BECOMING AN ADVOCATE FOR MATERNAL MENTAL HEALTH
# TABLE OF CONTENTS

## INTRODUCTION .................................................................................................. 1

## BECOMING AN ADVOCATE ......................................................................... 2

This section is designed to help new advocates learn how to navigate the state legislative process. The term advocacy has historical roots in the legal system, but today is used to describe a person lending their voice in support of a person or cause. Anyone can be an advocate. Here you will find Tips for Effective Legislative Visits and a graphic example of how a bill become a law.

- Tips for Effective Legislative Visits................................................................. 3
- How a Bill Becomes a Law .............................................................................. 4

## SAMPLE LEGISLATION ................................................................................... 5

Find examples of legislation from several states that speak to maternal mental health.

- Illinois: Maternal Mental Health Education, Early Diagnosis and Treatment Act .......... 6
- Arizona: Mental Health Senate Bill ..................................................................... 10
- Florida: Perinatal Mental Health House Bill ...................................................... 27
- California: Telehealth: Mental Health Assembly Bill .......................................... 30
- Massachusetts: Act relative to postpartum depression screening ...................... 36

## ONLINE ADVOCATE TOOLKIT WITH CUSTOMIZABLE MATERIALS ......................... 40

Learn about the additional materials specific to maternal mental health that you can customize based on your location and organization at marchofdimes.org/mentalhealth.
A mother’s mental health is directly connected to her physical health and the health of her baby. Many women experience mental health challenges during pregnancy and the postpartum period, such as depression, anxiety, or post-traumatic stress disorder. Mental health issues are among the most common complications of pregnancy and childbirth, and when left untreated, maternal mental health disorders can have serious medical, societal, and economic consequences. According to the World Health Organization, about 10% of pregnant women and 13% of women who have just given birth experience a mental disorder, primarily depression. It’s long overdue to spotlight moms’ mental health and implement policies to improve screening, diagnosis, and treatment.

This toolkit developed by March of Dimes is designed to build empowered community champions to advocate for maternal mental health policy solutions and create impactful change. This toolkit is full of resources, customizable tools such as factsheets and talking points, sample legislation, and more, to support advocates, both novice and experienced, in their advocacy efforts. The ultimate goal is to reinforce maternal mental health advocacy and create a movement of empowered individuals. Collectively, we can make a difference, no matter your background or level of expertise.

In addition to this toolkit, March of Dimes has hosted a virtual “advocacy power” training. The training provides an overview of advocacy 101, the who, what, why, and how. The training demystifies the legislative process and provides participants with the knowledge to become an impactful advocate for maternal and mental health policy solutions. As an “ambassador” for maternal mental health, you can use the skills and knowledge from the training to educate your elected officials and advocate for impactful maternal mental health policies.

Learn more and find resources at marchofdimes.org/mentalhealth.
BECOMING AN ADVOCATE
TIPS FOR EFFECTIVE LEGISLATIVE VISITS

BEFORE THE MEETING...

• Do your homework.
• Know the correct spelling and pronunciation of the legislator’s name.
• Research committee assignments if possible.
• Review your legislator's voting record and any publicly stated views or opinions.
• Anticipate how the legislator(s) may respond and have rebuttals prepared.

AT THE MEETING...

• Be on time.
• Do not be insulted if you meet with the legislator’s staff.
• Staff are extremely important.
• Staff often have the “ear” of the legislator - thousands of bills are filed, they will turn to staff for more information (though different officials operate differently).
• Make limited small talk and keep the tone and climate of the meeting casual and friendly - not defensive or accusatory.
• Introduce, Inquire, Inform, and Request.
• State your purpose clearly: “I’m here to talk about X and/or to ask for your support specifically on...”
• Make the issue real, connect it to real life and use “human” examples when possible.
• Stay at “30,000” feet and do not get too technical unless talking to someone who has expertise in the area.
• Summarize your main points before leaving.
• Say thank you and leave on time—do not prolong meeting past requested time unless legislator is asking questions.

AFTER THE MEETING...

• Send a thank you note via mail or email.
• Even though the meeting is over, this isn’t the end. This is the beginning of an ongoing relationship with your legislator(s) that will allow you to voice your opinion in the future.
• Send updated information as it becomes available.
HOW DOES A BILL BECOME A LAW?

1. EVERY LAW STARTS WITH AN IDEA
   That idea can come from anyone, even you! Contact your elected officials to share your idea. If they want to try to make it a law, they will write a bill.

2. THE BILL IS INTRODUCED
   A bill can start in either house of Congress when it’s introduced by its primary sponsor, a Senator or a Representative. In the House of Representatives, bills are placed in a wooden box called “the hopper.” Here, the bill is assigned a legislative number before the Speaker of the House sends it to a committee.

3. THE BILL GOES TO COMMITTEE
   Representatives or Senators meet in a small group to research, talk about, and make changes to the bill. They vote to accept or reject the bill and its changes before sending it to the House or Senate floor for debate or to a subcommittee for further research.

4. CONGRESS DEBATES AND VOTES
   Members of the House or Senate can now debate the bill and propose changes or amendments before voting. If the majority vote for and pass the bill, it moves to the other house to go through a similar process of committees, debate, and voting. Both houses have to agree on the same version of the final bill before it goes to the President.

5. PRESIDENTIAL ACTION
   When the bill reaches the President, he or she can:

   - **APPROVE AND PASS**
     The president signs and approves the bill. The bill is law.

   - **CHOOSE NO ACTION**
     The President can decide to do nothing. If Congress is in session, after 10 days of no answer from the President, the bill then automatically becomes law.

   The president can also:

   - **VETO**
     The President rejects the bill and returns it to Congress with the reasons for the veto. Congress can override the veto with ⅔ vote of those present in both the House and the Senate and the bill will become law.

   - **POCKET VETO**
     If Congress adjourns (goes out of session) within the 10 day period after giving the President the bill, the President can choose not to sign it and the bill will not become law.

Source: usa.gov
SAMPLE

LEGISLATION
ILLINOIS
MATERNAL MENTAL HEALTH EDUCATION, EARLY DIAGNOSIS AND TREATMENT ACT
Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Maternal Mental Health Conditions Education, Early Diagnosis, and Treatment Act.

Section 5. Findings. The General Assembly finds the following:

(1) Maternal depression is a common complication of pregnancy. Maternal mental health disorders encompass a range of mental health conditions, such as depression, anxiety, and postpartum psychosis.

(2) Maternal mental health conditions affect one in 5 women during or after pregnancy, but all women are at risk of suffering from maternal mental health conditions.

(3) Untreated maternal mental health conditions significantly and negatively impact the short-term and long-term health and well-being of affected women and their children.

(4) Untreated maternal mental health conditions cause adverse birth outcomes, impaired maternal-infant bonding, poor infant growth, childhood emotional and behavioral problems, and significant medical and economic costs,
estimated to be $22,500 per mother.

(5) Lack of understanding and social stigma of mental health conditions prevent women and families from understanding the signs, symptoms, and risks involved with maternal mental health conditions and disproportionately affect women who lack access to social support networks.

(6) It is the intent of the General Assembly to raise awareness of the risk factors, signs, symptoms, and treatment options for maternal mental health conditions among pregnant women and their families, the general public, primary health care providers, and health care providers who care for pregnant women, postpartum women, and newborn infants.

Section 10. Definitions. In this Act:

"Birthing hospital" means a hospital that has an approved obstetric category of service and licensed beds by the Health Facilities and Services Review Board.

"Department" means the Department of Human Services.

"Maternal mental health condition" means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

Section 15. Educational materials about maternal mental health conditions. The Department shall develop educational
materials for health care professionals and patients about maternal mental health conditions. A birthing hospital shall, on or before January 1, 2021, distribute these materials to employees regularly assigned to work with pregnant or postpartum women and incorporate these materials in any employee training that is related to patient care of pregnant or postpartum women. A birthing hospital shall supplement the materials provided by the Department to include relevant resources to the region or community in which the birthing hospital is located. The educational materials developed under this Section shall include all of the following:

(1) Information for postpartum women and families about maternal mental health conditions, post-hospital treatment options, and community resources.

(2) Information for hospital employees regularly assigned to work in the perinatal unit, including, as appropriate, registered nurses and social workers, about maternal mental health conditions.

(3) Any other service the birthing hospital determines should be included in the program to provide optimal patient care.
State of Arizona
Senate
Fifty-fourth Legislature
Second Regular Session
2020

CHAPTER 4

SENATE BILL 1523

AN ACT

AMENDING SECTION 20-157.01, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 5, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1138; AMENDING TITLE 20, ARIZONA REVISED STATUTES, BY ADDING CHAPTER 28; AMENDING TITLE 36, CHAPTER 1, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 7; AMENDING TITLE 36, CHAPTER 34, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 36-3436 AND 36-3436.01; AMENDING SECTION 36-3504, ARIZONA REVISED STATUTES; APPROPRIATING MONIES; RELATING TO MENTAL HEALTH.

(TEXT OF BILL BEGINS ON NEXT PAGE)
S.B. 1523

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 20-157.01, Arizona Revised Statutes, is amended to read:

20-157.01. Confidentiality of insurer files and records; access by director; definition

A. Pursuant to the director's authority under sections 20-156, 20-157, 20-160, and 20-466 AND 20-3502, an insurer shall comply with a request to produce any documents, reports or other materials, whether maintained in written or electronic format, from an insurer's claim file OR AN INSURER'S RECORD THAT IS REQUIRED TO COMPLY WITH CHAPTER 28, ARTICLE 1 OF THIS TITLE.

B. Any documents, reports or other materials that are provided to the director pursuant to this section are confidential and are not subject to disclosure, including discovery or subpoena, unless the subpoena is issued by the attorney general or a county attorney or by a court at the request of the attorney general, a county attorney or any other law enforcement agency. The director may only disclose the information ONLY to a state or federal agency or officer pursuant to a lawful request, subpoena or formal discovery procedure. If the requesting party cannot warrant confidentiality pursuant to section 20-158, subsection I, the information that is provided pursuant to discovery, subpoena or lawful request as provided for in this subsection remains confidential. The director shall make reasonable efforts to notify an insurer of any request for a subpoena for documents, reports or other materials in an insurer INSURER'S claim file or OTHER record that are produced by the insurer pursuant to this section so that the insurer may assert, in a court of competent jurisdiction, any applicable privileges.

C. The director may use the documents, reports or other materials in the furtherance of any regulatory action brought by the director or in actions brought against the director.

D. For the purposes of this section, "insurer claim file" includes medical records, repair estimates, adjuster notes, insurance policy provisions, recordings or transcripts of witness interviews and any other records regarding coverage, settlement, payment or denial OR ADJUSTMENT of a claim asserted under an insurance policy.

Sec. 2. Title 20, chapter 5, article 1, Arizona Revised Statutes, is amended by adding section 20-1138, to read:

20-1138. Health insurance policies; member identification cards; applicability

A. AN IDENTIFICATION CARD THAT INCLUDES INFORMATION FACILITATING A SUBSCRIBER'S, ENROLLEE'S OR INSURED'S ACCESS TO SERVICES OR COVERAGE UNDER AN INDIVIDUAL OR GROUP HEALTH INSURANCE CONTRACT, EVIDENCE OF COVERAGE OR POLICY ISSUED OR RENEWED IN THIS STATE BY A HOSPITAL AND MEDICAL SERVICE CORPORATION, HEALTH CARE SERVICES ORGANIZATION OR DISABILITY INSURER MUST PROMINENTLY DISPLAY THE LETTERS "AZDOI" IN CAPITAL LETTERS ON THE BOTTOM
S.B. 1523

CHAPTER 28  
MENTAL HEALTH PARITY  
ARTICLE 1. GENERAL PROVISIONS

 Definitions

1. “CLASSIFICATION OF BENEFITS” MEANS THE FOLLOWING CLASSIFICATIONS OF BENEFITS PROVIDED BY A HEALTH PLAN:
   (a) INPATIENT, IN-NETWORK.
   (b) INPATIENT, OUT-OF-NETWORK.
   (c) OUTPATIENT, IN-NETWORK.
   (d) OUTPATIENT, OUT-OF-NETWORK.
   (e) EMERGENCY CARE.
   (f) PRESCRIPTION BENEFITS.

2. “HEALTH CARE INSURER” MEANS A DISABILITY INSURER, GROUP DISABILITY INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION, HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION OR HOSPITAL, MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATION THAT ISSUES A HEALTH PLAN IN THIS STATE.

3. “HEALTH PLAN” MEANS AN INDIVIDUAL HEALTH PLAN OR ACCOUNTABLE HEALTH PLAN THAT PROVIDES MENTAL HEALTH SERVICES OR MENTAL HEALTH BENEFITS, THAT FINANCES OR PROVIDES COVERED HEALTH CARE SERVICES, THAT IS ISSUED BY A HEALTH CARE INSURER IN THIS STATE AND THAT IS SUBJECT TO THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT.

4. “MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT” MEANS THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (42 UNITED STATES CODE SECTION 300gg-26) AND IMPLEMENTING REGULATIONS.

5. “PRODUCT NETWORK TYPE” MEANS THE NETWORK MODEL ASSOCIATED WITH THE TYPE OF HEALTH PLAN UNDER WHICH COVERED HEALTH CARE IS DELIVERED, SUCH AS A HEALTH CARE SERVICES ORGANIZATION, PREFERRED PROVIDER NETWORK ORGANIZATION, POINT OF SERVICE PLAN OR INDEMNITY PLAN.

6. “TREATMENT LIMITS”:
   (a) MEANS LIMITS ON BENEFITS BASED ON THE FREQUENCY OF TREATMENT, NUMBER OF VISITS, DAYS OF COVERAGE, DAYS IN A WAITING PERIOD OR OTHER SIMILAR LIMITS ON THE SCOPE OR DURATION OF TREATMENT.
   (b) INCLUDES BOTH QUANTITATIVE TREATMENT LIMITS THAT ARE EXPRESSED NUMERICALLY AND NONQUANTITATIVE TREATMENT LIMITS THAT OTHERWISE LIMIT THE SCOPE OR DURATION OF BENEFITS FOR TREATMENT UNDER A HEALTH PLAN.
S.B. 1523

(c) DOES NOT INCLUDE A PERMANENT EXCLUSION OF ALL BENEFITS FOR A PARTICULAR CONDITION OR DISORDER.

20-3502. Compliance with federal law; report

A. EACH HEALTH CARE INSURER THAT ISSUES A HEALTH PLAN IN THIS STATE SHALL COMPLY WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT.

B. AFTER JANUARY 1, 2022, ON A DATE SPECIFIED BY THE DIRECTOR, EACH HEALTH CARE INSURER THAT ISSUES A HEALTH PLAN IN THIS STATE SHALL SUBMIT A REPORT TO THE DEPARTMENT FOR EACH FULLY INSURED PRODUCT NETWORK TYPE THE HEALTH CARE INSURER ISSUES. IF THE HEALTH CARE INSURER DETERMINES THAT THE INFORMATION TO BE REPORTED VARIES BY NETWORK OR PLAN, OR VARIES IN THE INDIVIDUAL, SMALL GROUP OR LARGE GROUP MARKET, THE HEALTH CARE INSURER MUST SUBMIT A REPORT FOR EACH VARIATION. EACH REPORT MUST DO THE FOLLOWING:

1. DESCRIBE THE PROCESS THAT IS USED TO DEVELOP OR SELECT THE MEDICAL NECESSITY CRITERIA FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AND THE PROCESS USED TO DEVELOP OR SELECT THE MEDICAL NECESSITY CRITERIA FOR MEDICAL AND SURGICAL BENEFITS.

2. IDENTIFY ALL NONQUANTITATIVE TREATMENT LIMITS THAT ARE APPLIED TO MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AND ALL NONQUANTITATIVE TREATMENT LIMITS THAT ARE APPLIED TO MEDICAL AND SURGICAL BENEFITS WITHIN EACH CLASSIFICATION OF BENEFITS.

3. DEMONSTRATE THROUGH ANALYSIS THAT FOR ANY NONQUANTITATIVE TREATMENT LIMIT APPLIED TO MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS IN A CLASSIFICATION OF BENEFITS, AS WRITTEN AND IN OPERATION, ANY PROCESS, STRATEGY, EVIDENTIARY STANDARD OR OTHER FACTOR USED IN APPLYING THE NONQUANTITATIVE TREATMENT LIMIT TO MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS IN THE CLASSIFICATION ARE COMPARABLE TO, AND APPLIED NOT MORE STRINGENTLY THAN, ANY PROCESS, STRATEGY, EVIDENTIARY STANDARD OR OTHER FACTOR USED IN APPLYING THE TREATMENT LIMIT FOR MEDICAL AND SURGICAL BENEFITS IN THE CLASSIFICATION.

C. IN ADDITION TO ANALYZING THE REPORTS PRESCRIBED IN SUBSECTION B OF THIS SECTION, THE DEPARTMENT SHALL ALSO EVALUATE HEALTH PLAN COMPLIANCE WITH THE STANDARDS RELATED TO FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITS DESCRIBED IN THIS SECTION. THE DEPARTMENT SHALL PERFORM THIS ANALYSIS DURING ITS REVIEW OF REQUIRED HEALTH CARE INSURER FORM FILINGS, BUT MAY ALSO REQUIRE A HEALTH CARE INSURER TO SUBMIT ADDITIONAL DATA RELATING TO ITS METHODS FOR COMPLYING WITH FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMIT STANDARDS. THE DEPARTMENT MAY COLLECT AND ANALYZE DATA FOR EACH HEALTH CARE INSURER’S LARGE GROUP PLANS THROUGH A SEPARATE, CONSOLIDATED REPORT.

D. THE HEALTH PLAN MAY NOT APPLY ANY FINANCIAL REQUIREMENT OR QUANTITATIVE TREATMENT LIMIT TO MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS IN ANY CLASSIFICATION THAT IS MORE RESTRICTIVE THAN THE PREDOMINANT FINANCIAL REQUIREMENT OR QUANTITATIVE TREATMENT LIMIT OF THAT TYPE APPLIED TO SUBSTANTIALLY ALL MEDICAL AND SURGICAL BENEFITS IN THE
SAME CLASSIFICATION, UNLESS THE REQUIREMENT OR TREATMENT LIMIT IS MODIFIED BY ONE OF THE FOLLOWING EXCEPTIONS:

1. MULTITIERED PRESCRIPTION DRUG BENEFITS. IF A HEALTH PLAN APPLIES DIFFERENT LEVELS OF FINANCIAL REQUIREMENTS TO DIFFERENT TIERS OF PRESCRIPTION DRUG BENEFITS THAT ARE BASED ON REASONABLE FACTORS DETERMINED IN ACCORDANCE WITH THE REQUIREMENTS FOR NONQUANTITATIVE TREATMENT LIMITS AND WITHOUT REGARD TO WHETHER A DRUG IS GENERALLY PRESCRIBED WITH RESPECT TO MEDICAL AND SURGICAL BENEFITS OR WITH RESPECT TO MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS, THE HEALTH PLAN SATISFIES THE PARITY REQUIREMENTS OF THIS SECTION WITH RESPECT TO PRESCRIPTION DRUG BENEFITS. FOR THE PURPOSES OF THIS PARAGRAPH, "REASONABLE FACTORS" INCLUDE COST, EFFICACY, GENERIC VERSUS BRAND NAME AND MAIL ORDER VERSUS PHARMACY PICK UP.

2. MULTIPLE NETWORK TIERS. IF A HEALTH PLAN PROVIDES BENEFITS THROUGH MULTIPLE TIERS OF IN-NETWORK PROVIDERS, INCLUDING AN IN-NETWORK TIER OF PREFERRED PROVIDERS WITH MORE GENEROUS COST SHARING TO PARTICIPANTS THAN A SEPARATE IN-NETWORK TIER OF PARTICIPATING PROVIDERS, THE HEALTH PLAN MAY DIVIDE ITS BENEFITS PROVIDED ON AN IN-NETWORK BASIS INTO SUBCLASSIFICATIONS THAT REFLECT NETWORK TIERS, IF THE TIERING IS BASED ON REASONABLE FACTORS DETERMINED IN ACCORDANCE WITH THE REQUIREMENTS FOR NONQUANTITATIVE TREATMENT LIMITS AND WITHOUT REGARD TO WHETHER A PROVIDER PROVIDES SERVICES WITH RESPECT TO MEDICAL AND SURGICAL BENEFITS OR MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS IN ANY SUBCLASSIFICATION THAT IS MORE RESTRICTIVE THAN THE PREDOMINANT FINANCIAL REQUIREMENT OR TREATMENT LIMIT THAT APPLIES TO SUBSTANTIALLY ALL MEDICAL AND SURGICAL BENEFITS IN THE SUBCLASSIFICATION.

3. SUBCLASSIFICATIONS ALLOWED FOR OFFICE VISITS THAT ARE SEPARATE FROM OTHER OUTPATIENT SERVICES. FOR THE PURPOSES OF APPLYING THE FINANCIAL REQUIREMENTS AND TREATMENT LIMITS PRESCRIBED BY THIS SECTION, A HEALTH PLAN MAY DIVIDE ITS BENEFITS PROVIDED ON AN OUTPATIENT BASIS INTO THE TWO SUBCLASSIFICATIONS DESCRIBED IN THIS PARAGRAPH. AFTER THE SUBCLASSIFICATIONS ARE ESTABLISHED, THE HEALTH PLAN OR HEALTH CARE INSURER MAY NOT IMPOSE ANY FINANCIAL REQUIREMENT OR QUANTITATIVE TREATMENT LIMIT ON MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS IN ANY SUBCLASSIFICATION THAT IS MORE RESTRICTIVE THAN THE PREDOMINANT FINANCIAL REQUIREMENT OR QUANTITATIVE TREATMENT LIMIT THAT APPLIES TO SUBSTANTIALLY ALL MEDICAL AND SURGICAL BENEFITS IN THE SUBCLASSIFICATION. SUBCLASSIFICATIONS FOR GENERALISTS AND SPECIALISTS ARE PROHIBITED. ONLY THE FOLLOWING TWO SUBCLASSIFICATIONS ARE ALLOWED UNDER THIS PARAGRAPH:

   (a) OFFICE AND PHYSICIAN VISITS.

   (b) ALL OTHER OUTPATIENT ITEMS AND SERVICES, INCLUDING OUTPATIENT SURGERY, FACILITY CHARGES FOR DAY TREATMENT CENTERS, LABORATORY CHARGES OR OTHER SIMILAR MEDICAL ITEMS.
E. A HEALTH INSURER SHALL FILE THE REPORT REQUIRED BY SUBSECTION B OF THIS SECTION ONCE EVERY THREE YEARS. IN YEARS IN WHICH THE REPORT REQUIRED BY SUBSECTION B OF THIS SECTION IS NOT REQUIRED TO BE FILED, THE HEALTH CARE INSURER SHALL FILE A SUMMARY OF CHANGES MADE TO THE MEDICAL NECESSITY CRITERIA AND NONQUANTITATIVE TREATMENT LIMITS AND A WRITTEN ATTESTATION THAT SPECIFIES THAT THE HEALTH CARE INSURER IS IN COMPLIANCE WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT. THE DEPARTMENT MAY REQUIRE THE HEALTH CARE INSURER TO RESPOND TO ADDITIONAL QUESTIONS THAT ARE RELATED TO THE SUMMARY OF CHANGES OR TO SUPPLY ADDITIONAL DATA TO VERIFY COMPLIANCE. THREE YEARS AFTER THE HEALTH CARE INSURER SUBMITS AN ORIGINAL REPORT REQUIRED BY SUBSECTION B OF THIS SECTION OR AN UPDATED OR REFILED REPORT DESCRIBED IN THIS SUBSECTION, THE HEALTH CARE INSURER MAY EITHER:

1. FILE AN UPDATED REPORT.
2. RESUBMIT THE HEALTH CARE INSURER'S CURRENTLY FILED REPORT IF THE HEALTH CARE INSURER FILES A WRITTEN ATTESTATION TO THE DEPARTMENT THAT SPECIFIES THAT THERE HAVE BEEN NO CHANGES.

F. EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, IF A HEALTH CARE INSURER PROVIDED THE INFORMATION REQUIRED BY THIS SECTION IN AN EXISTING FILING OR REPORT, THE DEPARTMENT MAY NOT REQUIRE THE HEALTH CARE INSURER TO SUBMIT ANY ADDITIONAL FILING OR REPORT. THE DEPARTMENT IS NOT PROHIBITED FROM OTHERWISE REQUESTING INFORMATION OR DATA THAT IS NECESSARY TO VERIFY COMPLIANCE WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OR THIS CHAPTER. THE DEPARTMENT SHALL ANALYZE THE INFORMATION REQUIRED BY THIS SECTION THAT THE HEALTH CARE INSURER PREVIOUSLY SUBMITTED IN AN EXISTING FILING OR REPORT TO DETERMINE COMPLIANCE WITH THE REPORT REQUIRED BY THIS SECTION. THE DEPARTMENT MAY ESTABLISH BY RULE THE TERMS REGARDING ANY REQUIRED RE-submittal OF INFORMATION.

G. ALL DOCUMENTS, REPORTS OR OTHER MATERIALS PROVIDED TO THE DIRECTOR PURSUANT TO THIS SECTION ARE CONFIDENTIAL AND ARE NOT SUBJECT TO DISCLOSURE. SECTION 20-157.01, SUBSECTION B APPLIES TO THIS SECTION.

20-3503. Enforcement and oversight
A. THE DEPARTMENT SHALL ENFORCE THIS CHAPTER.
B. ON OR BEFORE JANUARY 1, 2021, THE DEPARTMENT SHALL DEVELOP A WEB PAGE THAT PROVIDES THE FOLLOWING INFORMATION IN NOTECHEMICAL AND READILY UNDERSTANDABLE LANGUAGE:
1. CONSUMER-FRIENDLY INFORMATION CONCERNING THE SCOPE AND APPPLICABILITY OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT AND THE MENTAL HEALTH PARITY REQUIREMENTS THAT APPLY TO HEALTH CARE INSURERS THAT ISSUE HEALTH PLANS IN THIS STATE.
2. A STEP-BY-STEP GUIDE WITH SUPPORTING INFORMATION THAT EXPLAINS HOW CONSUMERS CAN FILE AN APPEAL OR COMPLAINT WITH THE DEPARTMENT CONCERNING AN ALLEGED VIOLATION OF THIS CHAPTER. THE GUIDE MUST ALSO PROMINENTLY DISPLAY A LINK TO THE UNITED STATES DEPARTMENT OF LABOR'S WEBSITE, OR A RELATED WEBSITE, THAT PROVIDES INFORMATION ON APPEALS OR - 5 -
COMPLAINTS BY CONSUMERS WHO ARE COVERED BY SELF-INSURED PLANS THAT ARE
REGULATED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974
(P.L. 93-406; 88 STAT. 829).

C. ON OR BEFORE JANUARY 1, 2023, THE DEPARTMENT SHALL POST TO THE
WEB PAGE PRESCRIBED IN SUBSECTION B OF THIS SECTION AN AGGREGATED SUMMARY
OF ITS ANALYSIS OF THE REPORTS FILED BY HEALTH CARE INSURERS PURSUANT TO
SECTION 20-3502, SUBSECTION B, INCLUDING ANY CONCLUSIONS REGARDING
INDUSTRY COMPLIANCE WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY
ACT. THE DEPARTMENT MAY NOT POST ANY INFORMATION THAT:
    1. CONTAINS ANY PROPRIETARY OR CONFIDENTIAL INFORMATION OF A HEALTH
CARE INSURER.
    2. ENABLES A PERSON TO DETERMINE THE IDENTITY OF A HEALTH CARE
INSURER.

D. BEGINNING IN 2022, THE DEPARTMENT SHALL INCLUDE IN ITS ANNUAL
REPORT A SUMMARY OF ALL STAKEHOLDER OUTREACH AND REGULATORY ACTIVITY
RELATED TO THE IMPLEMENTATION, OVERSIGHT AND ENFORCEMENT OF THE MENTAL
HEALTH PARITY AND ADDICTION EQUITY ACT AND THE REQUIREMENTS OF THIS
CHAPTER.

20-3504. Access to behavioral health services for minors

A. NOTWITHSTANDING ANY OTHER PROVISION OF THIS TITLE, ANY HEALTH
CARE INSURER THAT ISSUES A HEALTH PLAN IN THIS STATE THAT INCLUDES MENTAL
HEALTH OR SUBSTANCE USE DISORDER BENEFITS MAY NOT DENY ANY CLAIM FOR
MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS FOR A MINOR SOLELY ON
GROUNDS THAT THE MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICE WAS
PROVIDED IN A SCHOOL OR OTHER EDUCATIONAL SETTING OR ORDERED BY A COURT IF
THE SERVICE WAS PROVIDED BY AN IN-NETWORK PROVIDER OR BY AN OUT-OF-NETWORK
PROVIDER ONLY AS ALLOWED BY THE HEALTH PLAN THAT COVERS THE SUBSCRIBER,
ENROLLEE OR INSURED.

B. THIS SECTION DOES NOT REQUIRE A HEALTH CARE INSURER TO APPROVE A
CLAIM OR PROVIDE REIMBURSEMENT FOR A MENTAL HEALTH OR SUBSTANCE USE
DISORDER SERVICE PROVIDED BY AN OUT-OF-NETWORK PROVIDER EXCEPT AS ALLOWED
BY THE HEALTH PLAN THAT COVERS THE SUBSCRIBER, ENROLLEE OR INSURED.

C. A HEALTH CARE INSURER MAY REQUIRE THAT ANY MENTAL HEALTH OR
SUBSTANCE USE DISORDER SERVICE OFFERED BY A MENTAL HEALTH PROVIDER IN AN
EDUCATIONAL SETTING BE PROVIDED IN A FACILITY OR LOCATION THAT IS
APPROPRIATE FOR THE TYPE OF SERVICE PROVIDED AND IN A MANNER THAT COMPLIES
WITH APPLICABLE LAWS GOVERNING THE PROVISION OF HEALTH CARE SERVICES,
INCLUDING PRIVACY AND PARENTAL CONSENT LAWS.

D. CLAIMS FOR COVERED MENTAL HEALTH OR SUBSTANCE USE DISORDER
SERVICES THAT ARE PROVIDED BY AN OUT-OF-NETWORK PROVIDER AND THAT ARE NOT
COVERED BY THE SUBSCRIBER’S, ENROLLEE’S OR INSURED’S HEALTH PLAN SOLELY
BECAUSE THE PROVIDER IS AN OUT-OF-NETWORK PROVIDER SHALL BE PAID FROM THE
CHILDREN’S BEHAVIORAL HEALTH SERVICES FUND ESTABLISHED BY SECTION 36-3436.
S.B. 1523

20-3505. Mental health parity advisory committee; members; committee termination
A. THE MENTAL HEALTH PARITY ADVISORY COMMITTEE IS ESTABLISHED TO ADVISE THE DIRECTORS OF THE DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS AND DEPARTMENT OF HEALTH SERVICES RELATING TO MATTERS PERTINENT TO MENTAL HEALTH PARITY, INCLUDING RECOMMENDATIONS RELATED TO CASE MANAGEMENT, DISCHARGE PLANNING AND EXPEDITED REVIEW AND APPEALS PROCESSES FOR CASES INVOLVING SUICIDAL IDEATION. THE DIRECTOR OF THE DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS SHALL APPOINT THE FOLLOWING MEMBERS TO THE COMMITTEE:
1. FOUR MEMBERS WHO REPRESENT HEALTH CARE INSURERS.
2. ONE MEMBER WHO IS A LICENSED BEHAVIORAL HEALTH SERVICES PROVIDER.
3. ONE MEMBER WHO REPRESENTS A BEHAVIORAL HEALTH ADVOCACY ORGANIZATION.
4. AT LEAST THREE MEMBERS OR FAMILY MEMBERS WHO ARE NOT EMPLOYED BY OR CONTRACTED WITH THE STATE AND WHO HAVE BEEN AFFECTED BY SUICIDE, SUBSTANCE USE OR A MENTAL HEALTH DISORDER.
5. AT LEAST ONE MEMBER WHO REPRESENTS A HOSPITAL THAT PROVIDES INPATIENT BEHAVIORAL HEALTH SERVICES.
C. THE COMMITTEE ESTABLISHED BY THIS SECTION ENDS ON JULY 1, 2028 PURSUANT TO SECTION 41-3103.

Sec. 4. Title 36, chapter 1, Arizona Revised Statutes, is amended by adding article 7, to read:

ARTICLE 7. SUICIDE MORTALITY
36-199. Suicide mortality review team; members; duties; review team termination
A. THE SUICIDE MORTALITY REVIEW TEAM IS ESTABLISHED IN THE DEPARTMENT OF HEALTH SERVICES. THE HEAD OF EACH OF THE FOLLOWING ENTITIES OR THAT PERSON'S DESIGNEE SHALL SERVE ON THE REVIEW TEAM:
1. THE DEPARTMENT OF HEALTH SERVICES.
2. THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.
3. THE DEPARTMENT OF ECONOMIC SECURITY.
4. THE GOVERNOR'S OFFICE OF YOUTH, FAITH AND FAMILY.
5. THE DEPARTMENT OF EDUCATION.
6. THE ARIZONA COUNCIL OF HUMAN SERVICES PROVIDERS.
7. THE DEPARTMENT OF PUBLIC SAFETY.
B. THE DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES SHALL APPOINT THE FOLLOWING MEMBERS TO SERVE ON THE REVIEW TEAM:
1. A MEDICAL EXAMINER WHO IS A RURAL FORENSIC PATHOLOGIST.
2. A MEDICAL EXAMINER WHO IS A METROPOLITAN FORENSIC PATHOLOGIST.
3. A REPRESENTATIVE OF A TRIBAL GOVERNMENT.
4. A REPRESENTATIVE OF A HEALTH CARE INSURER.
5. A PUBLIC MEMBER.
6. A REPRESENTATIVE OF AN EMERGENCY MANAGEMENT SYSTEM PROVIDER.
7. A HEALTH CARE PROFESSIONAL FROM A STATEWIDE ASSOCIATION REPRESENTING PEDIATRICIANS.
8. A HEALTH CARE PROFESSIONAL FROM A STATEWIDE ASSOCIATION REPRESENTING PHYSICIANS.
9. A HEALTH CARE PROFESSIONAL FROM A STATEWIDE ASSOCIATION REPRESENTING NURSES.
10. A REPRESENTATIVE OF AN ASSOCIATION OF COUNTY HEALTH OFFICERS.
11. A REPRESENTATIVE OF AN ASSOCIATION REPRESENTING HOSPITALS.
12. A PROFESSIONAL WHO SPECIALIZES IN THE PREVENTION, DIAGNOSIS AND TREATMENT OF BEHAVIORAL HEALTH PROBLEMS.
13. A COUNTY SHERIFF, OR THE SHERIFF'S DESIGNEE, WHO REPRESENTS A COUNTY WITH A POPULATION OF LESS THAN FIVE HUNDRED THOUSAND PERSONS AND A COUNTY SHERIFF, OR THE SHERIFF'S DESIGNEE, WHO REPRESENTS A COUNTY WITH A POPULATION OF AT LEAST FIVE HUNDRED THOUSAND PERSONS.
14. A REPRESENTATIVE OF A VETERANS ORGANIZATION OR MILITARY FAMILY ADVOCACY PROGRAM.
15. A REPRESENTATIVE OF A STATEWIDE ASSOCIATION REPRESENTING AREA AGENCIES ON AGING.
16. A REPRESENTATIVE OF A NONPROFIT COMMUNITY-BASED ORGANIZATION PROVIDING SUICIDE PREVENTION SERVICES.
17. A REPRESENTATIVE OF A RURAL HEALTH ORGANIZATION.
C. THE REVIEW TEAM SHALL:
1. DEVELOP A SUICIDE MORTALITIES DATA COLLECTION SYSTEM.
2. CONDUCT AN ANNUAL ANALYSIS ON THE INCIDENCES AND CAUSES OF SUICIDES IN THIS STATE DURING THE PRECEDING FISCAL YEAR.
3. ENCOURAGE AND ASSIST IN THE DEVELOPMENT OF LOCAL SUICIDE MORTALITY REVIEW TEAMS.
4. DEVELOP STANDARDS AND PROTOCOLS FOR LOCAL SUICIDE MORTALITY REVIEW TEAMS AND PROVIDE TRAINING AND TECHNICAL ASSISTANCE TO THESE TEAMS.
5. DEVELOP PROTOCOLS FOR SUICIDE INVESTIGATIONS, INCLUDING PROTOCOLS FOR LAW ENFORCEMENT AGENCIES, PROSECUTORS, MEDICAL EXAMINERS, HEALTH CARE FACILITIES AND SOCIAL SERVICE AGENCIES.
6. STUDY THE ADEQUACY OF STATUTES, ORDINANCES, RULES, TRAINING AND SERVICES TO DETERMINE WHAT CHANGES ARE NEEDED TO DECREASE THE INCIDENCE OF PREVENTABLE SUICIDES AND, AS APPROPRIATE, TAKE STEPS TO IMPLEMENT THESE CHANGES.
7. EDUCATE THE PUBLIC REGARDING THE INCIDENCES AND CAUSES OF SUICIDE AS WELL AS THE PUBLIC'S ROLE IN PREVENTING THESE DEATHS.
8. DESIGNATE A MEMBER OF THE REVIEW TEAM TO SERVE AS CHAIRPERSON.
D. REVIEW TEAM MEMBERS ARE NOT ELIGIBLE TO RECEIVE COMPENSATION, BUT MEMBERS APPOINTED PURSUANT TO SUBSECTION B OF THIS SECTION ARE
S.B. 1523

ELIGIBLE FOR REIMBURSEMENT OF EXPENSES PURSUANT TO TITLE 38, CHAPTER 4, ARTICLE 2.

E. THE DEPARTMENT OF HEALTH SERVICES SHALL PROVIDE PROFESSIONAL AND ADMINISTRATIVE SUPPORT TO THE TEAM.

F. THE REVIEW TEAM ESTABLISHED BY THIS SECTION ENDS ON JULY 1, 2028 PURSUANT TO SECTION 41-3103.

36-199.01. Access to information; confidentiality; violation; classification

A. ON REQUEST OF THE CHAIRPERSON OF THE SUICIDE MORTALITY REVIEW TEAM OR A LOCAL TEAM AND AS NECESSARY TO CARRY OUT THE TEAM’S DUTIES, THE CHAIRPERSON SHALL BE PROVIDED, WITHIN FIVE DAYS EXCLUDING WEEKENDS AND HOLIDAYS, WITH ACCESS TO INFORMATION AND RECORDS REGARDING A SUICIDE THAT IS BEING REVIEWED BY THE TEAM. THE TEAM MAY REQUEST THE INFORMATION AND RECORDS FROM ANY OF THE FOLLOWING:

1. A PROVIDER OF MEDICAL, DENTAL, NURSING OR MENTAL HEALTH CARE.
2. A HEALTH CARE INSURER.
3. THIS STATE OR A POLITICAL SUBDIVISION OF THIS STATE THAT MIGHT ASSIST THE TEAM IN REVIEWING THE FATALITY.

B. A LAW ENFORCEMENT AGENCY, WITH THE APPROVAL OF THE PROSECUTING ATTORNEY, MAY WITHHOLD FROM A REVIEW TEAM INVESTIGATIVE RECORDS THAT MIGHT INTERFERE WITH A PENDING CRIMINAL INVESTIGATION OR PROSECUTION.

C. THE DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES OR THE DIRECTOR’S DESIGNEE MAY APPLY TO THE SUPERIOR COURT FOR A SUBPOENA AS NECESSARY TO COMPEL THE PRODUCTION OF BOOKS, RECORDS, DOCUMENTS AND OTHER EVIDENCE RELATED TO THE PERSON WHO DIED BY SUICIDE. SUBPOENAS ISSUED UNDER THIS SUBSECTION SHALL BE SERVED AND, ON APPLICATION TO THE COURT BY THE DIRECTOR OR THE DIRECTOR’S DESIGNEE, ENFORCED IN THE MANNER PROVIDED BY LAW FOR THE SERVICE AND ENFORCEMENT OF SUBPOENAS. A LAW ENFORCEMENT AGENCY IS NOT REQUIRED TO PRODUCE THE INFORMATION REQUESTED UNDER THE SUBPOENA IF THE SUBPOENAED EVIDENCE RELATES TO A PENDING CRIMINAL INVESTIGATION OR PROSECUTION. ALL RECORDS SHALL BE RETURNED TO THE AGENCY OR ORGANIZATION ON COMPLETING THE REVIEW. THE REVIEW TEAM MAY NOT KEEP WRITTEN REPORTS OR RECORDS CONTAINING IDENTIFYING INFORMATION.

D. ALL INFORMATION AND RECORDS ACQUIRED BY THE SUICIDE MORTALITY REVIEW TEAM OR ANY LOCAL TEAM ARE CONFIDENTIAL AND ARE NOT SUBJECT TO SUBPOENA, DISCOVERY OR INTRODUCTION INTO EVIDENCE IN ANY CIVIL OR CRIMINAL PROCEEDING, EXCEPT THAT INFORMATION, DOCUMENTS AND RECORDS THAT ARE OTHERWISE AVAILABLE FROM OTHER SOURCES ARE NOT IMMUNE FROM SUBPOENA, DISCOVERY OR INTRODUCTION INTO EVIDENCE THROUGH THOSE SOURCES SOLELY BECAUSE THEY WERE PRESENTED TO OR REVIEWED BY A TEAM PURSUANT TO THIS ARTICLE.

E. MEMBERS OF A TEAM, PERSONS ATTENDING A TEAM MEETING AND PERSONS WHO PRESENT INFORMATION TO A TEAM MAY NOT BE QUESTIONED IN ANY CIVIL OR CRIMINAL PROCEEDING REGARDING INFORMATION PRESENTED IN OR OPINIONS FORMED AS A RESULT OF A MEETING. THIS SUBSECTION DOES NOT PREVENT A PERSON FROM
Testifying to information that is obtained independently of the team or that is public information.

F. Pursuant to policies adopted by the suicide mortality review team, a member of the suicide mortality review team or a local team may contact, interview or obtain information by request or subpoena from a family member of a deceased person who died by suicide. The suicide mortality review team or a local team must approve any contact, interview, request or subpoena before the team member contacts, interviews or obtains information from the family member of a deceased person who died by suicide.

G. Meetings of the suicide mortality review team or a local team are closed to the public and are not subject to Title 38, Chapter 3, Article 3.1 if the team is reviewing information on an individual who died by suicide. All other team meetings are open to the public.

H. A person who violates the confidentiality requirements of this section is guilty of a class 2 misdemeanor.

Sec. 5. Title 36, chapter 34, article 3, Arizona Revised Statutes, is amended by adding sections 36-3436 and 36-3436.01, to read:

36-3436. Children's behavioral health services fund; exemption; use of monies

A. The children's behavioral health services fund is established consisting of monies appropriated to the fund, any gifts or donations to the fund and interest earned on those monies. The director shall administer the fund.

B. Monies in the fund:
1. Are exempt from the provisions of section 35-190 relating to lapsing of appropriations.
2. Are continuously appropriated.

C. The administration shall enter into an agreement with one or more contractors for children's behavioral health services using monies from the children's behavioral health services fund to pay for behavioral health services for children. To be eligible to receive behavioral health services paid by the fund, an individual must meet all of the following conditions:
1. Meet the legal age requirements for school admission under Title 15 at the time the individual was admitted and be enrolled in school.
2. Be uninsured or underinsured.
3. Be referred for behavioral health services by an educational institution.
4. Have written parental consent to obtain the behavioral health services.
5. Receive the behavioral health services by a contracted licensed behavioral health provider.
6. Receive the behavioral health services on or off school grounds.
D. IN ADDITION TO TERMS AND CONDITIONS THE DIRECTOR DEEMS
APPROPRIATE, THE AGREEMENT BETWEEN THE ADMINISTRATION AND EACH CONTRACTOR
SHALL REQUIRE THAT:

1. THE MONIES ALLOCATED IN THE AGREEMENT NOT BE USED FOR PERSONS
WHO ARE ELIGIBLE UNDER TITLE XIX OR TITLE XXI OF THE SOCIAL SECURITY ACT.
PREFERENCE SHALL BE GIVEN TO PERSONS WITH LOWER HOUSEHOLD INCOMES.

2. THE CONTRACTOR COORDINATE BENEFITS PROVIDED UNDER THIS SECTION
WITH ANY THIRD PARTIES THAT ARE LEGALLY RESPONSIBLE FOR THE COST OF
SERVICES.

3. THE CONTRACTOR MAKE PAYMENTS TO PROVIDERS BASED ON CONTRACTS
WITH PROVIDERS OR, IN THE ABSENCE OF A CONTRACT, AT THE CAPPED FEE
SCHEDULE ESTABLISHED BY THE ADMINISTRATION.

4. THE CONTRACTOR SUBMIT EXPENDITURE REPORTS MONTHLY IN A FORMAT
DETERMINED BY THE DIRECTOR FOR REIMBURSEMENT OF SERVICES PROVIDED UNDER
THE AGREEMENT. THE AGREEMENT MAY ALSO PROVIDE FOR ADDITIONAL
REIMBURSEMENT FOR ADMINISTERING THE AGREEMENT IN AN AMOUNT NOT TO EXCEED
EIGHT PERCENT OF THE EXPENDITURES FOR SERVICES.

5. THE ADMINISTRATION NOT BE HELD FINANCIALLY RESPONSIBLE TO THE
CONTRACTOR FOR ANY COSTS INCURRED BY THE CONTRACTOR IN EXCESS OF THE
MONIES ALLOCATED IN THE AGREEMENT.

E. THE ADMINISTRATION MAY IMPOSE COST SHARING REQUIREMENTS ON A
SLIDING FEE SCALE FOR BEHAVIORAL HEALTH SERVICES PROVIDED BY CONTRACTORS.

F. THE ADMINISTRATION SHALL ACT AS PAYOR OF LAST RESORT FOR PERSONS
WHO ARE ELIGIBLE PURSUANT TO THIS SECTION. ON RECEIPT OF SERVICES UNDER
THIS SECTION, A PERSON IS DEEMED TO HAVE ASSIGNED TO THE ADMINISTRATION
ALL RIGHTS TO ANY TYPE OF MEDICAL BENEFIT TO WHICH THE PERSON IS ENTITLED.

G. THIS SECTION DOES NOT ESTABLISH:
1. AN ENTITLEMENT FOR ANY PERSON TO RECEIVE ANY PARTICULAR SERVICE.
2. A DUTY ON THE ADMINISTRATION TO PROVIDE SERVICES OR SPEND MONIES
IN EXCESS OF THE MONIES IN THE FUND.

36-3436.01. School-based behavioral health services;
referrals; requirements; annual report

A. BEFORE A SCHOOL PROVIDES SCHOOL-BASED REFERRALS FOR BEHAVIORAL
HEALTH SERVICES TO A CONTRACTED BEHAVIORAL HEALTH SERVICES PROVIDER EITHER
PURSUANT TO THE CHILDREN’S BEHAVIORAL HEALTH SERVICES FUND ESTABLISHED BY
SECTION 36-3436 OR FOR SERVICES PROVIDED THROUGH THE ARIZONA HEALTH CARE
COST CONTAINMENT SYSTEM, THE SCHOOL DISTRICT GOVERNING BOARD OR CHARTER
SCHOOL GOVERNING BODY SHALL ADOPT POLICIES RELATING TO SCHOOL-BASED
REFERRALS. THESE POLICIES SHALL BE VETTED AT A PUBLIC MEETING IN WHICH
THE SCHOOL DISTRICT GOVERNING BOARD OR CHARTER SCHOOL GOVERNING BODY
CONSiders ANY COMMENTS SUBMITTED BY THE PUBLIC BEFORE THE GOVERNING BOARD
OR GOVERNING BODYadopts THE POLICIES. THE SCHOOL DISTRICT GOVERNING
BOARD OR CHARTER SCHOOL GOVERNING BODY SHALL POST THE POLICIES ADOPTED
Pursuant to this Section on each applicable school website. The policies
shall include the following:
1. A process to allow a parent to annually opt into the school-based referrals.

2. A process to conduct a survey of parents whose children were referred to and received behavioral health services pursuant to this section. The survey may be completed online. The survey shall include at least the following:
   (a) Whether the parent opted into the program.
   (b) Whether the parent was notified before the referral took place.
   (c) Whether the behavioral health services referred were appropriate to meet the student's need.
   (d) Whether the parent is satisfied with the choice of behavioral health services providers.
   (e) Whether the parent intends to opt into a program again in the following school year.

3. A requirement that each school's website contain a list of behavioral health services providers with whom the school contracts.

B. At the end of each school year, each participating school district and charter school shall report to the administration the school survey results.

C. The administration shall compile a report based on the surveys received from participating school districts and charter schools as well as utilization data for behavioral health services received pursuant to the children's behavioral health services fund established by section 36-3436. On or before December 31 each year, the administration shall provide the report to the governor, the president of the senate and the speaker of the house of representatives and provide a copy of the report to the secretary of state. The report shall include at least all of the following information:
   1. The number of students served.
   2. The types of behavioral health services provided.
   3. The costs of the behavioral health services provided.

Sec. 6. Section 36-3504, Arizona Revised Statutes, is amended to read:

36-3504. Child fatality review fund

A. The child fatality review fund is established consisting of appropriations, monies received pursuant to sections 36-342 36-341, subsection E and gifts, grants and donations made to the department of health services to implement subsection B of this section. The department of health services shall administer the fund. The department shall deposit, pursuant to sections 35-146 and 35-147, all monies it receives in the fund.

B. The department of health services shall use fund monies to staff the state child fatality review team and the suicide mortality review team and to train and support local child fatality review teams and suicide mortality review teams.
C. Monies spent for the purposes specified in subsection B of this section are subject to legislative appropriation. Any fee revenue collected in excess of one hundred thousand dollars $200,000 in any fiscal year is appropriated from the child fatality review fund to the child abuse prevention fund established pursuant to section 8-550.01, subsection A, to be used for healthy start programs.

Sec. 7. Arizona health care cost containment system; behavioral health survey of schools; report; delayed repeal

A. The Arizona health care cost containment system shall conduct a survey of public schools to obtain information regarding the referral of behavioral health services to students by contracted licensed behavioral health providers. The survey shall include all of the following:

1. The types of behavioral health providers providing the services.
2. The types of settings where behavioral health services were delivered to students.
3. The number of students who received services.
4. The most common diagnoses that resulted in the need for services.

B. On or before December 31, 2022, the Arizona health care cost containment system shall provide a copy of the result of the survey to the governor, the president of the senate and the speaker of the house of representatives and provide a copy of the report to the secretary of state.

C. This section is repealed from and after June 30, 2023.

Sec. 8. Rulemaking; department of insurance and financial institutions

A. On or before April 1, 2021, the department of insurance and financial institutions shall adopt by rule both of the following:

1. Forms or worksheets that health care insurers must use to prepare the reports required by section 20-3502, Arizona Revised Statutes, as added by this act.
2. Standards to determine compliance with the mental health parity and addiction equity act.

B. The department of insurance and financial institutions may also allow health care insurers to demonstrate compliance with subsection A of this section and section 20-3502, Arizona Revised Statutes, as added by this act, by other means that are at least as comprehensive as the forms or worksheets required by subsection A, paragraph 1 of this section.

C. In developing the forms, worksheets or other means that health care insurers must use to prepare the reports required by section 20-3502, Arizona Revised Statutes, as added by this act, the department of insurance and financial institutions shall:
1. Conduct workshops and listening sessions to seek and obtain input from stakeholders, including health care insurers, behavioral health providers, advocacy organizations and individuals who have been impacted by mental health or substance use disorders.

2. Review the United States department of labor's self-compliance tool for the mental health parity and addiction equity act and other reasonable and applicable resources.

Sec. 9. **Rulemaking; department of health services**

A. The department of health services shall adopt rules relating to admitting and discharging patients who have attempted suicide or exhibit suicidal ideation from inpatient care at a health care institution. The rules shall include protocols based on best practices for requiring health care institutions to implement discharge protocols and provide information to patients and caregivers on a continuum during the stay, including at admission and before and at discharge.

B. The rules shall address the following topics:

1. The availability and contact information of age appropriate crisis services.

2. Information and referrals to the next appropriate level of treatment and care after discharge, including scheduling treatment when practicable.

3. Information on the department of insurance and financial institution's website relating to how to challenge an adverse decision by a health care insurer or health plan.

4. Conducting a suicide assessment before discharging a patient and informing the patient and caregivers of the results.

C. Notwithstanding any other law, for the purposes of this section, the department of health services is exempt from the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes, for eighteen months after the effective date of this section, except that the department shall provide public notice and an opportunity for public comment on proposed rules at least sixty days before the rules are amended or adopted.

Sec. 10. **Appropriation; department of insurance and financial institutions; exemption**

A. The sum of $250,000 and one FTE position are appropriated from the state general fund in fiscal year 2020-2021 to the department of insurance and financial institutions to administer title 20, chapter 28, Arizona Revised Statutes, as added by this act.

B. The appropriation made in subsection A of this section is exempt from the provisions of section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations.
Sec. 11. **Appropriation; children's behavioral health services fund; exemption**

A. The sum of $8,000,000 is appropriated from the state general fund in fiscal year 2020-2021 to the children's behavioral health services fund established by section 36-3436, Arizona Revised Statutes, as added by this act, to pay contractors for services as prescribed in section 36-3436, Arizona Revised Statutes, as added by this act.

B. The appropriation made in subsection A of this section is exempt from the provisions of section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations until June 30, 2022.

Sec. 12. **Short title**

This act may be cited as "Jake's Law".


FLORIDA
PERINATAL MENTAL HEALTH HOUSE BILL
A bill to be entitled
An act relating to perinatal mental health; providing
a short title; creating s. 383.014, F.S.; requiring
the Department of Health to offer perinatal mental
health care information through the Family Health Line
toll-free hotline accessible to the general public;
amending s. 383.318, F.S.; revising components that
are included in the postpartum evaluation and followup
care provided by birth centers to include a mental
health screening and the provision of certain
information on postpartum depression; providing an
effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. This act may be cited as the "Florida Families
First Act."

Section 2. Section 383.014, Florida Statutes, is created
to read:

383.014 Perinatal mental health care.—By January 1, 2019,
the Department of Health shall offer perinatal mental health
care information through the Family Health Line toll-free
hotline, accessible to the general public, which:

(1) Provides basic information on postpartum depression;
(2) May recommend that a caller be further evaluated by a
qualified health care provider; and

(3) May refer a caller to an appropriate health care provider in the caller's local area.

Section 3. Subsection (3) of section 383.318, Florida Statutes, is amended to read:

383.318 Postpartum care for birth center clients and infants.—

(3) The birth center shall provide a postpartum evaluation and followup care that includes all of the following shall be provided, which shall include:

(a) Physical examination of the infant.
(b) Metabolic screening tests required by s. 383.14.
(c) Referral to sources for pediatric care.
(d) Maternal postpartum assessment that incorporates mental health screening.
(e) Information on postpartum depression and the telephone number of the Family Health Line operated pursuant to s. 383.011.
(f) Instruction in child care, including immunization, breastfeeding, safe sleep practices, and possible causes of Sudden Unexpected Infant Death.
(g) Family planning services.
(h) Referral to secondary or tertiary care, as indicated.

Section 4. This act shall take effect July 1, 2018.
Assembly Bill No. 2360

Passed the Assembly August 30, 2020

Chief Clerk of the Assembly

Passed the Senate August 28, 2020

Secretary of the Senate

This bill was received by the Governor this _____ day of ______________, 2020, at _____ o’clock _____м.

Private Secretary of the Governor
CHAPTER _______

An act to add Section 1367.626 to the Health and Safety Code, and to add Section 10123.868 to the Insurance Code, relating to mental health.

LEGISLATIVE COUNSEL’S DIGEST

AB 2360, Maienschein. Telehealth: mental health.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of that act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, of a person of any age. Existing law also requires health care service plans and health insurers, by July 1, 2019, to develop maternal mental health programs, as specified.

This bill would require health care service plans and health insurers, by July 1, 2021, to provide access to a telehealth consultation program that meets specified criteria and provides providers who treat children and pregnant and certain postpartum persons with access to a mental health consultation program, as specified. The bill would require the consultation by a mental health clinician with expertise appropriate for pregnant, postpartum, and pediatric patients to be conducted by telephone or telehealth video, and to include guidance on the range of evidence-based treatment options, screening tools, and referrals. The bill would require health care service plans and insurers to communicate information relating to the telehealth program at least twice a year in writing. The bill would require health care service plans and health insurers to monitor data pertaining to the utilization of the program to facilitate ongoing quality improvements, as necessary, and to provide a description of the program to the appropriate department. The bill would exempt certain specialized health care service plans and health insurers from these provisions. Because
a willful violation of the bill’s requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known, and may be cited, as the Mothers and Children Mental Health Support Act of 2020.

SEC. 2. Section 1367.626 is added to the Health and Safety Code, to read:

1367.626. (a) In order to more quickly diagnose and treat children and pregnant and postpartum persons suffering from mental illness, by July 1, 2021, a health care service plan shall provide access to a telehealth consultation program that provides contracting providers who treat children and persons who are pregnant or up to one year postpartum with access to a mental health consultation program during the treating provider’s standard provider hours, which may include evenings and weekends. The telehealth consultation program shall include a triage service and consultation by a mental health clinician with expertise appropriate for pregnant, postpartum, and pediatric patients, including a psychiatrist when appropriate or requested by the treating provider, by telephone or telehealth video, and shall include guidance on the range of evidence-based treatment options, including psychotherapy, as determined to be appropriate, screening tools, and referrals.

(b) A health care service plan shall communicate information relating to the telehealth program and its availability to contracting medical providers who treat children and pregnant and postpartum persons, including pediatricians, obstetricians, and primary care providers, at least twice a year in writing.

(c) A health care service plan shall monitor data pertaining to the utilization of its telehealth consultation program to facilitate ongoing quality improvements to the program, as necessary.
(d) A health care service plan shall provide a description of the telehealth consultation program to the department in a manner and format prescribed by the department.

(e) This section does not apply to a specialized health care service plan, except a specialized behavioral health-only plan offering professional mental health services.

SEC. 3. Section 10123.868 is added to the Insurance Code, to read:

10123.868. (a) In order to more quickly diagnose and treat children and pregnant and postpartum persons suffering from mental illness, by July 1, 2021, a health insurer shall provide access to a telehealth consultation program that provides contracting providers who treat children and persons who are pregnant or up to one year postpartum with access to a mental health consultation program during the treating provider’s standard provider hours, which may include evenings and weekends. The telehealth consultation program shall include a triage service and consultation by a mental health clinician with expertise appropriate for pregnant, postpartum, and pediatric patients, including a psychiatrist when appropriate or requested by the treating provider, by telephone or telehealth video, and shall include guidance on the range of evidence-based treatment options, including psychotherapy, as determined to be appropriate, screening tools, and referrals.

(b) A health insurer shall communicate information relating to the telehealth program and its availability to contracting medical providers who treat children and pregnant and postpartum persons, including pediatricians, obstetricians, and primary care providers, at least twice a year in writing.

(c) A health insurer shall monitor data pertaining to the utilization of its telehealth consultation program to facilitate ongoing quality improvements to the program, as necessary.

(d) A health insurer shall provide a description of the telehealth consultation program to the department in a manner and format prescribed by the department.

(e) This section does not apply to a specialized health insurer, except a specialized behavioral health-only insurer offering professional mental health services.

(f) This section shall not be construed to alter a health insurer’s obligations pursuant to Section 10112.2 or 10144.4.
SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.
MASSACHUSETTS

ACT RELATIVE TO POSTPARTUM DEPRESSION SCREENING
The Commonwealth of Massachusetts

PRESENTED BY:

Carole A. Fiola

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act relative to postpartum depression screening.

PETITION OF:

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<tbody>
<tr>
<td>Carole A. Fiola</td>
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<td>Christine P. Barber</td>
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<td>Mark C. Montigny</td>
<td>Second Bristol and Plymouth</td>
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By Ms. Fiola of Fall River, a petition (accompanied by bill, House, No. 1879) of Carole A. Fiola and others that the Division of Medical Assistance be directed to provide coverage for screenings for postpartum depression. Public Health.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. 1156 OF 2017-2018.]

The Commonwealth of Massachusetts

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

An Act relative to postpartum depression screening.

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

SECTION 1. Chapter 118E of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by inserting after Section 10H the following:

Section 10I. The division shall provide coverage of screenings by pediatricians for postpartum depression in mothers of newly born children during any visit to a pediatrician’s office taking place for up to one year from the date of the child’s birth.
ONLINE ADVOCATE TOOLKIT WITH CUSTOMIZABLE MATERIALS
Below is an overview of additional materials specific to maternal mental health available for you to customize at marchofdimes.org/mentalhealth.

**MARCH OF DIMES POSITION STATEMENT**
As the leading organization that fights for the health of ALL moms and babies, the March of Dimes position statement and policy recommendations around maternal mental health can be used as an additional tool.

**FACTSHEET**
Factsheets are common when advocating on a particular issue or bill. A factsheet helps identify your organization or group with a particular issue; answers frequently-asked questions; and provides statistics and other facts to inform and educate elected officials. This factsheet is designed as a template. You can add state specific information, group or organization information, or add graphics and charts.

**TALKING POINTS**
Brief speaking points to aid advocates in meeting with policymakers.

**TESTIMONY**
Providing verbal or written testimony is one of the most effective ways to educate policymakers about the impact, either positive or negative, of the proposed legislation. Here you will find customizable, sample testimony – both written and verbal.

**OP-ED**
A written article for publication in a local magazine or newspaper.

**STATE HEALTH PROCLAMATION**
Proclamations are used to draw attention to an issue, dedicate a month or day for awareness, and/or highlight the need for policy solutions. This proclamation serves as a template that can be used with an elected official.

**RESOURCES LIST**
A list of additional resources and links to more information on maternal mental health.