HOUSE DOCKET, NO. 2729 FILED ON: 1/16/2015

HOUSE . . . . . No. 1786

The Commonwealth of Massachusetts

PRESENTED BY:

Mark J. Cusack

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 to ensure behavioral health integration.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Mark J. Cusack	*5th Norfolk*	*1/16/2015*

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HOUSE . . . . . No. 1786

By Mr. Cusack of Braintree, a petition (accompanied by bill, House, No. 1786) of Mark J. Cusack for legislation to expand access to behavioral health services. Mental Health and Substance Abuse.

The Commonwealth of Massachusetts

In the One Hundred and Eighty-Ninth General Court
(2015-2016)

An Act to ensure behavioral health integration.

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. Subsection (b) of section 16T of chapter 6A of the General Laws, as appearing in the 2012 Official Edition, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:--

The plan shall identify certain categories of health care resources, including acute care units; non-acute care units; specialty care units, including, but not limited to, burn, coronary care, cancer care, neonatal care, post-obstetric and post operative recovery care, pulmonary care, renal dialysis and surgical, including trauma and intensive care units; skilled nursing facilities; assisted living facilities; long-term care facilities; home health, behavioral health and mental health services, including outpatient behavioral health and mental health services; treatment and prevention services for alcohol and other drug abuse; emergency care; ambulatory care services; primary care resources; pharmacy and pharmacological services; family planning services; obstetrics and gynecology services; allied health services including, but not limited to,

optometric care, chiropractic services, dental care and midwifery services; federally qualified health centers and free clinics; numbers of technologies or equipment defined as innovative services or new technologies by the department under section 25C of chapter 111; and health screening and early intervention services.

SECTION 2. Section 5 of chapter 6D of the General Laws, as so appearing, is hereby amended by striking out clauses (vi) and (vii) and inserting in place thereof the following 3 clauses—

(vi) monitor and review the impact of changes within the health care marketplace; (vii) protect patient access to necessary health care services; and (viii) monitor and review the integration and reimbursement of behavioral health care.

SECTION 3. Paragraph (a) of section 14 of chapter 6D of the General Laws, as so appearing, is hereby amended by striking out clauses 3 to 5, inclusive, and inserting in place thereof the following four clauses:--

(3) encouraging shared decision-making for preference-sensitive conditions such as chronic back pain, early stage of breast and prostate cancers, hip osteoarthritis, and cataracts; provided that shared decision-making shall be conducted on, but not be limited to, long-term care and supports and palliative care;

(4) ensuring that patient-centered medical homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including an assessment of health risks and chronic conditions;

(5) ensuring integration of behavioral health services with medical services, including but not limited to the inclusion of behavioral health services in alternative payment methodologies and reimbursement for behavioral health services commensurate with equivalent medical services; and

(6) such other criteria as the commission deems appropriate.

SECTION 4. Subsection (b) of section 15 of said chapter 6D is hereby amended by striking out clause (iii) and inserting in place thereof the following clause:--

(iii) receive reimbursements or compensation from alternative payment methodologies that aim to reduce racial, ethnic and linguistic health disparities in the patient population to the greatest extent possible;

SECTION 5. Said subsection (b) of section 15 of chapter 6D, as so appearing, is hereby further amended by striking out clause (x) and inserting in place thereof the following two clauses:--

(x) shall engage patients in shared decision-making, including, but not limited to, shared-decision making on palliative care and long-term care services and supports; and (xi) ensuring integration of behavioral health services with medical services, including but not limited to the inclusion of behavioral health services in alternative payment methodologies and reimbursement for behavioral health services commensurate with equivalent medical services.

SECTION 6. Subsection (b) of section 16 of chapter 6D, as so appearing, is hereby amended by adding the following paragraph:--

If the external review process results in a full or partial overturning of the adverse determination in question, the carrier shall be subject to a civil penalty of $15,000. Such funds shall be used to support the commission's efforts toward behavioral health integration.

SECTION 7. Section 20 of chapter 12C of the General Laws, as so appearing, is hereby amended by striking out subsection (b) and inserting in place thereof the following section:--

(b) The website shall provide updated information on a regular basis, but no more than 90 days after data required to post such information has been reported to the center, and additional comparative quality, price and cost information shall be published as determined by the center. To the extent possible, the website shall include: (1) comparative price and cost information for the most common referral or prescribed services, as determined by the center, categorized by payer and listed by facility, provider, and provider organization or other groupings, as determined by the center; (2) comparative quality information from the standard quality measure set and verified by the center, available by facility, provider, provider organization or any other provider grouping, as determined by the center, for each such service or category of service for which comparative price and cost information is provided; (3) general information related to each service or category of service for which comparative information is provided; (4) comparative quality information from the standard quality measure set and verified by the center, available by facility, provider, provider organization or other groupings, as determined by the center, that is not service-specific, including information related to patient safety and satisfaction; (5) data concerning healthcare-associated infections and serious reportable events reported under section 51H of chapter 111; (6) definitions of common health insurance and medical terms, including, but not limited to, those determined under sections 2715(g) (2) and (3) of the Public Health Service Act, so that consumers may compare health coverage and

understand the terms of their coverage; (7) a list of health care provider types, including but not limited to primary care physicians, nurse practitioners and physician assistants, and what types of services they are authorized to perform in the commonwealth under applicable state and federal scope of practice laws; (8) factors consumers should consider when choosing an insurance product or provider group, including, but not limited to, provider network, premium, cost-sharing, covered services, and tiering; (9) patient decision aids, which are interactive, written or audio-visual tools that provide a balanced presentation of the condition and treatment or screening options, benefits and harms, with attention to the patient's preferences and values, and which may facilitate conversations between patients and their health care providers about preference-sensitive conditions or diseases such as chronic back pain, early stage of breast and prostate cancers, hip osteoarthritis, and cataracts; provided, however, that decision aids shall be made available on, but not be limited to, long-term care and supports and palliative care; (10) a list of provider services that are physically and programmatically accessible for people with disabilities; and (11) descriptions of standard quality measures, as determined by the statewide quality advisory committee and verified by the center.

SECTION 8. Subsection (b) of section 19 of chapter 19 of the General Laws, as so appearing, is hereby amended by adding the following three sentences:--

Any facility licensed under this chapter or under chapter 123 shall report to the department when a patient is denied admissions and the reasoning for such denials. This information shall be transmitted to the office of patient protection, established under section 16 of chapter 6D of the General Laws. The department shall promulgate regulations defining types of denials and the process by which facilities must report such denials.

SECTION 9. Chapter 32A of the General Laws, as so appearing, is hereby amended by inserting after section 17N the following section:--

Section 17O. Any coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission shall provide coverage and reimbursement to primary care providers for the administration, scoring, and interpretation of behavioral health screening at every well child visit up to age 21. This coverage shall include postpartum screening for parents and reimbursement for both mental health and substance abuse screening in a single visit when necessary.

SECTION 10. Subsection (g) of section 22 of said chapter 32A, as so appearing, is hereby amended by adding the following four paragraphs:--

The commission shall require any carriers or third party administrators with which it contracts to conduct searches for inpatient mental health or substance abuse placements for their members of insured if the individuals suffering from a mental health or substance abuse condition remain in a hospital's emergency department two hours after the decision to admit has been made.

If a medically necessary and covered mental health or substance abuse health service is not available to a member who is boarded in a hospital for more than 24 hours due to a lack of capacity at an appropriate behavioral health facility within the carrier's provider network the carrier shall approve placement and cover the services out-of-network for as long as the service is unavailable in-network. If the member is still boarded after 24 hours after the decision to admit, the commission or any carriers or third party administrators with which it contracts shall reimburse providers at a rate not less than twice the average contracted rate for inpatient

psychiatric services. If the member is still boarded after 48 hours after the decision to admit, the rate of reimbursement shall increase to not less than three times the average contracted rate for inpatient psychiatric services. If the member is still boarded after 96 hours, and the provider and the commission, or any carriers or third party administrators with which the commission contracts, agree that all appropriate behavioral health facilities both in our out of the carrier's provider network are at full capacity, then the rate of reimbursement shall reset to the standard rate. Any regulations adopted pursuant to this section shall be utilized and included by the commission, or any carriers or third party administrators with which it contracts, in developing future payment reform and alternative contract arrangement.

If a mental health or substance abuse health service recommended by a provider is not covered by the commission or any carriers or third party administrators with which it contracts, the commission or any carriers or third party administrators with which it contracts shall put in place an alternative reimbursable plan.

Behavioral health services determined to be medically necessary shall be reimbursable regardless of where such services are provided.

SECTION 11. Chapter 118E of the General Laws, as so appearing, is hereby amended by inserting after section 10H the following section:--

Section 10I. The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract to a Medicaid managed care organization or primary care clinician plan shall provide coverage and reimbursement to primary care providers for the administration, scoring, and interpretation of behavioral health screening at every well child visit up to age 21. This

coverage shall include postpartum screening for parents and reimbursement for both mental health and substance abuse screening in a single visit when necessary.

SECTION 12. Said Chapter 118E, as so appearing, is hereby further amended by striking out section 13B and inserting in place thereof the following section:--

Section 13B. Hospital rate increases shall be made contingent upon hospital adherence to quality standards and achievement of performance benchmarks, including the reduction of racial and ethnic disparities in the provision of health care. Such benchmarks shall be developed or adopted by the executive office of health and human services so as to advance a common national framework for quality measurement and reporting, drawing on measures that are approved by the National Quality Forum and adopted by the Hospitals Quality Alliance and other national groups concerned with quality, in addition to the Boston Public Health Commission Disparities Project Hospital Working Group Report Guidelines. To the greatest extent possible, the executive office of health and human services shall limit the number of measures to those in the statewide quality measure set in order to align and coordinate quality measures across all payers. The office of Medicaid shall consult with the MassHealth payment policy advisory board established under section 16M of said chapter 6A, during the process of developing these quality standards and performance benchmarks.

SECTION 13. Said Chapter 118E, as so appearing, is hereby further amended by adding the following two sections:--

Section 78. The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract to a Medicaid managed care organization or primary care clinician plan shall

conduct searches for inpatient mental health or substance abuse placements for their members of insured if the individuals suffering from a mental health or substance abuse condition remain in a hospital's emergency department two hours after the decision to admit has been made.

If a medically necessary and covered mental health or substance abuse health service is not available to a member who is boarded in a hospital for more than 24 hours due to a lack of capacity at an appropriate behavioral health facility within the carrier's provider network, the carrier shall approve placement and cover the services out-of-network for as long as the service is unavailable in-network. If the member is still boarded after 24 hours after the decision to admit, the division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract to a Medicaid managed care organization or primary care clinician plan shall reimburse providers at a rate not less than twice the contracted rate for inpatient psychiatric services. If the member is still boarded after 48 hours after the decision to admit, the rate of reimbursement shall increase to not less than three times the average contracted rate for inpatient psychiatric services. If the member is still boarded after 96 hours, and the provider and the division, or a contracted entity, agree that all appropriate behavioral health facilities both in our out of the carrier's provider network are at full capacity, then the rate of reimbursement shall reset to the standard rate. Any regulations adopted pursuant to this section shall be utilized and included by the division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract to a Medicaid managed care organization or primary care clinician plan, in developing future payment reform and alternative contract arrangement.

If a mental health or substance abuse health service recommended by a provider is not covered by the division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract to a Medicaid managed care organization or primary care clinician, the division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract to a Medicaid managed care organization or primary care clinician shall put in place an alternative reimbursable plan.

Behavioral health services determined to be medically necessary shall be reimbursable regardless of where such services are provided.

Section 79. To the extent permissible under applicable state and federal privacy laws, the division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract to a Medicaid managed care organization or primary care clinician plan shall disclose patient-level data to providers in their network solely for the purpose of carrying out treatment, coordinating care among providers and managing the care of their own patient panel; provided, that an individual provider shall only receive patient-level data related to patients treated by said provider. Patient-level data shall include, but not be limited to, health care service utilization, medical expenses, and demographics.

The division, in consultation with the division of insurance, shall develop procedures and a standard format for disclosing such patient-level information. The division may require carriers to disclose such information through the all-payer claims database established under section 12

of chapter 12C if the division and the center for health information and analysis determine that the all-payer claims database is an efficient means to provide such information.

The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract to a Medicaid managed care organization or primary care clinician plan shall make available to any provider with whom they have entered into an alternative payment contract, the contracted prices of individual health care services within such payer's network for the purpose of referrals.

SECTION 14. Section 3 of chapter 123 of the General Laws, as so appearing, is hereby amended by adding the following sentence:--

The department shall provide assistance with discharge planning for all patients discharged from acute inpatient psychiatric units who are referred to department run continuing-care facilities in order to ensure access to appropriate community placements.

SECTION 15. Subsection (g) of section 47B of chapter 175 of the General Laws, as so appearing, is hereby amended by adding the following four paragraphs:--

An insurer shall conduct searches for inpatient mental health or substance abuse placements for their members of insured if the individuals suffering from a mental health or substance abuse condition remain in a hospital's emergency department two hours after the decision to admit has been made.

If a medically necessary and covered mental health or substance abuse health service is not available to a member who is boarded in a hospital for more than 24 hours due to a lack of capacity at an appropriate behavioral health facility within the carrier's provider network, the

carrier shall approve placement and cover the services out-of-network for as long as the service is unavailable in-network. If the member is still boarded after 24 hours after the decision to admit, the insurer shall reimburse providers at a rate not less than twice the average contracted rate for inpatient psychiatric services. If the member is still boarded after 48 hours after the decision to admit, the rate of reimbursement shall increase to not less than three times the average contracted rate for inpatient psychiatric services. If the member is still boarded after 96 hours, and the provider and the insurer agree that all appropriate behavioral health facilities both in our out of the carrier's provider network are at full capacity, then the rate of reimbursement shall reset to the standard rate. Any regulations adopted pursuant to this section shall be utilized and included by an insurer with a contracted entity in developing future payment reform and alternative contract arrangement.

If a mental health or substance abuse health service recommended by a provider is not covered by an insurer, the insurer shall put in place an alternative reimbursable plan.

Behavioral health services determined to be medically necessary shall be reimbursable regardless of where such services are provided.

SECTION 16. Said chapter 175, as so appearing, is hereby amended by inserting after section 47GG the following new section:--

Section 47HH. Any policy, contract, agreement, plan or certificate of insurance issued, delivered or renewed within the commonwealth, which is considered creditable coverage under section 1 of chapter 118M, shall provide coverage and reimbursement to primary care providers for the administration, scoring, and interpretation of behavioral health screening at every well child visit up to age 21. This coverage shall include postpartum screening for parents and

reimbursement for both mental health and substance abuse screening in a single visit when necessary.

SECTION 17. Subsection (g) of section 8A of chapter 176A of the General Laws, as so appearing, is hereby amended by adding the following four paragraphs:--

A nonprofit hospital service corporation shall conduct searches for inpatient mental health or substance abuse placements for their members of insured if the individuals suffering from a mental health or substance abuse condition remain in a hospital's emergency department two hours after the decision to admit has been made.

If a medically necessary and covered mental health or substance abuse health service is not available to a member who is boarded in a hospital for more than 24 hours due to a lack of capacity at an appropriate behavioral health facility within the carrier's provider network, the carrier shall approve placement and cover the services out-of-network for as long as the service is unavailable in-network. If the member is still boarded after 24 hours after the decision to admit, the nonprofit hospital service corporation shall reimburse providers at a rate not less than twice the average contracted rate for inpatient psychiatric services. If the member is still boarded after 48 hours after the decision to admit, the rate of reimbursement shall increase to not less than three times the average contracted rate for inpatient psychiatric services. If the member is still boarded after 96 hours, and the provider and the nonprofit hospital service corporation agree that all appropriate behavioral health facilities both in our out of the carrier's provider network are at full capacity, then the rate of reimbursement shall reset to the standard rate. Any regulations adopted pursuant to this section shall be utilized and included by a nonprofit hospital service

corporation with a contracted entity in developing future payment reform and alternative contract arrangement.

If a mental health or substance abuse health service recommended by a provider is not covered by a nonprofit hospital service corporation, the nonprofit hospital service corporation shall put in place an alternative reimbursable plan.

Behavioral health services determined to be medically necessary shall be reimbursable regardless of where such services are provided.

SECTION 18. Said chapter 176A, as so appearing, is hereby amended by inserting after section 8II the following new section:--

Section 8JJ. Any contract between a subscriber and the corporation under an individual or group hospital service plan which is delivered, issued or renewed within the commonwealth shall provide coverage and reimbursement to primary care providers for the administration, scoring, and interpretation of behavioral health screening at every well child visit up to age 21. This coverage shall include postpartum screening for parents and reimbursement for both mental health and substance abuse screening in a single visit when necessary.

SECTION 19. Subsection (g) of section 4A of chapter 176B of the General Laws, as so appearing, is hereby amended by adding the following four paragraphs:--

A medical service corporation shall conduct searches for inpatient mental health or substance abuse placements for their members of insured if the individuals suffering from a mental health or substance abuse condition remain in a hospital’s emergency department two hours after the decision to admit has been made.

If a medically necessary and covered mental health or substance abuse health service is not available to a member who is boarded in a hospital for more than 24 hours due to a lack of capacity at an appropriate behavioral health facility within the carrier's provider network, the carrier shall approve placement and cover the services out-of-network for as long as the service is unavailable in-network. If the member is still boarded after 24 hours after the decision to admit, the medical service corporation shall reimburse providers at a rate not less than twice the average contracted rate for inpatient psychiatric services. If the member is still boarded after 48 hours after the decision to admit, the rate of reimbursement shall increase to not less than three times the average contracted rate for inpatient psychiatric services. If the member is still boarded after 96 hours, and the provider and the medical service corporation agree that all appropriate behavioral health facilities both in our out of the carrier's provider network are at full capacity, then the rate of reimbursement shall reset to the standard rate. Any regulations adopted pursuant to this section shall be utilized and included by a medical service corporation with a contracted entity in developing future payment reform and alternative contract arrangement.

If a mental health or substance abuse health service recommended by a provider is not covered by a medical service corporation, the medical service corporation shall put in place an alternative reimbursable plan.

Behavioral health services determined to be medically necessary shall be reimbursable regardless of where such services are provided.

SECTION 20. Said chapter 176B, as so appearing, is hereby amended by inserting after section 4II the following new section:--

Section 4JJ. Any subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall provide coverage and reimbursement to primary care providers for the administration, scoring, and interpretation of behavioral health screening at every well child visit up to age 21. This coverage shall include postpartum screening for parents and reimbursement for both mental health and substance abuse screening in a single visit when necessary.

SECTION 21. Subsection (g) of section 4M of chapter 176G of the General Laws, as so appearing, is hereby amended by adding the following four paragraphs:--

A health maintenance organization shall conduct searches for inpatient mental health or substance abuse placements for their members of insured if the individuals suffering from a mental health or substance abuse condition remain in a hospital's emergency department two hours after the decision to admit has been made.

If a medically necessary and covered mental health or substance abuse health service is not available to a member who is boarded in a hospital for more than 24 hours due to a lack of capacity at an appropriate behavioral health facility within the carrier's provider network, the carrier shall approve placement and cover the services out-of-network for as long as the service is unavailable in-network. If the member is still boarded after 24 hours after the decision to admit, the health maintenance organization shall reimburse providers at a rate not less than twice the average contracted rate for inpatient psychiatric services. If the member is still boarded after 48 hours after the decision to admit, the rate of reimbursement shall increase to not less than three times the average contracted rate for inpatient psychiatric services. If the member is still boarded after 96 hours, and the provider and the health maintenance organization agree that all

appropriate behavioral health facilities both in our out of the carrier's provider network are at full capacity, then the rate of reimbursement shall reset to the standard rate. Any regulations adopted pursuant to this section shall be utilized and included by a health maintenance organization with a contracted entity in developing future payment reform and alternative contract arrangement.

If a mental health or substance abuse health service recommended by a provider is not covered by a health maintenance organization, the health maintenance organization shall put in place an alternative reimbursable plan.

Behavioral health services determined to be medically necessary shall be reimbursable regardless of where such services are provided.

SECTION 22. Said chapter 176G, as so appearing, is hereby amended by inserting after section 4AA the following new section:--

Section 4BB. Any individual or group health maintenance contract that is issued or renewed shall provide coverage and reimbursement to primary care providers for the administration, scoring, and interpretation of behavioral health screening at every well child visit up to age 21. This coverage shall include postpartum screening for parents and reimbursement for both mental health and substance abuse screening in a single visit when necessary.

SECTION 23. Section 14 of chapter 176J of the General Laws, as so appearing, is hereby amended by adding the following four paragraphs:--

Carriers shall conduct searches for inpatient mental health or substance abuse placements for their members of insured if the individuals suffering from a mental health or substance abuse

condition remain in a hospital's emergency department two hours after the decision to admit has been made.

If a medically necessary and covered mental health or substance abuse health service is not available to a member who is boarded in a hospital for more than 24 hours due to a lack of capacity at an appropriate behavioral health facility within the carrier's provider network, the carrier shall approve placement and cover the services out-of-network for as long as the service is unavailable in-network. If the member is still boarded after 24 hours after the decision to admit, the carrier shall reimburse providers at a rate not less than twice the average contracted rate for inpatient psychiatric services. If the member is still boarded after 48 hours after the decision to admit, the rate of reimbursement shall increase to not less than three times the average contracted rate for inpatient psychiatric services. If the member is still boarded after 96 hours, and the provider and the carrier agree that all appropriate behavioral health facilities both in our out of the carrier's provider network are at full capacity, then the rate of reimbursement shall reset to the standard rate. Any regulations adopted pursuant to this section shall be utilized and included by a carrier with a contracted entity in developing future payment reform and alternative contract arrangement.

If a mental health or substance abuse health service recommended by a provider is not covered by a carrier, the carrier shall put in place an alternative reimbursable plan.

Behavioral health services determined to be medically necessary shall be reimbursable regardless of where such services are provided.

SECTION 24. Chapter 176T of the General Laws, as so appearing, is hereby amended by adding the following section:--

Section 10. The division shall develop standard criteria and oversight guidelines to delegate credentialing of providers to risk-bearing provider. Such criteria and oversight guidelines shall meet applicable national accreditation standards.

SECTION 25. The first paragraph of section 230 of chapter 165 of the Acts of 2014 is hereby amended by adding the following sentence:--

The task force shall also develop recommendations on necessary statutory and regulatory changes in order to allow the department of mental health to collect and report data relating to patient flow for behavioral health continuing care services.

SECTION 26. Subsection (a) of section 44 of chapter 258 of the acts of 2014 is hereby amended by striking out clauses 4 and 5 and inserting in place thereof the following four clauses:--

(4) develop recommendations that the department of mental health, the department of public health and other appropriate state agencies may adopt under existing regulatory authority to create and enhance access for said placement services; (5) develop recommendations as to whether the website should be a state run and operated function; (6) develop recommendations to educate providers about the availability of the bed finding tool; and (7) develop recommendations as to the manner in which commercial insurance carriers should be required to utilize such a bed finding tool.

SECTION 27. (a) There shall be a Massachusetts Interagency Council on Behavioral Health Integration convened to determine regulatory and payment structure barriers to comprehensive behavioral health integration. The Interagency Council shall: (i) review potential changes to the division of medical assistance’s payment structure for behavioral health services

in order to assess potential impacts, including but not limited to the inclusion of behavioral health services in alternative payment methodologies and the restructuring of the division of medical assistance's rapid admission incentive operated by the division of medical assistance's behavioral health vendor; (ii) review potential changes to licensing authority of psychiatric units and the impacts of such changes on patient access to behavioral health services; (iii) review regulatory barriers that inhibit behavioral health integration, including but not limited to regulations that impede facilities and units from processing discharge and admissions authorizations on weekends and the reimbursement of behavioral health care and physical health care on the same day; (iv) review regulations and protocols of health care payers that inhibit the ability of locating appropriate behavioral health services for patients following acute inpatient hospitalization; (v) review methods to incentivize the managed care entities that contract with the division of medical assistance to educate patients and providers about the availability of community-based emergency service program services; and (vi) review potential funding mechanisms to increase reimbursement rates for community level behavioral health services and inpatient behavioral health services, including but not limited to the establishment of a trust fund to subsidize payments for behavioral health care provided in community settings and at community hospitals.

(b) The interagency council shall consist of the following members of their designees: the secretary of health and human services, who shall serve as chair; the director of the division of medical assistance; the commissioner of mental health; the commissioner of public health, the commissioner of insurance; the executive director of the health policy commission; and the executive director of the center for health information and analysis.

(c) The interagency council shall meet at least 4 times annually and shall establish task groups, meetings and any other activity deemed necessary to carry out its mandate.

(d) All affected agencies, departments and boards of the commonwealth shall fully cooperate with the interagency council. The council may call and rely upon the expertise and services of individuals and entities outside of its membership for research, advice, support or other functions necessary and appropriate to further accomplish its mission.

SECTION 28. The health policy commission shall issue a report detailing the effect of health care payers using behavioral health managers. This report should take into account the effect on finances, quality, access, and the integration of behavioral health services with medical services.