SENATE . . . . No. 2572

The Commonwealth of Massachusetts

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

SENATE, November 9, 2021.

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

For the committee,
Michael J. Rodrigues

FILED ON: 11/9/2021

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

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

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

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

6 "Awaiting residential disposition", waiting not less than 72 hours to be moved from an
7 acute level of psychiatric care to a less intensive or less restrictive, clinically-appropriate level of
8 psychiatric care.

9 "Boarding", waiting not less than 12 hours to be placed in an appropriate therapeutic
10 setting after: (i) being assessed; (ii) determined to be in need of acute psychiatric treatment, crisis
11 stabilization unit placement, community-based acute treatment, intensive community-based acute
12 treatment, continuing care unit placement or post-hospitalization residential placement; and (iii)

13 receiving a determination from a licensed health care provider to be medically stable without
14 needing urgent medical assessment or hospitalization for a physical condition.

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

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

25 (c) The online portal shall include, but not be limited to, the following data: (i) the total
26 number of children and adolescents boarding, including a breakdown, by location, of where the
27 children and adolescents are boarding, which may include, but shall not be limited to, hospital
28 emergency rooms, emergency services sites, medical floors after having received medical
29 stabilization treatment or their homes; (ii) the total number of children and adolescents awaiting
30 residential disposition, including a breakdown, by facility type, of where children and
31 adolescents are awaiting residential disposition and the level of care or type of placement sought;
32 and (iii) the total number of children and adolescents in the care or custody of a state agency who
33 are hospitalized and have waited not less than 72 hours for discharge to an appropriate foster

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

36 (d) For each category of data included under subsection (c), the online portal shall
37 include: (i) the average wait time for discharge to the appropriate level of care or placement; (ii)
38 the level of care required as determined by a licensed health care provider; (iii) the primary
39 behavioral health diagnosis and any co-morbidities relevant for the purposes of placement; (iv)
40 the primary reason for boarding, awaiting residential disposition or, for children and adolescents
41 in the care or custody of a state agency, for having waited not less than 72 hours for discharge to
42 an appropriate foster home or a congregate or group care program after an assessment that
43 hospital-level care is no longer necessary; (v) whether the children and adolescents are in the
44 care or custody of the department of children and families or the department of youth services or
45 are eligible for services from the department of mental health or the department of
46 developmental services; (vi) data on the insurance coverage type for the children and
47 adolescents; and (vii) data on the ages, race, ethnicity, preferred spoken languages and gender of
48 the children and adolescents.

49 (e) The online portal shall include information on the specific availability of pediatric
50 acute psychiatric beds, crisis stabilization unit beds, community-based acute treatment beds,
51 intensive community-based acute treatment beds, continuing care beds and post-hospitalization
52 residential beds. The online portal shall also enable a real-time bed search within a specified
53 geographic region that shall include, but not be limited to: (i) the total number of beds licensed
54 by the department of mental health, the department of public health and the department of early
55 education and care; (ii) the total number of available beds, broken down by licensing authority
56 and age ranges; (iii) the average daily bed availability, broken down by licensing authority and

57 age ranges; (iv) daily bed admissions, broken down by licensing authority and age ranges; (v) the
58 facility or location in which a child or adolescent was admitted; (vi) daily bed discharges, broken
59 down by licensing authority and age ranges; and (vii) the average length of stay in a bed, broken
60 down by licensing authority and age ranges.

61 (f) Quarterly, not later than 14 days after the end of the preceding quarter, the secretary
62 shall report on the status of children and adolescents who are boarding, awaiting residential
63 disposition or in the care or custody of a state agency and awaiting discharge to an appropriate
64 foster home or a congregate or group care program. The report shall include a summary and
65 assessment of the data published on the online portal under subsections (c) to (e), inclusive, for
66 the immediately preceding quarter and may include a summary and assessment of the data over
67 several quarters; provided, however, that the report shall present the data in an aggregate and de-
68 identified form. The report shall be submitted to the children's behavioral health advisory
69 council established in section 16Q, the office of the child advocate, the health policy
70 commission, the clerks of the senate and the house of representatives, the joint committee on
71 health care financing, the joint committee on mental health, substance use and recovery, the joint
72 committee on children, families and persons with disabilities and the senate and house
73 committees on ways and means.

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

76 (b) The secretary of health and human services shall facilitate psychiatric and substance
77 use disorder inpatient admissions for adults seeking to be admitted from an emergency
78 department or hospital medical floor by developing and maintaining a confidential and secure

79 online portal that enables health care providers, health care facilities and payors to conduct a
80 real-time bed search for patient placement. The online portal shall provide real-time information
81 on the specific availability of all licensed psychiatric and substance use disorder inpatient beds
82 that shall include, but not limited to: (i) location; (ii) care specialty; and (iii) insurance
83 requirements. The online portal and information contained in the online portal shall not be a
84 public record under clause Twenty-sixth of section 7 of chapter 4 or under chapter 66.

85 SECTION 2. Said chapter 6A is hereby further amended by inserting after section 16DD
86 the following section:-

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

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

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

105 (c) The office shall: (i) facilitate the development of interagency initiatives that: (A) are
106 informed by the science of promotion and prevention; (B) advance health equity and trauma-
107 informed care; and (C) address the social determinants of health; (ii) develop and implement a
108 comprehensive plan to strengthen community and state-level promotion programming and
109 infrastructure through training, technical assistance, resource development and dissemination and
110 other initiatives; (iii) advance the identification and dissemination of evidence-based practices
111 designed to further promote behavioral health and the provision of supportive behavioral health
112 services and programming to address substance use conditions and associated disability; (iv)
113 collect and analyze data measuring population-based indicators of behavioral health from
114 existing data sources, track changes over time and make programming and policy
115 recommendations to address the needs of populations at greatest risk; (v) coordinate behavioral
116 health promotion and wellness programs, campaigns and initiatives; and (vi) provide staffing
117 support for the commission on community behavioral health promotion established in section
118 219 of chapter 6. The office may enter into service agreements with the department of mental
119 health or the department of public health to fulfill the obligations of the office.

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

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

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

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

132 SECTION 5 Section 16 of said chapter 6D, as so appearing, is hereby amended by
133 inserting after the figure "176O", in line 66, the following words:- , including a process for
134 identifying and referring matters to the division of insurance and the office of the attorney
135 general for review of compliance with state and federal mental health and substance use disorder
136 parity laws.

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

139 Section 20. Every 5 years, the commission, in collaboration with the department of public
140 health, the department of mental health and the department of developmental services, shall
141 prepare a pediatric behavioral health planning report analyzing the status of pediatric behavioral
142 health in the commonwealth. The report shall include, but not be limited to: (i) a review of data
143 from the online portal established in section 16P of chapter 6A and the reports submitted to the
144 commission pursuant to subsection (f) of said section 16P of said chapter 6A; (ii) an analysis of
145 the availability of pediatric acute psychiatric beds, crisis stabilization unit beds, community-

146 based acute treatment beds, intensive community-based acute treatment beds, continuing care
147 unit beds and post-hospitalization residential beds, broken down by geographic region and by
148 sub-specialty, and an identification of any service limitations; (iii) an analysis of the capacity of
149 the pediatric behavioral health workforce to respond to the acute behavioral health needs of
150 children and adolescents across the commonwealth; (iv) any statutory, regulatory or operational
151 factors that may impact pediatric boarding under said section 16P of said chapter 6A; and (v) any
152 other information deemed relevant by the commission. The report shall be published on the
153 commission's website.

154 Section 21. The commission shall develop a standard release form for exchanging
155 confidential mental health and substance use disorder information. The standard release form
156 shall be available in electronic and paper format and shall be accepted and used by all public and
157 private agencies, departments, corporations, provider organizations and licensed professionals
158 involved with the treatment of an individual experiencing mental illness, serious emotional
159 disturbance or substance use disorder. The commission shall promulgate regulations for the
160 proper use of the standard release form that shall comply with federal and state laws relating to
161 the protection of individually identifiable health information.

162 SECTION 7. Section 16 of chapter 12C of the General Laws, as appearing in the 2020
163 Official Edition, is hereby amended by striking out, in lines 41 to 43, inclusive, the words "and
164 (11) the impact of health care payment and delivery reform on the quality of care delivered in the
165 commonwealth" and inserting in place thereof the following words:- (11) the impact of health
166 care payment and delivery reform on the quality of care delivered in the commonwealth; and
167 (12) costs, cost trends, price, quality, utilization and patient outcomes related to behavioral health
168 service subcategories described in section 21A.

169 SECTION 8. Section 21A of said chapter 12C, as so appearing, is hereby amended by
170 adding the following sentence:- The investigation and study shall also include developing and
171 defining criteria for health care services to be categorized as behavioral health services, with
172 subcategories including, but not limited to: (i) mental health; (ii) substance use disorder; (iii)
173 outpatient; (iv) inpatient; (v) services for children; (vi) services for adults; and (vii) provider
174 type.

175 SECTION 9. Chapter 13 of the General Laws is hereby amended by striking out section
176 80, as so appearing, and inserting in place thereof the following section:-

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

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

193 Any qualifying student health insurance plan authorized under this chapter shall comply
194 with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity
195 Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including
196 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part
197 156.115(a)(3), and the benefit mandates and other obligations under section 47B of chapter 175,
198 section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter
199 176G, as if the student health insurance plan was issued by such carriers licensed under said
200 chapters 175, 176A, 176B and 176G without regard to any limitation under section 1 of chapter
201 176J.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

345 (j) Nothing in this section shall limit: (i) the rights of parents, legal guardians or children
346 under chapter 71B, the Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq., or
347 section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 et seq; or (ii) the rights of parents
348 under state or federal law to make decisions about a child's health care.

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

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

354 SECTION 13. Chapter 26 of the General Laws is hereby amended by striking out section
355 8K, as appearing in the 2020 Official Edition, and inserting in place thereof the following
356 section:-

357 Section 8K. (a) The commissioner of insurance shall implement and enforce applicable
358 provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction
359 Equity Act of 2008, as amended, any federal guidance or regulations relevant to the act,
360 including 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part
361 156.115(a)(3), and applicable state mental health parity laws, including, but not limited to,
362 section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and sections
363 4, 4B and 4M of chapter 176G, in regard to any carrier licensed under said chapters 175, 176A,
364 176B or 176G or any carrier offering a student health plan issued under section 18 of chapter
365 15A by:

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

369 (ii) performing behavioral health parity compliance market conduct examinations of each
370 carrier not less than once every 36 months, or more frequently if noncompliance is suspected,
371 with a focus on: (A) nonquantitative treatment limitations under the federal Paul Wellstone and
372 Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and
373 applicable state mental health and substance use disorder parity laws, including, but not limited
374 to, prior authorization, concurrent review, retrospective review, step-therapy, network admission
375 standards, reimbursement rates, network adequacy and geographic restrictions; (B) denials of
376 authorization, payment and coverage; and (C) any other criteria determined by the division of
377 insurance, including factors identified through consumer or provider complaints; provided,
378 however, that: (1) a market conduct examination of a carrier subject to said chapter 175, 176A,
379 176B or 176G shall follow the procedural requirements in subsections 10, 11 and 15 of section 4
380 of said chapter 175 regarding notice and rebuttal of examination findings, subsequent hearings
381 and conflicts of interest; (2) the commissioner shall publicize the fees for a market conduct
382 examination under section 3B of chapter 7 and said subsection 11 of said section 4 of said
383 chapter 175; and (3) nothing contained in clause (ii) or in said section 4 of said chapter 175,
384 section 7 of said chapter 176A, section 9 of said chapter 176B and section 10 of said chapter
385 176G shall limit the commissioner's authority to use and, if appropriate, publish any final or
386 preliminary examination report, any examiner or company work papers or other documents or
387 any other information discovered or developed during the course of any examination in the

388 furtherance of any legal or regulatory action that the commissioner may, in their sole discretion,
389 deem appropriate;

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

394 (iv) updating applicable regulations as necessary to effectuate any provisions of the
395 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
396 2008, as amended that relate to insurance; and

397 (v) assessing a fee upon any carrier for the costs and expenses incurred in any market
398 conduct examination authorized by law, consistent with the costs associated with the use of
399 division personnel and examiners, the costs of retaining qualified contract examiners necessary
400 to perform an examination, electronic data processing costs, supervision and preparation of an
401 examination report and lodging and travel expenses; provided, however, that the commissioner
402 shall maintain active management and oversight of examination costs and fees to ensure that the
403 examination costs and fees comply with the National Association of Insurance Commissioners
404 market conduct examiners handbook unless the commissioner demonstrates that the fees
405 prescribed in the handbook are inadequate under the circumstances of the examination; and
406 provided further, that the commissioner or the commissioner's examiners shall not receive or
407 accept any additional emolument on account of any examination.

408 (b) The commissioner may impose a penalty against a carrier that provides mental health
409 or substance use disorder benefits, directly or through a behavioral health manager as defined in

410 section 1 of chapter 176O or any other entity that manages or administers such benefits for the
411 carrier, for any violation by the carrier or the entity that manages or administers mental health
412 and substance use disorder benefits for the carrier of state laws related to mental health and
413 substance use disorder parity or the mental health parity provisions of the federal Paul Wellstone
414 and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j),
415 as amended, and federal guidance or regulations issued under the act.

416 The amount of any penalty imposed shall be $100 for each day in the noncompliance
417 period per product line with respect to each participant or beneficiary to whom such violation
418 relates; provided, however, that the maximum annual penalty under this subsection shall be
419 $1,000,000; provided further, that for purposes of this subsection, the term "noncompliance
420 period" shall mean the period beginning on the date a violation first occurs and ending on the
421 date the violation is corrected.

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

425 (c) If a violation of state laws related to mental health and substance use disorder parity
426 or the mental health parity provisions of the federal Paul Wellstone and Pete Domenici Mental
427 Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as amended, and federal
428 guidance or regulations issued under the act, was likely to have caused denial of access to
429 behavioral health services, the commissioner shall require carriers to provide remedies for any
430 failure to meet the requirements of state laws related to mental health and substance use disorder
431 parity or the mental health parity provisions of the federal Paul Wellstone and Pete Domenici

432 Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as amended, and
433 federal guidance or regulations issued under the act, which may include, but shall not be limited
434 to:

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

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

438 (iii) informing plan members of changes;

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

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

444 (d) Any proprietary information submitted to the commissioner by a carrier as a result of
445 the requirements of this section shall not be a public record under clause Twenty-sixth of section
446 7 of chapter 4 or chapter 66; provided, however, that the commissioner may produce reports
447 summarizing any findings.

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

451 (f) The commissioner shall evaluate and resolve a consumer complaint alleging a
452 carrier's non-compliance with a state or federal law related to mental health and substance use

453 disorder parity, including any matters referred to the commissioner by the office of patient
454 protection under subsection (g) of section 14 of chapter 176O. A consumer complaint may be
455 submitted orally or in writing; provided, however, that an oral complaint shall be followed by a
456 written submission to the commissioner that shall include, but not be limited to, the
457 complainant's name and address, the nature of the complaint and the complainant's signature
458 authorizing the release of any information regarding the complaint to help the commissioner with
459 the review of the complaint; and provided further, that the commissioner shall create a process
460 for a consumer to request the appointment of an authorized representative to act on the
461 consumer's behalf.

462 The commissioner shall review consumer complaints under this subsection using the
463 legal standards pertaining to quantitative treatment limitations and nonquantitative treatment
464 limitations under applicable state and federal mental health and substance use disorder parity
465 laws, regulations and guidance, including, but not limited to, 45 CFR Part 146.136 and 29 C.F.R.
466 § 2590.712. When reviewing the complaint, the commissioner shall consider: (i) any related right
467 to a treatment or service under any related state or federal law or regulation; (ii) written
468 documents submitted by the complainant; (iii) medical records and medical opinions by the
469 complainant's treating provider that requested or provided a disputed service, which shall be
470 obtained by the complainant's carrier or by the commissioner if the carrier fails to do so; (iv) the
471 relevant results of any behavioral health parity compliance market conduct examination
472 conducted and completed under clause (ii) of subsection (a); (v) any relevant information
473 included in a carrier's annual reporting requirements under section 8M; (vi) additional
474 information from the involved parties or outside sources that the commissioner deems necessary
475 or relevant; and (vii) information obtained from any informal meeting held by the commissioner

476 with the parties. The commissioner shall send final written disposition of the complaint and the
477 reasons for the commissioner's decision to the complainant and the carrier not more than 90 days
478 after the receipt of the written complaint. If the commissioner determines that a violation of a
479 state or federal mental health and substance use disorder parity law occurred, the commissioner
480 shall exercise its enforcement authority under subsections (b) and (c).

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

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

487 (h) Nothing in this section shall prevent the commissioner from publishing any
488 illustrative utilization review criteria, medical necessity standard, clinical guideline or other
489 policy, procedure, criteria or standard, regardless of its origin, as an example of the type of
490 policy, procedure, criteria or standard that contributes to a violation of state or federal law parity
491 requirements, including any document that would normally be subject to disclosure to plan
492 members or their providers under section 16 of chapter 6D, section 16 of chapter 176O or the
493 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
494 2008, as amended.

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

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

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

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

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

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

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

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

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

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

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

534 compliance with mental health parity requirements.

535 (b) If federal guidance, including, but not limited to, the Self-Compliance Tool for the
536 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
537 2008, as amended, is released that indicates a nonquantitative treatment limitation analysis
538 process and reporting format that is significantly different from, contrary to or more efficient
539 than the nonquantitative treatment limitation analysis process and reporting format requirements

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

544 (c) Any proprietary portions of information submitted to the commissioner by a carrier as
545 a result of the requirements of this section shall not be a public record under clause Twenty-sixth
546 of section 7 of chapter 4 or chapter 66; provided, however, that: (i) the commissioner may
547 produce reports summarizing any findings; (ii) nothing in this section shall limit the authority of
548 the commissioner to use and, if appropriate, publish any final or preliminary examination report,
549 examiner or company work papers or other documents or other information discovered or
550 developed during the course of an examination in the furtherance of any legal or regulatory
551 action that the commissioner may, in their sole discretion, deem appropriate; and (iii) nothing in
552 this section shall prevent the commissioner of insurance from publishing any illustrative
553 utilization review criteria, medical necessity standard, clinical guideline or other policy,
554 procedure, criteria or standard, regardless of its origin, as an example of the type of policy,
555 procedure, criteria or standard that contributes to a violation of state or federal law parity
556 requirements, including any document that would normally be subject to disclosure to plan
557 members or their providers under section 16 of chapter 6D, section 16 of chapter 176O or under
558 the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
559 2008, as amended.

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

563 recovery and the joint committee on health care financing; provided, that the summary shall

564 include, but not be limited to:

565 (i) the methodology the commissioner is using to check for compliance with the federal

566 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as

567 amended, and any federal guidance or regulations relevant to the act;

568 (ii) the methodology the commissioner is using to check for compliance with section 47B

569 of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and section 4M of

570 chapter 176G;

571 (iii) the report of each market conduct examination conducted or completed during the

572 immediately preceding calendar year regarding access to behavioral health services or

573 compliance with parity in mental health and substance use disorder benefits under state and

574 federal laws and any actions taken as a result of such market conduct examinations;

575 (iv) a breakdown of treatment authorization data for each carrier for mental health

576 treatment services, substance use disorder treatment services and medical and surgical treatment

577 services for the immediately preceding calendar year indicating for each treatment service: (A)

578 the number of inpatient days, outpatient services and total services requested; (B) the number

579 and per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day

580 requests modified resulting in a lower amount of inpatient days authorized than requested and the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

628 Section 22A. For the purposes of this section, "psychiatric collaborative care model"
629 shall mean the evidence-based, integrated behavioral health service delivery method described in
630 81 FR 80230.

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

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

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

644 (ii) performing audits of each of the commission's health benefit plans at least once every
645 36 months, or more frequently if noncompliance is suspected, with a focus on: (A)
646 nonquantitative treatment limitations under the federal Paul Wellstone and Pete Domenici
647 Mental Health Parity and Addiction Equity Act of 2008, as amended, and applicable state mental

648 health and substance use disorder parity laws, including, but not limited to, prior authorization,
649 concurrent review, retrospective review, step-therapy, network admission standards,
650 reimbursement rates, network adequacy and geographic restrictions; (B) denials of authorization,
651 payment and coverage; and (C) any other criteria determined by the commission, including
652 factors identified through consumer or provider complaints;

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

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

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

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

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

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

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

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

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

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

691 2008, as amended, is released that indicates a nonquantitative treatment limitation analysis
692 process and reporting format that is significantly different from, contrary to or more efficient
693 than the nonquantitative treatment limitation analysis process and reporting format requirements
694 described in subsection (b), the commission may revise the analysis and reporting requirements
695 described in said subsection (b).

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

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

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

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

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

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

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

722 SECTION 17. Said chapter 32A is hereby further amended by adding the following 2
723 sections:-

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

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

730 "Licensed mental health professional", a licensed physician who specializes in the
731 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
732 licensed mental health counselor, a licensed supervised mental health counselor, a licensed nurse

733 mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1
734 of chapter 111J, or a licensed marriage and family therapist within the lawful scope of practice
735 for such therapist.

736 "Mental health wellness examination", a screening or assessment that seeks to identify
737 any behavioral or mental health needs and appropriate resources for treatment. The examination
738 may include: (i) observation, a behavioral health screening, education and consultation on
739 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
740 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
741 screenings or observations to understand a covered person's mental health history, personal
742 history and mental or cognitive state and, when appropriate, relevant adult input through
743 screenings, interviews and questions.

744 "Primary care provider", a health care professional qualified to provide general medical
745 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise
746 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
747 maintains continuity of care within the scope of practice.

748 (b) Any coverage offered by the commission to an active or retired employee of the
749 commonwealth insured under the group insurance commission shall provide coverage for an
750 annual mental health wellness examination that is performed by a licensed mental health
751 professional or primary care provider, which may be provided by the primary care provider as
752 part of an annual preventive visit. The examination shall be covered with no patient cost-
753 sharing.

754 SECTION 18. Section 25C½ of chapter 111 of the General Laws, as appearing in the
755 2020 Official Edition, is hereby amended by striking out, in line 28, the word "or".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

842 The division and its contracted health insurers, health plans, health maintenance
843 organizations, behavioral health management firms and third-party administrators under contract
844 to a Medicaid managed care organization or primary care clinician plan shall provide coverage
845 for mental health or substance use disorder services that are delivered through the psychiatric
846 collaborative care model.

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

849 "Licensed mental health professional", a licensed physician who specializes in the
850 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
851 licensed mental health counselor, a licensed supervised mental health counselor, a licensed nurse
852 mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1
853 of chapter 111J, or a licensed marriage and family therapist within the lawful scope of practice
854 for such therapist.

855 "Mental health wellness examination", a screening or assessment that seeks to identify
856 any behavioral or mental health needs and appropriate resources for treatment. The examination
857 may include: (i) observation, a behavioral health screening, education and consultation on
858 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
859 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
860 screenings or observations to understand a covered person's mental health history, personal

861 history and mental or cognitive state and, when appropriate, relevant adult input through
862 screenings, interviews and questions.

863 "Primary care provider", a health care professional qualified to provide general medical
864 care for common health care problems who: (i) supervises, coordinates, prescribes or otherwise
865 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
866 maintains continuity of care within the scope of practice.

867 (b) The division shall provide coverage for an annual mental health wellness examination
868 that is performed by a licensed mental health professional or primary care provider, which may
869 be provided by the primary care provider as part of an annual preventive visit. The examination
870 shall be covered with no patient cost-sharing.

871 SECTION 28. Section 47 of said chapter 118E, as appearing in the 2020 Official Edition,
872 is hereby amended by inserting after the first paragraph the following paragraph:-
873 Notwithstanding any general or special law to the contrary, the division shall promulgate
874 regulations that require the division, its contracted health insurers, health plans, health
875 maintenance organizations, behavioral health management firms and third-party administrators
876 under contract with the division, a Medicaid managed care organization or primary care clinician
877 plan, to maintain documentation of all requests for benefits or services, whether the request is
878 submitted by, or on behalf of, the intended recipient of those benefits or services. Any request
879 that is not fulfilled in full shall be considered a denial and shall result in the prompt written
880 notification to the intended recipient through electronic means, if possible. The notification shall
881 include a description of the requested service, the response by the entity and the intended

882 recipient's due process and appeal rights. All such entities shall accept requests for authorized
883 representatives or for appeals by electronic means.

884 SECTION 29. Said chapter 118E is hereby further amended by adding the following 4
885 sections:-

886 Section 80. (a) The division, its managed care organizations, accountable care
887 organizations or other entity contracting with the division to manage or administer mental health
888 and substance use disorder benefits shall ensure that there are no separate non-quantitative
889 treatment limitations that apply to mental health and substance use disorder benefits but do not
890 apply to medical and surgical benefits within any classification of benefits as defined under the
891 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
892 2008, as amended, and applicable state mental health parity laws, including, but not limited to,
893 section 81; provided, however, that the non-quantitative treatment limitations shall include the
894 processes, strategies or methodologies for developing and applying the division's reimbursement
895 rates for mental health and substance use disorder benefits and medical and surgical benefits
896 within each classification of benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

957 (d) If federal guidance, including, but not limited to, the Self-Compliance Tool for the
958 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of
959 2008, as amended, is released that indicates a non-quantitative treatment limitation analysis
960 process and reporting format that is significantly different from, contrary to or more efficient
961 than the non-quantitative treatment limitation analysis process and reporting format requirements
962 described in subsection (b), the division may promulgate regulations that delineate a non-
963 quantitative treatment limitation analysis process and reporting format that may be used in lieu of
964 the non-quantitative treatment limitation analysis and reporting requirements described in said
965 subsection (b).

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

968 section 7 of chapter 4 or chapter 66; provided, however, that nothing in this section shall limit
969 the authority of the director of Medicaid to use and, if appropriate, publish any final or
970 preliminary examination report, examiner or company work papers or other documents or other
971 information discovered or developed during the course of an examination in the furtherance of
972 any legal or regulatory action that the director may, in their sole discretion, deem appropriate;
973 provided further, that nothing in this section shall prevent the director of Medicaid from
974 publishing any illustrative utilization review criteria, medical necessity standard, clinical
975 guideline or other policy, procedure, criteria or standard, regardless of its origin, as an example
976 of the type of policy, procedure, criteria or standard that contributes to a violation of state or
977 federal law parity requirements, including any information that is subject to disclosure to plan
978 members under the federal Paul Wellstone and Pete Domenici Mental Health Parity and
979 Addiction Equity Act of 2008, as amended, or under any member right to receive such guideline
980 under applicable federal law.

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

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

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

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

994 (iv) a breakdown of treatment authorization data for the division, and for each Medicaid
995 managed care organization, accountable care organization or other entity that manages or
996 administers benefits for the division, for mental health treatment services, substance use disorder
997 treatment services and medical and surgical treatment services for the immediately preceding
998 calendar year indicating for each treatment service: (A) the number of inpatient days, outpatient
999 services and total number of services requested; (B) the number and per cent of inpatient day
1000 requests authorized, inpatient day requests modified, inpatient day requests modified resulting in
1001 a lesser amount of inpatient days authorized than requested and the reason for the modification,
1002 inpatient day requests denied and the reason for the denial, inpatient day requests where an
1003 internal appeal was filed and approved, inpatient day requests where an internal appeal was filed
1004 and denied, inpatient day requests where an external review under section 47B or hearing before
1005 the board of hearings under section 48 was filed and upheld and inpatient day requests where an
1006 external review under said section 47B or hearing before the board of hearings under said section
1007 48 was filed and overturned; and (C) the number and per cent of outpatient service requests
1008 authorized, outpatient service requests modified, outpatient service requests modified resulting in
1009 a lower amount of outpatient service authorized than requested and the reason for the
1010 modification, outpatient service requests denied and the reason for the denial, outpatient service
1011 requests where an internal appeal was filed and approved, outpatient service requests where an
1012 internal appeal was filed and denied, outpatient service requests where an external review under

1013 said section 47B or hearing before the board of hearings under said section 48 was filed and
1014 upheld and outpatient service requests where an external review under said section 47B or
1015 hearing before the board of hearings under said section 48 was filed and overturned;

1016 (v) the number of complaints the division, or any Medicaid managed care organization,
1017 accountable care organization or other entity contracting with the division to manage or
1018 administer mental health and substance use disorder benefits, has received in the immediately
1019 preceding calendar year regarding access to behavioral health services or compliance with parity
1020 in mental health and substance use disorder benefits under state and federal laws and a summary
1021 of all complaints resolved by the division, or any Medicaid managed care organization,
1022 accountable care organization or other entity contracting with the division to manage or
1023 administer mental health and substance use disorder benefits, during that time period; and

1024 (vi) information about any educational or corrective actions the division has taken to
1025 ensure carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health
1026 Parity and Addiction Equity Act of 2008, as amended, and section 81.

1027 The summary report shall be written in non-technical, readily understandable language
1028 and shall be made publicly available on the division's website.

1029 Section 81. (a) The division and its health insurers, health plans, health maintenance
1030 organizations, behavioral health management firms and third-party administrators under contract
1031 with the division, a Medicaid managed care organization or a primary care clinician plan shall
1032 provide mental health and substance use disorder benefits for the diagnosis and medically-
1033 necessary treatment of any behavioral health disorder described in the most recent edition of the
1034 Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric

1035 Association or the most current version of the International Classification of Diseases. The
1036 benefits shall be provided on a nondiscriminatory basis.

1037 (b) In addition to the mental health and substance use disorder benefits established
1038 pursuant to this section, the division shall provide benefits on a non-discriminatory basis for
1039 children and adolescents under the age of 19 for the diagnosis and treatment of mental,
1040 behavioral, emotional or substance use disorders described in the most recent edition of the
1041 Diagnostic and Statistical Manual of Mental Disorders that substantially interfere with or
1042 substantially limit the functioning and social interactions of such a child or adolescent; provided,
1043 however, that the interference or limitation is documented by and the referral for the diagnosis
1044 and treatment is made by the primary care provider, primary pediatrician or a licensed mental
1045 health professional of such a child or adolescent or is evidenced by conduct including, but not
1046 limited to: (i) an inability to attend school as a result of such a disorder; (ii) the need to
1047 hospitalize the child or adolescent as a result of such a disorder; or (iii) a pattern of conduct or
1048 behavior caused by such a disorder that poses a serious danger to oneself or others.

1049 (c) For the purposes of this section, the division shall be deemed to be providing such
1050 coverage on a non-discriminatory basis if the plan or coverage does not contain any annual or
1051 lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of the
1052 mental disorders that is less than any annual or lifetime dollar or unit of service limitation
1053 imposed on coverage for the diagnosis and treatment of physical conditions.

1054 (d) Benefits authorized pursuant to this section shall consist of a range of inpatient,
1055 intermediate and outpatient services that shall permit medically-necessary, active and
1056 noncustodial treatment for the mental disorders to take place in the least restrictive clinically

1057 appropriate setting. For purposes of this section, inpatient services may be provided in a general
1058 hospital licensed to provide such services, in a facility under the direction and supervision of the
1059 department of mental health, in a private mental hospital licensed by the department of mental
1060 health or in a substance abuse facility licensed by the department of public health. Intermediate
1061 services shall include, but not be limited to, Level III community-based detoxification, acute
1062 residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or
1063 approved by the department of public health or the department of mental health. Outpatient
1064 services may be provided in a licensed hospital, a mental health or substance abuse clinic
1065 licensed by the department of public health, a public community mental health center, a
1066 professional office or as home-based services.

1067 (e) The division and its health insurers, health plans, health maintenance organizations,
1068 behavioral health management firms and third-party administrators under contract with the
1069 division, a Medicaid managed care organization or a primary care clinician plan shall not require,
1070 as a condition of receiving benefits mandated by this section, consent to the disclosure of
1071 information regarding services for mental disorders under different terms and conditions than
1072 consent is required for disclosure of information for other medical conditions. A determination
1073 by the division or its agents that services authorized pursuant to this section are not medically
1074 necessary shall only be made by a mental health professional licensed in the appropriate
1075 specialty related to such services and, where applicable, by a provider in the same licensure
1076 category as the ordering provider; provided, however, that this subsection shall not apply to
1077 denials of service resulting from an enrollee's lack of coverage or use of a facility or professional
1078 that has not entered into a negotiated agreement with the division or its agents. The benefits

1079 provided by the division or its agents pursuant to this section shall meet all other terms and

1080 conditions of the plan consistent with state or federal law.

1081 (f) Nothing in this section shall require the division to pay for mental health or substance

1082 use disorder benefits or services that:

1083 (i) are otherwise covered by third-party insurance;

1084 (ii) are provided to a person who is presently incarcerated, confined or committed to a

1085 jail, house of correction or prison;

1086 (iii) constitute educational services required to be provided by a school committee

1087 pursuant to section 5 of chapter 71B;

1088 (iv) constitute services provided by the department of mental health, the department of

1089 public health or the department of developmental services; or

1090 (v) are not eligible for federal financial participation.

1091 Section 82. Notwithstanding any general or special law to the contrary, the office of

1092 Medicaid shall seek a waiver and promulgate regulations in order to require the division and its

1093 health insurers, health plans, health maintenance organizations, behavioral health management

1094 firms and third-party administrators under contract with the division, a Medicaid managed care

1095 organization or primary care clinician plan to meet the parity requirements described under the

1096 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of

1097 2008, as amended, and any federal guidance or regulations relevant to the act, including 42 CFR

1098 438 Subpart K, 42 CFR 440.395 and 42 CFR 457.496, for all enrollees. For persons under the

1099 age of 21, MassHealth and its agents may comply with this section by meeting the obligations

1100 related to Early and Periodic Screening, Diagnostic and Treatment benefits under 42 CFR
1101 457.496(b) or 440.395(c).

1102 Section 83. Medical necessity and utilization management determinations for treatments
1103 for substance use disorder or co-occurring mental illness and substance use disorder authorized
1104 under this chapter shall be made in accordance with the criteria established by the American
1105 Society of Addiction Medicine. No additional criteria may be used to make medical necessity or
1106 utilization management determinations for treatments for substance use disorder or co-occurring
1107 mental illness and substance use disorder, unless such criteria are less restrictive than those
1108 established by the American Society of Addiction Medicine. Authorization or coverage for
1109 treatment for substance use disorder or co-occurring mental illness and substance use disorder
1110 shall not be denied by the division, or a Medicaid managed care organization, accountable care
1111 organization or other entity that manages or administers mental health and substance use disorder
1112 benefits for the division, on the basis that such treatment was authorized or ordered by a court of
1113 law or other law enforcement agency. Any such authorization or order for such services shall be
1114 considered a factor in support of coverage for such treatment.

1115 SECTION 30. Chapter 123 of the General Laws is hereby amended by inserting after
1116 section 2 the following section:-

1117 Section 2A. When promulgating regulations governing the contracting for services, the
1118 department shall establish within its regulations additional factors to be considered when
1119 contracting for services in geographically-isolated communities, including, but not limited to,
1120 travel and transportation, to ensure availability and access to services.

1121 SECTION 31. Section 1 of chapter 175 of the General Laws, as appearing in the 2020
1122 Official Edition, is hereby amended by inserting after the definition of "Domestic company" the
1123 following definition:-

1124 "Emergency services programs", all programs subject to contract between the
1125 Massachusetts Behavioral Health Partnership and nonprofit organizations for the provision of
1126 community-based emergency psychiatric services, including, but not limited to, behavioral
1127 health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per
1128 week, through: (i) mobile crisis intervention services for youth; (ii) mobile crisis intervention
1129 services for adults; (iii) emergency service provider community-based locations; and (iv) adult
1130 community crisis stabilization services.

1131 SECTION 32. Section 47B of said chapter 175, as so appearing, is hereby amended by
1132 inserting after the word "specialist", in line 122, the following words:-, a clinician practicing
1133 under the supervision of a licensed professional and working towards licensure in a clinic
1134 licensed under chapter 111.

1135 SECTION 33. Said chapter 175 is hereby further amended by inserting after section
1136 47PP, the following 4 sections:-

1137 Section 47QQ. For the purposes of this section, "psychiatric collaborative care model"
1138 shall mean the evidence-based, integrated behavioral health service delivery method described in
1139 81 FR 80230.

1140 An individual policy of accident and sickness insurance issued pursuant to section 108
1141 that provides hospital expense and surgical expense insurance or a group blanket or general
1142 policy of accident and sickness insurance issued pursuant to section 110 that provides hospital

1143 expense and surgical expense insurance that is issued or renewed within or without the
1144 commonwealth shall provide coverage for mental health or substance use disorder services that
1145 are delivered through the psychiatric collaborative care model.

1146 Section 47RR. An individual policy of accident and sickness insurance issued under
1147 section 108 that provides hospital expense and surgical expense insurance or a group blanket or
1148 general policy of accident and sickness insurance issued under section 110 that provides hospital
1149 expense and surgical expense insurance that is issued or renewed within or without the
1150 commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary
1151 emergency services programs.

1152 Section 47SS. (a) For the purposes of this section, the following terms shall have the
1153 following meanings unless the context clearly requires otherwise:

1154 "Community-based acute treatment", 24-hour clinically managed mental health
1155 diversionary or step-down services for children and adolescents that is usually provided as an
1156 alternative to mental health acute treatment.

1157 "Intensive community-based acute treatment", intensive 24-hour clinically managed
1158 mental health diversionary or step-down services for children and adolescents that is usually
1159 provided as an alternative to mental health acute treatment.

1160 "Mental health acute treatment", 24-hour medically supervised mental health services
1161 provided in an inpatient facility licensed by the department of mental health that provides
1162 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1163 milieu.

1164 (b) A policy, contract, agreement, plan or certificate of insurance issued, delivered or
1165 renewed within or without the commonwealth, which is considered creditable coverage under
1166 section 1 of chapter 111M, shall provide coverage for medically necessary mental health acute
1167 treatment, community-based acute treatment and intensive community-based acute treatment and
1168 shall not require a preauthorization before the administration of such treatment; provided,
1169 however, that the facility shall notify the carrier of the admission and the initial treatment plan
1170 within 72 hours of admission.

1171 Section 47TT. (a) For the purpose of this section, the following words shall have the
1172 following meanings unless the context clearly requires otherwise:

1173 "Licensed mental health professional," a licensed physician who specializes in the
1174 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
1175 licensed mental health counselor, a licensed supervised mental health counselor, a licensed nurse
1176 mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1
1177 of chapter 111J or a licensed marriage and family therapist within the lawful scope of practice
1178 for such therapist.

1179 "Mental health wellness examination," a screening or assessment that seeks to identify
1180 any behavioral or mental health needs and appropriate resources for treatment. The examination
1181 may include: (i) observation, a behavioral health screening, education and consultation on
1182 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1183 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
1184 screenings or observations to understand a covered person's mental health history, personal

1185 history and mental or cognitive state and, when appropriate, relevant adult input through
1186 screenings, interviews and questions.

1187 "Primary care provider", a health care professional qualified to provide general medical
1188 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise
1189 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1190 maintains continuity of care within the scope of practice.

1191 (b) The following shall provide coverage for an annual mental health wellness
1192 examination that is performed by a licensed mental health professional or primary care provider,
1193 which may be provided by the primary care provider as part of an annual preventive visit: (i) any
1194 policy of accident and sickness insurance, as described in section 108, which provides hospital
1195 expense and surgical expense insurance and which is delivered, issued or subsequently renewed
1196 by agreement between the insurer and policyholder in the commonwealth; (ii) any blanket or
1197 general policy of insurance described in subdivision (A), (C) or (D) of section 110 which
1198 provides hospital expense and surgical expense insurance and which is delivered, issued or
1199 subsequently renewed by agreement between the insurer and the policyholder in or outside of the
1200 commonwealth; and (iii) any employees' health and welfare fund which provides hospital
1201 expense and surgical expense benefits and which is delivered, issued to or renewed for any
1202 person or group of persons in the commonwealth. The examination shall be covered with no
1203 patient cost-sharing.

1204 (c) The division of insurance, in consultation with the office of Medicaid, and the
1205 department of mental health, shall develop guidelines to implement this section.

1206 SECTION 34. Section 8A of chapter 176A of the General Laws, as appearing in the 2020

1207 Official Edition, is hereby amended by inserting after the word "specialist", in line 125, the

1208 following words:- , a clinician practicing under the supervision of a licensed professional and

1209 working towards licensure in a clinic licensed under chapter 111.

1210 SECTION 35. Said chapter 176A is hereby further amended by inserting after section

1211 8QQ the following 4 sections:-

1212 Section 8RR. For the purposes of this section, "psychiatric collaborative care model"

1213 shall mean the evidence-based, integrated behavioral health service delivery method described in

1214 81 FR 80230.

1215 A contract between a subscriber and the corporation under an individual or group hospital

1216 service plan that is delivered, issued or renewed within or without the commonwealth shall

1217 provide coverage for mental health or substance use disorder services that are delivered through

1218 the psychiatric collaborative care model.

1219 Section 8SS. (a) For the purposes of this section, the following terms shall have the

1220 following meanings unless the context clearly requires otherwise:

1221 "Community-based acute treatment", 24-hour clinically managed mental health

1222 diversionary or step-down services for children and adolescents that is usually provided as an

1223 alternative to mental health acute treatment.

1224 "Intensive community-based acute treatment", intensive 24-hour clinically managed

1225 mental health diversionary or step-down services for children and adolescents that is usually

1226 provided as an alternative to mental health acute treatment.

1227 “Mental health acute treatment”, 24-hour medically supervised mental health services
1228 provided in an inpatient facility, licensed by the department of mental health, that provides
1229 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1230 milieu.

1231 (b) A contract between a subscriber and the corporation under an individual or group
1232 hospital service plan that is delivered, issued or renewed within the commonwealth shall provide
1233 coverage for medically necessary mental health acute treatment, community-based acute
1234 treatment and intensive community-based acute treatment and shall not require a
1235 preauthorization before the administration of any such treatment; provided, however, that the
1236 facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of
1237 admission.

1238 Section 8TT. A contract between a subscriber and the corporation under an individual or
1239 group hospital service plan that is delivered, issued or renewed within or without the
1240 commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary
1241 emergency services programs, as defined in section 1 of chapter 175.

1242 Section 8UU. (a) For the purpose of this section, the following words shall have the
1243 following meanings:

1244 “Licensed mental health professional,” a licensed physician who specializes in the
1245 practice of psychiatry, a licensed psychologist, a licensed supervised mental health counselor, a
1246 licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse
1247 mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1

1248 of chapter 111J of the General Laws, or a licensed marriage and family therapist within the
1249 lawful scope of practice for such therapist.

1250 "Mental health wellness examination," a screening or assessment that seeks to identify
1251 any behavioral or mental health needs and appropriate resources for treatment. The examination
1252 may include: (i) observation, a behavioral health screening, education and consultation on
1253 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1254 necessary supports and discussion of potential options for medication; and (ii) age-appropriate
1255 screenings or observations to understand a covered person's mental health history, personal
1256 history and mental or cognitive state and, when appropriate, relevant adult input through
1257 screenings, interviews, and questions.

1258 "Primary care provider", a health care professional qualified to provide general medical
1259 care for common health care problems, who (i) supervises, coordinates, prescribes or otherwise
1260 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1261 maintains continuity of care within the scope of practice.

1262 (b) A contract between a subscriber and the corporation under an individual or group
1263 hospital service plan which is delivered, issued or renewed within the commonwealth shall
1264 provide coverage for an annual mental health wellness examination that is performed by a
1265 licensed mental health professional or primary care provider, which may be provided by the
1266 primary care provider as part of an annual preventive visit. The examination shall be covered
1267 with no patient cost-sharing.

1268 (c) The division of insurance, in consultation with the office of Medicaid, and the
1269 department of mental health, shall develop guidelines to implement this section.

1270 SECTION 36. Section 4A of chapter 176B of the General Laws, as appearing in the 2020
1271 Official Edition, is hereby amended by inserting after the word "specialist", in line 120, the
1272 following words:- , a clinician practicing under the supervision of a licensed professional and
1273 working towards licensure in a clinic licensed under chapter 111.

1274 SECTION 37. Said chapter 176B is hereby further amended by inserting after section
1275 4QQ the following 4 sections:-

1276 Section 4RR. (a) For the purposes of this section, "psychiatric collaborative care model"
1277 shall mean the evidence-based, integrated behavioral health service delivery method described in
1278 81 FR 80230.

1279 A subscription certificate under an individual or group medical service agreement that is
1280 issued or renewed within or without the commonwealth shall provide coverage for mental health
1281 or substance use disorder services that are delivered through the psychiatric collaborative care
1282 model.

1283 Section 4SS. For the purposes of this section, the following terms shall have the
1284 following meanings unless the context clearly requires otherwise:

1285 "Community-based acute treatment", 24-hour clinically managed mental health
1286 diversionary or step-down services for children and adolescents that is usually provided as an
1287 alternative to mental health acute treatment.

1288 "Intensive community-based acute treatment", intensive 24-hour clinically managed
1289 mental health diversionary or step-down services for children and adolescents that is usually
1290 provided as an alternative to mental health acute treatment.

1291 “Mental health acute treatment”, 24-hour medically supervised mental health services
1292 provided in an inpatient facility, licensed by the department of mental health, that provides
1293 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1294 milieu.

1295 (b) A subscription certificate under an individual or group medical service agreement
1296 delivered, issued or renewed within the commonwealth shall provide coverage for medically
1297 necessary mental health acute treatment, community-based acute treatment, intensive
1298 community-based acute treatment and shall not require a preauthorization before obtaining
1299 treatment; provided, however, that the facility shall notify the carrier of the admission and the
1300 initial treatment plan within 72 hours of admission.

1301 Section 4TT. A subscription certificate under an individual or group medical service
1302 agreement that is issued or renewed shall provide benefits on a nondiscriminatory basis for
1303 medically necessary emergency services programs, as defined in section 1 of chapter 175.

1304 Section 4UU. (a) For the purpose of this section, the following words shall have the
1305 following meanings:

1306 “Licensed mental health professional,” a licensed physician who specializes in the
1307 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
1308 licensed mental health counselor, a licensed supervised mental health counselor, a licensed nurse
1309 mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1
1310 of chapter 111J, or a licensed marriage and family therapist within the lawful scope of practice
1311 for such therapist.

1312 “Mental health wellness examination,” a screening or assessment that seeks to identify
1313 any behavioral or mental health needs and appropriate resources for treatment. The examination
1314 may include: (i) observation, a behavioral health screening, education and consultation on
1315 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1316 necessary supports, and discussion of potential options for medication; and (ii) age-appropriate
1317 screenings or observations to understand a covered person’s mental health history, personal
1318 history and mental or cognitive state and, when appropriate, relevant adult input through
1319 screenings, interviews, and questions.

1320 “Primary care provider”, a health care professional qualified to provide general medical
1321 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise
1322 provides or proposes health care services; (ii) initiates referrals for specialist care; (iii) and
1323 maintains continuity of care within the scope of practice.

1324 (b) A subscription certificate under an individual or group medical service agreement
1325 delivered, issued or renewed within the commonwealth shall provide coverage for an annual
1326 mental health wellness examination that is performed by a licensed mental health professional or
1327 primary care provider, which may be provided by the primary care provider as part of an annual
1328 preventive visit. The examination shall be covered with no patient cost-sharing.

1329 (c) The division of insurance, in consultation with the office of Medicaid, and the
1330 department of mental health, shall develop guidelines to implement this section.

1331 SECTION 38. Section 4M of chapter 176G of the General Laws, as appearing in the
1332 2020 Official Edition, is hereby amended by inserting after the word “specialist”, in line 117, the

1333 following words:- , a clinician practicing under the supervision of a licensed professional and
1334 working towards licensure in a clinic licensed under chapter 111.

1335 SECTION 39. Said chapter 176G is hereby further amended by inserting after section 4II
1336 the following 4 sections:-

1337 Section 4JJ. For the purposes of this section, "psychiatric collaborative care model" shall
1338 mean the evidence-based, integrated behavioral health service delivery method described in 81
1339 FR 80230.

1340 Any individual or group health maintenance contract that is issued or renewed within or
1341 without the commonwealth shall provide coverage for mental health or substance use disorder
1342 services that are delivered through the psychiatric collaborative care model.

1343 Section 4KK. (a) For the purposes of this section, the following terms shall have the
1344 following meanings unless the context clearly requires otherwise:

1345 "Community-based acute treatment", 24-hour clinically managed mental health
1346 diversionary or step-down services for children and adolescents that is usually provided as an
1347 alternative to mental health acute treatment.

1348 "Intensive community-based acute treatment", intensive 24-hour clinically managed
1349 mental health diversionary or step-down services for children and adolescents that is usually
1350 provided as an alternative to mental health acute treatment.

1351 "Mental health acute treatment", 24-hour medically supervised mental health services
1352 provided in an inpatient facility, licensed by the department of mental health, that provides

1353 psychiatric evaluation, management, treatment and discharge planning in a structured treatment
1354 milieu.

1355 (b) An individual or group health maintenance contract that is issued or renewed within
1356 or without the commonwealth shall provide coverage for medically necessary mental health
1357 acute treatment, community-based acute treatment and intensive community-based acute
1358 treatment and shall not require a preauthorization before the administration of such treatment;
1359 provided, however, that the facility shall notify the carrier of the admission and the initial
1360 treatment plan within 72 hours of admission.

1361 Section 4JJ. An individual or group health maintenance contract that is issued or renewed
1362 within or without the commonwealth shall provide benefits on a nondiscriminatory basis for
1363 medically necessary emergency services programs, as defined in section 1 of chapter 175.

1364 Section 4LL. (a) For the purpose of this section, the following words shall have the
1365 following meanings unless the context clearly requires otherwise:

1366 "Licensed mental health professional," a licensed physician who specializes in the
1367 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a
1368 licensed mental health counselor, a licensed supervised mental health counselor, a licensed nurse
1369 mental health clinical specialist, a licensed alcohol and drug counselor I, as defined in section 1
1370 of chapter 111J, or a licensed marriage and family therapist within the lawful scope of practice
1371 for such therapist.

1372 "Mental health wellness examination," a screening or assessment that seeks to identify
1373 any behavioral or mental health needs and appropriate resources for treatment. The examination
1374 may include: (i) observation, a behavioral health screening, education and consultation on

1375 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other
1376 necessary supports, and discussion of potential options for medication; and (ii) age-appropriate
1377 screenings or observations to understand a covered person's mental health history, personal
1378 history and mental or cognitive state and, when appropriate, relevant adult input through
1379 screenings, interviews and questions.

1380 "Primary care provider", a health care professional qualified to provide general medical
1381 care for common health care problems, who (i) supervises, coordinates, prescribes or otherwise
1382 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
1383 maintains continuity of care within the scope of practice.

1384 (b) An individual or group health maintenance contract that is issued or renewed within
1385 or without the commonwealth shall provide coverage for an annual mental health wellness
1386 examination that is performed by a licensed mental health professional or primary care provider,
1387 which may be provided by the primary care provider as part of an annual preventive visit. The
1388 examination shall be covered with no patient cost-sharing.

1389 (c) The division of insurance, in consultation with the office of Medicaid, and the
1390 department of mental health, shall develop guidelines to implement this section.

1391 SECTION 40. Chapter 176O of the General Laws is hereby amended by inserting after
1392 section 5C the following section:-

1393 Section 5D. For the purposes of this section, the term "base fee schedule" shall mean the
1394 minimum rates, typically set forth in fee schedules, paid by the carrier to an in-network health
1395 care provider who is not paid under an alternative payment arrangement for covered health care

1396 services; provided, however, that final rates may be subject to negotiations or adjustments that
1397 may result in payments to in-network providers that are different from the base fee schedule.

1398 A carrier, directly or through any entity that manages or administers mental health or
1399 substance use disorder benefits for the carrier, shall establish a base fee schedule for primary care
1400 services for behavioral health providers that is not less than the base fee schedule used for
1401 evaluation and management services for primary care providers of the same or similar licensure
1402 type and in the same geographic region; provided, however, that a carrier shall not lower its base
1403 fee schedule for primary care providers to comply with this section.

1404 The division shall promulgate regulations to implement this section.

1405 SECTION 41. Subsection (a) of section 13 of said chapter 176O, as appearing in the
1406 2020 Official Edition, is hereby amended by striking out the first sentence and inserting in place
1407 thereof the following sentence:-

1408 A carrier or utilization review organization shall maintain a formal internal grievance
1409 process that is compliant with the Patient Protection and Affordable Care Act, Public Law 111–
1410 148, as amended, as well as with any rules, regulations or guidance applicable thereto, and such
1411 formal internal grievance process shall provide for adequate consideration and timely resolution
1412 of grievances, which shall include but not be limited to: (i) a system for maintaining records of
1413 each grievance filed by an insured or on the insured's behalf, and responses thereto, for a period
1414 of 7 years, which records shall be subject to inspection by the commissioner; (ii) the provision of
1415 a clear, concise and complete description of the carrier's formal internal grievance process and
1416 the procedures for obtaining external review pursuant to section 14 with each notice of an
1417 adverse determination; (iii) the carrier's toll-free telephone number for assisting insureds in

1418 resolving such grievances and the consumer assistance toll-free telephone number maintained by
1419 the office of patient protection; (iv) a written acknowledgement of the receipt of a grievance
1420 within 15 days and a written resolution of each grievance sent to the insured by certified or
1421 registered mail, or other express carrier with proof of delivery, within 30 days from receipt
1422 thereof; (v) a procedure to accept grievances by telephone, in person, by mail and by electronic
1423 means; (vi) a process for an insured to request the appointment of an authorized representative to
1424 act on the insured's behalf; and (vii) a procedure to accept an insured's request for medical
1425 release forms by electronic means, which shall include delivery to a designated email address or
1426 access to an online consumer portal accessible by the insured, the insured's family member or
1427 the insured's authorized representative who can provide the insured's membership identification
1428 number.

1429 SECTION 42. Subsection (b) of said section 13 of said chapter 176O, as so appearing, is
1430 hereby amended by striking out the third sentence and inserting in place thereof the following
1431 sentence:- If the expedited review process affirms the denial of coverage or treatment, the carrier
1432 shall provide the insured, within 2 business days of the decision, including by any electronic
1433 means consented to by the insured: (1) a statement setting forth the specific medical and
1434 scientific reasons for denying coverage or treatment; (2) a description of alternative treatment,
1435 services or supplies covered or provided by the carrier, if any; (3) a description of the insured's
1436 rights to any further appeal; and (4) a description of the insured's right to request a conference.

1437 SECTION 43. Subsection (c) of said section 13 of said chapter 176O, as so appearing, is
1438 hereby amended by adding the following sentence:- The external review of a grievance under
1439 section 14 shall be decided in favor of the insured unless the carrier provides substantial

1440 evidence, such as proof of delivery, that the carrier properly complied with the time limits
1441 required under this section.

1442 SECTION 44. Subsection (a) of section 14 of chapter 176O of the General Laws, as so
1443 appearing , is hereby amended by striking out the eighth sentence and inserting in place thereof
1444 the following sentence:- The panel shall consider, but not be limited to considering: (i) any
1445 related right to such treatment or service under any related state statute or regulation; (ii) written
1446 documents submitted by the insured; (iii) medical records and medical opinions regarding
1447 medical necessity by the insured's treating provider that requested or provided the disputed
1448 service, which shall be obtained by the carrier, or by the panel if the carrier fails to do so; (iv)
1449 additional information from the involved parties or outside sources that the review panel deems
1450 necessary or relevant; and (v) information obtained from any informal meeting held by the panel
1451 with the parties.

1452 SECTION 45. Subsection (b) of said section 14 of said chapter 176O, as so appearing, is
1453 hereby amended by striking out the second sentence and inserting in place thereof the following
1454 sentence:- An insured may apply to the external review panel to seek continued provision of
1455 health care services that are the subject of the grievance during the course of an expedited or
1456 non-expedited external review upon a showing of substantial harm to the insured's health absent
1457 such continuation or other good cause as determined by the panel; provided, however, that good
1458 cause shall include a pattern of denials that have been overturned by prior internal or external
1459 appeals.

1460 SECTION 46. Subsection (c) of said section 14 of said chapter 176O, as so appearing, is
1461 hereby amended by adding the following sentence:- A carrier's failure to promptly comply with

1462 a decision of the review panel shall be an unfair and deceptive practice in violation of chapter
1463 93A.

1464 SECTION 47. Said section 14 of said chapter 176O, as so appearing, is hereby further
1465 amended by adding following subsection:-

1466 (g) The office of patient protection shall monitor carrier denials and shall identify any
1467 trends regarding particular treatments or services or carrier practices and may refer such matters
1468 to the division of insurance, the group insurance commission or the office of the attorney general
1469 for review for compliance with state or federal laws related to mental health and substance use
1470 disorder parity including, but not limited to, section 22 of chapter 32A, section 47B of chapter
1471 175, section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of
1472 chapter 176G, in regard to any carrier licensed under chapters 175, 176A, 176B or 176G, any
1473 carrier offering a student health plan issued under section 18 of chapter 15A or the group
1474 insurance commission, or the mental health parity provisions of the federal Paul Wellstone and
1475 Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as
1476 amended, and federal guidance or regulations issued under the act. The office of patient
1477 protection shall refer any questions or concerns from consumers about carrier compliance with
1478 state or federal laws related to mental health and substance use disorder parity to the division of
1479 insurance, the group insurance commission or the office of the attorney general.

1480 SECTION 48. Subsection (b) of section 16 of said chapter 176O, as so appearing, is
1481 hereby amended by striking out the last sentence and inserting in place thereof the following
1482 sentence:- If a carrier or utilization review organization intends to implement a new medical
1483 necessity guideline or amend an existing requirement or restriction, the carrier or utilization

1484 review organization shall ensure that the new guideline or amended requirement or restriction
1485 shall not be implemented unless: (i) the carrier's or utilization review organization's website has
1486 been updated to reflect the new or amended requirement or restriction; and (ii) the carrier or
1487 utilization review organization has assessed the limitation to show it is in compliance with state
1488 and federal parity requirements under chapter 26.

1489 SECTION 49. Said section 16 of said chapter 176O, as so appearing, is hereby further
1490 amended by adding the following subsection:-

1491 (d) Medical necessity and utilization management determinations for treatments for
1492 substance use disorder or co-occurring mental illness and substance use disorder shall be made in
1493 accordance with the criteria established by the American Society of Addiction Medicine. No
1494 additional criteria may be used to make medical necessity or utilization management
1495 determinations for treatments for substance use disorder or co-occurring mental illness and
1496 substance use disorder, unless such criteria are less restrictive. A carrier, or any entity that
1497 manages or administers mental health and substance use disorder benefits for the carrier, shall
1498 not deny authorization or coverage for treatment for substance use disorder or co-occurring
1499 mental illness and substance use disorder on the basis that such treatment was authorized or
1500 ordered by a court of law or other law enforcement agency. Such authorization shall be
1501 considered a factor in support of coverage for such treatment, including as allowed under clause
1502 (4) of subsection (a) of section 6 and clause (7) of subsection (a) of section 7.

1503 SECTION 50. The interagency health equity team, as supported through the office of
1504 health equity, shall, in consultation with the advisory council appointed in this section, study
1505 ways to improve access to, and the quality of, culturally competent behavioral health services.

1506 The review shall include, but not be limited to: (i) the need for greater racial, ethnic and
1507 linguistic diversity within the behavioral health workforce; (ii) the role of gender, sexual
1508 orientation, gender identity, race, ethnicity, linguistic barriers, status as a client of the department
1509 of children and families, status as an incarcerated or formerly incarcerated individual, including
1510 justice-involved youth and emerging adults, status as a veteran, status as an individual with post-
1511 traumatic stress disorder, status as an aging adult, status as a person with any other physical or
1512 invisible disability and social determinants of health regarding behavioral health needs; and (iii)
1513 any other factors identified by the team that create disparities in access and quality within the
1514 existing behavioral health service delivery system, including stigma, transportation and cost.

1515 The advisory council shall consist of: the chairs of the joint committee on mental health,
1516 substance use and recovery; the chair of the Black and Latino Caucus or a designee; and 8
1517 members to be appointed by the commissioner of public health, 1 of whom shall be a local public
1518 health official representing a majority-minority municipality, 1 of whom shall be a representative
1519 of a racial or ethnic equity advocacy group, 1 of whom shall be a representative of a linguistic
1520 equity advocacy group, 1 of whom shall be a licensed behavioral health provider, 1 of whom
1521 shall be a representative of a behavioral health advocacy group, 1 of whom shall be a
1522 representative of an organization serving the health care needs of the lesbian, gay, bisexual,
1523 transgender, queer and questioning community, 1 of whom shall be a representative of an
1524 organization serving the health care needs of individuals experiencing housing insecurity and 1
1525 of whom shall be an individual with expertise in school-based behavioral health services.

1526 The team shall meet not less than quarterly with the advisory council. Not later than
1527 March 30, 2022, and annually for the following 3 years at the close of the fiscal year, the team
1528 shall issue a report with legislative, regulatory or budgetary recommendations to improve the

1529 access and quality of culturally competent mental and behavioral health services. The report shall
1530 be written in non-technical, readily understandable language and shall be made publicly
1531 available on the office of health equity's website.

1532 The office of health equity, the department of mental health and the department of public
1533 health may, subject to appropriation, provide administrative, logistical and research support to
1534 produce the report.

1535 SECTION 51. The health policy commission, in consultation with the division of
1536 insurance, shall conduct an analysis of the effects of behavioral health managers, as defined in
1537 section 1 of chapter 176O of the General Laws, on the commonwealth's health care delivery
1538 system. The commission shall seek input from the executive office of health and human services,
1539 other state agencies, health care providers and payers, behavioral health and economic experts,
1540 patients and caregivers.

1541 The commission shall analyze: (i) the services that behavioral health managers provide;
1542 (ii) the effect of behavioral health managers on accessibility, quality and cost of behavioral
1543 health services, including an analysis of their impact on patient outcomes; (iii) the oversight
1544 practices by other states on behavioral health managers; (iv) the effects of behavioral health
1545 manager state licensure, regulation or registration on access to behavioral health services; and (v)
1546 any other issues pertaining to behavioral health managers as deemed relevant by the commission.

1547 Not later than December 31, 2022, the health policy commission shall file a report of its
1548 findings, together with any recommendations for legislation, with the clerks of the senate and
1549 house of representatives, the joint committee on health care financing, the joint committee on
1550 mental health, substance use and recovery and the joint committee on financial services.

1551 SECTION 52. There shall be a special commission to study and make recommendations
1552 on the establishment of a common set of criteria for providers and payers to use in making
1553 medical necessity determinations for behavioral health treatment.

1554 The commission shall consist of the following members or their designees: the
1555 commissioner of mental health, who shall serve as chair; the commissioner of insurance; the
1556 director of the bureau of substance addiction services within the department of public health; the
1557 assistant secretary for MassHealth; the executive director of the group insurance commission;
1558 and 16 members to be appointed by the chair: 1 of whom shall be a representative of the health
1559 policy commission; 2 of whom shall be representatives of the Massachusetts Psychiatric Society,
1560 Inc., 1 of whom shall specialize in the treatment of children; 2 of whom shall be representatives
1561 of the Massachusetts Psychological Association, Inc., 1 of whom shall specialize in the treatment
1562 of children; 1 of whom shall be a representative of the Massachusetts Society of Addiction
1563 Medicine, Inc.; 1 of whom shall be a representative of the National Association of Social
1564 Workers, Inc.; 1 of whom shall be a representative of the Massachusetts Mental Health
1565 Counselors Association, Inc.; 1 of whom shall be a representative of the Children's Mental
1566 Health Campaign; 1 of whom shall be a representative of the Association for Behavioral
1567 Healthcare, Inc.; 1 of whom shall be a representative of the Massachusetts Association of
1568 Behavioral Health Systems, Inc.; 1 of whom shall be a representative of the Massachusetts
1569 Association for Mental Health, Inc.; 1 of whom shall be a representative of the National Alliance
1570 on Mental Illness of Massachusetts, Inc.; 1 of whom shall be a representative of the
1571 Massachusetts Organization for Addiction Recovery, Inc.; 1 of whom shall be a representative of
1572 Blue Cross and Blue Shield of Massachusetts, Inc.; and 1 of whom shall be a representative of
1573 the Massachusetts Association of Health Plans, Inc..

1574 The commission's review shall include, but not be limited to: (i) existing reference
1575 sources or services utilized by payers to make medical necessity determinations for behavioral
1576 health treatment; (ii) commonly accepted treatment guidelines and standards of care utilized by
1577 behavioral health providers and the evidentiary basis for those guidelines and standards; (iii) the
1578 feasibility of establishing a common set of medical necessity criteria that behavioral health
1579 providers and payers can agree to and any barriers to this task; and (iv) the experiences of other
1580 states in addressing the standardization of medical necessity for behavioral health.

1581 Not later than 1 year after the effective date of this act, the commission shall submit its
1582 findings and recommendations, together with drafts of legislation or regulations necessary to
1583 carry those recommendations into effect, to the clerks of the senate and house of representatives
1584 and the joint committee on mental health, substance use and recovery.

1585 SECTION 53. The health policy commission shall convene an advisory group to advise
1586 the commission on the implementation of section 21 of chapter 6D of the General Laws. The
1587 advisory group shall include: the director of the health policy commission or a designee, who
1588 shall serve as chair; the secretary of health and human services or a designee; the assistant
1589 secretary of MassHealth or a designee; the commissioner of insurance or a designee; 1 member
1590 appointed by the governor, who shall be from a commonwealth-based electronic health record
1591 vendor who specializes in behavioral health care; 1 member appointed by the Association for
1592 Behavioral Healthcare, Inc.; 1 member appointed by Blue Cross and Blue Shield of
1593 Massachusetts, Inc.; 1 member appointed by Health Law Advocates, Inc.; 1 member appointed
1594 by the Massachusetts Association of Health Plans, Inc.; 1 member appointed by the
1595 Massachusetts Health and Hospital Association, Inc.; 1 member appointed by National Alliance
1596 on Mental Illness of Massachusetts, Inc.; 1 member appointed by the Massachusetts

1597 Organization for Addiction Recovery, Inc.; and 1 member appointed by the Parent/Professional
1598 Advocacy League, Inc.

1599 The advisory group study and make recommendations on the development proper use of
1600 the standard release form required under said section 21 of said chapter 6D. The advisory group
1601 shall consider: (i) existing and potential technologies that could be used to securely transmit a
1602 standard release form; (ii) national standards pertaining to electronic release of confidential
1603 information, including protecting a patient's identity and privacy in accordance with the federal
1604 Health Insurance Portability and Accountability Act of 1996, P.L. 104-191; (iii) any prior release
1605 forms and methodologies used in the commonwealth; (iv) any prior release forms and
1606 methodologies developed by federal agencies; and (v) any other factors the advisory group
1607 deems relevant.

1608 The advisory group shall submit written recommendations to the commission not more
1609 than 6 months after the effective date of this act. The commission shall develop the standard
1610 release form after receiving the advisory group's recommendations.

1611 SECTION 54. The health policy commission shall publish its first pediatric behavioral
1612 health planning report required by section 7 of chapter 6D of the General Laws not later than 18
1613 months after the effective date of this act.

1614 SECTION 55. The office of the child advocate shall publish the first annual report
1615 required by section 10A of chapter 18C of the General Laws not later than 18 months after the
1616 development of the online portal established by section 16P of chapter 6A of the General Laws.

1617 SECTION 56. For the purposes of section 22A of chapter 32A, section 10P of chapter
1618 118E, section 47MM of chapter 175, section 8OO of chapter 176A, section 4OO of chapter 176B

1619 and section 4GG of chapter 176G of the General Laws, reimbursement for the psychiatric
1620 collaborative care model shall include, but not be limited to, the following current procedural
1621 terminology billing codes established by the American Medical Association: (1) 99492; (2)
1622 99493; and (3) 99494.

1623 SECTION 57. The division of insurance shall promulgate regulations to implement
1624 section 5D of chapter 176O of the General Laws not later than 1 year from the effective date of
1625 this act; provided, however, that the division shall, upon publication, forward any draft
1626 regulations to the joint committee on health care financing and the joint committee on mental
1627 health, substance use and recovery.

1628 SECTION 58. Section 16P½ of chapter 6A of the General Laws shall take effect 1 year
1629 after the effective date of this act.