

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:
<i>Mark J. Cusack</i>	<i>5th Norfolk</i>	<i>1/16/2015</i>

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:

1 SECTION 1. Subsection (b) of section 16T of chapter 6A of the General Laws, as
2 appearing in the 2012 Official Edition, is hereby amended by striking out the second paragraph
3 and inserting in place thereof the following paragraph:--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

325 If a medically necessary and covered mental health or substance abuse health service is
326 not available to a member who is boarded in a hospital for more than 24 hours due to a lack of
327 capacity at an appropriate behavioral health facility within the carrier's provider network, the
328 carrier shall approve placement and cover the services out-of-network for as long as the service
329 is unavailable in-network. If the member is still boarded after 24 hours after the decision to
330 admit, the health maintenance organization shall reimburse providers at a rate not less than twice
331 the average contracted rate for inpatient psychiatric services. If the member is still boarded after
332 48 hours after the decision to admit, the rate of reimbursement shall increase to not less than
333 three times the average contracted rate for inpatient psychiatric services. If the member is still
334 boarded after 96 hours, and the provider and the health maintenance organization agree that all

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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