

SENATE No. 3097

The Commonwealth of Massachusetts

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

SENATE, August 1, 2022

Report of the committee of conference on the disagreeing votes of the two branches, with reference to the House amendments to the Senate addressing barriers to care for mental health (Senate, No. 2584) (amended by the House by striking out all after the enacting clause and inserting in place thereof the text of House document numbered 4891),-- reports, a “Bill addressing barriers to care for mental health” (Senate, No. 3097).

For the Committee:

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

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:

1 SECTION 1. Subsection (d) of section 219 of chapter 6 of the General Laws, as
2 appearing in the 2020 Official Edition, is hereby amended by striking out clauses (5) and (6) and
3 inserting in place thereof the following 8 clauses:-

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

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

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

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

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

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

22 (11) serve as an advisory board to the office of behavioral health promotion established in
23 section 16DD of chapter 6A; and

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

26 SECTION 2. Chapter 6A of the General Laws is hereby amended by striking out section
27 16P, as so appearing, and inserting in place thereof the following section:-

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

30 “Adult”, an individual who is older than 22 years of age.

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

34 “Boarding”, waiting not less than 12 hours to be placed in an appropriate therapeutic
35 setting after: (i) being assessed; (ii) being determined in need of acute psychiatric treatment,
36 crisis stabilization unit placement, community-based acute treatment, intensive community-based
37 acute treatment, continuing care unit placement or post-hospitalization residential placement; and
38 (iii) receiving a determination from a licensed health care provider of medical stability without
39 the need for urgent medical assessment or hospitalization for a physical condition.

40 “Children and adolescents”, individuals who are 22 years of age or less.

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

50 (2) The online portal shall include, but not be limited to, the following data: (i) the total
51 number of children and adolescents boarding, including a breakdown, by location, of where the
52 children and adolescents are boarding, which shall include, but not be limited to, hospital
53 emergency rooms, emergency services sites and medical floors after having received medical
54 stabilization treatment or their homes; (ii) the total number of children and adolescents awaiting
55 residential disposition, including a breakdown, by facility type, of where children and

56 adolescents are awaiting residential disposition and the level of care or type of placement sought;
57 and (iii) the total number of children and adolescents in the care or custody of a state agency who
58 are hospitalized and have waited not less than 72 hours for discharge to an appropriate foster
59 home or a congregate or group care program after having been determined to no longer need
60 hospital-level care.

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

74 (4) The online portal shall include information on the specific availability of pediatric
75 acute psychiatric beds, crisis stabilization unit beds, community-based acute treatment beds,
76 intensive community-based acute treatment beds, continuing care beds and post-hospitalization
77 residential beds. The online portal shall also enable a real-time bed search within a specified
78 geographic region that shall include, but not be limited to: (i) the total number of beds licensed

79 by the department of mental health, the department of public health and the department of early
80 education and care; (ii) the total number of available beds, broken down by location, licensing
81 authority, age ranges and the distance, in miles, from where a child or adolescent currently
82 resides and is boarding; (iii) the average daily bed availability, broken down by licensing
83 authority and age ranges; (iv) daily bed admissions, broken down by licensing authority and age
84 ranges; (v) the facility or location in which a child or adolescent was admitted; (vi) daily bed
85 discharges, broken down by licensing authority and age ranges; and (vii) the average length of
86 stay in a bed, broken down by licensing authority and age ranges.

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

100 (c) The secretary of health and human services shall facilitate psychiatric and substance
101 use disorder inpatient admissions for adults seeking to be admitted from an emergency

102 department or hospital medical floor by developing and maintaining a confidential and secure
103 online portal that enables health care providers, health care facilities and payors to conduct a
104 real-time bed search for patient placement. The online portal shall provide real-time information
105 on the specific availability of all licensed psychiatric and substance use disorder inpatient beds
106 that shall include, but not be limited to: (i) location; (ii) care specialty; and (iii) insurance
107 requirements. The online portal and information contained in the online portal shall not be a
108 public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66.

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

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

117 (b) The team shall consist of: the secretary of health and human services or a designee,
118 who shall serve as co-chair; the commissioner of elementary and secondary education or a
119 designee, who shall serve as co-chair; the assistant secretary of MassHealth or a designee; the
120 commissioner of mental health or a designee; the commissioner of children and families or a
121 designee; the commissioner of developmental services or a designee; the commissioner of youth
122 services or a designee; the commissioner of early education and care or a designee; the secretary
123 of the executive office of education or a designee; a representative from the office of the child

124 advocate; and a representative from the school district or districts responsible for any aspect of
125 an individual's education. The co-chairs may agree to convene a subset of the above-listed team
126 members according to the circumstances of the individual's case; provided however, that a
127 representative from the office of the child advocate shall be present at all team meetings.

128 (c)(1) An individual may be referred to the team by the individual themselves if the
129 individual is age 16 years or older, a state agency including a representative from the agency's
130 ombudsman's office, the juvenile court, a hospital or emergency service provider, a school
131 district, an attorney representing the individual or the individual's parent or guardian, a physician
132 or behavioral health care provider authorized to act on behalf of a parent or guardian who is
133 seeking access to services for the individual or the individual's parent or guardian.

134 (2) Not later than 5 business days after referral of an individual to the team, the co-chairs
135 shall convene the team; provided, however, that for referrals involving an individual waiting in a
136 hospital emergency department or medical bed, or at home for not less than 5 days to be placed
137 in an appropriate therapeutic setting or to be provided with appropriate evaluations and services,
138 the co-chairs shall convene the team not later than 1 business day after receiving the referral. The
139 team may order expedited eligibility determinations by a state agency or an extended evaluation
140 at a special education residential school in order for the team to make determinations about the
141 individual's current service needs if deemed necessary after the receipt of the referral and a
142 review of relevant materials, including educational records and evaluations and review of any
143 report issued from the area or regional level of state agencies involved.

144 (3) Upon receipt and review of all necessary and updated information regarding the
145 individual's service needs and eligibility decisions, the team shall determine the services

146 currently in place, additional services that are needed to meet the current needs of the individual,
147 which agencies shall provide said services, including location or placement where appropriate
148 and ongoing case management services, and which agencies have fiscal responsibilities to pay
149 for such services. The team shall complete its review within 30 business days; provided,
150 however, that for referrals involving an individual waiting in a hospital emergency department or
151 medical bed, or at home for not less than 5 days to be placed in an appropriate therapeutic setting
152 or to be provided with appropriate evaluations and services, the team shall complete its review
153 within 5 business days. The co-chairs may authorize the expenditure of funds pursuant to section
154 2TTTTT of chapter 29 to effectuate the purposes of this section. If the team does not come to
155 resolution regarding which agency or agencies have fiscal responsibility, the co-chairs shall
156 assume joint fiscal responsibility to avoid any delay in an individual receiving needed services.
157 The co-chairs may authorize the expenditure of funds pursuant to said section 2TTTTT of said
158 chapter 29 to cover the costs of needed services for an individual until a resolution regarding
159 agency fiscal responsibility is reached.

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

166 (e) Notwithstanding chapters 66A, 112 and 119 or any other state or federal law related to
167 the confidentiality of personal data, the team, the secretary of health and human services and the
168 division of administrative law appeals shall have access to and may discuss materials related to

169 the case while the case is under review; provided, that the individual or their parent or guardian
170 shall consent in writing; and provided further, that such materials shall not be considered public
171 records and that those having access shall agree in writing to keep the materials confidential.

172 (f) The secretary of health and human services with the commissioner of elementary and
173 secondary education shall promulgate regulations to effectuate the purposes of this section. The
174 regulations shall include, but not be limited to: (i) the respective roles of the secretary of health
175 and human services and the commissioner of elementary and secondary education for facilitating
176 the work of the team; (ii) processes, including expedited processes, and timelines for required
177 notifications between state agencies, the team and individuals who may be eligible for assistance
178 or their parent or a person legally authorized to act on their behalf; (iii) record sharing processes,
179 including requirements for obtaining consumer or parental consent; (iv) data gathering and
180 reporting requirements; (v) protocols to ensure that individuals, parents and guardians are aware
181 of the interagency review available in accordance with this section, and are provided with regular
182 updates from the team and afforded opportunities to provide input and make decisions
183 throughout the review process; and (vi) the interagency services reserve fund established in
184 section 2TTTTT of chapter 29, including allowable uses of resources from said fund, processes
185 for requesting and documenting requests, authorizations and denials and issuance of resources
186 from said fund.

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

192 (h) Nothing in this section shall limit the rights of parents, guardians or children under
193 chapter 71B, the federal Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq. or
194 section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 et seq. No decision or action taken
195 under this section by the team shall be considered prejudicial by the Bureau of Special Education
196 Appeals, the Division of Administrative Law Appeals or the MassHealth Board of Hearings.

197 SECTION 4. Said chapter 6A is hereby further amended by inserting after section 16CC
198 the following 3 sections:-

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

201 “Office”, the office of behavioral health promotion.

202 “Secretary”, the secretary of health and human services

203 (b) There shall be an office of behavioral health promotion within the executive office of
204 health and human services. The office shall be under the supervision and control of a director of
205 behavioral health promotion who shall be appointed by and shall report to the secretary. The
206 commission on community behavioral health promotion established in section 219 of chapter 6
207 shall serve as an advisory board to the office.

208 (c) The office shall facilitate the coordination of all executive office, state agency,
209 independent agency and state commission activities that promote behavioral health and wellness.
210 The office shall set goals for the promotion of services and programming for behavioral health
211 and substance use conditions. The office shall, in collaboration with the office of health equity
212 established under section 16AA, fully integrate health equity principles and apply a health equity

213 framework to all its duties and obligations. The office shall prepare and implement an annual
214 plan for the promotion of behavioral health.

215 (d) The office shall collaborate with the executive offices and state agencies on
216 behavioral health promotion. The executive offices and agencies shall include, but not be limited
217 to: the executive office of health and human services, the executive office of education, the
218 executive office of elder affairs, the department of mental health, the department of public
219 health, the department of children and families, department of youth services, the department of
220 veterans' services, the department of early education and care, the department of elementary and
221 secondary education, the office for refugees and immigrants, the office of health equity, the
222 office of the child advocate and any other relevant office, agency or commission. The office shall
223 facilitate communication and partnership between relevant entities to develop and promote
224 understanding of the intersections between entity activities and behavioral health promotion.

225 (e) The office shall:

226 (i) facilitate the development of interagency initiatives that: (A) are informed by the
227 science of promotion and prevention; (B) advance health equity and trauma-informed care; and
228 (C) address the social determinants of health;

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

232 (iii) advance the identification and dissemination of evidence-based or evidence-informed
233 practices designed to further promote behavioral health and the provision of supportive

234 behavioral health services and programming to address substance use conditions and sequelae
235 and to prevent violence through trauma-specific intervention and rehabilitation;

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

239 (v) coordinate behavioral health promotion and wellness programs, campaigns and
240 initiatives;

241 (vi) provide staffing support for the commission on community behavioral health
242 promotion established in section 219 of chapter 6;

243 (vii) ascertain the behavioral health needs of veterans, including but not limited to an
244 examination of: (A) the extent to which veterans seek, receive or are required to participate in
245 behavioral health screening and treatment, if known; (B) barriers to veterans receiving or
246 participating in behavioral health screening and treatment; (C) current programs and best
247 practices to incentivize and support veterans to seek, receive and participate in behavioral health
248 screening and treatment; and (D) any recommendations for improving access to and participation
249 in behavioral health screening and treatment by veterans;

250 (viii) examine: (A) the extent to which municipal and state police, firefighters and public
251 safety personnel seek, receive or are required to participate in behavioral health screening and
252 treatment, if known; (B) barriers to municipal and state police, firefighters and public safety
253 personnel receiving or participating in behavioral health screening and treatment; (C) current
254 programs and best practices to incentivize and support municipal and state police, firefighters
255 and public safety personnel to seek, receive and participate in behavioral health screening and

256 treatment; and (D) any recommendations for improving access to and participation in behavioral
257 health screening and treatment by municipal and state police, firefighters and public safety
258 personnel;

259 (ix) establish a statewide evidence-based or evidence-informed education and awareness
260 initiative to: (A) identify and disseminate best practices for preventing suicide and improving the
261 behavioral health, mental wellness and resiliency among health care professionals; (B) encourage
262 health care professionals to seek behavioral health support and care; (C) help such professionals
263 identify risk factors associated with suicide and behavioral health crisis and to help such
264 professionals learn how best to respond to such risks;

265 (x) convene a student stakeholder advisory committee on mental health to work in
266 collaboration with the department of elementary and secondary education to develop and
267 implement school-based programs that promote student mental health and wellbeing, including
268 but not limited to: (A) addressing and eliminating the stigma associated with mental health
269 conditions and substance use disorder; (B) recognizing the signs and symptoms of mental health
270 conditions; (C) addressing cyberbullying; (D) preventing and responding to student suicide and
271 suicidal ideation, including actions involving self-harm; (E) promoting positive coping behaviors
272 and helping students avoid behaviors that can cause harm to students; and (F) promoting mental
273 health treatment and recovery; provided, however, that no less than 1/3 of the committee
274 members shall be secondary school students; provided further, that the committee shall submit an
275 annual report by June 30 with its findings and recommendations, including any legislative or
276 regulatory changes that may be necessary, to the office, which shall provide such report to the
277 clerks of the house of representatives and the senate, the joint committee on mental health,

278 substance use and recovery, the joint committee on health care financing, the joint committee on
279 education and, the house and senate committees on ways and means;

280 (xi) address the stigma associated with seeking behavioral health services; and

281 (xii) analyze and address any other issues pertaining to behavioral health promotion as
282 deemed relevant by the office or the secretary. The office may enter into service agreements with
283 the department of mental health or the department of public health to fulfill the obligations of the
284 office.

285 (f) The office shall evaluate the effectiveness of programs and interventions to promote
286 behavioral health and wellness, identifying best practices and model programs for the
287 commonwealth.

288 (g) Annually, not later than July 1, the office shall report on its progress, and the overall
289 progress of the commonwealth, toward promoting behavioral health and wellness and preventing
290 substance use and violence using, when possible, quantifiable measures and comparative
291 benchmarks, including a description of quantitative and qualitative metrics used to evaluate the
292 office's activities and outcomes of the office's initiatives. The report shall be filed with the
293 governor, the clerks of the senate and house of representatives and the joint committee on mental
294 health, substance use and recovery. The report shall be posted on the official website of the
295 commonwealth.

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

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

302 “Community crisis stabilization program”, a program providing crisis stabilization
303 services with the capacity for diagnosis, initial management, observation, crisis stabilization and
304 follow-up referral services to all persons in a home-like environment, including, but not limited
305 to, emergency service providers and restoration centers.

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

310 (c) A 988 crisis hotline center shall: (i) meet the United States Department of Health and
311 Human Services’ Ambulatory Behavioral Health System standards and the National Suicide
312 Prevention Lifeline requirements and best practices guidelines for operational and clinical
313 standards; (ii) provide data, report and participate in evaluations and related quality improvement
314 activities as required by the United States Department of Health and Human Services; (iii) utilize
315 technology, including, but not limited to, chat and text capabilities, that is interoperable between
316 and across crisis and emergency response systems and services, including 911 and 211, as
317 necessary; (iv) have the authority to deploy crisis and outgoing services, including mobile
318 behavioral health crisis responders, and coordinate access to crisis triage, evaluation and
319 counseling services, community crisis stabilization programs or other resources as appropriate;

320 (v) maintain standing partnership agreements with community behavioral health centers and
321 other behavioral health programs and facilities, including programs led by individuals who are or
322 were consumers of mental health or substance use disorder supports or services; (vi) coordinate
323 access to crisis evaluation, counseling, receiving and stabilization services for individuals
324 accessing the 988 suicide prevention and behavioral health crisis hotline through appropriate
325 information sharing regarding availability of services; (vii) have the capability to serve high-risk
326 and specialized populations including, but not limited to, people with co-occurring substance use
327 and mental health conditions and people with autism spectrum disorders or intellectual or
328 developmental disabilities; (viii) have the capability to serve people of diverse races, ethnicities,
329 ages, sexual orientations and gender identities with linguistically and culturally competent care;
330 (ix) have the capability to provide crisis and outgoing services within a reasonable time period in
331 all geographic areas of the commonwealth; and (x) provide follow-up services to individuals
332 accessing the 988 suicide prevention and behavioral health crisis hotline.

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

336 (2) The commission shall review national guidelines and best practices and make
337 recommendations for implementation of a statewide 988 suicide prevention and behavioral
338 health crisis system, including any legislative or regulatory changes that may be necessary for
339 988 implementation and recommendations for funding that may include the establishment of user
340 fees. The commission shall also advise on promoting the 988 number including, but not limited
341 to, recommendations for including information about calling 988 on student identification cards
342 and on signage in locations where there have been known suicide attempts.

343 (3) The commission shall consist of: the secretary of health and human services or the
344 secretary's designee, who shall serve as chair; the secretary of public safety and security or the
345 secretary's designee; the commissioner of mental health or the commissioner's designee; the
346 commissioner of public health or the commissioner's designee; the executive director of the
347 Massachusetts Behavioral Health Partnership or the executive director's designee; the executive
348 director of the state 911 department or the executive director's designee; the executive director of
349 Mass 2-1-1 or the executive director's designee; a representative designated by the
350 Massachusetts Chapter of the National Association of Social Workers, Inc.; a 911 dispatcher
351 designated by the Massachusetts Chiefs of Police Association Incorporated; an emergency
352 medical technician or first responder nominated by the Massachusetts Ambulance Association,
353 Incorporated; and the following members to be appointed by the chair: 1 representative from an
354 emergency service provider, nominated by the Association for Behavioral Healthcare, Inc.; 1
355 representative from the Association for Behavioral Healthcare, Inc.; 1 representative from a
356 suicide prevention hotline in the commonwealth, nominated by the Samaritans, Inc.; 1
357 representative from the Riverside Community Care, Inc. MassSupport program; 1 representative
358 from the Massachusetts Coalition for Suicide Prevention; 1 representative from the Children's
359 Mental Health Campaign; 1 representative from the INTERFACE Referral Service at William
360 James College, Inc.; 1 representative from the National Alliance on Mental Illness of
361 Massachusetts, Inc.; 1 representative from the Parent/Professional Advocacy League, Inc.; 1
362 representative from the Massachusetts Association for Mental Health, Inc.; 1 representative from
363 the Boston branch of the National Association for the Advancement of Colored People; 1
364 representative from the American Civil Liberties Union of Massachusetts, Inc.; 1 representative
365 from the mental health legal advisors committee; and 3 persons who are or have been consumers

366 of mental health or substance use disorder supports or services. Every reasonable effort shall be
367 made to ensure representation from all geographic areas of the commonwealth.

368 (4) Annually, not later than March 1, the commission shall submit its findings and
369 recommendations to the clerks of the senate and house of representatives, the joint committee on
370 mental health, substance use and recovery and the joint committee on health care financing.

371 Section 16FF. (a) Subject to appropriation, the executive office of health and human
372 services, in coordination with the department of elementary and secondary education, shall
373 develop and implement a statewide program to assist in implementing behavioral health services
374 and supports in each school district which shall include, but not be limited to, consultation,
375 coaching and technical assistance.

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

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

387 Health Integrated Resources for Children Project within the University of Massachusetts at
388 Boston.

389 SECTION 5. Section 8 of chapter 6D of the General Laws, as appearing in the 2020
390 Official Edition, is hereby amended by inserting after the word “system”, in line 9, the following
391 words:- and trends in annual behavioral health expenditures.

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

395 (b) There shall be, within the executive office of public safety and security, a state 911
396 commission to provide strategic oversight and guidance to the department, and to advise the
397 department relative to its annual budget and all material changes thereto and in all matters
398 regarding enhanced 911 service in the commonwealth. The commission shall consist of: the
399 secretary of public safety and security, who shall serve as chairperson; the chief information
400 officer of the information technology division; the colonel of state police; the state fire marshal;
401 the police commissioner of the city of Boston; the director of the Massachusetts office on
402 disability; the commissioner of public health; the commissioner of mental health; the
403 commissioner of the Massachusetts commission for the deaf and hard of hearing; and 13
404 members to be appointed by the governor, 1 of whom shall be a sitting police chief and a
405 representative of the Massachusetts Chiefs of Police Association, Inc., 1 of whom shall be a
406 representative of the Massachusetts Police Association, Inc., 1 of whom shall be a sitting police
407 chief and a representative of the Massachusetts Major City Chiefs Association, 2 of whom shall
408 be sitting fire chiefs and representatives of the Massachusetts Fire Chiefs Association, 1 of

409 whom shall be a representative of the Professional Fire Fighters of Massachusetts, 1 of whom
410 shall be a representative of the Massachusetts Sheriffs Association, Inc., 1 of whom shall be a
411 representative of the Massachusetts Municipal Association, Inc., 1 of whom shall be a
412 representative of the Massachusetts Emergency Medical Care Advisory Board, 1 of whom shall
413 be a representative of the Massachusetts Ambulance Association, Inc., 1 of whom shall be a
414 manager or supervisor of a PSAP and a representative of the Massachusetts Communication
415 Supervisors Association, Inc., 1 of whom shall be a representative of the Association for
416 Behavioral Healthcare, Inc. with experience in delivering psychiatric emergency services, and 1
417 of whom shall be an individual with lived experience with behavioral health conditions and
418 interactions with police. One of the governor's appointees shall be elected annually by the
419 commission as its vice chairperson. Members of the commission shall be appointed for terms of
420 3 years with no limit on the number of terms they may serve. Members shall hold office until a
421 successor is appointed and no member shall serve beyond the time the member ceases to hold the
422 office or employment that made the member eligible for appointment to the commission. The
423 commission shall meet at least twice annually, and at other times as necessary. A meeting of the
424 commission may be called by its chairperson, the vice chairperson or 3 of its members. A
425 quorum for the transaction of business shall consist of 9 members. Members of the commission
426 shall receive no compensation, but shall be reimbursed for their expenses actually and
427 necessarily incurred in the discharge of their duties. The commission shall review and approve
428 by a majority vote of those members present all formulas, percentages, guidelines or other
429 mechanisms used to distribute the grants described in this section, and all major contracts that the
430 department proposes to enter into for enhanced 911 services. The commission shall review and

431 approve by a majority vote of those members present all regulations and standards proposed by
432 the department.

433 SECTION 7. Paragraph (2) of subsection (i) of said section 18B of said chapter 6A, as so
434 appearing, is hereby amended by striking out the ninth and tenth sentences and inserting in place
435 thereof the following 2 sentences:- In the guidelines administering this grant, the department may
436 include provisions to increase the allocation of funds to primary PSAPs provided under this grant
437 that dispatch police, fire protection, emergency medical services and mobile behavioral health
438 crisis response services, taking into account if any such services are provided by a private safety
439 department. The department may include in such guidelines provisions to increase the allocation
440 of funds to regional secondary PSAPs that dispatch any combination of regional police, fire
441 protection, emergency medical services or mobile behavioral health crisis response services.

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

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

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

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

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

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

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

463 SECTION 9. Said section 8 of said chapter 6D, as so appearing, is hereby further
464 amended by striking out, in line 94, the word “and” and inserting in place thereof the following
465 words:- , including behavioral health expenditures, and.

466 SECTION 10. Section 16 of said chapter 6D, as so appearing, is hereby amended by
467 inserting after the figure “1760”, in line 66, the following words:- , including a process for
468 identifying and referring matters to the division of insurance and the office of the attorney
469 general for review of compliance with state and federal mental health and substance use disorder
470 parity laws.

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

473 Section 20. Every 3 years, the commission, in collaboration with the department of public
474 health, the department of mental health and the department of developmental services, shall
475 prepare a pediatric behavioral health planning report analyzing the status of pediatric behavioral
476 health in the commonwealth. The report shall include, but not be limited to: (i) a review of data
477 from the online portal established in section 16P of chapter 6A and the reports submitted to the
478 commission pursuant to subsection (f) of said section 16P of said chapter 6A; (ii) an analysis of
479 the availability of pediatric acute psychiatric beds, crisis stabilization unit beds, community-
480 based acute treatment beds, intensive community-based acute treatment beds, continuing care
481 unit beds and post-hospitalization residential beds, broken down by geographic region and by
482 sub-specialty, and an identification of any service limitations; (iii) an analysis of the capacity of
483 the pediatric behavioral health workforce to respond to the acute behavioral health needs of
484 children and adolescents across the commonwealth; (iv) any statutory, regulatory or operational
485 factors that may impact pediatric boarding under said section 16P of said chapter 6A; and (v) any
486 other information deemed relevant by the commission. The report shall be published on the
487 commission's website.

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

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

504 SECTION 13. Section 21A of said chapter 12C, as so appearing, is hereby amended by
505 adding the following sentence:- The investigation and study shall also include developing and
506 defining criteria for health care services to be categorized as behavioral health services, with
507 subcategories including, but not limited to: (i) mental health; (ii) substance use disorder; (iii)
508 outpatient; (iv) inpatient; (v) services for children; (vi) services for adults; and (vii) provider
509 type.

510 SECTION 14. Section 88 of chapter 13 of the General Laws, as so appearing, is hereby
511 amended by striking out the figure “13”, in line 4, and inserting in place thereof the following
512 figure:- 15.

513 SECTION 15. Section 89 of said chapter 13, as so appearing, is hereby amended by
514 striking out paragraph (A) in its entirety and inserting in place thereof the following paragraph:-

515 (A) 12 members shall be licensed practicing mental health and human services
516 professionals and shall have been, for at least 5 years immediately preceding appointment,
517 actively engaged as a practitioner rendering professional services in that field, in the education

518 and training of graduate students or interns in the field, in appropriate human developmental
519 research, or in another area substantially equivalent thereto, and shall, during the 2 years
520 preceding the appointment, have spent the majority of their professional time in such activity in
521 the commonwealth. One of the 12 shall also be a member of a union licensable under sections
522 163 to 172, inclusive, of chapter 112.

523 Said members shall be appointed in such a manner as to proportionally represent the total
524 number of active holders of each professional license type, as determined from time to time by
525 the board; provided, that at least 1 member shall be a marriage and family therapist, at least 1
526 shall be a rehabilitation counselor, at least 1 shall be a clinical mental health counselor, at least 1
527 shall be an educational psychologist and at least 1 shall be a behavior analyst who meet the
528 qualifications in the last 2 paragraphs of section 165 of chapter 112.

529 SECTION 16. Chapter 13 of the General Laws is hereby amended by striking out section
530 80, as so appearing, and inserting in place thereof the following section:-

531 Section 80. There shall be a board of registration of social workers that shall consist of:
532 the commissioner of children and families or a designee who shall be licensed as a certified
533 social worker or as an independent clinical social worker under sections 130 to 137, inclusive, of
534 chapter 112; the commissioner of mental health or a designee who shall be licensed as a certified
535 social worker or as an independent clinical social worker under said sections 130 to 137,
536 inclusive, of said chapter 112; and 7 persons to be appointed by the governor, 1 of whom shall be
537 a representative of an accredited school of social work, 3 of whom shall be licensed as certified
538 social workers or as independent clinical social workers under said sections 130 to 137,
539 inclusive, of said chapter 112, 1 of whom shall be an active member of an organized labor

540 organization representing social workers who shall be licensed under said sections 130 to 137,
541 inclusive, of said chapter 112 and 2 of whom shall be members of the general public . At least 1
542 member who is a licensed social worker and at least 1 member from the general public shall
543 represent an underserved population as defined by the United States Department of Health and
544 Human Services.

545 SECTION 17. Section 18 of chapter 15A of the General Laws, as so appearing, is hereby
546 amended by adding the following paragraph:-

547 Any qualifying student health insurance plan authorized under this chapter shall comply
548 with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity
549 Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including
550 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part
551 156.115(a)(3), and the benefit mandates and other obligations under section 47B of chapter 175,
552 section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter
553 176G, as if the student health insurance plan was issued by such carriers licensed under said
554 chapters 175, 176A, 176B and 176G without regard to any limitation under section 1 of chapter
555 176J.

556 SECTION 18. Chapter 15D of the General Laws is hereby amended by inserting after
557 section 12 the following section:-

558 Section 12A. (a)(1) The department shall develop performance standards necessary for
559 prohibiting or significantly limiting the use of suspension and expulsion in all licensed early
560 education and care programs pursuant to clause (t) of section 2. The standards shall be developed

561 with input from relevant stakeholders including, but not limited to the mixed delivery early
562 education and child care field.

563 (2) The standards shall ensure that expulsion and suspension are limited to extraordinary
564 circumstances where there is a documented assessment that the child’s behavior poses a serious
565 ongoing threat to the safety of others that cannot be reduced or eliminated by reasonable program
566 modifications that are accessible to the program.

567 (b) The performance standards shall include, but not be limited to: (i) benchmarks and
568 goals for supporting children’s social, emotional and behavioral development to (A) reduce the
569 use of expulsion as a disciplinary tool; (B) guidance on eliminating disparities in the use of
570 suspension and expulsion, (C) facilitate referrals for children with intensive needs; and (D)
571 establish programs to provide transitional support for children returning to early education and
572 care programming after extended absences, including behavioral health-related absences; (ii)
573 engagement steps to be taken with the child and parent or guardian prior to suspension or
574 expulsion; (iii) requirements for communicating disciplinary policies, including suspension and
575 expulsion policies, to staff, families, guardians and community partners; (iv) pathways for
576 programs to access technical assistance through the statewide program established in section
577 16EE of chapter 6A to support ongoing development of staff and teacher skills for supporting
578 children’s social, emotional and behavioral development, reducing disparities and limiting the
579 use of suspension and expulsion; and (v) requirements for assessing and documenting a serious
580 ongoing threat to the safety of others.

581 SECTION 19. Section 5 of chapter 18C of the General Laws, as appearing in the 2020
582 Official Edition, is hereby amended by striking out subsection (d) and inserting in place thereof
583 the following subsection:-

584 (d) The child advocate shall receive complaints from children, including children in the
585 care of the commonwealth, families and guardians and shall assist such persons in resolving
586 problems and concerns associated with placement, access to behavioral health services, plans for
587 life-long adult connections and independent living and decisions regarding custody of persons
588 aged between 18 and 22, including ensuring that relevant executive agencies have been alerted to
589 the complaint and facilitating inter-agency cooperation, if appropriate. For the purposes of this
590 section, the office shall develop procedures to ensure appropriate responses to the concerns of
591 youth in foster care.

592 SECTION 20. Chapter 18C of the General Laws is hereby amended by inserting after
593 section 10 the following section:-

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

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

604 SECTION 21. Said chapter 19 is hereby further amended by adding the following
605 section:-

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

614 (b) The advisory council shall consist of the following members: the commissioner of
615 mental health or a designee, who shall serve as chair; the commissioner of public health or a
616 designee; the director of the office of Medicaid or a designee; the commissioner of insurance or a
617 designee; a representative from the Massachusetts Association of Health Plans, Inc.; a
618 representative of Blue Cross and Blue Shield of Massachusetts, Inc.; a representative of the
619 Massachusetts Health and Hospital Association, Inc.; a representative of the Massachusetts
620 College of Emergency Physicians, Inc.; a representative of the Association for Behavioral
621 Healthcare, Inc.; a representative of the National Alliance on Mental Illness of Massachusetts,
622 Inc.; a representative of the Massachusetts Association of Behavioral Health Systems, Inc.; a

623 member representing emergency services providers; and a consumer representative with lived
624 experience boarding in an emergency department.

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

634 (d) Notwithstanding any general or special law to the contrary, the expedited psychiatric
635 inpatient admissions protocol established by the department shall: (i) require, for patients under
636 the age of 18, notification by the hospital emergency department to the department in order to
637 expedite placement in or admission to an appropriate treatment program or facility within 48
638 hours of boarding or within 48 hours of being assessed to need acute psychiatric treatment and
639 having been determined by a licensed health care provider to be medically stable without the
640 need for urgent medical assessment or hospitalization for a physical health condition; (ii)
641 include, within the escalation protocol, patients who initially had a primary medical diagnosis or
642 primary presenting problem requiring treatment on a medical-surgical floor, who have been
643 subsequently medically cleared and are boarding on a medical-surgical floor for an inpatient
644 psychiatric placement; and (iii) include, for patients under the age of 18, notification upon

645 discharge from the emergency department, satellite emergency facility or medical-surgical floor
646 to the patient’s primary care physician or treating behavioral health clinician, if known.

647 SECTION 22. Chapter 26 of the General Laws is hereby amended by striking out section
648 8K, as appearing in the 2020 Official Edition, and inserting in place thereof the following
649 section:-

650 Section 8K. (a) The commissioner of insurance shall implement and enforce applicable
651 provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction
652 Equity Act of 2008, as amended, any federal guidance or regulations relevant to the act,
653 including 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part
654 156.115(a)(3), and applicable state mental health parity laws, including, but not limited to,
655 section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and sections
656 4, 4B and 4M of chapter 176G, in regard to any carrier licensed under said chapters 175, 176A,
657 176B or 176G or any carrier offering a student health plan issued under section 18 of chapter
658 15A by:

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

662 (ii) performing behavioral health parity compliance market conduct examinations of each
663 carrier not less than once every 4 years, or more frequently if noncompliance is suspected, with a
664 focus on: (A) nonquantitative treatment limitations under the federal Paul Wellstone and Pete
665 Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and applicable
666 state mental health and substance use disorder parity laws, including, but not limited to, prior

667 authorization, concurrent review, retrospective review, step-therapy, network admission
668 standards, reimbursement rates, network adequacy and geographic restrictions; (B) denials of
669 authorization, payment and coverage; and (C) any other criteria determined by the division of
670 insurance, including factors identified through consumer or provider complaints; provided,
671 however, that: (1) a market conduct examination of a carrier subject to said chapter 175, 176A,
672 176B or 176G shall follow the procedural requirements in subsections 10, 11 and 15 of section 4
673 of said chapter 175 regarding notice and rebuttal of examination findings, subsequent hearings
674 and conflicts of interest; (2) the commissioner shall publicize the fees for a market conduct
675 examination under section 3B of chapter 7 and said subsection 11 of said section 4 of said
676 chapter 175; and (3) nothing contained in clause (ii) or in said section 4 of said chapter 175,
677 section 7 of said chapter 176A, section 9 of said chapter 176B and section 10 of said chapter
678 176G shall limit the commissioner's authority to use and, if appropriate, publish any final or
679 preliminary examination report, any examiner or company work papers or other documents or
680 any other information discovered or developed during the course of any examination in the
681 furtherance of any legal or regulatory action that the commissioner may, in their sole discretion,
682 deem appropriate;

683 (iii) requiring that carriers that provide mental health or substance use disorder benefits
684 directly or through a behavioral health manager as defined in section 1 of chapter 176O or any
685 other entity that manages or administers such benefits for the carrier comply with the annual
686 reporting requirements under section 8M;

687 (iv) updating applicable regulations as necessary to effectuate any provisions of the
688 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
689 2008, as amended that relate to insurance; and

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

701 (b) The commissioner may impose a penalty against a carrier that provides mental health
702 or substance use disorder benefits, directly or through a behavioral health manager as defined in
703 section 1 of chapter 176O or any other entity that manages or administers such benefits for the
704 carrier, for any violation by the carrier or the entity that manages or administers mental health
705 and substance use disorder benefits for the carrier of state laws related to mental health and
706 substance use disorder parity or the mental health parity provisions of the federal Paul Wellstone
707 and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j),
708 as amended, and federal guidance or regulations issued under the act.

709 The amount of any penalty imposed shall be \$100 for each day in the noncompliance
710 period per product line with respect to each participant or beneficiary to whom such violation
711 relates; provided, however, that the maximum annual penalty under this subsection shall be
712 \$1,000,000; provided further, that for purposes of this subsection, the term "noncompliance

713 period” shall mean the period beginning on the date a violation first occurs and ending on the
714 date the violation is corrected.

715 A penalty shall not be imposed for a violation if the commissioner determines that the
716 violation was due to reasonable cause and not to willful neglect or if the violation is corrected
717 not more than 30 days after the start of the noncompliance period.

718 (c) If a violation of state laws related to mental health and substance use disorder parity
719 or the mental health parity provisions of the federal Paul Wellstone and Pete Domenici Mental
720 Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as amended, and federal
721 guidance or regulations issued under the act, was likely to have caused denial of access to
722 behavioral health services, the commissioner shall require carriers to provide remedies for any
723 failure to meet the requirements of state laws related to mental health and substance use disorder
724 parity or the mental health parity provisions of the federal Paul Wellstone and Pete Domenici
725 Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as amended, and
726 federal guidance or regulations issued under the act, which may include, but shall not be limited
727 to:

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

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

731 (iii) informing plan members of changes;

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

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

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

737 (d) Any proprietary information submitted to the commissioner by a carrier as a result of
738 the requirements of this section shall not be a public record under clause Twenty-sixth of section
739 7 of chapter 4 or chapter 66; provided, however, that the commissioner may produce reports
740 summarizing any findings.

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

744 (f) The commissioner shall evaluate and resolve a consumer complaint alleging a
745 carrier's non-compliance with a state or federal law related to mental health and substance use
746 disorder parity, including any matters referred to the commissioner by the office of patient
747 protection under subsection (g) of section 14 of chapter 176O. A consumer complaint may be
748 submitted orally or in writing; provided, however, that an oral complaint shall be followed by a
749 written submission to the commissioner that shall include, but not be limited to, the
750 complainant's name and address, the nature of the complaint and the complainant's signature
751 authorizing the release of any information regarding the complaint to help the commissioner with
752 the review of the complaint; and provided further, that the commissioner shall create a process
753 for a consumer to request the appointment of an authorized representative to act on the
754 consumer's behalf.

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

774 The commissioner shall respond as soon as practicable to all questions or concerns from
775 consumers about carrier compliance with state or federal laws related to mental health and
776 substance use disorder parity that are referred to the commissioner from the office of patient
777 protection under subsection (g) of section 14 of chapter 176O.

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

780 (h) Nothing in this section shall prevent the commissioner from publishing any
781 illustrative utilization review criteria, medical necessity standard, clinical guideline or other
782 policy, procedure, criteria or standard, regardless of its origin, as an example of the type of
783 policy, procedure, criteria or standard that contributes to a violation of state or federal law parity
784 requirements, including any document that would normally be subject to disclosure to plan
785 members or their providers under section 16 of chapter 6D, section 16 of chapter 176O or the
786 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
787 2008, as amended.

788 SECTION 23. Said chapter 26 is hereby further amended by inserting after section 8L the
789 following section:-

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

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

800 the carrier's reimbursement rates for mental health and substance use disorder benefits and
801 medical and surgical benefits in each respective benefits classification;

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

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

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

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

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

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

825 (viii) any other data or information the commissioner deems necessary to assess a
826 carrier's compliance with mental health parity requirements.

827 (b) If federal guidance, including, but not limited to, the Self-Compliance Tool for the
828 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
829 2008, as amended, is released that indicates a nonquantitative treatment limitation analysis
830 process and reporting format that is significantly different from, contrary to or more efficient
831 than the nonquantitative treatment limitation analysis process and reporting format requirements
832 described in subsection (a), the commissioner may promulgate regulations that delineate a
833 nonquantitative treatment limitation analysis process and reporting format that may be used in
834 lieu of the nonquantitative treatment limitation analysis and reporting requirements described in
835 said subsection (a).

836 (c) Any proprietary portions of information submitted to the commissioner by a carrier as
837 a result of the requirements of this section shall not be a public record under clause Twenty-sixth
838 of section 7 of chapter 4 or chapter 66; provided, however, that: (i) the commissioner may
839 produce reports summarizing any findings; (ii) nothing in this section shall limit the authority of
840 the commissioner to use and, if appropriate, publish any final or preliminary examination report,
841 examiner or company work papers or other documents or other information discovered or

842 developed during the course of an examination in the furtherance of any legal or regulatory
843 action that the commissioner may, in their sole discretion, deem appropriate; and (iii) nothing in
844 this section shall prevent the commissioner of insurance from publishing any illustrative
845 utilization review criteria, medical necessity standard, clinical guideline or other policy,
846 procedure, criteria or standard, regardless of its origin, as an example of the type of policy,
847 procedure, criteria or standard that contributes to a violation of state or federal law parity
848 requirements, including any document that would normally be subject to disclosure to plan
849 members or their providers under section 16 of chapter 6D, section 16 of chapter 176O or under
850 the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
851 2008, as amended.

852 (d) Annually, not later than December 1, the commissioner shall submit a summary of the
853 reports that the commissioner receives from all carriers under subsection (a) to the clerks of the
854 senate and house of representatives, the joint committee on mental health, substance use and
855 recovery and the joint committee on health care financing; provided, that the summary shall
856 include, but not be limited to:

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

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

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

867 (iv) a breakdown of treatment authorization data for each carrier for mental health
868 treatment services, substance use disorder treatment services and medical and surgical treatment
869 services for the immediately preceding calendar year indicating for each treatment service: (A)
870 the number of inpatient days, outpatient services and total services requested; (B) the number
871 and per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day
872 requests modified resulting in a lower amount of inpatient days authorized than requested and the
873 reason for the modification, inpatient day requests denied and the reason for the denial, inpatient
874 day requests where an internal appeal was filed and approved, inpatient day requests where an
875 internal appeal was filed and denied, inpatient day requests where an external appeal was filed
876 and upheld and inpatient day requests where an external appeal was filed and overturned; and
877 (C) the number and per cent of outpatient service requests authorized, outpatient service requests
878 modified, outpatient service requests modified resulting in a lower amount of outpatient service
879 authorized than requested and the reason for the modification, outpatient service requests denied
880 and the reason for the denial, outpatient service requests where an internal appeal was filed and
881 approved, outpatient service requests where an internal appeal was filed and denied, outpatient
882 service requests where an external appeal was filed and upheld and outpatient service requests
883 where an external appeal was filed and overturned;

884 (v) the number of consumer complaints received by the division of insurance under
885 subsection (f) of section 8K in the immediately preceding calendar year and a summary of all

886 such complaints resolved by the division during that time period, including: (A) the number of
887 complaints resolved in favor of the consumer; (B) the number of complaints resolved in favor of
888 the carrier; and (C) any enforcement actions taken in response to such complaints; and

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

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

896 (e) The commissioner shall, upon receipt of an annual report submitted pursuant to
897 subsection (a), provide the annual report to the attorney general. The commissioner shall, upon
898 request by the attorney general, provide to the attorney general: (i) the comparative analyses and
899 related information described in 42 U.S.C. 300gg-26(a)(8)(A); and (ii) any findings that may be
900 shared with the commissioner pursuant to 42 U.S.C. 300gg-26(a)(8)(C)(iii), 29 U.S.C.
901 1185a(a)(8)(C)(iii) and 26 U.S.C. 9812(a)(8)(C)(iii).

902 SECTION 24. Chapter 29 of the General Laws is hereby amended by inserting after
903 section 2SSSSS the following section:-

904 Section 2TTTTT. (a) There shall be an interagency services reserve fund established on
905 the books of the commonwealth to be expended without prior appropriation. The fund shall be
906 credited with money from public and private sources, including gifts, grants and donations,
907 interest earned on such money, any other money authorized by the general court and specifically

908 designated to be credited to the fund and any funds provided from other sources. Money in the
909 fund shall be used to fund the operations of the interagency review team established under
910 section 16R of chapter 6A. The secretary of health and human services shall administer the fund
911 and shall make expenditures for the purpose of covering the cost of providing additional
912 evaluation as needed by the interagency review team for an individual eligible under said section
913 16R of said chapter 6A. Any unexpended balance in the fund at the end of a fiscal year shall not
914 revert to the General Fund and shall be available for expenditure in the subsequent fiscal year.

915 (b) Annually, not later than August 1, the interagency review team shall submit required
916 financial reporting on the fund, including reporting of expenditures from the fund, to the
917 secretary of health and human services, the secretary of education and the house and senate
918 committees on ways and means.

919 SECTION 25. Chapter 32A of the General Laws is hereby amended by inserting after
920 section 17R the following section:-

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

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

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

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

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

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

941 SECTION 26. Said chapter 32A is hereby further amended by inserting after section 22
942 the following 2 sections:-

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

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

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

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

962 (ii) performing audits of each of the commission's health benefit plans at least once every
963 4 years, or more frequently if noncompliance is suspected, with a focus on: (A) nonquantitative
964 treatment limitations under the federal Paul Wellstone and Pete Domenici Mental Health Parity
965 and Addiction Equity Act of 2008, as amended, and applicable state mental health and substance
966 use disorder parity laws, including, but not limited to, prior authorization, concurrent review,
967 retrospective review, step-therapy, network admission standards, reimbursement rates, network
968 adequacy and geographic restrictions; (B) denials of authorization, payment and coverage; and
969 (C) any other criteria determined by the commission, including factors identified through
970 consumer or provider complaints;

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

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

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

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

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

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

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

999 (v) the specific findings and conclusions reached by the health benefit plan with respect
1000 to health insurance coverage, including any results of the analysis described in clause (iv) that
1001 indicate whether the health benefit plan is in compliance with this section and the federal Paul
1002 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as
1003 amended, and any federal guidance or regulations relevant to the act; and

1004 (vi) any other data or information the commission deems necessary to assess a health
1005 benefit plan's compliance with state or federal laws related to mental health and substance use
1006 disorder parity.

1007 (c) If federal guidance, including, but not limited to, the Self-Compliance Tool for the
1008 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
1009 2008, as amended, is released that indicates a nonquantitative treatment limitation analysis
1010 process and reporting format that is significantly different from, contrary to or more efficient
1011 than the nonquantitative treatment limitation analysis process and reporting format requirements
1012 described in subsection (b), the commission may revise the analysis and reporting requirements
1013 described in said subsection (b).

1014 (d) Any proprietary portions of information submitted to the commission by a health
1015 benefit plan as a result of the requirements of this section shall not be a public record under
1016 clause Twenty-sixth of section 7 of chapter 4 or chapter 66; provided, however, that the
1017 commission may produce reports summarizing any findings.

1018 (e) Annually, not later than December 1, the commission shall submit a summary of the
1019 reports that the commission receives from all health benefit plans under subsection (b) to the
1020 clerks of the senate and house of representatives, the joint committee on mental health, substance
1021 use and recovery and the joint committee on health care financing. The summary report shall
1022 include, but not be limited to:

1023 (i) the methodology the commission is using to check for compliance with the federal
1024 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as
1025 amended, and any federal guidance or regulations relevant to the act;

1026 (ii) the methodology the commission is using to check for compliance with applicable
1027 state mental health parity laws and regulations, including section 22 of chapter 32A, and, to the
1028 degree applicable to its health benefit plans, guidance issued by the commissioner of insurance
1029 under section 8K of chapter 26;

1030 (iii) a summary of any audit findings for audits conducted and completed under clause (ii)
1031 of subsection (a) during the immediately preceding calendar year regarding access to behavioral
1032 health services or compliance with parity in mental health and substance use disorder benefits
1033 under state and federal laws and any actions taken as a result of such audit; and

1034 (iv) the number of consumer complaints the commission has received in the immediately
1035 preceding calendar year regarding access to behavioral health services or compliance with parity

1036 in mental health and substance use disorder benefits under state and federal laws and a summary
1037 of all complaints resolved by the commission during that time period.

1038 The summary report shall be written in nontechnical, readily understandable language
1039 and made available to the public by posting the report on the commission's website.

1040 SECTION 27. Said chapter 32A is hereby further amended by adding the following 2
1041 sections:-

1042 Section 31. The commission shall provide to any active or retired employee of the
1043 commonwealth who is insured under the group insurance commission benefits on a
1044 nondiscriminatory basis for medically necessary emergency services programs, as defined in
1045 section 1 of chapter 175.

1046 Section 32. (a) For the purpose of this section, the following words shall have the
1047 following meanings:

1048 "Licensed mental health professional", a licensed physician who specializes in the
1049 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
1050 licensed certified social worker, a licensed mental health counselor, a licensed supervised mental
1051 health counselor, a licensed psychiatric nurse mental health clinical specialist, a licensed
1052 psychiatric mental health nurse practitioner, a licensed physician assistant who practices in the
1053 area of psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter
1054 111J, or a licensed marriage and family therapist within the lawful scope of practice for such
1055 therapist.

1056 “Mental health wellness examination”, a screening or assessment that seeks to identify
1057 any behavioral or mental health needs and appropriate resources for treatment. The examination
1058 may include: (i) observation, a behavioral health screening, education and consultation on
1059 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1060 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
1061 screenings or observations to understand a covered person’s mental health history, personal
1062 history and mental or cognitive state and, when appropriate, relevant adult input through
1063 screenings, interviews and questions.

1064 “Primary care provider”, a health care professional qualified to provide general medical
1065 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise
1066 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1067 maintains continuity of care within the scope of practice.

1068 (b) Any coverage offered by the commission to an active or retired employee of the
1069 commonwealth insured under the group insurance commission shall provide coverage for an
1070 annual mental health wellness examination that is performed by a licensed mental health
1071 professional or primary care provider, which may be provided by the primary care provider as
1072 part of an annual preventive visit. The examination shall be covered with no patient cost-sharing;
1073 provided, however, that cost-sharing shall be required if the applicable plan is governed by the
1074 Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition
1075 on cost-sharing for this service.

1076 SECTION 28. Chapter 69 of the General Laws is hereby amended by striking out section
1077 8A, as appearing in the 2020 Official Edition, and inserting in place thereof the following
1078 section:-

1079 Section 8A. (a) Each school committee and commonwealth charter school board of
1080 trustees shall ensure that every school under its jurisdiction has a written emergency response
1081 plan that addresses both medical and behavioral health crises to reduce the incidence of life-
1082 threatening medical emergencies and behavioral health crises and to promote efficient and
1083 appropriate responses to such emergencies. The plan shall be in addition to the multi-hazard
1084 evacuation plan required under section 363 of chapter 159 of the acts of 2000.

1085 (b) Each plan shall include:

1086 (1) a method for establishing a rapid communication system linking all parts of the school
1087 campus, including outdoor facilities and practice fields, to the emergency medical or mobile
1088 behavioral health crisis response services and protocols to clarify when the emergency medical
1089 services or mobile behavioral health mobile crisis response services and other emergency contact
1090 people shall be called;

1091 (2) a determination of medical or behavioral health emergency response time to any
1092 location on the school campus;

1093 (3) a list of relevant contacts and telephone numbers with a protocol indicating when each
1094 person shall be called, including names of professionals to help with post-emergency support;

1095 (4) a method to efficiently direct emergency medical services or behavioral health mobile
1096 crisis personnel to any location on campus, including to the location of available rescue
1097 equipment;

1098 (5) protocols for informing parents and guardians and reporting to the department when
1099 police, emergency medical technicians or other non-behavioral health personnel are contacted to
1100 respond to a behavioral health crisis;

1101 (6) safety precautions to prevent injuries in classrooms and facilities;

1102 (7) a method of providing access to training in cardiopulmonary resuscitation and first aid
1103 for teachers, athletic coaches, trainers and other school staff, which may include training high
1104 school students in cardiopulmonary resuscitation; and

1105 (8) the location of any automated external defibrillator device the school possesses,
1106 whether its location is fixed or portable and those personnel who are trained in its use.

1107 (c) Each plan shall be developed in consultation with the school principal, school nurse,
1108 school mental health counselor or social worker, school athletic director, team physicians,
1109 coaches, trainers and local police, fire, behavioral health mobile crisis team and emergency
1110 personnel, as appropriate. Schools shall practice the response sequence at the beginning of each
1111 school year and periodically throughout the year and evaluate and modify the plan as necessary.
1112 School officials shall review the response sequence with local fire and police officials at least 1
1113 time each year and shall conduct periodic walk-throughs of school campuses. Plans shall be
1114 submitted once every 3 years to the department, the local police department and the local fire
1115 department on or before September 1 of the third year. Plans shall be updated in the event of new

1116 construction or physical changes to the school campus as determined by the local police or fire
1117 department.

1118 (d) Included in each initial and subsequent filing of an emergency response plan, each
1119 school district shall report on the availability of automated external defibrillators in each school
1120 within the district, including the total amount available in each school, the location of each
1121 within the school, whether the device is in a fixed location or is portable, those personnel or
1122 volunteers who are trained in its use, those personnel with access to the device during and after
1123 regular school hours and the total estimated amount of automated external defibrillators
1124 necessary to ensure campus-wide access during school hours, after-school activities and public
1125 events.

1126 (e) The department, in consultation with the department of public health and the
1127 department of mental health, shall develop a cost-neutral model emergency response plan that
1128 includes both medical and behavioral health crisis response in order to promote best practices,
1129 including clear guidelines for the roles and responsibilities of behavioral and other health
1130 professionals, including, but not limited to, school counselors and community intervention
1131 professionals and, where applicable, school resource officers or police officers on school
1132 campuses; provided, however, that such model plan shall be designed to limit referrals to law
1133 enforcement or arrests on school property to cases in which an imminent risk to the health and
1134 safety of individuals on school property necessitates such referral or arrest. The model plan shall
1135 be made available to school committees and commonwealth charter school boards. In developing
1136 the model plan, the department shall refer to research prepared by the American Heart
1137 Association, Inc., the American Academy of Pediatrics, MassHealth and other relevant
1138 organizations that identify the essential components of an emergency response plan. The

1139 department shall biennially review and update the model plan and publicly post the model plan
1140 on its website.

1141 SECTION 29. Section 37H³/₄ of chapter 71 of the General Laws, as so appearing, is
1142 hereby amended by striking out paragraph (b) and inserting in place thereof the following
1143 paragraph:-

1144 (b) Any principal, headmaster, superintendent or person acting as a decision-maker at a
1145 student meeting or hearing, when deciding the consequences for the student, shall consider ways
1146 to re-engage the student in the learning process; and shall not suspend or expel a student until
1147 alternative remedies have been employed and their use and results documented, following and in
1148 direct response to a specific incident or incidents, unless specific reasons are documented as to
1149 why such alternative remedies are unsuitable or counter-productive, and in cases where the
1150 student's continued presence in school would pose a specific, documentable concern about the
1151 infliction of serious bodily injury or other serious harm upon another person while in school.
1152 Alternative remedies may include, but shall not be limited to: (i) mediation; (ii) conflict
1153 resolution; (iii) restorative justice; and (iv) collaborative problem solving. The principal,
1154 headmaster, superintendent or person acting as a decision-maker shall also implement school- or
1155 district-wide models to re-engage students in the learning process which shall include but not be
1156 limited to: (i) positive behavioral interventions and supports models and (ii) trauma sensitive
1157 learning models; provided, however, that school- or district-wide models shall not be considered
1158 a direct response to a specific incident.

1159 SECTION 30. Section 37Q of chapter 71 of the General Laws, as so appearing, is hereby
1160 amended by inserting after the word "school", in line 22, the first time it appears, the following

1161 words:- ; provided, that the medical and behavioral health emergency response plans submitted
1162 pursuant to section 8A of chapter 69 shall satisfy the requirement for emergency and acute
1163 treatment planning required by this section.

1164 SECTION 31. Chapter 75 of the General Laws is hereby amended by inserting after
1165 section 36D, as so appearing, the following new section:-

1166 Section 36E. (a) The University of Massachusetts medical school in Worcester shall
1167 develop a continuing education program for licensed mental health professionals on military
1168 service-related behavioral health conditions.

1169 (b) The training and curriculum for the program shall include, but not be limited to: (i)
1170 military culture and its influence on the behavioral health of service members and veterans; (ii)
1171 symptoms of deployment-related and non-deployment-related behavioral health conditions,
1172 including, but not limited to, depression, suicide, insomnia, substance use and post-traumatic
1173 stress disorder; (iii) deployment cycle stressors for students who are service members and
1174 veterans; (iv) deployment cycle stressors that impact the behavioral health of service members
1175 and veterans; (v) outreach strategies for available administrative, non-clinical and clinical
1176 services; and (vi) available resources and methods of referral for the treatment of deployment-
1177 related behavioral health conditions, including peer support.

1178 (c) In developing the curriculum for the program, the University of Massachusetts
1179 medical school shall consult with relevant stakeholders, including, but not limited to: (i) medical
1180 professional associations; (ii) peers and other service members and veterans who have lived
1181 experience of seeking or receiving behavioral health services or treatment; and (iii) behavioral
1182 health professionals with expertise in providing culturally-competent care.

1183 SECTION 32. Said chapter 111 is hereby further amended by inserting after section 51½
1184 the following section:-

1185 Section 51¾. The department, in consultation with the department of mental health, shall
1186 promulgate regulations requiring all acute-care hospitals licensed under section 51G to provide,
1187 or arrange for, licensed mental health professionals during all operating hours of an emergency
1188 department or a satellite emergency facility as defined in section 51½ to evaluate and stabilize a
1189 person admitted with a mental health presentation to the emergency department or satellite
1190 facility and to refer such person for appropriate treatment or inpatient admission. The regulations
1191 shall define “licensed mental health professional”, which shall include, but not be limited to, a:
1192 (i) licensed physician who specializes in the practice of psychiatry; (ii) licensed psychologist;
1193 (iii) licensed independent clinical social worker; (iv) licensed certified social worker; (v) licensed
1194 mental health counselor; (vi) licensed supervised mental health counselor; (vi) licensed physician
1195 assistant who practices in the field of psychiatry (vii) licensed psychiatric clinical nurse
1196 specialist; or (ix) healthcare provider, as defined in section 1, qualified within the scope of the
1197 individual's license to conduct an evaluation of a mental health condition, including an intern,
1198 resident or fellow pursuant to the policies and practices of the hospital and medical staff.

1199 The regulations shall permit evaluation via telemedicine, electronic or telephonic
1200 consultation, as deemed appropriate by the department.

1201 The regulations shall be promulgated after consultation with the department of mental
1202 health and the division of medical assistance and shall include, but not be limited to,
1203 requirements that individuals under the age of 22 receive an expedited evaluation and
1204 stabilization process.

1205 SECTION 33. Section 232 of said chapter 111, as appearing in the 2020 Official Edition,
1206 is hereby amended by striking out, in lines 12 and 13, the words “and (vii) a record of past
1207 mental health treatment of the decedent” and inserting in place thereof the following words:-
1208 “(vii) a record of past mental health treatment of the decedent; and (viii) the physical location of
1209 the suicide, whether the location is private or public property and the number of known attempts
1210 previously made by any other person at the same location.

1211 SECTION 34. Said chapter 111 is hereby further amended by adding the following
1212 section:-

1213 Section 244. The department shall administer an initiative to increase public awareness of
1214 and education on the availability of the extreme risk protection order process established
1215 pursuant to sections 131R to 131Y, inclusive, of chapter 140, to remove a firearm from the
1216 control, ownership or possession of an individual who poses a risk of causing bodily injury to
1217 themselves or others. The initiative shall focus on the heightened risk of suicide associated with the
1218 possession of a firearm and shall include information on: (i) eligibility to petition for an extreme
1219 risk protection order; (ii) the procedure to petition for an extreme risk protection order; (iii)
1220 options to voluntarily surrender a firearm to a law enforcement agency; and (iv) the availability
1221 of existing legal resources and support services for a potential petitioner.

1222 SECTION 35. Section 80I of chapter 112, as so appearing, is hereby amended by
1223 inserting after the word “practitioner”, in line 4, the following words:- or psychiatric nurse
1224 mental health clinical specialist.

1225 SECTION 36. Said chapter 112 is hereby further amended by inserting after section 65F
1226 the following section:-

1227 Section 65G. (a) As used in this section, the following words shall, unless the context
1228 clearly requires otherwise, have the following meanings:-

1229 “Applicant”, a licensed health care professional who believes a mental health or
1230 substance use condition may impede or has affected their ability to safely practice their
1231 profession and submits to the program a completed and signed application form provided by the
1232 program for that purpose.

1233 “Board of registration”, a board of registration: (i) serving in the department pursuant to
1234 section 9 of chapter 13; (ii) serving pursuant to section 76 of said chapter 13; (iii) serving
1235 pursuant to section 80 of said chapter 13; (iv) serving pursuant to section 88 of said chapter 13;
1236 or (v) serving under the supervision of the commissioner pursuant to section 1.

1237 “Commissioner”, the commissioner of public health.

1238 “Department”, the department of public health.

1239 “License”, a license, registration, authorization or certificate issued by a board of
1240 registration.

1241 “Licensed health care professional”, an individual who holds a license.

1242 “Licensing board”, a board of registration that has issued a license.

1243 “Participant”, a licensed health care professional who has been admitted into the program
1244 under this section.

1245 “Program”, the voluntary program established by the department in paragraph (1) of
1246 subsection (b).

1247 “Record of participation”, the materials received and reviewed by the program’s director,
1248 rehabilitation evaluation committee or a licensing board in connection with the application of a
1249 licensed health care professional for admission into the program and in connection with the
1250 progress of a participant during the program and compliance with an individualized rehabilitation
1251 plan.

1252 (b)(1) The department shall establish a voluntary program for monitoring the
1253 rehabilitation of licensed health care professionals who seek support for their mental health or
1254 substance use or who are referred to the program by a licensing board.

1255 (2) A board of registration that is required to establish a similar rehabilitation program by
1256 another requirement of this chapter shall fulfill that requirement by formally adopting the
1257 program in lieu of establishing its own.

1258 (c)(1) There shall be an advisory committee to assist the department in the development
1259 and implementation of the program. The committee shall consist of not less than the following
1260 members or their designees: the commissioner, who shall serve as chair; the director of the
1261 bureau of health professions licensure; and 9 persons to be appointed by the commissioner, 1 of
1262 whom shall have expertise in the treatment of health care professionals with a mental health or
1263 substance use condition, 1 of whom shall be a representative of the Massachusetts Nurses
1264 Association, 1 of whom shall be a representative of Local 509 Service Employees International
1265 Union, 1 of whom shall be a representative of Local 1199 Service Employees International
1266 Union, 1 of whom shall be a representative of the Massachusetts Chapter of the National
1267 Association of Social Workers, Inc., 1 of whom shall be a representative of the Massachusetts
1268 Association of Physician Assistants, Inc., 1 of whom shall be a representative of the

1269 Massachusetts Dental Society, 1 of whom shall be a representative of the Massachusetts
1270 Pharmacists Association Foundation, Inc. and 1 of whom shall be a representative of the
1271 Massachusetts Health and Hospital Association, Inc.; provided, however, that the commissioner
1272 may appoint additional members as the commissioner determines necessary.

1273 (2) The committee shall: (i) review data, medical literature and expert opinions on the
1274 prevalence of mental health and substance use conditions among licensed health care
1275 professionals; (ii) make estimates regarding the number of licensed health care professionals who
1276 could potentially benefit from participation in the program; (iii) examine the effectiveness of the
1277 rehabilitation program for registered pharmacists, pharmacy interns and pharmacy technicians
1278 established in section 24H and the rehabilitation program for nurses established in section 80F
1279 including, but not limited to, overall trends in enrollment, completion rates, non-completion
1280 rates, program design, eligibility criteria, application requirements, wait times for admissions,
1281 program duration, conditions of participation, penalties for noncompliance, privacy and
1282 confidentiality protections and return-to-work restrictions; (iv) identify best practices in
1283 voluntary, alternative-to-discipline rehabilitation programs that have been adopted in other states
1284 and any opportunities to modernize standards in the commonwealth; and (v) make
1285 recommendations to the department regarding eligibility criteria for admission into the program
1286 and the attributes necessary for the program to expand its access to licensed health care
1287 professionals, minimize stigma and other deterrents to participation, increase participation and
1288 completion rates, facilitate the successful return of participants to professional practice and
1289 enhance public health and safety, including, but not limited to, the size, scope and design of the
1290 program, the level of staffing and other resources necessary to adequately operate the program

1291 and protocols to ensure that the rehabilitation evaluation committee established in subsection (d)
1292 performs its duties in a timely fashion.

1293 (d)(1) There shall be a rehabilitation evaluation committee which shall consist of the
1294 following members to be appointed by the commissioner: 1 medical doctor or advanced practice
1295 registered nurse with experience in the treatment of mental health or substance use conditions; 3
1296 licensed health care professionals with demonstrated experience in the field of mental health or
1297 substance use; 1 licensed health care professional in recovery from substance use for not less
1298 than 3 years; 1 licensed health care professional living with a mental health condition; 1 person
1299 who is either a peer specialist or a person with experience advocating for people with mental
1300 health or substance use conditions; and 2 current or former consumers of behavioral health
1301 services, 1 of whom shall be a current or former consumer of mental health services and 1 of
1302 whom shall be a current or former consumer of substance use disorder services. Four members of
1303 the committee shall constitute a quorum. The committee shall elect a chair and a vice chair from
1304 its membership. Members of the committee shall serve for terms of 4 years. No member shall be
1305 appointed or reappointed to the committee who is licensed to practice by a board of registration
1306 and has had any disciplinary or enforcement action taken against them by their respective
1307 licensing board during the 5 years preceding their appointment or reappointment to the
1308 committee. No current member of any board of registration shall serve on the committee.
1309 Meetings of the committee shall not be subject to sections 18 to 25, inclusive, of chapter 30A.

1310 (2) The rehabilitation evaluation committee shall: (i) receive and review information
1311 concerning participants in the program; (ii) evaluate licensed health care professionals who
1312 request to participate in the program within 5 business days of receipt of such request and
1313 provide recommendations regarding the admission of such licensed health care professionals;

1314 (iii) review and designate treatment facilities and services to which participants may be referred;
1315 (iv) make recommendations for each participant as to whether the participant may continue or
1316 resume professional practice within the full scope of the participant's license; and (v) make
1317 recommendations for an individualized rehabilitation plan with requirements for supervision and
1318 surveillance for each participant; provided, however, that no action taken by the rehabilitation
1319 evaluation committee pursuant to this section shall be construed as the practice of medicine or
1320 behavioral health care.

1321 (e) The department shall employ a program director with demonstrated professional
1322 expertise in the field of mental health or substance use care and treatment to oversee participants
1323 in the rehabilitation program. The director shall: (i) admit eligible licensed health care
1324 professionals who request to participate in the program; (ii) receive and review information
1325 concerning participants in the program; (iii) provide each participant with a written
1326 individualized rehabilitation plan with requirements for supervision and surveillance and update
1327 the plan as appropriate, taking into account the participant's compliance with the program and
1328 recommendations of the rehabilitation evaluation committee; (iv) call meetings of the
1329 rehabilitation evaluation committee as necessary to review the requests of licensed health care
1330 professionals to participate in the program and review reports regarding participants; (v) serve as
1331 a liaison among the participant, the participant's licensing board, the rehabilitation evaluation
1332 committee and approved treatment programs and providers; (vi) terminate a participant from the
1333 program based on the participant's noncompliance with the participant's individualized
1334 rehabilitation plan or material misrepresentations by the participant concerning the participant's
1335 participation in the program or professional practice; (vii) provide information to licensed health
1336 care professionals who request to participate in the program; and (viii) in such cases where an

1337 applicant or participant is referred to the program by a licensing board or if an applicant or
1338 participant is the subject of a pending or completed investigation or complaint that arises from or
1339 relates to an applicant's or participant's mental health or substance use, report to the licensing
1340 board of the applicant or participant the name and license number of the applicant or participant
1341 in the event of: (A) the applicant's failure to complete the program's admission process; (B) the
1342 participant's admission into the program; (C) the participant's termination from the program; (D)
1343 the participant's withdrawal from the program before completion; and (E) the initial restrictions
1344 or conditions relating to the participant's professional practice incorporated into the participant's
1345 individualized rehabilitation plan and any changes or removal of the restrictions or conditions
1346 during the course of the participant's participation and the basis for such restrictions or
1347 conditions and any changes to them; provided, however, that any restriction or condition relating
1348 to a participant's professional practice required under this subsection or any changes to a
1349 restriction or condition shall be subject to the approval of the participant's licensing board.

1350 (f) A licensed health care professional who applies to participate in or is referred by the
1351 licensing board to the program shall specify, in a form and format as set forth by the department,
1352 the mental health condition or substance use that they believe may impede or has affected their
1353 ability to safely practice their profession and shall agree to comply, to the best of their ability,
1354 with an individualized rehabilitation plan to be admitted into the program. Noncompliance with
1355 an individualized rehabilitation plan may result in a participant's termination from the program
1356 only if the participant's individual rehabilitation plan states that noncompliance with the plan
1357 will result in termination from the program.

1358 (g) Upon admission of a licensed health care professional into the program, the licensing
1359 board may dismiss any pending investigation or complaint against the participant that arises from

1360 or relates to the participant's mental health or substance use. The licensing board may change the
1361 participant's publicly-available license status to reflect the existence of non-disciplinary
1362 restrictions or conditions. The licensing board may immediately suspend the participant's license
1363 as is necessary to protect the public health, safety and welfare upon receipt of notice from the
1364 director that the participant has withdrawn from the program before completion or that the
1365 director has terminated the participant from the program.

1366 (h) The record of participation shall not be a public record and shall be exempt from
1367 disclosure pursuant to clause Twenty-sixth of section 7 of chapter 4 and chapter 66. If a licensed
1368 health care professional referred to the program by a licensing board fails to complete the
1369 application process, a licensing board may use information and documents in the record of
1370 participation as evidence in a disciplinary proceeding as necessary to protect public health, safety
1371 and welfare. In all other instances, the record of participation or application to the program shall
1372 be kept confidential and shall not be subject to subpoena or discovery in any civil, criminal,
1373 legislative or administrative proceeding without the prior written consent of the participant or
1374 applicant. Upon the determination by the rehabilitation evaluation committee that a participant
1375 has successfully completed the program and their ability to safely practice their profession is not
1376 impaired or affected by their mental health or substance use, the department, the program, the
1377 rehabilitation evaluation committee and the licensing board, if applicable, shall seal all records
1378 pertaining to the participant's participation in the program. The records of participation of
1379 participants who successfully complete the program shall be destroyed 3 years following the date
1380 of successful completion.

1381 SECTION 37. Section 130 of chapter 112 of the General Laws, as appearing in the 2020
1382 Official Edition, is hereby amended by striking the definition of “The independent practice of
1383 clinical social work” and inserting in place thereof the following definition:-

1384 “The independent practice of clinical social work”, rendering or offering to render
1385 professional services for any fee, monetary or otherwise, to individuals, families or groups of
1386 individuals which services involve the application of evidence-informed social work theories and
1387 methods in the comprehensive assessment and treatment of cognitive, affective, mental,
1388 emotional and behavioral disorders and distress arising from physical, environmental,
1389 psychological, emotional or relational conditions application of social work theory and methods
1390 in the treatment of mental and emotional disorders through the use of psychotherapy of a
1391 nonmedical nature by an individual who is not providing such services under the employ of a
1392 recognized educational institution, federal, state or municipal institution, or an institution, facility
1393 or agency which is licensed to operate under the laws of the commonwealth.

1394 The scope of the independent practice of clinical social work shall include, but not be
1395 limited to: (i) assessment, evaluation, psychotherapy and counseling for individuals, families and
1396 groups; (ii) client-centered advocacy, consultation and supervision; and (iii) case management
1397 services. The independent practice of clinical social work shall be within an ecological and
1398 ethically-principled framework and shall be multi-systemic, trauma-informed and committed to
1399 public health and well-being.

1400 SECTION 38. Section 163 of said chapter 112, as so appearing, is hereby amended by
1401 inserting after the definition of “Licensed mental health counselor” the following definition:-

1402 “Licensed supervised mental health counselor”, a person licensed or eligible for license
1403 under section 165.

1404 SECTION 39. Section 164 of said chapter 112, as so appearing, is hereby amended by
1405 inserting after the word “consultant”, in line 7, the following words:- or licensed supervised
1406 mental health counselor, advisor or consultant.

1407 SECTION 40. Section 165 of said chapter 112, as so appearing, is hereby amended by
1408 inserting after the word “health”, in line 16, the following words:- or the department of public
1409 health.

1410 SECTION 41. Said section 165 of said chapter 112, as so appearing, is hereby further
1411 amended by adding the following 3 paragraphs:-

1412 The board may issue a license to an applicant as a supervised mental health counselor;
1413 provided, however, that each applicant, in addition to complying with clauses (1) and (2) of the
1414 first paragraph, shall provide satisfactory evidence to the board that the applicant: (i)
1415 demonstrates to the board the successful completion of a master’s degree in a relevant field from
1416 an educational institution licensed by the state in which it is located and meets national standards
1417 for granting of a master’s degree with a sub-specialization in counseling or a relevant sub-
1418 specialization approved by the board; and (ii) has successfully passed a board-approved
1419 examination.

1420 A supervised mental health counselor shall practice under supervision of a clinician in a
1421 clinic or hospital licensed by the department of mental health or the department of public health
1422 or accredited by the Joint Commission on Accreditation of Hospitals or in an equivalent center or
1423 institute or under the direction of a supervisor approved by the board.

1424 The board shall promulgate rules and regulations specifying the required qualifications of
1425 the supervising clinician.

1426 SECTION 42. Chapter 118E of the General Laws is hereby amended by inserting after
1427 section 10N the following 3 sections:-

1428 Section 10O. For the purposes of this section, the following terms shall have the
1429 following meanings unless the context clearly requires otherwise:-

1430 “Community-based acute treatment”, 24-hour clinically managed mental health
1431 diversionary or step-down services for children and adolescents that is usually provided as an
1432 alternative to mental health acute treatment.

1433 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
1434 mental health diversionary or step-down services for children and adolescents that is usually
1435 provided as an alternative to mental health acute treatment.

1436 “Mental health acute treatment”, 24-hour medically supervised mental health services
1437 provided in an inpatient facility, licensed by the department of mental health, that provides
1438 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1439 milieu.

1440 The division and its contracted health insurers, health plans, health maintenance
1441 organizations, behavioral health management firms and third-party administrators under contract
1442 to a Medicaid managed care organization or primary care clinician plan shall cover the cost of
1443 medically necessary mental health acute treatment, community-based acute treatment and
1444 intensive community-based acute treatment and shall not require a preauthorization before

1445 obtaining treatment; provided, however, that the facility shall notify the carrier of the admission
1446 and the initial treatment plan within 72 hours of admission.

1447 Section 10P. (a) For the purposes of this section, “psychiatric collaborative care model”
1448 shall mean the evidence-based, integrated behavioral health service delivery method in which a
1449 primary care team consisting of a primary care provider and a care manager provides structured
1450 care management to a patient, and that works in collaboration with a psychiatric consultant that
1451 provides regular consultations to the primary care team to review the clinical status and care of
1452 patients and to make recommendations.

1453 (b) The division and its contracted health insurers, health plans, health maintenance
1454 organizations, behavioral health management firms and third-party administrators under contract
1455 to a Medicaid managed care organization or primary care clinician plan shall provide coverage
1456 for mental health or substance use disorder services that are delivered through the psychiatric
1457 collaborative care model.

1458 Section 10Q. (a) For the purpose of this section, the following words shall have the
1459 following meanings:

1460 “Licensed mental health professional”, a licensed physician who specializes in the
1461 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
1462 licensed certified social worker, a licensed mental health counselor, a licensed supervised mental
1463 health counselor, a licensed psychiatric nurse mental health clinical specialist, a licensed
1464 psychiatric mental health nurse practitioner, a licensed physician assistant who practices in the
1465 area of psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter

1466 111J, or a licensed marriage and family therapist within the lawful scope of practice for such
1467 therapist.

1468 “Mental health wellness examination”, a screening or assessment that seeks to identify
1469 any behavioral or mental health needs and appropriate resources for treatment. The examination
1470 may include: (i) observation, a behavioral health screening, education and consultation on
1471 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1472 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
1473 screenings or observations to understand a covered person’s mental health history, personal
1474 history and mental or cognitive state and, when appropriate, relevant adult input through
1475 screenings, interviews and questions.

1476 “Primary care provider”, a health care professional qualified to provide general medical
1477 care for common health care problems who: (i) supervises, coordinates, prescribes or otherwise
1478 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1479 maintains continuity of care within the scope of practice.

1480 (b) The division and its contracted health insurers, health plans, health maintenance
1481 organizations, behavioral health management firms and third-party administrators under contract
1482 to a Medicaid managed care organization or primary care clinician plan shall provide coverage
1483 for an annual mental health wellness examination that is performed by a licensed mental health
1484 professional or primary care provider, which may be provided by the primary care provider as
1485 part of an annual preventive visit. The examination shall be covered with no patient cost-sharing,
1486 provided, however, that cost-sharing shall be required if the applicable plan is governed by the

1487 Federal Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition
1488 on cost-sharing for this service.

1489 SECTION 43. Said chapter 118E is hereby further amended by inserting after section
1490 13D the following section:-

1491 Section 13D½. (a) As used in this section, the following words shall, unless the context
1492 clearly requires otherwise, have the following meanings:-

1493 “Behavioral health services”, the evaluation, diagnosis, treatment, care coordination,
1494 management or peer support of patients with mental health, developmental or substance use
1495 disorders.

1496 “Community behavioral health center”, organizations that are designated by the executive
1497 office of health and human services, licensed clinics that hold a contract with the department of
1498 mental health to provide community-based mental health services and other licensed clinics
1499 designated by the department of public health.

1500 “Division”, the division of medical assistance.

1501 “Managed care entity”, health insurers, health plans, health maintenance organizations,
1502 behavioral health management firms and third party administrators under contract with a
1503 Medicaid managed care organization or primary care clinician plan; provided, however, that
1504 “managed care entity” shall also include accountable care organizations.

1505 “Minimum payment rates”, rates of payment for services below which managed care
1506 entities shall not enter into provider agreements.

1507 (b) Annually, not later than January 1, the division shall review the minimum payment
1508 rates to be paid to providers of behavioral health services delivered in community behavioral
1509 health centers by managed care entities and submit a report to the house and senate committees
1510 on ways and means, the joint committee on health care financing and the joint committee on
1511 mental health, substance use and recovery identifying the difference between the minimum
1512 payment rates decided by the division and the payment rates that managed care entities
1513 contractually agree to pay providers for all behavioral health services delivered in community
1514 behavioral health centers.

1515 SECTION 43A. Section 47 of said chapter 118E, as appearing in the 2020 Official
1516 Edition, is hereby amended by inserting after the first paragraph the following paragraph:-

1517 Notwithstanding any general or special law to the contrary, the division shall promulgate
1518 regulations that require the division, its contracted health insurers, health plans, health
1519 maintenance organizations, behavioral health management firms and third-party administrators
1520 under contract with the division, a Medicaid managed care organization or primary care clinician
1521 plan, to maintain documentation of all requests for benefits or services, whether the request is
1522 submitted by, or on behalf of, the intended recipient of those benefits or services. Any request
1523 that is not fulfilled in full shall be considered a denial and shall result in the prompt written
1524 notification to the intended recipient through electronic means, if possible. The notification shall
1525 include a description of the requested service, the response by the entity and the intended
1526 recipient's due process and appeal rights. All such entities shall accept requests for authorized
1527 representatives or for appeals by electronic means.

1528 SECTION 44. Said chapter 118E is hereby further amended by adding the following 3
1529 sections:-

1530 Section 80. (a) The division, its managed care organizations, accountable care
1531 organizations or other entity contracting with the division to manage or administer mental health
1532 and substance use disorder benefits shall ensure that there are no separate non-quantitative
1533 treatment limitations that apply to mental health and substance use disorder benefits but do not
1534 apply to medical and surgical benefits within any classification of benefits as defined under the
1535 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
1536 2008, as amended, and applicable state mental health parity laws, including, but not limited to,
1537 section 81; provided, however, that the non-quantitative treatment limitations shall include the
1538 processes, strategies or methodologies for developing and applying the division's reimbursement
1539 rates for mental health and substance use disorder benefits and medical and surgical benefits
1540 within each classification of benefits.

1541 (b) The division shall perform a behavioral health parity compliance examination of each
1542 Medicaid managed care organization, accountable care organization or other entity contracted
1543 with the agency that manages or administers mental health and substance use disorder benefits
1544 for the division at least once every 4 years. The examination shall include examination of entities
1545 that manage medical and surgical benefits, as necessary. The examination shall only apply where
1546 the division is the primary payer. The examination shall include, but not be limited to:

1547 (i) non-quantitative treatment limitations, including, but not limited to, prior
1548 authorization, concurrent review, retrospective review, step-therapy, network admission
1549 standards, reimbursement rates and geographic restrictions;

1550 (ii) approvals and denials of authorization, payment and coverage; and
1551 (iii) any other specific criteria as may be determined by the division, including factors
1552 identified through consumer or provider complaints.

1553 (c) The division shall require each of its managed care organizations, accountable care
1554 organizations or other entity contracting with the division to manage or administer mental health
1555 and substance use disorder benefits to submit an annual report to the division on or before July 1
1556 that shall include:

1557 (i) the specific plan or coverage terms or other relevant terms regarding the non-
1558 quantitative treatment limitations and a description of all mental health and substance use
1559 disorder benefits and medical and surgical benefits to which each term applies in each respective
1560 benefits classification; provided, however, that the non-quantitative treatment limitations shall
1561 include the processes, strategies, evidentiary standards or other factors used to develop and apply
1562 the entity's reimbursement rates for mental health and substance use disorder benefits and
1563 medical and surgical benefits in each respective benefits classification;

1564 (ii) the factors used to determine that the non-quantitative treatment limitations will apply
1565 to mental health and substance use disorder benefits and medical and surgical benefits;

1566 (iii) the evidentiary standards used to define the factors identified in clause (ii), when
1567 applicable; provided, however, that every factor shall be defined and any other source or
1568 evidence relied upon to design and apply the non-quantitative treatment limitations to mental
1569 health and substance use disorder benefits and medical and surgical benefits;

1570 (iv) a comparative analyses demonstrating that the processes, strategies, evidentiary
1571 standard and other factors used to apply the non-quantitative treatment limitations to mental
1572 health and substance use disorder benefits, as written and in operation, are comparable to and are
1573 applied no more stringently than the processes, strategies, evidentiary standards and other factors
1574 used to apply the non-quantitative treatment limitations to medical and surgical benefits in the
1575 benefits classification;

1576 (v) the specific findings and conclusions reached by the entity with respect to health
1577 insurance coverage, including any results of the analysis described in clause (iv) that indicates
1578 whether the entity is in compliance with this section and the federal Paul Wellstone and Pete
1579 Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal
1580 guidelines and regulations relevant to the act, including, but not limited to, 42 CFR Part 457.496;

1581 (vi) the treatment authorization data for the prior calendar year, which shall include, but
1582 not be limited to: (A) the number of inpatient days, outpatient services and total number of
1583 services requested; (B) the number and per cent of inpatient day requests authorized, inpatient
1584 day requests modified, inpatient day requests modified resulting in a lesser amount of inpatient
1585 days authorized than requested and the reason for the modification, inpatient day requests denied
1586 and the reason for the denial, inpatient day requests where an internal appeal was filed and
1587 approved, inpatient day requests where an internal appeal was filed and denied, inpatient day
1588 requests where an external appeal was filed and upheld and inpatient day requests where an
1589 external appeal was filed and overturned; and (C) the number and per cent of outpatient service
1590 requests authorized, outpatient service requests modified, outpatient service requests modified
1591 resulting in a lower amount of outpatient service authorized than requested and the reason for the
1592 modification, outpatient service requests denied and the reason for the denial, outpatient service

1593 requests where an internal appeal was filed and approved, outpatient service requests where an
1594 internal appeal was filed and denied, outpatient service requests where an external appeal or
1595 hearing before the board of hearings was filed and upheld and outpatient service requests where
1596 an external appeal was filed and overturned;

1597 (vii) the additional information, if any, that an entity is required to provide under 42
1598 U.S.C. 300gg-26(a)(8)(B)(ii); and

1599 (viii) any other data or information the division deems necessary to assess an entity's
1600 compliance with mental health parity requirements.

1601 (d) If federal guidance, including, but not limited to, the Self-Compliance Tool for the
1602 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
1603 2008, as amended, is released that indicates a non-quantitative treatment limitation analysis
1604 process and reporting format that is significantly different from, contrary to or more efficient
1605 than the non-quantitative treatment limitation analysis process and reporting format requirements
1606 described in subsection (b), the division may promulgate regulations that delineate a non-
1607 quantitative treatment limitation analysis process and reporting format that may be used in lieu of
1608 the non-quantitative treatment limitation analysis and reporting requirements described in said
1609 subsection (b).

1610 (e) Any proprietary information submitted to the general court by the division as a result
1611 of the requirements in this section shall not be a public record under clause Twenty-sixth of
1612 section 7 of chapter 4 or chapter 66; provided, however, that nothing in this section shall limit
1613 the authority of the director of Medicaid to use and, if appropriate, publish any final or
1614 preliminary examination report, examiner or company work papers or other documents or other

1615 information discovered or developed during the course of an examination in the furtherance of
1616 any legal or regulatory action that the director may, in their sole discretion, deem appropriate;
1617 provided further, that nothing in this section shall prevent the director of Medicaid from
1618 publishing any illustrative utilization review criteria, medical necessity standard, clinical
1619 guideline or other policy, procedure, criteria or standard, regardless of its origin, as an example
1620 of the type of policy, procedure, criteria or standard that contributes to a violation of state or
1621 federal law parity requirements, including any information that is subject to disclosure to plan
1622 members under the federal Paul Wellstone and Pete Domenici Mental Health Parity and
1623 Addiction Equity Act of 2008, as amended, or under any member right to receive such guideline
1624 under applicable federal law.

1625 (f) Annually, not later than December 1, the division shall submit a summary of the
1626 reports that the division receives from all entities under subsection (c) to the clerks of the senate
1627 and house of representatives, the joint committee on mental health, substance use and recovery
1628 and the joint committee on health care financing. The summary report shall include, but not be
1629 limited to:

1630 (i) the methodology the division is using to check for compliance with the federal Paul
1631 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as
1632 amended, and any federal regulations or guidance relevant to the act;

1633 (ii) the methodology the division is using to check for compliance with section 81;

1634 (iii) the report of each examination conducted or completed under subsection (b) during
1635 the immediately preceding calendar year regarding access to behavioral health services or

1636 compliance with parity in mental health and substance use disorder benefits under state and
1637 federal laws and any actions taken as a result of such examinations;

1638 (iv) a breakdown of treatment authorization data for the division, and for each Medicaid
1639 managed care organization, accountable care organization or other entity that manages or
1640 administers benefits for the division, for mental health treatment services, substance use disorder
1641 treatment services and medical and surgical treatment services for the immediately preceding
1642 calendar year indicating for each treatment service: (A) the number of inpatient days, outpatient
1643 services and total number of services requested; (B) the number and per cent of inpatient day
1644 requests authorized, inpatient day requests modified, inpatient day requests modified resulting in
1645 a lesser amount of inpatient days authorized than requested and the reason for the modification,
1646 inpatient day requests denied and the reason for the denial, inpatient day requests where an
1647 internal appeal was filed and approved, inpatient day requests where an internal appeal was filed
1648 and denied, inpatient day requests where an external review under section 47B or hearing before
1649 the board of hearings under section 48 was filed and upheld and inpatient day requests where an
1650 external review under said section 47B or hearing before the board of hearings under said section
1651 48 was filed and overturned; and (C) the number and per cent of outpatient service requests
1652 authorized, outpatient service requests modified, outpatient service requests modified resulting in
1653 a lower amount of outpatient service authorized than requested and the reason for the
1654 modification, outpatient service requests denied and the reason for the denial, outpatient service
1655 requests where an internal appeal was filed and approved, outpatient service requests where an
1656 internal appeal was filed and denied, outpatient service requests where an external review under
1657 said section 47B or hearing before the board of hearings under said section 48 was filed and

1658 upheld and outpatient service requests where an external review under said section 47B or
1659 hearing before the board of hearings under said section 48 was filed and overturned;

1660 (v) the number of complaints the division, or any Medicaid managed care organization,
1661 accountable care organization or other entity contracting with the division to manage or
1662 administer mental health and substance use disorder benefits, has received in the immediately
1663 preceding calendar year regarding access to behavioral health services or compliance with parity
1664 in mental health and substance use disorder benefits under state and federal laws and a summary
1665 of all complaints resolved by the division, or any Medicaid managed care organization,
1666 accountable care organization or other entity contracting with the division to manage or
1667 administer mental health and substance use disorder benefits, during that time period; and

1668 (vi) information about any educational or corrective actions the division has taken to
1669 ensure carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health
1670 Parity and Addiction Equity Act of 2008, as amended, and section 81.

1671 The summary report shall be written in non-technical, readily understandable language
1672 and shall be made publicly available on the division's website.

1673 (g) The division shall evaluate all consumer or provider complaints regarding mental
1674 health and substance use disorder coverage for possible parity violations within 3 months of
1675 receipt of the complaint.

1676 Section 81. (a) The division and its health insurers, health plans, health maintenance
1677 organizations, behavioral health management firms and third-party administrators under contract
1678 with the division, a Medicaid managed care organization or a primary care clinician plan shall
1679 provide mental health and substance use disorder benefits for the diagnosis and medically-

1680 necessary treatment of any behavioral health disorder described in the most recent edition of the
1681 Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric
1682 Association or the most current version of the International Classification of Diseases. The
1683 benefits shall be provided on a nondiscriminatory basis.

1684 (b) In addition to the mental health and substance use disorder benefits established
1685 pursuant to this section, the division shall provide benefits on a non-discriminatory basis for
1686 children and adolescents under the age of 19 for the diagnosis and treatment of mental,
1687 behavioral, emotional or substance use disorders described in the most recent edition of the
1688 Diagnostic and Statistical Manual of Mental Disorders that substantially interfere with or
1689 substantially limit the functioning and social interactions of such a child or adolescent; provided,
1690 however, that the interference or limitation is documented by and the referral for the diagnosis
1691 and treatment is made by the primary care provider, primary pediatrician or a licensed mental
1692 health professional of such a child or adolescent or is evidenced by conduct including, but not
1693 limited to: (i) an inability to attend school as a result of such a disorder; (ii) the need to
1694 hospitalize the child or adolescent as a result of such a disorder; or (iii) a pattern of conduct or
1695 behavior caused by such a disorder that poses a serious danger to oneself or others.

1696 (c) For the purposes of this section, the division shall be deemed to be providing such
1697 coverage on a non-discriminatory basis if the plan or coverage does not contain any annual or
1698 lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of the
1699 mental disorders that is less than any annual or lifetime dollar or unit of service limitation
1700 imposed on coverage for the diagnosis and treatment of physical conditions.

1701 (d) Benefits authorized pursuant to this section shall consist of a range of inpatient,
1702 intermediate and outpatient services that shall permit medically necessary, active and
1703 noncustodial treatment for the mental disorders to take place in the least restrictive clinically
1704 appropriate setting. For purposes of this section, inpatient services may be provided in a general
1705 hospital licensed to provide such services, in a facility under the direction and supervision of the
1706 department of mental health, in a private mental hospital licensed by the department of mental
1707 health or in a substance abuse facility licensed by the department of public health. Intermediate
1708 services shall include, but not be limited to, Level III community-based detoxification, acute
1709 residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or
1710 approved by the department of public health or the department of mental health. Outpatient
1711 services may be provided in a licensed hospital, a mental health or substance abuse clinic
1712 licensed by the department of public health, a public community mental health center, a
1713 professional office or as home-based services.

1714 (e) The division and its health insurers, health plans, health maintenance organizations,
1715 behavioral health management firms and third-party administrators under contract with the
1716 division, a Medicaid managed care organization or a primary care clinician plan shall not require,
1717 as a condition of receiving benefits mandated by this section, consent to the disclosure of
1718 information regarding services for mental disorders under different terms and conditions than
1719 consent is required for disclosure of information for other medical conditions. A determination
1720 by the division or its agents that services authorized pursuant to this section are not medically
1721 necessary shall only be made by a mental health professional licensed in the appropriate
1722 specialty related to such services and, where applicable, by a provider in the same licensure
1723 category as the ordering provider; provided, however, that this subsection shall not apply to

1724 denials of service resulting from an enrollee's lack of coverage or use of a facility or professional
1725 that has not entered into a negotiated agreement with the division or its agents. The benefits
1726 provided by the division or its agents pursuant to this section shall meet all other terms and
1727 conditions of the plan consistent with state or federal law.

1728 (f) Nothing in this section shall require the division to pay for mental health or substance
1729 use disorder benefits or services that:

1730 (i) are otherwise covered by third-party insurance;

1731 (ii) are provided to a person who is presently incarcerated, confined or committed to a
1732 jail, house of correction or prison;

1733 (iii) constitute educational services required to be provided by a school committee
1734 pursuant to section 5 of chapter 71B;

1735 (iv) constitute services provided by the department of mental health, the department of
1736 public health or the department of developmental services; or

1737 (v) are not eligible for federal financial participation.

1738 Section 82. Notwithstanding any general or special law to the contrary, the office of
1739 Medicaid shall seek a waiver and promulgate regulations in order to require the division and its
1740 health insurers, health plans, health maintenance organizations, behavioral health management
1741 firms and third-party administrators under contract with the division, a Medicaid managed care
1742 organization or primary care clinician plan to meet the parity requirements described under the
1743 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
1744 2008, as amended, and any federal guidance or regulations relevant to the act, including 42 CFR

1745 438 Subpart K, 42 CFR 440.395 and 42 CFR 457.496, for all enrollees. For persons under the
1746 age of 21, MassHealth and its agents may comply with this section by meeting the obligations
1747 related to Early and Periodic Screening, Diagnostic and Treatment benefits under 42 CFR
1748 457.496(b) or 440.395(c).

1749 SECTION 45. Section 32 of chapter 119 of the General Laws, as appearing in the 2020
1750 Official Edition, is hereby amended by striking out the second paragraph and inserting in place
1751 thereof the following paragraph:-

1752 The department shall ensure that every child, upon entry into the foster care system, shall
1753 be screened and evaluated under the early and periodic screening, diagnostic and treatment
1754 standards established by Title XIX of the Social Security Act and assessed for behavioral health
1755 symptoms and sequelae, including those related to the precipitating factors of their entry into
1756 care, unless the child has been screened and evaluated within 30 days prior to the child's entry
1757 into the system; provided, however, that each child with identified behavioral health needs shall
1758 be provided appropriate referrals to related professionals to conduct more comprehensive
1759 diagnostic assessment, prescribe treatment and ensure the behavioral health and trauma-related
1760 needs of such child are addressed in a timely manner.

1761 SECTION 46. Chapter 123 of the General Laws is hereby amended by inserting after
1762 section 2 the following section:-

1763 Section 2A. When promulgating regulations governing the contracting for services, the
1764 department shall establish within its regulations additional factors to be considered when
1765 contracting for services in geographically-isolated communities, including, but not limited to,
1766 travel and transportation, to ensure availability and access to services.

1767 SECTION 47. Section 18 of said chapter 123, as appearing in the 2020 Official Edition,
1768 is hereby amended by striking out, in lines 27 to 34, inclusive, the words “; provided, however,
1769 that, notwithstanding the court’s failure, after an initial hearing or after any subsequent hearing,
1770 to make a finding required for commitment to the Bridgewater state hospital, the prisoner shall
1771 be confined at said hospital if the findings required for commitment to a facility are made and if
1772 the commissioner of correction certifies to the court that confinement of the prisoner at said
1773 hospital is necessary to insure his continued retention in custody.

1774 SECTION 48. Said section 18 of said chapter 123, as so appearing, is hereby further
1775 amended by inserting after subsection (a) the following subsection:-

1776 (a¹/₂)(1) For purposes of this subsection, “mental health watch” shall mean a status
1777 designated by the place of detention intended to protect a prisoner from a risk of imminent and
1778 serious self-harm.

1779 (2) A prisoner or a prisoner’s legal representative, or a staff person at the request of a
1780 prisoner, may petition the district court with jurisdiction over the prisoner’s place of detention or,
1781 if the prisoner is awaiting trial to the court with jurisdiction of the criminal case, to be transferred
1782 to a suitable inpatient psychiatric facility or unit licensed or operated by the department of
1783 mental health or to Bridgewater state hospital. The court may order the prisoner’s requested
1784 transfer if the prisoner: (i) has been on mental health watch for at least 72 hours; or (ii) is at
1785 serious risk of imminent and serious self-harm. A transfer under this subsection to Bridgewater
1786 state hospital shall only be ordered if: (i) the prisoner is male and no bed is available in a timely
1787 manner at a unit licensed or operated by the department of mental health; or (ii)(A) the prisoner
1788 is not a proper person for commitment to an inpatient psychiatric facility or unit licensed or

1789 operated by the department of mental health; and (B) the failure to retain the prisoner in strict
1790 custody would create a likelihood of serious harm. When a prisoner has been on mental health
1791 watch for 48 hours, and once every 24 hours thereafter that the prisoner remains on mental health
1792 watch, a member of the mental health staff of the place of detention shall advise the prisoner of
1793 the prisoner’s right to petition under this subsection and advise the prisoner that staff at the place
1794 of detention may also, at the prisoner’s request, petition on the prisoner’s behalf. If the prisoner
1795 requests, either orally or in writing, that staff at the place of detention petition under this
1796 subsection, an employee, representative, agent or other designee of the place of detention shall
1797 file a petition with the appropriate court within 12 hours. If a prisoner, a prisoner’s legal
1798 representative or a staff person files a petition in a court that lacks jurisdiction under this
1799 subsection, the clerk of the court shall, as soon as is practicable, determine the court with
1800 jurisdiction and forward the petition to that court for adjudication. The court may order periodic
1801 reviews of transfers under this subsection.

1802 SECTION 49. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby
1803 amended by inserting after the definition of “Domestic company” the following definition:-

1804 “Emergency services programs”, all programs subject to contract between the
1805 Massachusetts Behavioral Health Partnership and nonprofit organizations for the provision of
1806 community-based emergency psychiatric services, including, but not limited to, behavioral
1807 health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per
1808 week, through: (i) mobile crisis intervention services for youth; (ii) mobile crisis intervention
1809 services for adults; (iii) emergency service provider community-based locations; and (iv) adult
1810 community crisis stabilization services.

1811 SECTION 50. Section 47B of said chapter 175, as so appearing, is hereby amended by
1812 inserting after the word “specialist”, in line 122, the following words:- , a clinician practicing
1813 under the supervision of a licensed professional and working towards licensure in a clinic
1814 licensed under chapter 111.

1815 SECTION 51. Said chapter 175 is hereby further amended by inserting after section
1816 47PP, the following 4 sections:-

1817 Section 47QQ. (a) For the purposes of this section, “psychiatric collaborative care model”
1818 shall mean the evidence-based, integrated behavioral health service delivery method in which a
1819 primary care team consisting of a primary care provider and a care manager provides structured
1820 care management to a patient, and that works in collaboration with a psychiatric consultant that
1821 provides regular consultations to the primary care team to review the clinical status and care of
1822 patients and to make recommendations.

1823 (b) An individual policy of accident and sickness insurance issued pursuant to section
1824 108 that provides hospital expense and surgical expense insurance or a group blanket or general
1825 policy of accident and sickness insurance issued pursuant to section 110 that provides hospital
1826 expense and surgical expense insurance that is issued or renewed within or without the
1827 commonwealth shall provide coverage for mental health or substance use disorder services that
1828 are delivered through the psychiatric collaborative care model.

1829 Section 47RR. An individual policy of accident and sickness insurance issued under
1830 section 108 that provides hospital expense and surgical expense insurance or a group blanket or
1831 general policy of accident and sickness insurance issued under section 110 that provides hospital
1832 expense and surgical expense insurance that is issued or renewed within or without the

1833 commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary
1834 emergency services programs.

1835 Section 47SS. (a) For the purposes of this section, the following terms shall have the
1836 following meanings unless the context clearly requires otherwise:

1837 “Community-based acute treatment”, 24-hour clinically managed mental health
1838 diversionary or step-down services for children and adolescents that is usually provided as an
1839 alternative to mental health acute treatment.

1840 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
1841 mental health diversionary or step-down services for children and adolescents that is usually
1842 provided as an alternative to mental health acute treatment.

1843 “Mental health acute treatment”, 24-hour medically supervised mental health services
1844 provided in an inpatient facility licensed by the department of mental health that provides
1845 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1846 milieu.

1847 (b) A policy, contract, agreement, plan or certificate of insurance issued, delivered or
1848 renewed within or without the commonwealth, which is considered creditable coverage under
1849 section 1 of chapter 111M, shall provide coverage for medically necessary mental health acute
1850 treatment, community-based acute treatment and intensive community-based acute treatment and
1851 shall not require a preauthorization before the administration of such treatment; provided,
1852 however, that the facility shall notify the carrier of the admission and the initial treatment plan
1853 within 72 hours of admission.

1854 Section 47TT. (a) For the purpose of this section, the following words shall have the
1855 following meanings unless the context clearly requires otherwise:

1856 “Licensed mental health professional,” a licensed physician who specializes in the
1857 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
1858 licensed certified social worker, a licensed mental health counselor, a licensed supervised mental
1859 health counselor, a licensed psychiatric nurse mental health clinical specialist, a licensed
1860 psychiatric mental health nurse practitioner, a licensed physician assistant who practices in the
1861 area of psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter
1862 111J or a licensed marriage and family therapist within the lawful scope of practice for such
1863 therapist.

1864 “Mental health wellness examination,” a screening or assessment that seeks to identify
1865 any behavioral or mental health needs and appropriate resources for treatment. The examination
1866 may include: (i) observation, a behavioral health screening, education and consultation on
1867 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1868 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
1869 screenings or observations to understand a covered person’s mental health history, personal
1870 history and mental or cognitive state and, when appropriate, relevant adult input through
1871 screenings, interviews and questions.

1872 “Primary care provider”, a health care professional qualified to provide general medical
1873 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise
1874 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1875 maintains continuity of care within the scope of practice.

1876 (b) The following shall provide coverage for an annual mental health wellness
1877 examination that is performed by a licensed mental health professional or primary care provider,
1878 which may be provided by the primary care provider as part of an annual preventive visit: (i) any
1879 policy of accident and sickness insurance, as described in section 108, which provides hospital
1880 expense and surgical expense insurance and which is delivered, issued or subsequently renewed
1881 by agreement between the insurer and policyholder in the commonwealth; (ii) any blanket or
1882 general policy of insurance described in subdivision (A), (C) or (D) of section 110 which
1883 provides hospital expense and surgical expense insurance and which is delivered, issued or
1884 subsequently renewed by agreement between the insurer and the policyholder in or outside of the
1885 commonwealth; and (iii) any employees' health and welfare fund which provides hospital
1886 expense and surgical expense benefits and which is delivered, issued to or renewed for any
1887 person or group of persons in the commonwealth. The examination shall be covered with no
1888 patient cost-sharing, provided, however, that cost-sharing shall be required if the applicable plan
1889 is governed by the Federal Internal Revenue Code and would lose its tax-exempt status as a
1890 result of the prohibition on cost-sharing for this service.

1891 (c) The division of insurance, in consultation with the office of Medicaid, and the
1892 department of mental health, shall develop guidelines to implement this section.

1893 SECTION 52. Section 110 of said chapter 175, as appearing in the 2020 Official Edition,
1894 is hereby amended by inserting after the word "age", in line 463, the following words:- or
1895 without regard to age, so long as the dependent, who is covered under the membership of their
1896 parent as a member of a family group, is mentally or physically incapable of earning their own
1897 living due to disability.

1898 SECTION 53. Section 8BB of chapter 176A, as appearing in the 2020 Official Edition, is
1899 hereby amended by inserting after the word “age”, in line 8, the following words:- or without
1900 regard to age, so long as the dependent, who is covered under the membership of their parent as a
1901 member of a family group, is mentally or physically incapable of earning their own living due to
1902 disability.

1903 SECTION 54. Section 8A of chapter 176A of the General Laws, as appearing in the 2020
1904 Official Edition, is hereby amended by inserting after the word “specialist”, in line 125, the
1905 following words:- , a clinician practicing under the supervision of a licensed professional and
1906 working towards licensure in a clinic licensed under chapter 111.

1907 SECTION 55. Said chapter 176A is hereby further amended by inserting after section
1908 8QQ the following 4 sections:-

1909 Section 8RR. (a) For the purposes of this section, “psychiatric collaborative care model”
1910 shall mean the evidence-based, integrated behavioral health service delivery method in which a
1911 primary care team consisting of a primary care provider and a care manager provides structured
1912 care management to a patient, and that works in collaboration with a psychiatric consultant that
1913 provides regular consultations to the primary care team to review the clinical status and care of
1914 patients and to make recommendations.

1915 (b) A contract between a subscriber and the corporation under an individual or group
1916 hospital service plan that is delivered, issued or renewed within or without the commonwealth
1917 shall provide coverage for mental health or substance use disorder services that are delivered
1918 through the psychiatric collaborative care model.

1919 Section 8SS. (a) For the purposes of this section, the following terms shall have the
1920 following meanings unless the context clearly requires otherwise:

1921 “Community-based acute treatment”, 24-hour clinically managed mental health
1922 diversionary or step-down services for children and adolescents that is usually provided as an
1923 alternative to mental health acute treatment.

1924 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
1925 mental health diversionary or step-down services for children and adolescents that is usually
1926 provided as an alternative to mental health acute treatment.

1927 “Mental health acute treatment”, 24-hour medically supervised mental health services
1928 provided in an inpatient facility, licensed by the department of mental health, that provides
1929 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1930 milieu.

1931 (b) A contract between a subscriber and the corporation under an individual or group
1932 hospital service plan that is delivered, issued or renewed within the commonwealth shall provide
1933 coverage for medically necessary mental health acute treatment, community-based acute
1934 treatment and intensive community-based acute treatment and shall not require a
1935 preauthorization before the administration of any such treatment; provided, however, that the
1936 facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of
1937 admission.

1938 Section 8TT. A contract between a subscriber and the corporation under an individual or
1939 group hospital service plan that is delivered, issued or renewed within or without the

1940 commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary
1941 emergency services programs, as defined in section 1 of chapter 175.

1942 Section 8UU. (a) For the purpose of this section, the following words shall have the
1943 following meanings:

1944 “Licensed mental health professional,” a licensed physician who specializes in the
1945 practice of psychiatry, a licensed psychologist, a licensed supervised mental health counselor, a
1946 licensed independent clinical social worker, a licensed certified social worker, a licensed mental
1947 health counselor, a licensed psychiatric nurse mental health clinical specialist, a licensed
1948 psychiatric mental health nurse practitioner, a licensed physician assistant who practices in the
1949 area of psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter
1950 111J of the General Laws, or a licensed marriage and family therapist within the lawful scope of
1951 practice for such therapist.

1952 “Mental health wellness examination,” a screening or assessment that seeks to identify
1953 any behavioral or mental health needs and appropriate resources for treatment. The examination
1954 may include: (i) observation, a behavioral health screening, education and consultation on
1955 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1956 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
1957 screenings or observations to understand a covered person’s mental health history, personal
1958 history and mental or cognitive state and, when appropriate, relevant adult input through
1959 screenings, interviews, and questions.

1960 “Primary care provider”, a health care professional qualified to provide general medical
1961 care for common health care problems, who (i) supervises, coordinates, prescribes or otherwise

1962 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1963 maintains continuity of care within the scope of practice.

1964 (b) A contract between a subscriber and the corporation under an individual or group
1965 hospital service plan which is delivered, issued or renewed within the commonwealth shall
1966 provide coverage for an annual mental health wellness examination that is performed by a
1967 licensed mental health professional or primary care provider, which may be provided by the
1968 primary care provider as part of an annual preventive visit. The examination shall be covered
1969 with no patient cost-sharing, provided, however, that cost-sharing shall be required if the
1970 applicable plan is governed by the Federal Internal Revenue Code and would lose its tax-exempt
1971 status as a result of the prohibition on cost-sharing for this service.

1972 (c) The division of insurance, in consultation with the office of Medicaid, and the
1973 department of mental health, shall develop guidelines to implement this section.

1974 SECTION 56. Section 4A of chapter 176B of the General Laws, as appearing in the 2020
1975 Official Edition, is hereby amended by inserting after the word “specialist”, in line 120, the
1976 following words:- , a clinician practicing under the supervision of a licensed professional and
1977 working towards licensure in a clinic licensed under chapter 111.

1978 SECTION 57. Section 4BB of said chapter 176B, as appearing in the 2020 Official
1979 Edition, is hereby amended by inserting after the word “age”, in line 8, the following words:- or
1980 without regard to age, so long as the dependent, who is covered under the membership of their
1981 parent as a member of a family group, is mentally or physically incapable of earning their own
1982 living due to disability.

1983 SECTION 58. Said chapter 176B is hereby further amended by inserting after section
1984 4QQ the following 4 sections:-

1985 Section 4RR. (a) For the purposes of this section, “psychiatric collaborative care model”
1986 shall mean the evidence-based, integrated behavioral health service delivery method in which a
1987 primary care team consisting of a primary care provider and a care manager provides structured
1988 care management to a patient, and that works in collaboration with a psychiatric consultant that
1989 provides regular consultations to the primary care team to review the clinical status and care of
1990 patients and to make recommendations.

1991 (b) A subscription certificate under an individual or group medical service agreement that
1992 is issued or renewed within or without the commonwealth shall provide coverage for mental
1993 health or substance use disorder services that are delivered through the psychiatric collaborative
1994 care model.

1995 Section 4SS. For the purposes of this section, the following terms shall have the
1996 following meanings unless the context clearly requires otherwise:

1997 “Community-based acute treatment”, 24-hour clinically managed mental health
1998 diversionary or step-down services for children and adolescents that is usually provided as an
1999 alternative to mental health acute treatment.

2000 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
2001 mental health diversionary or step-down services for children and adolescents that is usually
2002 provided as an alternative to mental health acute treatment.

2003 “Mental health acute treatment”, 24-hour medically supervised mental health services
2004 provided in an inpatient facility, licensed by the department of mental health, that provides
2005 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
2006 milieu.

2007 (b) A subscription certificate under an individual or group medical service agreement
2008 delivered, issued or renewed within the commonwealth shall provide coverage for medically
2009 necessary mental health acute treatment, community-based acute treatment, intensive
2010 community-based acute treatment and shall not require a preauthorization before obtaining
2011 treatment; provided, however, that the facility shall notify the carrier of the admission and the
2012 initial treatment plan within 72 hours of admission.

2013 Section 4TT. A subscription certificate under an individual or group medical service
2014 agreement that is issued or renewed shall provide benefits on a nondiscriminatory basis for
2015 medically necessary emergency services programs, as defined in section 1 of chapter 175.

2016 Section 4UU. (a) For the purpose of this section, the following words shall have the
2017 following meanings:

2018 “Licensed mental health professional,” a licensed physician who specializes in the
2019 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
2020 licensed certified social worker, a licensed mental health counselor, a licensed supervised mental
2021 health counselor, a licensed psychiatric nurse mental health clinical specialist, a licensed
2022 psychiatric mental health nurse practitioner, a licensed physician assistant who practices in the
2023 area of psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter

2024 111J, or a licensed marriage and family therapist within the lawful scope of practice for such
2025 therapist.

2026 “Mental health wellness examination,” a screening or assessment that seeks to identify
2027 any behavioral or mental health needs and appropriate resources for treatment. The examination
2028 may include: (i) observation, a behavioral health screening, education and consultation on
2029 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
2030 necessary supports, and discussion of potential options for medication; and (ii) age-appropriate
2031 screenings or observations to understand a covered person’s mental health history, personal
2032 history and mental or cognitive state and, when appropriate, relevant adult input through
2033 screenings, interviews, and questions.

2034 “Primary care provider”, a health care professional qualified to provide general medical
2035 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise
2036 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
2037 maintains continuity of care within the scope of practice.

2038 (b) A subscription certificate under an individual or group medical service agreement
2039 delivered, issued or renewed within the commonwealth shall provide coverage for an annual
2040 mental health wellness examination that is performed by a licensed mental health professional or
2041 primary care provider, which may be provided by the primary care provider as part of an annual
2042 preventive visit. The examination shall be covered with no patient cost-sharing, provided,
2043 however, that cost-sharing shall be required if the applicable plan is governed by the Federal
2044 Internal Revenue Code and would lose its tax-exempt status as a result of the prohibition on cost-
2045 sharing for this service.

2046 (c) The division of insurance, in consultation with the office of Medicaid, and the
2047 department of mental health, shall develop guidelines to implement this section.

2048 SECTION 59. Section 4M of chapter 176G of the General Laws, as appearing in the
2049 2020 Official Edition, is hereby amended by inserting after the word “specialist”, in line 117, the
2050 following words:- , a clinician practicing under the supervision of a licensed professional and
2051 working towards licensure in a clinic licensed under chapter 111.

2052 SECTION 60. Section 4T of said chapter 176G, as so appearing, is hereby amended by
2053 inserting after the word “age”, in line 6, the following words:- or without regard to age, so long
2054 as the dependent, who is covered under the membership of the dependent’s parent as a member
2055 of a family group, is mentally or physically incapable of earning their own living due to
2056 disability.

2057 SECTION 61. Said chapter 176G is hereby further amended by inserting after section 4II
2058 the following 4 sections:-

2059 Section 4JJ. (a) For the purposes of this section, “psychiatric collaborative care model”
2060 shall mean the evidence-based, integrated behavioral health service delivery method in which a
2061 primary care team consisting of a primary care provider and a care manager provides structured
2062 care management to a patient, and that works in collaboration with a psychiatric consultant that
2063 provides regular consultations to the primary care team to review the clinical status and care of
2064 patients and to make recommendations.

2065 (b) Any individual or group health maintenance contract that is issued or renewed within
2066 or without the commonwealth shall provide coverage for mental health or substance use disorder
2067 services that are delivered through the psychiatric collaborative care model.

2068 Section 4KK. (a) For the purposes of this section, the following terms shall have the
2069 following meanings unless the context clearly requires otherwise:

2070 “Community-based acute treatment”, 24-hour clinically managed mental health
2071 diversionary or step-down services for children and adolescents that is usually provided as an
2072 alternative to mental health acute treatment.

2073 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
2074 mental health diversionary or step-down services for children and adolescents that is usually
2075 provided as an alternative to mental health acute treatment.

2076 “Mental health acute treatment”, 24-hour medically supervised mental health services
2077 provided in an inpatient facility, licensed by the department of mental health, that provides
2078 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
2079 milieu.

2080 (b) An individual or group health maintenance contract that is issued or renewed within
2081 or without the commonwealth shall provide coverage for medically necessary mental health
2082 acute treatment, community-based acute treatment and intensive community-based acute
2083 treatment and shall not require a preauthorization before the administration of such treatment;
2084 provided, however, that the facility shall notify the carrier of the admission and the initial
2085 treatment plan within 72 hours of admission.

2086 Section 4LL. An individual or group health maintenance contract that is issued or
2087 renewed within or without the commonwealth shall provide benefits on a nondiscriminatory
2088 basis for medically necessary emergency services programs, as defined in section 1 of chapter
2089 175.

2090 Section 4MM. (a) For the purpose of this section, the following words shall have the
2091 following meanings unless the context clearly requires otherwise:

2092 “Licensed mental health professional,” a licensed physician who specializes in the
2093 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
2094 licensed certified social worker, a licensed mental health counselor, a licensed supervised mental
2095 health counselor, a licensed psychiatric nurse mental health clinical specialist, a licensed
2096 psychiatric mental health nurse practitioner, a licensed physician assistant who practices in the
2097 area of psychiatry, a licensed alcohol and drug counselor I, as defined in section 1 of chapter
2098 111J, or a licensed marriage and family therapist within the lawful scope of practice for such
2099 therapist.

2100 “Mental health wellness examination,” a screening or assessment that seeks to identify
2101 any behavioral or mental health needs and appropriate resources for treatment. The examination
2102 may include: (i) observation, a behavioral health screening, education and consultation on
2103 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
2104 necessary supports, and discussion of potential options for medication; and (ii) age-appropriate
2105 screenings or observations to understand a covered person’s mental health history, personal
2106 history and mental or cognitive state and, when appropriate, relevant adult input through
2107 screenings, interviews and questions.

2108 “Primary care provider”, a health care professional qualified to provide general medical
2109 care for common health care problems, who (i) supervises, coordinates, prescribes or otherwise
2110 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
2111 maintains continuity of care within the scope of practice.

2112 (b) An individual or group health maintenance contract that is issued or renewed within
2113 or without the commonwealth shall provide coverage for an annual mental health wellness
2114 examination that is performed by a licensed mental health professional or primary care provider,
2115 which may be provided by the primary care provider as part of an annual preventive visit. The
2116 examination shall be covered with no patient cost-sharing, provided, however, that cost-sharing
2117 shall be required if the applicable plan is governed by the Federal Internal Revenue Code and
2118 would lose its tax-exempt status as a result of the prohibition on cost-sharing for this service.

2119 (c) The division of insurance, in consultation with the office of Medicaid, and the
2120 department of mental health, shall develop guidelines to implement this section.

2121 SECTION 62. Section 1 of chapter 176J of the General Laws, as appearing in the 2020
2122 Official Edition, is hereby amended by inserting after the word “age”, in line 86, the following
2123 words:- or without regard to age, so long as the dependent, who is covered under the membership
2124 of the dependent’s parent as a member of a family group is mentally or physically incapable of
2125 earning their own living due to disability.

2126 SECTION 63. Chapter 176O of the General Laws is hereby amended by inserting after
2127 section 5C the following section:-

2128 Section 5D. For the purposes of this section, the term “base fee schedule” shall mean the
2129 minimum rates, typically set forth in fee schedules, paid by the carrier to an in-network health
2130 care provider who is not paid under an alternative payment arrangement for covered health care
2131 services; provided, however, that final rates may be subject to negotiations or adjustments that
2132 may result in payments to in-network providers that are different from the base fee schedule.

2133 A carrier, directly or through any entity that manages or administers mental health or
2134 substance use disorder benefits for the carrier, shall establish a base fee schedule for evaluation
2135 and management services for behavioral health providers that is not less than the base fee
2136 schedule used for evaluation and management services for primary care providers of the same or
2137 similar licensure type and in the same geographic region; provided, however, that a carrier shall
2138 not lower its base fee schedule for primary care providers to comply with this section.

2139 The division shall promulgate regulations to implement this section.

2140 SECTION 64. Subsection (a) of section 13 of said chapter 176O, as appearing in the
2141 2020 Official Edition, is hereby amended by striking out the first sentence and inserting in place
2142 thereof the following sentence:-

2143 A carrier or utilization review organization shall maintain a formal internal grievance
2144 process that is compliant with the Patient Protection and Affordable Care Act, Public Law 111-
2145 148, as amended, as well as with any rules, regulations or guidance applicable thereto, and such
2146 formal internal grievance process shall provide for adequate consideration and timely resolution
2147 of grievances, which shall include but not be limited to: (i) a system for maintaining records of
2148 each grievance filed by an insured or on the insured's behalf, and responses thereto, for a period
2149 of 7 years, which records shall be subject to inspection by the commissioner; (ii) the provision of
2150 a clear, concise and complete description of the carrier's formal internal grievance process and
2151 the procedures for obtaining external review pursuant to section 14 with each notice of an
2152 adverse determination; (iii) the carrier's toll-free telephone number for assisting insureds in
2153 resolving such grievances and the consumer assistance toll-free telephone number maintained by
2154 the office of patient protection; (iv) a written acknowledgement of the receipt of a grievance

2155 within 15 days and a written resolution of each grievance sent to the insured by certified or
2156 registered mail, or other express carrier with proof of delivery, within 30 days from receipt
2157 thereof; (v) a procedure to accept grievances by telephone, in person, by mail and by electronic
2158 means; (vi) a process for an insured to request the appointment of an authorized representative to
2159 act on the insured's behalf; and (vii) a procedure to accept an insured's request for medical
2160 release forms by electronic means, which shall include delivery to a designated email address or
2161 access to an online consumer portal accessible by the insured, the insured's family member or
2162 the insured's authorized representative who can provide the insured's membership identification
2163 number.

2164 SECTION 65. Subsection (b) of said section 13 of said chapter 176O, as so appearing, is
2165 hereby amended by striking out the third sentence and inserting in place thereof the following
2166 sentence:- If the expedited review process affirms the denial of coverage or treatment, the carrier
2167 shall provide the insured, within 2 business days of the decision, including by any electronic
2168 means consented to by the insured: (1) a statement setting forth the specific medical and
2169 scientific reasons for denying coverage or treatment; (2) a description of alternative treatment,
2170 services or supplies covered or provided by the carrier, if any; (3) a description of the insured's
2171 rights to any further appeal; and (4) a description of the insured's right to request a conference.

2172 SECTION 66. Subsection (c) of said section 13 of said chapter 176O, as so appearing, is
2173 hereby amended by adding the following sentence:- The external review of a grievance under
2174 section 14 shall be decided in favor of the insured unless the carrier provides substantial
2175 evidence, such as proof of delivery, that the carrier properly complied with the time limits
2176 required under this section.

2177 SECTION 67. Subsection (a) of section 14 of said chapter 176O, as so appearing, is
2178 hereby amended by striking out the eighth sentence and inserting in place thereof the following
2179 sentence:- The panel shall consider, but not be limited to considering: (i) any related right to such
2180 treatment or service under any related state statute or regulation; (ii) written documents
2181 submitted by the insured; (iii) medical records and medical opinions regarding medical necessity
2182 by the insured's treating provider that requested or provided the disputed service, which shall be
2183 obtained by the carrier, or by the panel if the carrier fails to do so; (iv) additional information
2184 from the involved parties or outside sources that the review panel deems necessary or relevant;
2185 and (v) information obtained from any informal meeting held by the panel with the parties.

2186 SECTION 68. Subsection (b) of said section 14 of said chapter 176O, as so appearing, is
2187 hereby amended by striking out the second sentence and inserting in place thereof the following
2188 sentence:- An insured may apply to the external review panel to seek continued provision of
2189 health care services that are the subject of the grievance during the course of an expedited or
2190 non-expedited external review upon a showing of substantial harm to the insured's health absent
2191 such continuation or other good cause as determined by the panel; provided, however, that good
2192 cause shall include a pattern of denials that have been overturned by prior internal or external
2193 appeals.

2194 SECTION 69. Subsection (c) of said section 14 of said chapter 176O, as so appearing, is
2195 hereby amended by adding the following sentence:- A carrier's failure to promptly comply with
2196 a decision of the review panel shall be an unfair and deceptive practice in violation of chapter
2197 93A.

2198 SECTION 70. Said section 14 of said chapter 176O, as so appearing, is hereby further
2199 amended by adding following subsection:-

2200 (g) The office of patient protection shall monitor carrier denials and shall identify any
2201 trends regarding particular treatments or services or carrier practices and may refer such matters
2202 to the division of insurance, the group insurance commission or the office of the attorney general
2203 for review for compliance with state or federal laws related to mental health and substance use
2204 disorder parity including, but not limited to, section 22 of chapter 32A, section 47B of chapter
2205 175, section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of
2206 chapter 176G, in regard to any carrier licensed under chapters 175, 176A, 176B or 176G, any
2207 carrier offering a student health plan issued under section 18 of chapter 15A or the group
2208 insurance commission, or the mental health parity provisions of the federal Paul Wellstone and
2209 Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as
2210 amended, and federal guidance or regulations issued under the act. The office of patient
2211 protection shall refer any questions or concerns from consumers about carrier compliance with
2212 state or federal laws related to mental health and substance use disorder parity to the division of
2213 insurance, the group insurance commission or the office of the attorney general.

2214 SECTION 71. Subsection (b) of section 16 of said chapter 176O, as so appearing, is
2215 hereby amended by striking out the last sentence and inserting in place thereof the following
2216 sentence:- If a carrier or utilization review organization intends to implement a new medical
2217 necessity guideline or amend an existing requirement or restriction, the carrier or utilization
2218 review organization shall ensure that the new guideline or amended requirement or restriction
2219 shall not be implemented unless: (i) the carrier's or utilization review organization's website has
2220 been updated to reflect the new or amended requirement or restriction; and (ii) the carrier or

2221 utilization review organization has assessed the limitation to show it is in compliance with state
2222 and federal parity requirements under chapter 26.

2223 SECTION 72. The interagency health equity team, as supported through the office of
2224 health equity, shall, in consultation with the advisory council appointed in this section, study
2225 ways to improve access to, and the quality of, culturally competent behavioral health services.
2226 The review shall include, but not be limited to: (i) the need for greater racial, ethnic and
2227 linguistic diversity within the behavioral health workforce; (ii) the role of gender, sexual
2228 orientation, gender identity, race, ethnicity, linguistic barriers, status as a client of the department
2229 of children and families, status as an incarcerated or formerly incarcerated individual, including
2230 justice-involved youth and emerging adults, status as a veteran, status as an individual with post-
2231 traumatic stress disorder, status as an aging adult, status as a person with any other physical or
2232 invisible disability and social determinants of health regarding behavioral health needs; and (iii)
2233 any other factors identified by the team that create disparities in access and quality within the
2234 existing behavioral health service delivery system, including stigma, transportation and cost.

2235 The advisory council shall consist of: the chairs of the joint committee on mental health,
2236 substance use and recovery; the chair of the Black and Latino Caucus or a designee; and 8
2237 members to be appointed by the commissioner of public health, 1 of whom shall be a local public
2238 health official representing a majority-minority municipality, 1 of whom shall be a representative
2239 of a racial or ethnic equity advocacy group, 1 of whom shall be a representative of a linguistic
2240 equity advocacy group, 1 of whom shall be a licensed behavioral health provider, 1 of whom
2241 shall be a representative of a behavioral health advocacy group, 1 of whom shall be a
2242 representative of an organization serving the health care needs of the lesbian, gay, bisexual,
2243 transgender, queer and questioning community, 1 of whom shall be a representative of an

2244 organization serving the health care needs of individuals experiencing housing insecurity and 1
2245 of whom shall be an individual with expertise in school-based behavioral health services.

2246 The team shall meet not less than quarterly with the advisory council. Not later than
2247 March 30, 2022, and annually for the following 3 years at the close of the fiscal year, the team
2248 shall issue a report with legislative, regulatory or budgetary recommendations to improve the
2249 access and quality of culturally competent mental and behavioral health services. The report shall
2250 be written in non-technical, readily understandable language and shall be made publicly
2251 available on the office of health equity’s website.

2252 The office of health equity, the department of mental health and the department of public
2253 health may, subject to appropriation, provide administrative, logistical and research support to
2254 produce the report.

2255 SECTION 73. The executive office of health and human services and the department of
2256 public health shall conduct a study relative to the feasibility and cost, if any, of creating a board
2257 of registration of mental health counselors. The report shall be submitted not later than June 30,
2258 2023, to the clerks of the senate and house of representatives, the joint committee on mental
2259 health and substance use and recovery and the joint committee on labor and workforce
2260 development.

2261 SECTION 74. The health policy commission, in consultation with the division of
2262 insurance, shall conduct an analysis of the effects of behavioral health managers, as defined in
2263 section 1 of chapter 176O of the General Laws, on the commonwealth’s health care delivery
2264 system. The commission shall seek input from the executive office of health and human services,

2265 other state agencies, health care providers and payers, behavioral health and economic experts,
2266 patients and caregivers.

2267 The commission shall analyze: (i) the services that behavioral health managers provide;
2268 (ii) the effect of behavioral health managers on accessibility, quality and cost of behavioral
2269 health services, including an analysis of their impact on patient outcomes; (iii) the oversight
2270 practices by other states on behavioral health managers; (iv) the effects of behavioral health
2271 manager state licensure, regulation or registration on access to behavioral health services; and (v)
2272 any other issues pertaining to behavioral health managers as deemed relevant by the commission.

2273 Not later than December 31, 2022, the health policy commission shall file a report of its
2274 findings, together with any recommendations for legislation, with the clerks of the senate and
2275 house of representatives, the joint committee on health care financing, the joint committee on
2276 mental health, substance use and recovery and the joint committee on financial services.

2277 SECTION 75. There shall be a special commission to study and make recommendations
2278 on the establishment of a common set of criteria for providers and payers to use in making
2279 medical necessity determinations for behavioral health treatment.

2280 The commission shall consist of the following members or their designees: the
2281 commissioner of mental health, who shall serve as chair; the commissioner of insurance; the
2282 director of the bureau of substance addiction services within the department of public health; the
2283 assistant secretary for MassHealth; the executive director of the group insurance commission;
2284 and 17 members to be appointed by the chair: 1 of whom shall be a representative of the health
2285 policy commission; 2 of whom shall be representatives of the Massachusetts Psychiatric Society,
2286 Inc., 1 of whom shall specialize in the treatment of children; 2 of whom shall be representatives

2287 of the Massachusetts Psychological Association, Inc., 1 of whom shall specialize in the treatment
2288 of children; 1 of whom shall be a representative of the Massachusetts Society of Addiction
2289 Medicine, Inc.; 1 of whom shall be a representative of the National Association of Social
2290 Workers, Inc.; 1 of whom shall be a representative of the Massachusetts Mental Health
2291 Counselors Association, Inc.; 1 of whom shall be a representative of the Children’s Mental
2292 Health Campaign; 1 of whom shall be a representative of the Association for Behavioral
2293 Healthcare, Inc.; 1 of whom shall be a representative of the Massachusetts Association of
2294 Behavioral Health Systems, Inc.; 1 of whom shall be a representative of the Massachusetts
2295 Health and Hospital Association;; 1 of whom shall be a representative of the Massachusetts
2296 Association for Mental Health, Inc.; 1 of whom shall be a representative of the National Alliance
2297 on Mental Illness of Massachusetts, Inc.; 1 of whom shall be a representative of the
2298 Massachusetts Organization for Addiction Recovery, Inc.; 1 of whom shall be a representative of
2299 Blue Cross and Blue Shield of Massachusetts, Inc.; and 1 of whom shall be a representative of
2300 the Massachusetts Association of Health Plans, Inc..

2301 The commission’s review shall include, but not be limited to: (i) existing reference
2302 sources or services utilized by payers to make medical necessity determinations for behavioral
2303 health treatment; (ii) commonly accepted treatment guidelines and standards of care utilized by
2304 behavioral health providers and the evidentiary basis for those guidelines and standards; (iii) the
2305 feasibility of establishing a common set of medical necessity criteria that behavioral health
2306 providers and payers can agree to and any barriers to this task; and (iv) the experiences of other
2307 states in addressing the standardization of medical necessity for behavioral health.

2308 Not later than 1 year after the effective date of this act, the commission shall submit its
2309 findings and recommendations, together with drafts of legislation or regulations necessary to

2310 carry those recommendations into effect, to the clerks of the senate and house of representatives
2311 and the joint committee on mental health, substance use and recovery.

2312 SECTION 76. The health policy commission shall convene an advisory group to advise
2313 the commission on the implementation of section 21 of chapter 6D of the General Laws. The
2314 advisory group shall include: the director of the health policy commission or a designee, who
2315 shall serve as chair; the secretary of health and human services or a designee; the assistant
2316 secretary of MassHealth or a designee; the commissioner of insurance or a designee; 1 member
2317 appointed by the governor, who shall be from a commonwealth-based electronic health record
2318 vendor who specializes in behavioral health care; 1 member appointed by the Association for
2319 Behavioral Healthcare, Inc.; 1 member appointed by Blue Cross and Blue Shield of
2320 Massachusetts, Inc.; 1 member appointed by Health Law Advocates, Inc.; 1 member appointed
2321 by the Massachusetts Association of Health Plans, Inc.; 1 member appointed by the
2322 Massachusetts Health and Hospital Association, Inc.; 1 member appointed by National Alliance
2323 on Mental Illness of Massachusetts, Inc.; 1 member appointed by the Massachusetts
2324 Organization for Addiction Recovery, Inc. ; 1 of who shall be a person who has received mental
2325 health or substance use disorder treatment; 1 of whom shall be a family member of a person
2326 being treated for a mental health or substance use disorder substance use disorder; and 1 member
2327 appointed by the Parent/Professional Advocacy League, Inc.

2328 The advisory group shall study and make recommendations on the development and
2329 proper use of the standard release form required under said section 21 of said chapter 6D. The
2330 advisory group shall consider: (i) existing and potential technologies that could be used to
2331 securely transmit a standard release form; (ii) national standards pertaining to electronic release
2332 of confidential information, including protecting a patient's identity and privacy in accordance

2333 with the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191; (iii)
2334 any prior release forms and methodologies used in the commonwealth; (iv) any prior release
2335 forms and methodologies developed by federal agencies; and (v) any other factors the advisory
2336 group deems relevant.

2337 The advisory group shall submit written recommendations to the commission not more
2338 than 6 months after the effective date of this act. The commission shall develop the standard
2339 release form after receiving the advisory group's recommendations.

2340 SECTION 77. (a) The department of veterans' services shall convene an advisory
2341 committee that shall consist of: 2 representatives of the Massachusetts chapter of Team Red,
2342 White & Blue; 2 representatives of the Red Sox Foundation and Massachusetts General
2343 Hospital's Home Base Program; 2 representatives of the Wounded Warriors Project; 2
2344 representatives of the Mass Mentoring Partnership, Inc.; 2 representatives of the Massachusetts
2345 Coalition for Suicide Prevention; 2 representatives of the Massachusetts Psychological
2346 Association, Inc.; and such other members as the committee deems necessary. The members of
2347 the committee shall have experience in mental health or veterans' support services with an
2348 emphasis on treatment of post-traumatic stress disorder, depression and anxiety among veterans.

2349 (b) The committee, in coordination with the department of veterans' services and the
2350 department of mental health, shall investigate and study: (i) ways to augment services to
2351 returning veterans to reduce the rate of suicide and the effects of post-traumatic stress disorder,
2352 depression and anxiety; and (ii) the complexity of reintegration into civilian life and issues
2353 related to isolation and suicide among veterans. The committee shall provide support and
2354 expertise to reduce isolation and suicide among returning veterans.

2355 The committee shall examine: (i) the impact of having a community peer liaison on a
2356 veteran’s reintegration into society; (ii) the relationship between isolation and suicide among
2357 veterans; and (iii) the impact of having a community peer liaison on symptoms of post-traumatic
2358 stress disorder, depression and anxiety in diagnosed veterans.

2359 The committee shall file a report of its findings and any recommendations, with the
2360 clerks of the senate and house of representatives, the joint committee on veterans and federal
2361 affairs and the joint committee on mental health, substance use and recovery not later than
2362 January 1, 2023.

2363 SECTION 78. Notwithstanding any general or special law to the contrary, the division of
2364 insurance shall promulgate regulations or issue sub-regulatory guidance, within 30 days of the
2365 effective date of this act, to establish reasonable rates at which carriers shall reimburse acute care
2366 hospitals for each day a member waits in an emergency department, observation unit or inpatient
2367 floor, for placement in an appropriate inpatient psychiatric placement. The division of insurance
2368 shall consult with the division of medical assistance on establishing a reasonable rate for said
2369 reimbursement.

2370 SECTION 79. The department of mental health shall prepare a comprehensive plan to
2371 address access to continuing care beds, intensive residential treatment programs and community-
2372 based programs for patients awaiting discharge from acute psychiatric hospitals and units. The
2373 plan shall include, but not be limited to, strategies to reduce the wait times for patients awaiting
2374 discharge so that the patients determined appropriate for continuing care, intensive residential
2375 treatment and community-based programs would be admitted to an appropriate continuing care
2376 bed, intensive residential treatment program, community-based program or other appropriate

2377 setting within 30 days after approval of their application. The department of mental health shall
2378 submit a copy of the plan to the governor, the clerks of the senate and house of representatives
2379 and the joint committee on mental health, substance use and recovery within 60 days after the
2380 effective date of this act.

2381 SECTION 80. (a) There shall be within the department of public health's division of
2382 violence and injury prevention a suicide postvention task force to address the after effects of a
2383 confirmed suicide. Using recent data, the task force shall prepare best practices and mental health
2384 standards and a postvention care kit that shall include materials and contact information for
2385 behavioral health resources and supports, including but not limited to grief counseling, that shall
2386 be made available to individuals in the aftermath of a suicide. The task force shall study best
2387 practices and privacy considerations in proactively distributing the care kit or other resources to
2388 family members and others at risk of suicide behavior contagion.

2389 (b) The suicide postvention task force shall consist of the following members or their
2390 designees: the director of the Massachusetts Suicide Prevention Program, who shall serve as
2391 chair; the secretary of health and human services; and 7 persons to be appointed by the chair, 1
2392 of whom shall be a representative of the National Alliance on Mental Illness of Massachusetts,
2393 Inc., 1 of whom shall be a representative of the Parent/Professional Advocacy League, Inc., 1 of
2394 whom shall be a representative of the Massachusetts Coalition for Suicide Prevention, 1 of whom
2395 shall be a representative of Riverside Community Care, Inc., 1 of whom shall be a representative
2396 of the Samaritans, Inc., 1 of whom shall be a representative of an organization that provides
2397 suicide prevention and postvention support to communities of color and 1 of whom shall be an
2398 individual who has experienced a suicide within their family.

2399 (c) The task force shall prepare its findings and recommendations, together with drafts of
2400 legislation or regulations necessary to carry those recommendations into effect, by filing the
2401 same with the clerks of the senate and house of representatives and the joint committee on
2402 mental health, substance use and recovery not later than 1 year after the effective date of this act.

2403 SECTION 81. The state 911 department shall update 560 CMR 5.00 to integrate training
2404 on identification of and response to callers experiencing behavioral health crises, which may
2405 include crisis intervention training and training on the appropriate diversion of people with
2406 behavioral health conditions away from law enforcement response to appropriate behavioral
2407 health treatment and support, into the certification standards for certified enhanced 911
2408 telecommunicators.

2409 SECTION 82. The division of insurance shall promulgate regulations to implement
2410 section 5D of chapter 176O of the General Laws not later than 1 year from the effective date of
2411 this act; provided, however, that the division shall, upon publication, forward any draft
2412 regulations to the joint committee on health care financing and the joint committee on mental
2413 health, substance use and recovery.

2414 SECTION 83. The health policy commission shall publish its first pediatric behavioral
2415 health planning report required by section 20 of chapter 6D of the General Laws not later than 18
2416 months after the effective date of this act.

2417 SECTION 84. For the purposes of section 22A of chapter 32A of the General Laws,
2418 section 10P of chapter 118E of the General Laws, section 47MM of chapter 175 of the General
2419 Laws, section 8OO of chapter 176A of the General Laws, section 4OO of chapter 176B of the
2420 General Laws and section 4GG of chapter 176G of the General Laws, reimbursement for the

2421 psychiatric collaborative care model shall include, but not be limited to, the following current
2422 procedural terminology billing codes established by the American Medical Association: (i)
2423 99492; (ii) 99493; and (iii) 99494.

2424 SECTION 85. The office of the child advocate shall publish the first annual report
2425 required by section 10A of chapter 18C of the General Laws not later than 18 months after the
2426 development of the online portal established pursuant to section 16P of chapter 6A of the
2427 General Laws.

2428 SECTION 86. Section 5D of chapter 176O of the General Laws shall take effect 1 year
2429 after the effective date of this act.

2430 SECTION 87. Section 51³/₄ of chapter 111 of the General Laws, inserted by section 23,
2431 shall take effect on January 1, 2023; provided, however, the department of public health shall
2432 promulgate regulations to implement said section 51³/₄ of said chapter 111 not later than 90 days
2433 after the effective date of this act.