

**HOUSE . . . . . No. 4891**

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Text of an amendment, recommended by the committee on Ways and Means, to the Senate Bill addressing barriers to care for mental health (Senate, No. 2584), as further amended by the House. June 16, 2022.

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**The Commonwealth of Massachusetts**

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**In the One Hundred and Ninety-Second General Court  
(2021-2022)**  
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An Act addressing barriers to care for mental health.

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

1           SECTION 1. Subsection (d) of section 219 of chapter 6 of the General Laws, as  
2     appearing in the 2020 Official Edition, is hereby amended by striking out clauses (5) and (6) and  
3     inserting in place thereof the following 7 clauses:-

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

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

10          (7) advance the identification and dissemination of evidence-based practices designed to  
11     further promote behavioral health and the provision of supportive behavioral health services and

12 programming to address substance use conditions and to prevent violence through trauma-  
13 responsive intervention and rehabilitation;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

121 ombudsman from the executive office of education; a representative from the office of the child  
122 advocate; and a representative from the school district.

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

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

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

140 (d) If the individual or their parent or guardian disputes the decision of the team, the  
141 individual or their parent or guardian may file an appeal with the division of administrative law  
142 appeals, established under section 4H of chapter 7, which shall conduct an adjudicatory

143 proceeding and order any necessary relief consistent with state or federal law; provided,  
144 however, that nothing in this section shall be construed to entitle an individual to services that  
145 the individual would otherwise be ineligible for under applicable agency statutes or regulations.

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

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



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

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

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

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

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

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

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

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

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

197 (c) A 988 crisis hotline center shall: (i) meet the United States Department of Health and  
198 Human Services’ Ambulatory Behavioral Health System standards and the National Suicide  
199 Prevention Lifeline requirements and best practices guidelines for operational and clinical  
200 standards; (ii) provide data and reports and participate in evaluations and related quality  
201 improvement activities as required by the United States Department of Health and Human  
202 Services; (iii) utilize technology, including, but not limited to, chat and text capabilities, that is  
203 interoperable between and across crisis and emergency response systems and services, including  
204 911 and 211, as necessary; (iv) have the authority to deploy crisis and outgoing services,  
205 including, but not limited to, mobile behavioral health crisis responders, and coordinate access to

206 crisis triage, evaluation and counseling services, community crisis stabilization programs or  
207 other resources as appropriate; (v) maintain standing partnership agreements with community  
208 behavioral health centers and other behavioral health programs and facilities, including, but not  
209 limited to, programs led by individuals who are or were consumers of mental health or substance  
210 use disorder supports or services; (vi) coordinate access to crisis evaluation, counseling,  
211 receiving and stabilization services for individuals accessing the 988 suicide prevention and  
212 behavioral health crisis hotline through appropriate information sharing regarding availability of  
213 services; (vii) have the capability to serve high-risk and specialized populations, including, but  
214 not limited to, people with co-occurring substance use and mental health conditions and people  
215 with autism spectrum disorders or intellectual or developmental disabilities; (viii) have the  
216 capability to serve people of diverse races, ethnicities, ages, sexual orientations and gender  
217 identities with linguistically and culturally-competent care; (ix) have the capability to provide  
218 crisis and outgoing services within a reasonable time period in all geographic areas of the  
219 commonwealth; and (x) provide follow-up services to individuals accessing the 988 suicide  
220 prevention and behavioral health crisis hotline.

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

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

228 (3) The commission shall consist of: the secretary of health and human services or the  
229 secretary's designee, who shall serve as chair; the secretary of public safety and security or the  
230 secretary's designee; the commissioner of mental health or the commissioner's designee; the  
231 commissioner of public health or the commissioner's designee; the executive director of the  
232 Massachusetts Behavioral Health Partnership or the executive director's designee; the executive  
233 director of the state 911 department or the executive director's designee; the executive director of  
234 Mass 2-1-1 or the executive director's designee; a representative designated by the  
235 Massachusetts chapter of the National Association of Social Workers, Inc.; a 911 dispatcher  
236 designated by the Massachusetts Chiefs of Police Association Incorporated; an emergency  
237 medical technician or first responder nominated by the Massachusetts Ambulance Association,  
238 Incorporated; and the following members to be appointed by the chair: 1 representative from an  
239 emergency service provider, nominated by the Association for Behavioral Healthcare, Inc.; 1  
240 representative from the Association for Behavioral Healthcare, Inc.; 1 representative from a  
241 suicide prevention hotline in the commonwealth, nominated by the Samaritans, Inc.; 1  
242 representative from the Riverside Community Care, Inc. MassSupport program; 1 representative  
243 from the Massachusetts Coalition for Suicide Prevention; 1 representative from the Children's  
244 Mental Health Campaign; 1 representative from the INTERFACE Referral Service at William  
245 James College, Inc.; 1 representative from the National Alliance on Mental Illness of  
246 Massachusetts, Inc.; 1 representative from the Parent/Professional Advocacy League, Inc.; 1  
247 representative from the Massachusetts Association for Mental Health, Inc.; 1 representative from  
248 the Boston branch of the National Association for the Advancement of Colored People; 1  
249 representative from the American Civil Liberties Union of Massachusetts, Inc.; 1 representative  
250 from the mental health legal advisors committee; and 3 persons who are or have been consumers

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

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

256 Section 16EE. (a) Subject to appropriation, the executive office of health and human  
257 services, in coordination with the department of elementary and secondary education, shall  
258 develop and implement a statewide program to assist in implementing behavioral health services  
259 and supports in each school district which shall include, but not be limited to, consultation,  
260 coaching and technical assistance.

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

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

272 Health Integrated Resources for Children Project within the University of Massachusetts at  
273 Boston.

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

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

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

285 (b) There shall be, within the executive office of public safety and security, a state 911  
286 commission to provide strategic oversight and guidance to the department, and to advise the  
287 department relative to its annual budget and all material changes thereto and in all matters  
288 regarding enhanced 911 service in the commonwealth. The commission shall consist of: the  
289 secretary of public safety and security, who shall serve as chairperson; the chief information  
290 officer of the information technology division; the colonel of state police; the state fire marshal;  
291 the police commissioner of the city of Boston; the director of the Massachusetts office on  
292 disability; the commissioner of public health; the commissioner of mental health; the  
293 commissioner of the Massachusetts commission for the deaf and hard of hearing; and 13

294 members to be appointed by the governor, 1 of whom shall be a sitting police chief and a  
295 representative of the Massachusetts Chiefs of Police Association, Inc., 1 of whom shall be a  
296 representative of the Massachusetts Police Association, Inc., 1 of whom shall be a sitting police  
297 chief and a representative of the Massachusetts Major City Chiefs Association, 2 of whom shall  
298 be sitting fire chiefs and representatives of the Massachusetts Fire Chiefs Association, 1 of  
299 whom shall be a representative of the Professional Fire Fighters of Massachusetts, 1 of whom  
300 shall be a representative of the Massachusetts Sheriffs Association, Inc., 1 of whom shall be a  
301 representative of the Massachusetts Municipal Association, Inc., 1 of whom shall be a  
302 representative of the Massachusetts Emergency Medical Care Advisory Board, 1 of whom shall  
303 be a representative of the Massachusetts Ambulance Association, Inc., 1 of whom shall be a  
304 manager or supervisor of a PSAP and a representative of the Massachusetts Communication  
305 Supervisors Association, Inc., 1 of whom shall be a representative of the Association for  
306 Behavioral Healthcare, Inc. with experience in delivering psychiatric emergency services, and 1  
307 of whom shall be an individual with lived experience with behavioral health conditions and  
308 interactions with police. One of the governor's appointees shall be elected annually by the  
309 commission as its vice chairperson. Members of the commission shall be appointed for terms of  
310 3 years with no limit on the number of terms they may serve. Members shall hold office until a  
311 successor is appointed and no member shall serve beyond the time the member ceases to hold the  
312 office or employment that made the member eligible for appointment to the commission. The  
313 commission shall meet at least twice annually, and at other times as necessary. A meeting of the  
314 commission may be called by its chairperson, the vice chairperson or 3 of its members. A  
315 quorum for the transaction of business shall consist of 9 members. Members of the commission  
316 shall receive no compensation, but shall be reimbursed for their expenses actually and

317 necessarily incurred in the discharge of their duties. The commission shall review and approve  
318 by a majority vote of those members present all formulas, percentages, guidelines or other  
319 mechanisms used to distribute the grants described in this section, and all major contracts that the  
320 department proposes to enter into for enhanced 911 services. The commission shall review and  
321 approve by a majority vote of those members present all regulations and standards proposed by  
322 the department.

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

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

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

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



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

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

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

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

353 SECTION 8A. Said chapter 6A is hereby further amended by inserting after section 18D  
354 the following section:-

355 Section 18D½. (a) The department shall, in consultation with organizations representing  
356 the mobility, hearing, speech and sight impaired communities, create and publish on its website a  
357 statewide disability indicator form which a person may complete and submit to the department to  
358 notify primary and regional PSAPs of certain disabilities as described in subsection (c). The  
359 disability indicator form shall be available to subscribers of a wireless carrier, a wireline carrier  
360 or a prepaid wireless telephone service.

361 (b) The disability indicator form shall be written in clear language that is comprehensible  
362 to a person proficient in English at the fifth grade level and accessible to persons with visual  
363 disabilities. In any area where at least 5 per cent of citizens speak a language other than English  
364 as determined by the most recent American Community Survey of the United States Census  
365 Bureau, the disability indicator form shall be translated into such language.

366 (c) The disability indicator form shall include space for the person to identify any mental  
367 health needs, intellectual and developmental disabilities, complex medical needs or neurological  
368 impairments, including, but not limited to, identification that the person: (i) uses equipment  
369 required to sustain the person's life; (ii) is bedridden, a wheelchair user or has another mobility  
370 impairment; (iii) is legally blind; (iv) is deaf or hard of hearing; (v) may communicate on the  
371 telephone via teletypewriter; (vi) has a speech impairment; (vii) is cognitively impaired; (viii)  
372 has a service animal; (ix) requires translation services; or (x) has other potential triggers for  
373 which first responders should be aware. The disability indicator form shall also include an option  
374 for a person to remove or change any disability indicators.

375 (d) The department, in consultation with organizations representing the mobility, hearing,  
376 speech and sight impaired communities, shall annually review the contents of the disability  
377 indicator form and amend the disability indicator form as needed, as determined by the  
378 department.

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

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

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

389 Section 20. Every 3 years, the commission, in collaboration with the department of public  
390 health, the department of mental health and the department of developmental services, shall  
391 prepare a pediatric behavioral health planning report analyzing the status of pediatric behavioral  
392 health in the commonwealth. The report shall include, but not be limited to: (i) a review of data  
393 from the online portal established in section 16P of chapter 6A and the reports submitted to the  
394 commission pursuant to paragraph (5) of subsection (b) of said section 16P; (ii) an analysis of the  
395 availability of pediatric acute psychiatric beds, crisis stabilization unit beds, community-based  
396 acute treatment beds, intensive community-based acute treatment beds, continuing care unit beds  
397 and post-hospitalization residential beds, broken down by geographic region and by sub-  
398 specialty, and an identification of any service limitations; (iii) an analysis of the capacity of the  
399 pediatric behavioral health workforce to respond to the acute behavioral health needs of children  
400 and adolescents across the commonwealth; (iv) any statutory, regulatory or operational factors  
401 that may impact pediatric boarding under said section 16P; and (v) any other information deemed  
402 relevant by the commission. The report shall be published on the commission’s website.

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

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

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

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

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

430 (A) 12 members shall be licensed practicing mental health and human services  
431 professionals and shall have been, for at least 5 years immediately preceding appointment,  
432 actively engaged as a practitioner rendering professional services in that field, in the education  
433 and training of graduate students or interns in the field, in appropriate human developmental  
434 research, or in another area substantially equivalent thereto, and shall, during the 2 years  
435 preceding the appointment, have spent the majority of their professional time in such activity in  
436 the commonwealth. One of the 12 shall also be a member of a union licensable under sections  
437 163 to 172, inclusive, of chapter 112.

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

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

446 Any qualifying student health insurance plan authorized under this chapter shall comply  
447 with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity  
448 Act of 2008, sections 511 and 512 of Public Law 110–343, as amended, and any federal  
449 guidance or regulations relevant to the act, including 45 CFR Part 146.136, 45 CFR Part  
450 147.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3), and the benefit mandates and  
451 other obligations under section 47B of chapter 175, section 8A of chapter 176A, section 4A of  
452 chapter 176B and sections 4, 4B and 4M of chapter 176G, as if the student health insurance plan  
453 was issued by such carriers licensed under said chapters 175, 176A, 176B and 176G without  
454 regard to any limitation under section 1 of chapter 176J.

455

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

458 Section 12A. (a)(1) The department shall develop performance standards necessary for  
459 prohibiting or significantly limiting the use of suspension and expulsion in all licensed early  
460 education and care programs pursuant to clause (t) of section 2. The standards shall be developed  
461 with input from relevant stakeholders including, but not limited to the mixed delivery early  
462 education and child care field.

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

467 (b) The performance standards shall include, but not be limited to: (i) benchmarks and  
468 goals for supporting children’s social, emotional and behavioral development to (A) reduce the  
469 use of expulsion as a disciplinary tool; (B) guidance on eliminating disparities in the use of  
470 suspension and expulsion, (C) facilitate referrals for children with intensive needs; and (D)  
471 establish programs to provide transitional support for children returning to early education and  
472 care programming after extended absences, including behavioral health-related absences; (ii)  
473 engagement steps to be taken with the child and parent or guardian prior to suspension or  
474 expulsion; (iii) requirements for communicating disciplinary policies, including suspension and  
475 expulsion policies, to staff, families, guardians and community partners; (iv) pathways for  
476 programs to access technical assistance through the statewide program established in section  
477 16EE of chapter 6A to support ongoing development of staff and teacher skills for supporting  
478 children’s social, emotional and behavioral development, reducing disparities and limiting the  
479 use of suspension and expulsion; and (v) requirements for assessing and documenting a serious  
480 ongoing threat to the safety of others. SECTION 16. Section 5 of chapter 18C of the General  
481 Laws, as appearing in the 2020 Official Edition, is hereby amended by striking out subsection (d)  
482 and inserting in place thereof the following subsection:-

483 (d) The child advocate shall receive complaints from children, including children in the  
484 care of the commonwealth, families and guardians and shall assist such persons in resolving  
485 problems and concerns associated with placement, access to behavioral health services, plans for  
486 life-long adult connections and independent living and decisions regarding custody of persons  
487 aged between 18 and 22, including ensuring that relevant executive agencies have been alerted to  
488 the complaint and facilitating inter-agency cooperation, if appropriate. For the purposes of this

489 section, the office shall develop procedures to ensure appropriate responses to the concerns of  
490 youth in foster care.

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

493 Section 19A. (a) The department shall establish clinical competencies and additional  
494 operational standards for care and treatment of patients admitted to facilities licensed pursuant to  
495 104 CMR 27.00, including for specialty populations identified by the department. In establishing  
496 the clinical competencies and operational standards, the department shall consider national and  
497 local standards of practice where such standards of practice exist, and to the extent deemed  
498 appropriate by the department. In establishing the clinical competencies, the department shall  
499 utilize all data collected to identify the behavioral health needs of the commonwealth and consult  
500 with relevant stakeholders, including, but not limited to, inpatient psychiatric facilities,  
501 emergency departments, emergency service providers, Medicaid managed care organizations and  
502 commercial carriers. The department shall update the clinical competencies on a biennial or as-  
503 needed basis.

504 (b) The department shall issue regulations requiring facilities licensed pursuant to 104  
505 CMR 27.00 to have a clinical affiliation with an acute care hospital to ensure access by patients  
506 to medical services; provided, however, that facilities that are located within an acute care  
507 hospital licensed under section 51 of chapter 111 are not subject to said regulations. Such  
508 affiliation shall include, but not be limited to, patient care, testing and patient diagnostics.

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



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

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

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

524 (c) Notwithstanding any general or special law to the contrary, and subject to any  
525 applicable federal law, a facility may deny admission to a patient whose needs have been  
526 determined by the facility's medical director to exceed the facility's capability at the time  
527 admission is sought. The determination shall include the factors justifying denial of admission  
528 and why mitigating efforts, such as utilization of additional staff, would have been inadequate.  
529 This determination shall be recorded in writing and shall be subject to review by the department;  
530 provided, however, that such written determination provided to the department shall not be  
531 required to include personally identifiable information.

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

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

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

546 (b) The advisory council shall consist of the following members: the commissioner of  
547 mental health or a designee, who shall serve as chair; the commissioner of public health or a  
548 designee; the director of the office of Medicaid or a designee; the commissioner of insurance or a  
549 designee; a representative from the Massachusetts Association of Health Plans, Inc.; a  
550 representative of Blue Cross and Blue Shield of Massachusetts, Inc.; a representative of the  
551 Massachusetts Health and Hospital Association, Inc.; a representative of the Massachusetts  
552 College of Emergency Physicians, Inc.; a representative of the Association for Behavioral  
553 Healthcare, Inc.; a representative of the National Alliance on Mental Illness of Massachusetts,

554 Inc.; a representative of the Massachusetts Association of Behavioral Health Systems, Inc.; a  
555 member representing emergency services providers; and a consumer representative with lived  
556 experience boarding in an emergency department.

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

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

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

579 SECTION 19. Chapter 26 of the General Laws is hereby amended by striking out section  
580 8K, as appearing in the 2020 Official Edition, and inserting in place thereof the following  
581 section:-

582 Section 8K. (a) The commissioner of insurance shall implement and enforce applicable  
583 provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction  
584 Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended, any federal  
585 guidance or regulations relevant to the act, including 45 CFR Part 146.136, 45 CFR Part  
586 147.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3), and applicable state mental  
587 health parity laws, including, but not limited to, section 47B of chapter 175, section 8A of  
588 chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter 176G, in regard  
589 to any carrier licensed under said chapters 175, 176A, 176B or 176G or any carrier offering a  
590 student health plan issued under section 18 of chapter 15A by:

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

594 (ii) performing behavioral health parity compliance market conduct examinations of each  
595 carrier not less than once every 5 years, or more frequently if noncompliance is suspected, with a  
596 focus on: (A) non-quantitative treatment limitations under the federal Paul Wellstone and Pete  
597 Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of  
598 Public Law 110–343, as amended, and applicable state mental health and substance use disorder

599 parity laws, including, but not limited to, prior authorization, concurrent review, retrospective  
600 review, step-therapy, network admission standards, reimbursement rates, network adequacy and  
601 geographic restrictions; (B) denials of authorization, payment and coverage; and (C) any other  
602 criteria determined by the division of insurance, including factors identified through consumer or  
603 provider complaints; provided, however, that: (1) a market conduct examination of a carrier  
604 subject to said chapter 175, 176A, 176B or 176G shall follow the procedural requirements in  
605 subsections 10, 11 and 15 of section 4 of said chapter 175 regarding notice and rebuttal of  
606 examination findings, subsequent hearings and conflicts of interest; (2) the commissioner shall  
607 publicize the fees for a market conduct examination under section 3B of chapter 7 and said  
608 subsection 11 of said section 4 of said chapter 175; and (3) nothing contained in this clause or in  
609 said section 4 of said chapter 175, section 7 of said chapter 176A, section 9 of said chapter 176B  
610 and section 10 of said chapter 176G shall limit the commissioner's authority to use and, if  
611 appropriate, publish any final or preliminary examination report, any examiner or company work  
612 papers or other documents or any other information discovered or developed during the course of  
613 any examination in the furtherance of any legal or regulatory action that the commissioner may,  
614 in their sole discretion, deem appropriate;

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

619 (iv) updating applicable regulations as necessary to effectuate any provisions of the  
620 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of  
621 2008, sections 511 and 512 of Public Law 110-343, as amended, that relate to insurance; and

622 (v) assessing a fee upon any carrier for the costs and expenses incurred in any market  
623 conduct examination authorized by law, consistent with the costs associated with the use of  
624 division personnel and examiners, the costs of retaining qualified contract examiners necessary  
625 to perform an examination, electronic data processing costs, supervision and preparation of an  
626 examination report and lodging and travel expenses; provided, however, that the commissioner  
627 shall maintain active management and oversight of examination costs and fees to ensure that the  
628 examination costs and fees comply with the National Association of Insurance Commissioners  
629 market conduct examiners standards unless the commissioner demonstrates that the fees  
630 prescribed in the handbook are inadequate under the circumstances of the examination; and  
631 provided further, that the commissioner or the commissioner's examiners shall not receive or  
632 accept any additional emolument on account of any examination.

633 (b) The commissioner may impose a penalty against a carrier that provides mental health  
634 or substance use disorder benefits, directly or through a behavioral health manager as defined in  
635 section 1 of chapter 176O, or any other entity that manages or administers such benefits for the  
636 carrier, for any violation, by the carrier or the entity that manages or administers mental health  
637 and substance use disorder benefits for the carrier, of state laws related to mental health and  
638 substance use disorder parity or the mental health parity provisions of the federal Paul Wellstone  
639 and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and  
640 512 of Public Law 110-343, as amended, and federal guidance or regulations issued under the  
641 act.

642 The amount of any penalty imposed shall be \$100 for each day in the noncompliance  
643 period per product line with respect to each participant or beneficiary to whom such violation  
644 relates; provided, however, that the maximum annual penalty under this subsection shall be

645 \$1,000,000; provided further, that for purposes of this subsection, the term “noncompliance  
646 period” shall mean the period beginning on the date a violation first occurs and ending on the  
647 date the violation is corrected.

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

651 (c) If a violation of state laws related to mental health and substance use disorder parity  
652 or the mental health parity provisions of the federal Paul Wellstone and Pete Domenici Mental  
653 Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343,  
654 as amended, and federal guidance or regulations issued under the act, was likely to have caused  
655 denial of access to behavioral health services, the commissioner shall require the carrier to  
656 provide remedies for any failure to meet the requirements of state laws related to mental health  
657 and substance use disorder parity or the mental health parity provisions of the federal Paul  
658 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, sections  
659 511 and 512 of Public Law 110–343, as amended, and federal guidance or regulations issued  
660 under the act, which may include, but shall not be limited to:

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

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

664 (iii) informing plan members of changes;

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

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

670 (d) Any proprietary information submitted to the commissioner by a carrier as a result of  
671 the requirements of this section shall not be a public record under clause Twenty-sixth of section  
672 7 of chapter 4 or chapter 66; provided, however, that the commissioner may produce reports  
673 summarizing any findings.

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

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



687           The commissioner shall review consumer complaints under this subsection using the  
688 legal standards pertaining to quantitative treatment limitations and non-quantitative treatment  
689 limitations under applicable state and federal mental health and substance use disorder parity  
690 laws, regulations and guidance, including, but not limited to, 45 CFR Part 146.136 and 29 CFR  
691 Part 2590.712. When reviewing the complaint, the commissioner shall consider: (i) any related  
692 right to a treatment or service under any related state or federal law or regulation; (ii) written  
693 documents submitted by the complainant; (iii) medical records and medical opinions by the  
694 complainant’s treating provider that requested or provided a disputed service, which shall be  
695 obtained by the complainant’s carrier or by the commissioner if the carrier fails to do so; (iv) the  
696 relevant results of any behavioral health parity compliance market conduct examination  
697 conducted and completed under clause (ii) of subsection (a); (v) any relevant information  
698 included in a carrier’s annual reporting requirements under section 8M; (vi) additional  
699 information from the involved parties or outside sources that the commissioner deems necessary  
700 or relevant; and (vii) information obtained from any informal meeting held by the commissioner  
701 with the parties. The commissioner shall send final written disposition of the complaint and the  
702 reasons for the commissioner’s decision to the complainant and the carrier not more than 90 days  
703 after the receipt of the written complaint. If the commissioner determines that a violation of a  
704 state or federal mental health and substance use disorder parity law occurred, the commissioner  
705 shall exercise its enforcement authority pursuant to subsections (b) and (c).

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

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

712 (h) Nothing in this section shall prevent the commissioner from publishing any  
713 illustrative utilization review criteria, medical necessity standard, clinical guideline or other  
714 policy, procedure, criteria or standard, regardless of its origin, as an example of the type of  
715 policy, procedure, criteria or standard that contributes to a violation of state or federal law parity  
716 requirements, including any document that would normally be subject to disclosure to plan  
717 members or their providers under section 16 of chapter 6D, section 16 of chapter 176O or the  
718 federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of  
719 2008, sections 511 and 512 of Public Law 110–343, as amended.

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

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

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

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

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

739 (iii) the results of an analysis that demonstrates that for the medical necessity criteria  
740 described in clause (i) and for each non-quantitative treatment limitation identified in clause (ii),  
741 as written and in operation, the processes, strategies, evidentiary standards or other factors used  
742 in applying the medical necessity criteria and each non-quantitative treatment limitation to  
743 mental health and substance use disorder benefits within each classification of benefits are  
744 comparable to, and are applied no more stringently than, the processes, strategies, evidentiary  
745 standards or other factors used in applying the medical necessity criteria and each non-  
746 quantitative treatment limitation for medical and surgical benefits within the corresponding  
747 classification of benefits.

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

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

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

753 (iii) provide the comparative analyses, including the results of the analyses performed to  
754 determine that the processes and strategies used to design each non-quantitative treatment  
755 limitation, as written, and the as-written processes and strategies used to apply the non-  
756 quantitative treatment limitation to mental health and substance use disorder benefits are  
757 comparable to, and are applied no more stringently than, the processes and strategies used to  
758 design each non-quantitative treatment limitation, as written, and the as written processes and  
759 strategies used to apply the non-quantitative treatment limitation for medical and surgical  
760 benefits;

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

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

772 (4) In completing the analyses required in clause (iii) of paragraph (2), carriers shall not  
773 be required to examine each medical or surgical benefit subject to a non-quantitative treatment  
774 limitation that also applies to mental health and substance use disorder benefits in the

775 classification and shall perform the required analyses broadly across each classification of  
776 benefits. Carriers may use any reasonable method to determine the method of selecting medical  
777 and surgical benefits subject to a non-quantitative treatment limitation in the classification for the  
778 purpose of performing the comparative analyses; provided, that it shall not be considered  
779 reasonable to select only certain medical and surgical benefits with the same characteristics as  
780 the mental health and substance use disorder benefits subject to the non-quantitative treatment  
781 limitation, and not all medical and surgical benefits sharing the same characteristics as the  
782 mental health and substance use disorder benefits subject to the non-quantitative treatment  
783 limitation, in a classification for the purposes of performing the analyses.

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

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

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

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

801 (iv) information on any educational or corrective actions the commissioner has taken to  
802 ensure health carrier compliance with the federal Paul Wellstone and Pete Domenici Mental  
803 Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343,  
804 as amended, and section 22 of chapter 32A, section 47B of chapter 175, section 8A of chapter  
805 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter 176G; and

806 (v) to the extent that any requirements of this section are inconsistent with or in excess of  
807 the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and  
808 Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended, and  
809 any amendments to, or regulations issued under that act, the requirements of federal law will  
810 prevail over the requirements of this section, in accordance with 42 U.S.C. 300gg-23(a)(1). If  
811 federal guidance, including, but not limited to, the Self-Compliance Tool for the federal Paul  
812 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, is  
813 released that indicates a non-quantitative treatment limitation analysis and reporting process that  
814 is significantly different than, contrary to, or more efficient than the non-quantitative treatment  
815 limitation analysis and reporting requirements described in clause (iii) of paragraph (2) of  
816 subsection (a), the commissioner may promulgate regulations that delineate a non-quantitative  
817 treatment limitation analysis and reporting format that may be used in lieu of the non-  
818 quantitative treatment limitation analysis and reporting requirements described in said clause  
819 (iii).

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

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

824 Section 2TTTTT. (a) There shall be an interagency services reserve fund established on  
825 the books of the commonwealth to be expended without prior appropriation. The fund shall be  
826 credited with money from public and private sources, including gifts, grants and donations,  
827 interest earned on such money, any other money authorized by the general court and specifically  
828 designated to be credited to the fund and any funds provided from other sources. Money in the  
829 fund shall be used to fund the operations of the interagency review team established under  
830 section 16R of chapter 6A. The secretary of health and human services shall administer the fund  
831 and shall make expenditures for the purpose of covering the cost of providing additional  
832 evaluation as needed by the interagency review team for an individual eligible under said section  
833 16R of said chapter 6A. Any unexpended balance in the fund at the end of a fiscal year shall not  
834 revert to the General Fund and shall be available for expenditure in the subsequent fiscal year.

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

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

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

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

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

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

853 (b) The commission shall provide to any active or retired employee of the commonwealth  
854 who is insured under the group insurance commission coverage for medically necessary mental  
855 health acute treatment, community-based acute treatment and intensive community-based acute  
856 treatment and shall not require a preauthorization before obtaining treatment; provided, however,  
857 that the facility shall notify the carrier of the admission and the initial treatment plan within 72  
858 hours of admission.

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



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

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

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

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

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

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

880 “Licensed mental health professional”, a licensed physician who specializes in the  
881 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a

882 licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed  
883 physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor  
884 I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the  
885 lawful scope of practice for such therapist.

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

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

898 (b) Any coverage offered by the commission to an active or retired employee of the  
899 commonwealth insured under the group insurance commission shall provide coverage for an  
900 annual mental health wellness examination that is performed by a licensed mental health  
901 professional or primary care provider, which may be provided by the primary care provider as  
902 part of an annual preventive visit.

903 SECTION 25. Chapter 69 of the General Laws is hereby amended by striking out section  
904 8A, as appearing in the 2020 Official Edition, and inserting in place thereof the following  
905 section:-

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

912 (b) Each plan shall include:

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

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

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

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

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

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

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

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

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

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

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

953 (e) The department, in consultation with the department of public health and the  
954 department of mental health, shall develop a cost-neutral model medical and behavioral health  
955 emergency response plan in order to promote best practices, including clear guidelines for the  
956 roles and responsibilities of behavioral health professionals, including, but not limited to, school  
957 counselors and community intervention professionals and, where applicable, school resource  
958 officers or police officers on school campuses; provided, that such model plan shall be designed  
959 to limit referrals to law enforcement or arrests on school property to cases in which an imminent  
960 risk to the health and safety of individuals on school property necessitates such referral or arrest.  
961 The model plan shall be made available to school committees and commonwealth charter school  
962 boards. In developing the model plan, the department shall refer to research prepared by the  
963 American Heart Association, Inc., the American Academy of Pediatrics, MassHealth and other  
964 relevant organizations that identify the essential components of a medical and behavioral health

965 emergency response plan. The department shall biennially review and update the model plan and  
966 publicly post the model plan on its website.

967 SECTION 25A. Section 37H<sup>3</sup>/<sub>4</sub> of chapter 71 of the General Laws, as so appearing, is  
968 hereby amended by striking out paragraph (b) and inserting in place thereof the following  
969 paragraph:-

970 (b) Any principal, headmaster, superintendent or person acting as a decision-maker at a  
971 student meeting or hearing, when deciding the consequences for the student, shall consider ways  
972 to re-engage the student in the learning process; and shall not suspend or expel a student until  
973 alternative remedies have been employed and their use and results documented, following and in  
974 direct response to a specific incident or incidents, except in cases where the student's continued  
975 presence in school would pose a specific, documentable concern about the infliction of serious  
976 bodily injury upon another person while in school. Alternative remedies may include, but shall  
977 not be limited to: (i) mediation; (ii) conflict resolution; (iii) restorative justice; and (iv)  
978 collaborative problem solving. The principal, headmaster, superintendent or person acting as a  
979 decision-maker shall also implement school- or district-wide models to re-engage students in the  
980 learning process, which shall include but not be limited to: (i) positive behavioral interventions  
981 and supports models and (ii) trauma sensitive learning models; provided, however, that school-  
982 or district-wide models shall not be considered a direct response to a specific incident.

983 SECTION 26. Section 37Q of chapter 71 of the General Laws, as so appearing, is hereby  
984 amended by inserting after the word "school", in line 22, the first time it appears, the following  
985 words:- ; provided, that the medical and behavioral health emergency response plans submitted

986 pursuant to section 8A of chapter 69 shall satisfy the requirement for emergency and acute  
987 treatment planning required by this section.

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

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

993 (b) The training and curriculum for the program shall include, but not be limited to: (i)  
994 military culture and its influence on the behavioral health of service members and veterans; (ii)  
995 symptoms of deployment-related and non-deployment-related behavioral health conditions,  
996 including, but not limited to, depression, suicide, insomnia, substance use and post-traumatic  
997 stress disorder; (iii) deployment cycle stressors for students who are service members and  
998 veterans; (iv) deployment cycle stressors that impact the behavioral health of service members  
999 and veterans; (v) outreach strategies for available administrative, non-clinical and clinical  
1000 services; and (vi) available resources and methods of referral for the treatment of deployment-  
1001 related behavioral health conditions, including peer support.

1002 (c) In developing the curriculum for the program, the University of Massachusetts  
1003 medical school shall consult with relevant stakeholders, including, but not limited to: (i) medical  
1004 professional associations; (ii) peers and other service members and veterans who have lived  
1005 experience of seeking or receiving behavioral health services or treatment; and (iii) behavioral  
1006 health professionals with expertise in providing culturally-competent care.

1007 SECTION 28. Chapter 111 of the General Laws is hereby amended by inserting after  
1008 section 51½ the following section:-

1009 Section 51¾. The department, in consultation with the department of mental health, shall  
1010 promulgate regulations requiring all acute-care hospitals licensed under section 51G to provide,  
1011 or arrange for, licensed mental health professionals during all operating hours of an emergency  
1012 department or a satellite emergency facility as defined in section 51½ to evaluate and stabilize a  
1013 person admitted with a mental health presentation to the emergency department or satellite  
1014 emergency facility and to refer such person for appropriate treatment or inpatient admission. The  
1015 regulations shall define “licensed mental health professional”, which shall include, but not be  
1016 limited to, a: (i) licensed physician who specializes in the practice of psychiatry; (ii) licensed  
1017 psychologist; (iii) licensed independent clinical social worker; (iv) licensed certified social  
1018 worker; (v) licensed mental health counselor; (vi) licensed physician assistant who practices in  
1019 the field of psychiatry (vii) licensed psychiatric clinical nurse specialist; or (viii) healthcare  
1020 provider, as defined in section 1, qualified within the scope of the individual’s license to conduct  
1021 an evaluation of a mental health condition, including an intern, resident or fellow pursuant to the  
1022 policies and practices of the hospital and medical staff.

1023 The regulations shall permit evaluation via telemedicine, electronic or telephonic  
1024 consultation, as deemed appropriate by the department.

1025 The regulations shall be promulgated after consultation with the department of mental  
1026 health and the division of medical assistance and shall include, but not be limited to,  
1027 requirements that individuals under the age of 22 receive an expedited evaluation and  
1028 stabilization process.



1029 SECTION 29. Said chapter 111 is hereby further amended by inserting after section 51K  
1030 the following section:-

1031 Section 51L. (a) For the purposes of this section, the following words shall, unless the  
1032 context clearly requires otherwise, have the following meanings:

1033 “Acute-care hospital”, any hospital licensed pursuant to section 51G that contains a  
1034 majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the  
1035 department and the teaching hospital of the University of Massachusetts medical school.

1036 “Satellite emergency facility”, a health care facility that operates 7 days per week, 24  
1037 hours per day that is located off the premises of a hospital but is listed on the license of a hospital  
1038 and is authorized to accept patients transported to the facility by ambulance.

1039 (b) An acute-care hospital or a satellite emergency facility shall ensure that all policies  
1040 and protocols developed by the acute-care hospital or satellite emergency facility shall be applied  
1041 and implemented on a nondiscriminatory basis such that such policies and protocols shall not  
1042 discriminate between patients presenting with a mental health or substance use condition and  
1043 patients presenting with a medical or surgical condition.

1044 (c) An acute-care hospital or a satellite emergency facility shall annually review its  
1045 policies and procedures to ensure that such policies and procedures do not discriminate between  
1046 patients presenting with a mental health or substance use condition and patients presenting with a  
1047 medical or surgical condition and are applied and implemented on a nondiscriminatory basis.  
1048 Following the review, the acute-care hospital or the satellite emergency facility shall submit a  
1049 certification to the department and the department of mental health, signed by the acute-care  
1050 hospital’s or the satellite emergency facility’s chief executive officer and chief medical officer,

1051 that states that the acute-care hospital or the satellite emergency facility has completed a  
1052 comprehensive review of the policies and procedures of the acute-care hospital or the satellite  
1053 emergency facility for the preceding calendar year for compliance with this section and any  
1054 accompanying regulations.

1055 (d) As part of the review pursuant to subsection (c), an acute-care hospital or a satellite  
1056 emergency facility shall review its policies and procedures in the following areas:

1057 (1) administrative policies and procedures, which may include, but shall not be limited to,  
1058 acquiring and maintaining equipment, policies on vendor requirements, licensing and credentials,  
1059 and records requirements;

1060 (2) operational policies and procedures, which may include, but shall not be limited to,  
1061 information technology, physical maintenance, safety and security, food preparation, emergency  
1062 management and disaster plans;

1063 (3) patient care policies and procedures, which may include, but shall not be limited to,  
1064 patient admission and discharge policies and decision-making, patient flow policies, patient  
1065 discharge planning, consultation, clinical competencies, charting processes and patient rights,  
1066 patient and staff security and infection prevention;

1067 (4) medication policies and procedures, which may include, but shall not be limited to,  
1068 paperwork requirements for medicine, inventory control, dose distribution systems and disposing  
1069 of expired drugs;

1070 (5) human resources and staffing policies and procedures, which may include, but shall  
1071 not be limited to, staff hiring decisions, training, patient care ratios, scheduling and staffing for  
1072 emergency management and disaster plans; and

1073 (6) payment and financial policies and procedures, which may include, but shall not be  
1074 limited to, investment and resource allocation, billing and payment policies and staff salaries and  
1075 reimbursement.

1076 (e) The department, in consultation with the department of mental health, shall  
1077 promulgate regulations necessary to carry out this section, including the development of  
1078 reporting procedures and a standard format for facility self-reporting and annual compliance  
1079 certification.

1080 SECTION 30. Said chapter 111 is hereby further amended by adding the following  
1081 section:-

1082 Section 244. The department shall administer an initiative to increase public awareness of  
1083 and education on the availability of the extreme risk protection order process established  
1084 pursuant to sections 131R to 131Y, inclusive, of chapter 140, to remove a firearm from the  
1085 control, ownership or possession of an individual who poses a risk of causing bodily injury to  
1086 themselves or others. The initiative shall focus on the heightened risk of suicide associated with the  
1087 possession of a firearm and shall include information on: (i) eligibility to petition for an extreme  
1088 risk protection order; (ii) the procedure to petition for an extreme risk protection order; (iii)  
1089 options to voluntarily surrender a firearm to a law enforcement agency; and (iv) the availability  
1090 of existing legal resources and support services for a potential petitioner.

1091 SECTION 31. Chapter 118E of the General Laws is hereby amended by inserting after  
1092 section 10N the following 3 sections:-

1093 Section 10O. As used in this section, the following terms shall, unless the context clearly  
1094 requires otherwise, have the following meanings:

1095 “Community-based acute treatment”, 24-hour clinically managed mental health  
1096 diversionary or step-down services for children and adolescents that is usually provided as an  
1097 alternative to mental health acute treatment.

1098 “Intensive community-based acute treatment”, intensive 24-hour clinically managed  
1099 mental health diversionary or step-down services for children and adolescents that is usually  
1100 provided as an alternative to mental health acute treatment.

1101 “Mental health acute treatment”, 24-hour medically supervised mental health services  
1102 provided in an inpatient facility, licensed by the department of mental health, that provides  
1103 psychiatric evaluation, management, treatment and discharge planning in a structured treatment  
1104 environment.

1105 The division and its contracted health insurers, health plans, health maintenance  
1106 organizations, behavioral health management firms and third-party administrators under contract  
1107 to a Medicaid managed care organization or primary care clinician plan shall cover the cost of  
1108 medically necessary mental health acute treatment, community-based acute treatment and  
1109 intensive community-based acute treatment and shall not require a preauthorization before  
1110 obtaining treatment; provided, however, that the facility shall notify the carrier of the admission  
1111 and the initial treatment plan within 72 hours of admission.

1112 Section 10P. (a) For the purposes of this section, “psychiatric collaborative care model”  
1113 shall mean the evidence-based, integrated behavioral health service delivery method in which a  
1114 primary care team consisting of a primary care provider and a care manager provides structured  
1115 care management to a patient, and that works in collaboration with a psychiatric consultant that  
1116 provides regular consultations to the primary care team to review the clinical status and care of  
1117 patients and to make recommendations.

1118 (b) The division and its contracted health insurers, health plans, health maintenance  
1119 organizations, behavioral health management firms and third-party administrators under contract  
1120 to a Medicaid managed care organization or primary care clinician plan shall provide coverage  
1121 for mental health or substance use disorder services that are delivered through the psychiatric  
1122 collaborative care model.

1123 Section 10Q. (a) As used in this section, the following words shall, unless the context  
1124 clearly requires otherwise, have the following meanings:

1125 “Licensed mental health professional”, a licensed physician who specializes in the  
1126 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a  
1127 licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed  
1128 physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor  
1129 I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the  
1130 lawful scope of practice for such therapist.

1131 “Mental health wellness examination”, a screening or assessment that seeks to identify  
1132 any behavioral or mental health needs and appropriate resources for treatment. The examination  
1133 may include: (i) observation, a behavioral health screening, education and consultation on

1134 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other  
1135 necessary supports and discussion of potential options for medication; and (ii) age-appropriate  
1136 screenings or observations to understand a covered person’s mental health history, personal  
1137 history and mental or cognitive state and, when appropriate, relevant adult input through  
1138 screenings, interviews and questions.

1139 “Primary care provider”, a health care professional qualified to provide general medical  
1140 care for common health care problems who: (i) supervises, coordinates, prescribes or otherwise  
1141 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)  
1142 maintains continuity of care within the scope of practice.

1143 (b) The division and its contracted health insurers, health plans, health maintenance  
1144 organizations, behavioral health management firms and third-party administrators under contract  
1145 to a Medicaid managed care organization or primary care clinician plan shall provide coverage  
1146 for an annual mental health wellness examination that is performed by a licensed mental health  
1147 professional or primary care provider, which may be provided by the primary care provider as  
1148 part of an annual preventive visit.

1149 SECTION 32. Said chapter 118E is hereby further amended by inserting after section  
1150 13D the following section:-

1151 Section 13D½. (a) As used in this section, the following words shall, unless the context  
1152 clearly requires otherwise, have the following meanings:

1153 “Behavioral health services”, the evaluation, diagnosis, treatment, care coordination,  
1154 management or peer support of a patient with a mental health, developmental or substance use  
1155 disorder.

1156 “Community mental health center”, clinic which provides comprehensive ambulatory  
1157 mental health services and which is not financially or physically an integral part of a hospital.

1158 “Division”, the division of medical assistance.

1159 “Managed care entity”, health insurers, health plans, health maintenance organizations,  
1160 behavioral health management firms and third-party administrators under contract with a  
1161 Medicaid managed care organization or primary care clinician plan; provided, however, that  
1162 “managed care entity” shall also include accountable care organizations.

1163 “Minimum payment rates”, rates of payment for services below which managed care  
1164 entities shall not enter into provider agreements.

1165 (b) Annually, not later than January 1, the division shall review the minimum payment  
1166 rates to be paid to providers of behavioral health services delivered in community mental health  
1167 centers by managed care entities and submit a report to the house and senate committees on ways  
1168 and means, the joint committee on health care financing and the joint committee on mental  
1169 health, substance use and recovery identifying the difference between the minimum payment  
1170 rates decided by the division and the payment rates that managed care entities contractually agree  
1171 to pay providers for all behavioral health services delivered in community mental health centers.

1172 SECTION 33. Section 16C of said chapter 118E, as appearing in the 2020 Official  
1173 Edition, is hereby amended by inserting after paragraph (5) the following 2 paragraphs:-

1174 (6) The division shall submit an annual report not later than January 31 to the attorney  
1175 general, a summary of which shall be sent to the clerks of the house of representatives and the  
1176 senate not later than June 30 each year, that contains the following information regarding

1177 compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction  
1178 Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended, by the child  
1179 health insurance program:

1180 (a) a description of the process used to develop or select the medical necessity criteria for  
1181 mental health and substance use disorder benefits and the process used to develop or select the  
1182 medical necessity criteria for medical and surgical benefits;

1183 (b) identification of all non-quantitative treatment limitations that are applied to mental  
1184 health and substance use disorder benefits and medical and surgical benefits within each  
1185 classification of benefits, as defined in 42 CFR Part 457.496(d)(4)(ii); and that the processes,  
1186 strategies or methodologies for developing and applying the reimbursement rates for mental  
1187 health and substance use disorder benefits are comparable to and applied no more stringently  
1188 than those processes, strategies or methodologies for developing and applying the reimbursement  
1189 rates for medical and surgical benefits; and

1190 (c) the results of an analysis that demonstrates that for the medical necessity criteria  
1191 described in clause (a) and for each non-quantitative treatment limitation identified in clause (b),  
1192 as written and in operation, the processes, strategies, evidentiary standards or other factors used  
1193 in applying the medical necessity criteria and each non-quantitative treatment limitation to  
1194 mental health and substance use disorder benefits within each classification of benefits are  
1195 comparable to, and are applied no more stringently than, the processes, strategies, evidentiary  
1196 standards or other factors used in applying the comparable medical necessity criteria and non-  
1197 quantitative treatment limitation for medical and surgical benefits within the corresponding  
1198 classification of benefits; provided that, at a minimum, the results of the analysis shall:



1199 (i) identify the factors used to determine whether a non-quantitative treatment limitation  
1200 will apply to a benefit;

1201 (ii) identify any processes, strategies, or evidentiary standards used to define the factors  
1202 identified in subclause (i);

1203 (iii) provide the comparative analyses, including the results of the analyses subject to  
1204 paragraph (f) of clause (7), performed to determine that the processes and strategies used to  
1205 design each non-quantitative treatment limitation, as written, and the as written processes and  
1206 strategies used to apply the non-quantitative treatment limitation to mental health and substance  
1207 use disorder benefits are comparable to, and are applied no more stringently than, the processes  
1208 and strategies used to design each non-quantitative treatment limitation, as written, and the as  
1209 written processes and strategies used to apply the non-quantitative treatment limitation to  
1210 medical and surgical benefits;

1211 (iv) provide the comparative analyses, including the results of the analyses subject to  
1212 paragraph (f) of clause (7), performed to determine that the processes and strategies used to  
1213 apply each non-quantitative treatment limitation, in operation, for mental health and substance  
1214 use disorder benefits, including provider reimbursement rates, are comparable to, and applied no  
1215 more stringently than, the processes or strategies used to apply each non-quantitative treatment  
1216 limitation, in operation, for medical and surgical benefits, including provider reimbursement  
1217 rates;

1218 (v) subject to paragraph (f) of clause (7), disclose the findings and conclusions reached  
1219 by the division that the results of the analyses above indicate that the child health insurance  
1220 program is in compliance with this section and the federal Paul Wellstone and Pete Domenici

1221 Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related  
1222 regulations, including but not limited to 42 CFR Part 457.496; and

1223 (d) In completing the analyses required under this paragraph, the division or any  
1224 Medicaid managed care organization that contracts with the division shall not have to examine  
1225 each medical or surgical benefit subject to a non-quantitative treatment limitation that also  
1226 applies to mental health and substance use disorder benefits in the classification and shall  
1227 perform the required analyses broadly across each classification of benefits. The division or any  
1228 Medicaid managed care organization that contracts with the division may use any reasonable  
1229 method to determine how they will select medical and surgical benefits subject to a non-  
1230 quantitative treatment limitation in the classification for the purpose of performing the  
1231 comparative analyses, provided that selecting only certain medical and surgical benefits with the  
1232 same characteristics as the mental health and substance use disorder benefits subject to the non-  
1233 quantitative treatment limitation, and not all medical and surgical benefits sharing the same  
1234 characteristics as the mental health and substance use disorder benefits subject to the non-  
1235 quantitative treatment limitation, in a classification for the purposes of performing the analyses  
1236 shall not be considered reasonable.

1237 (7) The division shall issue a report to the clerks of the house of representatives and the  
1238 senate and the joint committee on mental health, substance use and recovery, which shall:

1239 (a) include the methodology the division uses to ensure compliance with the federal Paul  
1240 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and any  
1241 federal regulations or guidance relating to the compliance and oversight of the federal Paul  
1242 Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008;

1243 (b) identify any action taken by the division during the preceding 12-month period  
1244 regarding compliance with parity in mental health and substance use disorder benefits under state  
1245 and federal laws and summarize the results of such action;

1246 (c) detail any educational or corrective actions the division has taken to ensure Medicaid  
1247 managed care compliance with the federal Paul Wellstone and Pete Domenici Mental Health  
1248 Parity and Addiction Equity Act of 2008; and

1249 (d) be written in non-technical, readily understandable language. Medicaid managed care  
1250 organizations shall make a summary report, as approved by the division, available to the public  
1251 by, posting the report on the division's website.

1252 (e) To the extent that any requirements of this section are inconsistent with or in excess of  
1253 the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and  
1254 Addiction Equity Act of 2008 and any amendments to, or regulations issued under that act, the  
1255 requirements of federal law will prevail over the requirements of this section. If federal guidance,  
1256 including, but not limited to, the Self-Compliance Tool for the federal Paul Wellstone and Pete  
1257 Domenici Mental Health Parity and Addiction Equity Act of 2008, is released that indicates a  
1258 non-quantitative treatment limitation analysis and reporting process that is significantly different  
1259 than, contrary to, or more efficient than the non-quantitative treatment limitation analysis and  
1260 reporting requirements described in paragraph (6), the division may promulgate regulations that  
1261 delineate a non-quantitative treatment limitation analysis and reporting format that may be used  
1262 in lieu of the non-quantitative treatment limitation analysis and reporting requirements described  
1263 in paragraph (6).

1264 (f) Any proprietary portions of information submitted to the division by a Medicaid  
1265 managed care organization as a result of the requirements in this section shall not be made public  
1266 record.

1267 SECTION 34. Section 47 of said chapter 118E, as so appearing, is hereby amended by  
1268 inserting after the first paragraph the following paragraph:-

1269 Notwithstanding any general or special law to the contrary, the division shall promulgate  
1270 regulations that require the division, its contracted health insurers, health plans, health  
1271 maintenance organizations, behavioral health management firms and third-party administrators  
1272 under contract with the division, a Medicaid managed care organization or primary care clinician  
1273 plan, to maintain documentation of all requests for benefits or services, whether the request is  
1274 submitted by, or on behalf of, the intended recipient of those benefits or services. Any request  
1275 that is not fulfilled in full shall be considered a denial and shall result in the prompt written  
1276 notification to the intended recipient through electronic means, if possible. The notification shall  
1277 include a description of the requested service, the response by the entity and the intended  
1278 recipient's due process and appeal rights. All such entities shall accept requests for authorized  
1279 representatives or for appeals by electronic means.

1280 SECTION 35. Said chapter 118E is hereby further amended by adding the following 2  
1281 sections:-

1282 Section 80. Each Medicaid managed care organization or alternative benefit plan shall  
1283 submit an annual report not later than January 31 to the division, a copy of which shall be sent to  
1284 the clerks of the house of representatives and the senate not later than June 30 each year by the  
1285 division, that contains the following information:

1286 (a) a description of the process used to develop or select the medical necessity criteria for  
1287 mental health and substance use disorder benefits and the process used to develop or select the  
1288 medical necessity criteria for medical and surgical benefits;

1289 (b) identification of all non-quantitative treatment limitations that are applied to mental  
1290 health and substance use disorder benefits and medical and surgical benefits within each  
1291 classification of benefits, as defined in 42 CFR Part 438.910(d)(1) and 42 CFR Part  
1292 440.395(b)(4)(i); provided further, that the processes, strategies or methodologies for developing  
1293 and applying the reimbursement rates for mental health and substance use disorder benefits are  
1294 comparable to and applied no more stringently than those processes, strategies or methodologies  
1295 for developing and applying the reimbursement rates for medical and surgical benefits; and

1296 (c) the results of an analysis that demonstrates that for the medical necessity criteria  
1297 described in subsection (a) and for each non-quantitative treatment limitation identified in  
1298 subsection (b), as written and in operation, the processes, strategies, evidentiary standards or  
1299 other factors used in applying the medical necessity criteria and each non-quantitative treatment  
1300 limitation to mental health and substance use disorder benefits within each classification of  
1301 benefits are comparable to, and are applied no more stringently than, the processes, strategies,  
1302 evidentiary standards or other factors used in applying the medical necessity criteria and each  
1303 non-quantitative treatment limitation to medical and surgical benefits within the corresponding  
1304 classification of benefits; provided, however, that, at a minimum, the results of the analysis shall:

1305 (1) identify the factors used to determine whether a non-quantitative treatment limitation  
1306 will apply to a benefit;

1307 (2) identify any processes, strategies or evidentiary standards used to define the factors  
1308 identified in paragraph (1);

1309 (3) provide the comparative analyses, including the results of the analyses, subject to  
1310 paragraph (7), performed to determine that the processes and strategies used to design each non-  
1311 quantitative treatment limitation, as written, and the as written processes and strategies used to  
1312 apply the non-quantitative treatment limitation to mental health and substance use disorder  
1313 benefits are comparable to, and are applied no more stringently than, the processes and strategies  
1314 used to design each non-quantitative treatment limitation, as written, and the as written processes  
1315 and strategies used to apply the non-quantitative treatment limitation to medical and surgical  
1316 benefits;

1317 (4) provide the comparative analyses, including the results of the analyses, subject to  
1318 paragraph (7), performed to determine that the processes and strategies used to apply each non-  
1319 quantitative treatment limitation, in operation, for mental health and substance use disorder  
1320 benefits, including provider reimbursement rates, are comparable to, and applied no more  
1321 stringently than, the processes or strategies used to apply each non-quantitative treatment  
1322 limitation, in operation, for medical and surgical benefits, including provider reimbursement  
1323 rates; and

1324 (5) subject to paragraph (7), disclose the findings and conclusions reached by the  
1325 Medicaid managed care organization or alternative benefit plan that the results of the analyses  
1326 above indicate that the Medicaid managed care organization or alternative benefit plan is in  
1327 compliance with this section and the Paul Wellstone and Pete Domenici Mental Health Parity  
1328 and Addiction Equity Act of 2008, sections 511 and 512 of Public Law 110–343, as amended,

1329 and its implementing and related regulations, including, but not limited, to 42 CFR Part 438.910  
1330 and 42 CFR Part 440.395.

1331 (6) In completing the analyses required under this subsection, a Medicaid managed care  
1332 organization does not have to examine each medical or surgical benefit subject to a non-  
1333 quantitative treatment limitation that also applies to mental health and substance use disorder  
1334 benefits in the classification and is expected to perform the required analyses broadly across each  
1335 classification of benefits. A Medicaid managed care organization may use any reasonable  
1336 method to determine how it will select medical and surgical benefits subject to a non-quantitative  
1337 treatment limitation in the classification for the purpose of performing the comparative analyses,  
1338 provided that selecting only certain medical and surgical benefits with the same characteristics as  
1339 the mental health and substance use disorder benefits subject to the non-quantitative treatment  
1340 limitation, and not all medical and surgical benefits sharing the same characteristics as the  
1341 mental health and substance use disorder benefits subject to the non-quantitative treatment  
1342 limitation, in a classification for the purposes of performing the analyses shall not be considered  
1343 reasonable.

1344 (7) Any proprietary portions of information submitted to the division by a Medicaid  
1345 managed care organization as a result of the requirements in this section shall not be made public  
1346 record.

1347 Section 81. (a) The division shall develop a streamlined process to enhance the current  
1348 community-based behavioral health screening process and direct Medicaid contracted health  
1349 insurers, health plans, health maintenance organizations, behavioral health management firms  
1350 and third-party administrators under contract to a Medicaid managed care organization or the

1351 Medicaid primary care clinician plans to allow admission to inpatient behavioral health services  
1352 from a community-based setting where a patient under the age of 22 is presenting with a  
1353 behavioral health condition that requires such admission but does not require a medical screening  
1354 examination in an emergency department. Said process shall be developed after consultation  
1355 with relevant stakeholders and community members.

1356 (b) Annually, not later than April 1, the division shall file a report on the progress of the  
1357 streamlined process, results and any legislative recommendations with the house and senate  
1358 clerks, the joint committee on mental health, substance use and recovery, the joint committee on  
1359 public health, the joint committee on health care financing, the joint committee on children,  
1360 families and persons with disabilities and the house and senate committees on ways and means.

1361 SECTION 36. Section 32 of chapter 119 of the General Laws, as appearing in the 2020  
1362 Official Edition, is hereby amended by striking out the second paragraph and inserting in place  
1363 thereof the following paragraph:-

1364 The department shall ensure that every child, upon entry into the foster care system, shall  
1365 be screened and evaluated under the early and periodic screening, diagnostic and treatment  
1366 standards established by Title XIX of the Social Security Act and assessed for behavioral health  
1367 symptoms and sequelae, including those related to the precipitating factors of their entry into  
1368 care, unless the child has been screened and evaluated within 30 days prior to the child's entry  
1369 into the system; provided, however, that each child with identified behavioral health needs shall  
1370 be provided appropriate referrals to related professionals to conduct more comprehensive  
1371 diagnostic assessment, prescribe treatment and ensure the behavioral health and trauma-related  
1372 needs of such child are addressed in a timely manner.



1373 SECTION 37. Section 18 of chapter 123 of the General Laws, as so appearing, is hereby  
1374 amended by striking out, in lines 27 to 34, inclusive, the words “; provided, however, that,  
1375 notwithstanding the court’s failure, after an initial hearing or after any subsequent hearing, to  
1376 make a finding required for commitment to the Bridgewater state hospital, the prisoner shall be  
1377 confined at said hospital if the findings required for commitment to a facility are made and if the  
1378 commissioner of correction certifies to the court that confinement of the prisoner at said hospital  
1379 is necessary to insure his continued retention in custody”.

1380 SECTION 38. Said section 18 of said chapter 123, as so appearing, is hereby further  
1381 amended by inserting after subsection (a) the following subsection:-

1382 (a<sup>1</sup>/<sub>2</sub>)(1) For purposes of this subsection, “mental health watch” shall mean a status  
1383 intended to protect a prisoner from a risk of imminent and serious self-harm.

1384 (2) A prisoner or a prisoner’s legal representative, or a mental health staff person at the  
1385 request of a prisoner, may petition the district court with jurisdiction over the prisoner’s place of  
1386 detention or, if the prisoner is awaiting trial to the court with jurisdiction of the criminal case, to  
1387 be transferred to a suitable inpatient psychiatric facility or unit licensed or operated by the  
1388 department of mental health or to Bridgewater state hospital. The court may order the prisoner’s  
1389 requested transfer if the prisoner: (i) has been on mental health watch for at least 72 hours; or (ii)  
1390 is at serious risk of imminent and serious self-harm. A transfer under this subsection to  
1391 Bridgewater state hospital shall only be ordered if: (i) the prisoner is male and no bed is available  
1392 in a timely manner at a unit licensed or operated by the department of mental health; or (ii)(A)  
1393 the prisoner is not a proper person for commitment to an inpatient psychiatric facility or unit  
1394 licensed or operated by the department of mental health; and (B) the failure to retain the prisoner

1395 in strict custody would create a likelihood of serious harm. When a prisoner has been on mental  
1396 health watch for 72 hours, and once every 24 hours thereafter that the prisoner remains on mental  
1397 health watch, a member of the mental health staff of the place of detention shall advise the  
1398 prisoner of the prisoner's right to petition under this subsection and advise the prisoner that staff  
1399 at the place of detention may also, at the prisoner's request, petition on the prisoner's behalf. If  
1400 the prisoner requests, either orally or in writing, that staff at the place of detention petition under  
1401 this subsection, an employee, representative, agent or other designee of the place of detention  
1402 shall file a petition with the appropriate court within 24 hours. The court may order periodic  
1403 reviews of transfers under this subsection.

1404 SECTION 39. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby  
1405 amended by inserting after the definition of "Domestic company" the following definition:-

1406 "Emergency services programs", all programs subject to contract between the  
1407 Massachusetts Behavioral Health Partnership and nonprofit organizations for the provision of  
1408 community-based emergency psychiatric services, including, but not limited to, behavioral  
1409 health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per  
1410 week, through: (i) mobile crisis intervention services for youth; (ii) mobile crisis intervention  
1411 services for adults; (iii) emergency service provider community-based locations; and (iv) adult  
1412 community crisis stabilization services.

1413 SECTION 40. Said chapter 175 is hereby further amended by inserting after section 47PP  
1414 the following 4 sections:-

1415 Section 47QQ. (a) For the purposes of this section, "psychiatric collaborative care model"  
1416 shall mean the evidence-based, integrated behavioral health service delivery method in which a

1417 primary care team consisting of a primary care provider and a care manager provides structured  
1418 care management to a patient, and that works in collaboration with a psychiatric consultant that  
1419 provides regular consultations to the primary care team to review the clinical status and care of  
1420 patients and to make recommendations.

1421 (b) An individual policy of accident and sickness insurance issued pursuant to section  
1422 108 that provides hospital expense and surgical expense insurance or a group blanket or general  
1423 policy of accident and sickness insurance issued pursuant to section 110 that provides hospital  
1424 expense and surgical expense insurance that is issued or renewed within or without the  
1425 commonwealth shall provide coverage for mental health or substance use disorder services that  
1426 are delivered through the psychiatric collaborative care model.

1427 Section 47RR. An individual policy of accident and sickness insurance issued under  
1428 section 108 that provides hospital expense and surgical expense insurance or a group blanket or  
1429 general policy of accident and sickness insurance issued under section 110 that provides hospital  
1430 expense and surgical expense insurance that is issued or renewed within or without the  
1431 commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary  
1432 emergency services programs.

1433 Section 47SS. (a) As used in this section, the following terms shall, unless the context  
1434 clearly requires otherwise, have the following meanings:

1435 “Community-based acute treatment”, 24-hour clinically managed mental health  
1436 diversionary or step-down services for children and adolescents that is usually provided as an  
1437 alternative to mental health acute treatment.

1438 “Intensive community-based acute treatment”, intensive 24-hour clinically managed  
1439 mental health diversionary or step-down services for children and adolescents that is usually  
1440 provided as an alternative to mental health acute treatment.

1441 “Mental health acute treatment”, 24-hour medically supervised mental health services  
1442 provided in an inpatient facility licensed by the department of mental health that provides  
1443 psychiatric evaluation, management, treatment and discharge planning in a structured treatment  
1444 environment.

1445 (b) A policy, contract, agreement, plan or certificate of insurance issued, delivered or  
1446 renewed within or without the commonwealth, which is considered creditable coverage under  
1447 section 1 of chapter 111M, shall provide coverage for medically necessary mental health acute  
1448 treatment, community-based acute treatment and intensive community-based acute treatment and  
1449 shall not require a preauthorization before obtaining treatment; provided, however, that the  
1450 facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of  
1451 admission.

1452 Section 47TT. (a) As used in this section, the following words shall, unless the context  
1453 clearly requires otherwise, have the following meanings:

1454 “Licensed mental health professional,” a licensed physician who specializes in the  
1455 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a  
1456 licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed  
1457 physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor  
1458 I, as defined in section 1 of chapter 111J or a licensed marriage and family therapist within the  
1459 lawful scope of practice for such therapist.

1460 “Mental health wellness examination,” a screening or assessment that seeks to identify  
1461 any behavioral or mental health needs and appropriate resources for treatment. The examination  
1462 may include: (i) observation, a behavioral health screening, education and consultation on  
1463 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other  
1464 necessary supports and discussion of potential options for medication; and (ii) age-appropriate  
1465 screenings or observations to understand a covered person’s mental health history, personal  
1466 history and mental or cognitive state and, when appropriate, relevant adult input through  
1467 screenings, interviews and questions.

1468 “Primary care provider”, a health care professional qualified to provide general medical  
1469 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise  
1470 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)  
1471 maintains continuity of care within the scope of practice.

1472 (b) The following shall provide coverage for an annual mental health wellness  
1473 examination that is performed by a licensed mental health professional or primary care provider,  
1474 which may be provided by the primary care provider as part of an annual preventive visit: (i) any  
1475 policy of accident and sickness insurance, as described in section 108, that provides hospital  
1476 expense and surgical expense insurance and is delivered, issued or subsequently renewed by  
1477 agreement between the insurer and policyholder in the commonwealth; (ii) any blanket or  
1478 general policy of insurance described in subdivision (A), (C) or (D) of section 110 that provides  
1479 hospital expense and surgical expense insurance and is delivered, issued or subsequently  
1480 renewed by agreement between the insurer and the policyholder in or outside of the  
1481 commonwealth; and (iii) any employees’ health and welfare fund that provides hospital expense

1482 and surgical expense benefits and is delivered, issued to or renewed for any person or group of  
1483 persons in the commonwealth.

1484 (c) The division of insurance, in consultation with the office of Medicaid, and the  
1485 department of mental health, shall develop guidelines to implement this section.

1486 SECTION 41. Section 110 of said chapter 175, as appearing in the 2020 Official Edition,  
1487 is hereby amended by inserting after the word “age”, in line 463, the following words:- or  
1488 without regard to age, so long as the dependent, who is covered under the membership of their  
1489 parent as a member of a family group, is mentally or physically incapable of earning their own  
1490 living due to disability.

1491 SECTION 42. Chapter 176A of the General Laws is hereby amended by inserting after  
1492 section 8QQ the following 4 sections:-

1493 Section 8RR. (a) For the purposes of this section, “psychiatric collaborative care model”  
1494 shall mean the evidence-based, integrated behavioral health service delivery method in which a  
1495 primary care team consisting of a primary care provider and a care manager provides structured  
1496 care management to a patient, and that works in collaboration with a psychiatric consultant that  
1497 provides regular consultations to the primary care team to review the clinical status and care of  
1498 patients and to make recommendations.

1499 (b) A contract between a subscriber and the corporation under an individual or group  
1500 hospital service plan that is delivered, issued or renewed within or without the commonwealth  
1501 shall provide coverage for mental health or substance use disorder services that are delivered  
1502 through the psychiatric collaborative care model.

1503           Section 8SS. (a) As used in this section, the following terms shall, unless the context  
1504 clearly requires otherwise, have the following meanings:

1505           “Community-based acute treatment”, 24-hour clinically managed mental health  
1506 diversionary or step-down services for children and adolescents that is usually provided as an  
1507 alternative to mental health acute treatment.

1508           “Intensive community-based acute treatment”, intensive 24-hour clinically managed  
1509 mental health diversionary or step-down services for children and adolescents that is usually  
1510 provided as an alternative to mental health acute treatment.

1511           “Mental health acute treatment”, 24-hour medically supervised mental health services  
1512 provided in an inpatient facility, licensed by the department of mental health, that provides  
1513 psychiatric evaluation, management, treatment and discharge planning in a structured treatment  
1514 environment.

1515           (b) A contract between a subscriber and the corporation under an individual or group  
1516 hospital service plan that is delivered, issued or renewed within the commonwealth shall provide  
1517 coverage for medically necessary mental health acute treatment, community-based acute  
1518 treatment and intensive community-based acute treatment and shall not require a  
1519 preauthorization before the administration of any such treatment; provided, however, that the  
1520 facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of  
1521 admission.

1522           Section 8TT. A contract between a subscriber and the corporation under an individual or  
1523 group hospital service plan that is delivered, issued or renewed within or without the

1524 commonwealth shall provide benefits on a nondiscriminatory basis for medically necessary  
1525 emergency services programs, as defined in section 1 of chapter 175.

1526 Section 8UU. (a) As used in this section, the following words shall, unless the context  
1527 clearly requires otherwise, have the following meanings:

1528 “Licensed mental health professional,” a licensed physician who specializes in the  
1529 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a  
1530 licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed  
1531 physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor  
1532 I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the  
1533 lawful scope of practice for such therapist.

1534 “Mental health wellness examination,” a screening or assessment that seeks to identify  
1535 any behavioral or mental health needs and appropriate resources for treatment. The examination  
1536 may include: (i) observation, a behavioral health screening, education and consultation on  
1537 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other  
1538 necessary supports and discussion of potential options for medication; and (ii) age-appropriate  
1539 screenings or observations to understand a covered person’s mental health history, personal  
1540 history and mental or cognitive state and, when appropriate, relevant adult input through  
1541 screenings, interviews and questions.

1542 “Primary care provider”, a health care professional qualified to provide general medical  
1543 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise  
1544 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)  
1545 maintains continuity of care within the scope of practice.



1546 (b) A contract between a subscriber and the corporation under an individual or group  
1547 hospital service plan which is delivered, issued or renewed within the commonwealth shall  
1548 provide coverage for an annual mental health wellness examination that is performed by a  
1549 licensed mental health professional or primary care provider, which may be provided by the  
1550 primary care provider as part of an annual preventive visit.

1551 (c) The division of insurance, in consultation with the office of Medicaid, and the  
1552 department of mental health, shall develop guidelines to implement this section.

1553 SECTION 43. Chapter 176B of the General Laws is hereby amended by inserting after  
1554 section 4QQ the following 4 sections:-

1555 Section 4RR. (a) For the purposes of this section, “psychiatric collaborative care model”  
1556 shall mean the evidence-based, integrated behavioral health service delivery method in which a  
1557 primary care team consisting of a primary care provider and a care manager provides structured  
1558 care management to a patient, and that works in collaboration with a psychiatric consultant that  
1559 provides regular consultations to the primary care team to review the clinical status and care of  
1560 patients and to make recommendations.

1561 (b) A subscription certificate under an individual or group medical service agreement that  
1562 is delivered, issued or renewed within or without the commonwealth shall provide coverage for  
1563 mental health or substance use disorder services that are delivered through the psychiatric  
1564 collaborative care model.

1565 Section 4SS. As used in this section, the following terms shall, unless the context clearly  
1566 requires otherwise, have the following meanings:

1567 “Community-based acute treatment”, 24-hour clinically managed mental health  
1568 diversionary or step-down services for children and adolescents that is usually provided as an  
1569 alternative to mental health acute treatment.

1570 “Intensive community-based acute treatment”, intensive 24-hour clinically managed  
1571 mental health diversionary or step-down services for children and adolescents that is usually  
1572 provided as an alternative to mental health acute treatment.

1573 “Mental health acute treatment”, 24-hour medically supervised mental health services  
1574 provided in an inpatient facility, licensed by the department of mental health, that provides  
1575 psychiatric evaluation, management, treatment and discharge planning in a structured treatment  
1576 environment.

1577 (b) A subscription certificate under an individual or group medical service agreement  
1578 delivered, issued or renewed within the commonwealth shall provide coverage for medically  
1579 necessary mental health acute treatment, community-based acute treatment and intensive  
1580 community-based acute treatment and shall not require a preauthorization before obtaining  
1581 treatment; provided, however, that the facility shall notify the carrier of the admission and the  
1582 initial treatment plan within 72 hours of admission.

1583 Section 4TT. A subscription certificate under an individual or group medical service  
1584 agreement that is delivered, issued or renewed shall provide benefits on a nondiscriminatory  
1585 basis for medically necessary emergency services programs, as defined in section 1 of chapter  
1586 175.

1587 Section 4UU. (a) As used in this section, the following words shall, unless the context  
1588 clearly requires otherwise, have the following meanings:

1589 “Licensed mental health professional,” a licensed physician who specializes in the  
1590 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a  
1591 licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed  
1592 physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor  
1593 I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the  
1594 lawful scope of practice for such therapist.

1595 “Mental health wellness examination,” a screening or assessment that seeks to identify  
1596 any behavioral or mental health needs and appropriate resources for treatment. The examination  
1597 may include: (i) observation, a behavioral health screening, education and consultation on  
1598 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other  
1599 necessary supports and discussion of potential options for medication; and (ii) age-appropriate  
1600 screenings or observations to understand a covered person’s mental health history, personal  
1601 history and mental or cognitive state and, when appropriate, relevant adult input through  
1602 screenings, interviews and questions.

1603 “Primary care provider”, a health care professional qualified to provide general medical  
1604 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise  
1605 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)  
1606 maintains continuity of care within the scope of practice.

1607 (b) A subscription certificate under an individual or group medical service agreement  
1608 delivered, issued or renewed within the commonwealth shall provide coverage for an annual  
1609 mental health wellness examination that is performed by a licensed mental health professional or

1610 primary care provider, which may be provided by the primary care provider as part of an annual  
1611 preventive visit.

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

1614 SECTION 44. Section 4T of chapter 176G of the General Laws, as appearing in the 2020  
1615 Official Edition, is hereby amended by inserting after the word “age”, in line 6, the following  
1616 words:- or without regard to age, so long as the dependent, who is covered under the membership  
1617 of the dependent’s parent as a member of a family group, is mentally or physically incapable of  
1618 earning their own living due to disability.

1619 SECTION 45. Said chapter 176G is hereby further amended by inserting after section 4II  
1620 the following 4 sections:-

1621 Section 4JJ. (a) For the purposes of this section, “psychiatric collaborative care model”  
1622 shall mean the evidence-based, integrated behavioral health service delivery method in which a  
1623 primary care team consisting of a primary care provider and a care manager provides structured  
1624 care management to a patient, and that works in collaboration with a psychiatric consultant that  
1625 provides regular consultations to the primary care team to review the clinical status and care of  
1626 patients and to make recommendations.

1627 (b) An individual or group health maintenance contract that is issued or renewed within  
1628 or without the commonwealth shall provide coverage for mental health or substance use disorder  
1629 services that are delivered through the psychiatric collaborative care model.

1630 Section 4KK. (a) As used in this section, the following terms shall, unless the context  
1631 clearly requires otherwise, have the following meanings,:

1632 “Community-based acute treatment”, 24-hour clinically managed mental health  
1633 diversionary or step-down services for children and adolescents that is usually provided as an  
1634 alternative to mental health acute treatment.

1635 “Intensive community-based acute treatment”, intensive 24-hour clinically managed  
1636 mental health diversionary or step-down services for children and adolescents that is usually  
1637 provided as an alternative to mental health acute treatment.

1638 “Mental health acute treatment”, 24-hour medically supervised mental health services  
1639 provided in an inpatient facility, licensed by the department of mental health, that provides  
1640 psychiatric evaluation, management, treatment and discharge planning in a structured treatment  
1641 environment.

1642 (b) An individual or group health maintenance contract that is issued or renewed within  
1643 or without the commonwealth shall provide coverage for medically necessary mental health  
1644 acute treatment, community-based acute treatment and intensive community-based acute  
1645 treatment and shall not require a preauthorization before obtaining treatment; provided, however,  
1646 that the facility shall notify the carrier of the admission and the initial treatment plan within 72  
1647 hours of admission.

1648 Section 4LL. An individual or group health maintenance contract that is issued or  
1649 renewed within or without the commonwealth shall provide benefits on a nondiscriminatory  
1650 basis for medically necessary emergency services programs, as defined in section 1 of chapter  
1651 175.

1652           Section 4MM. (a) As used in this section, the following words shall, unless the context  
1653 clearly requires otherwise, have the following meanings:

1654           “Licensed mental health professional,” a licensed physician who specializes in the  
1655 practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a  
1656 licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed  
1657 physician assistant who practices in the area of psychiatry, a licensed alcohol and drug counselor  
1658 I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the  
1659 lawful scope of practice for such therapist.

1660           “Mental health wellness examination,” a screening or assessment that seeks to identify  
1661 any behavioral or mental health needs and appropriate resources for treatment. The examination  
1662 may include: (i) observation, a behavioral health screening, education and consultation on  
1663 healthy lifestyle changes, referrals to ongoing treatment, mental health services and other  
1664 necessary supports and discussion of potential options for medication; and (ii) age-appropriate  
1665 screenings or observations to understand a covered person’s mental health history, personal  
1666 history and mental or cognitive state and, when appropriate, relevant adult input through  
1667 screenings, interviews and questions.

1668           “Primary care provider”, a health care professional qualified to provide general medical  
1669 care for common health care problems, who: (i) supervises, coordinates, prescribes or otherwise  
1670 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)  
1671 maintains continuity of care within the scope of practice.

1672           (b) An individual or group health maintenance contract that is issued or renewed within  
1673 or without the commonwealth shall provide coverage for an annual mental health wellness

1674 examination that is performed by a licensed mental health professional or primary care provider,  
1675 which may be provided by the primary care provider as part of an annual preventive visit.

1676 (c) The division of insurance, in consultation with the office of Medicaid, and the  
1677 department of mental health, shall develop guidelines to implement this section.

1678 SECTION 46. Section 1 of chapter 176J of the General Laws, as appearing in the 2020  
1679 Official Edition, is hereby amended by inserting after the word “age”, in line 86, the following  
1680 words:- or without regard to age, so long as the dependent, who is covered under the membership  
1681 of the dependent’s parent as a member of a family group is mentally or physically incapable of  
1682 earning their own living due to disability.

1683 SECTION 47. Chapter 176O of the General Laws is hereby amended by inserting after  
1684 section 5C, as so appearing, the following section:-

1685 Section 5D. (a) For the purposes of this section, the term “base fee schedule” shall mean  
1686 the minimum rates, typically set forth in fee schedules, paid by the carrier to an in-network  
1687 health care provider who is not paid under an alternative payment arrangement for covered  
1688 health care services; provided, however, that final rates may be subject to negotiations or  
1689 adjustments that may result in payments to in-network providers that are different from the base  
1690 fee schedule.

1691 (b) A carrier, directly or through any entity that manages or administers mental health or  
1692 substance use disorder benefits for the carrier, shall establish a base fee schedule for evaluation  
1693 and management services for behavioral health providers that is not less than the base fee  
1694 schedule used for evaluation and management services for primary care providers of the same or

1695 similar licensure type and in the same geographic region; provided, however, that a carrier shall  
1696 not lower its base fee schedule for primary care providers to comply with this section.

1697 (c) The division shall promulgate regulations to implement this section.

1698 SECTION 48. Subsection (a) of section 13 of said chapter 176O, as so appearing, is  
1699 hereby amended by striking out the first sentence and inserting in place thereof the following  
1700 sentence:-

1701 A carrier or utilization review organization shall maintain a formal internal grievance  
1702 process that is compliant with the Patient Protection and Affordable Care Act, Public Law 111–  
1703 148, as amended, as well as with any rules, regulations or guidance applicable thereto, and such  
1704 formal internal grievance process shall provide for adequate consideration and timely resolution  
1705 of grievances, which shall include, but shall not be limited to: (i) a system for maintaining  
1706 records of each grievance filed by an insured or on the insured’s behalf, and responses thereto,  
1707 for a period of 7 years, which records shall be subject to inspection by the commissioner; (ii) the  
1708 provision of a clear, concise and complete description of the carrier’s formal internal grievance  
1709 process and the procedures for obtaining external review pursuant to section 14 with each notice  
1710 of an adverse determination; (iii) the carrier’s toll-free telephone number for assisting insureds in  
1711 resolving such grievances and the consumer assistance toll-free telephone number maintained by  
1712 the office of patient protection; (iv) a procedure to accept grievances by telephone, in person, by  
1713 mail and by electronic means; (v) a process for an insured to request the appointment of an  
1714 authorized representative to act on the insured’s behalf; and (vi) a procedure to accept an  
1715 insured’s request for medical release forms by electronic means, which shall include delivery to  
1716 a designated email address or access to an online consumer portal accessible by the insured, the



1717 insured's family member or the insured's authorized representative who can provide the  
1718 insured's membership identification number.

1719 SECTION 49. Subsection (b) of said section 13 of said chapter 176O, as so appearing, is  
1720 hereby amended by striking out the third sentence and inserting in place thereof the following  
1721 sentence:- If the expedited review process affirms the denial of coverage or treatment, the carrier  
1722 shall provide the insured, within 5 business days of the decision, including by any electronic  
1723 means consented to by the insured: (1) a statement setting forth the specific medical and  
1724 scientific reasons for denying coverage or treatment; (2) a description of alternative treatment,  
1725 services or supplies covered or provided by the carrier, if any; (3) a description of the insured's  
1726 rights to any further appeal; and (4) a description of the insured's right to request a conference.

1727 SECTION 50. Subsection (c) of said section 13 of said chapter 176O, as so appearing, is  
1728 hereby amended by adding the following sentence:- The external review of a grievance under  
1729 section 14 shall be decided in favor of the insured unless the carrier provides substantial  
1730 evidence, such as proof of delivery, that the carrier properly complied with the time limits  
1731 required under this section.

1732 SECTION 51. Subsection (a) of section 14 of said chapter 176O, as so appearing, is  
1733 hereby amended by striking out the eighth sentence and inserting in place thereof the following  
1734 sentence:- The panel shall consider, but shall not be limited to considering: (i) any related right  
1735 to such treatment or service under any related state statute or regulation; (ii) written documents  
1736 submitted by the insured; (iii) medical records and medical opinions regarding medical necessity  
1737 by the insured's treating provider that requested or provided the disputed service, which shall be  
1738 obtained by the carrier, or by the panel if the carrier fails to do so; (iv) additional information

1739 from the involved parties or outside sources that the review panel deems necessary or relevant;  
1740 and (v) information obtained from any informal meeting held by the panel with the parties.

1741 SECTION 52. Subsection (b) of said section 14 of said chapter 176O, as so appearing, is  
1742 hereby amended by striking out the second sentence and inserting in place thereof the following  
1743 sentence:- An insured may apply to the external review panel to seek continued provision of  
1744 health care services that are the subject of the grievance during the course of an expedited or  
1745 non-expedited external review upon a showing of substantial harm to the insured's health absent  
1746 such continuation or other good cause as determined by the panel; provided, however, that good  
1747 cause shall include a pattern of denials that have been overturned by prior internal or external  
1748 appeals.

1749 SECTION 53. Subsection (c) of said section 14 of said chapter 176O, as so appearing, is  
1750 hereby amended by adding the following sentence:- A carrier's failure to promptly comply with  
1751 a decision of the review panel shall be an unfair and deceptive practice in violation of chapter  
1752 93A.

1753 SECTION 54. Said section 14 of said chapter 176O, as so appearing, is hereby further  
1754 amended by adding following subsection:-

1755 (g) The office of patient protection shall monitor carrier denials and shall identify any  
1756 trends regarding particular treatments or services or carrier practices and may refer such matters  
1757 to the division of insurance, the group insurance commission or the office of the attorney general  
1758 for review of compliance with state or federal laws related to mental health and substance use  
1759 disorder parity, including, but not limited to, section 22 of chapter 32A, section 47B of chapter  
1760 175, section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of

1761 chapter 176G, in regard to any carrier licensed under said chapters 175, 176A, 176B or 176G,  
1762 any carrier offering a student health plan issued under section 18 of chapter 15A or the group  
1763 insurance commission, or the mental health parity provisions of the federal Paul Wellstone and  
1764 Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, sections 511 and 512 of  
1765 Public Law 110–343, as amended, and guidance or regulations issued under the act. The office of  
1766 patient protection shall refer any questions or concerns from consumers about carrier compliance  
1767 with state or federal laws related to mental health and substance use disorder parity to the  
1768 division of insurance, the group insurance commission or the office of the attorney general.

1769 SECTION 55. Subsection (b) of section 16 of said chapter 176O, as so appearing, is  
1770 hereby amended by striking out the last sentence and inserting in place thereof the following  
1771 sentence:- If a carrier or utilization review organization intends to implement a new medical  
1772 necessity guideline or amend an existing requirement or restriction, the carrier or utilization  
1773 review organization shall ensure that the new guideline or amended requirement or restriction  
1774 shall not be implemented unless: (i) the carrier’s or utilization review organization’s website has  
1775 been updated to reflect the new or amended requirement or restriction; and (ii) the carrier or  
1776 utilization review organization has assessed the limitation to show it is in compliance with state  
1777 and federal parity requirements pursuant to chapter 26.

1778 SECTION 56. Chapter 77 of the acts of 2022 is hereby amended by inserting after section  
1779 1 the following section:-

1780 Section 1A. (a) For the purposes of this section, “integrated care” shall mean full  
1781 collaboration in merged or transformed practices offering behavioral health and physical health  
1782 services within the same shared practice space in the same facility, where the practice: (i)

1783 provides services in a shared practice space that ensures services will be available and accessible  
1784 promptly and in a manner which preserves human dignity and assures continuity of care; (ii)  
1785 ensures communication among the integrated care team that is consistent and team-based; (iii)  
1786 ensures shared decision-making between mental and behavioral health providers, primary care  
1787 providers and other service providers involved in promoting the health and wellbeing of the  
1788 client; (iv) provides evidence-based services in a mode of service delivery appropriate for the  
1789 target population; (v) employs staff who are multidisciplinary and culturally-competent and  
1790 linguistically-competent; (vi) provides integrated services related to screening, diagnosis and  
1791 treatment of mental health and substance use conditions and co-occurring physical health  
1792 conditions and chronic diseases; and (vii) provides targeted case management, including services  
1793 to assist individuals gaining access to needed medical, social, educational and other services and  
1794 applying for income security, housing, employment and other benefits to which the individual  
1795 may be entitled.

1796 (b) The commission established in section 1 shall develop and make recommendations to  
1797 the general court for grant programs to be administered by the commissioner of public health, in  
1798 consultation with the department of mental health, to enhance access to behavioral health  
1799 services in the commonwealth and support a diverse behavioral health workforce. In developing  
1800 its recommendations, the commission shall consider:

1801 (1) a program to support the behavioral health needs of health care providers through  
1802 grants to: (i) health care entities, including provider organizations, as defined in section 1 of  
1803 chapter 6D of the General Laws, or (ii) professional associations to establish or enhance  
1804 evidence-based or evidence-informed programs dedicated to improving the behavioral health,  
1805 mental wellness and resiliency of health care professionals;

1806 (2) a scholarship program to encourage a culturally, ethnically and linguistically diverse  
1807 behavioral health workforce that helps students obtain academic credits toward a master’s degree  
1808 in the field of behavioral health with a preference for students who commit to serving high-need  
1809 populations, including children, veterans, clients of the department of children and families,  
1810 incarcerated or formerly incarcerated individuals, including justice-involved youth and emerging  
1811 adults, individuals with post-traumatic stress disorder, aging adults, school-aged youth and  
1812 individuals with a comorbidity, including substance use disorder; and

1813 (3) a program to promote integrated care, through which the secretary of health and  
1814 human services may award grants to, or enter into cooperative agreements with, health care  
1815 facilities to support improvements to facilities to promote full collaboration between primary and  
1816 behavioral health in an integrated care setting.

1817 SECTION 56A. The executive office of health and human services and the department of  
1818 public health shall conduct a study relative to the feasibility and cost, if any, of creating a board  
1819 of registration of mental health counselors. The report shall be submitted not later than June 30,  
1820 2023 to the clerks of the senate and house of representatives, the joint committee on mental  
1821 health and substance use and recovery and the joint committee on labor and workforce  
1822 development.

1823 SECTION 57. The interagency health equity team, as supported through the office of  
1824 health equity, shall, in consultation with the advisory council appointed in this section, study  
1825 ways to improve access to, and the quality of, culturally-competent behavioral health services.  
1826 The review shall include, but not be limited to: (i) the need for greater racial, ethnic and  
1827 linguistic diversity within the behavioral health workforce; (ii) the role of gender, sexual

1828 orientation, gender identity, race, ethnicity, linguistic barriers, status as a client of the department  
1829 of children and families, status as an incarcerated or formerly incarcerated individual, including  
1830 justice-involved youth and emerging adults, status as a veteran, status as an individual with post-  
1831 traumatic stress disorder, status as an aging adult, status as a person with any other physical or  
1832 invisible disability and social determinants of health regarding behavioral health needs; and (iii)  
1833 any other factors identified by the team that create disparities in access and quality within the  
1834 existing behavioral health service delivery system, including stigma, transportation and cost.

1835           The advisory council shall consist of: the chairs of the joint committee on mental health,  
1836 substance use and recovery; the chair of the Black and Latino caucus or a designee; and 8  
1837 members to be appointed by the commissioner of public health, 1 of whom shall be a local public  
1838 health official representing a majority-minority municipality, 1 of whom shall be a representative  
1839 of a racial or ethnic equity advocacy group, 1 of whom shall be a representative of a linguistic  
1840 equity advocacy group, 1 of whom shall be a licensed behavioral health provider, 1 of whom  
1841 shall be a representative of a behavioral health advocacy group, 1 of whom shall be a  
1842 representative of an organization serving the health care needs of the lesbian, gay, bisexual,  
1843 transgender, queer and questioning community, 1 of whom shall be a representative of an  
1844 organization serving the health care needs of individuals experiencing housing insecurity and 1  
1845 of whom shall be an individual with expertise in school-based behavioral health services.

1846           The team shall meet with the advisory council not less than quarterly. Not later than July  
1847 1, 2023, and annually for the following 3 years at the close of each state fiscal year, the team  
1848 shall issue a report with legislative, regulatory or budgetary recommendations to improve the  
1849 access and quality of culturally-competent mental and behavioral health services. The report

1850 shall be written in non-technical, readily understandable language and shall be made publicly  
1851 available on the office of health equity's website.

1852 The office of health equity, the department of mental health and the department of public  
1853 health may, subject to appropriation, provide administrative, logistical and research support to  
1854 produce the report.

1855 SECTION 58. The health policy commission, in consultation with the division of  
1856 insurance, shall conduct an analysis of the effects of behavioral health managers, as defined in  
1857 section 1 of chapter 176O of the General Laws, on the commonwealth's health care delivery  
1858 system. The commission shall seek input from the executive office of health and human services,  
1859 other relevant state agencies, health care providers and payers, behavioral health and economic  
1860 experts, patients and caregivers.

1861 The commission shall analyze: (i) the services that behavioral health managers provide;  
1862 (ii) the effect of behavioral health managers on accessibility, quality and cost of behavioral  
1863 health services, including an analysis of impacts on patient outcomes; (iii) the oversight practices  
1864 by other states on behavioral health managers; (iv) the effects of behavioral health manager state  
1865 licensure, regulation or registration on access to behavioral health services; and (v) any other  
1866 issues pertaining to behavioral health managers as deemed relevant by the commission.

1867 Not later than December 31, 2022, the health policy commission shall file a report of its  
1868 findings, together with any recommendations for legislation, with the clerks of the senate and  
1869 house of representatives, the joint committee on health care financing, the joint committee on  
1870 mental health, substance use and recovery and the joint committee on financial services.

1871 SECTION 59. (a) The department of veterans' services shall convene an advisory  
1872 committee that shall consist of: 2 representatives of the Massachusetts chapter of Team Red,  
1873 White & Blue; 2 representatives of the Red Sox Foundation, Inc. and Massachusetts General  
1874 Hospital's Home Base Program; 2 representatives of the Wounded Warriors Project; 2  
1875 representatives of the Mass Mentoring Partnership, Inc.; 2 representatives of the Massachusetts  
1876 Coalition for Suicide Prevention; 2 representatives of the Massachusetts Psychological  
1877 Association, Inc.; and such other members as the committee deems necessary. The members of  
1878 the committee shall have experience in mental health or veterans' support services with an  
1879 emphasis on treatment of post-traumatic stress disorder, depression and anxiety among veterans.

1880 (b) The committee, in coordination with the department of veterans' services and the  
1881 department of mental health, shall investigate and study: (i) ways to augment services to  
1882 returning veterans to reduce the rate of suicide and the effects of post-traumatic stress disorder,  
1883 depression and anxiety; and (ii) the complexity of reintegration into civilian life and issues  
1884 related to isolation and suicide among veterans. The committee shall provide support and  
1885 expertise to reduce isolation and suicide among veterans returning from deployment.

1886 (c) The committee shall examine: (i) the impact of having a community peer liaison on a  
1887 veteran's reintegration into society; (ii) the relationship between isolation and suicide among  
1888 veterans; and (iii) the impact of having a community peer liaison on symptoms of post-traumatic  
1889 stress disorder, depression and anxiety diagnosed in veterans.

1890 (d) The committee shall file a report of its findings and any recommendations with the  
1891 clerks of the senate and house of representatives, the joint committee on veterans and federal



1892 affairs and the joint committee on mental health, substance use and recovery not later than  
1893 January 1, 2023.

1894 SECTION 60. The department of mental health shall prepare a comprehensive plan to  
1895 address access to continuing care beds, intensive residential treatment programs and community-  
1896 based programs for patients awaiting discharge from acute psychiatric hospitals and units. The  
1897 plan shall include, but shall not be limited to, strategies to reduce the wait times for patients  
1898 awaiting discharge to ensure that the patients determined appropriate for continuing care,  
1899 intensive residential treatment and community-based programs would be admitted to an  
1900 appropriate continuing care bed, intensive residential treatment program, community-based  
1901 program or other appropriate setting within 30 days after approval of the patient's application.  
1902 The department of mental health shall submit a copy of the plan to the governor, the clerks of the  
1903 senate and house of representatives and the joint committee on mental health, substance use and  
1904 recovery not later than 60 days after the effective date of this act.

1905 SECTION 61. (a) The secretary of health and human services shall establish a statewide  
1906 evidence-based or evidence-informed education and awareness initiative to: (i) identify and  
1907 disseminate best practices for preventing suicide and improving the behavioral health, mental  
1908 wellness and resiliency among health care professionals; (ii) encourage health care professionals  
1909 to seek behavioral health support and care; (iii) to help such professionals identify risk factors  
1910 associated with suicide and behavioral health crisis and to help such professionals learn how best  
1911 to respond to such risks; and (iv) to address the stigma associated with seeking behavioral health  
1912 services.

1913 (b) Not later than 2 years after the effective date of this act, the secretary of health and  
1914 human services shall submit a report, with legislative and regulatory recommendations,  
1915 containing updates on the activities and outcomes of the initiative, including a description of  
1916 quantitative and qualitative metrics used to evaluate such activities and outcomes, to the  
1917 governor and the general court by filing the report and recommendations with the clerks of the  
1918 house of representatives and the senate, the joint committee on mental health, substance use and  
1919 recovery and the senate and house committees on ways and means.

1920 SECTION 61A. Notwithstanding any general or special law to the contrary, the division  
1921 of insurance shall promulgate regulations or issue sub-regulatory guidance, within 30 days of the  
1922 effective date of this act, to establish reasonable rates at which carriers shall reimburse acute care  
1923 hospitals for the delivery of health care services for each day a member waits in an emergency  
1924 department, observation unit or inpatient floor, for placement in an appropriate inpatient  
1925 psychiatric placement. The division of insurance shall consult with the division of medical  
1926 assistance on establishing a reasonable rate for said reimbursement.

1927 SECTION 62. The secretary of health and human services and the commissioner of  
1928 elementary and secondary education shall promulgate regulations pursuant to section 16R of  
1929 chapter 6A, inserted by section 3, not later than 90 days after the effective date of this act.

1930 SECTION 63. The division of insurance shall promulgate regulations to implement  
1931 section 5D of chapter 176O of the General Laws not later than 1 year after the effective date of  
1932 this act.

1933 SECTION 64. The health policy commission shall publish its first pediatric behavioral  
1934 health planning report required by section 20 of chapter 6D of the General Laws not later than 18  
1935 months after the effective date of this act.

1936 SECTION 65. The division of medical assistance shall file its first report on the  
1937 implementation of the streamlined community-based behavioral health screening process  
1938 established in section 81 of chapter 118E not later than 1 year after the effective date of this act.

1939 SECTION 66. Subsection (c) of section 16P of chapter 6A of the General Laws and  
1940 section 5D of chapter 176O of the General Laws shall take effect 1 year after the effective date  
1941 of this act.

1942 SECTION 67. Subsection (b) of section 16DD chapter 6A of the General Laws shall take  
1943 effect on July 16, 2022; provided, however, that the secretary of health and human services may  
1944 designate 988 crisis hotline centers before July 16, 2022.

1945 SECTION 68. Section 51<sup>3</sup>/<sub>4</sub> of chapter 111 of the General Laws, inserted by section 28,  
1946 shall take effect on January 1, 2023; provided, however, the department of public health shall  
1947 promulgate regulations to implement said section 51<sup>3</sup>/<sub>4</sub> of said chapter 111 not later than October  
1948 1, 2022.

1949 SECTION\_69. There is hereby established a permanent standing student stakeholder  
1950 advisory commission on mental health whose members shall work in collaboration with the  
1951 department of elementary and secondary education to develop and implement school-based  
1952 programs to promote student mental health and well-being and to evaluate the effectiveness of  
1953 current statutes related to these issues. The commission shall meet not less than two times a year  
1954 with the commissioner of elementary and secondary education and not less than once a year with

1955 the board of elementary and secondary education to ensure that students and their families in the  
1956 commonwealth have access to a wide range of comprehensive mental health programs and  
1957 services. The commission shall work with the department and the board to develop programs and  
1958 services related to, but not limited to, the following: (i) eliminating the stigma associated with  
1959 mental health illness; (ii) recognizing the signs of mental health problems; (iii) addressing  
1960 cyberbullying; (iv) preventing and responding to student suicide and actions involving self-harm;  
1961 (v) helping students avoid negative coping behaviors such as substance use; and (vi) promoting  
1962 treatment and recovery from mental illness. The commission shall consist of 15 members,  
1963 including the commissioner of the department of mental health, or a designee, who shall serve as  
1964 the chair; one representative from the National Alliance on Mental Illness (NAMI)  
1965 Massachusetts' Allies for Student Mental Health program; one representative from the  
1966 Massachusetts Association for Mental Health; four representatives from the Massachusetts  
1967 School Mental Health Consortium who shall each reflect geographically diverse areas of the  
1968 commonwealth; one representative from the Massachusetts School Counselors Association; one  
1969 representative from the Parent Professional Advocacy League (PPAL); one medical professional  
1970 appointed by the Massachusetts Medical Society who shall be a licensed psychiatrist specializing  
1971 in adolescent mental health care; one student representative from the Massachusetts Association  
1972 of Student Councils; and four secondary school students, one of whom shall be appointed by the  
1973 speaker of the house, one of whom shall be appointed by the president of the senate, one of  
1974 whom shall be appointed by the minority leader of the house of representatives, and one of  
1975 whom shall be appointed by the minority leader of the senate. All secondary school student  
1976 members of the commission shall be appointed on an annual basis and shall be eligible for re-  
1977 appointment provided they have not yet graduated high school. The commission shall issue an

1978 annual report by June 30 updating the legislature on its findings and recommendations, including  
1979 any proposed changes to current statute, with copies provided to the house and senate chairs of  
1980 the joint committee on mental health, substance use and recovery, the house and senate chairs of  
1981 the joint committee on health care financing, the house and senate chairs of the joint committee  
1982 on education, the house and senate chairs of ways and means, and the clerks of the house and the  
1983 senate.

1984 SECTION 70. Chapter 118E of the General Laws is hereby amended by inserting after  
1985 section 10A the following section:-

1986 Section 10A½. The division shall provide coverage of screenings by pediatricians for  
1987 postpartum depression in mothers of newly born children during any visit to a pediatrician's  
1988 office taking place for up to 1 year from the date of the child's birth.