

SENATE No. 675

The Commonwealth of Massachusetts

PRESENTED BY:

Cindy F. Friedman

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act relative to mental health parity implementation.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
<i>Cindy F. Friedman</i>	<i>Fourth Middlesex</i>	
<i>Julian Cyr</i>	<i>Cape and Islands</i>	
<i>Susannah M. Whipps</i>	<i>2nd Franklin</i>	<i>3/24/2021</i>
<i>Sal N. DiDomenico</i>	<i>Middlesex and Suffolk</i>	<i>4/1/2021</i>
<i>Joanne M. Comerford</i>	<i>Hampshire, Franklin and Worcester</i>	<i>4/1/2021</i>
<i>John F. Keenan</i>	<i>Norfolk and Plymouth</i>	<i>6/3/2021</i>
<i>Natalie M. Higgins</i>	<i>4th Worcester</i>	<i>9/13/2021</i>

SENATE No. 675

By Ms. Friedman, a petition (accompanied by bill, Senate, No. 675) of Cindy F. Friedman, Julian Cyr, Susannah M. Whipps, Sal N. DiDomenico and others for legislation relative to mental health parity implementation. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. 588 OF 2019-2020.]

The Commonwealth of Massachusetts

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

An Act relative to mental health parity implementation.

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. Paragraph (5) of subsection (a) of section 16 of chapter 6D of the General
2 Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the words
3 “established by”, in lines 41 and 42, the following words:- section 47B of chapter 118E and.

4 SECTION 2. Section 18 of chapter 15A of the General Laws, as appearing in the 2018
5 Official Edition, is hereby amended by adding the following paragraph:-

6 Any qualifying student health insurance plan authorized under this chapter shall comply
7 with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity
8 Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including
9 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part

10 156.115(a)(3), and the benefit mandates and other obligations under section 47B of chapter 175,
11 section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter
12 176G, as if the student health insurance plan was issued by such carriers licensed under chapters
13 175, 176A, 176B and 176G, without regard to any limitation under section 1 of chapter 176J.

14 SECTION 3. Chapter 26 of the General Laws, as appearing in the 2018 Official Edition,
15 is hereby amended by striking out section 8K and inserting in place thereof the following
16 section:-

17 Section 8K. (a) The commissioner of insurance shall implement and enforce applicable
18 provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction
19 Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act,
20 including 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part
21 156.115(a)(3), and applicable state mental health parity laws, including, but not limited to,
22 section 22 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A
23 of chapter 176B and sections 4, 4B and 4M of chapter 176G, in regard to any carrier licensed
24 under chapters 175, 176A, 176B and 176G, any carrier offering a student health plan issued
25 under section 18 of chapter 15A or the group insurance commission, by:

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

28 (ii) performing behavioral health parity compliance market conduct examinations of each
29 carrier at least once every 36 months, or more frequently if noncompliance is suspected, with a
30 focus on: (A) non-quantitative treatment limitations under the federal Paul Wellstone and Pete
31 Domenici Mental Health Parity and Addiction Equity Act of 2008 and applicable state mental

32 health and substance use disorder parity laws, including, but not limited to, prior authorization,
33 concurrent review, retrospective review, step-therapy, network admission standards,
34 reimbursement rates, network adequacy and geographic restrictions; (B) denials of authorization,
35 payment and coverage; and (C) any other criteria determined by the division, including factors
36 identified through consumer or provider complaints; provided, however, that: (1) a market
37 conduct examination of a carrier subject to chapters 175, 176A, 176B or 176G and any plans
38 authorized or regulated under chapter 32A shall follow the procedural requirements in
39 subsections 10, 11 and 15 of section 4 of said chapter 175 regarding notice and rebuttal of
40 examination findings, subsequent hearings and conflicts of interest; (2) the commissioner shall
41 publicize the fees for a market conduct examination under section 3B of chapter 7 and said
42 subsection 11 of said section 4 of said chapter 175; and (3) nothing contained in clause (ii) or in
43 said section 4 of said chapter 175, section 7 of said chapter 176A, section 9 of said chapter 176B
44 and section 10 of said chapter 176G shall limit the commissioner's authority to use, and if
45 appropriate, to make public any final or preliminary examination report, any examiner or
46 company work papers or other documents or any other information discovered or developed
47 during the course of any examination in the furtherance of any legal or regulatory action which
48 the commissioner may, in their sole discretion, deem appropriate;

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

53 (iv) updating applicable regulations as necessary to effectuate any provisions of the
54 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
55 2008 that relate to insurance; and

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

67 (b) The division of insurance may impose a penalty against a carrier that provides mental
68 health or substance use disorder benefits, directly or through a behavioral health manager as
69 defined in section 1 of chapter 176O or any other entity that manages or administers such
70 benefits for the carrier, for any violation by the carrier or the entity that manages or administers
71 mental health and substance use disorder benefits for the carrier of state laws related to mental
72 health and substance use disorder parity or provisions of the federal Paul Wellstone and Pete
73 Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as
74 amended, and federal guidance or regulations issued under the act.

75 The amount of any penalty imposed shall be \$100 for each day in the noncompliance
76 period per product line with respect to each participant or beneficiary to whom such failure
77 relates; provided, however, that the maximum annual penalty under this subsection shall be
78 \$1,000,000. For purposes of this subsection, the term “noncompliance period” shall mean the
79 period beginning on the date a failure first occurs and ending on the date such failure is
80 corrected.

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

84 (c) In the event that a parity violation was likely to have caused denials of access to
85 behavioral health services, the division of insurance shall require carriers to provide remedies for
86 any failure to meet the requirements of state laws related to mental health and substance use
87 disorder parity or provisions of the federal Paul Wellstone and Pete Domenici Mental Health
88 Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as amended, and federal guidance
89 or regulations issued under the act, including, but not limited to:

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

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

93 (iii) informing plan members of changes;

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

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

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

99 (d) Any proprietary information submitted to the commissioner by a carrier as a result of
100 the requirements of this section shall not be public records under clause Twenty-sixth of section
101 7 of chapter 4 or chapter 66; provided, however, that the commissioner may produce reports
102 summarizing any findings.

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

106 (f) Nothing in this section shall prevent the commissioner of insurance from publishing
107 any illustrative utilization review criteria, medical necessity standard, clinical guideline, or other
108 policy, procedure, criteria or standard, regardless of its origin, as an example of the type of
109 policy, procedure, criteria or standard that contributes to a violation of state or federal law parity
110 requirements, including any document that would normally be subject to disclosure to plan
111 members or their providers under section 16 of chapter 6D, section 16 of chapter 176O or the
112 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
113 2008, as amended.

114 SECTION 4. Said chapter 26 is hereby further amended by inserting after Section 8L the
115 following section:-

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

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

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

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

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

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

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

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

164 (E) disclose the specific findings and conclusions reached by the carrier or the group
165 insurance commission that the results of the analyses in this clause indicate that the carrier or
166 group insurance commission is in compliance with this section and the federal Paul Wellstone
167 and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any
168 federal guidance or regulations relevant to the act, including, but not limited to, 45 CFR Part
169 146.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3); and

170 (F) disclose the number of requests for parity documents received under 29 CFR
171 2590.712(d)(3) or 45 CFR 146.136(d)(3) and the number of any such requests for which the plan
172 refused, declined or was unable to provide documents.

173 (b) If federal guidance, including, but not limited to, the Self-Compliance Tool for the
174 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
175 2008, as amended, is released that indicates a non-quantitative treatment limitation analysis
176 process and reporting format that is significantly different from, contrary to or more efficient
177 than the non-quantitative treatment limitation analysis process and reporting format requirements
178 described in subsection (a), the commissioner may promulgate regulations that delineate a non-
179 quantitative treatment limitation analysis process and reporting format that may be used in lieu of

180 the non-quantitative treatment limitation analysis and reporting requirements described in said
181 subsection (a).

182 (c) Any proprietary portions of information submitted to the commissioner by a carrier as
183 a result of the requirements of this section shall not be public records under clause Twenty-sixth
184 of section 7 of chapter 4 or chapter 66; provided, however, that: (i) the commissioner may
185 produce reports summarizing any findings; (ii) nothing in this section shall limit the authority of
186 the commissioner to use and, if appropriate, make public any final or preliminary examination
187 report, examiner or company work papers or other documents or other information discovered or
188 developed during the course of an examination in the furtherance of any legal or regulatory
189 action that the commissioner may, in their sole discretion, deem appropriate; and (iii) nothing in
190 this section shall prevent the commissioner of insurance from publishing any illustrative
191 utilization review criteria, medical necessity standard, clinical guideline, or other policy,
192 procedure, criteria or standard, regardless of its origin, as an example of the type of policy,
193 procedure, criteria or standard that contributes to a violation of state or federal law parity
194 requirements, including any document that would normally be subject to disclosure to plan
195 members or their providers under section 16 of Chapter 6D, section 16 of Chapter 176O or under
196 the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
197 2008, as amended.

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

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

206 (ii) the methodology the commissioner is using to check for compliance with section 22
207 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter
208 176B and section 4M of chapter 176G;

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

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

225 authorized than requested and the reason for the modification, outpatient service requests denied
226 and the reason for the denial, outpatient service requests where an internal appeal was filed and
227 approved, outpatient service requests where an internal appeal was filed and denied, outpatient
228 service requests where an external appeal was filed and upheld and outpatient service requests
229 where an external appeal was filed and overturned;

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

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

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

241 SECTION 5. Section 47 of chapter 118E of the General Laws, as appearing in the 2018
242 Official Edition, is hereby amended by inserting after the first paragraph the following
243 paragraphs:-

244 Any recipient of medical assistance denied authorization or approval for a covered
245 service by the division or its contracted health insurers, health plans, health maintenance
246 organizations, behavioral health management firms or third party administrators under contract

247 with the division, a Medicaid managed care organization or primary care clinician plan, on the
248 basis of medical necessity shall have the right to pursue an independent external review through
249 the office of patient protection under section 47B. Such review shall be available to the recipient
250 of medical assistance as an optional component of any internal review process conducted by the
251 division and shall not interfere with the recipient's right to a hearing under this section or the
252 recipient's right to a board of hearing under section 48. Upon completion of an independent
253 external review, the recipient of medical assistance shall have 30 days to submit a request for a
254 hearing under this section.

255 Notwithstanding any general or special law to the contrary, the division shall promulgate
256 regulations that require the division, its contracted health insurers, health plans, health
257 maintenance organizations, behavioral health management firms and third party administrators
258 under contract with the division, a Medicaid managed care organization or primary care clinician
259 plan, to maintain documentation of all requests for benefits or services, whether the request is
260 submitted by or on behalf of the intended recipient of those benefits or services. Any request that
261 is not fulfilled in full shall be considered a denial, and shall result in the prompt written
262 notification to the recipient through electronic means, if possible. Such notification shall include
263 a description of the requested service, the response by the entity, and the recipient's due process
264 and appeal rights. All such entities shall accept requests for authorized representatives or for
265 appeals by electronic means.

266 SECTION 6. Said chapter 118E, as so appearing, is hereby further amended by inserting
267 after section 47A the following section:-

268 Section 47B. (a) Any recipient of medical assistance that is denied authorization or
269 approval for a covered service by the division or its contracted health insurers, health plans,
270 health maintenance organizations, behavioral health management firms or third party
271 administrators under contract with the division, a Medicaid managed care organization or
272 primary care clinician plan, may seek further review of the denial by a review panel established
273 by the office of patient protection pursuant to paragraph (5) of subsection (a) of section 16 of
274 chapter 6D. The division or its applicable contracted health insurers, health plans, health
275 maintenance organizations, behavioral health management firms or third party administrators
276 under contract with the division, a Medicaid managed care organization or primary care clinician
277 plan, shall be responsible for the cost of the review pursuant to regulations promulgated by the
278 executive director of the health policy commission in consultation with the commissioner. The
279 office of patient protection shall contract with at least 3 unrelated and objective review agencies
280 through a bidding process and refer denials of a covered service to 1 of the review agencies on a
281 random selection basis. The review agencies shall be accredited by a national accrediting
282 organization and shall develop review panels appropriate for the given covered service denial,
283 which shall include qualified clinical decision-makers experienced in the determination of
284 medical necessity, utilization management protocols and covered service denial resolution, and
285 shall not have any financial relationship with the division or its applicable contracted health
286 insurers, health plans, health maintenance organizations, behavioral health management firms or
287 third party administrators under contract with the division, a Medicaid managed care
288 organization or primary care clinician plan, making the initial determination to deny a covered
289 service. For denials related to medical necessity, the standard for review of a denial of a covered
290 service by such a panel shall be the determination of whether the requested treatment or service

291 is medically necessary and a covered benefit under the policy or contract; provided, that the word
292 “medically necessary” shall include a determination of whether access to an out-of-network
293 provider is required when no qualified in-network provider is available. For denials related to a
294 violation of the federal or state mental health parity laws, the standard for review of a grievance
295 by such a panel shall be the legal standards related to QTLs and NQTLs under those statutes,
296 regulations and guidance, including, but not limited to, 45 CFR Part 146.136 and 29 C.F.R. §
297 2590.712. The panel shall consider, but not be limited to considering: (i) any related right to such
298 treatment or services under any related state statute or regulation; (ii) written documents
299 submitted by the recipient of medical assistance; (iii) medical records and medical opinions
300 regarding medical necessity by the treating provider that requested or provided the disputed
301 service to the recipient of medical assistance, which shall be obtained by the division, or by the
302 panel if the division fails to do so; (iv) additional information from the involved parties or
303 outside sources that the review panel deems necessary or relevant; and (v) information obtained
304 from any informal meeting held by the panel with the parties. The panel shall send final written
305 disposition of the covered service denial and the reasons therefore, to the recipient of medical
306 assistance and the division or its applicable contracted health insurers, health plans, health
307 maintenance organizations, behavioral health management firms or third party administrators
308 under contract with the division, a Medicaid managed care organization or primary care clinician
309 plan, within 45 days of receipt of the request for review; provided, however, that if the panel
310 discovers new facts or a new rationale to deny the treatment or service that was not previously
311 relied upon by the division or its applicable contracted health insurers, health plans, health
312 maintenance organizations, behavioral health management firms or third party administrators
313 under contract with the division, a Medicaid managed care organization or primary care clinician

314 plan, in their denial of a covered service determination, the panel shall provide the division or its
315 applicable contracted health insurers, health plans, health maintenance organizations, behavioral
316 health management firms or third party administrators under contract with the division, a
317 Medicaid managed care organization or primary care clinician plan, with notice of such rationale
318 and an opportunity to respond to such rationale before issuing a final decision on the denial of a
319 covered service. Notwithstanding the requirements of this section, such review shall be available
320 to the recipient of medical assistance as an optional component of any internal review process
321 conducted by the division and shall not interfere with the recipient's right to a hearing under
322 section 47 or the recipient's right to a board of hearing under section 48.

323 (b) If a denial of a covered service includes the termination of ongoing coverage or
324 treatment, the recipient of medical assistance may apply to the external review panel to seek
325 continued provision of health care services which are the subject of the denial during the course
326 of an external review upon a showing of substantial harm to the health of the recipient of medical
327 assistance absent such continuation, or other good cause as determined by the panel; provided,
328 that good cause shall include a history or pattern of denials that have been overturned by prior
329 internal or external appeals.

330 (c) A recipient of medical assistance may request reconsideration of a decision by the
331 review panel within 30 days. A decision shall be reconsidered if the review panel makes a clear
332 error regarding essential facts, demonstrates a lack of adequate medical expertise in an area of
333 specialty, or fails to address an articulated right to health care benefits under state or federal law.
334 Absent such reconsideration, the decision of the review panel shall be binding on the recipient of
335 medical assistance and on the division or its applicable contracted health insurers, health plans,
336 health maintenance organizations, behavioral health management firms or third party

337 administrators under contract with the division, a Medicaid managed care organization or
338 primary care clinician plan. The office of patient protection, the commissioner, the office of the
339 attorney general, and any aggrieved recipient of medical assistance seeking redress in superior
340 court shall have jurisdiction to enforce the decision of the review panel; provided, that if the
341 recipient of medical assistance prevails in superior court, the court shall order the division or its
342 applicable contracted health insurers, health plans, health maintenance organizations, behavioral
343 health management firms or third party administrators under contract with the division, a
344 Medicaid managed care organization or primary care clinician plan, to pay the recipient of
345 medical assistance for the costs of the action and any reasonable attorneys' fees.

346 (d) The division or its contracted health insurers, health plans, health maintenance
347 organizations, behavioral health management firms or third party administrators under contract
348 with the division, a Medicaid managed care organization or primary care clinician plan, shall
349 allow a guardian, conservator, holder of a power of attorney, family member, or other
350 responsible party to act as a representative for the recipient of medical assistance in the event that
351 a recipient is unable to pursue a denial of a covered service due to physical or mental disability.
352 A recipient of medical assistance may designate such a representative or, if the recipient of
353 medical assistance is unable to so designate, a guardian, conservator, holder of a power of
354 attorney or family member, in order of priority, may serve as representative or may designate
355 another responsible party to act as representative. The representative shall have the same rights
356 of review of a denial of a covered service as the recipient of medical assistance, including the
357 right to review the recipient's medical file relevant to a dispute concerning coverage or
358 treatment.

359 (e) The external review panel procedures authorized by this section shall be in addition to
360 any other procedures that may be available to any recipient of medical assistance pursuant to
361 contract or law, and failure to pursue, exhaust or engage in the procedures described in this
362 subsection shall not preclude the use of any other remedy provided by any contract or law.

363 (f) No health care provider and no agent or employee of a health care provider shall
364 provide information relative to unpaid charges for health care services to a consumer reporting
365 agency, as defined in section 50 of chapter 93, while a review under this section is pending or for
366 30 days following the resolution of a denial of a covered service.

367 SECTION 7. Said chapter 118E is hereby further amended by adding the following
368 sections:-

369 Section 79. (a) The division, its managed care organizations, accountable care
370 organizations or other entity contracting with the division to manage or administer mental health
371 and substance use disorder benefits shall ensure that there are no separate non-quantitative
372 treatment limitations that apply to mental health and substance use disorder benefits but do not
373 apply to medical and surgical benefits within any classification of benefits as defined under the
374 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
375 2008 and applicable state mental health parity laws, including, but not limited to, section 80;
376 provided, however, that the non-quantitative treatment limitations shall include the processes,
377 strategies or methodologies for developing and applying the division's reimbursement rates for
378 mental health and substance use disorder benefits and medical and surgical benefits within each
379 classification of benefits.

380 (b) The division shall perform a behavioral health parity compliance examination of each
381 Medicaid managed care organization, accountable care organization or other entity contracted
382 with the agency that manages or administers mental health and substance use disorder benefits
383 for the division at least once every 24 months. The examination shall include examination of
384 entities that manage medical and surgical benefits, as necessary. The examination shall only
385 apply where the division is the primary payer. The examination shall include but not be limited
386 to:

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

390 (2) approvals and denials of authorization, payment, and coverage; and

391 (3) any other specific criteria as may be determined by the division, including factors
392 identified through consumer or provider complaints.

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

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

400 (ii) identification of all non-quantitative treatment limitations that are applied to mental
401 health and substance use disorder benefits and medical and surgical benefits, including, but not
402 limited to, prior authorization, concurrent review, retrospective review, step-therapy, network
403 admission standards, reimbursement rates, network adequacy and geographic restrictions, within
404 each classification of benefits, as defined in 42 CFR Part 457.496(d)(2)(ii); and

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

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

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

419 (C) provide the comparative analyses, including the results of the analyses, performed to
420 determine that the processes and strategies used to design each non-quantitative treatment
421 limitation, as written, and the as-written processes and strategies used to apply the non-

422 quantitative treatment limitation to mental health and substance use disorder benefits are
423 comparable to, and are not applied more stringently than, the processes and strategies used to
424 design each non-quantitative treatment limitation, as written, and the as-written processes and
425 strategies used to apply the non-quantitative treatment limitation to medical and surgical
426 benefits;

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

433 (E) disclose the specific findings and conclusions reached by the division that the results
434 of the analyses under this clause indicate compliance with this section and the federal Paul
435 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as
436 amended, and federal guidelines and regulations relevant to the act, including, but not limited to,
437 42 CFR Part 457.496;

438 (F) The treatment authorization data for the prior calendar year, which shall include, but
439 not be limited to: the number of inpatient days, outpatient services and total number of services
440 requested; the number and per cent of inpatient day requests authorized, inpatient day requests
441 modified, inpatient day requests modified resulting in a lesser amount of inpatient days
442 authorized than requested and the reason for the modification, inpatient day requests denied and
443 the reason for the denial, inpatient day requests where an internal appeal was filed and approved,

444 inpatient day requests where an internal appeal was filed and denied, inpatient day requests
445 where an external appeal was filed and upheld and inpatient day requests where an external
446 appeal was filed and overturned; and the number and per cent of outpatient service requests
447 authorized, outpatient service requests modified, outpatient service requests modified resulting in
448 a lower amount of outpatient service authorized than requested and the reason for the
449 modification, outpatient service requests denied and the reason for the denial, outpatient service
450 requests where an internal appeal was filed and approved, outpatient service requests where an
451 internal appeal was filed and denied, outpatient service requests where an external appeal or
452 hearing before the board of hearings was filed and upheld and outpatient service requests where
453 an external appeal was filed and overturned; and

454 (vii) any other information required by the division.

455 (d) If federal guidance, including, but not limited to, the Self-Compliance Tool for the
456 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
457 2008, as amended, is released that indicates a non-quantitative treatment limitation analysis
458 process and reporting format that is significantly different from, contrary to or more efficient
459 than the non-quantitative treatment limitation analysis process and reporting format requirements
460 described in subsection (c), the division may promulgate regulations that delineate a non-
461 quantitative treatment limitation analysis process and reporting format that may be used in lieu of
462 the non-quantitative treatment limitation analysis and reporting requirements described in said
463 subsection (c).

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

466 section 7 of chapter 4 or chapter 66; provided, however, that nothing in this section shall limit
467 the authority of the director of Medicaid to use and, if appropriate, make public any final or
468 preliminary examination report, examiner or company work papers or other documents or other
469 information discovered or developed during the course of an examination in the furtherance of
470 any legal or regulatory action that the director may, in their sole discretion, deem appropriate;
471 provided, that nothing in this section shall prevent the director of Medicaid from publishing any
472 illustrative utilization review criteria, medical necessity standard, clinical guideline, or other
473 policy, procedure, criteria or standard, regardless of its origin, as an example of the type of
474 policy, procedure, criteria or standard that contributes to a violation of state or federal law parity
475 requirements, including any information that is subject to disclosure to plan members under the
476 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
477 2008, as amended, or under any member right to receive such guideline under applicable federal
478 law.

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

484 (g) The division shall file an annual report with the clerks of the senate and house of
485 representatives, the joint committee on mental health, substance use and recovery and the joint
486 committee on health care financing not later than December 1. The report shall include, but not
487 be limited to:

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

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

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

497 The treatment authorization data shall include, but not be limited to: (A) the number of
498 inpatient days, outpatient services and total number of services requested; (B) the number and
499 per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day
500 requests modified resulting in a lesser amount of inpatient days authorized than requested and the
501 reason for the modification, inpatient day requests denied and the reason for the denial, inpatient
502 day requests where an internal appeal was filed and approved, inpatient day requests where an
503 internal appeal was filed and denied, inpatient day requests where an external review under
504 section 47B or hearing before the board of hearings under section 48 was filed and upheld and
505 inpatient day requests where an external review under section 47B or hearing before the board of
506 hearings under section 48 was filed and overturned; and (C) the number and per cent of
507 outpatient service requests authorized, outpatient service requests modified, outpatient service
508 requests modified resulting in a lower amount of outpatient service authorized than requested
509 and the reason for the modification, outpatient service requests denied and the reason for the

510 denial, outpatient service requests where an internal appeal was filed and approved, outpatient
511 service requests where an internal appeal was filed and denied, outpatient service requests where
512 an external review under section 47B or hearing before the board of hearings under section 48
513 was filed and upheld and outpatient service requests where an external review under section 47B
514 or hearing before the board of hearings under section 48 was filed and overturned;

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

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

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

528 (h) The division shall evaluate all consumer or provider complaints regarding mental
529 health and substance use disorder coverage for possible parity violations within 3 months of
530 receipt of the complaint.

531 Section 80. (a) The division and its health insurers, health plans, health maintenance
532 organizations, behavioral health management firms and third-party administrators under contract
533 with the division, a Medicaid managed care organization or a primary care clinician plan shall
534 provide mental health and substance use disorder benefits for the diagnosis and medically
535 necessary treatment of any behavioral health disorder described in the most recent edition of the
536 Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric
537 Association, or the most current version of the International Classification of Diseases (ICD).
538 The benefits shall be provided on a nondiscriminatory basis.

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

551 (c) For the purposes of this section, the division shall be deemed to be providing such
552 coverage on a non-discriminatory basis if the plan or coverage does not contain any annual or
553 lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of the

554 mental disorders that is less than any annual or lifetime dollar or unit of service limitation
555 imposed on coverage for the diagnosis and treatment of physical conditions.

556 (d) Benefits authorized pursuant to this section shall consist of a range of inpatient,
557 intermediate and outpatient services that shall permit medically necessary and active and
558 noncustodial treatment for the mental disorders to take place in the least restrictive clinically
559 appropriate setting. For purposes of this section, inpatient services may be provided in a general
560 hospital licensed to provide such services, in a facility under the direction and supervision of the
561 department of mental health, in a private mental hospital licensed by the department of mental
562 health or in a substance abuse facility licensed by the department of public health. Intermediate
563 services shall include, but not be limited to, Level III community-based detoxification, acute
564 residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or
565 approved by the department of public health or the department of mental health. Outpatient
566 services may be provided in a licensed hospital, a mental health or substance abuse clinic
567 licensed by the department of public health, a public community mental health center, a
568 professional office or as home-based services.

569 (e) The division and its health insurers, health plans, health maintenance organizations,
570 behavioral health management firms and third-party administrators under contract with the
571 division, a Medicaid managed care organization or a primary care clinician plan shall not require,
572 as a condition to receiving benefits mandated by this section, consent to the disclosure of
573 information regarding services for mental disorders under different terms and conditions than
574 consent is required for disclosure of information for other medical conditions. A determination
575 by the division or its agents that services authorized pursuant to this section are not medically
576 necessary shall only be made by a mental health professional licensed in the appropriate

577 specialty related to such services and, where applicable, by a provider in the same licensure
578 category as the ordering provider; provided, however, that this subsection shall not apply to
579 denials of service resulting from an enrollee's lack of coverage or use of a facility or professional
580 that has not entered into a negotiated agreement with the division or its agents. The benefits
581 provided by the division or its agents pursuant to this section shall meet all other terms and
582 conditions of the plan not inconsistent with state or federal law.

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

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

586 (ii) are provided to a person who is presently incarcerated, confined or committed to a
587 jail, house of correction, or prison within the commonwealth or a political subdivision of the
588 commonwealth;

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

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

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

594 Section 81. Notwithstanding any general or special law to the contrary, the office of
595 Medicaid shall seek a waiver and promulgate regulations in order to require the division and its
596 health insurers, health plans, health maintenance organizations, behavioral health management
597 firms and third-party administrators under contract with the division, a Medicaid managed care

598 organization or primary care clinician plan to meet the parity requirements described under the
599 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
600 2008, as amended, and any federal guidance or regulations relevant to the act, including 42 CFR
601 438 Subpart K, 42 CFR 440.395 and 42 CFR 457.496, for all enrollees. For persons under the
602 age of 21, MassHealth and its agents may comply with this section by meeting the obligations
603 related to Early and Periodic Screening, Diagnostic and Treatment benefits under 42 CFR
604 457.496(b) or 440.395(c).

605 SECTION 8. Subsection (a) of section 13 of chapter 176O of the General Laws is hereby
606 amended by striking out the first sentence and inserting in place thereof the following sentence:-

607 A carrier or utilization review organization shall maintain a formal internal grievance
608 process that is compliant with the Patient Protection and Affordable Care Act, Public Law 111-
609 148, as amended from time to time, as well as with any rules, regulations or guidance applicable
610 thereto, and such formal internal grievance process shall provide for adequate consideration and
611 timely resolution of grievances, which shall include but not be limited to: (1) a system for
612 maintaining records of each grievance filed by an insured or on his behalf, and responses thereto,
613 for a period of seven years, which records shall be subject to inspection by the commissioner; (2)
614 the provision of a clear, concise and complete description of the carrier's formal internal
615 grievance process and the procedures for obtaining external review pursuant to section 14 with
616 each notice of an adverse determination; (3) the carrier's toll-free telephone number for assisting
617 insureds in resolving such grievances and the consumer assistance toll-free telephone number
618 maintained by the office of patient protection; (4) a written acknowledgement of the receipt of a
619 grievance within 15 days and a written resolution of each grievance sent to the insured by
620 certified or registered mail, or other express carrier with proof of delivery, within 30 days from

621 receipt thereof; (5) a procedure to accept grievances by telephone, in person, by mail, and by
622 electronic means; (6) a process for an insured to request the appointment of an authorized
623 representative to act on the insured's behalf; (7) a procedure to accept an insured's request for
624 medical release forms by electronic means, which shall include a designated email address or an
625 online consumer portal accessible by the insured or their family member or authorized
626 representative that can provide the insured's membership identification number.

627 SECTION 9. Subsection (b) of said section 13 of said chapter 176O, as so appearing, is
628 hereby amended by striking out the third sentence, in lines 55 to 62, inclusive, and inserting in
629 place thereof the following sentence:-

630 If the expedited review process affirms the denial of coverage or treatment, the carrier
631 shall provide the insured, as soon as possible, including by any electronic means consented to by
632 the insured, (1) a statement setting forth the specific medical and scientific reasons for denying
633 coverage or treatment; (2) a description of alternative treatment, services or supplies covered or
634 provided by the carrier, if any; (3) a description of the insured's rights to any further appeal; and
635 (4) a description of the insured's right to request a conference.

636 SECTION 10. Subsection (c) of said section 13 of said chapter 176O, as so appearing, is
637 hereby amended by adding the following sentence:-

638 The office of patient protection shall decide a grievance in favor of the insured unless the
639 carrier provides substantial evidence, such as proof of delivery, that the carrier complied with the
640 time limits required under this section.

641 SECTION 11. Subsection (a) of section 14 of chapter 176O of the General Laws, as
642 appearing in the 2018 Official Edition, is hereby amended by striking out, in lines 24 to 35,

643 inclusive, the seventh, eight and ninth sentences and inserting in place thereof the following
644 sentence:-

645 For denials related to medical necessity, the standard for review of a grievance by such a
646 panel shall be a determination of whether the requested treatment or service is medically
647 necessary, as defined in section 1, and a covered benefit under the policy or contract. For denials
648 related to a violation of the federal or state mental health parity laws, the standard for review of a
649 grievance by such a panel shall be the legal standards related to QTLs and NQTLs under those
650 statutes, regulations and guidance, including, but not limited to, 45 CFR Part 146.136 and 29
651 C.F.R. § 2590.712. The panel shall consider, but not be limited to considering: (i) any related
652 right to such treatment or services under any related state statute or regulation (ii) written
653 documents submitted by the insured, (iii) medical records and medical opinions regarding
654 medical necessity by the insured's treating provider that requested or provided the disputed
655 service, which shall be obtained by the carrier, or by the panel if the carrier fails to do so, (iv)
656 additional information from the involved parties or outside sources that the review panel deems
657 necessary or relevant, (v) information obtained from any informal meeting held by the panel with
658 the parties. The panel shall send final written disposition of the grievance and the reasons
659 therefore, to the insured and the carrier within 45 days of receipt of the request for review;
660 provided, however, that if the panel discovers new facts or a new rationale to deny the treatment
661 or service that was not previously relied upon by the carrier in their final adverse benefit
662 determination, the panel shall provide the insured with notice of such a rationale, and an
663 opportunity to respond to such rationale before issuing a final decision on the grievance.

664 SECTION 12. Subsection (b) of said section 14 of said chapter 176O, as so appearing, is
665 hereby amended by striking out, in lines 43 to 47, the second sentence and inserting in place
666 thereof the following sentence:-

667 An insured may apply to the external review panel to seek continued provision of health
668 care services which are the subject of the grievance during the course of an expedited or non-
669 expedited external review upon a showing of substantial harm to the insured's health absent such
670 continuation, or other good cause as determined by the panel; provided, that good cause shall
671 include a history or pattern of denials that have been overturned by prior internal or external
672 appeals.

673 SECTION 13. Said section 14 of said chapter 176O, as so appearing, is hereby further
674 amended by striking out subsection (c) and inserting in place thereof the following subsection:-

675 (c) An insured may request reconsideration of a decision by the review panel within 30
676 days. A decision shall be reconsidered if the review panel makes a clear error regarding essential
677 facts, demonstrates a lack of adequate medical expertise in an area of specialty, or fails to
678 address an articulated right to health care benefits under state or federal law. Absent such
679 reconsideration, the decision of the review panel shall be binding on the insured and on the
680 carrier. The office of patient protection, the commissioner, the office of the attorney general, and
681 any aggrieved party seeking redress in superior court shall have jurisdiction to enforce the
682 decision of the review panel. A carrier's failure to promptly comply with a decision of the review
683 panel shall be an unfair and deceptive practice in violation of chapter 93A.

684 SECTION 14. Subsection (b) of section 16 of chapter 176O of the General Laws, as
685 appearing in the 2018 Official Edition, is hereby amended by striking out the last sentence and
686 inserting in place thereof the following sentence:-

687 If a carrier or utilization review organization intends to implement a new medical
688 necessity guideline or amend an existing requirement or restriction, the carrier or utilization
689 review organization shall ensure that the new guideline or amended requirement or restriction
690 shall not be implemented unless: (i) the carrier's or utilization review organization's website has
691 been updated to reflect the new or amended requirement or restriction; and (ii) the carrier or
692 utilization review organization has assessed the limitation to show it is in compliance with state
693 and federal parity requirements under chapter 26.

694 SECTION 15. The health policy commission, in consultation with the division of
695 insurance, shall conduct an analysis of and issue a report on the effects of behavioral health
696 managers, as defined in section 1 of chapter 176O of the General Laws, on the commonwealth's
697 health care delivery system, including on the accessibility, quality and cost of behavioral health
698 care services. In developing the report, the commission shall seek input from the executive office
699 of health and human services, other state agencies, health care providers and payers, behavioral
700 health and economic experts and patients and caregivers.

701 The commission shall analyze: (i) a detailed description of the types of services that
702 behavioral health managers provide; (ii) an assessment of the effect of behavioral health
703 managers on patient outcomes and access to behavioral health services; (iii) an inventory of
704 oversight practices by other states on behavioral health managers; (iv) an examination of the
705 effects of behavioral health manager state licensure, regulation or registration on access to

706 behavioral health services; and (v) other aspects of behavioral health managers as deemed
707 appropriate by the commission.

708 Not later than January 1, 2023, the health policy commission shall file a report of its
709 findings, together with any recommendations for legislation, with the clerks of the senate and
710 house of representatives, the joint committee on health care financing, the joint committee on
711 mental health, substance use and recovery and the joint committee on financial services.