FACT SHEET: AN ACT ADDRESSING BARRIERS TO CARE FOR MENTAL HEALTH

On August 10, 2022, Governor Baker signed *An Act addressing barriers to care for mental health* (Chapter 177 of the Acts of 2022). This law is a historic achievement and a reflection of the Administration's, the Legislature's, and behavioral health stakeholders' shared commitment to fundamentally transforming the Commonwealth's behavioral health system to better meet the needs of individuals, families, and communities.

Chapter 177 of the Acts of 2022 will address a broad range of behavioral health issues, including emergency department boarding, low reimbursement rates for behavioral health providers, lack of insurance coverage for certain behavioral health services, and the demand for school-based behavioral health services. The law also will support ongoing initiatives, such as implementation of the Massachusetts Executive Office of Health and Human Services' (EOHHS) Roadmap for Behavioral Health Reform and the 988 Suicide and Crisis Lifeline. Some provisions have specific effective dates noted below. The remaining provisions take effect on November 8, 2022.

Provisions are organized into two main categories: *Service Delivery and System Reforms*; and *Access Equity, Quality Accountability, and Professional Practice Provisions*. Within these two categories, key provisions of the 110+ page *Act addressing barriers to care for mental health* are further sorted into a dozen subcategories.

Behavioral Health Service Delivery and System Reforms

BEHAVIORAL HEALTH PROMOTION

- Establish an **Office of Behavioral Health Promotion** (Office) within EOHHS to facilitate the development of interagency initiatives, implement a plan to strengthen promotion programming and infrastructure, disseminate evidence-based behavioral health practices, collect, and analyze behavioral health data, and coordinate behavioral health wellness campaigns and initiatives (Section 4)
- Require the Office to:
    - Examine improving access to and participation in behavioral health screening and treatment by veterans, police, firefighters, and public safety personnel
    - Establish an education and awareness initiative to improve behavioral health understanding among healthcare professionals
    - Convene a student stakeholder advisory commission on mental health tasked with developing school-based programs to promote student mental health and well being that must submit an annual report with its findings and recommendations to the Legislature by June 30
    - Address the stigma associated with seeking behavioral health services
    - Report on its progress to the Governor, the Legislature, and on its website annually by July 1
- Expand the charge of the Community Behavioral Health Promotion and Prevention Commission to include responsibilities identical to those listed in the first bullet point above for the Office; The Commission will serve as an advisory board to the Office. (Section 1)

SUICIDE PREVENTION

- Direct the Department of Public Health (DPH), as a part of its **suicide data collection**, to record the location, property type, and past number of suicide attempts at the location (Section 33)
- Require the Department of Veterans' Services to convene an advisory committee to study reducing isolation and suicide among returning veterans and the impact of having a community peer liaison and file a report with the Legislature by January 1, 2023 (Section 77)
- Establish a **suicide postvention task force** within DPH to address the aftereffects of a confirmed suicide and require the taskforce to file its recommendations with the Legislature by November 8, 2023 (within one year of the effective date of this act) (Section 80)
- Require DPH to administer **an initiative that focuses on the heightened risk of suicide associated with firearm possession by increasing public awareness and education** on the availability of extreme risk protection orders (ERPOs), also known as red flag laws, to remove a firearm from a person who is at risk of injuring themself or others (Section 34)

988 SUICIDE AND CRISIS LIFELINE

- Require the **Secretary of EOHHS to designate at least one 988 suicide and crisis lifeline center that is available 24/7 to provide crisis intervention services and care coordination**; Require the 988 suicide and crisis lifeline center to utilize technology that is interoperable between and across 911 and 211, coordinate access to crisis evaluation, counseling, receiving, and stabilization services, serve high-risk and specialized populations, provide linguistically and culturally competent care, and provide follow-up services (Section 4)
- Establish a **state 988 Commission** within EOHHS to provide ongoing strategic oversight and guidance regarding 988 service and require the commission to submit its findings to the Legislature annually by March 1 (Section 4)
    - Ensure the commission's recommendations include legislative or regulatory changes necessary for implementation and recommendations for funding that may include the establishment of user fees
    - Require the commission to advise on promoting the 988 number, such as including 988 information on student ID cards and on signs in places where there have been known suicide attempts

911 ENHANCEMENT

- **Amend the membership of the state 911 Commission** to include the Commissioner of the Department of Mental Health (DMH), an Association for Behavioral Healthcare representative/emergency service program provider, and a person with lived behavioral health experience and a history of interactions with the police (Section 6)
- Expand a grant program supporting Public Service Access Points (PSAPs) and regional emergency communication centers to include mobile behavioral health crisis response services (Section 7)
- **Require PSAPs to be equipped to respond to requests for emergency services from individuals with mental health or substance use conditions** (Section 8)
- Direct the State 911 Department to update state regulations on certification requirements for enhanced 911 telecommunicators by integrating training on identification of and response to callers experiencing behavioral health crises (Section 81)

BEHAVIORAL HEALTH IN SCHOOLS

- Require EOHHS, in coordination with Department of Elementary and Secondary Education (DESE), to establish a statewide program to assist in **implementing behavioral health services and supports, including consultation, coaching and technical assistance, in each school district, subject to appropriation** and a central base of operations within the University of Massachusetts, as well as regional sites, to carry out the program (Section 4)
- Require any school administrator acting as a decision maker at a student meeting or hearing that will result in consequences for a student to **consider ways to re-engage the student in the learning process and not suspend or expel** the student until alternative remedies have been employed and their use and results documented (Section 29)
    - Allow exceptions if administrators have documented specific reasons as to why alternative remedies are unsuitable or counter-productive; Allow exceptions if the student's continued presence in school would pose concern about serious bodily injury or other serious harm upon another person while in school
- Require DESE to **develop performance standards for prohibiting or significantly limiting the use of preschool suspension and expulsion** (Section 18)
- Require each **school to have an emergency response plan** that includes both medical and behavioral health crisis response, incorporates an existing requirement regarding acute mental health treatment planning for students, and includes a method for establishing rapid communication between the school and mobile behavioral health crisis response
    - Require DESE in consultation with DMH and DPH to develop a cost-neutral model emergency response plan that limits referrals to law enforcement except in instances of imminent risk of health and safety (Sections 28 and 30)

EMERGENCY DEPARTMENT (ED) BOARDING

- Require the Secretary of EOHHS to develop a **youth ED boarding data portal** to provide data to health care providers, facilities, payors, and relevant state agencies on children and adolescents who are boarding, waiting for a less intensive, clinically appropriate level of psychiatric care, or in the care or custody of a state agency and awaiting discharge to an appropriate community-based setting (Section 2)
    - Require the online portal to include a real-time bed search function for pediatric acute psychiatric beds, crisis stabilization beds, community-based acute treatment beds (CBAT), intensive community-based acute treatment beds (ICBAT), continuing care beds, and post-hospitalization residential beds (Section 2)
    - Require the Secretary of EOHHS to make quarterly reports to the Children's Behavioral Health Advisory Council (CBHAC), the Office of the Child Advocate (OCA), the Health Policy Commission (HPC), and the Legislature (Section 2)
- Require the **OCA to file a report making recommendations for decreasing and eliminating the number of children and adolescents awaiting clinically appropriate behavioral health services**, including a review of the data included on the youth ED boarding data portal; the report must be submitted to the Governor, the CBHAC, and the Legislature annually by April 1, with the first report due within 18 months of the development of the portal (Sections 20 and 85)

- Require the Secretary of EOHHS to develop an **adult ED boarding data portal** to provide data to health care providers, facilities, and payors on adults seeking to be admitted from an ED or hospital medical floor, including a real-time bed search function for psychiatric and substance use condition inpatient beds (Section 2)
- Establish a **complex case interagency review team**, co-chaired by the Secretary of EOHHS and the Commissioner of the DESE or their designees, to collaborate on complex cases of individuals under age 22, with disabilities or complex behavioral health or special needs, who qualify or may qualify for services from one or more state agencies or special education services, when there is an urgent need to address a lack of resolution about current service needs or placement.
    - Require the team to complete its review within 30 business days or within 5 business days for an individual waiting in a hospital ED, medical bed, or at home for an appropriate therapeutic setting.
    - Establish an interagency services reserve fund for the operations of the team, including to cover the cost of needed services for an individual until a resolution regarding agency fiscal responsibility is reached. The team must submit financial reporting on the fund to the Secretaries of EOHHS and Education and the Legislature annually by August 1 (Sections 3 and 24)
- Require the **OCA to receive complaints from all children, families, and guardians to assist with problems associated with placement**, access to behavioral health services, plans for independent living, and custody decisions of persons ages 18 – 22, and to develop procedures to ensure appropriate responses to the concerns of youth in foster care (Section 19)
- Establish an **expedited psychiatric inpatient admission (EPIA) advisory council** tasked with recommending policies and solutions regarding ED boarding by patients seeking mental health or substance use condition services and require the council to file a report with the Secretary of EOHHS and the Legislature annually by December 31; Require the EPIA protocol to include new provisions for individuals under the age of 18 and individuals who initially had a primary medical diagnosis, who subsequently have been medically cleared, and now are boarding for an inpatient psychiatric placement (Section 21)
- Require the DPH, in consultation with DMH, to promulgate regulations requiring acute care hospitals to have **mental health professionals available during all ED operating hours** to evaluate and stabilize a person admitted to the ED with a mental health presentation, and to refer the person for further treatment; Permit evaluations via telemedicine, electronic or telephonic consultation; DPH must promulgate regulations to implement these provisions by February 6, 2023 (within 90 days after the effective date of this act) (Sections 32 and 87)
- Require the Massachusetts Division of Insurance (DOI), in consultation with MassHealth, to promulgate regulations or issue sub-regulatory guidance to **establish reasonable rates for insurers to reimburse acute care hospitals for each day an individual waits in an ED or observation unit** for an appropriate inpatient psychiatric placement, by December 8, 2022 (within 30 days of the effective date of this act) (Section 78)
- **Require DMH to prepare a plan to address access to continuing care beds, intensive residential treatment programs, and community-based programs for patients awaiting discharge from acute psychiatric hospitals** and units and to submit the plan by January 7, 2023 (within 60 days of the effective date of this act) (Section 79)

CRIMINAL JUSTICE REFORM

- **Eliminate unconstitutional language in G.L. c. 123, § 18 that applies to people in carceral facilities;** the eliminated language, which authorizes the Department of Correction to confine a prisoner at Bridgewater State

Hospital after a court has declined to order such a placement, was recently found unconstitutional by the Massachusetts Supreme Judicial Court (Section 47)

- Establish a **procedure for an incarcerated person at risk of imminent and serious health harm to petition the court for a transfer from mental health watch** to a treatment facility (Section 48)

Access, Equity, Quality, Accountability, and Professional Practice Provisions

HEALTH INSURANCE BENEFITS COVERAGE

- Require health insurers[1] to provide insurance **coverage** for:
  - **Annual mental health wellness examinations with no patient cost-sharing**[2] (Sections 27, 42, 51, 55, 58, and 61)
  - **Community-based acute treatment (CBAT), intensive community-based acute treatment (ICBAT),[3] and mental health acute treatment[4] with no preauthorization required** (Sections 25, 42, 51, 55, 58, and 61)
  - Services provided pursuant to the **psychiatric collaborative care model**[5] which integrates psychiatric and primary care (Sections 26, 42, 51, 55, 58, 61)
    - Reimbursement for the model to include three specified current American Medical Association billing codes (Section 84)
  - **Medically necessary emergency services programs** (ESPs) (Sections 27, 49, 51, 55, 58, and 61)[6]
- Require health insurers and plans regulated by the DOI to maintain **coverage for dependent persons** over 26 years of age on a parent's insurance plan who are mentally or physically incapable of earning their own living due to disability (Sections 52, 53, 57, 60, and 62)

PARITY ENFORCEMENT AND CONSUMER PROTECTIONS

- **Require MassHealth and any entity it contracts with to provide mental health and substance use condition benefits to comply with state and federal mental health parity laws** by covering all behavioral health

[1] Inclusive of MassHealth and its plans and contractor, GIC plans, and all commercial health plans sold in Massachusetts as insurance and regulated by the DOI

[2] With no patient cost sharing unless the plan is governed by the federal Internal Revenue Code and would lose its tax-exempt status because of the prohibition on cost-sharing for this service (usually in the case of high deductible health plans)

[3] Community based acute treatment (CBAT) and Intensive community-based acute treatment (ICBAT) are 24-hour clinically managed mental health diversionary or step-down services provided to children and adolescents typically as an alternative to acute mental health treatment.

[4] Mental health acute treatment includes 24-hour medically supervised mental health services provided in an inpatient facility, licensed by DMH, that provides psychiatric evaluation, management, treatment, and discharge planning.

[5] The psychiatric collaborative care model is the evidence-based, integrated behavioral health service delivery method in which a primary care team consisting of a primary care provider and a care manager provides structured care management to a patient, and that works in collaboration with a psychiatric consultant that provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations.

[6] Emergency Services Programs are 24/7 behavioral health crisis assessment, intervention, and stabilization services including mobile crisis intervention, emergency community-based locations, and adult community crisis stabilization services (Section 49).

conditions[7] and ensuring that **any annual or lifetime dollar or unit of service limitation for behavioral health conditions is not less than any limitation for physical health conditions** (Section 44)

- Require MassHealth and any entity it contracts with to provide mental health and substance use condition benefits to ensure that **there are no separate non-quantitative treatment limitations** that apply to behavioral health that do not also apply to medical/surgical services; Require MassHealth to perform **behavioral health parity compliance examinations on its contractors every four years** and require its contractors to submit annual parity reports by July 1; Require MassHealth to submit an annual summary of all the reports that it receives to the Legislature by December 1 (Section 44)
- Require MassHealth, its contracted health insurers, MassHealth managed care organizations, and the Primary Care Clinician plan to **maintain documentation of all requests for benefits or services, and require prompt and detailed denial notices, when applicable, with information about due process and appeal rights** (Section 43A);
- Require MassHealth to evaluate all consumer or provider complaints about possible parity violations within three months of receipt of the complaint (Section 44)
- **Direct the Commissioner of Insurance to implement and enforce federal and state mental health parity laws, including by performing behavioral health parity compliance market conduct examinations** on each insurance carrier[8] every four years; Allow the Commissioner to impose penalties against carriers for violations, and require carriers to provide remedies if the violations resulted in denied access to behavioral health services; Require the Commissioner to evaluate and resolve consumer complaints alleging parity violations (Section 22)
- Require insurance carriers[9] to submit a self-assessment of their mental health parity compliance annually by July 1 to the Commissioner of Insurance and require the Commissioner to submit these reports to the Attorney General; Also require the Commissioner to submit a summary of the self-assessments, reports of each market conduct examination, a breakdown of treatment authorization data for each carrier, the number of consumer complaints received, and information about educational or corrective actions to the Legislature annually by December 1 (Section 23)
- Impose requirements before an insurance carrier or utilization review organization may amend or establish a medical necessity guideline (Section 71); Establish a **special commission to study medical necessity determinations** for behavioral health that must submit its recommendations to the Legislature by November 8, 2023 (within one year of the effective date of this act) (Section 75)
- **Require qualifying student health insurance plans to comply with federal mental health parity laws** and the benefits mandates and other obligations of state law (Section 17)
- Insurance Carrier Internal Grievance Process
    - **Require insurance carriers to allow individuals to request the appointment of an authorized representative to act on their behalf, and to accept requests for medical release forms by email** (Section 64)

[7] Behavioral health conditions in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders or the most current version of the International Classification of Diseases.

[8] Inclusive of health insurance providers, non-profit health insurance companies, medical service corporations, health maintenance organizations, and carriers offering student health plans, which are regulated by the DOI

[9] Inclusive of the GIC, as well as health insurers, non-profit hospital insurance companies, medical service corporations, and health maintenance organizations that directly or indirectly provide mental health and substance use condition benefits, which are regulated by the DOI

        - Require a formal internal grievance process to include a written acknowledgement of the receipt of a grievance within 15 days and a written resolution of each grievance sent to the insured person by express mail carrier with proof of delivery, within 30 days from receipt
    - **Set out notice requirements** that insurance carriers must provide insured persons if the expedited review process affirms the denial of coverage or treatment (Section 65)
        - Require insurance carriers to provide notice within two business days of the decision along with a description of rights to any further appeal
    - Require the external review of a grievance to be decided in favor of the insured unless the carrier provides evidence that all time limits under the internal grievance process were met (Section 66)
- Office of Patient Protection
    - Require the Office of Patient Protection **(OPP) review panel to consider any right to the treatment or service under state law or regulation**, written documents submitted by the insured person, medical records, and the treating provider's medical opinion on the medical necessity of the treatment or service when evaluating a denial of coverage (Section 67)
    - Permit an insured person to apply to the review panel for continued provision of the contested heath care services during the external review; continued provision during review requires a showing of substantial harm to the insured person's health absent such continuation or other good cause, including a pattern of prior denials that have been overturned by appeals (Section 68)
    - Make an insurer's failure to promptly comply with the review panel's decision an unfair and deceptive practice (Section 69)
    - Require OPP to monitor insurer denials and identify trends that they may refer to the DOI, the Group Insurance Commission (GIC), or the Attorney General's office for behavioral health parity compliance review (Section 70)
    - Require the OPP to develop a process for referring matters to the DOI and the Attorney General for review of compliance with state and federal mental health and substance use condition parity laws (Section 10)

BEHAVIORAL HEALTHCARE REIMBURSEMENT RATES

- Require health insurers to set **a minimum schedule of payment rates for evaluation and management services offered by behavioral health care providers** that are not less than payment rates for such services provided by primary care providers of the same or similar licensure type and in the same geographic region by November 8, 2023 (within one year from the effective date of this act) (Sections 63 and 86)
- Require DOI to issue regulations for the behavioral health provider rate schedule by November 8, 2023 (within one year from the effective date of this act), and to forward any draft regulations to the Legislature (Section 82)
- Require MassHealth to annually review minimum payment rates for behavioral health services provided in community behavioral health centers (CBHCs)[10] by health insurers, behavioral health management firms, and third party administrators under contract with MassHealth managed care organizations or MassHealth accountable care organizations; Require MassHealth to submit a report to the Legislature identifying the

[10] Community behavioral health centers (CBHC) are EOHHS designated organizations, DMH clinics that provide community-based mental health services, and DPH designated clinics.

difference between the MassHealth minimum payment rates and the MassHealth managed care and accountable care entities' contracted payment rates (Section 43)

HEATH POLICY COMMISSION (HPC) AND CENTER FOR HEALTH INFORMATION ANALYSIS (CHIA) REPORTING

- Require the **Health Policy Commission's (HPC's) annual report** and public hearings to include behavioral health expenditures (Sections 5 and 9)
- Direct the HPC to develop a **pediatric behavioral health planning report** every three years, its first by May 9, 2024 (within 18 months of the effective date of this act) (Sections 11 and 83)
- Direct the HPC to conduct an analysis of the effects of behavioral health managers on the health care delivery system and file a report with the Legislature by December 31, 2022 (Section 74)
- Require the **Center for Health Information and Analysis (CHIA)** to include, as part of its annual cost trends report, information on costs, cost trends, price, quality, utilization, and patient outcomes related to behavioral health services and to develop criteria for health care services to be categorized as behavioral health services (Sections 12 and 13)

PROFESSIONAL LICENSURE AND SCOPE OF PRACTICE

- Amend the membership of the Board of Registration of Social Workers to include the Commissioners of the Department of Children and Families (DCF) and DMH, a representative of an accredited school of social work, and a member that represents underserved populations (Section 16)
- Include, in the definition of "the independent practice of social work," the application of evidence-informed social work theories and methods in the comprehensive assessment and treatment of cognitive, affective, mental, emotional, and behavioral conditions and distress arising from physical, environmental, psychological, emotional, or relational conditions (Sections 37)
- Amend the membership of the Board of Registration of Allied Mental Health and Human Services Professions to proportionally represent each professional license type in the Commonwealth (Sections 14 and 15)
- Include, in the definition of "licensed supervised mental health counselor," marriage and family therapists (after completion of an additional two years of supervised clinical experience in a clinic or hospital licensed by DPH), rehabilitation counselors, mental health counselors, educational psychologists, and applied behavior analysts; Permit the Board of Registration of Allied Mental Health and Human Services Professions to issue licenses for a "licensed supervised mental health counselor;" Prohibit persons from advertising themselves as a "licensed supervised mental health counselor" unless they are licensed (Sections 38 – 41)
- Include in the definition of "licensed mental health professional," clinicians working towards licensure (Sections 50, 54, 56, and 59)
- Require EOHHS and DPH to study the feasibility and cost of creating a Board of Registration of Mental Health Counselors and to submit a report to the Legislature by June 30, 2023 (Section 73)
- Permit a psychiatric nurse mental health clinical specialist to provide a signature, certification, stamp, verification, affidavit, or endorsement when otherwise required to be provided by a physician (Section 35)

ACCESS, EQUITY, AND QUALITY PROVISIONS

- Require the interagency health equity team, as supported through the Office of Health Equity, and a new advisory council to study ways to improve access to and quality of culturally competent mental and behavioral health services (Section 72)
- Require **DCF to assess every child entering the foster care system for behavioral health symptoms and to provide referrals to professionals for further assessment and treatment to every child identified with behavioral health needs** (Section 45)
- Require DMH to consider additional factors such as transportation when contracting for services in geographically isolated communities to ensure accessibility of those services (Section 46)
- Direct DPH to establish a voluntary program for monitoring the rehabilitation of licensed health care professionals; Permit a licensing board to dismiss any pending investigation or complaint against a licensed health care professional admitted into the program that relates to their mental health or substance use (Section 36)
- Require HPC to develop a standard release form for the exchange of confidential mental health and substance use information and to promulgate regulations; Establish an advisory group to submit recommendations to HPC on the development of the form by May 9, 2023 (within 6 months of the effective date of this act) (Sections 11 and 76)
- Require UMass Medical School to develop a continuing education program for licensed mental health professionals regarding military service-related behavioral health conditions (Section 31)

PLEASE NOTE:

This document summarizes every section of the law. **For further details, please see the bill text here:** https://malegislature.gov/Laws/SessionLaws/Acts/2022/Chapter177

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