SENATE . . . . . No. 2572

The Commonwealth of Massachusetts

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

SENATE, November 9, 2021.

The committee on Senate Ways and Means to whom was referred the Senate Bill addressing barriers to care for mental health (Senate, No. 1276) (also based on Senate, Nos. 675 and 1288), - reports, recommending that the same ought to pass with an amendment substituting a new draft with the same title (Senate, No. 2572).

For the committee,
Michael J. Rodrigues

FILED ON: 11/9/2021

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

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

SECTION 1. Chapter 6A of the General Laws is hereby amended by striking out section 16P, as appearing in the 2020 Official Edition, and inserting in place thereof the following 2 sections:-

Section 16P. (a) For the purposes of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"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) determined to be 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 to be medically stable without needing urgent medical assessment or hospitalization for a physical condition.

"Children and adolescents", individuals who are not more than 22 years of age.

(b) 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.

(c) 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 may include, but shall not be limited to, hospital emergency rooms, emergency services sites, 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.

(d) For each category of data included under subsection (c), 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.

(e) 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 licensing authority and age ranges; (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.

(f) 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 under subsections (c) to (e), inclusive, 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 joint committee on health care financing, the joint committee on mental health, substance use and recovery, the joint committee on children, families and persons with disabilities and the senate and house committees on ways and means.

Section 16P½. (a) For the purpose of this section, "adults" shall mean individuals who are not less than 23 years of age.

(b) 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 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 2. Said chapter 6A is hereby further amended by inserting after section 16DD the following section:-

Section 16EE. (a) There shall be an office of behavioral health promotion within the executive office of health and human services. The office shall be under the supervision and control of a director of behavioral health promotion who shall be appointed by and report to the secretary of health and human services.

(b) The office shall facilitate the coordination of all executive office, state agency, independent agency and state commission activities that promote behavioral health and wellness. The office shall set goals for the promotion of behavioral health and substance use disorder services and programming. The office shall fully integrate health equity principles and apply a health equity framework to all its duties and obligations. The office shall prepare and implement an annual plan for the promotion of behavioral health. The office shall collaborate with the executive office of health and human services, the executive office of education, the executive office of elder affairs, the department of mental health, the department of public health, the department of children and families, the department of veterans' services, the department of early education and care, the department of elementary and secondary education, the office for

refugees and immigrants, the office of health equity, the office of the child advocate and any other relevant office, agency or commission. The office shall facilitate communication and partnership between relevant entities to develop promote understanding of the intersections between entity activities and behavioral health promotion.

(c) The office shall: (i) facilitate the development of interagency initiatives that: (A) are informed by the science of promotion and prevention; (B) advance health equity and trauma-informed care; and (C) address the social determinants of health; (ii) 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; (iii) 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 associated disability; (iv) 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; (v) coordinate behavioral health promotion and wellness programs, campaigns and initiatives; and (vi) provide staffing support for the commission on community behavioral health promotion established in section 219 of chapter 6. The office may enter into service agreements with the department of mental health or the department of public health to fulfill the obligations of the office.

(d) Annually, not later than July 1, the office shall report on its progress, and the overall progress of the commonwealth, toward promoting behavioral health and wellness and preventing substance use conditions. When possible, the report shall use quantifiable measures and comparative benchmarks. The report shall be filed with the governor, the clerks of the senate and

house of representatives and the joint committee on mental health, substance use and recovery. The report shall be posted on the official website of the commonwealth.

SECTION 3. Section 8 of chapter 6D of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after the word “system”, in line 9, the following words:- and trends in annual behavioral health expenditures.

SECTION 4. Said section 8 of said chapter 6D, as so appearing, is hereby further amended by striking out, in line 94, the word “and” and inserting in place thereof the following words:- , including behavioral health expenditures, and.

SECTION 5 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 6. Said chapter 6D is hereby further amended by adding the following 2 sections:-

Section 20. Every 5 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 subsection (f) of said section 16P of said chapter 6A; (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 of said chapter 6A; 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 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 7. Section 16 of chapter 12C of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by striking out, in lines 41 to 43, inclusive, the words "and (11) the impact of health care payment and delivery reform on the quality of care delivered in the commonwealth" and inserting in place thereof the following words:- (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 8. 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 9. Chapter 13 of the General Laws is hereby amended by striking out section 80, as so appearing, and inserting in place thereof the following section:-

Section 80. There shall be a board of registration of social workers that shall consist of: the commissioner of children and families or a designee who shall be licensed as a certified social worker or as an independent clinical social worker under sections 130 to 137, inclusive, of chapter 112; the commissioner of mental health or a designee who shall be licensed as a certified social worker or as an independent clinical social worker under said sections 130 to 137, inclusive, of said chapter 112; and 7 persons to be appointed by the governor, 1 of whom shall be a representative of an accredited school of social work, 3 of whom shall be licensed as certified social workers or as independent clinical social workers under said sections 130 to 137, inclusive, of said chapter 112, 1 of whom shall be an active member of an organized labor organization representing social workers who shall be licensed under said sections 130 to 137, inclusive, of said chapter 112 and 2 of whom shall be members of the general public . At least 1 member who is a licensed social worker and at least 1 member from the general public shall represent an underserved population as defined by the United States Department of Health and Human Services.

SECTION 10. Section 18 of chapter 15A of the General Laws, as so appearing, is hereby amended by adding the following paragraph:-

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

SECTION 11. Chapter 18C of the General Laws is hereby amended by inserting after section 10 the following section:-

Section 10A. Annually, not later than April 1, the child advocate shall file a report making recommendations for decreasing and eliminating the number of children and adolescents awaiting clinically-appropriate behavioral health services. The report shall include a review of the data included on the online portal established by section 16P of chapter 6A and the report submitted to the child advocate in accordance with subsection (f) of said section 16P of said chapter 6A. The child advocate's report shall be submitted to the governor, the children's behavioral health advisory committee established in section 16Q of said chapter 6A, the clerks of the senate and the house of representatives, the joint committee on health care financing, the

joint committee on mental health, substance use and recovery, the joint committee on children, families and persons with disabilities and the senate and house committees on ways and means.

SECTION 12. Said chapter 18C is hereby further amended by adding the following section:-

Section 15. (a) The office shall convene a complex case resolution panel to resolve matters referred to it under subsection (b). The panel shall include: the child advocate or a designee, who shall serve as chair; the secretary of health and human services or a designee; 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 elementary and secondary education or a designee; the commissioner of early education and care or a designee; the commissioner of developmental services or a designee; the commissioner of youth services or a designee; and 2 persons to be appointed by the child advocate to serve for 2-year terms, 1 of whom shall be a representative from an organization providing services to children who are consumers of behavioral health services and programs and their families and 1 of whom shall be a representative from an organization that assists families in navigating the behavioral health services system; provided, however, that the 2 individuals appointed for 2-year terms shall recuse themselves from any matter in which they have a direct conflict of interest; and provided further, that for the 2 individuals appointed for 2-year terms, if a vacancy occurs prior to the end of one such individual's 2-year term, the vacancy shall be immediately filled by the child advocate for the remainder of the term. The child advocate may require the participation of a local educational agency or insurance carrier as a panel member when the matter involves or may involve services provided by or paid for by such local educational agency or insurance carrier. Panel members shall be empowered by the agency or local educational

agency to act on behalf of the agency or local educational agency in making decisions and agreements.

(b) The panel shall review and resolve matters referred to the panel by a parent or legal guardian, a legal advocate for a child, a state agency or state agency ombudsperson or a physician or behavioral health provider authorized to act on behalf of a parent or legal guardian who is seeking to access services for a child: (i) with complex behavioral health needs; (ii) who has waited in a hospital emergency department or medical bed or at home for not less than 5 days to be placed in an appropriate therapeutic setting or be provided with appropriate evaluations and services after being assessed and determined to need psychiatric inpatient care, crisis stabilization unit placement, community-based acute treatment, intensive community-based acute treatment, continuing care unit placement or residential placement, including specialized foster care or partial hospitalization; and (iii) who has been determined by a licensed health care provider to be medically stable and without need for urgent medical assessment or hospitalization for a physical health condition. The panel shall resolve such matters by addressing any administrative, financial or clinical barriers to such services that arise from disputes between state agencies, MassHealth or local educational agencies.

(c)(1) The panel shall convene not later than 1 business day after accepting a referral under subsection (b). The panel shall address barriers to the child receiving appropriate services including, but not limited to, the designation of a single state agency or local educational agency to provide primary case management and the designation of the state agency or local educational agency responsible for payment for services for which a child is eligible, including placement and evaluations. The panel shall determine responsibility for aspects of complex cases in order to

best serve the needs of the child in an expeditious manner and to make interim designations of case management or financial responsibility if no immediate agreement can be reached.

(2) If the lack of a primary case manager is impeding the child's access to services and if, after 1 business day after the panel convenes for the first time on a matter, the panel cannot reach consensus regarding the primary state or local educational agency responsible for case management, the child advocate shall immediately designate a state agency or local educational agency to act as the interim primary case manager until a final decision is issued on the matter under subsection (d). Any assignment of interim primary case management responsibility by the child advocate shall have no prejudicial value at the bureau of special education appeals, the division of administrative law appeals or any other legal venue. If a civil, criminal or administrative legal body makes a determination on primary case management responsibility that is contrary to the interim responsibility assigned by the child advocate, the child advocate shall align responsibility allocation in accordance with the decision of the legal body. No panel member may receive reimbursement from any other panel member for any costs incurred as a result of assignment of interim primary case management responsibility by the child advocate under this section.

(3) If the child is unable to access services for which the child is eligible or entitled because of a disagreement relative to the responsibility for payment among state agencies and local educational agencies and if, after 1 business day after the panel convenes for the first time on a matter, the panel cannot reach consensus relative to such responsibility for payment among the state agencies or local educational agencies, the child advocate shall immediately require the relevant state agencies and local educational agencies to enter into a temporary cost-sharing agreement until a final decision is issued on the matter under subsection (d). Any assignment of

responsibility under a temporary cost-sharing agreement by the child advocate shall have no prejudicial value at the bureau of special education appeals or the division of administrative law appeals. If a civil, criminal or administrative body makes a determination that is contrary to the temporary cost-sharing agreement, the child advocate shall align responsibility allocation in accordance with the decision of the respective body. No panel member shall be entitled to reimbursement from any other panel member for any costs incurred as a result of a temporary cost-sharing agreement imposed by the child advocate under this section.

(d) Not later than 14 business days after the panel convenes for the first time on a matter, the panel shall complete its review and, after consulting with the parents or legal guardian of the child, relevant agencies and service providers and reviewing relevant materials, the panel shall issue an order requiring services and placement to be provided for the child, who shall provide such services and placement and who shall pay for such services and placement. To implement the recommendations of the panel, the parent of a child with a disability and the local educational agency may, in accordance with 20 U.S.C. 1414(d)(3)(D), agree not to convene an individualized education plan meeting and instead develop a written document to amend or modify the child's current individualized education plan.

If the lack of a primary case manager is impeding the child’s access to services and the panel cannot reach consensus regarding the agency or entity with primary responsibility for managing the child’s case, the child advocate shall immediately designate a state agency or local educational agency to act as the primary case manager. The designated agency shall remain the primary case manager until an alternative agreement is entered into or until the child no longer qualifies for services.

If the child is unable to access services for which such child is eligible or entitled because of a disagreement relative to the responsibility for payment among state agencies and local educational agencies and the panel cannot reach consensus relative to such responsibility for payment among the state agencies or local educational agencies, the child advocate shall immediately require the relevant state and local agencies to enter into a cost-sharing agreement. The cost-sharing agreement shall remain in effect until the child advocate is informed in writing that an alternative cost-sharing agreement or a payment agreement has been entered into or until the child no longer qualifies for services.

Any assignment of responsibility by the child advocate under this subsection shall have no prejudicial value at the bureau of special education appeals or the division of administrative law appeals. If a civil, criminal or administrative legal body makes a determination that is contrary to the assignment of responsibility by the child advocate under this section, the child advocate shall align responsibility allocation in accordance with the decision of the legal body. No panel member shall be entitled to reimbursement from any other panel member for any costs incurred as a result of an assignment of responsibility imposed by the child advocate under this section.

Panel decisions under this subsection shall be issued to the parent or legal guardian, and the individual who referred the case to the panel if such person is not the parent or legal guardian, in writing not later than 3 business days after the decision and shall include the basis for the decision, the basis for the denial of services, if any, and information regarding rights to further review or appeal of a decision.

(e) If the parent or legal guardian of the child disputes the decision of the panel under subsection (d), the parent or legal guardian may file an appeal with the division of administrative law appeals, which shall conduct an adjudicatory proceeding and order any necessary relief consistent with state or federal law, as applicable.

(f) If a local educational authority disputes the decision of the panel under subsection (d), the local educational authority may file an appeal with the division of administrative law appeals, which shall conduct an adjudicatory proceeding and order any necessary relief consistent with state or federal law if the local educational authority has demonstrated that the decision of the panel violates state or federal law, as applicable.

(g) The child advocate or the child advocate's designee shall have unrestricted access to all electronic information systems' records, reports, materials and employees of a local educational agency that is not otherwise restricted by state or federal law; provided, however, that the child advocate shall be bound by any limitations on the use or release of information imposed by law upon the party furnishing such information, except as provided in section 12.

(h) Nothing in this section shall be construed to entitle a child to services for which the child would otherwise be ineligible under applicable agency laws or regulations.

(i) Notwithstanding chapters 66A, 112 and 119 or any other law related to the confidentiality of personal data, the panel, the child advocate and the division of administrative law appeals shall have access to and may discuss materials related to a case while the case is under review once the parent or legal guardian has consented in writing and those having access consent in writing to keep the materials confidential. Once the review is complete, all materials shall be returned to the originating source.

(j) Nothing in this section shall limit: (i) the rights of parents, legal guardians or children under chapter 71B, the 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; or (ii) the rights of parents under state or federal law to make decisions about a child's health care.

(k) The child advocate shall publish an annual report on its website summarizing the cases reviewed by the panel in the previous year, the length of time spent at each stage and their final resolution; provided, however, that the report shall not include any information that could foreseeably reveal the identity of the child.

(l) The child advocate shall promulgate regulations to implement this section.

SECTION 13. 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, 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 36 months, or more frequently if noncompliance is suspected, with a focus on: (A) nonquantitative treatment limitations under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 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 clause (ii) or in said section 4 of said chapter 175, section 7 of said chapter 176A, section 9 of said chapter 176B and section 10 of said chapter 176G shall limit the commissioner's authority to use and, if appropriate, 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, 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 handbook unless the commissioner demonstrates that the fees prescribed in the handbook are inadequate under the circumstances of the examination; and provided further, that the commissioner or the commissioner's examiners shall not receive or accept any additional emolument on account of any examination.

(b) The 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, 42 U.S.C. 18031(j), as amended, and federal guidance or regulations issued under the act.

The amount of any penalty imposed shall be $100 for each day in the noncompliance period per product line with respect to each participant or beneficiary to whom such 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 not be imposed for a violation if the commissioner determines that the violation was due to reasonable cause and not to willful neglect or if the violation is corrected not more than 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, 42 U.S.C. 18031(j), 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 carriers 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, 42 U.S.C. 18031(j), 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; provided, however, that an oral complaint shall be followed by a written submission to the commissioner that 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; 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 nonquantitative 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 C.F.R. § 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 under 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, as amended.

SECTION 14. Said chapter 26 is hereby further amended by inserting after Section 8L the following section:-

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

(i) the specific plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations and a description of all mental health and substance use disorder benefits and medical and surgical benefits to which each term applies in each respective benefits classification, provided, however, that the nonquantitative treatment limitations shall include the processes, strategies, evidentiary standards or other factors used to develop and apply the carrier's reimbursement rates for mental health and substance use disorder benefits and medical and surgical benefits in each respective benefits classification;

(ii) the factors used to determine that the nonquantitative treatment limitations will apply to mental health and substance use disorder benefits and medical and surgical benefits;

(iii) the evidentiary standards used for the factors identified in clause (ii), when applicable, and any other source or evidence relied upon to design and apply the nonquantitative treatment limitations to mental health and substance use disorder benefits and medical and surgical benefits; provided, however, that every factor shall be defined;

(iv) a comparative analysis demonstrating that the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to mental health and substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards and other

factors used to apply the nonquantitative treatment limitations to medical and surgical benefits in the benefits classification;

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

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

(vii) the additional information, if any, that a carrier is required to provide under 42 U.S.C. 300gg-26(a)(8)(B)(ii); and

(viii) any other data or information the commissioner deems necessary to assess a carrier's

compliance with mental health parity requirements.

(b) If federal guidance, including, but not limited to, the Self-Compliance Tool for the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, is released that indicates a nonquantitative treatment limitation analysis process and reporting format that is significantly different from, contrary to or more efficient than the nonquantitative treatment limitation analysis process and reporting format requirements

described in subsection (a), the commissioner may promulgate regulations that delineate a nonquantitative treatment limitation analysis process and reporting format that may be used in lieu of the nonquantitative treatment limitation analysis and reporting requirements described in said subsection (a).

(c) Any proprietary portions of 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: (i) the commissioner may produce reports summarizing any findings; (ii) nothing in this section shall limit the authority of the commissioner to use and, if appropriate, publish any final or preliminary examination report, examiner or company work papers or other documents or other information discovered or developed during the course of an examination in the furtherance of any legal or regulatory action that the commissioner may, in their sole discretion, deem appropriate; and (iii) nothing in this section shall prevent the commissioner of insurance 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 under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended.

(d) Annually, not later than December 1, the commissioner shall submit a summary of the reports that the commissioner receives from all carriers under subsection (a) to the clerks of the senate and house of representatives, the joint committee on mental health, substance use and

recovery and the joint committee on health care financing; provided, that the summary shall include, but not be limited to:

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

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

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

(iv) a breakdown of treatment authorization data for each carrier for mental health treatment services, substance use disorder treatment services and medical and surgical treatment services for the immediately preceding calendar year indicating for each treatment service: (A) the number of inpatient days, outpatient services and total services requested; (B) the number and per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day requests modified resulting in a lower amount of inpatient days authorized than requested and the reason for the modification, inpatient day requests denied and the reason for the denial, inpatient day requests where an internal appeal was filed and approved, inpatient day requests where an internal appeal was filed and denied, inpatient day requests where an external appeal was filed and upheld and inpatient day requests where an external appeal was filed and overturned; and

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

(v) the number of consumer complaints received by the division of insurance under subsection (f) of section 8K in the immediately preceding calendar year and a summary of all such complaints resolved by the division during that time period, including: (A) the number of complaints resolved in favor of the consumer; (B) the number of complaints resolved in favor of the carrier; and (C) any enforcement actions taken in response to such complaints; and

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

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

SECTION 15. Chapter 32A of the General Laws is hereby amended by inserting after section 17R the following section:-

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

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

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

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

(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 not more than 72 hours after admission.

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

SECTION 16. Said chapter 32A is hereby further amended by inserting after section 22 the following 2 sections:-

Section 22A. For the purposes of this section, “psychiatric collaborative care model” shall mean the evidence-based, integrated behavioral health service delivery method described in 81 FR 80230.

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 22B. (a) The commission shall implement and enforce the mental health parity provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as amended, federal guidance or regulations issued under the act, applicable state mental health parity laws and regulations and, to the degree applicable to its health benefit plans, guidance issued by the commissioner of insurance under section 8K of chapter 26 by:

(i) utilizing the commission’s procurement, contracting, vendor oversight and auditing authority to ensure that the commission’s health benefit plans that provide medical and surgical benefits and mental health and substance use disorder benefits are compliant with the applicable state or federal laws related to mental health and substance use disorder parity;

(ii) performing audits of each of the commission’s health benefit plans at least once every 36 months, or more frequently if noncompliance is suspected, with a focus on: (A) nonquantitative treatment limitations under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 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 commission, including factors identified through consumer or provider complaints;

(iii) requiring the commission's health benefit plans that provide medical and surgical benefits and mental health and substance use disorder benefits to comply with the annual reporting requirements under subsection (b); and

(iv) evaluating all consumer or provider complaints regarding mental health and substance use disorder coverage for possible parity violations not more than 3 months after receipt.

(b) The commission's health benefit plans that provide medical and surgical benefits and mental health and substance use disorder benefits shall submit an annual report not later than July 1 to the commission that contains:

(i) the specific plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations and a description of all mental health and substance use disorder benefits and medical and surgical benefits to which each term applies in each respective benefits classification; provided, however, that the nonquantitative treatment limitations shall include the processes, strategies, evidentiary standards or other factors used to develop and apply the health benefit plan's reimbursement rates for mental health and substance use disorder benefits and medical and surgical benefits in each respective benefits classification;

(ii) the factors used to determine that the nonquantitative treatment limitations will apply to mental health and substance use disorder benefits and medical and surgical benefits;

(iii) the evidentiary standards used for the factors identified in clause (ii), when applicable; provided, that every factor shall be defined, and any other source or evidence relied upon to design and apply the nonquantitative treatment limitations to mental health and substance use disorder benefits and medical and surgical benefits;

(iv) a comparative analysis demonstrating that the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to mental health and substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to medical or surgical benefits in the benefits classification;

(v) the specific findings and conclusions reached by the health benefit plan with respect to health insurance coverage, including any results of the analysis described in clause (iv) that indicate whether the health benefit plan is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act; and

(vi) any other data or information the commission deems necessary to assess a health benefit plan’s compliance with state or federal laws related to mental health and substance use disorder parity.

(c) If federal guidance, including, but not limited to, the Self-Compliance Tool for the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of

2008, as amended, is released that indicates a nonquantitative treatment limitation analysis process and reporting format that is significantly different from, contrary to or more efficient than the nonquantitative treatment limitation analysis process and reporting format requirements described in subsection (b), the commission may revise the analysis and reporting requirements described in said subsection (b).

(d) Any proprietary portions of information submitted to the commission by a health benefit plan 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 commission may produce reports summarizing any findings.

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

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

(ii) the methodology the commission is using to check for compliance with applicable state mental health parity laws and regulations, including section 22 of chapter 32A, and, to the degree applicable to its health benefit plans, guidance issued by the commissioner of insurance under section 8K of chapter 26;

(iii) a summary of any audit findings for audits conducted and completed under clause (ii) of subsection (a) during the immediately preceding calendar year regarding access to behavioral health services or compliance with parity in mental health and substance use disorder benefits under state and federal laws and any actions taken as a result of such audit; and

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

The summary report shall be written in nontechnical, readily understandable language and made available to the public by posting the report on the commission's website.

SECTION 17. 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) For the purpose of this section, the following words shall 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 supervised mental health counselor, a licensed nurse

mental health clinical specialist, 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. The examination shall be covered with no patient cost-sharing.

SECTION 18. Section 25C½ of chapter 111 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by striking out, in line 28, the word “or”.

SECTION 19. Said section 25C½ of said chapter 111, as so appearing, is hereby further amended by striking out, in line 39, the word “combination.” and inserting in place thereof the following word:- combination;.

SECTION 20. Said section 25C½ of said chapter 111, as so appearing, is hereby further amended by striking out, in line 56, the word “act.” and inserting in place thereof the following words: act; or.

SECTION 21. Subsection (a) of said section 25C½ of said chapter 111, as so appearing, is hereby amended by adding the following clause:-

(5) A health care facility if the health care facility plans to make a capital expenditure solely for the development of acute psychiatric services, including inpatient, a crisis stabilization unit, community-based acute treatment, intensive community-based acute treatment, a continuing care unit or a partial hospitalization program; provided, however, that the health care facility applying for the exemption demonstrates the need for a license from the department of mental health pursuant to section 19 of chapter 19; provided further, that the department shall prioritize exemptions for expenditures that provide services for certain high-need patient populations including, but not limited to, children, individuals with autism spectrum disorder, intellectual disabilities or developmental disabilities, individuals who present with a high-level of acuity including severe behavior and assault risk, individuals with co-occurring substance use disorder, individuals with co-occurring medical conditions, individuals with eating disorders and geriatric

patients; and provided further, that the department shall prioritize exemptions for expenditures for services that would be located in underserved areas of the commonwealth.

SECTION 22. Said chapter 111 is hereby further amended by inserting after section 51½ the following section:-

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

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 23. Section 163 of chapter 112 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after the definition of "Licensed mental health counselor" the following definition:-

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

SECTION 24. Section 164 of said chapter 112, as so appearing, is hereby amended by inserting after the word “consultant”, in line 7, the following words:- or licensed supervised mental health counselor, advisor or consultant.

SECTION 25. Section 165 of said chapter 112, as so appearing, is hereby amended by inserting after the word “health”, in line 16, the following words:- or the department of public health.

SECTION 26. Said section 165 of said chapter 112, as so appearing, is hereby further amended by adding the following 3 paragraphs:-

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

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

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

SECTION 27. Chapter 118E of the General Laws is hereby amended by inserting after section 10N the following 3 sections:-

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

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

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

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

The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization or primary care clinician plan shall cover the cost of medically necessary mental health acute treatment, community-based acute treatment and intensive community-based acute treatment and shall not require a preauthorization before obtaining treatment; provided, however, that the facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of admission.

Section 10P. For the purposes of this section, “psychiatric collaborative care model” shall mean the evidence-based, integrated behavioral health service delivery method described in 81 FR 80230.

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) For the purpose of this section, the following words shall 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 supervised mental health counselor, a licensed nurse mental health clinical specialist, 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 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. The examination shall be covered with no patient cost-sharing.

SECTION 28. Section 47 of said chapter 118E, as appearing in the 2020 Official Edition, 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 29. Said chapter 118E is hereby further amended by adding the following 4 sections:-

Section 80. (a) The division, its managed care organizations, accountable care organizations or other entity contracting with the division to manage or administer mental health and substance use disorder benefits shall ensure that there are no separate non-quantitative treatment limitations that apply to mental health and substance use disorder benefits but do not apply to medical and surgical benefits within any classification of benefits as defined under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and applicable state mental health parity laws, including, but not limited to, section 81; provided, however, that the non-quantitative treatment limitations shall include the processes, strategies or methodologies for developing and applying the division’s reimbursement rates for mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits.

(b) The division shall perform a behavioral health parity compliance examination of each Medicaid managed care organization, accountable care organization or other entity contracted with the agency that manages or administers mental health and substance use disorder benefits for the division at least once every 36 months. The examination shall include examination of entities that manage medical and surgical benefits, as necessary. The examination shall only apply where the division is the primary payer. The examination shall include, but not be limited to:

(i) non-quantitative treatment limitations, including, but not limited to, prior authorization, concurrent review, retrospective review, step-therapy, network admission standards, reimbursement rates and geographic restrictions;

(ii) approvals and denials of authorization, payment and coverage; and

(iii) any other specific criteria as may be determined by the division.

(c) The division shall require each of its managed care organizations, accountable care organizations or other entity contracting with the division to manage or administer mental health and substance use disorder benefits to submit an annual report to the division on or before July 1 that includes:

(i) the specific plan or coverage terms or other relevant terms regarding the non-quantitative treatment limitations and a description of all mental health and substance use disorder benefits and medical and surgical benefits to which each term applies in each respective benefits classification; provided, however, that the non-quantitative treatment limitations shall include the processes, strategies, evidentiary standards or other factors used to develop and apply the entity's reimbursement rates for mental health and substance use disorder benefits and medical and surgical benefits in each respective benefits classification;

(ii) the factors used to determine that the non-quantitative treatment limitations will apply to mental health and substance use disorder benefits and medical and surgical benefits;

(iii) the evidentiary standards used to define the factors identified in clause (ii), when applicable; provided, however, that every factor shall be defined and any other source or

evidence relied upon to design and apply the non-quantitative treatment limitations to mental health and substance use disorder benefits and medical and surgical benefits;

(iv) a comparative analyses demonstrating that the processes, strategies, evidentiary standard and other factors used to apply the non-quantitative treatment limitations to mental health and substance use disorder benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards and other factors used to apply the non-quantitative treatment limitations to medical and surgical benefits in the benefits classification;

(v) the specific findings and conclusions reached by the entity with respect to health insurance coverage, including any results of the analysis described in clause (iv) that indicates whether the entity is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal guidelines and regulations relevant to the act, including, but not limited to, 42 CFR Part 457.496;

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

requests authorized, outpatient service requests modified, outpatient service requests modified resulting in a lower amount of outpatient service authorized than requested and the reason for the modification, outpatient service requests denied and the reason for the denial, outpatient service requests where an internal appeal was filed and approved, outpatient service requests where an internal appeal was filed and denied, outpatient service requests where an external appeal or hearing before the board of hearings was filed and upheld and outpatient service requests where an external appeal was filed and overturned;

(vii) the additional information, if any, that an entity is required to provide under 42 U.S.C. 300gg-26(a)(8)(B)(ii); and

(viii) any other data or information the division deems necessary to assess an entity's compliance with mental health parity requirements.

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

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

section 7 of chapter 4 or chapter 66; provided, however, that nothing in this section shall limit the authority of the director of Medicaid to use and, if appropriate, publish any final or preliminary examination report, examiner or company work papers or other documents or other information discovered or developed during the course of an examination in the furtherance of any legal or regulatory action that the director may, in their sole discretion, deem appropriate; provided further, that nothing in this section shall prevent the director of Medicaid 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 information that is subject to disclosure to plan members under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, or under any member right to receive such guideline under applicable federal law.

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

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

(ii) the methodology the division is using to check for compliance with section 81;

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

(iv) a breakdown of treatment authorization data for the division, and for each Medicaid managed care organization, accountable care organization or other entity that manages or administers benefits for the division, for mental health treatment services, substance use disorder treatment services and medical and surgical treatment services for the immediately preceding calendar year indicating for each treatment service: (A) the number of inpatient days, outpatient services and total number of services requested; (B) the number and per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day requests modified resulting in a lesser amount of inpatient days authorized than requested and the reason for the modification, inpatient day requests denied and the reason for the denial, inpatient day requests where an internal appeal was filed and approved, inpatient day requests where an internal appeal was filed and denied, inpatient day requests where an external review under section 47B or hearing before the board of hearings under section 48 was filed and upheld and inpatient day requests where an external review under said section 47B or hearing before the board of hearings under said section 48 was filed and overturned; and (C) the number and per cent of outpatient service requests authorized, outpatient service requests modified, outpatient service requests modified resulting in a lower amount of outpatient service authorized than requested and the reason for the modification, outpatient service requests denied and the reason for the denial, outpatient service requests where an internal appeal was filed and approved, outpatient service requests where an internal appeal was filed and denied, outpatient service requests where an external review under

said section 47B or hearing before the board of hearings under said section 48 was filed and upheld and outpatient service requests where an external review under said section 47B or hearing before the board of hearings under said section 48 was filed and overturned;

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

(vi) information about any educational or corrective actions the division has taken to ensure carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and section 81.

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

Section 81. (a) The division and its health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract with the division, a Medicaid managed care organization or a primary care clinician plan shall provide mental health and substance use disorder benefits for the diagnosis and medically-necessary treatment of any behavioral health disorder described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric

Association or the most current version of the International Classification of Diseases. The benefits shall be provided on a nondiscriminatory basis.

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

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

(d) Benefits authorized pursuant to this section shall consist of a range of inpatient, intermediate and outpatient services that shall permit medically-necessary, active and noncustodial treatment for the mental disorders to take place in the least restrictive clinically

appropriate setting. For purposes of this section, inpatient services may be provided in a general hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental hospital licensed by the department of mental health or in a substance abuse facility licensed by the department of public health. Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office or as home-based services.

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

provided by the division or its agents pursuant to this section shall meet all other terms and conditions of the plan consistent with state or federal law.

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

(i) are otherwise covered by third-party insurance;

(ii) are provided to a person who is presently incarcerated, confined or committed to a jail, house of correction or prison;

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

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

(v) are not eligible for federal financial participation.

Section 82. Notwithstanding any general or special law to the contrary, the office of Medicaid shall seek a waiver and promulgate regulations in order to require the division and its health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract with the division, a Medicaid managed care organization or primary care clinician plan to meet the parity requirements described under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including 42 CFR 438 Subpart K, 42 CFR 440.395 and 42 CFR 457.496, for all enrollees. For persons under the age of 21, MassHealth and its agents may comply with this section by meeting the obligations

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

Section 83. Medical necessity and utilization management determinations for treatments for substance use disorder or co-occurring mental illness and substance use disorder authorized under this chapter shall be made in accordance with the criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make medical necessity or utilization management determinations for treatments for substance use disorder or co-occurring mental illness and substance use disorder, unless such criteria are less restrictive than those established by the American Society of Addiction Medicine. Authorization or coverage for treatment for substance use disorder or co-occurring mental illness and substance use disorder shall not be denied by the division, or a Medicaid managed care organization, accountable care organization or other entity that manages or administers mental health and substance use disorder benefits for the division, on the basis that such treatment was authorized or ordered by a court of law or other law enforcement agency. Any such authorization or order for such services shall be considered a factor in support of coverage for such treatment.

SECTION 30. Chapter 123 of the General Laws is hereby amended by inserting after section 2 the following section:-

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

SECTION 31. Section 1 of chapter 175 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after the definition of “Domestic company” the following definition:-

“Emergency services programs”, all programs subject to contract between the Massachusetts Behavioral Health Partnership and nonprofit organizations for the provision of community-based emergency psychiatric services, including, but not limited to, behavioral health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per week, through: (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 32. Section 47B of said chapter 175, as so appearing, is hereby amended by inserting after the word “specialist”, in line 122, the following words:-, a clinician practicing under the supervision of a licensed professional and working towards licensure in a clinic licensed under chapter 111.

SECTION 33. Said chapter 175 is hereby further amended by inserting after section 47PP, the following 4 sections:-

Section 47QQ. For the purposes of this section, “psychiatric collaborative care model” shall mean the evidence-based, integrated behavioral health service delivery method described in 81 FR 80230.

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) For the purposes of this section, the following terms shall have the following meanings unless the context clearly requires otherwise:

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

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

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

(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 the administration of 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 47TT. (a) For the purpose of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"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 supervised mental health counselor, a licensed nurse mental health clinical specialist, 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, which provides hospital expense and surgical expense insurance and which 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 which provides hospital expense and surgical expense insurance and which 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 which provides hospital expense and surgical expense benefits and which is delivered, issued to or renewed for any person or group of persons in the commonwealth. The examination shall be covered with no patient cost-sharing.

(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 34. Section 8A of chapter 176A of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after the word “specialist”, in line 125, the following words:- , a clinician practicing under the supervision of a licensed professional and working towards licensure in a clinic licensed under chapter 111.

SECTION 35. Said chapter 176A is hereby further amended by inserting after section 8QQ the following 4 sections:-

Section 8RR. For the purposes of this section, “psychiatric collaborative care model” shall mean the evidence-based, integrated behavioral health service delivery method described in 81 FR 80230.

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) For the purposes of this section, the following terms shall have the following meanings unless the context clearly requires otherwise:

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

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

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

(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) For the purpose of this section, the following words shall have the following meanings:

"Licensed mental health professional," a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed supervised mental health counselor, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1

of chapter 111J of the General Laws, 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. The examination shall be covered with no patient cost-sharing.

(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 36. Section 4A of chapter 176B of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after the word “specialist”, in line 120, the following words:- , a clinician practicing under the supervision of a licensed professional and working towards licensure in a clinic licensed under chapter 111.

SECTION 37. Said chapter 176B is hereby further 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 described in 81 FR 80230.

A subscription certificate under an individual or group medical service agreement 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 4SS. For the purposes of this section, the following terms shall have the following meanings unless the context clearly requires otherwise:

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

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

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

(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, 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 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) For the purpose of this section, the following words shall 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 supervised mental health counselor, a licensed nurse mental health clinical specialist, 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; (iii) and 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. The examination shall be covered with no patient cost-sharing.

(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 38. Section 4M of chapter 176G of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after the word "specialist", in line 117, the

following words:- , a clinician practicing under the supervision of a licensed professional and working towards licensure in a clinic licensed under chapter 111.

SECTION 39. Said chapter 176G is hereby further amended by inserting after section 4II the following 4 sections:-

Section 4JJ. For the purposes of this section, “psychiatric collaborative care model” shall mean the evidence-based, integrated behavioral health service delivery method described in 81 FR 80230.

Any 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) For the purposes of this section, the following terms shall have the following meanings unless the context clearly requires otherwise:

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

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

“Mental health acute treatment”, 24-hour medically supervised mental health services provided in an inpatient facility, licensed by the department of mental health, that provides

psychiatric evaluation, management, treatment and discharge planning in a structured treatment milieu.

(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 the administration of 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 4JJ. 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 4LL. (a) For the purpose of this section, the following words shall have the following meanings unless the context clearly requires otherwise:

"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 supervised mental health counselor, a licensed nurse mental health clinical specialist, 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. The examination shall be covered with no patient cost-sharing.

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

Section 5D. For the purposes of this section, the term "base fee schedule" shall mean the minimum rates, typically set forth in fee schedules, paid by the carrier to an in-network health care provider who is not paid under an alternative payment arrangement for covered health care

services; provided, however, that final rates may be subject to negotiations or adjustments that may result in payments to in-network providers that are different from the base fee schedule.

A carrier, directly or through any entity that manages or administers mental health or substance use disorder benefits for the carrier, shall establish a base fee schedule for primary care services for behavioral health providers that is not less than the base fee schedule used for evaluation and management services for primary care providers of the same or similar licensure type and in the same geographic region; provided, however, that a carrier shall not lower its base fee schedule for primary care providers to comply with this section.

The division shall promulgate regulations to implement this section.

SECTION 41. Subsection (a) of section 13 of said chapter 176O, as appearing in the 2020 Official Edition, 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 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 written acknowledgement of the receipt of a grievance within 15 days and a written resolution of each grievance sent to the insured by certified or registered mail, or other express carrier with proof of delivery, within 30 days from receipt thereof; (v) a procedure to accept grievances by telephone, in person, by mail and by electronic means; (vi) a process for an insured to request the appointment of an authorized representative to act on the insured's behalf; and (vii) 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 42. 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 2 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 43. 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 44. Subsection (a) of section 14 of chapter 176O of the General Laws, 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 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 45. 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 46. 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 47. 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 for 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 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, 42 U.S.C. 18031(j), as amended, and federal 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 48. 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 under chapter 26.

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

(d) Medical necessity and utilization management determinations for treatments for substance use disorder or co-occurring mental illness and substance use disorder shall be made in accordance with the criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make medical necessity or utilization management determinations for treatments for substance use disorder or co-occurring mental illness and substance use disorder, unless such criteria are less restrictive. A carrier, or any entity that manages or administers mental health and substance use disorder benefits for the carrier, shall not deny authorization or coverage for treatment for substance use disorder or co-occurring mental illness and substance use disorder on the basis that such treatment was authorized or ordered by a court of law or other law enforcement agency. Such authorization shall be considered a factor in support of coverage for such treatment, including as allowed under clause (4) of subsection (a) of section 6 and clause (7) of subsection (a) of section 7.

SECTION 50. 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 not less than quarterly with the advisory council. Not later than March 30, 2022, and annually for the following 3 years at the close of the fiscal year, the team shall issue a report with legislative, regulatory or budgetary recommendations to improve the

access and quality of culturally competent mental and behavioral health services. The 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 51. 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 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 their impact 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 52. There shall be a special commission to study and make recommendations on the establishment of a common set of criteria for providers and payers to use in making medical necessity determinations for behavioral health treatment.

The commission shall consist of the following members or their designees: the commissioner of mental health, who shall serve as chair; the commissioner of insurance; the director of the bureau of substance addiction services within the department of public health; the assistant secretary for MassHealth; the executive director of the group insurance commission; and 16 members to be appointed by the chair: 1 of whom shall be a representative of the health policy commission; 2 of whom shall be representatives of the Massachusetts Psychiatric Society, Inc., 1 of whom shall specialize in the treatment of children; 2 of whom shall be representatives of the Massachusetts Psychological Association, Inc., 1 of whom shall specialize in the treatment of children; 1 of whom shall be a representative of the Massachusetts Society of Addiction Medicine, Inc.; 1 of whom shall be a representative of the National Association of Social Workers, Inc.; 1 of whom shall be a representative of the Massachusetts Mental Health Counselors Association, Inc.; 1 of whom shall be a representative of the Children’s Mental Health Campaign; 1 of whom shall be a representative of the Association for Behavioral Healthcare, Inc.; 1 of whom shall be a representative of the Massachusetts Association of Behavioral Health Systems, Inc.; 1 of whom shall be a representative of the Massachusetts Association for Mental Health, Inc.; 1 of whom shall be a representative of the National Alliance on Mental Illness of Massachusetts, Inc.; 1 of whom shall be a representative of the Massachusetts Organization for Addiction Recovery, Inc.; 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc.; and 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc..

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

Not later than 1 year after the effective date of this act, the commission shall submit its findings and recommendations, together with drafts of legislation or regulations necessary to carry those recommendations into effect, to the clerks of the senate and house of representatives and the joint committee on mental health, substance use and recovery.

SECTION 53. The health policy commission shall convene an advisory group to advise the commission on the implementation of section 21 of chapter 6D of the General Laws. The advisory group shall include: the director of the health policy commission or a designee, who shall serve as chair; the secretary of health and human services or a designee; the assistant secretary of MassHealth or a designee; the commissioner of insurance or a designee; 1 member appointed by the governor, who shall be from a commonwealth-based electronic health record vendor who specializes in behavioral health care; 1 member appointed by the Association for Behavioral Healthcare, Inc.; 1 member appointed by Blue Cross and Blue Shield of Massachusetts, Inc.; 1 member appointed by Health Law Advocates, Inc.; 1 member appointed by the Massachusetts Association of Health Plans, Inc.; 1 member appointed by the Massachusetts Health and Hospital Association, Inc.; 1 member appointed by National Alliance on Mental Illness of Massachusetts, Inc.; 1 member appointed by the Massachusetts

Organization for Addiction Recovery, Inc.; and 1 member appointed by the Parent/Professional Advocacy League, Inc.

The advisory group study and make recommendations on the development proper use of the standard release form required under said section 21 of said chapter 6D. The advisory group shall consider: (i) existing and potential technologies that could be used to securely transmit a standard release form; (ii) national standards pertaining to electronic release of confidential information, including protecting a patient's identity and privacy in accordance with the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191; (iii) any prior release forms and methodologies used in the commonwealth; (iv) any prior release forms and methodologies developed by federal agencies; and (v) any other factors the advisory group deems relevant.

The advisory group shall submit written recommendations to the commission not more than 6 months after the effective date of this act. The commission shall develop the standard release form after receiving the advisory group's recommendations.

SECTION 54. The health policy commission shall publish its first pediatric behavioral health planning report required by section 7 of chapter 6D of the General Laws not later than 18 months after the effective date of this act.

SECTION 55. The office of the child advocate shall publish the first annual report required by section 10A of chapter 18C of the General Laws not later than 18 months after the development of the online portal established by section 16P of chapter 6A of the General Laws.

SECTION 56. For the purposes of section 22A of chapter 32A, section 10P of chapter 118E, section 47MM of chapter 175, section 8OO of chapter 176A, section 4OO of chapter 176B

and section 4GG of chapter 176G of the General Laws, reimbursement for the psychiatric collaborative care model shall include, but not be limited to, the following current procedural terminology billing codes established by the American Medical Association: (1) 99492; (2) 99493; and (3) 99494.

SECTION 57. The division of insurance shall promulgate regulations to implement section 5D of chapter 176O of the General Laws not later than 1 year from the effective date of this act; provided, however, that the division shall, upon publication, forward any draft regulations to the joint committee on health care financing and the joint committee on mental health, substance use and recovery.

SECTION 58. Section 16P½ of chapter 6A of the General Laws shall take effect 1 year after the effective date of this act.