HOUSE . . . . . No. 4879

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, June 15, 2022.

The committee on Ways and Means, to whom was referred the Senate Bill addressing barriers to care for mental health (Senate, No. 2584), reports recommending that the same ought to pass with an amendment striking all after the enacting clause and inserting in place thereof the text contained in House document numbered 4879.

For the committee,

AARON MICHLEWITZ.

HOUSE . . . . . No. 4879

Text of an amendment, recommended by the committee on Ways and Means, to the Senate Bill addressing barriers to care for mental health (Senate, No. 2584). June 15, 2022.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Second General Court
(2021-2022)

By striking out all after the enacting clause and inserting in place thereof the following:–

SECTION 1. Subsection (d) of section 219 of chapter 6 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by striking out clauses (5) and (6) and inserting in place thereof the following 7 clauses:-

(5) facilitate the development of interagency initiatives that: (i) are informed by the science of promotion and prevention; (ii) advance health equity and trauma-informed care; and (iii) address the social determinants of health;

(6) develop and implement a comprehensive plan to strengthen community and state-level promotion programming and infrastructure through training, technical assistance, resource development and dissemination and other initiatives;

(7) advance the identification and dissemination of evidence-based practices designed to further promote behavioral health and the provision of supportive behavioral health services and programming to address substance use conditions and to prevent violence through trauma-specific intervention and rehabilitation;

(8) collect and analyze data measuring population-based indicators of behavioral health from existing data sources, track changes over time and make programming and policy recommendations to address the needs of populations at greatest risk;

(9) coordinate behavioral health promotion and wellness programs, campaigns and initiatives;

(10) hold public hearings and meetings to accept comment from the public and to seek advice from experts, including, but not limited to, those in the fields of neuroscience, public health, behavioral health, education and prevention science; and

(11) submit an annual report to the legislature as provided in subsection (e) on the state of preventing substance use disorder and promoting behavioral health in the commonwealth.

SECTION 2. Chapter 6A of the General Laws is hereby amended by striking out section 16P, as so appearing, and inserting in place thereof the following section:-

Section 16P. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Adult", an individual who is older than 22 years of age.

"Awaiting residential disposition", waiting not less than 72 hours to be moved from an acute level of psychiatric care to a less intensive or less restrictive, clinically-appropriate level of psychiatric care.

"Boarding", waiting not less than 12 hours to be placed in an appropriate therapeutic setting after: (i) being assessed; (ii) being determined in need of acute psychiatric treatment, crisis stabilization unit placement, community-based acute treatment, intensive community-based

acute treatment, continuing care unit placement or post-hospitalization residential placement; and (iii) receiving a determination from a licensed health care provider of medical stability without the need for urgent medical assessment or hospitalization for a physical condition.

"Children and adolescents", individuals who are 22 years of age or less.

(b)(1) The secretary of health and human services shall facilitate the coordination of services for children and adolescents awaiting clinically-appropriate behavioral health services by developing and maintaining a confidential and secure online portal that enables health care providers, health care facilities, payors and relevant state agencies to access real-time data on children and adolescents who are boarding, awaiting residential disposition or in the care or custody of a state agency and are awaiting discharge to an appropriate foster home or a congregate or group care program. The online portal and information contained in the online portal shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66.

(2) The online portal shall include, but not be limited to, the following data: (i) the total number of children and adolescents boarding, including a breakdown, by location, of where the children and adolescents are boarding, which shall include, but not be limited to, hospital emergency rooms, emergency services sites and medical floors after having received medical stabilization treatment or their homes; (ii) the total number of children and adolescents awaiting residential disposition, including a breakdown, by facility type, of where children and adolescents are awaiting residential disposition and the level of care or type of placement sought; and (iii) the total number of children and adolescents in the care or custody of a state agency who are hospitalized and have waited not less than 72 hours for discharge to an appropriate foster

home or a congregate or group care program after having been determined to no longer need hospital-level care.

(3) For each category of data included pursuant to paragraph (2), the online portal shall include: (i) the average wait time for discharge to the appropriate level of care or placement; (ii) the level of care required as determined by a licensed health care provider; (iii) the primary behavioral health diagnosis and any co-morbidities relevant for the purposes of placement; (iv) the primary reason for boarding, awaiting residential disposition or, for children and adolescents in the care or custody of a state agency, for having waited not less than 72 hours for discharge to an appropriate foster home or a congregate or group care program after an assessment that hospital-level care is no longer necessary; (v) whether the children and adolescents are in the care or custody of the department of children and families or the department of youth services or are eligible for services from the department of mental health or the department of developmental services; (vi) data on the insurance coverage type for the children and adolescents; and (vii) data on the ages, race, ethnicity, preferred spoken languages and gender of the children and adolescents.

(4) The online portal shall include information on the specific availability of pediatric acute psychiatric beds, crisis stabilization unit beds, community-based acute treatment beds, intensive community-based acute treatment beds, continuing care beds and post-hospitalization residential beds. The online portal shall also enable a real-time bed search within a specified geographic region that shall include, but not be limited to: (i) the total number of beds licensed by the department of mental health, the department of public health and the department of early education and care; (ii) the total number of available beds, broken down by location, licensing authority, age ranges and the distance, in miles, from where a child or adolescent currently

resides and is boarding; (iii) the average daily bed availability, broken down by licensing authority and age ranges; (iv) daily bed admissions, broken down by licensing authority and age ranges; (v) the facility or location in which a child or adolescent was admitted; (vi) daily bed discharges, broken down by licensing authority and age ranges; and (vii) the average length of stay in a bed, broken down by licensing authority and age ranges.

(5) Quarterly, not later than 14 days after the end of the preceding quarter, the secretary shall report on the status of children and adolescents who are boarding, awaiting residential disposition or in the care or custody of a state agency and awaiting discharge to an appropriate foster home or a congregate or group care program. The report shall include a summary and assessment of the data published on the online portal pursuant to paragraphs (3) and (4) for the immediately preceding quarter and may include a summary and assessment of the data over several quarters; provided, however, that the report shall present the data in an aggregate and de-identified form. The report shall be submitted to the children's behavioral health advisory council, established in section 16Q, the office of the child advocate, the health policy commission, the clerks of the senate and the house of representatives, the house and senate committees on ways and means, the joint committee on health care financing, the joint committee on mental health, substance use and recovery and the joint committee on children, families and persons with disabilities.

(c) The secretary of health and human services shall facilitate psychiatric and substance use disorder inpatient admissions for adults seeking to be admitted from an emergency department or hospital medical floor by developing and maintaining a confidential and secure online portal that enables health care providers, health care facilities and payors to conduct a real-time bed search for patient placement. The online portal shall provide real-time information

on the specific availability of all licensed psychiatric and substance use disorder inpatient beds that shall include, but not be limited to: (i) location; (ii) care specialty; and (iii) insurance requirements. The online portal and information contained in the online portal shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66.

SECTION 3. Said chapter 6A is hereby further amended by striking out section 16R, as so appearing, and inserting in place thereof the following section:-

Section 16R. (a) There shall be an interagency review team to collaborate on complex cases where there is a lack of consensus or resolution between state agencies about current service needs or placement of an individual who: (i) is under the age of 22; (ii) is disabled or has complex behavioral health or special needs; and (iii) qualifies or may qualify for services from 1 or more state agencies, including special education services through the individual's school district.

(b) The team shall consist of: the secretary of health and human services or a designee, who shall serve as co-chair; the commissioner of elementary and secondary of education or a designee, who shall serve as co-chair; the assistant secretary of MassHealth or a designee; the commissioner of mental health or a designee; the commissioner of children and families or a designee; the commissioner of developmental services or a designee; the commissioner of youth services or a designee; the commissioner of early education and care or a designee; the ombudsman from the executive office of education; a representative from the office of the child advocate; and a representative from the school district.

(c)(1) An individual may be referred to the team by a state agency, the juvenile court, a hospital or emergency service provider, a school district or the individual's parent or guardian.

(2) Not later than 5 business days after referral of an individual to the team, the co-chairs shall convene the team. The team may order expedited eligibility determinations by a state agency or an extended evaluation at a special education residential school in order for the team to make determinations about the individual's current service needs if deemed necessary after the receipt of the referral and a review of relevant materials, including educational records and evaluations and review of any report issued from the area or regional level of state agencies involved.

(3) Upon receipt and review of all necessary and updated information regarding the individual's service needs and eligibility decisions, the team shall determine the services currently in place, additional services that are needed to meet the current needs of the individual and which agencies shall provide said services, including location or placement where appropriate and ongoing case management services. The co-chairs may authorize the expenditure of funds pursuant to section 2TTTTT of chapter 29 to effectuate the purposes of this section, including funding for clinical or legal services and experts for families in special education disputes.

(d) If the individual or their parent or guardian disputes the decision of the team, the individual or their parent or guardian may file an appeal with the division of administrative law appeals, established under section 4H of chapter 7, which shall conduct an adjudicatory proceeding and order any necessary relief consistent with state or federal law; provided, however, that nothing in this section shall be construed to entitle an individual to services that the individual would otherwise be ineligible for under applicable agency statutes or regulations.

(e) Notwithstanding chapters 66A, 112 and 119 or any other state or federal law related to the confidentiality of personal data, the team, the secretary of health and human services and the division of administrative law appeals shall have access to and may discuss materials related to the case while the case is under review; provided, that the individual or their parent or guardian shall consent in writing; and provided further, that those having access shall agree in writing to keep the materials confidential.

(f) The secretary of health and human services and the commissioner of elementary and secondary education shall jointly promulgate regulations to effectuate the purposes of this section. The regulations shall include, but not be limited to: (i) the respective roles of the secretary of health and human services and the commissioner of elementary and secondary education for facilitating the work of the team; (ii) processes, including expedited processes, and timelines for required notifications between state agencies, the team and persons eligible for assistance or their parent or a person legally authorized to act on their behalf; (iii) record sharing processes, including requirements for obtaining consumer or parental consent; (iv) data gathering and reporting requirements; and (v) regulations pertaining to the interagency services reserve fund established in section 2TTTTT of chapter 29, including allowable uses of resources from said fund, processes for requesting and documenting requests, authorizations and denials and issuance of resources from said fund.

(g) The secretary of health and human services shall publish an annual report not later than October 1 summarizing the cases reviewed by the team in the previous year, the length of time spent at each stage and the final resolution; provided, however, that the report shall not include any personally identifiable information of an individual. The report shall be provided to the child advocate and the clerks of the senate and the house of representatives.

(h) Nothing in this section shall limit the rights of parents, guardians or children under chapter 71B, the federal Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq. or section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 et seq.

SECTION 4. Said chapter 6A is hereby further amended by inserting after section 16CC, as so appearing, the following 2 sections:-

Section 16DD. (a) As used in this section, the following words shall, unless the context requires otherwise, have the following meanings:

"Community behavioral health centers", organizations that are designated by the executive office of health and human services, licensed clinics that hold a contract with the department of mental health to provide community-based mental health services and other licensed clinics designated by the department of public health.

"Community crisis stabilization program", a program providing crisis stabilization services with the capacity for diagnosis, initial management, observation, and follow-up referral services to all persons in a home-like environment, including, but not limited to, emergency service providers, restoration centers and peer respite programs.

"Mobile behavioral health crisis responders", behavioral health professionals that provide professional onsite community-based intervention such as evaluation, de-escalation, stabilization, diversion and triage to acute intervention or community-based settings for individuals who are experiencing a behavioral health crisis; provided, that responders may include, but not be limited to: emergency service providers; mobile crisis intervention teams; and local or regional behavioral health teams, including crisis co-responders, peers and licensed mental health professionals.

"Peer", an individual employed based on their personal lived experience of mental health or substance use conditions who meets peer certification requirements where applicable.

(b) The secretary of health and human services shall designate 1 or more 988 crisis hotline centers that shall operate 24 hours a day, 7 days a week, to provide crisis intervention services and crisis care coordination to individuals accessing the federally-designated 988 suicide prevention and behavioral health crisis hotline.

(c) A 988 crisis hotline center shall: (i) meet the United States Department of Health and Human Services' Ambulatory Behavioral Health System standards and the National Suicide Prevention Lifeline requirements and best practices guidelines for operational and clinical standards; (ii) provide data and reports and participate in evaluations and related quality improvement activities as required by the United States Department of Health and Human Services; (iii) utilize technology, including, but not limited to, chat and text capabilities, that is interoperable between and across crisis and emergency response systems and services, including 911 and 211, as necessary; (iv) have the authority to deploy crisis and outgoing services, including, but not limited to, mobile behavioral health crisis responders, and coordinate access to crisis triage, evaluation and counseling services, community crisis stabilization programs or other resources as appropriate; (v) maintain standing partnership agreements with community behavioral health centers and other behavioral health programs and facilities, including, but not limited to, programs led by individuals who are or were consumers of mental health or substance use disorder supports or services; (vi) coordinate access to crisis evaluation, counseling, receiving and stabilization services for individuals accessing the 988 suicide prevention and behavioral health crisis hotline through appropriate information sharing regarding availability of services; (vii) have the capability to serve high-risk and specialized populations, including, but

not limited to, people with co-occurring substance use and mental health conditions and people with autism spectrum disorders or intellectual or developmental disabilities; (viii) have the capability to serve people of diverse races, ethnicities, ages, sexual orientations and gender identities with linguistically and culturally-competent care; (ix) have the capability to provide crisis and outgoing services within a reasonable time period in all geographic areas of the commonwealth; and (x) provide follow-up services to individuals accessing the 988 suicide prevention and behavioral health crisis hotline.

(d)(1) There shall be a state 988 commission within the executive office of health and human services to provide ongoing strategic oversight and guidance in all matters regarding 988 service in the commonwealth.

(2) The commission shall review national guidelines and best practices and make recommendations for implementation and promotion of a statewide 988 suicide prevention and behavioral health crisis system, including any legislative or regulatory changes that may be necessary for 988 implementation and recommendations for funding.

(3) The commission shall consist of: the secretary of health and human services or the secretary's designee, who shall serve as chair; the secretary of public safety and security or the secretary's designee; the commissioner of mental health or the commissioner's designee; the commissioner of public health or the commissioner's designee; the executive director of the Massachusetts Behavioral Health Partnership or the executive director's designee; the executive director of the state 911 department or the executive director's designee; the executive director of Mass 2-1-1 or the executive director's designee; a representative designated by the Massachusetts chapter of the National Association of Social Workers, Inc.; a 911 dispatcher

designated by the Massachusetts Chiefs of Police Association Incorporated; an emergency medical technician or first responder nominated by the Massachusetts Ambulance Association, Incorporated; and the following members to be appointed by the chair: 1 representative from an emergency service provider, nominated by the Association for Behavioral Healthcare, Inc.; 1 representative from the Association for Behavioral Healthcare, Inc.; 1 representative from a suicide prevention hotline in the commonwealth, nominated by the Samaritans, Inc.; 1 representative from the Riverside Community Care, Inc. MassSupport program; 1 representative from the Massachusetts Coalition for Suicide Prevention; 1 representative from the Children's Mental Health Campaign; 1 representative from the INTERFACE Referral Service at William James College, Inc.; 1 representative from the National Alliance on Mental Illness of Massachusetts, Inc.; 1 representative from the Parent/Professional Advocacy League, Inc.; 1 representative from the Massachusetts Association for Mental Health, Inc.; 1 representative from the Boston branch of the National Association for the Advancement of Colored People; 1 representative from the American Civil Liberties Union of Massachusetts, Inc.; 1 representative from the mental health legal advisors committee; and 3 persons who are or have been consumers of mental health or substance use disorder supports or services. Every reasonable effort shall be made to ensure representation from all geographic areas of the commonwealth.

(4) Annually, not later than March 1, the commission shall submit its findings and recommendations 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.

Section 16EE. (a) Subject to appropriation, the executive office of health and human services, in coordination with the department of elementary and secondary education, shall develop and implement a statewide program to assist in implementing behavioral health services

and supports in each school district which shall include, but not be limited to, consultation, coaching and technical assistance.

(b) The program shall provide web-based, in-person and remote supports to administrators, teachers and school behavioral health staff related to planning, administering and managing behavioral health promotion, prevention and intervention services and supports, including: (i) engagement of families and guardians, with a focus on ensuring equitable, linguistically-competent, culturally-competent and developmentally appropriate responses, and (ii) access to services.

(c) The executive office, in consultation with the department of elementary and secondary education, shall establish a central base of operations within the University of Massachusetts, as well as regional sites, to carry out the program; provided, that there shall be a preference for existing locations providing similar services, such as the state center on child wellbeing and trauma within the University of Massachusetts medical school and the Behavioral Health Integrated Resources for Children Project within the University of Massachusetts at Boston.

SECTION 5. Section 18A of said chapter 6A, as so appearing, is hereby amended by inserting after the definition of "Local exchange service" the following definition:-

"Mobile behavioral health crisis response services", response services provided by behavioral health professionals that provide professional onsite community-based intervention such as evaluation, de-escalation, stabilization, diversion and triage to acute intervention or community-based settings for individuals who are experiencing a behavioral health crisis, including, but not limited to, services provided by: emergency service providers; mobile crisis

intervention teams; and local or regional behavioral health teams, including crisis co-responders, peers and licensed mental health professionals.

SECTION 6. Section 18B of said chapter 6A, as so appearing, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) There shall be, within the executive office of public safety and security, a state 911 commission to provide strategic oversight and guidance to the department, and to advise the department relative to its annual budget and all material changes thereto and in all matters regarding enhanced 911 service in the commonwealth. The commission shall consist of: the secretary of public safety and security, who shall serve as chairperson; the chief information officer of the information technology division; the colonel of state police; the state fire marshal; the police commissioner of the city of Boston; the director of the Massachusetts office on disability; the commissioner of public health; the commissioner of mental health; the commissioner of the Massachusetts commission for the deaf and hard of hearing; and 13 members to be appointed by the governor, 1 of whom shall be a sitting police chief and a representative of the Massachusetts Chiefs of Police Association, Inc., 1 of whom shall be a representative of the Massachusetts Police Association, Inc., 1 of whom shall be a sitting police chief and a representative of the Massachusetts Major City Chiefs Association, 2 of whom shall be sitting fire chiefs and representatives of the Massachusetts Fire Chiefs Association, 1 of whom shall be a representative of the Professional Fire Fighters of Massachusetts, 1 of whom shall be a representative of the Massachusetts Sheriffs Association, Inc., 1 of whom shall be a representative of the Massachusetts Municipal Association, Inc., 1 of whom shall be a representative of the Massachusetts Emergency Medical Care Advisory Board, 1 of whom shall be a representative of the Massachusetts Ambulance Association, Inc., 1 of whom shall be a

manager or supervisor of a PSAP and a representative of the Massachusetts Communication Supervisors Association, Inc., 1 of whom shall be a representative of the Association for Behavioral Healthcare, Inc. with experience in delivering psychiatric emergency services, and 1 of whom shall be an individual with lived experience with behavioral health conditions and interactions with police. One of the governor's appointees shall be elected annually by the commission as its vice chairperson. Members of the commission shall be appointed for terms of 3 years with no limit on the number of terms they may serve. Members shall hold office until a successor is appointed and no member shall serve beyond the time the member ceases to hold the office or employment that made the member eligible for appointment to the commission. The commission shall meet at least twice annually, and at other times as necessary. A meeting of the commission may be called by its chairperson, the vice chairperson or 3 of its members. A quorum for the transaction of business shall consist of 9 members. Members of the commission shall receive no compensation, but shall be reimbursed for their expenses actually and necessarily incurred in the discharge of their duties. The commission shall review and approve by a majority vote of those members present all formulas, percentages, guidelines or other mechanisms used to distribute the grants described in this section, and all major contracts that the department proposes to enter into for enhanced 911 services. The commission shall review and approve by a majority vote of those members present all regulations and standards proposed by the department.

SECTION 7. Paragraph (2) of subsection (i) of said section 18B of said chapter 6A, as so appearing, is hereby amended by striking out the ninth and tenth sentences and inserting in place thereof the following 2 sentences:- In the guidelines administering this grant, the department may include provisions to increase the allocation of funds to primary PSAPs provided under this grant

that dispatch police, fire protection, emergency medical services and mobile behavioral health crisis response services, taking into account if any such services are provided by a private safety department. The department may include in such guidelines provisions to increase the allocation of funds to regional secondary PSAPs that dispatch any combination of regional police, fire protection, emergency medical services or mobile behavioral health crisis response services.

SECTION 8. Said chapter 6A is hereby further amended by striking out section 18C, as so appearing, and inserting in place thereof the following section:-

Section 18C. (a) Each PSAP shall be capable of transmitting a request for law enforcement, firefighting, medical, ambulance, emergency service provider or other emergency services to a public or private safety department that provides the requested services.

(b) Each primary and regional PSAP shall be equipped with a system approved by the department for the processing of requests for emergency services from persons with disabilities.

(c) Each primary and regional PSAP shall be equipped with a system approved by the department for the processing of requests for emergency services from persons with mental health or substance use conditions.

(d) A public safety department or private safety department that receives a request for emergency service outside of its jurisdiction shall promptly forward the request to the PSAP or public safety department responsible for that geographical area. Any emergency unit dispatched to a location outside its jurisdiction in the commonwealth in response to such request shall render service to the requesting party until relieved by the public safety department responsible for that geographical area.

(e) Except as approved by the department, no person shall permit an automatic alarm or other alerting device to dial the numbers 911 automatically or provide a prerecorded message in order to access emergency services directly.

(f) Municipalities may enter into written cooperative agreements to carry out subsections (a) through (d).

SECTION 9. Section 8 of chapter 6D of the General Laws, as so appearing, is hereby amended by striking out, in line 94, the word “and” and inserting in place thereof the following words:- , including behavioral health expenditures, and.

SECTION 10. Section 16 of said chapter 6D, as so appearing, is hereby amended by inserting after the figure “176O”, in line 66, the following words:- , including a process for identifying and referring matters to the division of insurance and the office of the attorney general for review of compliance with state and federal mental health and substance use disorder parity laws.

SECTION 11. Said chapter 6D is hereby further amended by adding the following 2 sections:-

Section 20. Every 3 years, the commission, in collaboration with the department of public health, the department of mental health and the department of developmental services, shall prepare a pediatric behavioral health planning report analyzing the status of pediatric behavioral health in the commonwealth. The report shall include, but not be limited to: (i) a review of data from the online portal established in section 16P of chapter 6A and the reports submitted to the commission pursuant to paragraph (5) of subsection (b) of said section 16P; (ii) an analysis of the availability of pediatric acute psychiatric beds, crisis stabilization unit beds, community-based

acute treatment beds, intensive community-based acute treatment beds, continuing care unit beds and post-hospitalization residential beds, broken down by geographic region and by sub-specialty, and an identification of any service limitations; (iii) an analysis of the capacity of the pediatric behavioral health workforce to respond to the acute behavioral health needs of children and adolescents across the commonwealth; (iv) any statutory, regulatory or operational factors that may impact pediatric boarding under said section 16P; and (v) any other information deemed relevant by the commission. The report shall be published on the commission's website.

Section 21. The commission shall develop a standard release form for exchanging confidential mental health and substance use disorder information. The standard release form shall be available in electronic and paper format and shall be accepted and used by all public and private agencies, departments, corporations, provider organizations and licensed professionals involved with the medical or behavioral health treatment of an individual experiencing mental illness, serious emotional disturbance or substance use disorder. The commission shall promulgate regulations for the proper use of the standard release form that shall comply with federal and state laws relating to the protection of individually identifiable health information.

SECTION 12. Subsection (a) of section 16 of chapter 12C of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by striking out clauses (10) and (11) and inserting in place thereof the following 3 clauses:- (10) the development and status of provider organizations in the commonwealth including, but not limited to, acquisitions, mergers, consolidations and any evidence of excess consolidation or anti-competitive behavior by provider organizations; (11) the impact of health care payment and delivery reform on the quality of care delivered in the commonwealth; and (12) costs, cost trends, price, quality, utilization and patient outcomes related to behavioral health service subcategories described in section 21A.

SECTION 13. Section 21A of said chapter 12C, as so appearing, is hereby amended by adding the following sentence:- The investigation and study shall also include developing and defining criteria for health care services to be categorized as behavioral health services, with subcategories 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.

SECTION 14. 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, sections 511 and 512 of Public Law 110–343, 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 said chapters 175, 176A, 176B and 176G without regard to any limitation under section 1 of chapter 176J.

SECTION 15. Chapter 15D of the General Laws is hereby amended by inserting after section 12 the following section:-

Section 12A. (a) The department shall develop performance standards for prohibiting or significantly limiting the use of suspension and expulsion in all licensed early education and care programs pursuant to clause (t) of section 2. The standards shall ensure that expulsion and

suspension are only used in extraordinary circumstances where there is a documented assessment that the child's behavior poses a serious ongoing threat to the safety of others that cannot be reduced or eliminated by reasonable program modifications.

(b) The performance standards shall include, but not be limited to: (i) benchmarks and goals for supporting children's social, emotional and behavioral development to (A) reduce the use of expulsion as a disciplinary tool; (B) eliminate disparities in the use of suspension and expulsion, (C) facilitate referrals for children with intensive needs; and (D) establish programs to provide transitional support for children returning to early education and care programming after extended absences, including behavioral health-related absences; (ii) engagement steps to be taken with the child and parent or guardian prior to suspension or expulsion; (iii) requirements for communicating disciplinary policies, including suspension and expulsion policies, to staff, families, guardians and community partners; (iv) pathways for programs to access technical assistance through the statewide program established in section 16EE of chapter 6A to support ongoing development of staff and teacher skills for supporting children's social, emotional and behavioral development, reducing disparities and limiting the use of suspension and expulsion; and (v) requirements for assessing and documenting a serious ongoing threat to the safety of others.

SECTION 16. Section 5 of chapter 18C of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by striking out subsection (d) and inserting in place thereof the following subsection:-

(d) The child advocate shall receive complaints from children, including children in the care of the commonwealth, families and guardians and shall assist such persons in resolving

problems and concerns associated with placement, access to behavioral health services, plans for life-long adult connections and independent living and decisions regarding custody of persons aged between 18 and 22, including ensuring that relevant executive agencies have been alerted to the complaint and facilitating inter-agency cooperation, if appropriate. For the purposes of this section, the office shall develop procedures to ensure appropriate responses to the concerns of youth in foster care.

SECTION 17. Chapter 19 of the General Laws is hereby amended by inserting after section 19 the following 2 sections:-

Section 19A. (a) The department shall establish clinical competencies and additional operational standards for care and treatment of patients admitted to facilities licensed pursuant to 104 CMR 27.00, including for specialty populations identified by the department. In establishing the clinical competencies and operational standards, the department shall consider national and local standards of practice where such standards of practice exist, and to the extent deemed appropriate by the department. In establishing the clinical competencies, the department shall utilize all data collected to identify the behavioral health needs of the commonwealth and consult with relevant stakeholders, including, but not limited to, inpatient psychiatric facilities, emergency departments, emergency service providers, Medicaid managed care organizations and commercial carriers. The department shall update the clinical competencies on a biennial or as-needed basis.

(b) The department shall issue regulations requiring facilities licensed pursuant to 104 CMR 27.00 to have a clinical affiliation with an acute care hospital to ensure access by patients to medical services; provided, however, that facilities that are located within an acute care

hospital licensed under section 51 of chapter 111 are not subject to said regulations. Such affiliation shall include, but not be limited to, patient care, testing and patient diagnostics.

(c) The department shall develop requirements for the reporting of quality and outcome measures by facilities to ensure compliance with this section.

(d) The department may impose a penalty against a facility for noncompliance with the clinical competencies, operational standards, regulations and reporting requirements in this section. The amount of any penalty imposed shall be $100 for each day of noncompliance for each patient whose care is affected by such noncompliance; provided, however, that the maximum annual penalty shall be not more than $500,000.

Section 19B. (a) No facility licensed by the department shall refuse to admit a patient who meets the general admission criteria for the facility, including all clinical competencies pursuant to section 19A, where such admission would not result in a census exceeding the facility's operational capacity; provided, however, that the department may promulgate regulations setting forth additional exceptions to this section.

(b) The department shall require facilities to collect and report data to the department, in a form and format as determined by the department, on the facility's total number of admission requests, admissions, admission denials and the reasons for the admission denials.

(c) Notwithstanding any general or special law to the contrary, and subject to any applicable federal law, a facility may deny admission to a patient whose needs have been determined by the facility's medical director to exceed the facility's capability at the time admission is sought. The determination shall include the factors justifying denial of admission and why mitigating efforts, such as utilization of additional staff, would have been inadequate.

This determination shall be recorded in writing and shall be subject to review by the department; provided, however, that such written determination provided to the department shall not be required to include personally identifiable information.

(d) Facilities shall keep data on patients referred for admission in a form and format and containing data elements as determined by the department; provided, however, that facilities shall not be required to maintain patient-identifiable data on individuals not accepted for admission. Such data shall be available for inspection by the department upon request.

SECTION 18. Said chapter 19 is hereby further amended by adding the following section:-

Section 26. (a) There shall be an expedited psychiatric inpatient admission advisory council within the department which shall investigate and recommend policies and solutions regarding the emergency department boarding of patients seeking mental health and substance use disorder services. The advisory council shall: (i) implement the expedited psychiatric inpatient admissions protocol, as established by the department; (ii) collect data on the number of patients boarding in emergency departments and the reasons for extended wait times, including capacity constraints; and (iii) make recommendations for measures to reduce the wait times for admissions.

(b) The advisory council shall consist of the following members: the commissioner of mental health or a designee, who shall serve as chair; the commissioner of public health or a designee; the director of the office of Medicaid or a designee; the commissioner of insurance or a designee; a representative from the Massachusetts Association of Health Plans, Inc.; a representative of Blue Cross and Blue Shield of Massachusetts, Inc.; a representative of the

Massachusetts Health and Hospital Association, Inc.; a representative of the Massachusetts College of Emergency Physicians, Inc.; a representative of the Association for Behavioral Healthcare, Inc.; a representative of the National Alliance on Mental Illness of Massachusetts, Inc.; a representative of the Massachusetts Association of Behavioral Health Systems, Inc.; a member representing emergency services providers; and a consumer representative with lived experience boarding in an emergency department.

(c) Annually, not later than December 31, the advisory council shall file a report with the secretary of health and human services, the joint committee on mental health, substance use and recovery and the joint committee on health care financing. The report shall: (i) summarize the data collected on the number of patients boarding in emergency departments identified by age, gender identity, race, ethnicity, insurance status, diagnosis and reason for the delay in admission; and (ii) include recommendations for reducing boarding in emergency departments and any suggested legislative or regulatory action to implement those recommendations, which shall include, but not be limited to, requirements for the delivery system to operate on a 24 hours a day, 7 days a week basis for admissions and discharges and penalties for noncompliance.

(d) Notwithstanding any general or special law to the contrary, the expedited psychiatric inpatient admissions protocol established by the department shall: (i) require, for patients under the age of 18, notification by the hospital emergency department to the department in order to expedite placement in or admission to an appropriate treatment program or facility within 48 hours of boarding or within 48 hours of being assessed to need acute psychiatric treatment and having been determined by a licensed health care provider to be medically stable without the need for urgent medical assessment or hospitalization for a physical health condition; (ii) include, within the escalation protocol, patients who initially had a primary medical diagnosis or

primary presenting problem requiring treatment on a medical-surgical floor, who have been subsequently medically cleared and are boarding on a medical-surgical floor for an inpatient psychiatric placement; and (iii) include, for patients under the age of 18, notification upon discharge from the emergency department, satellite emergency facility or medical-surgical floor to the patient's primary care physician or treating behavioral health clinician, if known.

SECTION 19. Chapter 26 of the General Laws is hereby amended by striking out section 8K, as appearing in the 2020 Official Edition, 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, sections 511 and 512 of Public Law 110–343, as amended, 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 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 said chapters 175, 176A, 176B or 176G or any carrier offering a student health plan issued under section 18 of chapter 15A by:

(i) evaluating and resolving all consumer complaints alleging a carrier's non-compliance with state or federal laws related to mental health and substance use disorder parity as described in subsection (f);

(ii) performing behavioral health parity compliance market conduct examinations of each carrier not less than once every 5 years, or more frequently if noncompliance is suspected, 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, sections 511 and 512 of Public Law 110–343, as amended, 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 of insurance, including factors identified through consumer or provider complaints; provided, however, that: (1) a market conduct examination of a carrier subject to said chapter 175, 176A, 176B or 176G 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 this clause 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, publish 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 that 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 2008, sections 511 and 512 of Public Law 110–343, as amended, that 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 standards 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 commissioner 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 the mental health parity provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343, 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 violation relates; provided, however, that the maximum annual penalty under this subsection shall be $1,000,000; provided further, that for purposes of this subsection, the term "noncompliance period" shall mean the period beginning on the date a violation first occurs and ending on the date the violation is corrected.

A penalty shall only be imposed for a violation if: (i) the commissioner determines that the violation was due to willful neglect; or (ii) if the violation is not corrected within 30 days after the start of the noncompliance period.

(c) If a violation of state laws related to mental health and substance use disorder parity or the mental health parity provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended, and federal guidance or regulations issued under the act, was likely to have caused denial of access to behavioral health services, the commissioner shall require the carrier to provide remedies for any failure to meet the requirements of state laws related to mental health and substance use disorder parity or the mental health parity provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended, and federal guidance or regulations issued under the act, which may include, but shall not be 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; or

(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 a public record 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) The commissioner shall consult with the office of patient protection in connection with any behavioral health parity compliance market conduct examination conducted and completed under clause (ii) of subsection (a).

(f) The commissioner shall evaluate and resolve a consumer complaint alleging a carrier's non-compliance with a state or federal law related to mental health and substance use disorder parity, including any matters referred to the commissioner by the office of patient protection under subsection (g) of section 14 of chapter 176O. A consumer complaint may be submitted orally or in writing and shall include, but not be limited to, the complainant's name and address, the nature of the complaint and the complainant's signature authorizing the release of any information regarding the complaint to help the commissioner with the review of the complaint; provided, however, that an oral complaint shall be followed by a written submission;

and provided further, that the commissioner shall create a process for a consumer to request the appointment of an authorized representative to act on the consumer's behalf.

The commissioner shall review consumer complaints under this subsection using the legal standards pertaining to quantitative treatment limitations and non-quantitative treatment limitations under applicable state and federal mental health and substance use disorder parity laws, regulations and guidance, including, but not limited to, 45 CFR Part 146.136 and 29 CFR Part 2590.712. When reviewing the complaint, the commissioner shall consider: (i) any related right to a treatment or service under any related state or federal law or regulation; (ii) written documents submitted by the complainant; (iii) medical records and medical opinions by the complainant's treating provider that requested or provided a disputed service, which shall be obtained by the complainant's carrier or by the commissioner if the carrier fails to do so; (iv) the relevant results of any behavioral health parity compliance market conduct examination conducted and completed under clause (ii) of subsection (a); (v) any relevant information included in a carrier's annual reporting requirements under section 8M; (vi) additional information from the involved parties or outside sources that the commissioner deems necessary or relevant; and (vii) information obtained from any informal meeting held by the commissioner with the parties. The commissioner shall send final written disposition of the complaint and the reasons for the commissioner's decision to the complainant and the carrier not more than 90 days after the receipt of the written complaint. If the commissioner determines that a violation of a state or federal mental health and substance use disorder parity law occurred, the commissioner shall exercise its enforcement authority pursuant to subsections (b) and (c).

The commissioner shall respond as soon as practicable to all questions or concerns from consumers about carrier compliance with state or federal laws related to mental health and

substance use disorder parity that are referred to the commissioner from the office of patient protection under subsection (g) of section 14 of chapter 176O.

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

(h) Nothing in this section shall prevent the commissioner from publishing any illustrative utilization review criteria, medical necessity standard, clinical guideline or other policy, procedure, criteria or standard, regardless of its origin, as an example of the type of policy, procedure, criteria or standard that contributes to a violation of state or federal law parity requirements, including any document that would normally be subject to disclosure to plan members or their providers under section 16 of chapter 6D, section 16 of chapter 176O or the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended.

SECTION 20. Said chapter 26 is hereby further amended by adding the following section:-

Section 8M. (a)(1) All carriers licensed under chapters 175, 176A, 176B and 176G that provide mental health or substance use disorder benefits, and the group insurance commission established in chapter 32A, or the carriers the group insurance commission contracts with for the administration of any self-insured plans, shall submit an annual report not later than January 31 to the commissioner of insurance, a summary of which shall be sent to the clerks of the house of representatives and the senate annually not later than June 30 by the division of insurance.

(2) The report shall contain the following information:

(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); and that the processes, strategies or methodologies for developing and applying the carrier's reimbursement rates for mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes, strategies or methodologies for developing and applying the carrier's reimbursement rates for medical and surgical 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 applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation for medical and surgical benefits within the corresponding classification of benefits.

(3) The results of the analysis in clause (iii) of paragraph (2) shall, at a minimum:

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

(ii) identify any processes, strategies or evidentiary standards used to define the factors identified in clause (i);

(iii) 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 applied no 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 for medical and surgical benefits;

(iv) 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 applied no more stringently than, the processes or strategies used to apply each non-quantitative treatment limitation, in operation, for medical and surgical benefits; and

(v) disclose the findings and conclusions reached by the carrier or the group insurance commission that the results of the analyses in this paragraph 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, sections 511 and 512 of Public Law 110–343, as amended, and its implementing and related regulations, including, but not limited to, 45 CFR Part 146.136, 45 CFR Part 147.160, and 45 CFR Part 156.115(a)(3).

(4) In completing the analyses required in clause (iii) of paragraph (2), carriers shall not be required to examine each medical or surgical benefit subject to a non-quantitative treatment limitation that also applies to mental health and substance use disorder benefits in the classification and shall perform the required analyses broadly across each classification of benefits. Carriers may use any reasonable method to determine the method of selecting medical and surgical benefits subject to a non-quantitative treatment limitation in the classification for the purpose of performing the comparative analyses; provided, that it shall not be considered reasonable to select only certain medical and surgical benefits with the same characteristics as the mental health and substance use disorder benefits subject to the non-quantitative treatment limitation, and not 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 for the purposes of performing the analyses.

(b) Annually, not later than June 30, the commissioner shall issue to the clerks of the house of representatives and the senate and the joint committee on mental health substance use and recovery a summary of the reports that the commissioner receives from all carriers under this section. The summary report shall be written in nontechnical, readily understandable language and made available to the public by posting the report on the division's website, and shall include the following information:

(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, sections 511 and 512 of Public Law 110–343, 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 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and section 4M of chapter 176G;

(iii) a report of each market conduct examinations conducted or completed during the preceding 12-month period regarding compliance with parity in mental health and substance use disorder benefits under state and federal laws and a summary of the results of such market conduct examinations;

(iv) information on any educational or corrective actions the commissioner has taken to ensure health carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended, and 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; and

(v) to the extent that any requirements of this section are inconsistent with or in excess of the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended, and any amendments to, or regulations issued under that act, the requirements of federal law will prevail over the requirements of this section, in accordance with 42 U.S.C. 300gg-23(a)(1). 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, is released that indicates a non-quantitative treatment limitation analysis and reporting process that is significantly different than, contrary to, or more efficient than the non-quantitative treatment limitation analysis and reporting requirements described in clause (iii) of paragraph (2) of

subsection (a), the commissioner 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 clause (iii).

(c) Any proprietary portions of information submitted to the commissioner by a carrier as a result of the requirements in this section shall not be a public record.

SECTION 21. Chapter 29 of the General Laws is hereby amended by inserting after section 2SSSSS the following section:-

Section 2TTTTT. (a) There shall be an interagency services reserve fund established on the books of the commonwealth to be expended without prior appropriation. The fund shall be credited with money from public and private sources, including gifts, grants and donations, interest earned on such money, any other money authorized by the general court and specifically designated to be credited to the fund and any funds provided from other sources. Money in the fund shall be used to fund the operations of the interagency review team established under section 16R of chapter 6A. The secretary of health and human services shall administer the fund and shall make expenditures for the purpose of covering the cost of providing additional evaluation as needed by the interagency review team for an individual eligible under said section 16R of said chapter 6A. Any unexpended balance in the fund at the end of a fiscal year shall not revert to the General Fund and shall be available for expenditure in the subsequent fiscal year.

(b) Annually, not later than August 1, the interagency review team shall submit required financial reporting on the fund, including reporting of expenditures from the fund, to the

secretary of health and human services, the secretary of education and the house and senate committees on ways and means.

SECTION 22. Chapter 32A of the General Laws is hereby amended by inserting after section 17R the following section:-

Section 17S. (a) As used in this section, the following terms shall, unless the context clearly requires otherwise, have the following meanings:

"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 environment.

(b) 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.

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

SECTION 23. Said chapter 32A is hereby further amended by inserting after section 22 the following section:-

Section 22A. (a) For the purposes of this section, "psychiatric collaborative care model" shall mean the evidence-based, integrated behavioral health service delivery method in which a primary care team consisting of a primary care provider and a care manager provides structured care management to a patient, and that works in collaboration with a psychiatric consultant that provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations.

(b) The commission shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage for mental health or substance use disorder services that are delivered through the psychiatric collaborative care model.

SECTION 24. Said chapter 32A is hereby further amended by adding the following 2 sections:-

Section 31. 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 services programs, as defined in section 1 of chapter 175.

Section 32. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Licensed mental health professional", a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the lawful scope of practice for such therapist.

"Mental health wellness examination", a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. The examination may include: (i) observation, a behavioral health screening, education and consultation on healthy lifestyle changes, referrals to ongoing treatment, mental health services and other necessary supports and discussion of potential options for medication; and (ii) age-appropriate screenings or observations to understand a covered person's mental health history, personal history and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews and questions.

"Primary care provider", a health care professional qualified to provide general medical care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii) maintains continuity of care within the scope of practice.

(b) Any coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission shall provide coverage for an

annual mental health wellness examination that is performed by a licensed mental health professional or primary care provider, which may be provided by the primary care provider as part of an annual preventive visit.

SECTION 25. Chapter 69 of the General Laws is hereby amended by striking out section 8A, as appearing in the 2020 Official Edition, and inserting in place thereof the following section:-

Section 8A. (a) Each school committee and commonwealth charter school board of trustees shall ensure that every school under its jurisdiction has a written medical and behavioral health emergency response plan to reduce the incidence of life-threatening emergencies and behavioral health crises and to promote efficient and appropriate responses to such emergencies. The plan shall be in addition to the multi-hazard evacuation plan required under section 363 of chapter 159 of the acts of 2000.

(b) Each plan shall include:

(1) a method for establishing a rapid communication system linking all parts of the school campus, including outdoor facilities and practice fields, to the emergency medical and mobile behavioral health crisis response services and protocols to clarify when the emergency medical services and mobile behavioral health mobile crisis response services and other emergency contact people shall be called;

(2) a determination of emergency medical service and behavioral health mobile crisis response time to any location on the school campus;

(3) a list of relevant contacts and telephone numbers with a protocol indicating when each person shall be called, including names of professionals to help with post-emergency support;

(4) a method to efficiently direct emergency medical services and behavioral health mobile crisis personnel to any location on campus, including to the location of available rescue equipment;

(5) protocols for informing parents and guardians and reporting to the department when police, emergency medical technicians or other non-behavioral health personnel are contacted to respond to a behavioral health crisis;

(6) safety precautions to prevent injuries in classrooms and facilities;

(7) a method of providing access to training in cardiopulmonary resuscitation and first aid for teachers, athletic coaches, trainers and other school staff, which may include training high school students in cardiopulmonary resuscitation; and

(8) the location of any automated external defibrillator device the school possesses, whether its location is fixed or portable and those personnel who are trained in its use.

(c) Plans shall be developed in consultation with the school principal, school nurse, school mental health counselor or social worker, school athletic director, team physicians, coaches, trainers and local police, fire, behavioral health mobile crisis team and emergency personnel, as appropriate. Schools shall practice the response sequence at the beginning of each school year and periodically throughout the year and evaluate and modify the plan as necessary. School officials shall review the response sequence with local fire and police officials at least 1 time each year and shall conduct periodic walk-throughs of school campuses. Plans shall be

submitted once every 3 years to the department, the local police department and the local fire department on or before September 1 of the third year. Plans shall be updated in the event of new construction or physical changes to the school campus as determined by the local police or fire department.

(d) Included in each initial and subsequent filing of a medical and behavioral health emergency response plan, each school district shall report on the availability of automated external defibrillators in each school within the district, including the total amount available in each school, the location of each within the school, whether the device is in a fixed location or is portable, those personnel or volunteers who are trained in its use, those personnel with access to the device during and after regular school hours and the total estimated amount of automated external defibrillators necessary to ensure campus-wide access during school hours, after-school activities and public events.

(e) The department, in consultation with the department of public health and the department of mental health, shall develop a cost-neutral model medical and behavioral health emergency response plan in order to promote best practices, including clear guidelines for the roles and responsibilities of behavioral health professionals, including, but not limited to, school counselors and community intervention professionals and, where applicable, school resource officers or police officers on school campuses; provided, that such model plan shall be designed to limit referrals to law enforcement or arrests on school property to cases in which an imminent risk to the health and safety of individuals on school property necessitates such referral or arrest. The model plan shall be made available to school committees and commonwealth charter school boards. In developing the model plan, the department shall refer to research prepared by the American Heart Association, Inc., the American Academy of Pediatrics, MassHealth and other

relevant organizations that identify the essential components of a medical and behavioral health emergency response plan. The department shall biennially review and update the model plan and publicly post the model plan on its website.

SECTION 26. Section 37Q of chapter 71 of the General Laws, as so appearing, is hereby amended by inserting after the word “school”, in line 22, the first time it appears, the following words:- ; provided, that the medical and behavioral health emergency response plans submitted pursuant to section 8A of chapter 69 shall satisfy the requirement for emergency and acute treatment planning required by this section.

SECTION 27. Chapter 75 of the General Laws is hereby amended by inserting after section 36D, as so appearing, the following new section:-

Section 36E. (a) The University of Massachusetts medical school in Worcester shall develop a continuing education program for licensed mental health professionals on military service-related behavioral health conditions.

(b) The training and curriculum for the program shall include, but not be limited to: (i) military culture and its influence on the behavioral health of service members and veterans; (ii) symptoms of deployment-related and non-deployment-related behavioral health conditions, including, but not limited to, depression, suicide, insomnia, substance use and post-traumatic stress disorder; (iii) deployment cycle stressors for students who are service members and veterans; (iv) deployment cycle stressors that impact the behavioral health of service members and veterans; (v) outreach strategies for available administrative, non-clinical and clinical services; and (vi) available resources and methods of referral for the treatment of deployment-related behavioral health conditions, including peer support.

(c) In developing the curriculum for the program, the University of Massachusetts medical school shall consult with relevant stakeholders, including, but not limited to: (i) medical professional associations; (ii) peers and other service members and veterans who have lived experience of seeking or receiving behavioral health services or treatment; and (iii) behavioral health professionals with expertise in providing culturally-competent care.

SECTION 28. Chapter 111 of the General Laws 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, licensed mental health professionals during all operating hours of an emergency department or a satellite emergency facility as defined in section 51½ to evaluate and stabilize a person admitted with a mental health presentation to the emergency department or satellite emergency facility and to refer such person for appropriate treatment or inpatient admission. The regulations shall define “licensed mental health professional”, which shall include, but not be limited to, a: (i) licensed physician who specializes in the practice of psychiatry; (ii) licensed psychologist; (iii) licensed independent clinical social worker; (iv) licensed certified social worker; (v) licensed mental health counselor; (vi) licensed physician assistant who practices in the field of psychiatry (vii) licensed psychiatric clinical nurse specialist; or (viii) healthcare provider, as defined in section 1, qualified within the scope of the individual’s license to conduct an evaluation of a mental health condition, including an intern, resident or fellow pursuant to the policies and practices of the hospital and medical staff.

The regulations shall permit evaluation via telemedicine, electronic or telephonic consultation, as deemed appropriate by the department.

The regulations shall be promulgated after consultation with the department of mental health and the division of medical assistance and shall include, but not be limited to, requirements that individuals under the age of 22 receive an expedited evaluation and stabilization process.

SECTION 29. Said chapter 111 is hereby further amended by inserting after section 51K the following section:-

Section 51L. (a) For the purposes of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Acute-care hospital", any hospital licensed pursuant to section 51G that contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department and the teaching hospital of the University of Massachusetts medical school.

"Satellite emergency facility", a health care facility that operates 7 days per week, 24 hours per day that is located off the premises of a hospital but is listed on the license of a hospital and is authorized to accept patients transported to the facility by ambulance.

(b) An acute-care hospital or a satellite emergency facility shall ensure that all policies and protocols developed by the acute-care hospital or satellite emergency facility shall be applied and implemented on a nondiscriminatory basis such that such policies and protocols shall not discriminate between patients presenting with a mental health or substance use condition and patients presenting with a medical or surgical condition.

(c) An acute-care hospital or a satellite emergency facility shall annually review its policies and procedures to ensure that such policies and procedures do not discriminate between patients presenting with a mental health or substance use condition and patients presenting with a medical or surgical condition and are applied and implemented on a nondiscriminatory basis. Following the review, the acute-care hospital or the satellite emergency facility shall submit a certification to the department and the department of mental health, signed by the acute-care hospital's or the satellite emergency facility's chief executive officer and chief medical officer, that states that the acute-care hospital or the satellite emergency facility has completed a comprehensive review of the policies and procedures of the acute-care hospital or the satellite emergency facility for the preceding calendar year for compliance with this section and any accompanying regulations.

(d) As part of the review pursuant to subsection (c), an acute-care hospital or a satellite emergency facility shall review its policies and procedures in the following areas:

(1) administrative policies and procedures, which may include, but shall not be limited to, acquiring and maintaining equipment, policies on vendor requirements, licensing and credentials, and records requirements;

(2) operational policies and procedures, which may include, but shall not be limited to, information technology, physical maintenance, safety and security, food preparation, emergency management and disaster plans;

(3) patient care policies and procedures, which may include, but shall not be limited to, patient admission and discharge policies and decision-making, patient flow policies, patient

discharge planning, consultation, clinical competencies, charting processes and patient rights, patient and staff security and infection prevention;

(4) medication policies and procedures, which may include, but shall not be limited to, paperwork requirements for medicine, inventory control, dose distribution systems and disposing of expired drugs;

(5) human resources and staffing policies and procedures, which may include, but shall not be limited to, staff hiring decisions, training, patient care ratios, scheduling and staffing for emergency management and disaster plans; and

(6) payment and financial policies and procedures, which may include, but shall not be limited to, investment and resource allocation, billing and payment policies and staff salaries and reimbursement.

(e) The department, in consultation with the department of mental health, shall promulgate regulations necessary to carry out this section, including the development of reporting procedures and a standard format for facility self-reporting and annual compliance certification.

SECTION 30. Said chapter 111 is hereby further amended by adding the following section:-

Section 244. The department shall administer an initiative to increase public awareness of and education on the availability of the extreme risk protection order process established pursuant to sections 131R to 131Y, inclusive, of chapter 140, to remove a firearm from the control, ownership or possession of an individual who poses a risk of causing bodily injury to

themself or others. The initiative shall focus on the heighted risk of suicide associated with the possession of a firearm and shall include information on: (i) eligibility to petition for an extreme risk protection order; (ii) the procedure to petition for an extreme risk protection order; (iii) options to voluntarily surrender a firearm to a law enforcement agency; and (iv) the availability of existing legal resources and support services for a potential petitioner.

SECTION 31. Chapter 118E of the General Laws is hereby amended by inserting after section 10N the following 3 sections:-

Section 10O. As used in this section, the following terms shall, unless the context clearly requires otherwise, have the following meanings:

"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 environment.

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 10P. (a) For the purposes of this section, "psychiatric collaborative care model" shall mean the evidence-based, integrated behavioral health service delivery method in which a primary care team consisting of a primary care provider and a care manager provides structured care management to a patient, and that works in collaboration with a psychiatric consultant that provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations.

(b) 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 provide coverage for mental health or substance use disorder services that are delivered through the psychiatric collaborative care model.

Section 10Q. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Licensed mental health professional", a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor

I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the lawful scope of practice for such therapist.

"Mental health wellness examination", a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. The examination may include: (i) observation, a behavioral health screening, education and consultation on healthy lifestyle changes, referrals to ongoing treatment, mental health services and other necessary supports and discussion of potential options for medication; and (ii) age-appropriate screenings or observations to understand a covered person's mental health history, personal history and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews and questions.

"Primary care provider", a health care professional qualified to provide general medical care for common health care problems who: (i) supervises, coordinates, prescribes or otherwise provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii) maintains continuity of care within the scope of practice.

(b) 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 provide coverage for an annual mental health wellness examination that is performed by a licensed mental health professional or primary care provider, which may be provided by the primary care provider as part of an annual preventive visit.

SECTION 32. Said chapter 118E is hereby further amended by inserting after section 13D the following section:-

Section 13D½. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Behavioral health services", the evaluation, diagnosis, treatment, care coordination, management or peer support of a patient with a mental health, developmental or substance use disorder.

"Community mental health center", clinic which provides comprehensive ambulatory mental health services and which is not financially or physically an integral part of a hospital.

"Division", the division of medical assistance.

"Managed care entity", health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract with a Medicaid managed care organization or primary care clinician plan; provided, however, that "managed care entity" shall also include accountable care organizations.

"Minimum payment rates", rates of payment for services below which managed care entities shall not enter into provider agreements.

(b) Annually, not later than January 1, the division shall review the minimum payment rates to be paid to providers of behavioral health services delivered in community mental health centers by managed care entities and submit a report to the house and senate committees on ways and means, the joint committee on health care financing and the joint committee on mental health, substance use and recovery identifying the difference between the minimum payment rates decided by the division and the payment rates that managed care entities contractually agree to pay providers for all behavioral health services delivered in community mental health centers.

SECTION 33. Section 16C of said chapter 118E, as appearing in the 2020 Official Edition, is hereby amended by inserting after paragraph (5) the following 2 paragraphs:-

(6) The division shall submit an annual report not later than January 31 to the attorney general, a summary of which shall be sent to the clerks of the house of representatives and the senate not later than June 30 each year, that contains the following information regarding compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended, by the child health insurance program:

(a) 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;

(b) 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)(4)(ii); and that the processes, strategies or methodologies for developing and applying the reimbursement rates for mental health and substance use disorder benefits are comparable to and applied no more stringently than those processes, strategies or methodologies for developing and applying the reimbursement rates for medical and surgical benefits; and

(c) the results of an analysis that demonstrates that for the medical necessity criteria described in clause (a) and for each non-quantitative treatment limitation identified in clause (b), 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 applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the comparable medical necessity criteria and non-quantitative treatment limitation for medical and surgical benefits within the corresponding classification of benefits; provided that, at a minimum, the results of the analysis shall:

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

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

(iii) provide the comparative analyses, including the results of the analyses subject to paragraph (f) of clause (7), 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 applied no 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;

(iv) provide the comparative analyses, including the results of the analyses subject to paragraph (f) of clause (7), 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, including provider reimbursement rates, are comparable to, and applied no more stringently than, the processes or strategies used to apply each non-quantitative treatment

limitation, in operation, for medical and surgical benefits, including provider reimbursement rates;

(v) subject to paragraph (f) of clause (7), disclose the findings and conclusions reached by the division that the results of the analyses above indicate that the child health insurance program is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related regulations, including but not limited to 42 CFR Part 457.496; and

(d) In completing the analyses required under this paragraph, the division or any Medicaid managed care organization that contracts with the division shall not have to examine each medical or surgical benefit subject to a non-quantitative treatment limitation that also applies to mental health and substance use disorder benefits in the classification and shall perform the required analyses broadly across each classification of benefits. The division or any Medicaid managed care organization that contracts with the division may use any reasonable method to determine how they will select medical and surgical benefits subject to a non-quantitative treatment limitation in the classification for the purpose of performing the comparative analyses, provided that selecting only certain medical and surgical benefits with the same characteristics as the mental health and substance use disorder benefits subject to the non-quantitative treatment limitation, and not 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 for the purposes of performing the analyses shall not be considered reasonable.

(7) The division shall issue a report to the clerks of the house of representatives and the senate and the joint committee on mental health, substance use and recovery, which shall:

(a) include the methodology the division uses to ensure compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and any federal regulations or guidance relating to the compliance and oversight of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008;

(b) identify any action taken by the division during the preceding 12-month period regarding compliance with parity in mental health and substance use disorder benefits under state and federal laws and summarize the results of such action;

(c) detail any educational or corrective actions the division has taken to ensure Medicaid managed care compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; and

(d) be written in non-technical, readily understandable language. Medicaid managed care organizations shall make a summary report, as approved by the division, available to the public by, posting the report on the division's website.

(e) To the extent that any requirements of this section are inconsistent with or in excess of the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and any amendments to, or regulations issued under that act, the requirements of federal law will prevail over the requirements of this section. 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, is released that indicates a non-quantitative treatment limitation analysis and reporting process that is significantly different

than, contrary to, or more efficient than the non-quantitative treatment limitation analysis and reporting requirements described in paragraph (6), 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 paragraph (6).

(f) Any proprietary portions of information submitted to the division by a Medicaid managed care organization as a result of the requirements in this section shall not be made public record.

SECTION 34. Section 47 of said chapter 118E, as so appearing, is hereby amended by inserting after the first paragraph the following paragraph:-

Notwithstanding any general or special law to the contrary, the division shall promulgate regulations that require the division, its contracted 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 maintain documentation of all requests for benefits or services, whether the request is submitted by, or on behalf of, the intended recipient of those benefits or services. Any request that is not fulfilled in full shall be considered a denial and shall result in the prompt written notification to the intended recipient through electronic means, if possible. The notification shall include a description of the requested service, the response by the entity and the intended recipient’s due process and appeal rights. All such entities shall accept requests for authorized representatives or for appeals by electronic means.

SECTION 35. Said chapter 118E is hereby further amended by adding the following 2 sections:-

Section 80. Each Medicaid managed care organization or alternative benefit plan shall submit an annual report not later than January 31 to the division, a copy of which shall be sent to the clerks of the house of representatives and the senate not later than June 30 each year by the division, that contains the following information:

(a) 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;

(b) 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 438.910(d)(1) and 42 CFR Part 440.395(b)(4)(i); provided further, that the processes, strategies or methodologies for developing and applying the reimbursement rates for mental health and substance use disorder benefits are comparable to and applied no more stringently than those processes, strategies or methodologies for developing and applying the reimbursement rates for medical and surgical benefits; and

(c) the results of an analysis that demonstrates that for the medical necessity criteria described in subsection (a) and for each non-quantitative treatment limitation identified in subsection (b), 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 applied no 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:

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

(2) identify any processes, strategies or evidentiary standards used to define the factors identified in paragraph (1);

(3) provide the comparative analyses, including the results of the analyses, subject to paragraph (7), 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 applied no 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;

(4) provide the comparative analyses, including the results of the analyses, subject to paragraph (7), 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, including provider reimbursement rates, are comparable to, and applied no more stringently than, the processes or strategies used to apply each non-quantitative treatment limitation, in operation, for medical and surgical benefits, including provider reimbursement rates; and

(5) subject to paragraph (7), disclose the findings and conclusions reached by the Medicaid managed care organization or alternative benefit plan that the results of the analyses above indicate that the Medicaid managed care organization or alternative benefit plan is in compliance with this section and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended, and its implementing and related regulations, including, but not limited, to 42 CFR Part 438.910 and 42 CFR Part 440.395.

(6) In completing the analyses required under this subsection, a Medicaid managed care organization does not have to examine each medical or surgical benefit subject to a non-quantitative treatment limitation that also applies to mental health and substance use disorder benefits in the classification and is expected to perform the required analyses broadly across each classification of benefits. A Medicaid managed care organization may use any reasonable method to determine how it will select medical and surgical benefits subject to a non-quantitative treatment limitation in the classification for the purpose of performing the comparative analyses, provided that selecting only certain medical and surgical benefits with the same characteristics as the mental health and substance use disorder benefits subject to the non-quantitative treatment limitation, and not 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 for the purposes of performing the analyses shall not be considered reasonable.

(7) Any proprietary portions of information submitted to the division by a Medicaid managed care organization as a result of the requirements in this section shall not be made public record.

Section 81. (a) The division shall develop a streamlined process to enhance the current community-based behavioral health screening process and direct Medicaid contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization or the Medicaid primary care clinician plans to allow admission to inpatient behavioral health services from a community-based setting where a patient under the age of 22 is presenting with a behavioral health condition that requires such admission but does not require a medical screening examination in an emergency department. Said process shall be developed after consultation with relevant stakeholders and community members.

(b) Annually, not later than April 1, the division shall file a report on the progress of the streamlined process, results and any legislative recommendations with the house and senate clerks, the joint committee on mental health, substance use and recovery, the joint committee on public health, the joint committee on health care financing, the joint committee on children, families and persons with disabilities and the house and senate committees on ways and means.

SECTION 36. Section 32 of chapter 119 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-

The department shall ensure that every child, upon entry into the foster care system, shall be screened and evaluated under the early and periodic screening, diagnostic and treatment standards established by Title XIX of the Social Security Act and assessed for behavioral health symptoms and sequelae, including those related to the precipitating factors of their entry into care, unless the child has been screened and evaluated within 30 days prior to the child’s entry

into the system; provided, however, that each child with identified behavioral health needs shall be provided appropriate referrals to related professionals to conduct more comprehensive diagnostic assessment, prescribe treatment and ensure the behavioral health and trauma-related needs of such child are addressed in a timely manner.

SECTION 37. Section 18 of chapter 123 of the General Laws, as so appearing, is hereby amended by striking out, in lines 27 to 34, inclusive, the words "; provided, however, that, notwithstanding the court's failure, after an initial hearing or after any subsequent hearing, to make a finding required for commitment to the Bridgewater state hospital, the prisoner shall be confined at said hospital if the findings required for commitment to a facility are made and if the commissioner of correction certifies to the court that confinement of the prisoner at said hospital is necessary to insure his continued retention in custody".

SECTION 38. Said section 18 of said chapter 123, as so appearing, is hereby further amended by inserting after subsection (a) the following subsection:-

(a½)(1) For purposes of this subsection, "mental health watch" shall mean a status intended to protect a prisoner from a risk of imminent and serious self-harm.

(2) A prisoner or a prisoner's legal representative, or a mental health staff person at the request of a prisoner, may petition the district court with jurisdiction over the prisoner's place of detention or, if the prisoner is awaiting trial to the court with jurisdiction of the criminal case, to be transferred to a suitable inpatient psychiatric facility or unit licensed or operated by the department of mental health or to Bridgewater state hospital. The court may order the prisoner's requested transfer if the prisoner: (i) has been on mental health watch for at least 72 hours; or (ii) is at serious risk of imminent and serious self-harm. A transfer under this subsection to

Bridgewater state hospital shall only be ordered if: (i) the prisoner is male and no bed is available in a timely manner at a unit licensed or operated by the department of mental health; or (ii)(A) the prisoner is not a proper person for commitment to an inpatient psychiatric facility or unit licensed or operated by the department of mental health; and (B) the failure to retain the prisoner in strict custody would create a likelihood of serious harm. When a prisoner has been on mental health watch for 72 hours, and once every 24 hours thereafter that the prisoner remains on mental health watch, a member of the mental health staff of the place of detention shall advise the prisoner of the prisoner's right to petition under this subsection and advise the prisoner that staff at the place of detention may also, at the prisoner's request, petition on the prisoner's behalf. If the prisoner requests, either orally or in writing, that staff at the place of detention petition under this subsection, an employee, representative, agent or other designee of the place of detention shall file a petition with the appropriate court within 24 hours. The court may order periodic reviews of transfers under this subsection.

SECTION 39. Section 1 of chapter 175 of the General Laws, as so appearing, 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: (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 40. Said chapter 175 is hereby further amended by inserting after section 47PP the following 4 sections:-

Section 47QQ. (a) For the purposes of this section, "psychiatric collaborative care model" shall mean the evidence-based, integrated behavioral health service delivery method in which a primary care team consisting of a primary care provider and a care manager provides structured care management to a patient, and that works in collaboration with a psychiatric consultant that provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations.

(b) An individual policy of accident and sickness insurance issued pursuant to section 108 that provides hospital expense and surgical expense insurance or a group blanket or general policy of accident and sickness insurance issued pursuant to section 110 that provides hospital expense and surgical expense insurance that is issued or renewed within or without the commonwealth shall provide coverage for mental health or substance use disorder services that are delivered through the psychiatric collaborative care model.

Section 47RR. An individual policy of accident and sickness insurance issued under section 108 that provides hospital expense and surgical expense insurance or a 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 within or without the commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary emergency services programs.

Section 47SS. (a) As used in this section, the following terms shall, unless the context clearly requires otherwise, have the following meanings:

"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 environment.

(b) A policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within or without 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 47TT. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Licensed mental health professional," a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed

physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J or a licensed marriage and family therapist within the lawful scope of practice for such therapist.

"Mental health wellness examination," a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. The examination may include: (i) observation, a behavioral health screening, education and consultation on healthy lifestyle changes, referrals to ongoing treatment, mental health services and other necessary supports and discussion of potential options for medication; and (ii) age-appropriate screenings or observations to understand a covered person's mental health history, personal history and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews and questions.

"Primary care provider", a health care professional qualified to provide general medical care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii) maintains continuity of care within the scope of practice.

(b) The following shall provide coverage for an annual mental health wellness examination that is performed by a licensed mental health professional or primary care provider, which may be provided by the primary care provider as part of an annual preventive visit: (i) any policy of accident and sickness insurance, as described in section 108, that provides hospital expense and surgical expense insurance and is delivered, issued or subsequently renewed by agreement between the insurer and policyholder in the commonwealth; (ii) any blanket or general policy of insurance described in subdivision (A), (C) or (D) of section 110 that provides

hospital expense and surgical expense insurance and is delivered, issued or subsequently renewed by agreement between the insurer and the policyholder in or outside of the commonwealth; and (iii) any employees' health and welfare fund that provides hospital expense and surgical expense benefits and is delivered, issued to or renewed for any person or group of persons in the commonwealth.

(c) The division of insurance, in consultation with the office of Medicaid, and the department of mental health, shall develop guidelines to implement this section.

SECTION 41. Section 110 of said chapter 175, as appearing in the 2020 Official Edition, is hereby amended by inserting after the word "age", in line 463, the following words:- or without regard to age, so long as the dependent, who is covered under the membership of their parent as a member of a family group, is mentally or physically incapable of earning their own living due to disability.

SECTION 42. Chapter 176A of the General Laws is hereby amended by inserting after section 8QQ the following 4 sections:-

Section 8RR. (a) For the purposes of this section, "psychiatric collaborative care model" shall mean the evidence-based, integrated behavioral health service delivery method in which a primary care team consisting of a primary care provider and a care manager provides structured care management to a patient, and that works in collaboration with a psychiatric consultant that provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations.

(b) A contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within or without the commonwealth

shall provide coverage for mental health or substance use disorder services that are delivered through the psychiatric collaborative care model.

Section 8SS. (a) As used in this section, the following terms shall, unless the context clearly requires otherwise, have the following meanings:

"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 environment.

(b) A 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 the administration of any such treatment; provided, however, that the facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of admission.

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

Section 8UU. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Licensed mental health professional," a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the lawful scope of practice for such therapist.

"Mental health wellness examination," a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. The examination may include: (i) observation, a behavioral health screening, education and consultation on healthy lifestyle changes, referrals to ongoing treatment, mental health services and other necessary supports and discussion of potential options for medication; and (ii) age-appropriate screenings or observations to understand a covered person's mental health history, personal history and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews and questions.

"Primary care provider", a health care professional qualified to provide general medical care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise

provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii) maintains continuity of care within the scope of practice.

(b) A contract between a subscriber and the corporation under an individual or group hospital service plan which is delivered, issued or renewed within the commonwealth shall provide coverage for an annual mental health wellness examination that is performed by a licensed mental health professional or primary care provider, which may be provided by the primary care provider as part of an annual preventive visit.

(c) The division of insurance, in consultation with the office of Medicaid, and the department of mental health, shall develop guidelines to implement this section.

SECTION 43. Chapter 176B of the General Laws is hereby amended by inserting after section 4QQ the following 4 sections:-

Section 4RR. (a) For the purposes of this section, "psychiatric collaborative care model" shall mean the evidence-based, integrated behavioral health service delivery method in which a primary care team consisting of a primary care provider and a care manager provides structured care management to a patient, and that works in collaboration with a psychiatric consultant that provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations.

(b) A subscription certificate under an individual or group medical service agreement that is delivered, issued or renewed within or without the commonwealth shall provide coverage for mental health or substance use disorder services that are delivered through the psychiatric collaborative care model.

Section 4SS. As used in this section, the following terms shall, unless the context clearly requires otherwise, have the following meanings:

"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 environment.

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

Section 4UU. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Licensed mental health professional," a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the lawful scope of practice for such therapist.

"Mental health wellness examination," a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. The examination may include: (i) observation, a behavioral health screening, education and consultation on healthy lifestyle changes, referrals to ongoing treatment, mental health services and other necessary supports and discussion of potential options for medication; and (ii) age-appropriate screenings or observations to understand a covered person's mental health history, personal history and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews and questions.

"Primary care provider", a health care professional qualified to provide general medical care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii) maintains continuity of care within the scope of practice.

(b) A subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall provide coverage for an annual

mental health wellness examination that is performed by a licensed mental health professional or primary care provider, which may be provided by the primary care provider as part of an annual preventive visit.

(c) The division of insurance, in consultation with the office of Medicaid, and the department of mental health, shall develop guidelines to implement this section.

SECTION 44. Section 4T of chapter 176G of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after the word “age”, in line 6, the following words:- or without regard to age, so long as the dependent, who is covered under the membership of the dependent’s parent as a member of a family group, is mentally or physically incapable of earning their own living due to disability.

SECTION 45. Said chapter 176G is hereby further amended by inserting after section 4II the following 4 sections:-

Section 4JJ. (a) For the purposes of this section, “psychiatric collaborative care model” shall mean the evidence-based, integrated behavioral health service delivery method in which a primary care team consisting of a primary care provider and a care manager provides structured care management to a patient, and that works in collaboration with a psychiatric consultant that provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations.

(b) An individual or group health maintenance contract that is issued or renewed within or without the commonwealth shall provide coverage for mental health or substance use disorder services that are delivered through the psychiatric collaborative care model.

Section 4KK. (a) As used in this section, the following terms shall, unless the context clearly requires otherwise, have the following meanings,:

"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 environment.

(b) An individual or group health maintenance contract that is issued or renewed within or without 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.

Section 4LL. An individual or group health maintenance contract that is issued or renewed within or without the commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary emergency services programs, as defined in section 1 of chapter 175.

Section 4MM. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Licensed mental health professional," a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the lawful scope of practice for such therapist.

"Mental health wellness examination," a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. The examination may include: (i) observation, a behavioral health screening, education and consultation on healthy lifestyle changes, referrals to ongoing treatment, mental health services and other necessary supports and discussion of potential options for medication; and (ii) age-appropriate screenings or observations to understand a covered person's mental health history, personal history and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews and questions.

"Primary care provider", a health care professional qualified to provide general medical care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii) maintains continuity of care within the scope of practice.

(b) An individual or group health maintenance contract that is issued or renewed within or without the commonwealth shall provide coverage for an annual mental health wellness

examination that is performed by a licensed mental health professional or primary care provider, which may be provided by the primary care provider as part of an annual preventive visit.

(c) The division of insurance, in consultation with the office of Medicaid, and the department of mental health, shall develop guidelines to implement this section.

SECTION 46. Section 1 of chapter 176J of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after the word “age”, in line 86, the following words:- or without regard to age, so long as the dependent, who is covered under the membership of the dependent’s parent as a member of a family group is mentally or physically incapable of earning their own living due to disability.

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

Section 5D. (a) 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.

(b) 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.

(c) The division shall promulgate regulations to implement this section.

SECTION 48. Subsection (a) of section 13 of said chapter 176O, as so appearing, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence:-

A carrier or utilization review organization shall maintain a formal internal grievance process that is compliant with the Patient Protection and Affordable Care Act, Public Law 111–148, as amended, as well as with any rules, regulations or guidance applicable thereto, and such formal internal grievance process shall provide for adequate consideration and timely resolution of grievances, which shall include, but shall not be limited to: (i) a system for maintaining records of each grievance filed by an insured or on the insured's behalf, and responses thereto, for a period of 7 years, which records shall be subject to inspection by the commissioner; (ii) the provision of a clear, concise and complete description of the carrier's formal internal grievance process and the procedures for obtaining external review pursuant to section 14 with each notice of an adverse determination; (iii) the carrier's toll-free telephone number for assisting insureds in resolving such grievances and the consumer assistance toll-free telephone number maintained by the office of patient protection; (iv) a procedure to accept grievances by telephone, in person, by mail and by electronic means; (v) a process for an insured to request the appointment of an authorized representative to act on the insured's behalf; and (vi) a procedure to accept an insured's request for medical release forms by electronic means, which shall include delivery to a designated email address or access to an online consumer portal accessible by the insured, the

insured's family member or the insured's authorized representative who can provide the insured's membership identification number.

SECTION 49. Subsection (b) of said section 13 of said chapter 176O, as so appearing, is hereby amended by striking out the third sentence and inserting in place thereof the following sentence:- If the expedited review process affirms the denial of coverage or treatment, the carrier shall provide the insured, within 5 business days of the decision, including by any electronic means consented to by the insured: (1) a statement setting forth the specific medical and scientific reasons for denying coverage or treatment; (2) a description of alternative treatment, services or supplies covered or provided by the carrier, if any; (3) a description of the insured's rights to any further appeal; and (4) a description of the insured's right to request a conference.

SECTION 50. Subsection (c) of said section 13 of said chapter 176O, as so appearing, is hereby amended by adding the following sentence:- The external review of a grievance under section 14 shall be decided in favor of the insured unless the carrier provides substantial evidence, such as proof of delivery, that the carrier properly complied with the time limits required under this section.

SECTION 51. Subsection (a) of section 14 of said chapter 176O, as so appearing, is hereby amended by striking out the eighth sentence and inserting in place thereof the following sentence:- The panel shall consider, but shall not be limited to considering: (i) any related right to such treatment or service under any related state statute or regulation; (ii) written documents submitted by the insured; (iii) medical records and medical opinions regarding medical necessity by the insured's treating provider that requested or provided the disputed service, which shall be obtained by the carrier, or by the panel if the carrier fails to do so; (iv) additional information

from the involved parties or outside sources that the review panel deems necessary or relevant; and (v) information obtained from any informal meeting held by the panel with the parties.

SECTION 52. Subsection (b) of said section 14 of said chapter 176O, as so appearing, is hereby amended by striking out the second sentence and inserting in place thereof the following sentence:- An insured may apply to the external review panel to seek continued provision of health care services that are the subject of the grievance during the course of an expedited or non-expedited external review upon a showing of substantial harm to the insured's health absent such continuation or other good cause as determined by the panel; provided, however, that good cause shall include a pattern of denials that have been overturned by prior internal or external appeals.

SECTION 53. Subsection (c) of said section 14 of said chapter 176O, as so appearing, is hereby amended by adding the following sentence:- A carrier's failure to promptly comply with a decision of the review panel shall be an unfair and deceptive practice in violation of chapter 93A.

SECTION 54. Said section 14 of said chapter 176O, as so appearing, is hereby further amended by adding following subsection:-

(g) The office of patient protection shall monitor carrier denials and shall identify any trends regarding particular treatments or services or carrier practices and may refer such matters to the division of insurance, the group insurance commission or the office of the attorney general for review of compliance with state or federal laws related to mental health and substance use disorder parity, 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 said chapters 175, 176A, 176B or 176G, any carrier offering a student health plan issued under section 18 of chapter 15A or the group insurance commission, or the mental health parity provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended, and guidance or regulations issued under the act. The office of patient protection shall refer any questions or concerns from consumers about carrier compliance with state or federal laws related to mental health and substance use disorder parity to the division of insurance, the group insurance commission or the office of the attorney general.

SECTION 55. Subsection (b) of section 16 of said chapter 176O, as so appearing, 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 pursuant to chapter 26.

SECTION 56. Chapter 77 of the acts of 2022 is hereby amended by inserting after section 1 the following section:-

Section 1A. (a) For the purposes of this section, "integrated care" shall mean full collaboration in merged or transformed practices offering behavioral health and physical health services within the same shared practice space in the same facility, where the practice: (i)

provides services in a shared practice space that ensures services will be available and accessible promptly and in a manner which preserves human dignity and assures continuity of care; (ii) ensures communication among the integrated care team that is consistent and team-based; (iii) ensures shared decision-making between mental and behavioral health providers, primary care providers and other service providers involved in promoting the health and wellbeing of the client; (iv) provides evidence-based services in a mode of service delivery appropriate for the target population; (v) employs staff who are multidisciplinary and culturally-competent and linguistically-competent; (vi) provides integrated services related to screening, diagnosis and treatment of mental health and substance use conditions and co-occurring physical health conditions and chronic diseases; and (vii) provides targeted case management, including services to assist individuals gaining access to needed medical, social, educational and other services and applying for income security, housing, employment and other benefits to which the individual may be entitled.

(b) The commission established in section 1 shall develop and make recommendations to the general court for grant programs to be administered by the commissioner of public health, in consultation with the department of mental health, to enhance access to behavioral health services in the commonwealth and support a diverse behavioral health workforce. In developing its recommendations, the commission shall consider:

(1) a program to support the behavioral health needs of health care providers through grants to: (i) health care entities, including provider organizations, as defined in section 1 of chapter 6D of the General Laws, or (ii) professional associations to establish or enhance evidence-based or evidence-informed programs dedicated to improving the behavioral health, mental wellness and resiliency of health care professionals;

(2) a scholarship program to encourage a culturally, ethnically and linguistically diverse behavioral health workforce that helps students obtain academic credits toward a master's degree in the field of behavioral health with a preference for students who commit to serving high-need populations, including children, veterans, clients of the department of children and families, incarcerated or formerly incarcerated individuals, including justice-involved youth and emerging adults, individuals with post-traumatic stress disorder, aging adults, school-aged youth and individuals with a comorbidity, including substance use disorder; and

(3) a program to promote integrated care, through which the secretary of health and human services may award grants to, or enter into cooperative agreements with, health care facilities to support improvements to facilities to promote full collaboration between primary and behavioral health in an integrated care setting.

SECTION 57. 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, sexual orientation, gender identity, race, ethnicity, linguistic barriers, status as a client of the department of children and families, status as an incarcerated or formerly incarcerated individual, including justice-involved youth and emerging adults, status as a veteran, status as an individual with post-traumatic stress disorder, status as an aging adult, status as a person with any other physical or invisible disability 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 8 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 behavioral 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 behavioral health services.

The team shall meet with the advisory council not less than quarterly. Not later than July 1, 2023, and annually for the following 3 years at the close of each state 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 report shall be written in non-technical, readily understandable language and shall be made publicly available on the office of health equity's website.

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 58. The health policy commission, in consultation with the division of insurance, shall conduct an analysis of the effects of behavioral health managers, as defined in

section 1 of chapter 176O of the General Laws, on the commonwealth's health care delivery system. The commission shall seek input from the executive office of health and human services, other relevant state agencies, health care providers and payers, behavioral health and economic experts, patients and caregivers.

The commission shall analyze: (i) the services that behavioral health managers provide; (ii) the effect of behavioral health managers on accessibility, quality and cost of behavioral health services, including an analysis of impacts on patient outcomes; (iii) the oversight practices by other states on behavioral health managers; (iv) the effects of behavioral health manager state licensure, regulation or registration on access to behavioral health services; and (v) any other issues pertaining to behavioral health managers as deemed relevant by the commission.

Not later than December 31, 2022, the health policy commission shall file a report of its findings, together with any recommendations for legislation, 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 59. (a) The department of veterans' services shall convene an advisory committee that shall consist of: 2 representatives of the Massachusetts chapter of Team Red, White & Blue; 2 representatives of the Red Sox Foundation, Inc. and Massachusetts General Hospital's Home Base Program; 2 representatives of the Wounded Warriors Project; 2 representatives of the Mass Mentoring Partnership, Inc.; 2 representatives of the Massachusetts Coalition for Suicide Prevention; 2 representatives of the Massachusetts Psychological Association, Inc.; and such other members as the committee deems necessary. The members of

the committee shall have experience in mental health or veterans' support services with an emphasis on treatment of post-traumatic stress disorder, depression and anxiety among veterans.

(b) The committee, in coordination with the department of veterans' services and the department of mental health, shall investigate and study: (i) ways to augment services to returning veterans to reduce the rate of suicide and the effects of post-traumatic stress disorder, depression and anxiety; and (ii) the complexity of reintegration into civilian life and issues related to isolation and suicide among veterans. The committee shall provide support and expertise to reduce isolation and suicide among veterans returning from deployment.

(c) The committee shall examine: (i) the impact of having a community peer liaison on a veteran's reintegration into society; (ii) the relationship between isolation and suicide among veterans; and (iii) the impact of having a community peer liaison on symptoms of post-traumatic stress disorder, depression and anxiety diagnosed in veterans.

(d) The committee shall file a report of its findings and any recommendations with the clerks of the senate and house of representatives, the joint committee on veterans and federal affairs and the joint committee on mental health, substance use and recovery not later than January 1, 2023.

SECTION 60. The department of mental health shall prepare a comprehensive plan to address access to continuing care beds, intensive residential treatment programs and community-based programs for patients awaiting discharge from acute psychiatric hospitals and units. The plan shall include, but shall not be limited to, strategies to reduce the wait times for patients awaiting discharge to ensure that the patients determined appropriate for continuing care, intensive residential treatment and community-based programs would be admitted to an

appropriate continuing care bed, intensive residential treatment program, community-based program or other appropriate setting within 30 days after approval of the patient's application. The department of mental health shall submit a copy of the plan to the governor, the clerks of the senate and house of representatives and the joint committee on mental health, substance use and recovery not later than 60 days after the effective date of this act.

SECTION 61. (a) The secretary of health and human services shall establish a statewide evidence-based or evidence-informed education and awareness initiative to: (i) identify and disseminate best practices for preventing suicide and improving the behavioral health, mental wellness and resiliency among health care professionals; (ii) encourage health care professionals to seek behavioral health support and care; (iii) to help such professionals identify risk factors associated with suicide and behavioral health crisis and to help such professionals learn how best to respond to such risks; and (iv) to address the stigma associated with seeking behavioral health services.

(b) Not later than 2 years after the effective date of this act, the secretary of health and human services shall submit a report, with legislative and regulatory recommendations, containing updates on the activities and outcomes of the initiative, including a description of quantitative and qualitative metrics used to evaluate such activities and outcomes, to the governor and the general court by filing the report and recommendations with the clerks of the house of representatives and the senate, the joint committee on mental health, substance use and recovery and the senate and house committees on ways and means.

SECTION 62. The secretary of health and human services and the commissioner of elementary and secondary education shall promulgate regulations pursuant to section 16R of chapter 6A, inserted by section 3, not later than 90 days after the effective date of this act.

SECTION 63. The division of insurance shall promulgate regulations to implement section 5D of chapter 176O of the General Laws not later than 1 year after the effective date of this act.

SECTION 64. The health policy commission shall publish its first pediatric behavioral health planning report required by section 20 of chapter 6D of the General Laws not later than 18 months after the effective date of this act.

SECTION 65. The division of medical assistance shall file its first report on the implementation of the streamlined community-based behavioral health screening process established in section 81 of chapter 118E not later than 1 year after the effective date of this act.

SECTION 66. Subsection (c) of section 16P of chapter 6A of the General Laws and section 5D of chapter 176O of the General Laws shall take effect 1 year after the effective date of this act.

SECTION 67. Subsection (b) of section 16DD chapter 6A of the General Laws shall take effect on July 16, 2022; provided, however, that the secretary of health and human services may designate 988 crisis hotline centers before July 16, 2022.

SECTION 68. Section 51¾ of chapter 111 of the General Laws, inserted by section 28, shall take effect on January 1, 2023; provided, however, the department of public health shall

promulgate regulations to implement said section 51¾ of said chapter 111 not later than October 1, 2022.