

HOUSE No. 4879

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, June 15, 2022.

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

For the committee,

AARON MICHLEWITZ.

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

The Commonwealth of Massachusetts

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

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

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 7 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-informed 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 specific 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; and

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

24 SECTION 2. Chapter 6A of the General Laws is hereby amended by striking out section
25 16P, as so appearing, and inserting in place thereof the following section:-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

197 (c) A 988 crisis hotline center shall: (i) meet the United States Department of Health and
198 Human Services’ Ambulatory Behavioral Health System standards and the National Suicide
199 Prevention Lifeline requirements and best practices guidelines for operational and clinical
200 standards; (ii) provide data and reports and participate in evaluations and related quality
201 improvement activities as required by the United States Department of Health and Human
202 Services; (iii) utilize technology, including, but not limited to, chat and text capabilities, that is
203 interoperable between and across crisis and emergency response systems and services, including
204 911 and 211, as necessary; (iv) have the authority to deploy crisis and outgoing services,
205 including, but not limited to, mobile behavioral health crisis responders, and coordinate access to
206 crisis triage, evaluation and counseling services, community crisis stabilization programs or
207 other resources as appropriate; (v) maintain standing partnership agreements with community
208 behavioral health centers and other behavioral health programs and facilities, including, but not
209 limited to, programs led by individuals who are or were consumers of mental health or substance
210 use disorder supports or services; (vi) coordinate access to crisis evaluation, counseling,
211 receiving and stabilization services for individuals accessing the 988 suicide prevention and
212 behavioral health crisis hotline through appropriate information sharing regarding availability of
213 services; (vii) have the capability to serve high-risk and specialized populations, including, but

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

304 manager or supervisor of a PSAP and a representative of the Massachusetts Communication
305 Supervisors Association, Inc., 1 of whom shall be a representative of the Association for
306 Behavioral Healthcare, Inc. with experience in delivering psychiatric emergency services, and 1
307 of whom shall be an individual with lived experience with behavioral health conditions and
308 interactions with police. One of the governor's appointees shall be elected annually by the
309 commission as its vice chairperson. Members of the commission shall be appointed for terms of
310 3 years with no limit on the number of terms they may serve. Members shall hold office until a
311 successor is appointed and no member shall serve beyond the time the member ceases to hold the
312 office or employment that made the member eligible for appointment to the commission. The
313 commission shall meet at least twice annually, and at other times as necessary. A meeting of the
314 commission may be called by its chairperson, the vice chairperson or 3 of its members. A
315 quorum for the transaction of business shall consist of 9 members. Members of the commission
316 shall receive no compensation, but shall be reimbursed for their expenses actually and
317 necessarily incurred in the discharge of their duties. The commission shall review and approve
318 by a majority vote of those members present all formulas, percentages, guidelines or other
319 mechanisms used to distribute the grants described in this section, and all major contracts that the
320 department proposes to enter into for enhanced 911 services. The commission shall review and
321 approve by a majority vote of those members present all regulations and standards proposed by
322 the department.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

399 SECTION 14. Section 18 of chapter 15A of the General Laws, as so appearing, is hereby
400 amended by adding the following paragraph:-

401 Any qualifying student health insurance plan authorized under this chapter shall comply
402 with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity
403 Act of 2008, sections 511 and 512 of Public Law 110-343, as amended, and any federal
404 guidance or regulations relevant to the act, including 45 CFR Part 146.136, 45 CFR Part
405 147.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3), and the benefit mandates and
406 other obligations under section 47B of chapter 175, section 8A of chapter 176A, section 4A of
407 chapter 176B and sections 4, 4B and 4M of chapter 176G, as if the student health insurance plan
408 was issued by such carriers licensed under said chapters 175, 176A, 176B and 176G without
409 regard to any limitation under section 1 of chapter 176J.

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

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

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

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

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

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

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

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

445 Section 19A. (a) The department shall establish clinical competencies and additional
446 operational standards for care and treatment of patients admitted to facilities licensed pursuant to
447 104 CMR 27.00, including for specialty populations identified by the department. In establishing
448 the clinical competencies and operational standards, the department shall consider national and
449 local standards of practice where such standards of practice exist, and to the extent deemed
450 appropriate by the department. In establishing the clinical competencies, the department shall
451 utilize all data collected to identify the behavioral health needs of the commonwealth and consult
452 with relevant stakeholders, including, but not limited to, inpatient psychiatric facilities,
453 emergency departments, emergency service providers, Medicaid managed care organizations and
454 commercial carriers. The department shall update the clinical competencies on a biennial or as-
455 needed basis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

531 SECTION 19. Chapter 26 of the General Laws is hereby amended by striking out section
532 8K, as appearing in the 2020 Official Edition, and inserting in place thereof the following
533 section:-

534 Section 8K. (a) The commissioner of insurance shall implement and enforce applicable
535 provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction
536 Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended, any federal
537 guidance or regulations relevant to the act, including 45 CFR Part 146.136, 45 CFR Part
538 147.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3), and applicable state mental
539 health parity laws, including, but not limited to, section 47B of chapter 175, section 8A of
540 chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter 176G, in regard
541 to any carrier licensed under said chapters 175, 176A, 176B or 176G or any carrier offering a
542 student health plan issued under section 18 of chapter 15A by:

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

546 (ii) performing behavioral health parity compliance market conduct examinations of each
547 carrier not less than once every 5 years, or more frequently if noncompliance is suspected, with a

548 focus on: (A) non-quantitative treatment limitations under the federal Paul Wellstone and Pete
549 Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of
550 Public Law 110–343, as amended, and applicable state mental health and substance use disorder
551 parity laws, including, but not limited to, prior authorization, concurrent review, retrospective
552 review, step-therapy, network admission standards, reimbursement rates, network adequacy and
553 geographic restrictions; (B) denials of authorization, payment and coverage; and (C) any other
554 criteria determined by the division of insurance, including factors identified through consumer or
555 provider complaints; provided, however, that: (1) a market conduct examination of a carrier
556 subject to said chapter 175, 176A, 176B or 176G shall follow the procedural requirements in
557 subsections 10, 11 and 15 of section 4 of said chapter 175 regarding notice and rebuttal of
558 examination findings, subsequent hearings and conflicts of interest; (2) the commissioner shall
559 publicize the fees for a market conduct examination under section 3B of chapter 7 and said
560 subsection 11 of said section 4 of said chapter 175; and (3) nothing contained in this clause or in
561 said section 4 of said chapter 175, section 7 of said chapter 176A, section 9 of said chapter 176B
562 and section 10 of said chapter 176G shall limit the commissioner’s authority to use and, if
563 appropriate, publish any final or preliminary examination report, any examiner or company work
564 papers or other documents or any other information discovered or developed during the course of
565 any examination in the furtherance of any legal or regulatory action that the commissioner may,
566 in their sole discretion, deem appropriate;

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

571 (iv) updating applicable regulations as necessary to effectuate any provisions of the
572 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
573 2008, sections 511 and 512 of Public Law 110–343, as amended, that relate to insurance; and

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

585 (b) The commissioner may impose a penalty against a carrier that provides mental health
586 or substance use disorder benefits, directly or through a behavioral health manager as defined in
587 section 1 of chapter 176O, or any other entity that manages or administers such benefits for the
588 carrier, for any violation, by the carrier or the entity that manages or administers mental health
589 and substance use disorder benefits for the carrier, of state laws related to mental health and
590 substance use disorder parity or the mental health parity provisions of the federal Paul Wellstone
591 and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and
592 512 of Public Law 110–343, as amended, and federal guidance or regulations issued under the
593 act.

594 The amount of any penalty imposed shall be \$100 for each day in the noncompliance
595 period per product line with respect to each participant or beneficiary to whom such violation
596 relates; provided, however, that the maximum annual penalty under this subsection shall be
597 \$1,000,000; provided further, that for purposes of this subsection, the term “noncompliance
598 period” shall mean the period beginning on the date a violation first occurs and ending on the
599 date the violation is corrected.

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

603 (c) If a violation of state laws related to mental health and substance use disorder parity
604 or the mental health parity provisions of the federal Paul Wellstone and Pete Domenici Mental
605 Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343,
606 as amended, and federal guidance or regulations issued under the act, was likely to have caused
607 denial of access to behavioral health services, the commissioner shall require the carrier to
608 provide remedies for any failure to meet the requirements of state laws related to mental health
609 and substance use disorder parity or the mental health parity provisions of the federal Paul
610 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, sections
611 511 and 512 of Public Law 110–343, as amended, and federal guidance or regulations issued
612 under the act, which may include, but shall not be limited to:

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

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

616 (iii) informing plan members of changes;

617 (iv) requiring the carrier to reprocess and pay all inappropriately denied claims to
618 affected plan members, notify members of their right to file claims for services previously denied
619 and for which members paid out-of-pocket and reimburse for services eligible for coverage
620 under corrected standards; or

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

622 (d) Any proprietary information submitted to the commissioner by a carrier as a result of
623 the requirements of this section shall not be a public record under clause Twenty-sixth of section
624 7 of chapter 4 or chapter 66; provided, however, that the commissioner may produce reports
625 summarizing any findings.

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

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

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

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

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

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

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

664 (h) Nothing in this section shall prevent the commissioner from publishing any
665 illustrative utilization review criteria, medical necessity standard, clinical guideline or other
666 policy, procedure, criteria or standard, regardless of its origin, as an example of the type of
667 policy, procedure, criteria or standard that contributes to a violation of state or federal law parity
668 requirements, including any document that would normally be subject to disclosure to plan
669 members or their providers under section 16 of chapter 6D, section 16 of chapter 176O or the
670 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
671 2008, sections 511 and 512 of Public Law 110–343, as amended.

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

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

680 (2) The report shall contain the following information:

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

684 (ii) identification of all non-quantitative treatment limitations that are applied to mental
685 health and substance use disorder benefits and medical and surgical benefits within each
686 classification of benefits, as defined in 45 CFR Part 146.136(c)(4)(i); and that the processes,
687 strategies or methodologies for developing and applying the carrier's reimbursement rates for
688 mental health and substance use disorder benefits are comparable to, and applied no more
689 stringently than, the processes, strategies or methodologies for developing and applying the
690 carrier's reimbursement rates for medical and surgical benefits; and

691 (iii) the results of an analysis that demonstrates that for the medical necessity criteria
692 described in clause (i) and for each non-quantitative treatment limitation identified in clause (ii),
693 as written and in operation, the processes, strategies, evidentiary standards or other factors used
694 in applying the medical necessity criteria and each non-quantitative treatment limitation to
695 mental health and substance use disorder benefits within each classification of benefits are
696 comparable to, and are applied no more stringently than, the processes, strategies, evidentiary
697 standards or other factors used in applying the medical necessity criteria and each non-
698 quantitative treatment limitation for medical and surgical benefits within the corresponding
699 classification of benefits.

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

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

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

705 (iii) provide the comparative analyses, including the results of the analyses performed to
706 determine that the processes and strategies used to design each non-quantitative treatment
707 limitation, as written, and the as-written processes and strategies used to apply the non-
708 quantitative treatment limitation to mental health and substance use disorder benefits are
709 comparable to, and are applied no more stringently than, the processes and strategies used to
710 design each non-quantitative treatment limitation, as written, and the as written processes and
711 strategies used to apply the non-quantitative treatment limitation for medical and surgical
712 benefits;

713 (iv) provide the comparative analyses, including the results of the analyses performed to
714 determine that the processes and strategies used to apply each non-quantitative treatment
715 limitation, in operation, for mental health and substance use disorder benefits are comparable to,
716 and applied no more stringently than, the processes or strategies used to apply each non-
717 quantitative treatment limitation, in operation, for medical and surgical benefits; and

718 (v) disclose the findings and conclusions reached by the carrier or the group insurance
719 commission that the results of the analyses in this paragraph indicate that the carrier or group
720 insurance commission is in compliance with this section and the federal Paul Wellstone and Pete
721 Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of
722 Public Law 110–343, as amended, and its implementing and related regulations, including, but
723 not limited to, 45 CFR Part 146.136, 45 CFR Part 147.160, and 45 CFR Part 156.115(a)(3).

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

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

742 (i) the methodology the commissioner is using to check for compliance with the federal
743 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008,
744 sections 511 and 512 of Public Law 110-343, as amended, and any federal guidance or
745 regulations relevant to the act;

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

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

753 (iv) information on any educational or corrective actions the commissioner has taken to
754 ensure health carrier compliance with the federal Paul Wellstone and Pete Domenici Mental
755 Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343,
756 as amended, and section 22 of chapter 32A, section 47B of chapter 175, section 8A of chapter
757 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter 176G; and

758 (v) to the extent that any requirements of this section are inconsistent with or in excess of
759 the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and
760 Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended, and
761 any amendments to, or regulations issued under that act, the requirements of federal law will
762 prevail over the requirements of this section, in accordance with 42 U.S.C. 300gg-23(a)(1). If
763 federal guidance, including, but not limited to, the Self-Compliance Tool for the federal Paul
764 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, is
765 released that indicates a non-quantitative treatment limitation analysis and reporting process that
766 is significantly different than, contrary to, or more efficient than the non-quantitative treatment
767 limitation analysis and reporting requirements described in clause (iii) of paragraph (2) of

768 subsection (a), the commissioner may promulgate regulations that delineate a non-quantitative
769 treatment limitation analysis and reporting format that may be used in lieu of the non-
770 quantitative treatment limitation analysis and reporting requirements described in said clause
771 (iii).

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

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

776 Section 2TTTTT. (a) There shall be an interagency services reserve fund established on
777 the books of the commonwealth to be expended without prior appropriation. The fund shall be
778 credited with money from public and private sources, including gifts, grants and donations,
779 interest earned on such money, any other money authorized by the general court and specifically
780 designated to be credited to the fund and any funds provided from other sources. Money in the
781 fund shall be used to fund the operations of the interagency review team established under
782 section 16R of chapter 6A. The secretary of health and human services shall administer the fund
783 and shall make expenditures for the purpose of covering the cost of providing additional
784 evaluation as needed by the interagency review team for an individual eligible under said section
785 16R of said chapter 6A. Any unexpended balance in the fund at the end of a fiscal year shall not
786 revert to the General Fund and shall be available for expenditure in the subsequent fiscal year.

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

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

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

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

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

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

801 “Mental health acute treatment”, 24-hour medically supervised mental health services
802 provided in an inpatient facility, licensed by the department of mental health, that provides
803 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
804 environment.

805 (b) The commission shall provide to any active or retired employee of the commonwealth
806 who is insured under the group insurance commission coverage for medically necessary mental
807 health acute treatment, community-based acute treatment and intensive community-based acute
808 treatment and shall not require a preauthorization before obtaining treatment; provided, however,

809 that the facility shall notify the carrier of the admission and the initial treatment plan within 72
810 hours of admission.

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

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

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

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

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

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

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

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

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

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

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

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

855 SECTION 25. Chapter 69 of the General Laws is hereby amended by striking out section
856 8A, as appearing in the 2020 Official Edition, and inserting in place thereof the following
857 section:-

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

864 (b) Each plan shall include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

943 SECTION 28. Chapter 111 of the General Laws is hereby amended by inserting after
944 section 51½ the following section:-

945 Section 51¾. The department, in consultation with the department of mental health, shall
946 promulgate regulations requiring all acute-care hospitals licensed under section 51G to provide,
947 or arrange for, licensed mental health professionals during all operating hours of an emergency
948 department or a satellite emergency facility as defined in section 51½ to evaluate and stabilize a
949 person admitted with a mental health presentation to the emergency department or satellite
950 emergency facility and to refer such person for appropriate treatment or inpatient admission. The
951 regulations shall define “licensed mental health professional”, which shall include, but not be
952 limited to, a: (i) licensed physician who specializes in the practice of psychiatry; (ii) licensed
953 psychologist; (iii) licensed independent clinical social worker; (iv) licensed certified social
954 worker; (v) licensed mental health counselor; (vi) licensed physician assistant who practices in
955 the field of psychiatry (vii) licensed psychiatric clinical nurse specialist; or (viii) healthcare
956 provider, as defined in section 1, qualified within the scope of the individual’s license to conduct
957 an evaluation of a mental health condition, including an intern, resident or fellow pursuant to the
958 policies and practices of the hospital and medical staff.

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

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

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

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

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

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

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

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

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

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

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

999 (3) patient care policies and procedures, which may include, but shall not be limited to,
1000 patient admission and discharge policies and decision-making, patient flow policies, patient

1001 discharge planning, consultation, clinical competencies, charting processes and patient rights,
1002 patient and staff security and infection prevention;

1003 (4) medication policies and procedures, which may include, but shall not be limited to,
1004 paperwork requirements for medicine, inventory control, dose distribution systems and disposing
1005 of expired drugs;

1006 (5) human resources and staffing policies and procedures, which may include, but shall
1007 not be limited to, staff hiring decisions, training, patient care ratios, scheduling and staffing for
1008 emergency management and disaster plans; and

1009 (6) payment and financial policies and procedures, which may include, but shall not be
1010 limited to, investment and resource allocation, billing and payment policies and staff salaries and
1011 reimbursement.

1012 (e) The department, in consultation with the department of mental health, shall
1013 promulgate regulations necessary to carry out this section, including the development of
1014 reporting procedures and a standard format for facility self-reporting and annual compliance
1015 certification.

1016 SECTION 30. Said chapter 111 is hereby further amended by adding the following
1017 section:-

1018 Section 244. The department shall administer an initiative to increase public awareness of
1019 and education on the availability of the extreme risk protection order process established
1020 pursuant to sections 131R to 131Y, inclusive, of chapter 140, to remove a firearm from the
1021 control, ownership or possession of an individual who poses a risk of causing bodily injury to

1022 themselves or others. The initiative shall focus on the heightened risk of suicide associated with the
1023 possession of a firearm and shall include information on: (i) eligibility to petition for an extreme
1024 risk protection order; (ii) the procedure to petition for an extreme risk protection order; (iii)
1025 options to voluntarily surrender a firearm to a law enforcement agency; and (iv) the availability
1026 of existing legal resources and support services for a potential petitioner.

1027 SECTION 31. Chapter 118E of the General Laws is hereby amended by inserting after
1028 section 10N the following 3 sections:-

1029 Section 10O. As used in this section, the following terms shall, unless the context clearly
1030 requires otherwise, have the following meanings:

1031 “Community-based acute treatment”, 24-hour clinically managed mental health
1032 diversionary or step-down services for children and adolescents that is usually provided as an
1033 alternative to mental health acute treatment.

1034 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
1035 mental health diversionary or step-down services for children and adolescents that is usually
1036 provided as an alternative to mental health acute treatment.

1037 “Mental health acute treatment”, 24-hour medically supervised mental health services
1038 provided in an inpatient facility, licensed by the department of mental health, that provides
1039 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1040 environment.

1041 The division and its contracted health insurers, health plans, health maintenance
1042 organizations, behavioral health management firms and third-party administrators under contract

1043 to a Medicaid managed care organization or primary care clinician plan shall cover the cost of
1044 medically necessary mental health acute treatment, community-based acute treatment and
1045 intensive community-based acute treatment and shall not require a preauthorization before
1046 obtaining treatment; provided, however, that the facility shall notify the carrier of the admission
1047 and the initial treatment plan within 72 hours of admission.

1048 Section 10P. (a) For the purposes of this section, “psychiatric collaborative care model”
1049 shall mean the evidence-based, integrated behavioral health service delivery method in which a
1050 primary care team consisting of a primary care provider and a care manager provides structured
1051 care management to a patient, and that works in collaboration with a psychiatric consultant that
1052 provides regular consultations to the primary care team to review the clinical status and care of
1053 patients and to make recommendations.

1054 (b) The division and its contracted health insurers, health plans, health maintenance
1055 organizations, behavioral health management firms and third-party administrators under contract
1056 to a Medicaid managed care organization or primary care clinician plan shall provide coverage
1057 for mental health or substance use disorder services that are delivered through the psychiatric
1058 collaborative care model.

1059 Section 10Q. (a) As used in this section, the following words shall, unless the context
1060 clearly requires otherwise, have the following meanings:

1061 “Licensed mental health professional”, a licensed physician who specializes in the
1062 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
1063 licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed
1064 physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor

1065 I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the
1066 lawful scope of practice for such therapist.

1067 “Mental health wellness examination”, a screening or assessment that seeks to identify
1068 any behavioral or mental health needs and appropriate resources for treatment. The examination
1069 may include: (i) observation, a behavioral health screening, education and consultation on
1070 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1071 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
1072 screenings or observations to understand a covered person’s mental health history, personal
1073 history and mental or cognitive state and, when appropriate, relevant adult input through
1074 screenings, interviews and questions.

1075 “Primary care provider”, a health care professional qualified to provide general medical
1076 care for common health care problems who: (i) supervises, coordinates, prescribes or otherwise
1077 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1078 maintains continuity of care within the scope of practice.

1079 (b) The division and its contracted health insurers, health plans, health maintenance
1080 organizations, behavioral health management firms and third-party administrators under contract
1081 to a Medicaid managed care organization or primary care clinician plan shall provide coverage
1082 for an annual mental health wellness examination that is performed by a licensed mental health
1083 professional or primary care provider, which may be provided by the primary care provider as
1084 part of an annual preventive visit.

1085 SECTION 32. Said chapter 118E is hereby further amended by inserting after section
1086 13D the following section:-

1087 Section 13D½. (a) As used in this section, the following words shall, unless the context
1088 clearly requires otherwise, have the following meanings:

1089 “Behavioral health services”, the evaluation, diagnosis, treatment, care coordination,
1090 management or peer support of a patient with a mental health, developmental or substance use
1091 disorder.

1092 “Community mental health center”, clinic which provides comprehensive ambulatory
1093 mental health services and which is not financially or physically an integral part of a hospital.

1094 “Division”, the division of medical assistance.

1095 “Managed care entity”, health insurers, health plans, health maintenance organizations,
1096 behavioral health management firms and third-party administrators under contract with a
1097 Medicaid managed care organization or primary care clinician plan; provided, however, that
1098 “managed care entity” shall also include accountable care organizations.

1099 “Minimum payment rates”, rates of payment for services below which managed care
1100 entities shall not enter into provider agreements.

1101 (b) Annually, not later than January 1, the division shall review the minimum payment
1102 rates to be paid to providers of behavioral health services delivered in community mental health
1103 centers by managed care entities and submit a report to the house and senate committees on ways
1104 and means, the joint committee on health care financing and the joint committee on mental
1105 health, substance use and recovery identifying the difference between the minimum payment
1106 rates decided by the division and the payment rates that managed care entities contractually agree
1107 to pay providers for all behavioral health services delivered in community mental health centers.

1108 SECTION 33. Section 16C of said chapter 118E, as appearing in the 2020 Official
1109 Edition, is hereby amended by inserting after paragraph (5) the following 2 paragraphs:-

1110 (6) The division shall submit an annual report not later than January 31 to the attorney
1111 general, a summary of which shall be sent to the clerks of the house of representatives and the
1112 senate not later than June 30 each year, that contains the following information regarding
1113 compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction
1114 Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended, by the child
1115 health insurance program:

1116 (a) a description of the process used to develop or select the medical necessity criteria for
1117 mental health and substance use disorder benefits and the process used to develop or select the
1118 medical necessity criteria for medical and surgical benefits;

1119 (b) identification of all non-quantitative treatment limitations that are applied to mental
1120 health and substance use disorder benefits and medical and surgical benefits within each
1121 classification of benefits, as defined in 42 CFR Part 457.496(d)(4)(ii); and that the processes,
1122 strategies or methodologies for developing and applying the reimbursement rates for mental
1123 health and substance use disorder benefits are comparable to and applied no more stringently
1124 than those processes, strategies or methodologies for developing and applying the reimbursement
1125 rates for medical and surgical benefits; and

1126 (c) the results of an analysis that demonstrates that for the medical necessity criteria
1127 described in clause (a) and for each non-quantitative treatment limitation identified in clause (b),
1128 as written and in operation, the processes, strategies, evidentiary standards or other factors used
1129 in applying the medical necessity criteria and each non-quantitative treatment limitation to

1130 mental health and substance use disorder benefits within each classification of benefits are
1131 comparable to, and are applied no more stringently than, the processes, strategies, evidentiary
1132 standards or other factors used in applying the comparable medical necessity criteria and non-
1133 quantitative treatment limitation for medical and surgical benefits within the corresponding
1134 classification of benefits; provided that, at a minimum, the results of the analysis shall:

1135 (i) identify the factors used to determine whether a non-quantitative treatment limitation
1136 will apply to a benefit;

1137 (ii) identify any processes, strategies, or evidentiary standards used to define the factors
1138 identified in subclause (i);

1139 (iii) provide the comparative analyses, including the results of the analyses subject to
1140 paragraph (f) of clause (7), performed to determine that the processes and strategies used to
1141 design each non-quantitative treatment limitation, as written, and the as written processes and
1142 strategies used to apply the non-quantitative treatment limitation to mental health and substance
1143 use disorder benefits are comparable to, and are applied no more stringently than, the processes
1144 and strategies used to design each non-quantitative treatment limitation, as written, and the as
1145 written processes and strategies used to apply the non-quantitative treatment limitation to
1146 medical and surgical benefits;

1147 (iv) provide the comparative analyses, including the results of the analyses subject to
1148 paragraph (f) of clause (7), performed to determine that the processes and strategies used to
1149 apply each non-quantitative treatment limitation, in operation, for mental health and substance
1150 use disorder benefits, including provider reimbursement rates, are comparable to, and applied no
1151 more stringently than, the processes or strategies used to apply each non-quantitative treatment

1152 limitation, in operation, for medical and surgical benefits, including provider reimbursement
1153 rates;

1154 (v) subject to paragraph (f) of clause (7), disclose the findings and conclusions reached
1155 by the division that the results of the analyses above indicate that the child health insurance
1156 program is in compliance with this section and the federal Paul Wellstone and Pete Domenici
1157 Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related
1158 regulations, including but not limited to 42 CFR Part 457.496; and

1159 (d) In completing the analyses required under this paragraph, the division or any
1160 Medicaid managed care organization that contracts with the division shall not have to examine
1161 each medical or surgical benefit subject to a non-quantitative treatment limitation that also
1162 applies to mental health and substance use disorder benefits in the classification and shall
1163 perform the required analyses broadly across each classification of benefits. The division or any
1164 Medicaid managed care organization that contracts with the division may use any reasonable
1165 method to determine how they will select medical and surgical benefits subject to a non-
1166 quantitative treatment limitation in the classification for the purpose of performing the
1167 comparative analyses, provided that selecting only certain medical and surgical benefits with the
1168 same characteristics as the mental health and substance use disorder benefits subject to the non-
1169 quantitative treatment limitation, and not all medical and surgical benefits sharing the same
1170 characteristics as the mental health and substance use disorder benefits subject to the non-
1171 quantitative treatment limitation, in a classification for the purposes of performing the analyses
1172 shall not be considered reasonable.

1173 (7) The division shall issue a report to the clerks of the house of representatives and the
1174 senate and the joint committee on mental health, substance use and recovery, which shall:

1175 (a) include the methodology the division uses to ensure compliance with the federal Paul
1176 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and any
1177 federal regulations or guidance relating to the compliance and oversight of the federal Paul
1178 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008;

1179 (b) identify any action taken by the division during the preceding 12-month period
1180 regarding compliance with parity in mental health and substance use disorder benefits under state
1181 and federal laws and summarize the results of such action;

1182 (c) detail any educational or corrective actions the division has taken to ensure Medicaid
1183 managed care compliance with the federal Paul Wellstone and Pete Domenici Mental Health
1184 Parity and Addiction Equity Act of 2008; and

1185 (d) be written in non-technical, readily understandable language. Medicaid managed care
1186 organizations shall make a summary report, as approved by the division, available to the public
1187 by, posting the report on the division's website.

1188 (e) To the extent that any requirements of this section are inconsistent with or in excess of
1189 the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and
1190 Addiction Equity Act of 2008 and any amendments to, or regulations issued under that act, the
1191 requirements of federal law will prevail over the requirements of this section. If federal guidance,
1192 including, but not limited to, the Self-Compliance Tool for the federal Paul Wellstone and Pete
1193 Domenici Mental Health Parity and Addiction Equity Act of 2008, is released that indicates a
1194 non-quantitative treatment limitation analysis and reporting process that is significantly different

1195 than, contrary to, or more efficient than the non-quantitative treatment limitation analysis and
1196 reporting requirements described in paragraph (6), the division may promulgate regulations that
1197 delineate a non-quantitative treatment limitation analysis and reporting format that may be used
1198 in lieu of the non-quantitative treatment limitation analysis and reporting requirements described
1199 in paragraph (6).

1200 (f) Any proprietary portions of information submitted to the division by a Medicaid
1201 managed care organization as a result of the requirements in this section shall not be made public
1202 record.

1203 SECTION 34. Section 47 of said chapter 118E, as so appearing, is hereby amended by
1204 inserting after the first paragraph the following paragraph:-

1205 Notwithstanding any general or special law to the contrary, the division shall promulgate
1206 regulations that require the division, its contracted health insurers, health plans, health
1207 maintenance organizations, behavioral health management firms and third-party administrators
1208 under contract with the division, a Medicaid managed care organization or primary care clinician
1209 plan, to maintain documentation of all requests for benefits or services, whether the request is
1210 submitted by, or on behalf of, the intended recipient of those benefits or services. Any request
1211 that is not fulfilled in full shall be considered a denial and shall result in the prompt written
1212 notification to the intended recipient through electronic means, if possible. The notification shall
1213 include a description of the requested service, the response by the entity and the intended
1214 recipient's due process and appeal rights. All such entities shall accept requests for authorized
1215 representatives or for appeals by electronic means.

1216 SECTION 35. Said chapter 118E is hereby further amended by adding the following 2
1217 sections:-

1218 Section 80. Each Medicaid managed care organization or alternative benefit plan shall
1219 submit an annual report not later than January 31 to the division, a copy of which shall be sent to
1220 the clerks of the house of representatives and the senate not later than June 30 each year by the
1221 division, that contains the following information:

1222 (a) a description of the process used to develop or select the medical necessity criteria for
1223 mental health and substance use disorder benefits and the process used to develop or select the
1224 medical necessity criteria for medical and surgical benefits;

1225 (b) identification of all non-quantitative treatment limitations that are applied to mental
1226 health and substance use disorder benefits and medical and surgical benefits within each
1227 classification of benefits, as defined in 42 CFR Part 438.910(d)(1) and 42 CFR Part
1228 440.395(b)(4)(i); provided further, that the processes, strategies or methodologies for developing
1229 and applying the reimbursement rates for mental health and substance use disorder benefits are
1230 comparable to and applied no more stringently than those processes, strategies or methodologies
1231 for developing and applying the reimbursement rates for medical and surgical benefits; and

1232 (c) the results of an analysis that demonstrates that for the medical necessity criteria
1233 described in subsection (a) and for each non-quantitative treatment limitation identified in
1234 subsection (b), as written and in operation, the processes, strategies, evidentiary standards or
1235 other factors used in applying the medical necessity criteria and each non-quantitative treatment
1236 limitation to mental health and substance use disorder benefits within each classification of
1237 benefits are comparable to, and are applied no more stringently than, the processes, strategies,

1238 evidentiary standards or other factors used in applying the medical necessity criteria and each
1239 non-quantitative treatment limitation to medical and surgical benefits within the corresponding
1240 classification of benefits; provided, however, that, at a minimum, the results of the analysis shall:

1241 (1) identify the factors used to determine whether a non-quantitative treatment limitation
1242 will apply to a benefit;

1243 (2) identify any processes, strategies or evidentiary standards used to define the factors
1244 identified in paragraph (1);

1245 (3) provide the comparative analyses, including the results of the analyses, subject to
1246 paragraph (7), performed to determine that the processes and strategies used to design each non-
1247 quantitative treatment limitation, as written, and the as written processes and strategies used to
1248 apply the non-quantitative treatment limitation to mental health and substance use disorder
1249 benefits are comparable to, and are applied no more stringently than, the processes and strategies
1250 used to design each non-quantitative treatment limitation, as written, and the as written processes
1251 and strategies used to apply the non-quantitative treatment limitation to medical and surgical
1252 benefits;

1253 (4) provide the comparative analyses, including the results of the analyses, subject to
1254 paragraph (7), performed to determine that the processes and strategies used to apply each non-
1255 quantitative treatment limitation, in operation, for mental health and substance use disorder
1256 benefits, including provider reimbursement rates, are comparable to, and applied no more
1257 stringently than, the processes or strategies used to apply each non-quantitative treatment
1258 limitation, in operation, for medical and surgical benefits, including provider reimbursement
1259 rates; and

1260 (5) subject to paragraph (7), disclose the findings and conclusions reached by the
1261 Medicaid managed care organization or alternative benefit plan that the results of the analyses
1262 above indicate that the Medicaid managed care organization or alternative benefit plan is in
1263 compliance with this section and the Paul Wellstone and Pete Domenici Mental Health Parity
1264 and Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended,
1265 and its implementing and related regulations, including, but not limited, to 42 CFR Part 438.910
1266 and 42 CFR Part 440.395.

1267 (6) In completing the analyses required under this subsection, a Medicaid managed care
1268 organization does not have to examine each medical or surgical benefit subject to a non-
1269 quantitative treatment limitation that also applies to mental health and substance use disorder
1270 benefits in the classification and is expected to perform the required analyses broadly across each
1271 classification of benefits. A Medicaid managed care organization may use any reasonable
1272 method to determine how it will select medical and surgical benefits subject to a non-quantitative
1273 treatment limitation in the classification for the purpose of performing the comparative analyses,
1274 provided that selecting only certain medical and surgical benefits with the same characteristics as
1275 the mental health and substance use disorder benefits subject to the non-quantitative treatment
1276 limitation, and not all medical and surgical benefits sharing the same characteristics as the
1277 mental health and substance use disorder benefits subject to the non-quantitative treatment
1278 limitation, in a classification for the purposes of performing the analyses shall not be considered
1279 reasonable.

1280 (7) Any proprietary portions of information submitted to the division by a Medicaid
1281 managed care organization as a result of the requirements in this section shall not be made public
1282 record.

1283 Section 81. (a) The division shall develop a streamlined process to enhance the current
1284 community-based behavioral health screening process and direct Medicaid contracted health
1285 insurers, health plans, health maintenance organizations, behavioral health management firms
1286 and third-party administrators under contract to a Medicaid managed care organization or the
1287 Medicaid primary care clinician plans to allow admission to inpatient behavioral health services
1288 from a community-based setting where a patient under the age of 22 is presenting with a
1289 behavioral health condition that requires such admission but does not require a medical screening
1290 examination in an emergency department. Said process shall be developed after consultation
1291 with relevant stakeholders and community members.

1292 (b) Annually, not later than April 1, the division shall file a report on the progress of the
1293 streamlined process, results and any legislative recommendations with the house and senate
1294 clerks, the joint committee on mental health, substance use and recovery, the joint committee on
1295 public health, the joint committee on health care financing, the joint committee on children,
1296 families and persons with disabilities and the house and senate committees on ways and means.

1297 SECTION 36. Section 32 of chapter 119 of the General Laws, as appearing in the 2020
1298 Official Edition, is hereby amended by striking out the second paragraph and inserting in place
1299 thereof the following paragraph:-

1300 The department shall ensure that every child, upon entry into the foster care system, shall
1301 be screened and evaluated under the early and periodic screening, diagnostic and treatment
1302 standards established by Title XIX of the Social Security Act and assessed for behavioral health
1303 symptoms and sequelae, including those related to the precipitating factors of their entry into
1304 care, unless the child has been screened and evaluated within 30 days prior to the child's entry

1305 into the system; provided, however, that each child with identified behavioral health needs shall
1306 be provided appropriate referrals to related professionals to conduct more comprehensive
1307 diagnostic assessment, prescribe treatment and ensure the behavioral health and trauma-related
1308 needs of such child are addressed in a timely manner.

1309 SECTION 37. Section 18 of chapter 123 of the General Laws, as so appearing, is hereby
1310 amended by striking out, in lines 27 to 34, inclusive, the words “; provided, however, that,
1311 notwithstanding the court’s failure, after an initial hearing or after any subsequent hearing, to
1312 make a finding required for commitment to the Bridgewater state hospital, the prisoner shall be
1313 confined at said hospital if the findings required for commitment to a facility are made and if the
1314 commissioner of correction certifies to the court that confinement of the prisoner at said hospital
1315 is necessary to insure his continued retention in custody”.

1316 SECTION 38. Said section 18 of said chapter 123, as so appearing, is hereby further
1317 amended by inserting after subsection (a) the following subsection:-

1318 (a¹/₂)(1) For purposes of this subsection, “mental health watch” shall mean a status
1319 intended to protect a prisoner from a risk of imminent and serious self-harm.

1320 (2) A prisoner or a prisoner’s legal representative, or a mental health staff person at the
1321 request of a prisoner, may petition the district court with jurisdiction over the prisoner’s place of
1322 detention or, if the prisoner is awaiting trial to the court with jurisdiction of the criminal case, to
1323 be transferred to a suitable inpatient psychiatric facility or unit licensed or operated by the
1324 department of mental health or to Bridgewater state hospital. The court may order the prisoner’s
1325 requested transfer if the prisoner: (i) has been on mental health watch for at least 72 hours; or (ii)
1326 is at serious risk of imminent and serious self-harm. A transfer under this subsection to

1327 Bridgewater state hospital shall only be ordered if: (i) the prisoner is male and no bed is available
1328 in a timely manner at a unit licensed or operated by the department of mental health; or (ii)(A)
1329 the prisoner is not a proper person for commitment to an inpatient psychiatric facility or unit
1330 licensed or operated by the department of mental health; and (B) the failure to retain the prisoner
1331 in strict custody would create a likelihood of serious harm. When a prisoner has been on mental
1332 health watch for 72 hours, and once every 24 hours thereafter that the prisoner remains on mental
1333 health watch, a member of the mental health staff of the place of detention shall advise the
1334 prisoner of the prisoner’s right to petition under this subsection and advise the prisoner that staff
1335 at the place of detention may also, at the prisoner’s request, petition on the prisoner’s behalf. If
1336 the prisoner requests, either orally or in writing, that staff at the place of detention petition under
1337 this subsection, an employee, representative, agent or other designee of the place of detention
1338 shall file a petition with the appropriate court within 24 hours. The court may order periodic
1339 reviews of transfers under this subsection.

1340 SECTION 39. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby
1341 amended by inserting after the definition of “Domestic company” the following definition:-

1342 “Emergency services programs”, all programs subject to contract between the
1343 Massachusetts Behavioral Health Partnership and nonprofit organizations for the provision of
1344 community-based emergency psychiatric services, including, but not limited to, behavioral
1345 health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per
1346 week, through: (i) mobile crisis intervention services for youth; (ii) mobile crisis intervention
1347 services for adults; (iii) emergency service provider community-based locations; and (iv) adult
1348 community crisis stabilization services.

1349 SECTION 40. Said chapter 175 is hereby further amended by inserting after section 47PP
1350 the following 4 sections:-

1351 Section 47QQ. (a) For the purposes of this section, “psychiatric collaborative care model”
1352 shall mean the evidence-based, integrated behavioral health service delivery method in which a
1353 primary care team consisting of a primary care provider and a care manager provides structured
1354 care management to a patient, and that works in collaboration with a psychiatric consultant that
1355 provides regular consultations to the primary care team to review the clinical status and care of
1356 patients and to make recommendations.

1357 (b) An individual policy of accident and sickness insurance issued pursuant to section
1358 108 that provides hospital expense and surgical expense insurance or a group blanket or general
1359 policy of accident and sickness insurance issued pursuant to section 110 that provides hospital
1360 expense and surgical expense insurance that is issued or renewed within or without the
1361 commonwealth shall provide coverage for mental health or substance use disorder services that
1362 are delivered through the psychiatric collaborative care model.

1363 Section 47RR. An individual policy of accident and sickness insurance issued under
1364 section 108 that provides hospital expense and surgical expense insurance or a group blanket or
1365 general policy of accident and sickness insurance issued under section 110 that provides hospital
1366 expense and surgical expense insurance that is issued or renewed within or without the
1367 commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary
1368 emergency services programs.

1369 Section 47SS. (a) As used in this section, the following terms shall, unless the context
1370 clearly requires otherwise, have the following meanings:

1371 “Community-based acute treatment”, 24-hour clinically managed mental health
1372 diversionary or step-down services for children and adolescents that is usually provided as an
1373 alternative to mental health acute treatment.

1374 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
1375 mental health diversionary or step-down services for children and adolescents that is usually
1376 provided as an alternative to mental health acute treatment.

1377 “Mental health acute treatment”, 24-hour medically supervised mental health services
1378 provided in an inpatient facility licensed by the department of mental health that provides
1379 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1380 environment.

1381 (b) A policy, contract, agreement, plan or certificate of insurance issued, delivered or
1382 renewed within or without the commonwealth, which is considered creditable coverage under
1383 section 1 of chapter 111M, shall provide coverage for medically necessary mental health acute
1384 treatment, community-based acute treatment and intensive community-based acute treatment and
1385 shall not require a preauthorization before obtaining treatment; provided, however, that the
1386 facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of
1387 admission.

1388 Section 47TT. (a) As used in this section, the following words shall, unless the context
1389 clearly requires otherwise, have the following meanings:

1390 “Licensed mental health professional,” a licensed physician who specializes in the
1391 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
1392 licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed

1393 physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor
1394 I, as defined in section 1 of chapter 111J or a licensed marriage and family therapist within the
1395 lawful scope of practice for such therapist.

1396 “Mental health wellness examination,” a screening or assessment that seeks to identify
1397 any behavioral or mental health needs and appropriate resources for treatment. The examination
1398 may include: (i) observation, a behavioral health screening, education and consultation on
1399 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1400 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
1401 screenings or observations to understand a covered person’s mental health history, personal
1402 history and mental or cognitive state and, when appropriate, relevant adult input through
1403 screenings, interviews and questions.

1404 “Primary care provider”, a health care professional qualified to provide general medical
1405 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise
1406 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1407 maintains continuity of care within the scope of practice.

1408 (b) The following shall provide coverage for an annual mental health wellness
1409 examination that is performed by a licensed mental health professional or primary care provider,
1410 which may be provided by the primary care provider as part of an annual preventive visit: (i) any
1411 policy of accident and sickness insurance, as described in section 108, that provides hospital
1412 expense and surgical expense insurance and is delivered, issued or subsequently renewed by
1413 agreement between the insurer and policyholder in the commonwealth; (ii) any blanket or
1414 general policy of insurance described in subdivision (A), (C) or (D) of section 110 that provides

1415 hospital expense and surgical expense insurance and is delivered, issued or subsequently
1416 renewed by agreement between the insurer and the policyholder in or outside of the
1417 commonwealth; and (iii) any employees' health and welfare fund that provides hospital expense
1418 and surgical expense benefits and is delivered, issued to or renewed for any person or group of
1419 persons in the commonwealth.

1420 (c) The division of insurance, in consultation with the office of Medicaid, and the
1421 department of mental health, shall develop guidelines to implement this section.

1422 SECTION 41. Section 110 of said chapter 175, as appearing in the 2020 Official Edition,
1423 is hereby amended by inserting after the word "age", in line 463, the following words:- or
1424 without regard to age, so long as the dependent, who is covered under the membership of their
1425 parent as a member of a family group, is mentally or physically incapable of earning their own
1426 living due to disability.

1427 SECTION 42. Chapter 176A of the General Laws is hereby amended by inserting after
1428 section 8QQ the following 4 sections:-

1429 Section 8RR. (a) For the purposes of this section, "psychiatric collaborative care model"
1430 shall mean the evidence-based, integrated behavioral health service delivery method in which a
1431 primary care team consisting of a primary care provider and a care manager provides structured
1432 care management to a patient, and that works in collaboration with a psychiatric consultant that
1433 provides regular consultations to the primary care team to review the clinical status and care of
1434 patients and to make recommendations.

1435 (b) A contract between a subscriber and the corporation under an individual or group
1436 hospital service plan that is delivered, issued or renewed within or without the commonwealth

1437 shall provide coverage for mental health or substance use disorder services that are delivered
1438 through the psychiatric collaborative care model.

1439 Section 8SS. (a) As used in this section, the following terms shall, unless the context
1440 clearly requires otherwise, have the following meanings:

1441 “Community-based acute treatment”, 24-hour clinically managed mental health
1442 diversionary or step-down services for children and adolescents that is usually provided as an
1443 alternative to mental health acute treatment.

1444 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
1445 mental health diversionary or step-down services for children and adolescents that is usually
1446 provided as an alternative to mental health acute treatment.

1447 “Mental health acute treatment”, 24-hour medically supervised mental health services
1448 provided in an inpatient facility, licensed by the department of mental health, that provides
1449 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1450 environment.

1451 (b) A contract between a subscriber and the corporation under an individual or group
1452 hospital service plan that is delivered, issued or renewed within the commonwealth shall provide
1453 coverage for medically necessary mental health acute treatment, community-based acute
1454 treatment and intensive community-based acute treatment and shall not require a
1455 preauthorization before the administration of any such treatment; provided, however, that the
1456 facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of
1457 admission.

1458 Section 8TT. A contract between a subscriber and the corporation under an individual or
1459 group hospital service plan that is delivered, issued or renewed within or without the
1460 commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary
1461 emergency services programs, as defined in section 1 of chapter 175.

1462 Section 8UU. (a) As used in this section, the following words shall, unless the context
1463 clearly requires otherwise, have the following meanings:

1464 “Licensed mental health professional,” a licensed physician who specializes in the
1465 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
1466 licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed
1467 physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor
1468 I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the
1469 lawful scope of practice for such therapist.

1470 “Mental health wellness examination,” a screening or assessment that seeks to identify
1471 any behavioral or mental health needs and appropriate resources for treatment. The examination
1472 may include: (i) observation, a behavioral health screening, education and consultation on
1473 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1474 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
1475 screenings or observations to understand a covered person’s mental health history, personal
1476 history and mental or cognitive state and, when appropriate, relevant adult input through
1477 screenings, interviews and questions.

1478 “Primary care provider”, a health care professional qualified to provide general medical
1479 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise

1480 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1481 maintains continuity of care within the scope of practice.

1482 (b) A contract between a subscriber and the corporation under an individual or group
1483 hospital service plan which is delivered, issued or renewed within the commonwealth shall
1484 provide coverage for an annual mental health wellness examination that is performed by a
1485 licensed mental health professional or primary care provider, which may be provided by the
1486 primary care provider as part of an annual preventive visit.

1487 (c) The division of insurance, in consultation with the office of Medicaid, and the
1488 department of mental health, shall develop guidelines to implement this section.

1489 SECTION 43. Chapter 176B of the General Laws is hereby amended by inserting after
1490 section 4QQ the following 4 sections:-

1491 Section 4RR. (a) For the purposes of this section, “psychiatric collaborative care model”
1492 shall mean the evidence-based, integrated behavioral health service delivery method in which a
1493 primary care team consisting of a primary care provider and a care manager provides structured
1494 care management to a patient, and that works in collaboration with a psychiatric consultant that
1495 provides regular consultations to the primary care team to review the clinical status and care of
1496 patients and to make recommendations.

1497 (b) A subscription certificate under an individual or group medical service agreement that
1498 is delivered, issued or renewed within or without the commonwealth shall provide coverage for
1499 mental health or substance use disorder services that are delivered through the psychiatric
1500 collaborative care model.

1501 Section 4SS. As used in this section, the following terms shall, unless the context clearly
1502 requires otherwise, have the following meanings:

1503 “Community-based acute treatment”, 24-hour clinically managed mental health
1504 diversionary or step-down services for children and adolescents that is usually provided as an
1505 alternative to mental health acute treatment.

1506 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
1507 mental health diversionary or step-down services for children and adolescents that is usually
1508 provided as an alternative to mental health acute treatment.

1509 “Mental health acute treatment”, 24-hour medically supervised mental health services
1510 provided in an inpatient facility, licensed by the department of mental health, that provides
1511 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1512 environment.

1513 (b) A subscription certificate under an individual or group medical service agreement
1514 delivered, issued or renewed within the commonwealth shall provide coverage for medically
1515 necessary mental health acute treatment, community-based acute treatment and intensive
1516 community-based acute treatment and shall not require a preauthorization before obtaining
1517 treatment; provided, however, that the facility shall notify the carrier of the admission and the
1518 initial treatment plan within 72 hours of admission.

1519 Section 4TT. A subscription certificate under an individual or group medical service
1520 agreement that is delivered, issued or renewed shall provide benefits on a nondiscriminatory
1521 basis for medically necessary emergency services programs, as defined in section 1 of chapter
1522 175.

1523 Section 4UU. (a) As used in this section, the following words shall, unless the context
1524 clearly requires otherwise, have the following meanings:

1525 “Licensed mental health professional,” a licensed physician who specializes in the
1526 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
1527 licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed
1528 physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor
1529 I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the
1530 lawful scope of practice for such therapist.

1531 “Mental health wellness examination,” a screening or assessment that seeks to identify
1532 any behavioral or mental health needs and appropriate resources for treatment. The examination
1533 may include: (i) observation, a behavioral health screening, education and consultation on
1534 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1535 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
1536 screenings or observations to understand a covered person’s mental health history, personal
1537 history and mental or cognitive state and, when appropriate, relevant adult input through
1538 screenings, interviews and questions.

1539 “Primary care provider”, a health care professional qualified to provide general medical
1540 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise
1541 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1542 maintains continuity of care within the scope of practice.

1543 (b) A subscription certificate under an individual or group medical service agreement
1544 delivered, issued or renewed within the commonwealth shall provide coverage for an annual

1545 mental health wellness examination that is performed by a licensed mental health professional or
1546 primary care provider, which may be provided by the primary care provider as part of an annual
1547 preventive visit.

1548 (c) The division of insurance, in consultation with the office of Medicaid, and the
1549 department of mental health, shall develop guidelines to implement this section.

1550 SECTION 44. Section 4T of chapter 176G of the General Laws, as appearing in the 2020
1551 Official Edition, is hereby amended by inserting after the word “age”, in line 6, the following
1552 words:- or without regard to age, so long as the dependent, who is covered under the membership
1553 of the dependent’s parent as a member of a family group, is mentally or physically incapable of
1554 earning their own living due to disability.

1555 SECTION 45. Said chapter 176G is hereby further amended by inserting after section 4II
1556 the following 4 sections:-

1557 Section 4JJ. (a) For the purposes of this section, “psychiatric collaborative care model”
1558 shall mean the evidence-based, integrated behavioral health service delivery method in which a
1559 primary care team consisting of a primary care provider and a care manager provides structured
1560 care management to a patient, and that works in collaboration with a psychiatric consultant that
1561 provides regular consultations to the primary care team to review the clinical status and care of
1562 patients and to make recommendations.

1563 (b) An individual or group health maintenance contract that is issued or renewed within
1564 or without the commonwealth shall provide coverage for mental health or substance use disorder
1565 services that are delivered through the psychiatric collaborative care model.

1566 Section 4KK. (a) As used in this section, the following terms shall, unless the context
1567 clearly requires otherwise, have the following meanings,:

1568 “Community-based acute treatment”, 24-hour clinically managed mental health
1569 diversionary or step-down services for children and adolescents that is usually provided as an
1570 alternative to mental health acute treatment.

1571 “Intensive community-based acute treatment”, intensive 24-hour clinically managed
1572 mental health diversionary or step-down services for children and adolescents that is usually
1573 provided as an alternative to mental health acute treatment.

1574 “Mental health acute treatment”, 24-hour medically supervised mental health services
1575 provided in an inpatient facility, licensed by the department of mental health, that provides
1576 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1577 environment.

1578 (b) An individual or group health maintenance contract that is issued or renewed within
1579 or without the commonwealth shall provide coverage for medically necessary mental health
1580 acute treatment, community-based acute treatment and intensive community-based acute
1581 treatment and shall not require a preauthorization before obtaining treatment; provided, however,
1582 that the facility shall notify the carrier of the admission and the initial treatment plan within 72
1583 hours of admission.

1584 Section 4LL. An individual or group health maintenance contract that is issued or
1585 renewed within or without the commonwealth shall provide benefits on a nondiscriminatory
1586 basis for medically necessary emergency services programs, as defined in section 1 of chapter
1587 175.

1588 Section 4MM. (a) As used in this section, the following words shall, unless the context
1589 clearly requires otherwise, have the following meanings:

1590 “Licensed mental health professional,” a licensed physician who specializes in the
1591 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
1592 licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed
1593 physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor
1594 I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the
1595 lawful scope of practice for such therapist.

1596 “Mental health wellness examination,” a screening or assessment that seeks to identify
1597 any behavioral or mental health needs and appropriate resources for treatment. The examination
1598 may include: (i) observation, a behavioral health screening, education and consultation on
1599 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1600 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
1601 screenings or observations to understand a covered person’s mental health history, personal
1602 history and mental or cognitive state and, when appropriate, relevant adult input through
1603 screenings, interviews and questions.

1604 “Primary care provider”, a health care professional qualified to provide general medical
1605 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise
1606 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1607 maintains continuity of care within the scope of practice.

1608 (b) An individual or group health maintenance contract that is issued or renewed within
1609 or without the commonwealth shall provide coverage for an annual mental health wellness

1610 examination that is performed by a licensed mental health professional or primary care provider,
1611 which may be provided by the primary care provider as part of an annual preventive visit.

1612 (c) The division of insurance, in consultation with the office of Medicaid, and the
1613 department of mental health, shall develop guidelines to implement this section.

1614 SECTION 46. Section 1 of chapter 176J of the General Laws, as appearing in the 2020
1615 Official Edition, is hereby amended by inserting after the word “age”, in line 86, the following
1616 words:- or without regard to age, so long as the dependent, who is covered under the membership
1617 of the dependent’s parent as a member of a family group is mentally or physically incapable of
1618 earning their own living due to disability.

1619 SECTION 47. Chapter 176O of the General Laws is hereby amended by inserting after
1620 section 5C, as so appearing, the following section:-

1621 Section 5D. (a) For the purposes of this section, the term “base fee schedule” shall mean
1622 the minimum rates, typically set forth in fee schedules, paid by the carrier to an in-network
1623 health care provider who is not paid under an alternative payment arrangement for covered
1624 health care services; provided, however, that final rates may be subject to negotiations or
1625 adjustments that may result in payments to in-network providers that are different from the base
1626 fee schedule.

1627 (b) A carrier, directly or through any entity that manages or administers mental health or
1628 substance use disorder benefits for the carrier, shall establish a base fee schedule for evaluation
1629 and management services for behavioral health providers that is not less than the base fee
1630 schedule used for evaluation and management services for primary care providers of the same or

1631 similar licensure type and in the same geographic region; provided, however, that a carrier shall
1632 not lower its base fee schedule for primary care providers to comply with this section.

1633 (c) The division shall promulgate regulations to implement this section.

1634 SECTION 48. Subsection (a) of section 13 of said chapter 176O, as so appearing, is
1635 hereby amended by striking out the first sentence and inserting in place thereof the following
1636 sentence:-

1637 A carrier or utilization review organization shall maintain a formal internal grievance
1638 process that is compliant with the Patient Protection and Affordable Care Act, Public Law 111-
1639 148, as amended, as well as with any rules, regulations or guidance applicable thereto, and such
1640 formal internal grievance process shall provide for adequate consideration and timely resolution
1641 of grievances, which shall include, but shall not be limited to: (i) a system for maintaining
1642 records of each grievance filed by an insured or on the insured's behalf, and responses thereto,
1643 for a period of 7 years, which records shall be subject to inspection by the commissioner; (ii) the
1644 provision of a clear, concise and complete description of the carrier's formal internal grievance
1645 process and the procedures for obtaining external review pursuant to section 14 with each notice
1646 of an adverse determination; (iii) the carrier's toll-free telephone number for assisting insureds in
1647 resolving such grievances and the consumer assistance toll-free telephone number maintained by
1648 the office of patient protection; (iv) a procedure to accept grievances by telephone, in person, by
1649 mail and by electronic means; (v) a process for an insured to request the appointment of an
1650 authorized representative to act on the insured's behalf; and (vi) a procedure to accept an
1651 insured's request for medical release forms by electronic means, which shall include delivery to
1652 a designated email address or access to an online consumer portal accessible by the insured, the

1653 insured's family member or the insured's authorized representative who can provide the
1654 insured's membership identification number.

1655 SECTION 49. Subsection (b) of said section 13 of said chapter 176O, as so appearing, is
1656 hereby amended by striking out the third sentence and inserting in place thereof the following
1657 sentence:- If the expedited review process affirms the denial of coverage or treatment, the carrier
1658 shall provide the insured, within 5 business days of the decision, including by any electronic
1659 means consented to by the insured: (1) a statement setting forth the specific medical and
1660 scientific reasons for denying coverage or treatment; (2) a description of alternative treatment,
1661 services or supplies covered or provided by the carrier, if any; (3) a description of the insured's
1662 rights to any further appeal; and (4) a description of the insured's right to request a conference.

1663 SECTION 50. Subsection (c) of said section 13 of said chapter 176O, as so appearing, is
1664 hereby amended by adding the following sentence:- The external review of a grievance under
1665 section 14 shall be decided in favor of the insured unless the carrier provides substantial
1666 evidence, such as proof of delivery, that the carrier properly complied with the time limits
1667 required under this section.

1668 SECTION 51. Subsection (a) of section 14 of said chapter 176O, as so appearing, is
1669 hereby amended by striking out the eighth sentence and inserting in place thereof the following
1670 sentence:- The panel shall consider, but shall not be limited to considering: (i) any related right
1671 to such treatment or service under any related state statute or regulation; (ii) written documents
1672 submitted by the insured; (iii) medical records and medical opinions regarding medical necessity
1673 by the insured's treating provider that requested or provided the disputed service, which shall be
1674 obtained by the carrier, or by the panel if the carrier fails to do so; (iv) additional information

1675 from the involved parties or outside sources that the review panel deems necessary or relevant;
1676 and (v) information obtained from any informal meeting held by the panel with the parties.

1677 SECTION 52. Subsection (b) of said section 14 of said chapter 176O, as so appearing, is
1678 hereby amended by striking out the second sentence and inserting in place thereof the following
1679 sentence:- An insured may apply to the external review panel to seek continued provision of
1680 health care services that are the subject of the grievance during the course of an expedited or
1681 non-expedited external review upon a showing of substantial harm to the insured's health absent
1682 such continuation or other good cause as determined by the panel; provided, however, that good
1683 cause shall include a pattern of denials that have been overturned by prior internal or external
1684 appeals.

1685 SECTION 53. Subsection (c) of said section 14 of said chapter 176O, as so appearing, is
1686 hereby amended by adding the following sentence:- A carrier's failure to promptly comply with
1687 a decision of the review panel shall be an unfair and deceptive practice in violation of chapter
1688 93A.

1689 SECTION 54. Said section 14 of said chapter 176O, as so appearing, is hereby further
1690 amended by adding following subsection:-

1691 (g) The office of patient protection shall monitor carrier denials and shall identify any
1692 trends regarding particular treatments or services or carrier practices and may refer such matters
1693 to the division of insurance, the group insurance commission or the office of the attorney general
1694 for review of compliance with state or federal laws related to mental health and substance use
1695 disorder parity, including, but not limited to, section 22 of chapter 32A, section 47B of chapter
1696 175, section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of

1697 chapter 176G, in regard to any carrier licensed under said chapters 175, 176A, 176B or 176G,
1698 any carrier offering a student health plan issued under section 18 of chapter 15A or the group
1699 insurance commission, or the mental health parity provisions of the federal Paul Wellstone and
1700 Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of
1701 Public Law 110–343, as amended, and guidance or regulations issued under the act. The office of
1702 patient protection shall refer any questions or concerns from consumers about carrier compliance
1703 with state or federal laws related to mental health and substance use disorder parity to the
1704 division of insurance, the group insurance commission or the office of the attorney general.

1705 SECTION 55. Subsection (b) of section 16 of said chapter 176O, as so appearing, is
1706 hereby amended by striking out the last sentence and inserting in place thereof the following
1707 sentence:- If a carrier or utilization review organization intends to implement a new medical
1708 necessity guideline or amend an existing requirement or restriction, the carrier or utilization
1709 review organization shall ensure that the new guideline or amended requirement or restriction
1710 shall not be implemented unless: (i) the carrier’s or utilization review organization’s website has
1711 been updated to reflect the new or amended requirement or restriction; and (ii) the carrier or
1712 utilization review organization has assessed the limitation to show it is in compliance with state
1713 and federal parity requirements pursuant to chapter 26.

1714 SECTION 56. Chapter 77 of the acts of 2022 is hereby amended by inserting after section
1715 1 the following section:-

1716 Section 1A. (a) For the purposes of this section, “integrated care” shall mean full
1717 collaboration in merged or transformed practices offering behavioral health and physical health
1718 services within the same shared practice space in the same facility, where the practice: (i)

1719 provides services in a shared practice space that ensures services will be available and accessible
1720 promptly and in a manner which preserves human dignity and assures continuity of care; (ii)
1721 ensures communication among the integrated care team that is consistent and team-based; (iii)
1722 ensures shared decision-making between mental and behavioral health providers, primary care
1723 providers and other service providers involved in promoting the health and wellbeing of the
1724 client; (iv) provides evidence-based services in a mode of service delivery appropriate for the
1725 target population; (v) employs staff who are multidisciplinary and culturally-competent and
1726 linguistically-competent; (vi) provides integrated services related to screening, diagnosis and
1727 treatment of mental health and substance use conditions and co-occurring physical health
1728 conditions and chronic diseases; and (vii) provides targeted case management, including services
1729 to assist individuals gaining access to needed medical, social, educational and other services and
1730 applying for income security, housing, employment and other benefits to which the individual
1731 may be entitled.

1732 (b) The commission established in section 1 shall develop and make recommendations to
1733 the general court for grant programs to be administered by the commissioner of public health, in
1734 consultation with the department of mental health, to enhance access to behavioral health
1735 services in the commonwealth and support a diverse behavioral health workforce. In developing
1736 its recommendations, the commission shall consider:

1737 (1) a program to support the behavioral health needs of health care providers through
1738 grants to: (i) health care entities, including provider organizations, as defined in section 1 of
1739 chapter 6D of the General Laws, or (ii) professional associations to establish or enhance
1740 evidence-based or evidence-informed programs dedicated to improving the behavioral health,
1741 mental wellness and resiliency of health care professionals;

1742 (2) a scholarship program to encourage a culturally, ethnically and linguistically diverse
1743 behavioral health workforce that helps students obtain academic credits toward a master's degree
1744 in the field of behavioral health with a preference for students who commit to serving high-need
1745 populations, including children, veterans, clients of the department of children and families,
1746 incarcerated or formerly incarcerated individuals, including justice-involved youth and emerging
1747 adults, individuals with post-traumatic stress disorder, aging adults, school-aged youth and
1748 individuals with a comorbidity, including substance use disorder; and

1749 (3) a program to promote integrated care, through which the secretary of health and
1750 human services may award grants to, or enter into cooperative agreements with, health care
1751 facilities to support improvements to facilities to promote full collaboration between primary and
1752 behavioral health in an integrated care setting.

1753 SECTION 57. The interagency health equity team, as supported through the office of
1754 health equity, shall, in consultation with the advisory council appointed in this section, study
1755 ways to improve access to, and the quality of, culturally-competent behavioral health services.
1756 The review shall include, but not be limited to: (i) the need for greater racial, ethnic and
1757 linguistic diversity within the behavioral health workforce; (ii) the role of gender, sexual
1758 orientation, gender identity, race, ethnicity, linguistic barriers, status as a client of the department
1759 of children and families, status as an incarcerated or formerly incarcerated individual, including
1760 justice-involved youth and emerging adults, status as a veteran, status as an individual with post-
1761 traumatic stress disorder, status as an aging adult, status as a person with any other physical or
1762 invisible disability and social determinants of health regarding behavioral health needs; and (iii)
1763 any other factors identified by the team that create disparities in access and quality within the
1764 existing behavioral health service delivery system, including stigma, transportation and cost.

1765 The advisory council shall consist of: the chairs of the joint committee on mental health,
1766 substance use and recovery; the chair of the Black and Latino caucus or a designee; and 8
1767 members to be appointed by the commissioner of public health, 1 of whom shall be a local public
1768 health official representing a majority-minority municipality, 1 of whom shall be a representative
1769 of a racial or ethnic equity advocacy group, 1 of whom shall be a representative of a linguistic
1770 equity advocacy group, 1 of whom shall be a licensed behavioral health provider, 1 of whom
1771 shall be a representative of a behavioral health advocacy group, 1 of whom shall be a
1772 representative of an organization serving the health care needs of the lesbian, gay, bisexual,
1773 transgender, queer and questioning community, 1 of whom shall be a representative of an
1774 organization serving the health care needs of individuals experiencing housing insecurity and 1
1775 of whom shall be an individual with expertise in school-based behavioral health services.

1776 The team shall meet with the advisory council not less than quarterly. Not later than July
1777 1, 2023, and annually for the following 3 years at the close of each state fiscal year, the team
1778 shall issue a report with legislative, regulatory or budgetary recommendations to improve the
1779 access and quality of culturally-competent mental and behavioral health services. The report
1780 shall be written in non-technical, readily understandable language and shall be made publicly
1781 available on the office of health equity’s website.

1782 The office of health equity, the department of mental health and the department of public
1783 health may, subject to appropriation, provide administrative, logistical and research support to
1784 produce the report.

1785 SECTION 58. The health policy commission, in consultation with the division of
1786 insurance, shall conduct an analysis of the effects of behavioral health managers, as defined in

1787 section 1 of chapter 176O of the General Laws, on the commonwealth's health care delivery
1788 system. The commission shall seek input from the executive office of health and human services,
1789 other relevant state agencies, health care providers and payers, behavioral health and economic
1790 experts, patients and caregivers.

1791 The commission shall analyze: (i) the services that behavioral health managers provide;
1792 (ii) the effect of behavioral health managers on accessibility, quality and cost of behavioral
1793 health services, including an analysis of impacts on patient outcomes; (iii) the oversight practices
1794 by other states on behavioral health managers; (iv) the effects of behavioral health manager state
1795 licensure, regulation or registration on access to behavioral health services; and (v) any other
1796 issues pertaining to behavioral health managers as deemed relevant by the commission.

1797 Not later than December 31, 2022, the health policy commission shall file a report of its
1798 findings, together with any recommendations for legislation, with the clerks of the senate and
1799 house of representatives, the joint committee on health care financing, the joint committee on
1800 mental health, substance use and recovery and the joint committee on financial services.

1801 SECTION 59. (a) The department of veterans' services shall convene an advisory
1802 committee that shall consist of: 2 representatives of the Massachusetts chapter of Team Red,
1803 White & Blue; 2 representatives of the Red Sox Foundation, Inc. and Massachusetts General
1804 Hospital's Home Base Program; 2 representatives of the Wounded Warriors Project; 2
1805 representatives of the Mass Mentoring Partnership, Inc.; 2 representatives of the Massachusetts
1806 Coalition for Suicide Prevention; 2 representatives of the Massachusetts Psychological
1807 Association, Inc.; and such other members as the committee deems necessary. The members of

1808 the committee shall have experience in mental health or veterans' support services with an
1809 emphasis on treatment of post-traumatic stress disorder, depression and anxiety among veterans.

1810 (b) The committee, in coordination with the department of veterans' services and the
1811 department of mental health, shall investigate and study: (i) ways to augment services to
1812 returning veterans to reduce the rate of suicide and the effects of post-traumatic stress disorder,
1813 depression and anxiety; and (ii) the complexity of reintegration into civilian life and issues
1814 related to isolation and suicide among veterans. The committee shall provide support and
1815 expertise to reduce isolation and suicide among veterans returning from deployment.

1816 (c) The committee shall examine: (i) the impact of having a community peer liaison on a
1817 veteran's reintegration into society; (ii) the relationship between isolation and suicide among
1818 veterans; and (iii) the impact of having a community peer liaison on symptoms of post-traumatic
1819 stress disorder, depression and anxiety diagnosed in veterans.

1820 (d) The committee shall file a report of its findings and any recommendations with the
1821 clerks of the senate and house of representatives, the joint committee on veterans and federal
1822 affairs and the joint committee on mental health, substance use and recovery not later than
1823 January 1, 2023.

1824 SECTION 60. The department of mental health shall prepare a comprehensive plan to
1825 address access to continuing care beds, intensive residential treatment programs and community-
1826 based programs for patients awaiting discharge from acute psychiatric hospitals and units. The
1827 plan shall include, but shall not be limited to, strategies to reduce the wait times for patients
1828 awaiting discharge to ensure that the patients determined appropriate for continuing care,
1829 intensive residential treatment and community-based programs would be admitted to an

1830 appropriate continuing care bed, intensive residential treatment program, community-based
1831 program or other appropriate setting within 30 days after approval of the patient's application.
1832 The department of mental health shall submit a copy of the plan to the governor, the clerks of the
1833 senate and house of representatives and the joint committee on mental health, substance use and
1834 recovery not later than 60 days after the effective date of this act.

1835 SECTION 61. (a) The secretary of health and human services shall establish a statewide
1836 evidence-based or evidence-informed education and awareness initiative to: (i) identify and
1837 disseminate best practices for preventing suicide and improving the behavioral health, mental
1838 wellness and resiliency among health care professionals; (ii) encourage health care professionals
1839 to seek behavioral health support and care; (iii) to help such professionals identify risk factors
1840 associated with suicide and behavioral health crisis and to help such professionals learn how best
1841 to respond to such risks; and (iv) to address the stigma associated with seeking behavioral health
1842 services.

1843 (b) Not later than 2 years after the effective date of this act, the secretary of health and
1844 human services shall submit a report, with legislative and regulatory recommendations,
1845 containing updates on the activities and outcomes of the initiative, including a description of
1846 quantitative and qualitative metrics used to evaluate such activities and outcomes, to the
1847 governor and the general court by filing the report and recommendations with the clerks of the
1848 house of representatives and the senate, the joint committee on mental health, substance use and
1849 recovery and the senate and house committees on ways and means.

1850 SECTION 62. The secretary of health and human services and the commissioner of
1851 elementary and secondary education shall promulgate regulations pursuant to section 16R of
1852 chapter 6A, inserted by section 3, not later than 90 days after the effective date of this act.

1853 SECTION 63. The division of insurance shall promulgate regulations to implement
1854 section 5D of chapter 176O of the General Laws not later than 1 year after the effective date of
1855 this act.

1856 SECTION 64. The health policy commission shall publish its first pediatric behavioral
1857 health planning report required by section 20 of chapter 6D of the General Laws not later than 18
1858 months after the effective date of this act.

1859 SECTION 65. The division of medical assistance shall file its first report on the
1860 implementation of the streamlined community-based behavioral health screening process
1861 established in section 81 of chapter 118E not later than 1 year after the effective date of this act.

1862 SECTION 66. Subsection (c) of section 16P of chapter 6A of the General Laws and
1863 section 5D of chapter 176O of the General Laws shall take effect 1 year after the effective date
1864 of this act.

1865 SECTION 67. Subsection (b) of section 16DD chapter 6A of the General Laws shall take
1866 effect on July 16, 2022; provided, however, that the secretary of health and human services may
1867 designate 988 crisis hotline centers before July 16, 2022.

1868 SECTION 68. Section 51³/₄ of chapter 111 of the General Laws, inserted by section 28,
1869 shall take effect on January 1, 2023; provided, however, the department of public health shall

1870 promulgate regulations to implement said section 51³/₄ of said chapter 111 not later than October
1871 1, 2022.