

**HOUSE . . . . . No. 1786**

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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:

*Mark J. Cusack*

DISTRICT/ADDRESS:

*5th Norfolk*

**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.