SENATE . . . . No. 2519

The Commonwealth of Massachusetts

In the One Hundred and Ninety-First General Court
(2019-2020)

SENATE, February 6, 2020.

The committee on Senate Ways and Means to whom was referred the Senate Bill relative to mental health parity implementation (Senate, No. 588) (also based on Senate, No. 1148), - reports, recommending that the same ought to pass with an amendment substituting a new draft entitled "An Act addressing barriers to care for mental health" (Senate, No. 2519).

For the committee,
Michael J. Rodrigues

FILED ON: 2/6/2020

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

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

1 SECTION 1. Subsection (a) of section 8 of chapter 6D of the General Laws, as appearing
2 in the 2018 Official Edition, is hereby amended by inserting after the word "system", in line 9,
3 the following words:- , and trends in annual behavioral health expenditures.
4 SECTION 2. Said section 8 of said chapter 6D, as so appearing, is hereby further
5 amended by striking out, in line 94, the word "and" and inserting in place thereof the following
6 words:- , including behavioral health expenditures, and.
7 SECTION 3. The first paragraph of subsection (a) of section 16 of chapter 12C of the
8 General Laws, as so appearing, is hereby amended by adding the following sentence:- In addition
9 to overall health costs, the center shall report on the subcategory of annual behavioral health
10 expenditures, as defined in regulation, and provide a similar analysis of costs and cost trends
11 related to behavioral health services.
12 SECTION 4. Section 21A of said chapter 12C, as so appearing, is hereby amended by
13 adding the following 2 sentences:- The center shall promulgate regulations to establish an annual
14 baseline expenditure for behavioral health services. The regulations shall define criteria for

15 health care services to be categorized as behavioral health services, with subcategories to the
16 extent feasible, including, but not limited to: (i) mental health; (ii) substance use disorder; (iii)
17 outpatient; (iv) inpatient; (v) services for children; (vi) services for adults; and (vii) provider
18 type. The regulations shall establish guidelines for data collection related to behavioral health
19 services, outcomes measures and expenditures.

20 SECTION 5. Section 9 of chapter 13 of the General Laws, as so appearing, is hereby
21 amended by inserting after the word "workers", in line 8, the
22 following words:- , the board of registration of social workers, the board of registration of
23 psychologists, the board of registration of allied mental health and human services professions.

24 SECTION 6. Section 79 of said chapter 13, as so appearing, is hereby amended by
25 striking out, in lines 17 and 18 and in line 27, the words "director of consumer affairs and
26 business regulations" and inserting in place thereof, in each instance, the following words:-
27 commissioner of public health.

28 SECTION 7. Said chapter 13 is hereby further amended by striking out
29 section 80, as so appearing, and inserting in place thereof the following section:-

30 Section 80. There shall be a board of registration of social workers that shall consist of:
31 the commissioner of children and families or a designee who is licensed as either a certified
32 social worker or an independent clinical social worker under sections 130 to 137, inclusive, of
33 chapter 112; the commissioner of mental health or a designee who is licensed as either a certified
34 social worker or an independent clinical social worker under said sections 130 to 137, inclusive,
35 of said chapter 112; and 7 members to be appointed by the governor, 1 of whom shall be a
36 representative of an accredited school of social work, 3 of whom shall be licensed as a certified
37 social worker or an independent clinical social worker under said sections 130 to 137, inclusive,

38 of said chapter 112, 1 of whom shall be licensed under said sections 130 to 137, inclusive, of
39 said chapter 112 and an active member of an organized labor organization representing social
40 workers and 2 of whom shall be members of the general public. At least 1 licensed social work
41 member and at least 1 member from the general public shall represent an underserved
42 population, as defined by the United States Department of Health and Human Services. Not more
43 than 6 members of the board shall belong to any 1 political party.

44 SECTION 8. Section 84 of said chapter 13, as so appearing, is hereby amended by
45 striking out, in lines 8 and 9, the words "division of professional licensure" and inserting in place
46 thereof the following words:- department of public health.

47 SECTION 9. Said section 84 of said chapter 13, as so appearing, is hereby further
48 amended by striking out, in lines 44 and 45, inclusive, the words "Division of Professional
49 Licensure Trust Fund established in section 35V" and inserting in place thereof the following
50 words:- Quality in Health Professions Trust Fund established in section 35X.

51 SECTION 10. Section 88 of said chapter 13, as so appearing, is hereby amended by
52 striking out, in lines 1 and 2, the words "division of professional licensure" and inserting in place
53 thereof the following words:- department of public health.

54 SECTION 11. The first paragraph of section 90 of said chapter 13, as so appearing, is
55 hereby amended by striking out the third sentence.

56 SECTION 12. Said section 90 of said chapter 13 is hereby further amended by striking
57 out the third paragraph, as so appearing, and inserting in place thereof the following paragraph:-
58 The commissioner of public health may review and approve the rules and regulations proposed
59 by the board.

60 SECTION 13. Section 18 of chapter 15A of the General Laws, as so appearing, is hereby
61 amended by adding the following paragraph:-
62 Any qualifying student health insurance plan authorized under this chapter shall comply
63 with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity
64 Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including
65 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part
66 156.115(a)(3), and the benefit mandates and other obligations under section 47B of chapter 175,
67 section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter
68 176G, as if the student health insurance plan was issued by such carriers licensed under chapters
69 175, 176A, 176B and 176G, without regard to any limitation under section 1 of chapter 176J.
70 SECTION 14. Chapter 26 of the General Laws is hereby amended by striking out section
71 8K, as so appearing, and inserting in place thereof the following section:-
72 Section 8K. (a) The commissioner of insurance shall implement and enforce applicable
73 provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction
74 Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act,
75 including 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part
76 156.115(a)(3), and applicable state mental health parity laws, including, but not limited to,
77 section 22 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A
78 of chapter 176B and sections 4, 4B and 4M of chapter 176G, in regard to any carrier licensed
79 under chapters 175, 176A, 176B and 176G, any carrier offering a student health plan issued
80 under section 18 of chapter 15A or the group insurance commission, by:
81 (i) evaluating all consumer or provider complaints regarding mental health and substance
82 use disorder coverage for possible parity violations within 3 months of receipt;

83 (ii) performing behavioral health parity compliance market conduct examinations of each
84 carrier at least once every 24 months with a focus on: (A) non-quantitative treatment limitations
85 under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity
86 Act of 2008 and applicable state mental health and substance use disorder parity laws, including,
87 but not limited to, prior authorization, concurrent review, retrospective review, step-therapy,
88 network admission standards, reimbursement rates, network adequacy and geographic
89 restrictions; (B) denials of authorization, payment and coverage; and (C) any other criteria
90 determined by the division, including factors identified through consumer or provider
91 complaints; provided, however, that: (1) a market conduct examination of a carrier subject to
92 chapters 175, 176A, 176B or 176G and any plans authorized or regulated under chapter 32A
93 shall follow the procedural requirements in subsections 10, 11 and 15 of section 4 of said chapter
94 175 regarding notice and rebuttal of examination findings, subsequent hearings and conflicts of
95 interest; (2) the commissioner shall publicize the fees for a market conduct examination under
96 section 3B of chapter 7 and said subsection 11 of said section 4 of said chapter 175; and (3)
97 nothing contained in clause (ii) or in said section 4 of said chapter 175, section 7 of said chapter
98 176A, section 9 of said chapter 176B and section 10 of said chapter 176G shall limit the
99 commissioner's authority to use, and if appropriate, to make public any final or preliminary
100 examination report, any examiner or company work papers or other documents or any other
101 information discovered or developed during the course of any examination in the furtherance of
102 any legal or regulatory action which the commissioner may, in their sole discretion, deem
103 appropriate;
104 (iii) requiring that carriers that provide mental health or substance use disorder benefits
105 directly or through a behavioral health manager as defined in section 1 of chapter 176O or any

106 other entity that manages or administers such benefits for the carrier comply with the annual
107 reporting requirements under section 8M;
108 (iv) updating applicable regulations as necessary to effectuate any provisions of the
109 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
110 2008that relate to insurance; and
111 (v) assessing a fee upon any carrier for the costs and expenses incurred in any market
112 conduct examination authorized by law, consistent with the costs associated with the use of
113 division personnel and examiners, the costs of retaining qualified contract examiners necessary
114 to perform an examination, electronic data processing costs, supervision and preparation of an
115 examination report and lodging and travel expenses; provided, however, that the commissioner
116 shall maintain active management and oversight of examination costs and fees to ensure that the
117 examination costs and fees comply with the National Association of Insurance Commissioners
118 market conduct examiners handbook, unless the commissioner demonstrates that the fees
119 prescribed in the handbook are inadequate under the circumstances of the examination; and
120 provided further, that the commissioner or the commissioner's examiners shall not receive or
121 accept any additional emolument on account of any examination.
122 (b) The division of insurance may impose a penalty against a carrier that provides mental
123 health or substance use disorder benefits, directly or through a behavioral health manager as
124 defined in section 1 of chapter 176O or any other entity that manages or administers such
125 benefits for the carrier, for any violation by the carrier or the entity that manages or administers
126 mental health and substance use disorder benefits for the carrier of state laws related to mental
127 health and substance use disorder parity or provisions of the federal Paul Wellstone and Pete

128 Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as
129 amended, and federal guidance or regulations issued under the act.
130 The amount of any penalty imposed shall be $100 for each day in the noncompliance
131 period per product line with respect to each participant or beneficiary to whom such failure
132 relates; provided, however, that the maximum annual penalty under this subsection shall be
133 $500,000. For purposes of this subsection, the term "noncompliance period" shall mean the
134 period beginning on the date a failure first occurs and ending on the date such failure is
135 corrected.
136 No penalty shall be imposed on any failure if the division of insurance determines that
137 such failure was due to reasonable cause and not to willful neglect or if such failure is corrected
138 within 30 days of the start of the noncompliance period.
139 (c) The division of insurance may require carriers to provide remedies for any failure to
140 meet the requirements of state laws related to mental health and substance use disorder parity or
141 provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction
142 Equity Act of 2008, 42 U.S.C. 18031(j), as amended, and federal guidance or regulations issued
143 under the act, including, but not limited to:
144 (i) requiring the carrier to change the benefit standard or practice, including updating plan
145 language, with notice to plan members;
146 (ii) providing training to staff on any changes to benefits and practices;
147 (iii) informing plan members of changes;
148 (iv) requiring the carrier to reprocess and pay all inappropriately denied claims to
149 affected plan members, notify members of their right to file claims for services previously denied

150 and for which members paid out-of-pocket and reimburse for services eligible for coverage
151 under corrected standards; and
152 (v) requiring the carrier to submit to ongoing monitoring to verify compliance.
153 (d) Any proprietary information submitted to the commissioner by a carrier as a result of
154 the requirements of this section shall not be public records under clause Twenty-sixth of section
155 7 of chapter 4 or chapter 66; provided, however, that the commissioner may produce reports
156 summarizing any findings.
157 (e) Nothing in this section shall limit the authority of the commonwealth, through the
158 attorney general, to enforce any state or federal law, regulation or guidance described in this
159 section.
160 SECTION 15. Said chapter 26 is hereby further amended by inserting after Section 8L
161 the following sections:-
162 Section 8M. (a) All carriers licensed under chapters 175, 176A, 176B and 176G that
163 provide mental health or substance use disorder benefits, directly or through a behavioral health
164 manager, as defined in section 1 of chapter 176O or any other entity that manages or administers
165 such benefits for the carrier, and the group insurance commission under chapter 32A, or the
166 carriers the group insurance commission contracts with for the administration of any self-insured
167 plans that provide mental health or substance use disorder benefits, directly or through a
168 behavioral health manager, as defined in section 1 of chapter 176O or any other entity that
169 manages or administers such benefits for the carrier, shall submit an annual report not later than
170 July 1 to the commissioner of insurance that contains:

171 (i) a description of the process used to develop or select the medical necessity criteria for
172 mental health and substance use disorder benefits and the process used to develop or select the
173 medical necessity criteria for medical and surgical benefits;
174 (ii) identification of all non-quantitative treatment limitations that are applied to mental
175 health and substance use disorder benefits and medical and surgical benefits within each
176 classification of benefits, as defined in 45 CFR Part 146.136(c)(4)(i); provided, however, that
177 there shall not be separate non-quantitative treatment limitations that apply to mental health and
178 substance use disorder benefits but do not apply to medical and surgical benefits within any
179 classification of benefits; provided further, that the non-quantitative treatment limitations shall
180 include the processes, strategies or methodologies for developing and applying the carrier's
181 reimbursement rates for mental health and substance use disorder benefits and medical and
182 surgical benefits within each classification of benefits; and
183 (iii) the results of an analysis that demonstrates that for the medical necessity criteria
184 described in clause (i) and for each non-quantitative treatment limitation identified in clause (ii),
185 as written and in operation, the processes, strategies, evidentiary standards or other factors used
186 in applying the medical necessity criteria and each non-quantitative treatment limitation to
187 mental health and substance use disorder benefits within each classification of benefits are
188 comparable to, and are not applied more stringently than, the processes, strategies, evidentiary
189 standards or other factors used in applying the medical necessity criteria and each non-
190 quantitative treatment limitation to medical and surgical benefits within the corresponding
191 classification of benefits; provided, however, that, at a minimum, the results of the analysis shall:
192 (A) identify the factors used to determine that an non-quantitative treatment limitation
193 will apply to a benefit;

194 (B) identify any processes, strategies or evidentiary standards used to define the factors
195 identified in subclause (A);
196 (C) provide the comparative analyses, including the results of the analyses, performed to
197 determine that the processes and strategies used to design each non-quantitative treatment
198 limitation, as written, and the as-written processes and strategies used to apply the non-
199 quantitative treatment limitation to mental health and substance use disorder benefits are
200 comparable to, and are not applied more stringently than, the processes and strategies used to
201 design each non-quantitative treatment limitation, as written, and the as-written processes and
202 strategies used to apply the non-quantitative treatment limitation to medical and surgical
203 benefits;
204 (D) provide the comparative analyses, including the results of the analyses, performed to
205 determine that the processes and strategies used to apply each non-quantitative treatment
206 limitation, in operation, for mental health and substance use disorder benefits and provider
207 reimbursement rates are comparable to, and are not applied more stringently than, the processes
208 or strategies used to apply each non-quantitative treatment limitation, in operation, for medical
209 and surgical benefits and provider reimbursement rates;
210 (E) disclose the specific findings and conclusions reached by the carrier or the group
211 insurance commission that the results of the analyses in this clause indicate that the carrier or
212 group insurance commission is in compliance with this section and the federal Paul Wellstone
213 and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any
214 federal guidance or regulations relevant to the act, including, but not limited to, 45 CFR Part
215 146.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3); and

216 (F) disclose the number of requests for parity documents received under 29 CFR
217 2590.712(d)(3) or 45 CFR 146.136(d)(3) and the number of any such requests for which the plan
218 refused, declined or was unable to provide documents.
219 (b) In completing the analyses required under subsection (a), carriers shall perform the
220 analyses broadly across each classification of benefits and shall not be required to examine each
221 medical and surgical benefit subject to an non-quantitative treatment limitation that also applies
222 to mental health and substance use disorder benefits in the classification of benefits. Carriers
223 may use any reasonable method to determine how the carrier selects medical and surgical
224 benefits subject to an non-quantitative treatment limitation in the classification of benefits for the
225 purpose of performing the comparative analyses; provided, however, that carriers shall select all
226 medical and surgical benefits sharing the same characteristics as the mental health and substance
227 use disorder benefits subject to the non-quantitative treatment limitation in a classification of
228 benefits for the purposes of performing the analyses.
229 (c) If federal guidance, including, but not limited to, the Self-Compliance Tool for the
230 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
231 2008, as amended, is released that indicates an non-quantitative treatment limitation analysis and
232 reporting process that is significantly different from, contrary to or more efficient than the non-
233 quantitative treatment limitation analysis and reporting requirements described in subsection (a),
234 the commissioner may promulgate regulations that delineate an non-quantitative treatment
235 limitation analysis and reporting format that may be used in lieu of the non-quantitative
236 treatment limitation analysis and reporting requirements described in said subsection (a).
237 (d) Any proprietary portions of information submitted to the commissioner by a carrier as
238 a result of the requirements of this section shall not be public records under clause Twenty-sixth

239 of section 7 of chapter 4 or chapter 66; provided, however, that the commissioner may produce
240 reports summarizing any findings.
241 (e) Annually, not later than December 1, the commissioner shall submit a summary of the
242 reports that the commissioner receives from all carriers under subsection (a) to the clerks of the
243 senate and house of representatives, the joint committee on mental health, substance use and
244 recovery and the joint committee on health care financing. The summary report shall include, but
245 not be limited to:
246 (i) the methodology the commissioner is using to check for compliance with the federal
247 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as
248 amended, and any federal guidance or regulations relevant to the act;
249 (ii) the methodology the commissioner is using to check for compliance with section 22
250 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter
251 176B and section 4M of chapter 176G;
252 (iii) the report of each market conduct examination conducted or completed during the
253 immediately preceding calendar year regarding access to behavioral health services or
254 compliance with parity in mental health and substance use disorder benefits under state and
255 federal laws and any actions taken as a result of such market conduct examinations;
256 (iv) a breakdown of treatment authorization data for each carrier for mental health
257 treatment services, substance use disorder treatment services and medical and surgical treatment
258 services for the immediately preceding calendar year indicating for each treatment service: (A)
259 the number of inpatient days, outpatient services and total services requested; (B) the number
260 and per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day
261 requests modified resulting in a lesser amount of inpatient days authorized than requested and the

262 reason for the modification, inpatient day requests denied and the reason for the denial, inpatient

263 day requests where an internal appeal was filed and approved, inpatient day requests where an

264 internal appeal was filed and denied, inpatient day requests where an external appeal was filed

265 and upheld and inpatient day requests where an external appeal was filed and overturned; and

266 (C) the number and per cent of outpatient service requests authorized, outpatient service requests

267 modified, outpatient service requests modified resulting in a lower amount of outpatient service

268 authorized than requested and the reason for the modification, outpatient service requests denied

269 and the reason for the denial, outpatient service requests where an internal appeal was filed and

270 approved, outpatient service requests where an internal appeal was filed and denied, outpatient

271 service requests where an external appeal was filed and upheld and outpatient service requests

272 where an external appeal was filed and overturned;

273 (v) the number of complaints the division has received in the immediately preceding

274 calendar year regarding access to behavioral health services or compliance with parity in mental

275 health and substance use disorder benefits under state and federal laws and a summary of all

276 complaints resolved by the division during that time period; and

277 (vi) information about any educational or corrective actions the commissioner has taken

278 to ensure carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health

279 Parity and Addiction Equity Act of 2008, as amended, and said section 22 of said chapter 32A,

280 said section 47B of said chapter 175, said section 8A of said chapter 176A, said section 4A of

281 said chapter 176B and said section 4M of said chapter 176G.

282 The summary report shall be written in non-technical, readily understandable language

283 and shall be made available to the public by posting the report on the division’s website.

284 SECTION 16. Chapter 32A of the General Laws is hereby amended by inserting after
285 section 17Q the following section:-
286 Section 17R. For the purposes of this section, the following terms shall have the
287 following meanings unless the context clearly requires otherwise:
288 "Community-based acute treatment", 24-hour clinically managed mental health
289 diversionary or step-down services for children and adolescents that is usually provided as an
290 alternative to mental health acute treatment.
291 "Intensive community-based acute treatment", intensive 24-hour clinically managed
292 mental health diversionary or step-down services for children and adolescents that is usually
293 provided as an alternative to mental health acute treatment.
294 "Mental health acute treatment", 24-hour medically supervised mental health services
295 provided in an inpatient facility, licensed by the department of mental health, that provides
296 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
297 milieu.
298 The commission shall provide to any active or retired employee of the commonwealth
299 who is insured under the group insurance commission coverage for medically necessary mental
300 health acute treatment, community-based acute treatment and intensive community-based acute
301 treatment and shall not require a preauthorization before obtaining treatment; provided, however,
302 that the facility shall notify the carrier of the admission and the initial treatment plan within 72
303 hours of admission.
304 Benefits for an employee under this section shall be the same for the employee's covered
305 spouse and covered dependents.

306 SECTION 17. Said chapter 32A is hereby further amended by adding the following
307 section:-
308 Section 30. The commission shall provide to any active or retired employee of the
309 commonwealth who is insured under the group insurance commission benefits on a
310 nondiscriminatory basis for medically necessary emergency service programs, as defined in
311 section 1 of chapter 175.
312 SECTION 18. Chapter 111 of the General Laws, as appearing in the 2018 Official
313 Edition, is hereby amended by inserting after section 51½ the following section:-
314 Section 51¾. The department, in consultation with the department of mental health, shall
315 promulgate regulations requiring all acute-care hospitals licensed under section 51G to provide
316 or arrange for qualified behavioral health clinicians, during all operating hours of the emergency
317 department, or to a satellite emergency facility as defined in section 51½, to evaluate and
318 stabilize a person admitted with a behavioral health presentation to the department, or to a
319 facility and to refer such person for appropriate treatment or inpatient admission.
320 The regulations shall include, but not be limited to, requirements that individuals under
321 the age of 22 receive an expedited evaluation and stabilization process.
322 SECTION 19. Section 61 of chapter 112 of the General Laws, as appearing in the 2018
323 Official Edition, is hereby amended by striking out, in line 18, the words "A board of
324 registration" and inserting in place thereof the following words:- Each board of registration
325 under the supervision of the department of public health may discipline a holder of a license,
326 certificate, registration or authority issued pursuant to this chapter and each board of registration.
327 SECTION 20. Said section 61 of said chapter 112, as so appearing, is hereby further

328 amended by striking out, in lines 49 and 50, the words “a board of registration” and inserting in
329 place thereof the following words:- each board of registration under the supervision of the
330 department of public health and each board of registration.
331 SECTION 21. Section 65B of said chapter 112, as so appearing, is hereby amended by
332 striking out, in line 1, the words “A board of registration” and inserting in place thereof the
333 following words:- Each board of registration under the supervision of the department of public
334 health and each board of registration.
335 SECTION 22. Section 65F of said chapter 112, as so appearing, is hereby amended by
336 inserting after the word “licensure”, in line 4, the following words:- or a board of registration
337 under the supervision of the department of public health.
338 SECTION 23. Section 126 of said chapter 112, as so appearing, is hereby amended by
339 adding the following paragraph:-
340 All application fees and civil administrative penalties and fines collected by the board
341 under sections 61 and 118 to 129B, inclusive, shall be deposited into the Quality in Health
342 Professions Trust Fund established in section 35X of chapter 10.
343 SECTION 24. Section 136 of said chapter 112, as so appearing, is hereby amended by
344 adding the following paragraph:-
345 All application fees and civil administrative penalties and fines collected by the board
346 under sections 61 and 130 to 137, inclusive, shall be deposited into the Quality in Health
347 Professions Trust Fund established in section 35X of chapter 10.
348 SECTION 25. Section 163 of said chapter 112, as so appearing, is hereby amended by
349 inserting after the definition of “Licensed mental health counselor,” the following definition:-

350 “Licensed supervised mental health counselor”, a person licensed or eligible for license
351 under section 165.
352 SECTION 26. Section 164 of said chapter 112, as so appearing, is hereby amended by
353 inserting after the word “consultant”, in line 7, the following words:- or licensed supervised
354 mental health counselor, advisor or consultant.
355 SECTION 27. Section 165 of said chapter 112, as so appearing, is hereby amended by
356 inserting after the word “health”, in line 16, the following words:- or the department of public
357 health.
358 SECTION 28. Said section 165 of said chapter 112, as so appearing, is hereby further
359 amended by adding the following 3 paragraphs:-
360 The board may issue a license to an applicant as a supervised mental health counselor;
361 provided, however, that each applicant, in addition to complying with clauses (1) and (2) of the
362 first paragraph, shall provide satisfactory evidence to the board that the applicant: (i)
363 demonstrates to the board the successful completion of a master’s degree in a relevant field from
364 an educational institution licensed by the state in which it is located and meets national standards
365 for granting of a master’s degree with a subspecialization in counseling, or a relevant
366 subspecialization approved by the board; and (ii) has successfully passed a board-approved
367 examination.
368 A supervised mental health counselor shall practice under supervision of a clinician in a
369 clinic or hospital licensed by the department of mental health or the department of public health
370 or accredited by the Joint Commission on Accreditation of Hospitals or in an equivalent center or
371 institute or under the direction of a supervisor approved by the board.

372 The board shall promulgate rules and regulations specifying the required qualifications of
373 the supervising clinician.
374 SECTION 29. Section 168 of said chapter 112, as so appearing, is hereby amended by
375 adding the following paragraph:-
376 All application fees and civil administrative penalties and fines collected by the board
377 under sections 61 and 163 to 172, inclusive, shall be deposited into the Quality in Health
378 Professions Trust Fund established in section 35X of chapter 10.
379 SECTION 30. Chapter 118E of the General Laws is hereby amended by inserting after
380 section 10M the following section:-
381 Section 10N. For the purposes of this section, the following terms shall have the
382 following meanings unless the context clearly requires otherwise:-
383 "Community-based acute treatment", 24-hour clinically managed mental health
384 diversionary or step-down services for children and adolescents that is usually provided as an
385 alternative to mental health acute treatment.
386 "Intensive community-based acute treatment", intensive 24-hour clinically managed
387 mental health diversionary or step-down services for children and adolescents that is usually
388 provided as an alternative to mental health acute treatment.
389 "Mental health acute treatment", 24-hour medically supervised mental health services
390 provided in an inpatient facility, licensed by the department of mental health, that provides
391 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
392 milieu.
393 The division and its contracted health insurers, health plans, health maintenance
394 organizations, behavioral health management firms and third-party administrators under contract

395 to a Medicaid managed care organization or primary care clinician plan shall cover the cost of
396 medically necessary mental health acute treatment, community-based acute treatment and
397 Intensive community-based acute treatment and shall not require a preauthorization before
398 obtaining treatment; provided, however, that the facility shall notify the carrier of the admission
399 and the initial treatment plan within 72 hours of admission.

400 SECTION 31. Section 12 of said chapter 118E, as appearing in the 2018 Official Edition,
401 is hereby amended by adding the following paragraph:-

402 The division shall develop and implement a standard credentialing form for use by health
403 care providers applying to participate in MassHealth. The division, all contracted entities, health
404 maintenance organizations established under this section and any subcontracted entities shall
405 accept the standard credentialing form as sufficient information necessary to conduct its
406 credentialing process.

407 SECTION 32. Said chapter 118E is hereby further amended by adding the following 4
408 sections:-

409 Section 79. (a) The division, its managed care organizations, accountable care
410 organizations or other entity contracting with the division to manage or administer mental health
411 and substance use disorder benefits shall ensure that there are no separate non-quantitative
412 treatment limitations, referred to in this section as the non-quantitative treatment limitations, that
413 apply to mental health and substance use disorder benefits but do not apply to medical and
414 surgical benefits within any classification of benefits as defined under the federal Paul Wellstone
415 and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

416 (b) The division shall perform a behavioral health parity compliance examination of each
417 Medicaid managed care organization, accountable care organization or other entity contracted

418 with the agency that manages or administers mental health and substance use disorder benefits
419 for the division at least once every 24 months. The examination shall include examination of
420 entities that manage medical and surgical benefits, as necessary. The examination shall only
421 apply where the division is the primary payer. The examination shall include but not be limited
422 to:
423 (i) a description of the process used to develop or select the medical necessity criteria for
424 mental health and substance use disorder benefits and the process used to develop or select the
425 medical necessity criteria for medical and surgical benefits;
426 (ii) identification of all non-quantitative treatment limitations that are applied to mental
427 health and substance use disorder benefits and medical and surgical benefits within each
428 classification of benefits, as defined in 42 CFR Part 457.496(d)(2)(ii); and
429 (iii) the results of an analysis that demonstrates that for the medical necessity criteria
430 described in clause (i) and for each non-quantitative treatment limitation identified in clause (ii),
431 as written and in operation, the processes, strategies, evidentiary standards or other factors used
432 in applying the medical necessity criteria and each non-quantitative treatment limitation to
433 mental health and substance use disorder benefits within each classification of benefits are
434 comparable to, and are not applied more stringently than, the processes, strategies, evidentiary
435 standards or other factors used in applying the medical necessity criteria and each non-
436 quantitative treatment limitation to medical and surgical benefits within the corresponding
437 classification of benefits; provided, however, that, at a minimum, the results of the analysis shall:
438 (A) identify the factors used to determine that a non-quantitative treatment limitation will
439 apply to a benefit;

440 (B) identify any processes, strategies or evidentiary standards used to define the factors
441 identified in subclause (A);
442 (C) provide the comparative analyses, including the results of the analyses, performed to
443 determine that the processes and strategies used to design each non-quantitative treatment
444 limitation, as written, and the as-written processes and strategies used to apply the non-
445 quantitative treatment limitation to mental health and substance use disorder benefits are
446 comparable to, and are not applied more stringently than, the processes and strategies used to
447 design each non-quantitative treatment limitation, as written, and the as-written processes and
448 strategies used to apply the non-quantitative treatment limitation to medical and surgical
449 benefits;
450 (D) provide the comparative analyses, including the results of the analyses, performed to
451 determine that the processes and strategies used to apply each non-quantitative treatment
452 limitation, in operation, for mental health and substance use disorder benefits are comparable to,
453 and are not applied more stringently than, the processes or strategies used to apply each non-
454 quantitative treatment limitation, in operation, for medical and surgical benefits; and
455 (E) disclose the specific findings and conclusions reached by the division that the results
456 of the analyses under this clause indicate compliance with this section and the federal Paul
457 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as
458 amended, and federal guidelines and regulations relevant to the act, including, but not limited to,
459 42 CFR Part 457.496.
460 (c) In completing the analyses required under subsection (b), the division shall perform
461 the analyses broadly across each classification of benefits. The division may use any reasonable
462 method to determine how it selects medical and surgical benefits subject to an NQTL in the

463 classification of benefits for the purpose of performing the comparative analyses; provided, that
464 the division shall select all medical and surgical benefits sharing the same characteristics as the
465 mental health and substance use disorder benefits subject to the NQTL in a classification of
466 benefits for the purposes of performing the analyses.

467 (d) If federal guidance, including, but not limited to, the Self-Compliance Tool for the
468 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
469 2008, as amended, is released that indicates a non-quantitative treatment limitation analysis and
470 reporting process that is significantly different from, contrary to or more efficient than the non-
471 quantitative treatment limitation analysis and reporting requirements described in subsection (b),
472 the division may promulgate regulations that delineate a non-quantitative treatment limitation
473 analysis and reporting format that may be used in lieu of the non-quantitative treatment
474 limitation analysis and reporting requirements described in said subsection (b).

475 (e) Any proprietary information submitted to the general court by the division as a result
476 of the requirements in this section shall not be a public record under clause Twenty-sixth of
477 section 7 of chapter 4 or chapter 66.

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

483 (g) The division shall file an annual report with the clerks of the senate and house, the
484 joint committee on mental health, substance use and recovery and the house and senate chairs of

485 the joint committee on health care financing not later than July 1. The report shall include, but
486 not be limited to:
487 (i) the methodology the division is using to check for compliance with the federal Paul
488 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as
489 amended, and any federal regulations or guidance relevant to the act;
490 (ii) the methodology the division is using to check for compliance with section 80;
491 (iii) a breakdown of treatment authorization data for the division, and for each Medicaid
492 managed care organization, accountable care organization or other entity that manages or
493 administers benefits for the division, for mental health treatment services, substance use disorder
494 treatment services and medical and surgical treatment services for the immediately preceding
495 calendar year.
496 The treatment authorization data shall include, but not be limited to: (A) the number of
497 inpatient days, outpatient services and total number of services requested; (B) the number and
498 per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day
499 requests modified resulting in a lesser amount of inpatient days authorized than requested and the
500 reason for the modification, inpatient day requests denied and the reason for the denial, inpatient
501 day requests where an internal appeal was filed and approved, inpatient day requests where an
502 internal appeal was filed and denied, inpatient day requests where an external appeal was filed
503 and upheld and inpatient day requests where an external appeal was filed and overturned; and
504 (C) the number and per cent of outpatient service requests authorized, outpatient service requests
505 modified, outpatient service requests modified resulting in a lower amount of outpatient service
506 authorized than requested and the reason for the modification, outpatient service requests denied
507 and the reason for the denial, outpatient service requests where an internal appeal was filed and

508 approved, outpatient service requests where an internal appeal was filed and denied, outpatient
509 service requests where an external appeal was filed and upheld and outpatient service requests
510 where an external appeal was filed and overturned;
511 (iv) the number of complaints the division, or any Medicaid managed care organization,
512 accountable care organization or other entity contracting with the division to manage or
513 administer mental health and substance use disorder benefits, has received in the immediately
514 preceding calendar year regarding access to behavioral health services or compliance with parity
515 in mental health and substance use disorder benefits under state and federal laws and a summary
516 of all complaints resolved by the division, or any Medicaid managed care organization,
517 accountable care organization or other entity contracting with the division to manage or
518 administer mental health and substance use disorder benefits, during that time period; and
519 (v) information about any educational or corrective actions the division has taken to
520 ensure carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health
521 Parity and Addiction Equity Act of 2008, as amended, and section 80.
522 The summary report shall be written in non-technical, readily understandable language
523 and shall be made publicly available on the division's website.
524 Section 80. (a) The division and its health insurers, health plans, health maintenance
525 organizations, behavioral health management firms and third-party administrators under contract
526 with the division, a Medicaid managed care organization or a primary care clinician plan shall
527 provide mental health and substance use disorder benefits for the diagnosis and treatment of any
528 behavioral health disorder described in the most recent edition of the Diagnostic and Statistical
529 Manual of Mental Disorders published by the American Psychiatric Association that is approved

530 by the commissioner of mental health. The benefits shall be provided on a nondiscriminatory
531 basis.
532 (b) In addition to the mental health and substance use disorder benefits established
533 pursuant to this section, the division shall provide benefits on a non-discriminatory basis for
534 children and adolescents under the age of 19 for the diagnosis and treatment of mental,
535 behavioral, emotional or substance use disorders described in the most recent edition of the
536 Diagnostic and Statistical Manual of Mental Disorders that substantially interfere with or
537 substantially limit the functioning and social interactions of such a child or adolescent; provided,
538 however, that the interference or limitation is documented by and the referral for the diagnosis
539 and treatment is made by the primary care provider, primary pediatrician or a licensed mental
540 health professional of such a child or adolescent or is evidenced by conduct, including, but not
541 limited to: (i) an inability to attend school as a result of such a disorder; (ii) the need to
542 hospitalize the child or adolescent as a result of such a disorder; or (iii) a pattern of conduct or
543 behavior caused by such a disorder that poses a serious danger to self or others.
544 (c) For the purposes of this section, the division shall be deemed to be providing such
545 coverage on a non-discriminatory basis if the plan does not contain any annual or lifetime dollar
546 or unit of service limitation on coverage for the diagnosis and treatment of the mental disorders
547 that is less than any annual or lifetime dollar or unit of service limitation imposed on coverage
548 for the diagnosis and treatment of physical conditions.
549 (d) Benefits authorized pursuant to this section shall consist of a range of inpatient,
550 intermediate and outpatient services that shall permit medically necessary and active and
551 noncustodial treatment for the mental disorders to take place in the least restrictive clinically
552 appropriate setting. For purposes of this section, inpatient services may be provided in a general

553 hospital licensed to provide such services, in a facility under the direction and supervision of the
554 department of mental health, in a private mental hospital licensed by the department of mental
555 health or in a substance abuse facility licensed by the department of public health. Intermediate
556 services shall include, but not be limited to, Level III community-based detoxification, acute
557 residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or
558 approved by the department of public health or the department of mental health. Outpatient
559 services may be provided in a licensed hospital, a mental health or substance abuse clinic
560 licensed by the department of public health, a public community mental health center, a
561 professional office or as home-based services; provided, however, that services delivered in such
562 offices or settings are rendered by a licensed mental health professional.
563 (e) The division and its health insurers, health plans, health maintenance organizations,
564 behavioral health management firms and third-party administrators under contract with the
565 division, a Medicaid managed care organization or a primary care clinician plan shall not require,
566 as a condition to receiving benefits mandated by this section, consent to the disclosure of
567 information regarding services for mental disorders under different terms and conditions than
568 consent is required for disclosure of information for other medical conditions. A determination
569 by the division or its agents that services authorized pursuant to this section are not medically
570 necessary shall only be made by a mental health professional licensed in the appropriate
571 specialty related to such services and, where applicable, by a provider in the same licensure
572 category as the ordering provider; provided, however, that this subsection shall not apply to
573 denials of service resulting from an enrollee’s lack of coverage or use of a facility or professional
574 that has not entered into a negotiated agreement with the division or its agents. The benefits

575 provided by the division or its agents pursuant to this section shall meet all other terms and

576 conditions of the plan not inconsistent with state or federal law.

577 (f) Nothing in this section shall require the division to pay for mental health or substance

578 use disorder benefits or services that:

579 (i) are provided to a person who has third-party insurance;

580 (ii) are provided to a person who is presently incarcerated, confined or committed to a

581 jail, house of correction, prison or custodial facility in the department of youth services within

582 the commonwealth or a political subdivision of the commonwealth;

583 (iii) constitute educational services required to be provided by a school committee

584 pursuant to section 5 of chapter 71B;

585 (iv) constitute services provided by the department of mental health, or the department of

586 public health or the department of developmental services; or

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

588 Section 81. Notwithstanding any general or special law to the contrary, the office of

589 Medicaid shall seek a waiver and promulgate regulations in order to require the division and its

590 health insurers, health plans, health maintenance organizations, behavioral health management

591 firms and third-party administrators under contract with the division, a Medicaid managed care

592 organization or primary care clinician plan to meet the parity requirements described under the

593 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of

594 2008, as amended, and any federal guidance or regulations relevant to the act, including 42 CFR

595 438 Subpart K, 42 CFR 440.395 and 42 CFR 457.496, for all enrollees. For persons under the

596 age of 22, MassHealth and its agents may comply with this section by meeting the obligations

597 related to Early and Periodic Screening, Diagnostic and Treatment benefits under 42 CFR
598 457.496(b) or 440.395(c).
599 Section 82. Medical necessity and utilization management determinations for treatments
600 for substance use disorder or co-occurring mental illness and substance use disorder authorized
601 under this chapter shall be made in accordance with the criteria established by the American
602 Society of Addiction Medicine. No additional criteria may be used to make medical necessity or
603 utilization management determinations for treatments for substance use disorder or co-occurring
604 mental illness and substance use disorder, unless such criteria are less restrictive. Authorization
605 or coverage for treatment for substance use disorder or co-occurring mental illness and substance
606 use disorder shall not be denied by the division, or a Medicaid managed care organization,
607 accountable care organization or other entity that manages or administers mental health and
608 substance use disorder benefits for the division, on the basis that such treatment was authorized
609 or ordered by a court of law or other law enforcement agency. Any such authorization or order
610 for such services shall be considered a factor in support of coverage for such treatment.
611 SECTION 33. Chapter 123 of the General Laws is hereby amended by inserting after
612 section 2 the following section:-
613 Section 2A. The department shall establish within its regulations additional factors to be
614 considered when contracting for services in geographically-isolated communities, including, but
615 not limited to, travel and transportation, to ensure availability and access to services.
616 SECTION 34. Section 1 of chapter 175 of the General Laws, as appearing in the 2018
617 Official Edition, is hereby amended by inserting after the definition of "Domestic company" the
618 following definition:-

619 “Emergency services programs”, all programs subject to contract between the
620 Massachusetts Behavioral Health Partnership and nonprofit organizations for the provision of
621 community-based emergency psychiatric services, including, but not limited to, behavioral
622 health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per
623 week, through the following service components: (i) mobile crisis intervention services for
624 youth; (ii) mobile crisis intervention services for adults; (iii) emergency service provider
625 community-based locations; and (iv) adult community crisis stabilization services.
626 SECTION 35. Section 47B of said chapter 175, as so appearing, is hereby amended by
627 inserting after the word “specialist,”, in line 122, the following words:-, a clinician practicing
628 under the supervision of a licensed professional, and working towards licensure, in a clinic
629 licensed under chapter 111.
630 SECTION 36. Subsection (i) of said section 47B of said chapter 175 is hereby amended
631 by inserting after the second paragraph, as so appearing, the following paragraph:-
632 An insurer shall not deny coverage for any behavioral health service or any evaluation
633 and management office visit solely because the services were delivered on the same day and in
634 the same practice or facility.
635 SECTION 37. Said chapter 175 is hereby further amended by inserting after section
636 47LL the following 2 sections:-
637 Section 47MM. An individual policy of accident and sickness insurance issued under
638 section 108 that provides hospital expense and surgical expense insurance and any group blanket
639 or general policy of accident and sickness insurance issued under section 110 that provides
640 hospital expense and surgical expense insurance that is issued or renewed shall provide benefits
641 on a nondiscriminatory basis for medically necessary emergency service programs.

642 Section 47NN. For the purposes of this section, the following terms shall have the
643 following meanings unless the context clearly requires otherwise:
644 "Community-based acute treatment", 24-hour clinically managed mental health
645 diversionary or step-down services for children and adolescents that is usually provided as an
646 alternative to mental health acute treatment.
647 "Intensive community-based acute treatment", intensive 24-hour clinically managed
648 mental health diversionary or step-down services for children and adolescents that is usually
649 provided as an alternative to mental health acute treatment.
650 "Mental health acute treatment", 24-hour medically supervised mental health services
651 provided in an inpatient facility, licensed by the department of mental health, that provides
652 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
653 milieu.
654 Any policy, contract, agreement, plan or certificate of insurance issued, delivered or
655 renewed within the commonwealth, which is considered creditable coverage under section 1 of
656 chapter 111M, shall provide coverage for medically necessary mental health acute treatment,
657 community-based acute treatment and intensive community-based acute treatment and shall not
658 require a preauthorization before obtaining treatment; provided, however, that the facility shall
659 notify the carrier of the admission and the initial treatment plan within 72 hours of admission.
660 SECTION 38. Section 8A of chapter 176A of the General Laws, as appearing in the 2018
661 Official Edition, is hereby amended by inserting after the word "specialist", in line 125, the
662 following words:- , a clinician practicing under the supervision of a licensed professional, and
663 working towards licensure, in a clinic licensed under chapter 111.

664 SECTION 39. Subsection (i) of said section 8A of said chapter 176A is hereby amended
665 by inserting after the second paragraph, as so appearing, the following paragraph:-
666 A non-profit hospital service corporation shall not deny coverage for any behavioral
667 health service or any evaluation and management office visit solely because the services were
668 delivered on the same day in the same practice or facility.
669 SECTION 40. Said chapter 176A is hereby further amended by inserting after section
670 8NN the following 2 sections:-
671 Section 8OO. For the purposes of this section, the following terms shall have the
672 following meanings unless the context clearly requires otherwise:
673 "Community-based acute treatment", 24-hour clinically managed mental health
674 diversionary or step-down services for children and adolescents that is usually provided as an
675 alternative to mental health acute treatment.
676 "Intensive community-based acute treatment", intensive 24-hour clinically managed
677 mental health diversionary or step-down services for children and adolescents that is usually
678 provided as an alternative to mental health acute treatment.
679 "Mental health acute treatment", 24-hour medically supervised mental health services
680 provided in an inpatient facility, licensed by the department of mental health, that provides
681 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
682 milieu.
683 Any contract between a subscriber and the corporation under an individual or group
684 hospital service plan that is delivered, issued or renewed within the commonwealth shall provide
685 coverage for medically necessary mental health acute treatment, community-based acute
686 treatment and intensive community-based acute treatment and shall not require a

687 preauthorization before obtaining treatment; provided, however, that the facility shall notify the
688 carrier of the admission and the initial treatment plan within 72 hours of admission.
689 Any contract between a subscriber and the corporation under an individual or group
690 hospital service plan that is delivered, issued or renewed within the commonwealth shall provide
691 coverage for medically necessary community-based acute treatment services and shall not
692 require preauthorization before obtaining such services; provided, however, that the facility shall
693 notify the carrier of the admission and the initial treatment plan within 72 hours of admission.
694 Any contract between a subscriber and the corporation under an individual or group
695 hospital service plan that is delivered, issued or renewed within the commonwealth shall provide
696 coverage for medically necessary intensive community-based acute treatment services and shall
697 not require preauthorization before obtaining such services; provided, however, that the facility
698 shall notify the carrier of the admission and the initial treatment plan within 72 hours of
699 admission.
700 Section 8PP. A contract between a subscriber and the corporation under an individual or
701 group hospital service plan that is issued or renewed within or without the commonwealth shall
702 provide benefits on a nondiscriminatory basis for medically necessary emergency service
703 programs, as defined in section 1 of chapter 175.
704 SECTION 41. Section 4A of chapter 176B of the General Laws, as appearing in the 2018
705 Official Edition, is hereby amended by inserting after the word "specialist", in line 120, the
706 following words:- , a clinician practicing under the supervision of a licensed professional, and
707 working towards licensure, in a clinic licensed under chapter 111.
708 SECTION 42. Subsection (i) of said section 4A of said chapter 176B is hereby amended
709 by inserting after the second paragraph, as so appearing, the following paragraph:-

710 A non-profit medical service corporation shall not deny coverage for any behavioral
711 health service or any evaluation and management office visit solely because the services were
712 delivered on the same day in the same practice or facility.
713 SECTION 43. Said chapter 176B is hereby further amended by inserting after section
714 4NN the following 2 sections:-
715 Section 4OO. For the purposes of this section, the following terms shall have the
716 following meanings unless the context clearly requires otherwise:
717 "Community-based acute treatment", 24-hour clinically managed mental health
718 diversionary or step-down services for children and adolescents that is usually provided as an
719 alternative to mental health acute treatment.
720 "Intensive community-based acute treatment", intensive 24-hour clinically managed
721 mental health diversionary or step-down services for children and adolescents that is usually
722 provided as an alternative to mental health acute treatment.
723 "Mental health acute treatment", 24-hour medically supervised mental health services
724 provided in an inpatient facility, licensed by the department of mental health, that provides
725 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
726 milieu.
727 Any subscription certificate under an individual or group medical service agreement
728 delivered, issued or renewed within the commonwealth shall provide coverage for medically
729 necessary mental health acute treatment, community-based acute treatment, intensive
730 community-based acute treatment and shall not require a preauthorization before obtaining
731 treatment; provided, however, that the facility shall notify the carrier of the admission and the
732 initial treatment plan within 72 hours of admission.

733 Section 4PP. A subscription certificate under an individual or group medical service
734 agreement that is issued or renewed shall provide benefits on a nondiscriminatory basis for
735 medically necessary emergency service programs, as defined in section 1 of chapter 175.
736 SECTION 44. Section 4M of chapter 176G of the General Laws, as appearing in the
737 2018 Official Edition, is hereby amended by inserting after the word "specialist", in line 117, the
738 following words:- , a clinician practicing under the supervision of a licensed professional, and
739 working towards licensure, in a clinic licensed under chapter 111.
740 SECTION 45. Subsection (i) of said section 4M of said chapter 176G is hereby amended
741 by inserting after the second paragraph, as so appearing, the following paragraph:-
742 A health maintenance organization shall not deny coverage for any behavioral health
743 service or any evaluation and management office visit solely because the services were delivered
744 on the same day in the same practice or facility.
745 SECTION 46. Said chapter 176G is hereby further amended by inserting after section
746 4FF the following 2 sections:-
747 Section 4GG. For the purposes of this section, the following terms shall have the
748 following meanings unless the context clearly requires otherwise:
749 "Community-based acute treatment", 24-hour clinically managed mental health
750 diversionary or step-down services for children and adolescents that is usually provided as an
751 alternative to mental health acute treatment.
752 "Intensive community-based acute treatment", intensive 24-hour clinically managed
753 mental health diversionary or step-down services for children and adolescents that is usually
754 provided as an alternative to mental health acute treatment.

755 “Mental health acute treatment”, 24-hour medically supervised mental health services
756 provided in an inpatient facility, licensed by the department of mental health, that provides
757 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
758 milieu.
759 Any individual or group health maintenance contract that is issued or renewed shall
760 provide coverage for medically necessary mental health acute treatment, community-based acute
761 treatment and intensive community-based acute treatment and shall not require a
762 preauthorization before obtaining treatment; provided, however, that the facility shall notify the
763 carrier of the admission and the initial treatment plan within 72 hours of admission.
764 Section 4HH. A health maintenance contract that is issued or renewed shall provide
765 benefits on a nondiscriminatory basis for medically necessary emergency service programs, as
766 defined in section 1 of chapter 175.
767 SECTION 47. Chapter 176O of the General Laws is hereby amended by inserting after
768 section 5C the following section:-
769 Section 5D. For the purposes of this section, the term “base fee schedule” shall mean the
770 minimum rates, typically set forth in fee schedules, paid by the carrier to an in-network health
771 care provider who is not paid under an alternative payment arrangement for covered health care
772 services; provided, however, that final rates may be subject to negotiations or adjustments that
773 may result in payments to in-network providers that are different from the base fee schedule.
774 A carrier, directly or through any entity that manages or administers mental health or
775 substance use disorder benefits for the carrier, shall establish a base fee schedule for evaluation
776 and management services for behavioral health providers that is not less than the base fee
777 schedule used for evaluation and management services for primary care providers of the same or

778 similar licensure type and in the same geographic region; provided, however, that a carrier shall
779 not lower its base fee schedule for primary care providers to comply with this section.
780 The division shall promulgate regulations to implement this section.
781 SECTION 48. Subsection (b) of section 16 of chapter 176O of the General Laws, as
782 appearing in the 2018 Official Edition, is hereby amended by striking out the last sentence and
783 inserting in place thereof the following sentence:- If a carrier or utilization review organization
784 intends to implement a new medical necessity guideline or amend an existing requirement or
785 restriction, the carrier or utilization review organization shall ensure that the new guideline or
786 amended requirement or restriction shall not be implemented unless: (i) the carrier's or
787 utilization review organization's website has been updated to reflect the new or amended
788 requirement or restriction; and (ii) the carrier or utilization review organization has assessed the
789 limitation to show it is in compliance with state and federal parity requirements under chapter 26.
790 SECTION 49. Said section 16 of said chapter 176O, as so appearing, is hereby further
791 amended by adding the following subsection:-
792 (d) Medical necessity and utilization management determinations for treatments for
793 substance use disorder or co-occurring mental illness and substance use disorder shall be made in
794 accordance with the criteria established by the American Society of Addiction Medicine. No
795 additional criteria may be used to make medical necessity or utilization management
796 determinations for treatments for substance use disorder or co-occurring mental illness and
797 substance use disorder, unless such criteria are less restrictive. A carrier, or any entity that
798 manages or administers mental health and substance use disorder benefits for the carrier, shall
799 not deny authorization or coverage for treatment for substance use disorder or co-occurring
800 mental illness and substance use disorder on the basis that such treatment was authorized or

801 ordered by a court of law or other law enforcement agency. Such authorization shall be
802 considered a factor in support of coverage for such treatment, including as allowed under clause
803 (4) of subsection (a) of section 6 and clause (7) of subsection (a) of section 7.
804 SECTION 50. Said chapter 176O is hereby further amended by adding the following
805 section:-
806 Section 29. (a) The bureau of managed care shall develop and implement standard
807 credentialing forms for health care providers. A carrier, or any entity that manages or administers
808 benefits for a carrier, shall accept the standard credentialing form for contracting providers as
809 sufficient information necessary to conduct its credentialing process.
810 (b) The bureau shall promulgate regulations establishing uniform standards and
811 methodologies for credentialing of health care providers. The regulations shall include, but not
812 be limited to, requirements that, for conducting a credentialing review of a health care provider, a
813 carrier, or any entity that manages or administers benefits for a carrier, shall: (i) use and accept
814 only the credentialing forms designated by the commissioner; and (ii) review a submitted
815 credentialing form for a health care provider and respond to the health care provider within 20
816 business days after receiving a completed credentialing request.
817 Nothing in this section shall prohibit a carrier, or any entity that manages or administers
818 benefits for a carrier, from using a credentialing methodology that utilizes an internet webpage,
819 internet webpage portal or similar electronic, internet and web-based system in lieu of a paper
820 form; provided, however, that upon request, a carrier, or any entity that manages or administers
821 benefits for a carrier, shall make a paper credentialing form available to a health care provider.
822 (c) A carrier, or an entity that manages or administers benefits for a carrier, that contracts
823 with another entity to perform some or all of the functions governed by this chapter shall be

824 responsible for ensuring compliance by the contracted entity with this chapter. A failure by the
825 contracted entity to meet the requirements of this chapter shall be the responsibility of the carrier
826 to remedy and shall subject the carrier to enforcement actions, including financial penalties,
827 authorized under this chapter.
828 SECTION 51. There shall be, subject to appropriation, a pilot program administered by
829 the department of higher education, in consultation with the department of mental health, to
830 encourage a culturally, ethnically and linguistically diverse behavioral health workforce. The
831 program shall be a partnership between colleges and behavioral health providers in the
832 community and may be funded through the behavioral health outreach, access and support trust
833 fund established under section 2GGGGG of chapter 29 of the General Laws.
834 Participants shall attend graduate-level classes to receive academic credits toward a
835 master's degree in the field of behavioral health and receive a clinical placement by the college
836 providing the graduate-level classes. The college shall prioritize placements with community
837 providers serving high-need populations, including children, veterans, school-aged youth and
838 individuals with a co-morbidity. Not more than 12 months after the completion of the pilot , the
839 department of higher education shall file a report with the clerks of the senate and house of
840 representatives, the joint committee on higher education and the joint committee on mental
841 health, substance use and recovery that provides: (i) a description of the community partners
842 participating in the pilot; (ii) a summary of post-program employment or continuing education
843 plans of participating students; and (iii) any recommendations on ways to further encourage a
844 culturally, ethnically and linguistically diverse behavioral health workforce.
845 SECTION 52. For the purposes of this section, "community health center" shall mean a
846 community health center receiving a grant under 42 USC 254b.

847 Notwithstanding any general or special law to the contrary, there shall be a 24-month
848 psychiatric mental health nurse practitioner fellowship pilot program to recruit and retain
849 psychiatric mental health nurse practitioners at community health centers to increase access to
850 high-quality community-based behavioral health care for medically underserved populations.
851 The program shall be administered by the department of public health and the department may
852 work with an external partner selected through a competitive grant process.

853 To be considered for selection in the psychiatric mental health nurse practitioner
854 fellowship pilot program, a community health center shall, at a minimum: (i) provide and
855 administer a 24-month post-graduate fellowship program for certified psychiatric mental health
856 nurse practitioners who have graduated from an accredited school of nursing and obtained
857 relevant licensure from a national licensing body designated by the board of registration in
858 nursing within the past 18 months; (ii) provide psychiatric mental health nurse practitioners in
859 the program with patient panels under the preceptorship of a psychiatrist or psychiatric mental
860 health nurse practitioner who has been licensed and in clinical practice for not less than 12
861 months before the beginning of the preceptorship; and (iii) demonstrate strategies and supports
862 for psychiatric mental health nurse practitioners to continue careers in integrated primary and
863 behavioral health care models or other fields at community health centers.

864 Nothing in this section shall be interpreted to conflict with, replace or supersede any
865 licensure requirements or standards for the advanced nursing practice established pursuant to
866 chapters 94C or 112 of the General Laws.

867 The department shall make expenditures, subject to appropriation, to implement this
868 program and shall consult, to the extent possible, with the executive office of health and human
869 services to maximize available federal funding for the program including, but not limited to,

870 Medicaid reimbursement. The fellowship may be funded through the behavioral health outreach,
871 access and support trust fund established under section 2GGGGG of chapter 29 of the General
872 Laws.

873 Not later than July 31 following the disbursement of funding to eligible community
874 health centers, the department of public health, in conjunction with any external partner, shall
875 submit a report including data on the number of psychiatric mental health nurse practitioner
876 applicants, participant retention, care provided to patients in underserved populations and all
877 program expenditures to the secretary of health and human services, the secretary for
878 administration and finance, the joint committee on health care financing, the clerks of the senate
879 and house of representatives and the house and senate committees on ways and means.

880 SECTION 53. Notwithstanding any general or special law to the contrary, the department
881 of public health, in consultation with the department of mental health and the department of
882 elementary and secondary education, shall establish a pilot program to increase student access to
883 telebehavioral health services in schools. The program shall provide for a competitive grant
884 program to allow local providers to provide telebehavioral health services through interactive
885 video conferencing technology on-site at local public schools, which may be funded through the
886 behavioral health outreach, access and support trust fund established under section 2GGGGG of
887 chapter 29 of the General Laws.

888 Delivery of behavioral health services shall be provided by a licensed mental health
889 provider through live video conferencing between the provider and an individual student.
890 Participating schools and providers shall follow best practices and ensure the privacy of all
891 participating students.

892 The department shall, subject to appropriation, provide funding to assist with costs for
893 the participating students, public school and local providers. The department shall ensure that
894 participating providers seek third-party reimbursement for these services; provided, however,
895 that the inability of a student or family to pay for services shall not be a barrier to accessing the
896 program.

897 When identifying criteria for participating sites, the department of public health shall
898 consider: (i) the availability of affordable behavioral health services for school-aged youth within
899 the geographic region; and (ii) barriers within the geographic region that may prevent school-
900 aged youth from accessing services outside the school.

901 One year after the implementation of the pilot program, the department of public health
902 shall submit a report on the program's performance, including, but not limited to: (i) the number
903 of students participating in the program; (ii) the frequency with which students use the program;
904 (iii) the cost of the services provided, including the use of support staff; and (iv) the manner in
905 which costs have been supported by third-party reimbursement. The report shall be submitted to
906 the clerks of the senate and the house of representatives, the joint committee of mental health,
907 substance use and recovery, the joint committee on education and the house and senate
908 committees on ways and means.

909 SECTION 54. The office of health equity, in consultation with the department of public
910 health and the department of mental health, shall, subject to appropriation, conduct a study
911 assessing the availability of culturally competent behavioral health providers in the
912 commonwealth. The study may be conducted by an entity with a demonstrated capacity to
913 deliver research results passing an academic peer-review process in analyzing both quantitative
914 and qualitative data and to communicate study results in an accessible manner.

915 The study shall review the availability of culturally competent behavioral health
916 providers within networks of both public and private health care payers and identify potential
917 barriers to care for underserved cultural, ethnic and linguistic populations in the community. The
918 review shall include, but not be limited to: (i) the number of culturally competent and diverse
919 behavioral health providers that reflect the cultural, ethnic and linguistic population of the
920 community; (ii) the existence of culturally competent services; (iii) geographic challenges to
921 access culturally competent providers; (iv) training opportunities for providers to most
922 effectively serve diverse populations; and (v) consideration of the impact of gender, gender
923 identity, race, ethnicity, sexual orientation, linguistic barriers and social determinants of health
924 on access to behavioral health services.
925 Pursuant to memorandums of understanding with the center for health information and
926 analysis established under chapter 12C of the General Laws, the group insurance commission
927 established under chapter 32A of the General Laws and MassHealth established under chapter
928 118E of the General Laws, respectively, the office shall receive data to complete the charge of
929 this study.
930 Not later than March 15, 2021, the office shall submit the study's findings with clerks of
931 the senate and house of representatives, the joint committee on mental health, substance use and
932 recovery, the joint committee on public health and the joint committee on health care financing.
933 SECTION 55. The interagency health equity team, as supported through the office of
934 health equity, shall, in consultation with the advisory council appointed in this section, study
935 ways to improve access to, and the quality of, culturally competent behavioral health services.
936 The review shall include, but not be limited to: (i) the need for greater racial, ethnic and
937 linguistic diversity within the behavioral health workforce; (ii) the role of gender, gender

938 identity, race, ethnicity, linguistic barriers, sexual orientation and social determinants of health
939 regarding behavioral health needs; and (iii) any other factors identified by the team that create
940 disparities in access and quality within the existing behavioral health service delivery system,
941 including stigma, transportation and cost.

942 The advisory council shall consist of: the chairs of the joint committee on mental health,
943 substance use and recovery; the chair of the Black and Latino Caucus or a designee; and the
944 following members to be appointed by the commissioner of public health, 1 of whom shall be a
945 local public health official representing a majority-minority municipality, 1 of whom shall be a
946 representative of a racial or ethnic equity advocacy group, 1 of whom shall be a representative of
947 a linguistic equity advocacy group, 1 of whom shall be a licensed behavioral health provider, 1
948 of whom shall be a representative of a mental health advocacy group, 1 of whom shall be a
949 representative of an organization serving the health care needs of the lesbian, gay, bisexual,
950 transgender, queer and questioning community, 1 of whom shall be a representative of an
951 organization serving the health care needs of individuals experiencing housing insecurity and 1
952 of whom shall be an individual with expertise in school-based mental health services.

953 The team shall meet not less than quarterly with the advisory council. Not later than
954 March 30, 2021 and annually for the following 3 years at the close of the fiscal year, the team
955 shall issue a report with legislative, regulatory or budgetary recommendations to improve the
956 access and quality of culturally competent mental and behavioral health services.

957 The office of health equity, the department of mental health and the department of public
958 health may, subject to appropriation, provide administrative, logistical and research support to
959 produce the report.

960 SECTION 56. The health policy commission, in consultation with the division of
961 insurance, shall review the role of behavioral health managers, as defined in section 1 of chapter
962 176O of the General Laws, within the health care delivery system. The commission shall review:
963 (i) oversight practices by other states on behavioral health managers; (ii) the effects of behavioral
964 health manager state licensure, regulation or registration on access to behavioral health services;
965 (iii) other aspects of behavioral health managers as deemed appropriate by the commission.
966 Not later than January 1, 2021, the health policy commission shall file a report of its
967 findings with the clerks of the senate and house of representatives, the joint committee on health
968 care financing, the joint committee on mental health, substance use and recovery and the joint
969 committee on financial services.
970 SECTION 57. Notwithstanding any special or general law to the contrary, there shall be a
971 special commission to study and make recommendations on the establishment of a common set
972 of criteria for providers and payers to use in making medical necessity determinations for
973 behavioral health treatment.
974 The commission shall consist of the following members or their designees: the
975 commissioner of mental health, who shall serve as chair; the commissioner of insurance; the
976 director of the bureau of substance addiction services within the department of public health; the
977 assistant secretary for MassHealth; the executive director of the group insurance commission;
978 and the following members to be appointed by the chair: 1 of whom shall be a representative of
979 the health policy commission; 2 of whom shall be representatives of the Massachusetts
980 Psychiatric Society, Inc., 1 of whom shall specialize in the treatment of children; 2 of whom
981 shall be representatives of the Massachusetts Psychological Association, Inc., 1 of whom shall
982 specialize in the treatment of children; 1 of whom shall be a representative of the Massachusetts

983 Society of Addiction Medicine, Inc.; 1 of whom shall be a representative of the National
984 Association of Social Workers, Inc.; 1 of whom shall be a representative of the Massachusetts
985 Mental Health Counselors Association, Inc.; 1 of whom shall be a representative of the
986 Children's Mental Health Campaign; 1 of whom shall be a representative of the Association for
987 Behavioral Healthcare, Inc.; 1 of whom shall be a representative of the Massachusetts
988 Association of Behavioral Health Systems, Inc.; 1 of whom shall be a representative of the
989 Massachusetts Association for Mental Health, Inc.; 1 of whom shall be a representative of the
990 National Alliance on Mental Illness of Massachusetts, Inc.; 1 of whom shall be a representative
991 of the Massachusetts Organization for Addiction Recovery, Inc.; 1 of whom shall be a
992 representative of Blue Cross and Blue Shield of Massachusetts, Inc.; and 1 of whom shall be a
993 representative of the Massachusetts Association of Health Plans, Inc..
994 The commission's review shall include, but not be limited to: (i) existing reference
995 sources or services utilized by payers to make medical necessity determinations for behavioral
996 health treatment, including, but not limited to American Society of Addiction Medicine,
997 InterQual and Milliman; (ii) commonly accepted treatment guidelines and standards of care
998 utilized by behavioral health providers and the evidentiary basis for those guidelines and
999 standards; (iii) the feasibility of establishing a common set of medical necessity criteria that
1000 behavioral health providers and payers can agree to and any barriers to this task; and (iv)
1001 experiences of other states addressing the standardization of medical necessity for behavioral
1002 health.
1003 The commission shall submit its findings and recommendations, together with drafts of
1004 legislation or regulations necessary to carry those recommendations into effect, to the clerks of

1005 the senate and house of representatives and the joint committee on mental health, substance use
1006 and recovery not later than 1 year after the effective date of this act.
1007 SECTION 58. The division of insurance shall promulgate regulations to implement
1008 section 5D of chapter 176O of the General Laws not later than 1 year from the effective date of
1009 this act; provided, further that the division shall, upon publication, forward any draft regulations
1010 to the joint committee on health care financing and joint committee on mental health, substance
1011 use and recovery.
1012 SECTION 59. The center for health information and analysis shall revise regulations
1013 relative to reporting requirements under sections 8, 9 and 10 of chapter 12C of the General Laws
1014 to implement section 4 within 6 months of the effective date of this act.
1015 SECTION 60. The department of public health shall promulgate regulations to implement
1016 section 51¾ of chapter 111 of the General Laws not later than October 1, 2020.
1017 SECTION 61. Sections 16, 17, 30, 34, 37, 38, 40, 43 and 46 shall apply to contracts
1018 entered into or reviewed on or after July 1, 2020.
1019 SECTION 62. Sections 5 to 12, inclusive, sections 19 to 24, inclusive and section 29
1020 shall take effect July 1, 2020.
1021 SECTION 63. Sections 47, 49 of the act and section 82 of chapter 118E of the General
1022 Laws shall take effect 1 year after the effective date of this act.