be immediately removed;

(b) If the potential inaccuracy relates to whether a Provider is accepting new patients, the Carrier shall remove the designation "accepting new patients" for that Provider until the information is updated;

(c) If the potential inaccuracy relates to whether a Provider is or continues to be an in-Network Provider, the Carrier should remove the full Provider listing from the online directory until it is updated.

(20) Carriers shall employ policies to ensure that directory information provided, updated and verified by behavioral health Providers is accurately uploaded and displayed in its directory and shall audit licensed behavioral health Providers' and licensed non-hospital behavioral health facilities' Provider directory information on a quarterly basis, including information with respect to:

52.15: continued

- (a) all licensed behavioral health Providers who have not submitted a claim within 12 months of the audit and who have not otherwise been audited or have not received an attestation in the past 12 months or for whom the Carrier has not received a written or electronic attestation certifying that all elements of the licensed behavioral health Provider's directory profile have been reviewed, updated as necessary and then confirmed as accurate has not been received in the past 12 months; and
- (b) a representative sample of no less than 15% of all licensed behavioral health Providers who have not been audited in the last 12 months or for whom as a written or electronic attestation certifying that all elements of the licensed behavioral health Provider's directory profile have been reviewed, updated, as necessary, and then confirmed as accurate has not been received in the past 120 days; and
- (c) Carriers should compare at least 2% of the attestations received in the prior 120 days to the related information or changes in their Provider directories to confirm that the data elements match the data elements in the directory.

(21) Quarterly behavioral health audits shall exclude licensed behavioral health Providers that have been audited in the last 12 months, or which have been removed from the Provider directory. In the event that three successive quarterly audits demonstrate that at least 85% of the auditable licensed behavioral health Providers are listed in a manner that is 100% accurate, the Carrier may shift to conducting behavioral health audits on a semi-annual basis.

(22) Non-behavioral Health Care Providers' Provider directory information should be audited to ensure accuracy of Provider directory information on at least an annual basis, or as directed by the Commissioner. Carriers shall initiate these required audits no later than the start of the second calendar quarter after these regulations are promulgated in final form.

(23) Carriers will maintain files of all Provider audits for no less than seven years from the completion of any audit so that they may be reviewed by Division staff upon request.

(24) A Carrier shall deliver a notice to at least one adult Insured in each household upon enrollment annually about how to access the Carrier's Provider directory.

(25) A Carrier shall deliver a Provider directory to an Insured or a prospective Insured upon request. The print copy of the requested Provider directory information shall be provided to the requester by mail postmarked no more than five business days after the date of the request, and the print copy may be limited to the geographic region in which the requester resides or works or intends to reside or work.

(26) In the case of a group policy, the Carrier shall deliver a Provider directory to the group representative on at least an annual basis.

(27) A Carrier shall update the print copies of the Carrier's Provider directory not less frequently than annually, and a Carrier shall include a disclosure in the print format of the Provider directory that the information included in the Provider directory is accurate as of the date of printing and that an individual may 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;

(28) A Carrier shall not be required to deliver a Provider directory upon enrollment if a Provider directory is delivered to the prospective or current Insured, or in the case of a group policy, to the group representative, during applicable open enrollment periods.

(29) A Carrier that provides specified services through a workers' compensation preferred Provider arrangement shall be deemed to have met the requirements of 211 CMR 52.15 if it has met the requirements of 211 CMR 51.00: *Preferred Provider Health Plans and Workers' Compensation Preferred Provider Arrangements* and 452 CMR 6.00: *Utilization Review and Quality Assessment*.

52.15: continued

(30) If a Carrier offers a Site of Service Plan, the Provider directory for this plan is to clearly and prominently specify which certain Network Providers or service locations will only be available for covered care when the care is deemed medically necessary to be provided by the Provider or a certain service location.

52.16: Access to Covered Services through Telehealth

(1) A Carrier shall provide coverage for Health Care Services delivered *via* Telehealth by a contracted Network Provider if:

- (a) the Health Care Services are covered by way of in-person consultation or delivery; and
- (b) the Health Care Services may be appropriately provided through the use of Telehealth.

(2) A Carrier shall not meet Network adequacy through significant reliance on Network Providers who deliver Health Care Services *via* Telehealth only 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. Coverage shall not be limited to services delivered by Providers who are contracted through third-party Telehealth vendors.

(3) A Carrier may undertake Utilization Review, including preauthorization, to determine the appropriateness of Telehealth as a means of delivering a Health Care Service; provided, however, that the determination shall be made in the same manner as if the service was delivered in person.

(4) A Carrier shall not be required to reimburse a Health Care Professional for a Health Care Service that is not a covered benefit under the plan. A Carrier shall not be required to reimburse a Health Care Professional not contracted under a closed Network plan except as provided for under M.G.L. c. 176O, § 6(a) subclause (4).

(5) A Health Care Professional shall not be required to document a barrier to an in-person Visit nor shall the type of setting where Telehealth services are provided be limited for Health Care Services provided *via* Telehealth; provided, however, that a patient may decline receiving services *via* Telehealth in order to receive in-person services.

(6) A Carrier's coverage may provide for patient Cost-sharing (copayment, coinsurance, deductible) for services delivered during a Telehealth Visit; provided that the patient Cost-sharing does not exceed the deductible, copayment, or coinsurance applicable to the same services provided during an in-person Visit with a Health Care Provider.

(7) Carriers shall ensure that the in-Network rate of reimbursement for services delivered during a Telehealth Visit with Health Care Professionals of covered Behavioral Health Services when provided *via* interactive audio-video technology or audio-only telephone shall be no less than the rate of payment for the same Behavioral Health Service provided *via* an in-person Visit with a Health Care Provider.

(8) The rate of payment for services delivered during a Telehealth Visit when provided *via* synchronous interactive audio-video technology or audio-only telephone may be greater than the rate of payment for the same service delivered by other Telehealth modalities.

(9) Coverage that reimburses a Health Care Professional with a Global Payment shall account for the provision of Telehealth services when setting the global payment reimbursement amount.

(10) Carriers will contractually require that Health Care Professionals use Telehealth technology that conforms to applicable federal and state health information privacy and security standards as well as standards for informed consent. As long as the technology meets these standards, a Carrier shall not limit the use of a Telehealth communications platform that conforms to such standards.

52.16: continued

(11) Carriers are to include information within Network Directories about which Providers are available to deliver services *via* Telehealth. A Carrier should forward its comprehensive Telehealth plan to the Division, and such plan will subsequently be forwarded as part of the biennial managed care Accreditation process. The Telehealth plan should include the following:

- (a) The communications that will be used with Providers to specify the service and documentation standards that a Provider will need to meet in order for services provided by Telehealth to be covered by the Carrier;
- (b) A statement that restricts covered Telehealth Visits to those that are compatible with state/federal privacy standards;
- (c) A list of the services that will not be covered when provided to a covered person *via* Telehealth, and an explanation for why these services are not covered;
- (d) An explanation of how and when Cost-sharing (copayments, coinsurance, and deductibles) will apply for Telehealth services, and if Cost-sharing is waived, a description of the exact circumstances under which the Cost-sharing will be waived.
- (e) A statement of how the Carrier intends to reimburse Providers for the following Telehealth services:
 1. Behavioral Health Services;
 2. Primary Care Services; and
 3. Chronic Disease Management services; and
 4. All other services, including those provided by Asynchronous Telehealth.
- (f) An identification of the billing codes, location codes or other codes that the Carrier intends to use to reimburse Providers for Telehealth services, including the following:
 1. when Telehealth may be used for follow-ups that may be considered less than a Visit, a description of how the Carrier intends to reimburse Providers for these follow-up Telehealth services; and
 2. physical exams, including those that have both Telehealth and in-person components.

52.17: Material to Be Provided to the Office of Patient Protection

(1) A Carrier shall provide the following to the Office of Patient Protection at the same time the Carrier provides such material to the Bureau of Managed Care:

- (a) A copy of every Evidence of Coverage and amendments thereto offered by the Carrier.
- (b) A copy of the Provider directory described in 211 CMR 52.15.
- (c) A copy of the materials specified in 211 CMR 52.14.

(2) A Carrier shall provide the following to the Office of Patient Protection by no later than April 1st:

- (a) A list of sources of independently published information assessing Insured satisfaction and evaluating the quality of Health Care Services offered by the Carrier.
- (b) A report of the percentage of physicians and Nurse Practitioners and Physician Assistants who voluntarily and involuntarily terminated participation contracts with the Carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary Provider disenrollment;
 1. For the purposes of 211 CMR 52.16(2)(b), Carriers shall exclude physicians, Nurse Practitioners, and Physician Assistants who have moved from one physician and/or Nurse Practitioner or Physician Assistant group to another but are still under contract with the Carrier.
 2. For the purposes of 211 CMR 52.16(2)(b), "voluntarily terminated" means that the physician, Nurse Practitioner, or Physician Assistant terminated the contract with the Carrier.
 3. For the purposes of 211 CMR 52.16(2)(b), "involuntarily terminated" means that the Carrier terminated its contract with the physician, Nurse Practitioner, or Physician Assistant;
- (c) The percentage of premium revenue expended by the Carrier for Health Care Services provided to Insureds for the most recent year for which information is available;
- (d) A report detailing, for the previous calendar year, the total number of:
 1. filed Grievances, Grievances that were approved internally, Grievances that were denied internally, and Grievances that were withdrawn before resolution; and

52.17: continued

2. external appeals pursued after exhausting the internal Grievance process and the resolution of all such external appeals. The report shall identify for each such category, to the extent such information is available, the demographics of such Insureds, which shall include, but need not be limited to, race, gender and age; and
- (e) A report detailing for the previous calendar year the total number of:
 1. medical or surgical claims submitted to the Carrier;
 2. medical or surgical claims denied by the Carrier;
 3. mental health or substance use disorder claims submitted to the Carrier;
 4. mental health or substance use disorder claims denied by the Carrier; and
 5. medical or surgical claims and mental health or substance use disorder claims denied by the Carrier because:
 - a. the Insured failed to obtain pre-treatment authorization or referral for services;
 - b. the service was not Medically Necessary;
 - c. the service was experimental or investigational;
 - d. the Insured was not covered or eligible for benefits at the time services occurred;
 - e. the Carrier does not cover the service or the Provider under the Insured's plan;
 - f. duplicate claims had been submitted;
 - g. incomplete claims had been submitted;
 - h. coding errors had occurred; or
 - i. of any other specified reason.
- (f) A Carrier that provides specified services through a workers' compensation preferred Provider arrangement shall be deemed to have meet the requirements of 211 CMR 52.16(1)(a) through (c) and (2)(c) through (e).

52.18: Noncompliance with 211 CMR 52.00

(1) Reporting. If the Commissioner issues a Finding of Neglect on the part of a Carrier, the Commissioner shall notify the Carrier in writing that the Carrier has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required. The notice shall identify all deficiencies and the manner in which the neglect must be remedied. Following the written notice, the Commissioner shall fine the Carrier \$5000 for each Day during which the neglect continues.

Following notice and hearing, the Commissioner shall suspend the Carrier's authority to do new business until all required reports or materials are received in a form satisfactory to the Commissioner and the Commissioner has determined that the Finding of Neglect can be removed.

(2) Noncompliance with 211 CMR 52.00.

(a) Investigation. The Bureau shall investigate all Complaints made against a Carrier or any entity with which it contracts for allegations of noncompliance with the Accreditation requirements established under 211 CMR 52.00.

(b) Notice. The Bureau shall notify a Carrier when, in the opinion of the Bureau, Complaints made against a Carrier or any entity with which it contracts indicate a pattern of noncompliance with a particular requirement. The notice shall detail the alleged noncompliance and establish a hearing date for the matter.

(c) Hearing Held Pursuant to 211 CMR 52.17(2)(b).

1. The hearing shall be held no later than 21 Days following the date of the notice specified in 211 CMR 52.17(2)(b).
2. The hearing shall be conducted pursuant to M.G.L. c. 30A.
3. The hearing shall provide the Carrier with an opportunity to respond to the alleged noncompliance.

(d) Penalties. Following the hearing specified in 211 CMR 52.17(2)(c), the Bureau may issue a finding against the Carrier including, but not limited to:

1. An order requesting a corrective action plan and timeframe to achieve compliance.
2. A reprimand or censure of the Carrier.
3. A penalty not to exceed \$10,000 for each classification of violation.
4. The suspension or revocation of the Carrier's Accreditation.

52.18: continued

(3) Action by a National Accreditation Organization. If a National Accreditation Organization takes any action to revoke the Accreditation or otherwise limit or negatively affect the Accreditation status of a Carrier, or any entity with which a Carrier contracts for services subject to M.G.L. c. 176O, the Carrier must notify the Bureau within two Days and shall specify the action taken and the reasons given by the National Accreditation Organization for such action.

(4) Revocation by a National Accreditation Organization. If the National Accreditation Organization revokes Accreditation, the Bureau shall initiate proceedings pursuant to M.G.L. c. 30A to revoke or suspend the Carrier's Accreditation.

(5) Informal Resolutions. Nothing in 211 CMR 52.17 shall be construed to prohibit the Bureau and a Carrier from resolving compliance issues through informal means.

52.19: Severability

If any provision of 211 CMR 52.00 or the applicability thereof to any person, entity or circumstance is held invalid by a court, the remainder of 211 CMR 52.00 or the applicability of such provision to other persons, entities or circumstances shall not be affected.

REGULATORY AUTHORITY

211 CMR 52.00: M.G.L. c. 175, § 24B; c. 176J, § 11; c. 176O, §§ 2 and 17; c. 176R, § 6; and c. 176S, § 6.

(PAGES 302.37 THROUGH 302.52 ARE RESERVED FOR FUTURE USE.)



THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin
Secretary of the Commonwealth

Notice of Correction

Regulation Filing To be completed by filing agency

CHAPTER NUMBER: 527 CMR 12.00

CHAPTER TITLE: Massachusetts Electrical Code

AGENCY: Board of Fire Prevention Regulations

ORIGINAL PUBLICATION REFERENCE: 1572 Date: 4/24/26

SUMMARY OF CORRECTION:

The Board of Fire Prevention Regulations respectfully submits this Notice of Correction to clarify two non substantive issues within the filed regulations. First, the date referenced in Rule 7 was intended to correspond with the date the regulations were published in the Massachusetts Register, specifically April 24, 2026. At the time of drafting, the Board anticipated a shorter promulgation timeline and used February 28, 2026 as a placeholder date pending final publication. Because the promulgation process extended beyond that anticipated timeframe, correction of the date is necessary to accurately reflect the intended effective date of 527 CMR 12.00 and to avoid any implication of retroactive application prior to publication. Second, Rule 11 contains a scrivener's error. The phrase "No. 2" was included inadvertently and should be removed.

AGENCY CONTACT: Glenn Rooney PHONE: 978-567-3183

ADDRESS: Department of Fire Services, 1 State Road, P.O. Box 1025, Stow, MA 01775

ATTESTATION - The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency. ATTEST:

SIGNATURE: SIGNATURE ON FILE DATE: May 18 2026

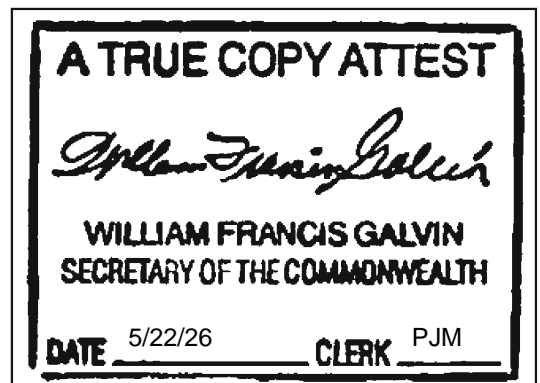
Publication - To be completed by the regulations Division

MASSACHUSETTS REGISTER NUMBER: 1575 DATE: 6/5/26

EFFECTIVE DATE: 4/24/26

CODE OF MASSACHUSETTS REGULATIONS

Table with 2 columns: Remove these Pages: and Insert these Pages:
137 & 138 | 137 & 138



527 CMR: BOARD OF FIRE PREVENTION REGULATIONS

527 CMR 12.00: MASSACHUSETTS ELECTRICAL CODE
(AMENDMENTS)

The Massachusetts Electrical Code (527 CMR 12.00) of the Board of Fire Prevention Regulations (BFPR) shall be the 2026 National Electrical Code (NEC), as published by the National Fire Protection Association (NFPA) as NFPA 70 in the form released by vote of the NFPA Standards Council on August 20, 2025, including all modifications made by the BFPR and duly promulgated from time to time in the Code of Massachusetts Regulations. Amendments made by NFPA subsequent to this date have no force or effect until and unless reviewed and promulgated by the BFPR.

Informational Note: The NFPA releases Tentative Interim Amendments (TIAs) from time to time to its standards, including the NEC. True to their title, these changes are tentative, they are of an interim nature, and they amend (in this case) the electrical code. They have not been processed through the NFPA normal standards making process. As of the 2020 NEC cycle, these amendments, subsequent to their release, will appear in all renditions of the NEC, both print and electronic, in a form that makes them visually indistinguishable from unamended text.

The NEC version adopted in Massachusetts will be that found in the first printing in book form, and that rendition will include TIAs adopted by the Standards Council at its August, 2025 meeting, but no others. Users of this code are advised to consult the front matter on the first page of the NEC for a list of TIAs issued by NFPA, organized by location and specified dates of issuance. In addition, the inside front cover now includes a clear designation of the printing and the TIAs (by number only) that are included. Specific information for each will be found on the NFPA website. The NEC version in effect in Massachusetts will usually vary, increasingly over time, from the version amended by NFPA depending on the timing of BFPR actions subsequent to initial promulgation.

NFPA also issues advisories of errata. These reflect errors in printing, and bring the published version of their standards, including the NEC, into agreement with the actual results of the standards development process. Because the legally enforceable standard is the form as developed through that process, errata are considered to be effective as of the original issuance of the standard, and therefore are considered effective in Massachusetts as of the date of the original promulgation of this code.

Insert the following provisions ahead of the body of the Code:

- Rule 1. All installations, repairs, maintenance, and removal of electrical wiring and electrical fixtures used for light, heat, power, signaling and communications purposes in buildings and structures subject to the provisions of M.G.L. c. 143 shall be reasonably safe to persons and property.
- Rule 2. Conformity of installations, repairs, maintenance, and removal of electrical wiring and electrical fixtures used for light, heat, power, signaling and communications with applicable regulations set forth in the Code, which is hereby filed with the Secretary of the Commonwealth shall be considered as complying with these requirements.
- Rule 3. Additions or modifications to an existing installation shall be made in accordance with this Code without bringing the remaining part of the installation into compliance with the requirements of this Code. The installation shall not create a violation of this Code, nor shall it increase the magnitude of an existing violation.
- Rule 4. Where an actual hazard exists, the owner of the property shall be notified in writing by the authority enforcing this Code. The notification shall contain specifications of the actual hazard that exists, together with a reference to the rule of this Code that is now in violation. (*See* M.G.L. c. 166, §§ 32 and 33, for enforcement authority.)
- Rule 5. References are made in this code to other standards. Those standards, where duly adopted by law or regulation, may be enforced by the appropriate official. They are not considered part of this Code and they are not enforceable under M.G.L. c. 143, § 3L. For Massachusetts Building Code references, *see* Appendix A.
- Rule 6. The approving authority may be guided in his approval of specific items of equipment and materials contemplated by the Code, by proof that such equipment and materials have been tested and conform to suitable recognized industry standards.

527 CMR: BOARD OF FIRE PREVENTION REGULATIONS

12.00: continued

Rule 7. 527 CMR 12.00 shall be effective on all installations for which a permit has been granted subsequent to April 24, 2026.

Rule 8. In accordance with the provisions of M.G.L. c. 143, § 3L, the permit application form to provide written notice of installation of wiring shall be uniform throughout the Commonwealth, and applications shall be filed on the prescribed form. Electronic transmittals of this form shall be permitted when done in accordance with the Uniform Electronic Transactions Act (M.G.L. c. 110G). After a permit application has been accepted by an Inspector of Wires appointed pursuant to M.G.L. c. 166, § 32, an electrical permit shall be issued to the person, firm or corporation stated on the permit application. Such entity shall be responsible for the notification of completion of the work as required in M.G.L. c. 143, § 3L.

Permits shall be limited as to the time of ongoing construction activity, and may be deemed by the Inspector of Wires abandoned and invalid if he or she has determined that the authorized work has not commenced or has not progressed during the preceding 12-month period. Upon written application, an extension of time for completion of work shall be permitted for reasonable cause. A permit shall be terminated upon the written request of either the owner or the installing entity stated on the permit application.

Rule 9. Installations, repairs, maintenance, or removals covered by 527 CMR 12.00 shall also comply with M.G.L. c. 141.

Rule 10. Electrical installations, repairs, maintenance, or removals shall not be concealed or covered from view until inspected by the inspector of wires within and not more than 24 hours for exterior or interior excavations nor more than 72 hours for exterior or interior installations after proper notice to the inspector, Saturdays, Sundays, and holidays excluded.

Rule 11. Electrical installations that appear incompatible with GFCI protection as covered in 210.8(D) Exception of this Code, regardless of the code requirements in effect at the time when the permit as described in Rule 8 was issued, or when the installation was completed, shall be inspected by a qualified person. The inspection shall review all field elements of the branch-circuit equipment grounding return path, and the quality of any field-accessible cord connections if applicable. The inspection shall be documented, subject to audit by the Inspector of Wires, and inspected by him or her as deemed necessary. Installations of listed equipment that, under normal operating conditions, are found to be incompatible with GFCI protective devices as made available by the manufacturer of the circuit protection currently installed shall be excused from providing GFCI protection. The inspection documentation required by this rule shall constitute the notice required in Rule 8 and no additional notice shall be required for corrections applied accordingly. The location and the date of this determination shall be forwarded to the Department of Fire Services for inclusion in a central registry of such allowances. The report shall also include the appliance manufacturer and model, together with the identity of the GFCI protective device. This rule shall expire on January 1, 2029.

90.2(A)(2)(5). Delete (d) and revise (c) to read as follows:

(c) Are located in legally established easements, rights-of-way, or by other agreements either designated by or recognized by the public service commissions, utility commissions, or other regulatory agencies having jurisdiction for such installations.

Informational Note: Wiring systems that are maintained by utilities and that operate under this exclusion from coverage by the Massachusetts Electrical Code include, regardless of ownership, luminaires for street and area lighting directly connected to such systems.



THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **830 CMR 62B.00**

CHAPTER TITLE: **Withholding of Taxes on Wages and Declaration of Estimated Income Tax**

AGENCY: **Department of Revenue**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

830 CMR 62B.2.1 contains revisions to incorporate the 4% surtax on income over a certain threshold. **Withholding agents must withhold the 4% surtax from payments made to certain individual performers where the aggregate amount of such payments in a given year exceeds the surtax threshold for that year. The amount of tax to withhold is determined based on the calculation methods or tables provided by the Commissioner. 830 CMR 62B.2.3** contains revisions to incorporate the 4% surtax. **Motion picture production companies must withhold the 4% surtax from payments made to independent contractors and loan-outs for the production of a motion picture where the annual aggregate amount of such payments exceeds the surtax's threshold.**

REGULATORY AUTHORITY: **M.G.L. c. 14, s.6; M.G.L. c. 62C, s. 3**

AGENCY CONTACT: **Rebecca Forter, Deputy Commissioner** PHONE: **617-852-3106**

ADDRESS: **Department of Revenue, Rulings and Regulations Bureau, 100 Cambridge Street, 7th floor, Boston, MA 02114**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

**Approved by the Secretary of Administration and Finance on October 23, 2025.
Notice to the Local Government Advisory Commission sent on October 24, 2025.**

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **December 10, 2025**

FISCAL EFFECT - Estimate the fiscal effect of the public and private sectors.

For the first and second year: No fiscal effect

For the first five years: No fiscal effect

No fiscal effect: No fiscal effect

SMALL BUSINESS IMPACT - M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.

Date amended small business impact statement was filed: May 19, 2026

CODE OF MASSACHUSETTS REGULATIONS INDEX - List key subjects that are relevant to this regulation:

**Withholding
Motion Picture Production Withholding
Personal Income Tax
Surtax**

PROMULGATION - State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:

Amends existing 830 CMR 62B.2.1 and 830 CMR 62B.2.3

ATTESTATION - The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency. ATTEST:

SIGNATURE: _____ SIGNATURE ON FILE _____ DATE: May 21 2026

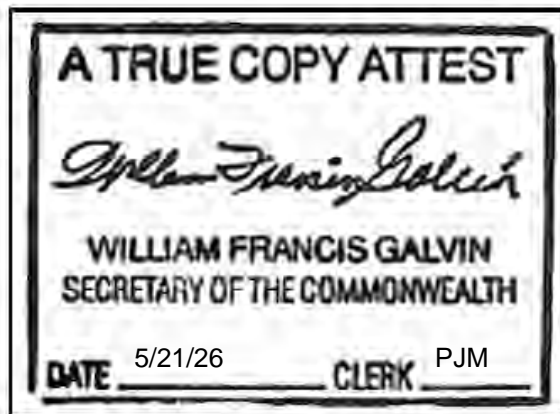
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Remove these Pages:	Insert these Pages:
91 - 96.2 96.11 - 96.14	91 - 96.2 96.11 - 96.14



830 CMR 62B.00: WITHHOLDING AND ESTIMATED TAXES

Section

- 62B.2.1: Withholding of Taxes on Wages and Other Payments
- 62B.2.2: Pass-through Entity Withholding
- 62B.2.3: Motion Picture Production Company Withholding
- 62B.2.4: Withholding on Sales of Massachusetts Real Estate

62B.2.1: Withholding of Taxes on Wages and Other Payments

(1) Statement of Purpose, Effective Date, Outline of Topics.

(a) Statement of Purpose. 830 CMR 62B.2.1 explains the requirements of employers and other persons to withhold the Massachusetts income tax on wages and payments, as required by M.G.L. c. 62B, §§ 1 through 12.

(b) Effective Date. All sections of 830 CMR 62B.2.1 except 830 CMR 62B.2.1(6) are effective as of November 18, 2005. 830 CMR 62B.2.1(6) is effective for taxable years beginning on or after January 1, 2006.

(c) Outline of Topics. 830 CMR 62B.2.1 is organized as follows:

1. Statement of Purpose
2. Definitions
3. Income Subject to Withholding
4. Employers and Other Persons Required to Withhold; Amount to Withhold
5. Employer and Employee Reporting Obligations
6. Registration and Reporting Obligations of Payers of Compensation to Performers or Performing Entities; Reporting Obligation of Performing Entity
7. Returns and Payments
8. Methods of Calculation
9. Multiple Withholding
10. Pensions, Annuities, and other Retirement Arrangements
11. Fringe Benefits
12. Interest and Penalties
13. Credit Against Taxes

(2) Definitions. For purposes of 830 CMR 62B.2.1, the following terms shall have the following meanings, unless the context requires otherwise:

Code. The Internal Revenue Code of the United States in effect for the applicable year.

Commissioner. The Commissioner of the Massachusetts Department of Revenue, or the Commissioner's duly authorized representative.

Employer. The same meaning as defined in the Internal Revenue Code § 3401(d).

Employee. The same meaning as defined in the Internal Revenue Code § 3401(c), except full-time students engaged in seasonal, temporary or part-time employment whose estimated annual income does not exceed \$2,000.

Performance. An event in which a performer or performing entity receives compensation for personal services performed in, derived from, or connected with sources within Massachusetts by competing, demonstrating, exhibiting, entertaining or educating an audience, making a public appearance, or endorsing merchandise.

Performer. A performer may be:

- (a) an athlete such as a wrestler, boxer, golfer, tennis player, sports team member or other athlete who is paid for competing, demonstrating, making a public appearance, or endorsing merchandise, as well as a person paid to further an athlete's performance or an athletic event, performing services such as owner or leader of a performing entity; agent or manager of a performing entity or performer; referee, coach, or trainer; member of a production crew; or
- (b) a paid entertainer or speaker, such as an actor, singer, musician, dancer, circus performer, comedian, celebrity, public speaker or lecturer, as well as any person paid to further an entertainer's or speaker's performance such as owner or leader of a performing entity; agent or manager of a performing entity or performer; or writer, director, coach, designer, or member of a sound, light, stage or production crew.

62B.2.1: continued

Performing Entity. A corporation, partnership, limited partnership, limited liability company, corporate trust or other entity that employs, engages, or comprises one or more performers.

Promoter. A person, association, corporation, partnership, limited partnership, limited liability company, corporate trust or other entity that organizes, produces, or sponsors a performance.

Quarter-monthly Period. The first seven days of a calendar month, the eighth through the 15th day of a calendar month, the 16th through the 22nd day of a calendar month, or the 23rd through the last day of a calendar month.

Seasonal Employer. An employer that is required to deduct and withhold Massachusetts income tax and that regularly has no withholding tax liability in the same one or more calendar months each year.

Taxpayer. Any person or entity subject to the tax imposed by M.G.L. c. 62 or M.G.L. c. 62B, including individuals, trustees and other fiduciaries, estates and corporate trusts, and employers or other entities required to withhold tax.

Transacting Business within the Commonwealth. Having or maintaining within this state, directly or indirectly, an office, distribution house, sales house, warehouse, or other place of business, or otherwise operating or engaging in business within this state by or through any agent or other representative under the authority of the employer.

Wages. For withholding purposes only, wages as defined in Code § 3401(a), periodic payments and nonperiodic distributions as defined in Code § 3405 and subject to federal withholding, and contributions paid by the employer on behalf of the employee pursuant to M.G.L. c. 32, § 22(10) or pursuant to M.G.L. c. 32, § 65D(i) and not otherwise included as wages.

(3) Income Subject to Withholding.

(a) Income Subject to Withholding. Employers and other withholders are required to withhold an amount from wages or payments that is substantially equivalent to the tax amount reasonably anticipated to be due, according to the calculation methods or tables, as applicable, provided by the Commissioner. Generally, income is subject to Massachusetts income tax withholding if:

1. it is taxable under the Massachusetts personal income tax law; and
2. it falls into one of the following categories:
 - a. wages for federal withholding purposes under Code § 3401(a);
 - b. periodic payments and nonperiodic distributions as defined in Code § 3405 and subject to federal withholding;
 - c. employer pension contributions by governmental units and free public libraries as provided in M.G.L. c. 32, § 22(10) and payments by governmental units for retirement pay of judges appointed on or after January 2, 1975, as provided in M.G.L. c. 32, § 65D(i); or
 - d. payments made as compensation in any form for performances by performers, including payments to individuals as independent contractors and payments to performing entities.

(b) Remuneration Excluded from Withholding. Certain types of income are excluded from the federal definition of wages under Code § 3401(a) and accordingly are not subject to withholding in Massachusetts. Code § 3401(a) excludes from withholding remuneration paid:

1. for certain armed forces service during active combat zone service;
2. for certain agricultural labor if the worker is paid in a medium other than cash or the employee earns less than \$150 annually and other conditions are met;
3. for domestic service in a private home;
4. for certain service not in the course of the employer's trade or business;
5. for services by a United States citizen or resident for a foreign government or an international organization as defined in Code § 7701(a)(18);
6. for certain services performed by certain non-resident alien individuals;
7. (intentionally omitted because omitted from Code § 3401(a));

62B.2.1: continued

8. for certain services performed by United States citizens living abroad;
 9. for certain services performed by a minister or religious leader;
 10. for certain services performed by a newspaper delivery person under the age of 18;
 11. for certain services not in the course of the employer's trade or business paid in a medium other than cash;
 12. to, or on behalf of, an employee or an employee's beneficiary:
 - a. from or to a trust described in Code § 401(a);
 - b. under or to a Code § 403(a) annuity plan;
 - c. for a payment described in Code § 402(h)(1) and (2) if it is reasonable to believe that the employee will be entitled to an exclusion;
 - d. under an arrangement to which Code § 408(p) applies;
 - e. under or to an eligible deferred compensation plan under Code § 457(b) (for distributions after December 31, 2001);
 13. pursuant to certain service performed under the Peace Corps Act;
 14. in the form of group-term life insurance on the life of an employee;
 15. to or on behalf of an employee for certain moving expenses that are reasonably expected to be deductible under Code § 217;
 16. as tips if the employee receives tips in a medium other than cash or receives less than \$20 in tips in a calendar month in the course of employment with one employer;
 17. for certain service on a fishing boat described in Code § 3121(b)(20);
 18. for payments or benefits to an employee that are reasonably expected to be excluded from income under Code § 127 (educational assistance programs) or Code § 129 (dependent care assistance programs) or Code § 134(b)(4) (dependent care assistance programs as a qualified military benefit);
 19. for benefits that are reasonably expected to be excluded from income under:
 - a. Code § 74(c) (certain employee achievement awards);
 - b. Code § 117 (qualified scholarships);
 - c. Code § 132 (certain fringe benefits);
 20. for medical care reimbursement paid under a self-insured medical reimbursement plan as defined in Code § 105(h)(6);
 21. for certain contributions to or for the benefit of an employee under a medical savings account as defined in Code § 106(b).
 22. any payment to or for the benefit of an employee if the employee could exclude the payment from income under Code § 106(d) (contributions to health savings accounts).
- (c) Differences between Withholding Requirement and Taxability. A determination of the requirement to withhold is not the same as a determination of taxability. Differences between withholding requirements and taxability occur for two reasons. First, income may be taxable in Massachusetts but not subject to withholding, either because it is excluded from the definition of wages for withholding purposes, or because of differences between federal and state taxable income. Second, Massachusetts withholding law is based on the current Code, while taxation of income is generally based on the Code as of a certain date. Because of these differences between withholding requirements and taxability, employers may meet their withholding obligations yet employees may still be required to pay estimated taxes or agree to additional withholding in order to avoid the imposition of underpayment penalties. 830 CMR 62B.2.1 addresses only withholding requirements.

(4) Employers and Other Persons Required to Withhold; Amount to Withhold.(a) Employers and their Agents.

1. Employers. Employers that maintain an office or transact business within Massachusetts and that make payment of wages taxable to a resident or nonresident individual shall deduct and withhold a tax from such wages for each payroll period. Employers not maintaining an office or transacting business within Massachusetts may, as a convenience to employees, withhold Massachusetts income taxes for employees who reside in Massachusetts and who request that their employer withhold Massachusetts taxes. Employers that withhold as a convenience to employees must meet all reporting, return, and payment obligations established under 830 CMR 62B.2.1.

62B.2.1: continued

2. Agents of Employers. If the person for whom the individual performs the services does not have control of the payment of the wages for such services, the term “employer” means the person having control of the payment of such wages. The federal approval of an agent under Code § 3504 is effective for Massachusetts income tax withholding purposes. All provisions of 830 CMR 62B.2.1 that are applicable to an employer shall be applicable to a fiduciary, agent, or other person having control of the payment of wages subject to withholding.
3. Amount Withheld. An employer shall withhold amounts determined according to the calculation methods or tables, as applicable, provided by the Commissioner. Amounts withheld shall be substantially equivalent to the tax imposed by M.G.L. c. 62.
- (b) Payers of Gambling or Sports Wagering Winnings. Payers of gambling winnings or sports wagering winnings are required to withhold 5% on winnings, with the exception of winnings from horse and dog racing, if:
1. the winnings are subject to tax under M.G.L. c. 62; and
 2. either:
 - a. the winnings are subject to withholding under Code §§ 3402(q) and 3406; or
 - b. for lottery winnings, the winnings are \$600 or greater (for tax periods beginning on or after January 1, 2005).
- Code § 3402(q) generally requires withholding if the proceeds of the wagering transaction are greater than \$5,000 and at least 300 times as large as the amount wagered. Code § 3402(q) requires withholding on state-conducted lotteries, sweepstakes, wagering pools, pari-mutuel pools, jai alai, lotteries, and proceeds from a wager, but does not require withholding on winnings from a slot machine, keno, and bingo.
- (c) Payers of Unemployment Compensation. If the recipient of an unemployment compensation payment, as defined in Code § 85(b), has elected withholding of federal income tax on such payment, then the payment shall be treated as if it were payment of wages by an employer to an employee. The payer of such benefits shall withhold the amount set forth in M.G.L. c. 151A, § 29E, and shall follow the applicable employer withholding schedule.
- (d) Trustees of Retirement Funds. If an individual recipient of a periodic or nonperiodic payment as defined in Code § 3405 has elected federal income tax withholding on such income, the payer shall withhold the amount of Massachusetts income tax withholding substantially equivalent to the amount reasonably anticipated to be due.
- (e) Trustees of Pooled Income Funds and Charitable Remainder Annuity Trusts or Unitrusts. Resident trustees of pooled income funds and resident trustees of charitable remainder annuity trusts or unitrusts who make payment to resident beneficiaries are required to withhold taxes, or pay estimated taxes, under M.G.L. c. 62, §§ 11A and 11B at the applicable tax rates.
- (f) Withholding Agents Paying Compensation to Performers or Performing Entities.
1. A person or entity that pays performers or performing entities compensation for one or more performances shall withhold. Compensation may not be paid to a performer or a performing entity unless the required tax has been withheld. Any person or entity that transfers funds ultimately payable in part or in full to a performer or performing entity may be held responsible for withholding and subject to the penalty and interest provisions described in 830 CMR 62B.2.1(12). If there is more than one contract for the same date and venue with a performer or performing entity, there may be a different withholding agent for each contract. The withholding agent shall be:
 - a. The Massachusetts venue or, if the venue is not a party to the contract with the performer or the performing entity, the lessee of the venue; or
 - b. If the venue or lessee of the venue is not a party to the contract with the performer or performing entity, the promoter; or
 - c. If there is no promoter, or if the promoter is not a party to the contract with the performer or performing entity, the payroll service provider making payments to performers, or the vendor selling merchandise for which a performer or performing entity will receive a percentage of the sales price; or
 - d. Notwithstanding the requirements of 830 CMR 62B.2.1(4)(f)1.a, b, and c, any person or entity the Commissioner designates who pays a performer or performing entity compensation for one or more performances.

62B.2.1: continued

2. A withholding agent must withhold tax at the rate imposed on Part B taxable income under M.G.L. c. 62, § 4(b) multiplied by the gross payment to the performer or the performing entity, unless the performer or performing entity requests in advance of the performance that withholding be reduced or waived, and the Commissioner grants the request. For purposes of 830 CMR 62B.2.1(4)(f), a gross payment is the sum of all payments made by one payer to the same performer or performing entity for performances during the calendar year. If the withholding agent's gross payment to an individual performer exceeds the taxable income threshold referenced in M.G.L. c. 62, § 4(d), then the tax rate applicable to the portion of such payments exceeding the taxable income threshold shall be the applicable rate under M.G.L. c. 62, § 4(b) plus an additional 4%.
 3. Withholding pursuant to 830 CMR 62B.2.1(4)(f) is not required if the payer reasonably anticipates that gross payment will not exceed the threshold established by the Commissioner. The Commissioner may direct a withholding agent to withhold notwithstanding the established threshold.
 4. A payer that is exempt from federal taxation under Code § 501(c)(3) is not required to withhold taxes from persons who are not employees, unless the aggregate amount paid for a particular performance exceeds \$10,000.
- (5) Employer and Employee Reporting Obligations.
- (a) Withholding Exemption Certificate.
 1. Obligation to Furnish. Withholding exemption certificates shall be in the form prescribed by the Commissioner. Every employee shall furnish his or her employer with a signed withholding exemption certificate setting forth the number of exemptions the employee claims pursuant to M.G.L. c. 62, § 3(B)(b). Withholding exemption certificates shall take effect as of the beginning of the first payroll period ending, or as of the time of the first payment of wages made without regard to payroll period, on or after the date on which such certificate is furnished. Each certificate continues in effect with respect to the employer to whom it was submitted until another certificate takes effect.
 2. Changes in Number of Exemptions. If a withholding exemption certificate is furnished to take the place of an existing certificate, the employer has the option to continue the old certificate in force with respect to all wages paid on or before the first status determination date which occurs at least 30 days after the date on which the new certificate is furnished. For the purpose of 830 CMR 62B.2.1(5) the term "status determination date" means January 1st and July 1st of each year. If changes occur in the number of dependency exemptions to which an employee is entitled, the employee shall furnish the employer with an accurate exemption certificate within ten days if the change occurs during the calendar year, or before the beginning of the next calendar year if the change is reasonably expected to occur at the beginning of the next calendar year.
 3. Commissioner may Determine Correct Number of Exemptions. If the Commissioner finds that an employee has no reasonable basis for the number of dependency exemptions the employee has claimed, the Commissioner shall determine the proper number of dependency exemptions and shall notify the employer. Upon such notification, the employer shall use the number of dependency exemptions determined by the Commissioner with respect to wages paid to that employee.
 4. Penalties. There is a \$500 penalty for an employee's false statement on a withholding exemption certificate that results in a decrease in the amount deducted and withheld. In addition, a person who willfully supplies false or fraudulent information, or who willfully fails to supply information that would require an increase in the tax to be withheld shall be guilty of a misdemeanor and subject to a fine of up to \$1,000 or imprisonment for up to one year, or both.
 - (b) Estimate Quarterly Wages. The employer may:
 1. estimate the wages that will be paid to any employee in any quarter of the calendar year;
 2. determine the amount to be deducted and withheld upon each payment of wages to the employee during that quarter as if the average of the estimated wages constituted the actual wages paid; and
 3. deduct and withhold upon any payment of wages to the employee during that quarter the amount necessary to adjust the amount actually deducted and withheld to the amount that would be required to be deducted and withheld during the quarter if the payroll period of the employee were quarterly.

62B.2.1: continued

(c) Miscellaneous Payroll Periods. If wages are paid with respect to a period that is not a payroll period, the amount to be deducted and withheld shall be for a miscellaneous payroll period containing a number of days, including Sundays and holidays, equal to the number of days in the period with respect to which the wages are paid. If wages are paid by an employer without regard to any payroll period, the amount to be deducted and withheld shall be for a miscellaneous payroll period containing the number of days, including Sundays and holidays, that have elapsed since the date of the last payment of wages by the employer during the calendar year, or the date of commencement of employment with the employer during the year, or January 1st of the year, whichever is later.

(d) Furnish Wage or Payment Statement by January 31st. Every employer and other withholding entity that deducts and withholds a tax from an employee or payee shall furnish a written statement in duplicate to each employee or payee in respect of the wages or other payments paid to that employee or payee during the calendar year. The written statement must show the name of the employer or payer, the name of the employee or payee and his or her social security number, if any, the total amount of wages or payments subject to taxation under M.G.L. c. 62, and the total amount deducted and withheld as tax. This statement shall be made on or before January 31st of the succeeding year, or, if employment is terminated before the close of the calendar year, within 30 days from the day on which the last payment of wages is made. The Commissioner may grant reasonable extensions of time, not exceeding 60 days, to furnish this statement.

(6) Registration and Reporting Obligations of designated Withholding Agents of Performers or Performing Entities; Reporting Obligation of Performing Entity.

(a) A withholding agent pursuant to 830 CMR 62B.2.1(4)(f)1. shall:

1. register electronically for Massachusetts withholding on compensation paid to performers or performing entities;
2. deduct and withhold Massachusetts income tax on payments to or for performers or performing entities as if such payments were wages paid by an employer to an employee, withholding an amount as determined under 830 CMR 62B.2.1(4)(f)2. from each payment to a performer or performing entity;
3. report and pay the amount of taxes withheld during a quarter-monthly period within three days after the close of the quarter-monthly period, using electronic media for all reports and making all payments as ACH debit transactions;
4. file an electronic return on or before the last day of the month following the close of the calendar quarter even if no tax was withheld during the calendar quarter;
5. show on federal Form 1099-MISC, federal Form 1099-NEC, federal Form 1042-S if the performer or performing entity is a foreign person, or other applicable federal form used to report payments made to the performer or performing entity the amount of Massachusetts income tax deducted and withheld, even if such form is not required under federal law. The person treated as an employer must furnish a federal Form 1099-MISC, federal Form 1099-NEC, or other applicable federal form to each person treated as an employee on or before the last day of January on the next succeeding calendar year, unless the person treated as an employee is a foreign person, in which case the person treated as an employer must furnish a federal Form 1042-S to each foreign person treated as an employee on or before March 15th of the next succeeding calendar year; and
6. keep complete records, showing the name and social security number or federal tax identification number of the performer or performing entity, the gross amount paid to the performer or performing entity, the amount of Massachusetts income tax withheld, and the date(s) and location(s) of the performance(s), as well as copies of all issued forms 1099-MISC, 1099-NEC, 1042-S, and any other applicable form forms used to report payments made to a performer or performing entity.

(b) Performing Entity; Member or Participant of Performing Entity. A performing entity must determine how much of the aggregate income and Massachusetts income tax withholding reported by the withholding agent on federal Form 1099-MISC, federal Form 1099-NEC, federal Form 1042-S, or other applicable federal form used to report payments made to the performer or performing entity is attributable to each member or participant and furnish to each member or participant a withholding allocation form showing the member or participant's attributed withholding amount. If the recipient of a withholding allocation form is not an individual, the recipient must furnish to each of its members or participants an additional withholding allocation form showing how its withholding amount is attributed to each of its members or participants. This process is repeated until the recipient of a withholding allocation form is an individual. Each entity shall keep copies of withholding allocation forms it has issued. Each individual recipient of a withholding allocation form shall file a copy of the form with his or her Massachusetts income tax return, and may claim a credit for the withheld amount shown on the withholding allocation form.

62B.2.1: continued

(7) Returns and Payments.(a) Withholding Schedules.1. Payroll Withholding.

a. Withholding Categories. For withholding tax purposes, employers shall be divided into the following categories:

i. Type 1: Every employer required to deduct and withhold taxes under M.G.L. c. 62B, § 2 that can reasonably expect that total taxes withheld will not exceed \$100 for the calendar year.

ii. Type 2: Every employer required to deduct and withhold taxes under M.G.L. c. 62B, § 2 that can reasonably expect that total taxes withheld will exceed \$100 but not \$1,200 for the calendar year.

iii. Type 3: Every employer required to deduct and withhold taxes under M.G.L. c. 62B, § 2 that can reasonably expect that total taxes withheld will exceed \$1,200 but not \$25,000 for the calendar year.

iv. Type 4: Every employer required to deduct and withhold taxes under M.G.L. c. 62B, § 2 that can reasonably expect that total taxes withheld will exceed \$25,000 for the calendar year.

b. Employers: General.

i. Type 1: Employers. Every Type 1 employer shall file a return and pay over to the Commissioner the taxes withheld during the calendar year on or before the last day of January following the close of the calendar year.

ii. Type 2: Employers. Every Type 2 employer shall file a return and pay over to the Commissioner the taxes withheld for each calendar quarter on or before the last day of the month following the close of the calendar quarter.

iii. Type 3: Employers. Every Type 3 employer shall file a return and pay over to the Commissioner the taxes withheld for each calendar month on or before the 15th day of the following calendar month, except that for the months of March, June, September and December, the return shall be filed and the taxes withheld shall be paid on or before the last day of the following calendar month.

iv. Type 4: Employers. Every Type 4 employer shall pay over to the Commissioner the cumulative amount of taxes withheld and not previously paid over, when this cumulative amount is \$500 or more at the end of any quarter-monthly period. Such payment shall be made within three business days after the close of the quarter-monthly period. Type 4 employers shall also file a return on or before the last day of the month following the close of each calendar quarter accompanied by any unpaid withheld taxes.

c. Employers: Seasonal. A seasonal employer may be permitted by the Department to file withholding tax returns for only those calendar months in which it is required to deduct and withhold Massachusetts income tax. Permission is granted to file as a seasonal employer when a business has indicated to the Department, either on Form TA-1 Application for Original Registration, or on Form TA-2 Application for Additional Registration, that taxes are withheld only during certain months of the year. Permission to file as a seasonal employer shall take effect immediately and remain in effect as long as the employer remains a seasonal employer.

2. Annual Withholding from Nonpayroll Payments.

a. Payers That may Report Annually. With the exception of payers of gambling winnings, payers of nonpayroll payments that withhold Massachusetts income taxes, and that report annually on Federal Form 945 for purposes of federal income tax withholding, may report withheld Massachusetts income taxes annually. An annual report is required from each payer registered to withhold, whether or not the payer withheld Massachusetts taxes during the calendar year. Withheld amounts that may be reported annually include, for example, certain annuities as described in Code § 3402(o)(1)(B) and pensions, annuities, IRAs, and certain other deferred income subject to withholding under Code § 3405. Annual returns filed under 830 CMR 62B.2.1(6)2. are due on or before the last day of January following the close of the calendar year. A reconciliation of deposits made and amounts withheld throughout the year shall accompany the annual filing. No withholding is required on nonpayroll payments that do not exceed the lesser of \$10 per payee or \$100 to all Massachusetts payees during one tax year.

62B.2.1: continued

b. Payment Requirements for Annual Reporters. Annually reported nonpayroll withheld taxes should be paid, accompanied by a Massachusetts tax deposit coupon, as follows:

- i. if the payer of nonpayroll payments can reasonably expect that the total taxes withheld will not exceed \$100 for the calendar year, payment shall accompany the annual return;
- ii. if the payer of nonpayroll payments can reasonably expect that the total taxes withheld will exceed \$100 but not \$1,200 for the calendar year, payment shall be made no later than the last day of the month following the close of a calendar quarter for the amount withheld during the calendar quarter;
- iii. if the payer of nonpayroll payments can reasonably expect that the total taxes withheld will exceed \$1,200 but not \$25,000 for the calendar year, payment shall be made no later than the 15th day of the calendar month for the amount withheld during the previous calendar month; or
- iv. if the payer of nonpayroll payments can reasonably expect that the total taxes withheld will exceed \$25,000 for the calendar year, payment shall be made no later than three business days after the close of the quarter monthly period when the cumulative amount of taxes withheld and not previously paid over is \$500 or more at the end of any quarter-monthly period.

3. Gambling Winnings. Gambling winnings withheld under Code § 3402(q) and reported annually for purposes of federal income tax must be treated as if they were wages paid by an employer to an employee and withheld according to the applicable employer withholding schedule.

(b) Form of Payment. The Commissioner may, in his discretion, provide that any taxes deducted and withheld under M.G.L. c. 62B, § 2 be paid over to a depository designated by him.

(8) Methods of Calculation. The amount of tax due may be calculated according to the calculation methods or tables, as applicable, provided by the Commissioner. Alternatively, employers may use accounting machines to calculate the proper amount to be deducted and withheld from wages, provided that such calculation produces substantially the tax required by such calculation methods or tables. In determining the amount to be deducted and withheld, wages may, at the election of the employer, be computed to the nearest dollar.

(9) Multiple Withholding.

(a) Two or More Employers.

1. If an employee works for two or more separate employers during the same or overlapping payroll periods, the employee is entitled to claim exemptions and deductions upon only one withholding exemption and deduction certificate. No exemptions or deductions may be claimed on certificates furnished to other employers.
2. If an employee works concurrently for two or more joint or related employers, the amount of tax required to be withheld on each wage payment to the employee, whether the wages are paid separately by each employer or paid in a lump sum by all of the employers, may be determined upon the aggregate amount of payments in the same manner as if that amount had been paid by one employer.
3. If a payment of wages is made to an employee by an employer through an agent, fiduciary, or other person who also has the control, receipt, custody, or disposal of, or pays the wages payable by another employer to the employee, the amount of tax required to be withheld on each wage payment made through such agent, fiduciary, or person, whether the wages are paid separately on behalf of each employer or paid in a lump sum on behalf of all of the employers, may be determined upon the aggregate amount of payments in the same manner as if that amount had been paid by one employer.
4. Under 830 CMR 62B.2.1(9)(a)(2), and 62B.2.1(9)(a)(3), each employer shall be liable for the return and payment of a pro rata portion of the tax so determined, in the ratio which the amount contributed or paid by the particular employer bears to the aggregate of such wages.

62B.2.2: continued

Example (6)(c)3. Same facts as Example (6)(c)2, except that Pass-through Entity makes its first installment payment on behalf of Member for the taxable year on April 15th. Member's estimated payment obligation with regard to her income from Pass-Through Entity has been met.

(7) Joint and Several Liability. A pass-through entity required to withhold, shall be jointly and severally liable with each member subject to withholding for taxes, together with related interest and penalties, imposed on the member by Massachusetts with respect to the income of the pass-through entity. A pass-through entity that reasonably relies, in good faith, on an exemption certificate presented by a member pursuant to 830 CMR 62B.2.2(3)(c) shall not be liable for failure to withhold. Notwithstanding the stated exception, joint liability will exist in any instance in which the member directly or indirectly owns more than a 50% interest in the pass-through entity.

(8) Withholding Registration, Payment, Reporting. A pass-through entity that is not exempt under 830 CMR 62B.2.2(3)(b) shall withhold with respect to members, other than those that are exempt from withholding pursuant to 830 CMR 62B.2.2(3)(c), that have been allocated Massachusetts taxable amounts of distributive share during the taxable year, using electronic media and the format designated by the Commissioner. If withholding is required for any member, a pass-through entity shall:

- (a) register for Massachusetts withholding on amounts paid, credited or allocated to a member;
- (b) report and pay over to the Commissioner the amount of taxes withheld during each quarter of the entity's taxable year on or before the last day of the month following the close of the quarter;
- (c) file an annual withholding return with the Commissioner, on or before the last day of the third month of the year following the taxable year, showing the total amount withheld for the taxable year (if no tax was withheld, report zero tax withheld) and any other information the Commissioner requires; and
- (d) furnish to each member subject to pass-through entity withholding a statement of amounts withheld and paid to the Commissioner during the taxable year on the member's behalf. If the pass-through entity is treated as a partnership, this information should be included on the partner's Massachusetts information schedule. Other types of pass-through entities should use a form approved by the Commissioner.

(9) Penalties. Any pass-through entity required to withhold that fails to meet its withholding obligation shall be subject to all applicable penalties for failure to adequately withhold under M.G.L. c. 62B and M.G.L. c. 62C. A pass-through entity that has not properly allocated distributive share to its members, as required for partnerships and entities treated as partnerships under M.G.L. c. 62, § 17, as required for S corporations under M.G.L. c. 62, § 17A, or as required under other applicable authority, may be liable for additional penalties.

62B.2.3: Motion Picture Production Company Withholding

(1) Statement of Purpose, Outline of Topics.

(a) Statement of Purpose. Under M.G.L. c. 62B, § 2, the Commissioner is authorized to require persons other than employers to deduct and withhold taxes from payments other than wages in order to protect the revenue of the commonwealth. 830 CMR 62B.2.3 establishes and explains the requirements of motion picture production companies to withhold Massachusetts personal income tax on payments to independent contractors and loan-outs for services rendered in Massachusetts. For coordination with live performance performer withholding *see* 830 CMR 62B.2.3(6)(c).

(b) Outline of Topics. 830 CMR 62B.2.3 is organized as follows:

1. Statement of Purpose; Outline of Topics
2. Definitions
3. Registration and Reporting Obligations of a Production Company; Qualification for the Credit

62B.2.3: continued

4. Withholding and Reporting Requirements as Prerequisites for Credit Qualification; Loan-out Filing Requirements
5. Personal Income Credit Against Taxes; Reporting Requirements
6. Coordination With Other Withholding Requirements
7. Effective Date

(2) Definitions. For purpose of 830 CMR 62B.2.3, the following terms shall have the following meanings, unless the context requires otherwise:

Commissioner, the Commissioner of the Massachusetts Department of Revenue or the Commissioner's duly authorized representative.

Credit, the motion picture production company credit.

Independent Contractor, an individual treated as an independent contractor for federal and Massachusetts tax purposes and contracted with and retained by the production company, such as artists, crew, actors, directors and producers, for the performance of services used directly in a production. It does not include entities retained by the production company to provide tangible property or outside contractor service, such as catering, construction, trailers, equipment and transportation.

Loan-out, a personal service corporation or other entity contracted with and retained by the production company to provide individual personnel, such as artists, crew, actors, directors and producers, for the performance of services used directly in a production, but not including entities retained by the production company to provide tangible property or outside contractor service, such as catering, construction, trailers, equipment and transportation.

Motion Picture Production Company Credit, the motion picture aggregate payroll or production expense credit allowed under M.G.L. c. 62, § 6(1) or M.G.L. c. 63, § 38X.

Performer Withholding Waiver, a waiver from performer withholding requirements authorized under 830 CMR 62B.2.1, issued by the Commissioner's performer withholding unit.

Production, a motion picture as defined in M.G.L. c. 62, § 6(1) and M.G.L. c. 63, § 38X.

Production Company, a motion picture production company as defined in M.G.L. c. 62, § 6(1) and M.G.L. c. 63, § 38X.

Surtax, the personal income tax imposed by M.G.L. c. 62, § 4(d).

(3) Registration and Reporting Obligations of a Production Company; Qualification for the Credit.

(a) Registration. A production company that seeks a motion picture production company credit as to payments made to a loan-out or an independent contractor must register for motion picture production company withholding prior to filing an application for the credit.

(b) Withholding Amount. A production company must withhold at the personal income tax rate under M.G.L. c. 62, § 4(b) on any payment to a loan-out or an independent contractor for that payment to qualify for the motion picture production company credit. Where the sum of all of payments made by a production company to the same individual loan-out or independent contractor during the calendar year exceed the taxable income threshold referenced in M.G.L. c. 62, § 4(d), then the tax rate applicable to the portion of such payments exceeding the taxable income threshold shall be the applicable rate under M.G.L. c. 62, § 4(b) plus an additional 4%. A payment to a loan-out or an independent contractor can only qualify for the motion picture production company credit if, and to the extent that, such payment if made directly to the individual(s) providing services used directly in the production on behalf of the loan-out, would be Massachusetts source income to such individual.

(c) Timing of Withholding Remittance. Any production company seeking a credit as to a payment made to a loan-out or an independent contractor, must withhold and remit to the Commissioner the withholding amount required under 830 CMR 62B.2.3(3)(b) prior to the filing of an application for the credit.

62B.2.3: continued

(4) Withholding and Reporting Requirements as Prerequisites for Credit Qualification; Loan-out Filing Requirements.(a) Withholding and Reporting Requirements. A payment to a loan-out or an independent contractor will not qualify for the credit:

1. if, or to the extent that, the withholding amount required under 830 CMR 62B.2.3(3)(b) is not remitted to the Commissioner prior to the filing of an application for the credit; and
2. if the reporting requirements are not met as required under 830 CMR 62B.2.3(5).

Example 1. A production company files an application for the credit and reports as an otherwise qualifying production expense a \$4,000,000 payment it made during the 2022 tax year to a loan-out for the services of the leading actor in the production. The production company has met the reporting requirements as required under 830 CMR 62B.2.3(5). Prior to filing the application for the credit, the production company had registered for production company withholding as required under 830 CMR 62B.2.3(3)(a). The withholding required under 830 CMR 62B.2.3 on the \$4,000,000 payment to the loan-out for the services of the leading actor is \$200,000 (5% x \$4,000,000). However, the production company withheld and remitted to the Commissioner only \$150,000, which is 75% of the required withholding. The production company will only be allowed to claim the credit on the portion of the payment on which it withheld and remitted to the Commissioner prior to filing its application for the credit. The \$150,000 withheld by the production company is the required withholding on a payment of \$3,000,000. Because this is so, the production company can only claim \$3,000,000 as qualifying expenses and the credit would be equal to 25% of this amount, or \$750,000. The remaining \$1,000,000 of the payment to the loan-out does not constitute a qualifying expense for purposes of the credit.

Example 2. Same facts as example 1, but the production company made the payment during the 2023 tax year. For the 2023 tax year, the surtax applies to income exceeding \$1,000,000. As a result, the withholding required under 830 CMR 62B.2.3 on the \$4,000,000 payment is \$320,000 (5% x \$4,000,000 plus 4% x \$3,000,000). Assume that the production company withheld \$150,000, which is the required withholding on a payment of \$2,111,111. As a result, the production company can only claim \$2,111,111 as a qualifying expense and the credit would be equal to 25% of this amount, or \$527,778. The remaining \$1,888,889 of the payment to the loan-out does not constitute a qualifying expense for purposes of the credit.

(b) Loan-out Filing Requirements. Upon the completion of its tax year(s) during which the production took place, the loan-out doing business in Massachusetts must file a Massachusetts tax return and report its income and pay any accompanying tax liability.(5) Personal Income Credit against Taxes; Reporting Requirements.(a) Allocation of Personal Income Credit Against Taxes. The amount deducted and withheld as tax under 830 CMR 62B.2.3 during any calendar year upon the payment from a production company to a loan-out or an independent contractor shall be allowed as a credit to the individual or individuals whose services were provided in the production against his or her income tax. If the services of multiple individuals are provided by the loan-out, the amount deducted and withheld under 830 CMR 62B.2.3 shall be allocated to each individual in proportion to the Massachusetts personal income tax imposed on each individual's respective Massachusetts source income received as payment for the individual's services used directly in the production.(b) Individual Filing Responsibility; Overpayment Applied to Estimated Tax; Refund. The individual providing services must file a Massachusetts personal income tax return attaching the allocation form provided by the production company as required under 830 CMR 62B.2.3(5), and apply the credit for the withholding tax allocated to him or her against the calculated individual income tax liability for that individual. The individual must sign the allocation form acknowledging that any overpayment of the income tax liability will, in this order, be:

1. applied to any required offsets or intercepts;
2. applied to estimated taxes for the next tax year unless all of the Massachusetts source income related to the allocated withholding tax has been reported on this, or a prior, Massachusetts personal income tax return;
3. refunded to the individual.

62B.2.3: continued

(c) Reporting Requirements; Loan-out Allocation Form. The production company and the loan-out must furnish to the Commissioner as an attachment to the production company's credit application, in the manner prescribed by the Commissioner, an accounting and allocation of the withholding amounts on the payments to the loan-out and the social security number or numbers of the individual or individuals allocated the credit against taxes as allowed under 830 CMR 62B.2.3(5)(a) as well as any other information required by the Commissioner. An authorized representative of the production company, an authorized representative of the loan-out and the individual providing services to the loan-out, must sign and declare that to the best of their knowledge and belief, the information contained on the allocation form is true, correct and complete. The production company must also furnish a copy of this allocation form to the individual allocated the withholding amount as allowed under 830 CMR 62B.2.3(5)(a).

Example. Same facts as Example 1 in 830 CMR 62B.2.3(4)(a) with the following additional facts: The withholding upon the payment to the loan-out occurs during the actor's 2022 tax year. However, the actor does not receive the Massachusetts source income reported on the allocation form until the actor's 2023 tax year. The actor does not have any Massachusetts source income, income tax liability or required offsets or intercepts for his or her 2022 tax year. The actor files a Massachusetts personal income tax return for his or her 2022 tax year, attaching the allocation form and applies the \$150,000 withholding amount to his or her estimated taxes for the 2023 tax year. The actor files a Massachusetts personal income tax return for the 2023 tax year, attaching the allocation form and receives a refund of any overpayment for his or her 2023 tax year, as allowed under 830 CMR 62B.2.3(5)(b).

(6) Coordination with Other Withholding Requirements.

(a) Employer Production Company Withholding. The 830 CMR 62B.2.3 withholding requirements apply to a payment made by a production company to a loan-out or an individual independent contractor. Wages and other payments made by a production company that is an employer to its employee are governed by the employer withholding requirements as explained in 830 CMR 62B.2.1. Nothing in 830 CMR 62B.2.3 limits the requirement that a production company must register and withhold Massachusetts income tax on employee wages subject to tax in Massachusetts.

(b) Loan-out Withholding. When a loan-out receives a payment from a production company on which there has been withholding under the withholding requirements of 830 CMR 62B.2.3, it does not have to further withhold under the production company withholding rules set forth in 830 CMR 62B.2.3, the employer withholding rules set forth in 830 CMR 62B.2.1 or the pass-through entity withholding rules set forth in 830 CMR 62B.2.2 as to any paid or allocated amount to an individual to the extent such payment or allocation relates to the same services previously withheld upon.

Example. Same facts as the example in 830 CMR 62B.2.3(4)(a), *e.g.*, the production company makes a \$4 million payment to the loan-out, but only withholds on \$3 million. The loan-out and the individual actor do not have to further withhold on the \$3 million payment to the loan-out for the services of the leading actor in the production. However, any withholding obligation imposed by M.G.L. c. 62B and the regulations thereunder, on the loan-out and the individual actor, is effective for the remaining \$1 million of the payment to the loan-out, as well as any related interest and penalties for failure to withhold.

(c) Performer Withholding. The performer withholding requirements and waivers explained in 830 CMR 62B.2.1 do not apply to a production that qualifies and submits an application for the motion picture production company credit as defined and allowed under M.G.L. c. 62, § 6(1)(1) or M.G.L. c. 63, § 38X. A production qualifying for the motion picture production company credit is generally defined as a film, video, digital media project or a television series. The performer withholding requirements and waivers explained in 830 CMR 62B.2.1 apply to live performances including, but not limited to, live entertainment, public appearances and athletic competitions.



THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin
Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **980 CMR 17.00**

CHAPTER TITLE: **Constructive Approval**

AGENCY: **Energy Facilities Siting Board**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

The 2024 Climate Act (St. 2024, c. 239) requires the Energy Facilities Siting Board (“Siting Board” or “EFSB”) to promulgate regulations to implement the changes to G.L. c. 164, §§ 69G to 69J¼, inclusive, §§ 69O and 69P, §§ 69R and 69S, and §§ 69T to 69W, inclusive. As modified, these sections authorize the Siting Board to issue a single consolidated permit that comprises all state, regional, and local permits that a clean energy infrastructure facility would otherwise need to commence construction and operation. The 2024 Climate Act further requires the Siting Board to promulgate the regulations not later than March 1, 2026, and the regulations will apply to all jurisdictional projects submitted to the Siting Board on and after July 1, 2026. St. 2024, c. 239, § 132. 980 CMR 17.00, Constructive Approval, will apply if the Siting Board does not issue a final decision on an Application by the statutory deadline.

REGULATORY AUTHORITY: **980 CMR 17.00, St. 2024, c. 239, Sections 74, 132, 139**

AGENCY CONTACT: **Joan Foster Evans** PHONE: **6176862138**

ADDRESS: **One South Station, Boston MA 02110**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

Approval from A&F and the Governor's legal office, 5/8/26.
Approval from the Energy Facilities Siting Board 5/11/26.
Notification to Local Government Advisory Commission
(Mass. Municipal Assoc., and Mass. Dept. of Housing and Community Development)

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **10/17/25-11/7/25**

FISCAL EFFECT - Estimate the fiscal effect of the public and private sectors.

For the first and second year: Fiscal effects are difficult to quantify.

For the first five years: Fiscal effects are difficult to quantify.

No fiscal effect: _____

SMALL BUSINESS IMPACT - M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.

Date amended small business impact statement was filed: 5/19/26

CODE OF MASSACHUSETTS REGULATIONS INDEX - List key subjects that are relevant to this regulation:

980 CMR 17.00 is a new regulation. Key subject relevant to this regulation include:: constructive approval, Consolidated Permit, Common Conditions, clean energy infrastructure facilities.

PROMULGATION - State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:

980 CMR 17.00 is a new regulation, and is part of a new regulatory process involving all other chapters of 980 CMR.

ATTESTATION - The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency. ATTEST:

SIGNATURE: _____ SIGNATURE ON FILE _____ DATE: May 20 2026

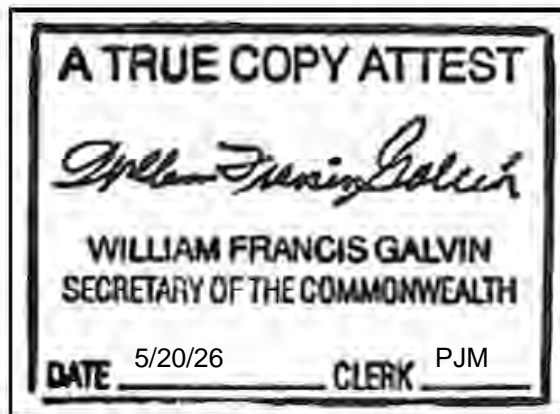
Publication - To be completed by the regulations Division

MASSACHUSETTS REGISTER NUMBER: 1575 DATE: 6/5/26

EFFECTIVE DATE: 6/5/26

CODE OF MASSACHUSETTS REGULATIONS

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2.1 & 2.2 -----	2.1 & 2.2 139 - 142



980 CMR: ENERGY FACILITIES SITING BOARD

Table of Contents

	<u>Page</u>
980 CMR 15.00: CUMULATIVE IMPACT ANALYSIS AND STANDARDS FOR APPLYING SITE SUITABILITY CRITERIA	109
Section 15.01: Purpose, Scope, Application, and Other General Provisions	109
Section 15.02: Definitions	110
Section 15.03: Overview of Cumulative Impact Analysis	112
Section 15.04: Determination of Burdened Areas	113
Section 15.05: Identification of Burdened Areas Intersecting the Specific Geographical Area of a Project Site or Route	114
Section 15.06: Assessment of Burdened Areas for Elevated Indicators	116
Section 15.07: Disproportionate Adverse Effect Analysis – Project Impacts that are Likely to Materially Exacerbate Elevated Indicators	116
Section 15.08: Remedial Actions to Avoid, Minimize or Mitigate Disproportionate Adverse Effects	116
Section 15.09: Contents of CIA Report	117
Section 15.10: Standards for Applying Site Suitability Criteria	117
Section 15.11: Board’s Findings in its Final Decision	118
980 CMR 16.00: PRE-FILING CONSULTATION AND ENGAGEMENT REQUIREMENTS	129
Section 16.01: Purpose and Scope	129
Section 16.02: Definitions	129
Section 16.03: Rules of General Applicability	130
Section 16.04: Overview of Requirements for the Pre-filing Outreach Period	131
Section 16.05: Pre-filing Requirements for Consultation with DPP and OEJE	133
Section 16.06: Pre-filing Requirements for Consultation with MEPA Office and Agency Consultation	133
Section 16.07: Pre-filing Engagement Requirements for Meetings with Key Stakeholders and Public Meetings with the Community	135
Section 16.08: Pre-filing Outreach Requirements for Public Meetings with the Community	135
Section 16.09: Pre-filing Requirements for Project Webpage(s)	136
Section 16.10: Pre-filing Notice (Notification of Intent to File Application) Requirements	137
Section 16.11: Pre-filing Consultation and Engagement Documents to be Submitted with Application and Petition to Construct to the Board	138
980 CMR 17.00: CONSTRUCTIVE APPROVALS	139
Section 17.01: Purpose and Scope	139
Section 17.02: Constructive Approval Procedure	139
Section 17.03: Contents and Form of a Constructive Approval	141
Section 17.04: Issuance of a Constructive Approval	142
Section 17.05: Effect of Decision and Right to Appeal	142

NON-TEXT PAGE

980 CMR 17.00: CONSTRUCTIVE APPROVALS

Section

- 17.01: Purpose and Scope
- 17.02: Constructive Approval Procedure
- 17.03: Contents and Form of a Constructive Approval
- 17.04: Issuance of a Constructive Approval
- 17.05: Effect of Decision and Right to Appeal

17.01: Purpose and Scope

(1) Purpose. 980 CMR 17.00 establishes the requirements pertaining to a Constructive Approval, which the Board shall issue if a Final Decision, pursuant to 980 CMR 13.10: *EFSB Consolidated Permit Decisions*, is not issued by the Board, pursuant to 980 CMR 13.02(4)(a): *Review Timeframe*.

(2) Scope. 980 CMR 17.00 applies to each Application submitted to the Board for a CEIF. M.G.L. c. 164, §§ 69T, 69U, 69V. 980 CMR 17.00 shall not apply to De Novo Adjudications pursuant to 980 CMR 14.00.

(3) Applicability of Earlier Sections. 980 CMR 1.00: *Rules for the Conduct of Adjudicatory Proceedings*, 2.00: *General Information and Conduct of Board Business*, 13.00: *Consolidated Permits for Clean Energy Infrastructure Facilities*, 15.00: *Cumulative Impact Analysis and Standards for Applying Site Suitability Criteria*, and 16.00: *Pre-filing Consultation and Engagement Requirements* apply to 980 CMR 17.00, unless otherwise noted.

(4) Definitions. The definitions in 980 CMR 1.00: *Rules for the Conduct of Adjudicatory Proceedings* and 13.00: *Consolidated Permits for Clean Energy Infrastructure Facilities* shall apply to 980 CMR 17.00. For the purpose of 980 CMR 17.00, the following additional definition applies unless the context or subject matter requires a different interpretation:

Constructive Approval means a Consolidated Permit or Consolidated State Permit that is constructively (automatically) approved and issued by operation of law under M.G.L. c. 164, §§ 69T, 69U, or 69V, and 980 CMR 17.05. A Constructive Approval may include zoning exemptions, provided that the Applicant at the time of the Completeness Determination includes a zoning exemption request, and the Applicant includes a Zoning Statement pursuant to 980 CMR 17.03(1)(b)4. The contents and form of Constructive Approvals are defined in 980 CMR 17.03.

17.02: Constructive Approval Procedure

(1) Procedural Assessment. At least 60 days before the applicable deadline established by 980 CMR 13.02(4)(a): *Review Timeframe*, the Presiding Officer shall assess the progress of the proceeding to determine whether there is reasonable assurance that the Board will issue a Consolidated Permit or Consolidated State Permit by the applicable deadline. The Presiding Officer may conduct a status conference to inform their assessment of progress of the proceeding.

(2) Notice of Likelihood of Constructive Approval. If the Presiding Officer does not find reasonable assurance that the Board will meet its deadline to issue a Final Decision, the Presiding Officer shall, at least 60 days before the applicable deadline, prepare and issue to the Parties, Limited Participants, Permit Enforcement Agencies, and the Board a Notice of Likelihood of Constructive Approval that references 980 CMR 17.02, states that a Constructive Approval is likely, and describes the reasons for that assessment.

(3) Issuance of Draft Constructive Approval. Within two weeks after the issuance of the Notice of Likelihood of Constructive Approval, the Applicant shall prepare and circulate the draft Constructive Approval to the service list prepared by the Presiding Officer for the proceeding pursuant to 980 CMR 1.03(3): *Service to Board, Parties, and Participants*, and any additional Permit Enforcement Agencies (PEAs) not included on the service list.

17.02: continued

(a) Form of Draft Constructive Approval. The draft Constructive Approval shall comply with the requirements of 980 CMR 17.03, except that the document will be titled “draft Constructive Approval” and will be marked “DRAFT” on all pages.

(b) Draft Constructive Approval. The draft Constructive Approval prepared by the Applicant shall consist of:

1. the Application at the time of the Completeness Determination, and updates to the Project filed pursuant to 980 CMR 13.07(1)(c): *Updated Filing*, and
2. the Recommended Permit Conditions and Requirements issued by the Presiding Officer pursuant to 980 CMR 13.07(6): *Conditions Conference*, that are consistent with:
 - a. the record evidence in the proceeding;
 - b. the Board’s statutory authority, and
 - c. the Board’s applicable rules, regulations, and other authority as provided in 980 CMR 2.02(3): *Scope of Review*. The Applicant may include a modification of a condition included in the Recommended Permit Conditions and Requirements issued by the Presiding Officer pursuant to 980 CMR 13.07(6): *Conditions Conference*, in the draft Constructive Approval, provided the modification is consistent with:
 - i. the record evidence in the proceeding;
 - ii. the Board’s statutory authority, and
 - iii. the Board’s applicable rules, regulations, and other authority as provided in 980 CMR 2.02(3): *Scope of Review*.

(4) Comment Period and Opportunity for Revision.

(a) The Presiding Officer shall designate a comment period, extending at least seven days and not more than 14 days, from the issuance of the draft Constructive Approval. During that time, the recipients of the draft Constructive Approval may file written comments regarding the draft to ensure compliance with 980 CMR 17.03.

(b) Within seven days after the conclusion of the comment period, the Applicant shall update the draft Constructive Approval to include revisions that are consistent with:

1. the record evidence in the proceeding;
2. the Board’s statutory authority, and
3. the Board’s applicable rules, regulations, and other authority as provided in 980 CMR 2.02(3): *Scope of Review*, and circulate it to the service list.

(c) Within seven days thereafter, the Presiding Officer may modify the updated draft Constructive Approval prepared by the Applicant if and to the extent that the draft Constructive Approval, as modified by the Applicant following the comment period held pursuant to 980 CMR 17.02(4)(a), is inconsistent with:

1. the record evidence in the proceeding;
2. the Board’s statutory authority, or
3. the Board’s applicable rules, regulations, and other authority as provided in 980 CMR 2.02(3): *Scope of Review*. The Presiding Officer shall explain any modifications and ensure compliance with 980 CMR 17.03.

(d) The draft Constructive Approval as updated by the Presiding Officer pursuant to 980 CMR 17.02(4) shall be issued as a final Constructive Approval consistent with 980 CMR 17.04.

(5) If the Presiding Officer issues the Notice of Likelihood of Constructive Approval prior to the Conditions Conference and the issuance of the Presiding Officer Recommended Permit Conditions and Requirements, then the Presiding Officer may schedule a Conditions Conference earlier than specified in 980 CMR 13.07(6): *Conditions Conference*. The Presiding Officer shall issue Recommended Permit Conditions and Requirements. The parties shall have an opportunity to comment on the Recommended Permit Conditions and Requirements consistent with 980 CMR 13.07(3): *Adjudicatory Proceeding*. The process for the draft Constructive Approval shall be consistent with 980 CMR 17.02(3) and the Comment Period and Opportunity for Revision shall be consistent with 980 CMR 17.02(4).

17.02: continued

(6) If the Presiding Officer fails to act regarding any provision of 980 CMR 17.00 in the timeframe provided, the Presiding Officer will have an additional seven days in which to perform the missed procedural step. If the Presiding Officer does not complete the missed procedural step by the end of the additional seven days, the next procedural step required in 980 CMR 17.00 shall commence regardless. In no event shall such action exceed the procedural timeframe for Constructive Approval set forth in 980 CMR 13.02(4)(a): *Review Timeframe*.

(7) Continuing Right to Issue a Decision on a Consolidated Permit or Consolidated State Permit. The Presiding Officer Notice of Likelihood of Constructive Approval shall not prohibit the Board from issuing a Final Decision pursuant to 980 CMR 13.10: *EFSB Consolidated Permit Decisions*, on an EFSB Consolidated Permit prior to the applicable statutory review timeframe pursuant to 980 CMR 13.02(4)(a): *Review Timeframe*.

17.03: Contents and Form of Constructive Approval

(1) Contents. A Constructive Approval shall be in writing and shall include the following contents:

(a) Identifying Information.

1. Name of the Applicant, docket number(s), and project name.
2. Name, address, telephone number, and email address of the Applicant representative(s). *See* 980 CMR 13.01(4): *Definitions* and 13.03(1)(a): *Application Summary Form*.
3. The Applicant's Description of the Project, Site, and Surrounding Area pursuant to 980 CMR 13.03(1)(b): *Description of the CEIF Project, Site, and Surrounding Area*, including any updates in the evidentiary record of the proceeding pursuant to 980 CMR 13.07(1)(c): *Updated Filing*.

(b) Required Permits and Approvals.

1. List. A list of all state, regional, and local permits and approvals listed on the Application pursuant to 980 CMR 13.05: *EFSB Consolidated Permit Application Requirements: Required Permits*.
2. Agency Permit Requirements. A list of the agency permit requirements based on the latest information provided by the Applicant.
3. Draft Documents. All draft permits and approvals provided by the Applicant pursuant to 980 CMR 13.05(1)(a): *State Permits*, (b): *Local Governmental Permits*, (d) *Ministerial Permits*, as the applicant may have updated during the proceeding pursuant to 980 CMR 13.07(1)(c): *Updated Filing*.
4. Zoning Statement. A statement of the zoning exemptions that the Applicant has included in its Application at the Completeness Determination.

(c) Common Conditions Applicable Common Conditions pursuant to 980 CMR 13.09(2): *Common Conditions*, as identified in "13.00: *EFSB Consolidated Permit Application Guidance*," Attachment 1: *Common Conditions and Requirements for EFSB Consolidated Permits*, unless expressly superseded by the Presiding Officer Recommended Permit Conditions and Requirements included in the draft Constructive Approval pursuant to 980 CMR 17.02.

(d) Presiding Officer Recommended Permit Conditions and Requirements included in the draft Constructive Approval pursuant to 980 CMR 17.02.

(e) The Applicant shall file an Abbreviated Procedural History that substantially complies with the following text: The Applicant(s), _____ [name(s)], filed its/their Application on _____ [date]. The EFSB docketed the Consolidated Permit proceeding as _____. On _____ [date], pursuant to 980 CMR 13.06: *Completeness Determination*, the Presiding Officer issued a Completeness Determination. The Completeness Determination confirmed that the Applicant substantially and materially complied with each Application filing requirement. The Board was required, pursuant to 980 CMR 13.02(4)(a): *Review Timeframe*, to issue a final decision on a Consolidated Permit or Consolidated State Permit by _____ [date]. The Board did not issue a Consolidated Permit or Consolidated State Permit by _____ [date]. Therefore, pursuant to M.G.L. c. 164, § 69T (for a large clean energy infrastructure facility), M.G.L. c. 164, § 69U (for a small clean transmission and distribution infrastructure facility), or M.G.L. c. 164, § 69V (for a small clean energy generation facility or small clean energy

17.03: continued

storage facility) a Constructive Approval of the Project has been issued. The Applicant has obtained Constructive Approval, issued by operation of law under M.G.L. 164, §§ 69T, 69U, or 69V, and 980 CMR 17.04 for all required state, regional, and local permits and approvals listed on part b(1) of this Constructive Approval as if the accompanying draft permits had issued in final form. The Applicant is likewise granted all requested zoning exemptions as referenced in part b(3) of this Constructive Approval.

(2) Statement of Decision's Effect and Appeal Rights. The Constructive Approval shall contain the text of 980 CMR 17.05(1) and 17.05(2).

(3) Form. The Board may specify the form of the Constructive Approval and may make available a template for that purpose.

17.04: Issuance of a Constructive Approval

(1) If the Board has not issued a Consolidated Permit or Consolidated State Permit pursuant to 980 CMR 13.10: *EFSB Consolidated Permit Decisions*, within the applicable statutory timeframe under 980 CMR 13.02(4)(a): *Review Timeframe*, the draft Constructive Approval, as developed and modified pursuant to 980 CMR 17.02, shall be deemed issued on the applicable deadline date as a final Constructive Approval.

(2) The Presiding Officer shall distribute the final Constructive Approval to all persons entitled to notice within five business days of the applicable review timeframe under 980 CMR 13.02(4)(a): *Review Timeframe*.

(3) The evidentiary record shall close upon the distribution of the final Constructive Approval.

17.05: Effect of Decision and Rights of Appeal

(1) Effect of Decision. In accordance with M.G.L. c. 164, §§ 69T(i), 69U(c), 69V(c), a Constructive Approval acts as an approval of all relevant permits and approvals from all state, regional, and local agencies required to construct and operate the Project. *See* 980 CMR 17.03(1).

(a) No state, regional, or local agency may require any other approval, consent, permit, certificate or condition for the construction, operation, or maintenance of the Project.

(b) No state, regional, or local agency may impose or enforce any law, ordinance, by-law, rule or regulation nor take any action nor fail to take any action, other than reasonably enforcing the conditions and requirements of the Constructive Approval, that would delay or prevent construction, operation, or maintenance of the Project.

(2) Rights of Appeal. Under M.G.L. c. 164, §§ 69T, 69U, or 69V, a Constructive Approval is deemed a final decision, and is subject to appeal under M.G.L. c. 164, § 69P. The appeal deadline shall be calculated from the date the Presiding Officer distributes the Constructive Approval pursuant to 980 CMR 17.04(2).

(3) Scope of Review. The scope of such judicial review is governed by M.G.L. c. 164, § 69P. The scope of the appeal shall be limited to whether the Constructive Approval:

(a) is in conformity with the Constitution of the Commonwealth and the United States Constitution;

(b) was made in accordance with the procedures established in M.G.L. c. 164, §§ 69H through 69O, and M.G.L. c. §§ 69T through 69W, and the rules and regulations of the Board with respect to such provisions;

(c) was supported by substantial evidence of record in the board's proceedings; or

(d) was arbitrary, capricious or an abuse of the Board's discretion under M.G.L. c. 164, §§ 69H through 69O, and M.G.L. c. 164, §§ 69T through 69W.

REGULATORY AUTHORITY

980 CMR 17.00: M.G.L. c. 164, §§69T(i), 69U(c), 69V(c)

