SENATE . . . . . No. 2519

The Commonwealth of Massachusetts

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

SENATE, February 6, 2020.

The committee on Senate Ways and Means to whom was referred the Senate Bill relative to mental health parity implementation (Senate, No. 588) (also based on Senate, No. 1148), - reports, recommending that the same ought to pass with an amendment substituting a new draft entitled "An Act addressing barriers to care for mental health" (Senate, No. 2519).

For the committee,
Michael J. Rodrigues

FILED ON: 2/6/2020

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In the One Hundred and Ninety-First General Court
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An Act addressing barriers to care for mental health.

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

SECTION 1. Subsection (a) of section 8 of chapter 6D of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the word “system”, in line 9, the following words:- , and trends in annual behavioral health expenditures.

SECTION 2. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 94, the word “and” and inserting in place thereof the following words:- , including behavioral health expenditures, and.

SECTION 3. The first paragraph of subsection (a) of section 16 of chapter 12C of the General Laws, as so appearing, is hereby amended by adding the following sentence:- In addition to overall health costs, the center shall report on the subcategory of annual behavioral health expenditures, as defined in regulation, and provide a similar analysis of costs and cost trends related to behavioral health services.

SECTION 4. Section 21A of said chapter 12C, as so appearing, is hereby amended by adding the following 2 sentences:- The center shall promulgate regulations to establish an annual baseline expenditure for behavioral health services. The regulations shall define criteria for

health care services to be categorized as behavioral health services, with subcategories to the extent feasible, including, but not limited to: (i) mental health; (ii) substance use disorder; (iii) outpatient; (iv) inpatient; (v) services for children; (vi) services for adults; and (vii) provider type. The regulations shall establish guidelines for data collection related to behavioral health services, outcomes measures and expenditures.

SECTION 5. Section 9 of chapter 13 of the General Laws, as so appearing, is hereby amended by inserting after the word “workers”, in line 8, the following words:- , the board of registration of social workers, the board of registration of psychologists, the board of registration of allied mental health and human services professions.

SECTION 6. Section 79 of said chapter 13, as so appearing, is hereby amended by striking out, in lines 17 and 18 and in line 27, the words “director of consumer affairs and business regulations” and inserting in place thereof, in each instance, the following words:- commissioner of public health.

SECTION 7. Said chapter 13 is hereby further amended by striking out section 80, as so appearing, and inserting in place thereof the following section:-

Section 80. There shall be a board of registration of social workers that shall consist of: the commissioner of children and families or a designee who is licensed as either a certified social worker or an independent clinical social worker under sections 130 to 137, inclusive, of chapter 112; the commissioner of mental health or a designee who is licensed as either a certified social worker or an independent clinical social worker under said sections 130 to 137, inclusive, of said chapter 112; and 7 members to be appointed by the governor, 1 of whom shall be a representative of an accredited school of social work, 3 of whom shall be licensed as a certified social worker or an independent clinical social worker under said sections 130 to 137, inclusive,

of said chapter 112, 1 of whom shall be licensed under said sections 130 to 137, inclusive, of said chapter 112 and an active member of an organized labor organization representing social workers and 2 of whom shall be members of the general public. At least 1 licensed social work member and at least 1 member from the general public shall represent an underserved population, as defined by the United States Department of Health and Human Services. Not more than 6 members of the board shall belong to any 1 political party.

SECTION 8. Section 84 of said chapter 13, as so appearing, is hereby amended by striking out, in lines 8 and 9, the words “division of professional licensure” and inserting in place thereof the following words:- department of public health.

SECTION 9. Said section 84 of said chapter 13, as so appearing, is hereby further amended by striking out, in lines 44 and 45, inclusive, the words “Division of Professional Licensure Trust Fund established in section 35V” and inserting in place thereof the following words:- Quality in Health Professions Trust Fund established in section 35X.

SECTION 10. Section 88 of said chapter 13, as so appearing, is hereby amended by striking out, in lines 1 and 2, the words “division of professional licensure” and inserting in place thereof the following words:- department of public health.

SECTION 11. The first paragraph of section 90 of said chapter 13, as so appearing, is hereby amended by striking out the third sentence.

SECTION 12. Said section 90 of said chapter 13 is hereby further amended by striking out the third paragraph, as so appearing, and inserting in place thereof the following paragraph:- The commissioner of public health may review and approve the rules and regulations proposed by the board.

SECTION 13. Section 18 of chapter 15A of the General Laws, as so appearing, is hereby amended by adding the following paragraph:-

Any qualifying student health insurance plan authorized under this chapter shall comply with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3), and the benefit mandates and other obligations under section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter 176G, as if the student health insurance plan was issued by such carriers licensed under chapters 175, 176A, 176B and 176G, without regard to any limitation under section 1 of chapter 176J.

SECTION 14. Chapter 26 of the General Laws is hereby amended by striking out section 8K, as so appearing, and inserting in place thereof the following section:-

Section 8K. (a) The commissioner of insurance shall implement and enforce applicable provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3), and applicable state mental health parity laws, including, but not limited to, section 22 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter 176G, in regard to any carrier licensed under chapters 175, 176A, 176B and 176G, any carrier offering a student health plan issued under section 18 of chapter 15A or the group insurance commission, by:

(i) evaluating all consumer or provider complaints regarding mental health and substance use disorder coverage for possible parity violations within 3 months of receipt;

(ii) performing behavioral health parity compliance market conduct examinations of each carrier at least once every 24 months with a focus on: (A) non-quantitative treatment limitations under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and applicable state mental health and substance use disorder parity laws, including, but not limited to, prior authorization, concurrent review, retrospective review, step-therapy, network admission standards, reimbursement rates, network adequacy and geographic restrictions; (B) denials of authorization, payment and coverage; and (C) any other criteria determined by the division, including factors identified through consumer or provider complaints; provided, however, that: (1) a market conduct examination of a carrier subject to chapters 175, 176A, 176B or 176G and any plans authorized or regulated under chapter 32A shall follow the procedural requirements in subsections 10, 11 and 15 of section 4 of said chapter 175 regarding notice and rebuttal of examination findings, subsequent hearings and conflicts of interest; (2) the commissioner shall publicize the fees for a market conduct examination under section 3B of chapter 7 and said subsection 11 of said section 4 of said chapter 175; and (3) nothing contained in clause (ii) or in said section 4 of said chapter 175, section 7 of said chapter 176A, section 9 of said chapter 176B and section 10 of said chapter 176G shall limit the commissioner's authority to use, and if appropriate, to make public any final or preliminary examination report, any examiner or company work papers or other documents or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the commissioner may, in their sole discretion, deem appropriate;

(iii) requiring that carriers that provide mental health or substance use disorder benefits directly or through a behavioral health manager as defined in section 1 of chapter 176O or any

other entity that manages or administers such benefits for the carrier comply with the annual reporting requirements under section 8M;

(iv) updating applicable regulations as necessary to effectuate any provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008that relate to insurance; and

(v) assessing a fee upon any carrier for the costs and expenses incurred in any market conduct examination authorized by law, consistent with the costs associated with the use of division personnel and examiners, the costs of retaining qualified contract examiners necessary to perform an examination, electronic data processing costs, supervision and preparation of an examination report and lodging and travel expenses; provided, however, that the commissioner shall maintain active management and oversight of examination costs and fees to ensure that the examination costs and fees comply with the National Association of Insurance Commissioners market conduct examiners handbook, unless the commissioner demonstrates that the fees prescribed in the handbook are inadequate under the circumstances of the examination; and provided further, that the commissioner or the commissioner's examiners shall not receive or accept any additional emolument on account of any examination.

(b) The division of insurance may impose a penalty against a carrier that provides mental health or substance use disorder benefits, directly or through a behavioral health manager as defined in section 1 of chapter 176O or any other entity that manages or administers such benefits for the carrier, for any violation by the carrier or the entity that manages or administers mental health and substance use disorder benefits for the carrier of state laws related to mental health and substance use disorder parity or provisions of the federal Paul Wellstone and Pete

Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as amended, and federal guidance or regulations issued under the act.

The amount of any penalty imposed shall be $100 for each day in the noncompliance period per product line with respect to each participant or beneficiary to whom such failure relates; provided, however, that the maximum annual penalty under this subsection shall be $500,000. For purposes of this subsection, the term "noncompliance period" shall mean the period beginning on the date a failure first occurs and ending on the date such failure is corrected.

No penalty shall be imposed on any failure if the division of insurance determines that such failure was due to reasonable cause and not to willful neglect or if such failure is corrected within 30 days of the start of the noncompliance period.

(c) The division of insurance may require carriers to provide remedies for any failure to meet the requirements of state laws related to mental health and substance use disorder parity or provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as amended, and federal guidance or regulations issued under the act, including, but not limited to:

(i) requiring the carrier to change the benefit standard or practice, including updating plan language, with notice to plan members;

(ii) providing training to staff on any changes to benefits and practices;

(iii) informing plan members of changes;

(iv) requiring the carrier to reprocess and pay all inappropriately denied claims to affected plan members, notify members of their right to file claims for services previously denied

and for which members paid out-of-pocket and reimburse for services eligible for coverage under corrected standards; and

(v) requiring the carrier to submit to ongoing monitoring to verify compliance.

(d) Any proprietary information submitted to the commissioner by a carrier as a result of the requirements of this section shall not be public records under clause Twenty-sixth of section 7 of chapter 4 or chapter 66; provided, however, that the commissioner may produce reports summarizing any findings.

(e) Nothing in this section shall limit the authority of the commonwealth, through the attorney general, to enforce any state or federal law, regulation or guidance described in this section.

SECTION 15. Said chapter 26 is hereby further amended by inserting after Section 8L the following sections:-

Section 8M. (a) All carriers licensed under chapters 175, 176A, 176B and 176G that provide mental health or substance use disorder benefits, directly or through a behavioral health manager, as defined in section 1 of chapter 176O or any other entity that manages or administers such benefits for the carrier, and the group insurance commission under chapter 32A, or the carriers the group insurance commission contracts with for the administration of any self-insured plans that provide mental health or substance use disorder benefits, directly or through a behavioral health manager, as defined in section 1 of chapter 176O or any other entity that manages or administers such benefits for the carrier, shall submit an annual report not later than July 1 to the commissioner of insurance that contains:

(i) a description of the process used to develop or select the medical necessity criteria for mental health and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(ii) identification of all non-quantitative treatment limitations that are applied to mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits, as defined in 45 CFR Part 146.136(c)(4)(i); provided, however, that there shall not be separate non-quantitative treatment limitations that apply to mental health and substance use disorder benefits but do not apply to medical and surgical benefits within any classification of benefits; provided further, that the non-quantitative treatment limitations shall include the processes, strategies or methodologies for developing and applying the carrier's reimbursement rates for mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits; and

(iii) the results of an analysis that demonstrates that for the medical necessity criteria described in clause (i) and for each non-quantitative treatment limitation identified in clause (ii), as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to mental health and substance use disorder benefits within each classification of benefits are comparable to, and are not applied more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits; provided, however, that, at a minimum, the results of the analysis shall:

(A) identify the factors used to determine that an non-quantitative treatment limitation will apply to a benefit;

(B) identify any processes, strategies or evidentiary standards used to define the factors identified in subclause (A);

(C) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each non-quantitative treatment limitation, as written, and the as-written processes and strategies used to apply the non-quantitative treatment limitation to mental health and substance use disorder benefits are comparable to, and are not applied more stringently than, the processes and strategies used to design each non-quantitative treatment limitation, as written, and the as-written processes and strategies used to apply the non-quantitative treatment limitation to medical and surgical benefits;

(D) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each non-quantitative treatment limitation, in operation, for mental health and substance use disorder benefits and provider reimbursement rates are comparable to, and are not applied more stringently than, the processes or strategies used to apply each non-quantitative treatment limitation, in operation, for medical and surgical benefits and provider reimbursement rates;

(E) disclose the specific findings and conclusions reached by the carrier or the group insurance commission that the results of the analyses in this clause indicate that the carrier or group insurance commission is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including, but not limited to, 45 CFR Part 146.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3); and

(F) disclose the number of requests for parity documents received under 29 CFR 2590.712(d)(3) or 45 CFR 146.136(d)(3) and the number of any such requests for which the plan refused, declined or was unable to provide documents.

(b) In completing the analyses required under subsection (a), carriers shall perform the analyses broadly across each classification of benefits and shall not be required to examine each medical and surgical benefit subject to an non-quantitative treatment limitation that also applies to mental health and substance use disorder benefits in the classification of benefits. Carriers may use any reasonable method to determine how the carrier selects medical and surgical benefits subject to an non-quantitative treatment limitation in the classification of benefits for the purpose of performing the comparative analyses; provided, however, that carriers shall select all medical and surgical benefits sharing the same characteristics as the mental health and substance use disorder benefits subject to the non-quantitative treatment limitation in a classification of benefits for the purposes of performing the analyses.

(c) If federal guidance, including, but not limited to, the Self-Compliance Tool for the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, is released that indicates an non-quantitative treatment limitation analysis and reporting process that is significantly different from, contrary to or more efficient than the non-quantitative treatment limitation analysis and reporting requirements described in subsection (a), the commissioner may promulgate regulations that delineate an non-quantitative treatment limitation analysis and reporting format that may be used in lieu of the non-quantitative treatment limitation analysis and reporting requirements described in said subsection (a).

(d) Any proprietary portions of information submitted to the commissioner by a carrier as a result of the requirements of this section shall not be public records under clause Twenty-sixth

of section 7 of chapter 4 or chapter 66; provided, however, that the commissioner may produce reports summarizing any findings.

(e) Annually, not later than December 1, the commissioner shall submit a summary of the reports that the commissioner receives from all carriers under subsection (a) to the clerks of the senate and house of representatives, the joint committee on mental health, substance use and recovery and the joint committee on health care financing. The summary report shall include, but not be limited to:

(i) the methodology the commissioner is using to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act;

(ii) the methodology the commissioner is using to check for compliance with section 22 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and section 4M of chapter 176G;

(iii) the report of each market conduct examination conducted or completed during the immediately preceding calendar year regarding access to behavioral health services or compliance with parity in mental health and substance use disorder benefits under state and federal laws and any actions taken as a result of such market conduct examinations;

(iv) a breakdown of treatment authorization data for each carrier for mental health treatment services, substance use disorder treatment services and medical and surgical treatment services for the immediately preceding calendar year indicating for each treatment service: (A) the number of inpatient days, outpatient services and total services requested; (B) the number and per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day requests modified resulting in a lesser amount of inpatient days authorized than requested and the

reason for the modification, inpatient day requests denied and the reason for the denial, inpatient day requests where an internal appeal was filed and approved, inpatient day requests where an internal appeal was filed and denied, inpatient day requests where an external appeal was filed and upheld and inpatient day requests where an external appeal was filed and overturned; and

(C) the number and per cent of outpatient service requests authorized, outpatient service requests modified, outpatient service requests modified resulting in a lower amount of outpatient service authorized than requested and the reason for the modification, outpatient service requests denied and the reason for the denial, outpatient service requests where an internal appeal was filed and approved, outpatient service requests where an internal appeal was filed and denied, outpatient service requests where an external appeal was filed and upheld and outpatient service requests where an external appeal was filed and overturned;

(v) the number of complaints the division has received in the immediately preceding calendar year regarding access to behavioral health services or compliance with parity in mental health and substance use disorder benefits under state and federal laws and a summary of all complaints resolved by the division during that time period; and

(vi) information about any educational or corrective actions the commissioner has taken to ensure carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and said section 22 of said chapter 32A, said section 47B of said chapter 175, said section 8A of said chapter 176A, said section 4A of said chapter 176B and said section 4M of said chapter 176G.

The summary report shall be written in non-technical, readily understandable language and shall be made available to the public by posting the report on the division’s website.

SECTION 16. Chapter 32A of the General Laws is hereby amended by inserting after section 17Q the following section:-

Section 17R. For the purposes of this section, the following terms shall have the following meanings unless the context clearly requires otherwise:

"Community-based acute treatment", 24-hour clinically managed mental health diversionary or step-down services for children and adolescents that is usually provided as an alternative to mental health acute treatment.

"Intensive community-based acute treatment", intensive 24-hour clinically managed mental health diversionary or step-down services for children and adolescents that is usually provided as an alternative to mental health acute treatment.

"Mental health acute treatment", 24-hour medically supervised mental health services provided in an inpatient facility, licensed by the department of mental health, that provides psychiatric evaluation, management, treatment and discharge planning in a structured treatment milieu.

The commission shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage for medically necessary mental health acute treatment, community-based acute treatment and intensive community-based acute treatment and shall not require a preauthorization before obtaining treatment; provided, however, that the facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of admission.

Benefits for an employee under this section shall be the same for the employee's covered spouse and covered dependents.

SECTION 17. Said chapter 32A is hereby further amended by adding the following section:-

Section 30. The commission shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission benefits on a nondiscriminatory basis for medically necessary emergency service programs, as defined in section 1 of chapter 175.

SECTION 18. Chapter 111 of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after section 51½ the following section:-

Section 51¾. The department, in consultation with the department of mental health, shall promulgate regulations requiring all acute-care hospitals licensed under section 51G to provide or arrange for qualified behavioral health clinicians, during all operating hours of the emergency department, or to a satellite emergency facility as defined in section 51½, to evaluate and stabilize a person admitted with a behavioral health presentation to the department, or to a facility and to refer such person for appropriate treatment or inpatient admission.

The regulations shall include, but not be limited to, requirements that individuals under the age of 22 receive an expedited evaluation and stabilization process.

SECTION 19. Section 61 of chapter 112 of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by striking out, in line 18, the words “A board of registration” and inserting in place thereof the following words:- Each board of registration under the supervision of the department of public health may discipline a holder of a license, certificate, registration or authority issued pursuant to this chapter and each board of registration.

SECTION 20. Said section 61 of said chapter 112, as so appearing, is hereby further

amended by striking out, in lines 49 and 50, the words “a board of registration” and inserting in place thereof the following words:- each board of registration under the supervision of the department of public health and each board of registration.

SECTION 21. Section 65B of said chapter 112, as so appearing, is hereby amended by striking out, in line 1, the words “A board of registration” and inserting in place thereof the following words:- Each board of registration under the supervision of the department of public health and each board of registration.

SECTION 22. Section 65F of said chapter 112, as so appearing, is hereby amended by inserting after the word “licensure”, in line 4, the following words:- or a board of registration under the supervision of the department of public health.

SECTION 23. Section 126 of said chapter 112, as so appearing, is hereby amended by adding the following paragraph:-

All application fees and civil administrative penalties and fines collected by the board under sections 61 and 118 to 129B, inclusive, shall be deposited into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 24. Section 136 of said chapter 112, as so appearing, is hereby amended by adding the following paragraph:-

All application fees and civil administrative penalties and fines collected by the board under sections 61 and 130 to 137, inclusive, shall be deposited into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 25. Section 163 of said chapter 112, as so appearing, is hereby amended by inserting after the definition of “Licensed mental health counselor,” the following definition:-

“Licensed supervised mental health counselor”, a person licensed or eligible for license under section 165.

SECTION 26. Section 164 of said chapter 112, as so appearing, is hereby amended by inserting after the word “consultant”, in line 7, the following words:- or licensed supervised mental health counselor, advisor or consultant.

SECTION 27. Section 165 of said chapter 112, as so appearing, is hereby amended by inserting after the word “health”, in line 16, the following words:- or the department of public health.

SECTION 28. Said section 165 of said chapter 112, as so appearing, is hereby further amended by adding the following 3 paragraphs:-

The board may issue a license to an applicant as a supervised mental health counselor; provided, however, that each applicant, in addition to complying with clauses (1) and (2) of the first paragraph, shall provide satisfactory evidence to the board that the applicant: (i) demonstrates to the board the successful completion of a master’s degree in a relevant field from an educational institution licensed by the state in which it is located and meets national standards for granting of a master’s degree with a subspecialization in counseling, or a relevant subspecialization approved by the board; and (ii) has successfully passed a board-approved examination.

A supervised mental health counselor shall practice under supervision of a clinician in a clinic or hospital licensed by the department of mental health or the department of public health or accredited by the Joint Commission on Accreditation of Hospitals or in an equivalent center or institute or under the direction of a supervisor approved by the board.

The board shall promulgate rules and regulations specifying the required qualifications of the supervising clinician.

SECTION 29. Section 168 of said chapter 112, as so appearing, is hereby amended by adding the following paragraph:-

All application fees and civil administrative penalties and fines collected by the board under sections 61 and 163 to 172, inclusive, shall be deposited into the Quality in Health Professions Trust Fund established in section 35X of chapter 10.

SECTION 30. Chapter 118E of the General Laws is hereby amended by inserting after section 10M the following section:-

Section 10N. For the purposes of this section, the following terms shall have the following meanings unless the context clearly requires otherwise:-

"Community-based acute treatment", 24-hour clinically managed mental health diversionary or step-down services for children and adolescents that is usually provided as an alternative to mental health acute treatment.

"Intensive community-based acute treatment", intensive 24-hour clinically managed mental health diversionary or step-down services for children and adolescents that is usually provided as an alternative to mental health acute treatment.

"Mental health acute treatment", 24-hour medically supervised mental health services provided in an inpatient facility, licensed by the department of mental health, that provides psychiatric evaluation, management, treatment and discharge planning in a structured treatment milieu.

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

to a Medicaid managed care organization or primary care clinician plan shall cover the cost of medically necessary mental health acute treatment, community-based acute treatment and Intensive community-based acute treatment and shall not require a preauthorization before obtaining treatment; provided, however, that the facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of admission.

SECTION 31. Section 12 of said chapter 118E, as appearing in the 2018 Official Edition, is hereby amended by adding the following paragraph:-

The division shall develop and implement a standard credentialing form for use by health care providers applying to participate in MassHealth. The division, all contracted entities, health maintenance organizations established under this section and any subcontracted entities shall accept the standard credentialing form as sufficient information necessary to conduct its credentialing process.

SECTION 32. Said chapter 118E is hereby further amended by adding the following 4 sections:-

Section 79. (a) The division, its managed care organizations, accountable care organizations or other entity contracting with the division to manage or administer mental health and substance use disorder benefits shall ensure that there are no separate non-quantitative treatment limitations, referred to in this section as the non-quantitative treatment limitations, that apply to mental health and substance use disorder benefits but do not apply to medical and surgical benefits within any classification of benefits as defined under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(b) The division shall perform a behavioral health parity compliance examination of each Medicaid managed care organization, accountable care organization or other entity contracted

with the agency that manages or administers mental health and substance use disorder benefits for the division at least once every 24 months. The examination shall include examination of entities that manage medical and surgical benefits, as necessary. The examination shall only apply where the division is the primary payer. The examination shall include but not be limited to:

(i) a description of the process used to develop or select the medical necessity criteria for mental health and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(ii) identification of all non-quantitative treatment limitations that are applied to mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits, as defined in 42 CFR Part 457.496(d)(2)(ii); and

(iii) the results of an analysis that demonstrates that for the medical necessity criteria described in clause (i) and for each non-quantitative treatment limitation identified in clause (ii), as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to mental health and substance use disorder benefits within each classification of benefits are comparable to, and are not applied more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits; provided, however, that, at a minimum, the results of the analysis shall:

(A) identify the factors used to determine that a non-quantitative treatment limitation will apply to a benefit;

(B) identify any processes, strategies or evidentiary standards used to define the factors identified in subclause (A);

(C) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each non-quantitative treatment limitation, as written, and the as-written processes and strategies used to apply the non-quantitative treatment limitation to mental health and substance use disorder benefits are comparable to, and are not applied more stringently than, the processes and strategies used to design each non-quantitative treatment limitation, as written, and the as-written processes and strategies used to apply the non-quantitative treatment limitation to medical and surgical benefits;

(D) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each non-quantitative treatment limitation, in operation, for mental health and substance use disorder benefits are comparable to, and are not applied more stringently than, the processes or strategies used to apply each non-quantitative treatment limitation, in operation, for medical and surgical benefits; and

(E) disclose the specific findings and conclusions reached by the division that the results of the analyses under this clause indicate compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal guidelines and regulations relevant to the act, including, but not limited to, 42 CFR Part 457.496.

(c) In completing the analyses required under subsection (b), the division shall perform the analyses broadly across each classification of benefits. The division may use any reasonable method to determine how it selects medical and surgical benefits subject to an NQTL in the

classification of benefits for the purpose of performing the comparative analyses; provided, that the division shall select all medical and surgical benefits sharing the same characteristics as the mental health and substance use disorder benefits subject to the NQTL in a classification of benefits for the purposes of performing the analyses.

(d) If federal guidance, including, but not limited to, the Self-Compliance Tool for the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, is released that indicates a non-quantitative treatment limitation analysis and reporting process that is significantly different from, contrary to or more efficient than the non-quantitative treatment limitation analysis and reporting requirements described in subsection (b), the division may promulgate regulations that delineate a non-quantitative treatment limitation analysis and reporting format that may be used in lieu of the non-quantitative treatment limitation analysis and reporting requirements described in said subsection (b).

(e) Any proprietary information submitted to the general court by the division as a result of the requirements in this section shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66.

(f) Not later than 60 days after the completion of the examination, the division shall submit a report of the examination conducted under subsection (b) and any actions taken as a result of such examination to the clerks of the senate and the house of representatives, the joint committee on mental health, substance use and recovery and the joint committee on health care financing.

(g) The division shall file an annual report with the clerks of the senate and house, the joint committee on mental health, substance use and recovery and the house and senate chairs of

the joint committee on health care financing not later than July 1. The report shall include, but not be limited to:

(i) the methodology the division is using to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal regulations or guidance relevant to the act;

(ii) the methodology the division is using to check for compliance with section 80;

(iii) a breakdown of treatment authorization data for the division, and for each Medicaid managed care organization, accountable care organization or other entity that manages or administers benefits for the division, for mental health treatment services, substance use disorder treatment services and medical and surgical treatment services for the immediately preceding calendar year.

The treatment authorization data shall include, but not be limited to: (A) the number of inpatient days, outpatient services and total number of services requested; (B) the number and per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day requests modified resulting in a lesser amount of inpatient days authorized than requested and the reason for the modification, inpatient day requests denied and the reason for the denial, inpatient day requests where an internal appeal was filed and approved, inpatient day requests where an internal appeal was filed and denied, inpatient day requests where an external appeal was filed and upheld and inpatient day requests where an external appeal was filed and overturned; and (C) the number and per cent of outpatient service requests authorized, outpatient service requests modified, outpatient service requests modified resulting in a lower amount of outpatient service authorized than requested and the reason for the modification, outpatient service requests denied and the reason for the denial, outpatient service requests where an internal appeal was filed and

approved, outpatient service requests where an internal appeal was filed and denied, outpatient service requests where an external appeal was filed and upheld and outpatient service requests where an external appeal was filed and overturned;

(iv) the number of complaints the division, or any Medicaid managed care organization, accountable care organization or other entity contracting with the division to manage or administer mental health and substance use disorder benefits, has received in the immediately preceding calendar year regarding access to behavioral health services or compliance with parity in mental health and substance use disorder benefits under state and federal laws and a summary of all complaints resolved by the division, or any Medicaid managed care organization, accountable care organization or other entity contracting with the division to manage or administer mental health and substance use disorder benefits, during that time period; and

(v) information about any educational or corrective actions the division has taken to ensure carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and section 80.

The summary report shall be written in non-technical, readily understandable language and shall be made publicly available on the division's website.

Section 80. (a) The division and its health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract with the division, a Medicaid managed care organization or a primary care clinician plan shall provide mental health and substance use disorder benefits for the diagnosis and treatment of any behavioral health disorder described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is approved

by the commissioner of mental health. The benefits shall be provided on a nondiscriminatory basis.

(b) In addition to the mental health and substance use disorder benefits established pursuant to this section, the division shall provide benefits on a non-discriminatory basis for children and adolescents under the age of 19 for the diagnosis and treatment of mental, behavioral, emotional or substance use disorders described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders that substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, however, that the interference or limitation is documented by and the referral for the diagnosis and treatment is made by the primary care provider, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including, but not limited to: (i) an inability to attend school as a result of such a disorder; (ii) the need to hospitalize the child or adolescent as a result of such a disorder; or (iii) a pattern of conduct or behavior caused by such a disorder that poses a serious danger to self or others.

(c) For the purposes of this section, the division shall be deemed to be providing such coverage on a non-discriminatory basis if the plan does not contain any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of the mental disorders that is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of physical conditions.

(d) Benefits authorized pursuant to this section shall consist of a range of inpatient, intermediate and outpatient services that shall permit medically necessary and active and noncustodial treatment for the mental disorders to take place in the least restrictive clinically appropriate setting. For purposes of this section, inpatient services may be provided in a general

hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental hospital licensed by the department of mental health or in a substance abuse facility licensed by the department of public health. Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office or as home-based services; provided, however, that services delivered in such offices or settings are rendered by a licensed mental health professional.

(e) The division and its health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract with the division, a Medicaid managed care organization or a primary care clinician plan shall not require, as a condition to receiving benefits mandated by this section, consent to the disclosure of information regarding services for mental disorders under different terms and conditions than consent is required for disclosure of information for other medical conditions. A determination by the division or its agents that services authorized pursuant to this section are not medically necessary shall only be made by a mental health professional licensed in the appropriate specialty related to such services and, where applicable, by a provider in the same licensure category as the ordering provider; provided, however, that this subsection shall not apply to denials of service resulting from an enrollee’s lack of coverage or use of a facility or professional that has not entered into a negotiated agreement with the division or its agents. The benefits

provided by the division or its agents pursuant to this section shall meet all other terms and conditions of the plan not inconsistent with state or federal law.

(f) Nothing in this section shall require the division to pay for mental health or substance use disorder benefits or services that:

(i) are provided to a person who has third-party insurance;

(ii) are provided to a person who is presently incarcerated, confined or committed to a jail, house of correction, prison or custodial facility in the department of youth services within the commonwealth or a political subdivision of the commonwealth;

(iii) constitute educational services required to be provided by a school committee pursuant to section 5 of chapter 71B;

(iv) constitute services provided by the department of mental health, or the department of public health or the department of developmental services; or

(v) are not eligible for federal financial participation.

Section 81. Notwithstanding any general or special law to the contrary, the office of Medicaid shall seek a waiver and promulgate regulations in order to require the division and its health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract with the division, a Medicaid managed care organization or primary care clinician plan to meet the parity requirements described under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including 42 CFR 438 Subpart K, 42 CFR 440.395 and 42 CFR 457.496, for all enrollees. For persons under the age of 22, MassHealth and its agents may comply with this section by meeting the obligations

related to Early and Periodic Screening, Diagnostic and Treatment benefits under 42 CFR 457.496(b) or 440.395(c).

Section 82. Medical necessity and utilization management determinations for treatments for substance use disorder or co-occurring mental illness and substance use disorder authorized under this chapter shall be made in accordance with the criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make medical necessity or utilization management determinations for treatments for substance use disorder or co-occurring mental illness and substance use disorder, unless such criteria are less restrictive. Authorization or coverage for treatment for substance use disorder or co-occurring mental illness and substance use disorder shall not be denied by the division, or a Medicaid managed care organization, accountable care organization or other entity that manages or administers mental health and substance use disorder benefits for the division, on the basis that such treatment was authorized or ordered by a court of law or other law enforcement agency. Any such authorization or order for such services shall be considered a factor in support of coverage for such treatment.

SECTION 33. Chapter 123 of the General Laws is hereby amended by inserting after section 2 the following section:-

Section 2A. The department shall establish within its regulations additional factors to be considered when contracting for services in geographically-isolated communities, including, but not limited to, travel and transportation, to ensure availability and access to services.

SECTION 34. Section 1 of chapter 175 of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the definition of “Domestic company” the following definition:-

“Emergency services programs”, all programs subject to contract between the Massachusetts Behavioral Health Partnership and nonprofit organizations for the provision of community-based emergency psychiatric services, including, but not limited to, behavioral health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per week, through the following service components: (i) mobile crisis intervention services for youth; (ii) mobile crisis intervention services for adults; (iii) emergency service provider community-based locations; and (iv) adult community crisis stabilization services.

SECTION 35. Section 47B of said chapter 175, as so appearing, is hereby amended by inserting after the word “specialist,”, in line 122, the following words:-, a clinician practicing under the supervision of a licensed professional, and working towards licensure, in a clinic licensed under chapter 111.

SECTION 36. Subsection (i) of said section 47B of said chapter 175 is hereby amended by inserting after the second paragraph, as so appearing, the following paragraph:-

An insurer shall not deny coverage for any behavioral health service or any evaluation and management office visit solely because the services were delivered on the same day and in the same practice or facility.

SECTION 37. Said chapter 175 is hereby further amended by inserting after section 47LL the following 2 sections:-

Section 47MM. An individual policy of accident and sickness insurance issued under section 108 that provides hospital expense and surgical expense insurance and any group blanket or general policy of accident and sickness insurance issued under section 110 that provides hospital expense and surgical expense insurance that is issued or renewed shall provide benefits on a nondiscriminatory basis for medically necessary emergency service programs.

Section 47NN. For the purposes of this section, the following terms shall have the following meanings unless the context clearly requires otherwise:

"Community-based acute treatment", 24-hour clinically managed mental health diversionary or step-down services for children and adolescents that is usually provided as an alternative to mental health acute treatment.

"Intensive community-based acute treatment", intensive 24-hour clinically managed mental health diversionary or step-down services for children and adolescents that is usually provided as an alternative to mental health acute treatment.

"Mental health acute treatment", 24-hour medically supervised mental health services provided in an inpatient facility, licensed by the department of mental health, that provides psychiatric evaluation, management, treatment and discharge planning in a structured treatment milieu.

Any policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth, which is considered creditable coverage under section 1 of chapter 111M, shall provide coverage for medically necessary mental health acute treatment, community-based acute treatment and intensive community-based acute treatment and shall not require a preauthorization before obtaining treatment; provided, however, that the facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of admission.

SECTION 38. Section 8A of chapter 176A of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the word "specialist", in line 125, the following words:- , a clinician practicing under the supervision of a licensed professional, and working towards licensure, in a clinic licensed under chapter 111.

SECTION 39. Subsection (i) of said section 8A of said chapter 176A is hereby amended by inserting after the second paragraph, as so appearing, the following paragraph:-

A non-profit hospital service corporation shall not deny coverage for any behavioral health service or any evaluation and management office visit solely because the services were delivered on the same day in the same practice or facility.

SECTION 40. Said chapter 176A is hereby further amended by inserting after section 8NN the following 2 sections:-

Section 8OO. For the purposes of this section, the following terms shall have the following meanings unless the context clearly requires otherwise:

"Community-based acute treatment", 24-hour clinically managed mental health diversionary or step-down services for children and adolescents that is usually provided as an alternative to mental health acute treatment.

"Intensive community-based acute treatment", intensive 24-hour clinically managed mental health diversionary or step-down services for children and adolescents that is usually provided as an alternative to mental health acute treatment.

"Mental health acute treatment", 24-hour medically supervised mental health services provided in an inpatient facility, licensed by the department of mental health, that provides psychiatric evaluation, management, treatment and discharge planning in a structured treatment milieu.

Any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall provide coverage for medically necessary mental health acute treatment, community-based acute treatment and intensive community-based acute treatment and shall not require a

preauthorization before obtaining treatment; provided, however, that the facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of admission.

Any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall provide coverage for medically necessary community-based acute treatment services and shall not require preauthorization before obtaining such services; provided, however, that the facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of admission.

Any contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall provide coverage for medically necessary intensive community-based acute treatment services and shall not require preauthorization before obtaining such services; provided, however, that the facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of admission.

Section 8PP. A contract between a subscriber and the corporation under an individual or group hospital service plan that is issued or renewed within or without the commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary emergency service programs, as defined in section 1 of chapter 175.

SECTION 41. Section 4A of chapter 176B of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the word “specialist”, in line 120, the following words:- , a clinician practicing under the supervision of a licensed professional, and working towards licensure, in a clinic licensed under chapter 111.

SECTION 42. Subsection (i) of said section 4A of said chapter 176B is hereby amended by inserting after the second paragraph, as so appearing, the following paragraph:-

A non-profit medical service corporation shall not deny coverage for any behavioral health service or any evaluation and management office visit solely because the services were delivered on the same day in the same practice or facility.

SECTION 43. Said chapter 176B is hereby further amended by inserting after section 4NN the following 2 sections:-

Section 4OO. For the purposes of this section, the following terms shall have the following meanings unless the context clearly requires otherwise:

"Community-based acute treatment", 24-hour clinically managed mental health diversionary or step-down services for children and adolescents that is usually provided as an alternative to mental health acute treatment.

"Intensive community-based acute treatment", intensive 24-hour clinically managed mental health diversionary or step-down services for children and adolescents that is usually provided as an alternative to mental health acute treatment.

"Mental health acute treatment", 24-hour medically supervised mental health services provided in an inpatient facility, licensed by the department of mental health, that provides psychiatric evaluation, management, treatment and discharge planning in a structured treatment milieu.

Any subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall provide coverage for medically necessary mental health acute treatment, community-based acute treatment, intensive community-based acute treatment and shall not require a preauthorization before obtaining treatment; provided, however, that the facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of admission.

Section 4PP. A subscription certificate under an individual or group medical service agreement that is issued or renewed shall provide benefits on a nondiscriminatory basis for medically necessary emergency service programs, as defined in section 1 of chapter 175.

SECTION 44. Section 4M of chapter 176G of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the word “specialist”, in line 117, the following words:- , a clinician practicing under the supervision of a licensed professional, and working towards licensure, in a clinic licensed under chapter 111.

SECTION 45. Subsection (i) of said section 4M of said chapter 176G is hereby amended by inserting after the second paragraph, as so appearing, the following paragraph:-

A health maintenance organization shall not deny coverage for any behavioral health service or any evaluation and management office visit solely because the services were delivered on the same day in the same practice or facility.

SECTION 46. Said chapter 176G is hereby further amended by inserting after section 4FF the following 2 sections:-

Section 4GG. For the purposes of this section, the following terms shall have the following meanings unless the context clearly requires otherwise:

“Community-based acute treatment”, 24-hour clinically managed mental health diversionary or step-down services for children and adolescents that is usually provided as an alternative to mental health acute treatment.

“Intensive community-based acute treatment”, intensive 24-hour clinically managed mental health diversionary or step-down services for children and adolescents that is usually provided as an alternative to mental health acute treatment.

"Mental health acute treatment", 24-hour medically supervised mental health services provided in an inpatient facility, licensed by the department of mental health, that provides psychiatric evaluation, management, treatment and discharge planning in a structured treatment milieu.

Any individual or group health maintenance contract that is issued or renewed shall provide coverage for medically necessary mental health acute treatment, community-based acute treatment and intensive community-based acute treatment and shall not require a preauthorization before obtaining treatment; provided, however, that the facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of admission.

Section 4HH. A health maintenance contract that is issued or renewed shall provide benefits on a nondiscriminatory basis for medically necessary emergency service programs, as defined in section 1 of chapter 175.

SECTION 47. Chapter 176O of the General Laws is hereby amended by inserting after section 5C the following section:-

Section 5D. For the purposes of this section, the term "base fee schedule" shall mean 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 fee schedule.

A carrier, directly or through any entity that manages or administers mental health or substance use disorder benefits for the carrier, shall establish 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; provided, however, that a carrier shall not lower its base fee schedule for primary care providers to comply with this section.

The division shall promulgate regulations to implement this section.

SECTION 48. Subsection (b) of section 16 of chapter 176O of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by striking out the last sentence and inserting in place thereof the following sentence:- If a carrier or utilization review organization intends to implement a new medical necessity guideline or amend an existing requirement or restriction, the carrier or utilization review organization shall ensure that the new guideline or amended requirement or restriction shall not be implemented unless: (i) the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction; and (ii) the carrier or utilization review organization has assessed the limitation to show it is in compliance with state and federal parity requirements under chapter 26.

SECTION 49. Said section 16 of said chapter 176O, as so appearing, is hereby further amended by adding the following subsection:-

(d) Medical necessity and utilization management determinations for treatments for substance use disorder or co-occurring mental illness and substance use disorder shall be made in accordance with the criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make medical necessity or utilization management determinations for treatments for substance use disorder or co-occurring mental illness and substance use disorder, unless such criteria are less restrictive. A carrier, or any entity that manages or administers mental health and substance use disorder benefits for the carrier, shall not deny authorization or coverage for treatment for substance use disorder or co-occurring mental illness and substance use disorder on the basis that such treatment was authorized or

ordered by a court of law or other law enforcement agency. Such authorization shall be considered a factor in support of coverage for such treatment, including as allowed under clause (4) of subsection (a) of section 6 and clause (7) of subsection (a) of section 7.

SECTION 50. Said chapter 176O is hereby further amended by adding the following section:-

Section 29. (a) The bureau of managed care shall develop and implement standard credentialing forms for health care providers. A carrier, or any entity that manages or administers benefits for a carrier, shall accept the standard credentialing form for contracting providers as sufficient information necessary to conduct its credentialing process.

(b) The bureau shall promulgate regulations establishing uniform standards and methodologies for credentialing of health care providers. The regulations shall include, but not be limited to, requirements that, for conducting a credentialing review of a health care provider, a carrier, or any entity that manages or administers benefits for a carrier, shall: (i) use and accept only the credentialing forms designated by the commissioner; and (ii) review a submitted credentialing form for a health care provider and respond to the health care provider within 20 business days after receiving a completed credentialing request.

Nothing in this section shall prohibit a carrier, or any entity that manages or administers benefits for a carrier, from using a credentialing methodology that utilizes an internet webpage, internet webpage portal or similar electronic, internet and web-based system in lieu of a paper form; provided, however, that upon request, a carrier, or any entity that manages or administers benefits for a carrier, shall make a paper credentialing form available to a health care provider.

(c) A carrier, or an entity that manages or administers benefits for a carrier, that contracts with another entity to perform some or all of the functions governed by this chapter shall be

responsible for ensuring compliance by the contracted entity with this chapter. A failure by the contracted entity to meet the requirements of this chapter shall be the responsibility of the carrier to remedy and shall subject the carrier to enforcement actions, including financial penalties, authorized under this chapter.

SECTION 51. There shall be, subject to appropriation, a pilot program administered by the department of higher education, in consultation with the department of mental health, to encourage a culturally, ethnically and linguistically diverse behavioral health workforce. The program shall be a partnership between colleges and behavioral health providers in the community and may be funded through the behavioral health outreach, access and support trust fund established under section 2GGGGG of chapter 29 of the General Laws.

Participants shall attend graduate-level classes to receive academic credits toward a master's degree in the field of behavioral health and receive a clinical placement by the college providing the graduate-level classes. The college shall prioritize placements with community providers serving high-need populations, including children, veterans, school-aged youth and individuals with a co-morbidity. Not more than 12 months after the completion of the pilot , the department of higher education shall file a report with the clerks of the senate and house of representatives, the joint committee on higher education and the joint committee on mental health, substance use and recovery that provides: (i) a description of the community partners participating in the pilot; (ii) a summary of post-program employment or continuing education plans of participating students; and (iii) any recommendations on ways to further encourage a culturally, ethnically and linguistically diverse behavioral health workforce.

SECTION 52. For the purposes of this section, "community health center" shall mean a community health center receiving a grant under 42 USC 254b.

Notwithstanding any general or special law to the contrary, there shall be a 24-month psychiatric mental health nurse practitioner fellowship pilot program to recruit and retain psychiatric mental health nurse practitioners at community health centers to increase access to high-quality community-based behavioral health care for medically underserved populations. The program shall be administered by the department of public health and the department may work with an external partner selected through a competitive grant process.

To be considered for selection in the psychiatric mental health nurse practitioner fellowship pilot program, a community health center shall, at a minimum: (i) provide and administer a 24-month post-graduate fellowship program for certified psychiatric mental health nurse practitioners who have graduated from an accredited school of nursing and obtained relevant licensure from a national licensing body designated by the board of registration in nursing within the past 18 months; (ii) provide psychiatric mental health nurse practitioners in the program with patient panels under the preceptorship of a psychiatrist or psychiatric mental health nurse practitioner who has been licensed and in clinical practice for not less than 12 months before the beginning of the preceptorship; and (iii) demonstrate strategies and supports for psychiatric mental health nurse practitioners to continue careers in integrated primary and behavioral health care models or other fields at community health centers.

Nothing in this section shall be interpreted to conflict with, replace or supersede any licensure requirements or standards for the advanced nursing practice established pursuant to chapters 94C or 112 of the General Laws.

The department shall make expenditures, subject to appropriation, to implement this program and shall consult, to the extent possible, with the executive office of health and human services to maximize available federal funding for the program including, but not limited to,

Medicaid reimbursement. The fellowship may be funded through the behavioral health outreach, access and support trust fund established under section 2GGGGG of chapter 29 of the General Laws.

Not later than July 31 following the disbursement of funding to eligible community health centers, the department of public health, in conjunction with any external partner, shall submit a report including data on the number of psychiatric mental health nurse practitioner applicants, participant retention, care provided to patients in underserved populations and all program expenditures to the secretary of health and human services, the secretary for administration and finance, the joint committee on health care financing, the clerks of the senate and house of representatives and the house and senate committees on ways and means.

SECTION 53. Notwithstanding any general or special law to the contrary, the department of public health, in consultation with the department of mental health and the department of elementary and secondary education, shall establish a pilot program to increase student access to telebehavioral health services in schools. The program shall provide for a competitive grant program to allow local providers to provide telebehavioral health services through interactive video conferencing technology on-site at local public schools, which may be funded through the behavioral health outreach, access and support trust fund established under section 2GGGGG of chapter 29 of the General Laws.

Delivery of behavioral health services shall be provided by a licensed mental health provider through live video conferencing between the provider and an individual student. Participating schools and providers shall follow best practices and ensure the privacy of all participating students.

The department shall, subject to appropriation, provide funding to assist with costs for the participating students, public school and local providers. The department shall ensure that participating providers seek third-party reimbursement for these services; provided, however, that the inability of a student or family to pay for services shall not be a barrier to accessing the program.

When identifying criteria for participating sites, the department of public health shall consider: (i) the availability of affordable behavioral health services for school-aged youth within the geographic region; and (ii) barriers within the geographic region that may prevent school-aged youth from accessing services outside the school.

One year after the implementation of the pilot program, the department of public health shall submit a report on the program's performance, including, but not limited to: (i) the number of students participating in the program; (ii) the frequency with which students use the program; (iii) the cost of the services provided, including the use of support staff; and (iv) the manner in which costs have been supported by third-party reimbursement. The report shall be submitted to the clerks of the senate and the house of representatives, the joint committee of mental health, substance use and recovery, the joint committee on education and the house and senate committees on ways and means.

SECTION 54. The office of health equity, in consultation with the department of public health and the department of mental health, shall, subject to appropriation, conduct a study assessing the availability of culturally competent behavioral health providers in the commonwealth. The study may be conducted by an entity with a demonstrated capacity to deliver research results passing an academic peer-review process in analyzing both quantitative and qualitative data and to communicate study results in an accessible manner.

The study shall review the availability of culturally competent behavioral health providers within networks of both public and private health care payers and identify potential barriers to care for underserved cultural, ethnic and linguistic populations in the community. The review shall include, but not be limited to: (i) the number of culturally competent and diverse behavioral health providers that reflect the cultural, ethnic and linguistic population of the community; (ii) the existence of culturally competent services; (iii) geographic challenges to access culturally competent providers; (iv) training opportunities for providers to most effectively serve diverse populations; and (v) consideration of the impact of gender, gender identity, race, ethnicity, sexual orientation, linguistic barriers and social determinants of health on access to behavioral health services.

Pursuant to memorandums of understanding with the center for health information and analysis established under chapter 12C of the General Laws, the group insurance commission established under chapter 32A of the General Laws and MassHealth established under chapter 118E of the General Laws, respectively, the office shall receive data to complete the charge of this study.

Not later than March 15, 2021, the office shall submit the study's findings with clerks of the senate and house of representatives, the joint committee on mental health, substance use and recovery, the joint committee on public health and the joint committee on health care financing.

SECTION 55. The interagency health equity team, as supported through the office of health equity, shall, in consultation with the advisory council appointed in this section, study ways to improve access to, and the quality of, culturally competent behavioral health services. The review shall include, but not be limited to: (i) the need for greater racial, ethnic and linguistic diversity within the behavioral health workforce; (ii) the role of gender, gender

identity, race, ethnicity, linguistic barriers, sexual orientation and social determinants of health regarding behavioral health needs; and (iii) any other factors identified by the team that create disparities in access and quality within the existing behavioral health service delivery system, including stigma, transportation and cost.

The advisory council shall consist of: the chairs of the joint committee on mental health, substance use and recovery; the chair of the Black and Latino Caucus or a designee; and the following members to be appointed by the commissioner of public health, 1 of whom shall be a local public health official representing a majority-minority municipality, 1 of whom shall be a representative of a racial or ethnic equity advocacy group, 1 of whom shall be a representative of a linguistic equity advocacy group, 1 of whom shall be a licensed behavioral health provider, 1 of whom shall be a representative of a mental health advocacy group, 1 of whom shall be a representative of an organization serving the health care needs of the lesbian, gay, bisexual, transgender, queer and questioning community, 1 of whom shall be a representative of an organization serving the health care needs of individuals experiencing housing insecurity and 1 of whom shall be an individual with expertise in school-based mental health services.

The team shall meet not less than quarterly with the advisory council. Not later than March 30, 2021 and annually for the following 3 years at the close of the fiscal year, the team shall issue a report with legislative, regulatory or budgetary recommendations to improve the access and quality of culturally competent mental and behavioral health services.

The office of health equity, the department of mental health and the department of public health may, subject to appropriation, provide administrative, logistical and research support to produce the report.

SECTION 56. The health policy commission, in consultation with the division of insurance, shall review the role of behavioral health managers, as defined in section 1 of chapter 176O of the General Laws, within the health care delivery system. The commission shall review: (i) oversight practices by other states on behavioral health managers; (ii) the effects of behavioral health manager state licensure, regulation or registration on access to behavioral health services; (iii) other aspects of behavioral health managers as deemed appropriate by the commission.

Not later than January 1, 2021, the health policy commission shall file a report of its findings with the clerks of the senate and house of representatives, the joint committee on health care financing, the joint committee on mental health, substance use and recovery and the joint committee on financial services.

SECTION 57. Notwithstanding any special or general law to the contrary, there shall be a special commission to study and make recommendations on the establishment of a common set of criteria for providers and payers to use in making medical necessity determinations for behavioral health treatment.

The commission shall consist of the following members or their designees: the commissioner of mental health, who shall serve as chair; the commissioner of insurance; the director of the bureau of substance addiction services within the department of public health; the assistant secretary for MassHealth; the executive director of the group insurance commission; and the following members to be appointed by the chair: 1 of whom shall be a representative of the health policy commission; 2 of whom shall be representatives of the Massachusetts Psychiatric Society, Inc., 1 of whom shall specialize in the treatment of children; 2 of whom shall be representatives of the Massachusetts Psychological Association, Inc., 1 of whom shall specialize in the treatment of children; 1 of whom shall be a representative of the Massachusetts

Society of Addiction Medicine, Inc.; 1 of whom shall be a representative of the National Association of Social Workers, Inc.; 1 of whom shall be a representative of the Massachusetts Mental Health Counselors Association, Inc.; 1 of whom shall be a representative of the Children's Mental Health Campaign; 1 of whom shall be a representative of the Association for Behavioral Healthcare, Inc.; 1 of whom shall be a representative of the Massachusetts Association of Behavioral Health Systems, Inc.; 1 of whom shall be a representative of the Massachusetts Association for Mental Health, Inc.; 1 of whom shall be a representative of the National Alliance on Mental Illness of Massachusetts, Inc.; 1 of whom shall be a representative of the Massachusetts Organization for Addiction Recovery, Inc.; 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc.; and 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc..

The commission's review shall include, but not be limited to: (i) existing reference sources or services utilized by payers to make medical necessity determinations for behavioral health treatment, including, but not limited to American Society of Addiction Medicine, InterQual and Milliman; (ii) commonly accepted treatment guidelines and standards of care utilized by behavioral health providers and the evidentiary basis for those guidelines and standards; (iii) the feasibility of establishing a common set of medical necessity criteria that behavioral health providers and payers can agree to and any barriers to this task; and (iv) experiences of other states addressing the standardization of medical necessity for behavioral health.

The commission shall submit its findings and recommendations, together with drafts of legislation or regulations necessary to carry those recommendations into effect, to the clerks of

the senate and house of representatives and the joint committee on mental health, substance use and recovery not later than 1 year after the effective date of this act.

SECTION 58. The division of insurance shall promulgate regulations to implement section 5D of chapter 176O of the General Laws not later than 1 year from the effective date of this act; provided, further that the division shall, upon publication, forward any draft regulations to the joint committee on health care financing and joint committee on mental health, substance use and recovery.

SECTION 59. The center for health information and analysis shall revise regulations relative to reporting requirements under sections 8, 9 and 10 of chapter 12C of the General Laws to implement section 4 within 6 months of the effective date of this act.

SECTION 60. The department of public health shall promulgate regulations to implement section 51¾ of chapter 111 of the General Laws not later than October 1, 2020.

SECTION 61. Sections 16, 17, 30, 34, 37, 38, 40, 43 and 46 shall apply to contracts entered into or reviewed on or after July 1, 2020.

SECTION 62. Sections 5 to 12, inclusive, sections 19 to 24, inclusive and section 29 shall take effect July 1, 2020.

SECTION 63. Sections 47, 49 of the act and section 82 of chapter 118E of the General Laws shall take effect 1 year after the effective date of this act.