HOUSE DOCKET, NO. 2194 FILED ON: 1/19/2017

HOUSE . . . . No. 2391

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 strengthen behavioral health integration.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Mark J. Cusack	*5th Norfolk*

HOUSE DOCKET, NO. 2194 FILED ON: 1/19/2017

HOUSE . . . . No. 2391

By Mr. Cusack of Braintree, a petition (accompanied by bill, House, No. 2391) of Mark J. Cusack relative to behavioral health services integration. Mental Health, Substance Use and Recovery.

The Commonwealth of Massachusetts

In the One Hundred and Ninetieth General Court
(2017-2018)

An Act to strengthen 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 2014 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. Subsection (b) of section 16 of chapter 6D, as so appearing, is hereby
18 amended by adding the following paragraph:--

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

22 SECTION 3. Section 20 of chapter 12C of the General Laws, as so appearing, is hereby
23 amended by striking out subsection (b) and inserting in place thereof the following section:--

24 (b) The website shall provide updated information on a regular basis, but no more than 90
25 days after data required to post such information has been reported to the center, and additional
26 comparative quality, price and cost information shall be published as determined by the center.
27 To the extent possible, the website shall include: (1) comparative price and cost information for
28 the most common referral or prescribed services, as determined by the center, categorized by
29 payer and listed by facility, provider, and provider organization or other groupings, as
30 determined by the center; (2) comparative quality information from the standard quality measure
31 set and verified by the center, available by facility, provider, provider organization or any other
32 provider grouping, as determined by the center, for each such service or category of service for
33 which comparative price and cost information is provided; (3) general information related to
34 each service or category of service for which comparative information is provided; (4)

35 comparative quality information from the standard quality measure set and verified by the center,
36 available by facility, provider, provider organization or other groupings, as determined by the
37 center, that is not service-specific, including information related to patient safety and
38 satisfaction; (5) data concerning healthcare-associated infections and serious reportable events
39 reported under section 51H of chapter 111; (6) definitions of common health insurance and
40 medical terms, including, but not limited to, those determined under sections 2715(g) (2) and (3)
41 of the Public Health Service Act, so that consumers may compare health coverage and
42 understand the terms of their coverage; (7) a list of health care provider types, including but not
43 limited to primary care physicians, nurse practitioners and physician assistants, and what types of
44 services they are authorized to perform in the commonwealth under applicable state and federal
45 scope of practice laws; (8) factors consumers should consider when choosing an insurance
46 product or provider group, including, but not limited to, provider network, premium, cost-
47 sharing, covered services, and tiering; (9) patient decision aids, which are interactive, written or
48 audio-visual tools that provide a balanced presentation of the condition and treatment or
49 screening options, benefits and harms, with attention to the patient's preferences and values, and
50 which may facilitate conversations between patients and their health care providers about
51 preference-sensitive conditions or diseases such as chronic back pain, early stage of breast and
52 prostate cancers, hip osteoarthritis, and cataracts; provided, however, that decision aids shall be
53 made available on, but not be limited to, long-term care and supports and palliative care; (10) a
54 list of provider services that are physically and programmatically accessible for people with
55 disabilities; and (11) descriptions of standard quality measures, as determined by the statewide
56 quality advisory committee and verified by the center.

57 SECTION 4. Subsection (b) of section 19 of chapter 19 of the General Laws, as so
58 appearing, is hereby amended by adding the following three sentences:--

59 Any facility licensed under this chapter or under chapter 123 shall report to the
60 department when a patient is denied admissions due to the lack of an appropriate placement at
61 the facility as a result of the patient requiring both behavioral health and medical services or
62 requiring both mental health and substance use services. This information shall be used solely as
63 a means to determine the need for treatment capacity for patients with co-occurring diagnoses
64 and shall not result in punitive action against the facilities reporting the information.

65 SECTION 5. Chapter 32A of the General Laws, as so appearing, is hereby amended by
66 inserting after section 17N the following section:--

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

73 SECTION 6. Subsection (g) of section 22 of said chapter 32A, as so appearing, is hereby
74 amended by adding the following four paragraphs:--

75 The commission shall require any carriers or third party administrators with which it
76 contracts to conduct searches, including, but not limited to the use of a bed finding tool, for
77 inpatient mental health or substance abuse placements for their members of insured if the

78 individuals suffering from a mental health or substance abuse condition remain in a hospital's
79 emergency department two hours after the decision to admit has been made.

80 If a medically necessary and covered mental health or substance abuse health service is
81 not available to a member who is boarded in a hospital for more than 24 hours due to a lack of
82 capacity at an appropriate behavioral health facility within the carrier's provider network the
83 carrier shall approve placement and cover the services out-of-network for as long as the service
84 is unavailable in-network. If the member is still boarded after 24 hours after the decision to
85 admit, the commission or any carriers or third party administrators with which it contracts shall
86 reimburse providers at a rate not less than twice the average contracted rate for inpatient
87 psychiatric services. If the member is still boarded after 48 hours after the decision to admit, the
88 rate of reimbursement shall increase to not less than three times the average contracted rate for
89 inpatient psychiatric services. If the member is still boarded after 96 hours, and the provider and
90 the commission, or any carriers or third party administrators with which the commission
91 contracts, agree that all appropriate behavioral health facilities both in our out of the carrier's
92 provider network are at full capacity, then the rate of reimbursement shall reset to the standard
93 rate. Any regulations adopted pursuant to this section shall be utilized and included by the
94 commission, or any carriers or third party administrators with which it contracts, in developing
95 future payment reform and alternative contract arrangement.

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

100 Behavioral health services determined to be medically necessary shall be reimbursable
101 regardless of where such services are provided, including services provided using telemedicine.
102 If determined to be medically appropriate, telemedicine services shall be reimbursed to allow for
103 a patient to receive behavioral health treatment at home until an appropriate inpatient placement
104 is identified. For the purposes of this section, "telemedicine" shall mean the use of interactive
105 audio, video or other electronic media for the purpose of diagnosis, consultation, and treatment
106 of a patient's physical and mental health.

107 SECTION 7. Chapter 118E of the General Laws, as so appearing, is hereby amended by
108 inserting after section 10H the following section:--

109 Section 10I. The division and its contracted health insurers, health plans, health
110 maintenance organizations, behavioral health management firms and third party administrators
111 under contract to a Medicaid managed care organization or primary care clinician plan shall
112 provide coverage and reimbursement to primary care providers for the administration, scoring,
113 and interpretation of behavioral health screening at every well child visit up to age 21. This
114 coverage shall include postpartum screening for parents and reimbursement for both mental
115 health and substance abuse screening in a single visit when necessary.

116 SECTION 8. Said Chapter 118E, as so appearing, is hereby further amended by striking
117 out section 13B and inserting in place thereof the following section:--

118 Section 13B. Hospital rate increases shall be made contingent upon hospital adherence to
119 quality standards and achievement of performance benchmarks, including the reduction of racial
120 and ethnic disparities in the provision of health care. Such benchmarks shall be developed or
121 adopted by the executive office of health and human services so as to advance a common

122 national framework for quality measurement and reporting, drawing on measures that are
123 approved by the National Quality Forum and adopted by the Hospitals Quality Alliance and
124 other national groups concerned with quality, in addition to the Boston Public Health
125 Commission Disparities Project Hospital Working Group Report Guidelines. To the greatest
126 extent possible, the executive office of health and human services shall limit, or require its
127 contracted health insurers, health plans, health maintenance organizations, behavioral health
128 management firms, and third party administrators under contract to a Medicaid managed care
129 organization or primary care clinical plan to limit, the number of measures to those in the
130 statewide quality measure set in order to align and coordinate quality measures across all payers.
131 The office of Medicaid shall consult with the MassHealth payment policy advisory board
132 established under section 16M of said chapter 6A, during the process of developing these quality
133 standards and performance benchmarks.

134 SECTION 9. Said Chapter 118E, as so appearing, is hereby further amended by adding
135 the following section:--

136 Section 78. The division and its contracted health insurers, health plans, health
137 maintenance organizations, behavioral health management firms and third party administrators
138 under contract to a Medicaid managed care organization or primary care clinician plan shall
139 conduct searches, including but not limited to the use of a bed finding tool, for inpatient mental
140 health or substance abuse placements for their members of insured if the individuals suffering
141 from a mental health or substance abuse condition remain in a hospital's emergency department
142 two hours after the decision to admit has been made.

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

162 If a mental health or substance abuse health service recommended by a provider is not
163 covered by the division and its contracted health insurers, health plans, health maintenance
164 organizations, behavioral health management firms and third party administrators under contract
165 to a Medicaid managed care organization or primary care clinician, the division and its

166 contracted health insurers, health plans, health maintenance organizations, behavioral health
167 management firms and third party administrators under contract to a Medicaid managed care
168 organization or primary care clinician shall put in place an alternative reimbursable plan.

169 Behavioral health services determined to be medically necessary shall be reimbursable
170 regardless of where such services are provided, including services provided using telemedicine.
171 If determined to be medically appropriate, telemedicine services shall be reimbursed to allow for
172 a patient to receive behavioral health treatment at home until an appropriate inpatient placement
173 is identified. For the purposes of this section, "telemedicine" shall mean the use of interactive
174 audio, video or other electronic media for the purpose of diagnosis, consultation, and treatment
175 of a patient's physical and mental health.

176 SECTION 10. Section 3 of chapter 123 of the General Laws, as so appearing, is hereby
177 amended by adding the following sentence:--

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

181 SECTION 11. Subsection (g) of section 47B of chapter 175 of the General Laws, as so
182 appearing, is hereby amended by adding the following four paragraphs:--

183 An insurer shall conduct searches, including but not limited to the use of a bed finding
184 tool, for inpatient mental health or substance abuse placements for their members of insured if
185 the individuals suffering from a mental health or substance abuse condition remain in a hospital's
186 emergency department two hours after the decision to admit has been made.

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

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

203 Behavioral health services determined to be medically necessary shall be reimbursable
204 regardless of where such services are provided, including services provided using telemedicine.
205 If determined to be medically appropriate, telemedicine services shall be reimbursed to allow for
206 a patient to receive behavioral health treatment at home until an appropriate inpatient placement
207 is identified. For the purposes of this section, "telemedicine" shall mean the use of interactive
208 audio, video or other electronic media for the purpose of diagnosis, consultation, and treatment
209 of a patient's physical and mental health.

210 SECTION 12. Said chapter 175, as so appearing, is hereby amended by inserting after
211 section 47GG the following new section:--

212 Section 47HH. Any policy, contract, agreement, plan or certificate of insurance issued,
213 delivered or renewed within the commonwealth, which is considered creditable coverage under
214 section 1 of chapter 118M, shall provide coverage and reimbursement to primary care providers
215 for the administration, scoring, and interpretation of behavioral health screening at every well
216 child visit up to age 21. This coverage shall include postpartum screening for parents and
217 reimbursement for both mental health and substance abuse screening in a single visit when
218 necessary.

219 SECTION 13. Subsection (g) of section 8A of chapter 176A of the General Laws, as so
220 appearing, is hereby amended by adding the following four paragraphs:--

221 A nonprofit hospital service corporation shall conduct searches, including but not limited
222 to the use of a bed finding tool, for inpatient mental health or substance abuse placements for
223 their members of insured if the individuals suffering from a mental health or substance abuse
224 condition remain in a hospital's emergency department two hours after the decision to admit has
225 been made.

226 If a medically necessary and covered mental health or substance abuse health service is
227 not available to a member who is boarded in a hospital for more than 24 hours due to a lack of
228 capacity at an appropriate behavioral health facility within the carrier's provider network, the
229 carrier shall approve placement and cover the services out-of-network for as long as the service
230 is unavailable in-network. If the member is still boarded after 24 hours after the decision to
231 admit, the nonprofit hospital service corporation shall reimburse providers at a rate not less than

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

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

244 Behavioral health services determined to be medically necessary shall be reimbursable
245 regardless of where such services are provided, including services provided using telemedicine.
246 If determined to be medically appropriate, telemedicine services shall be reimbursed to allow for
247 a patient to receive behavioral health treatment at home until an appropriate inpatient placement
248 is identified. For the purposes of this section, "telemedicine" shall mean the use of interactive
249 audio, video or other electronic media for the purpose of diagnosis, consultation, and treatment
250 of a patient's physical and mental health.

251 SECTION 14. Said chapter 176A, as so appearing, is hereby amended by inserting after
252 section 8II the following new section:--

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

259 SECTION 15. Subsection (g) of section 4A of chapter 176B of the General Laws, as so
260 appearing, is hereby amended by adding the following four paragraphs:--

261 A medical service corporation shall conduct searches, including, but not limited to the
262 use of a bed finding tool, for inpatient mental health or substance abuse placements for their
263 members of insured if the individuals suffering from a mental health or substance abuse
264 condition remain in a hospital's emergency department two hours after the decision to admit has
265 been made.

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

275 after 96 hours, and the provider and the medical service corporation agree that all appropriate
276 behavioral health facilities both in our out of the carrier's provider network are at full capacity,
277 then the rate of reimbursement shall reset to the standard rate. Any regulations adopted pursuant
278 to this section shall be utilized and included by a medical service corporation with a contracted
279 entity in developing future payment reform and alternative contract arrangement.

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

283 Behavioral health services determined to be medically necessary shall be reimbursable
284 regardless of where such services are provided, including services provided using telemedicine,
285 including services provided using telemedicine. If determined to be medically appropriate,
286 telemedicine services shall be reimbursed to allow for a patient to receive behavioral health
287 treatment at home until an appropriate inpatient placement is identified. For the purposes of this
288 section, "telemedicine" shall mean the use of interactive audio, video or other electronic media
289 for the purpose of diagnosis, consultation, and treatment of a patient's physical and mental
290 health.

291 SECTION 16. Said chapter 176B, as so appearing, is hereby amended by inserting after
292 section 4II the following new section:--

293 Section 4JJ. Any subscription certificate under an individual or group medical service
294 agreement delivered, issued or renewed within the commonwealth shall provide coverage and
295 reimbursement to primary care providers for the administration, scoring, and interpretation of
296 behavioral health screening at every well child visit up to age 21. This coverage shall include

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

299 SECTION 17. Subsection (g) of section 4M of chapter 176G of the General Laws, as so
300 appearing, is hereby amended by adding the following four paragraphs:--

301 A health maintenance organization shall conduct searches, including but not limited to
302 the use of a bed finding tool, for inpatient mental health or substance abuse placements for their
303 members of insured if the individuals suffering from a mental health or substance abuse
304 condition remain in a hospital's emergency department two hours after the decision to admit has
305 been made.

306 If a medically necessary and covered mental health or substance abuse health service is
307 not available to a member who is boarded in a hospital for more than 24 hours due to a lack of
308 capacity at an appropriate behavioral health facility within the carrier's provider network, the
309 carrier shall approve placement and cover the services out-of-network for as long as the service
310 is unavailable in-network. If the member is still boarded after 24 hours after the decision to
311 admit, the health maintenance organization shall reimburse providers at a rate not less than twice
312 the average contracted rate for inpatient psychiatric services. If the member is still boarded after
313 48 hours after the decision to admit, the rate of reimbursement shall increase to not less than
314 three times the average contracted rate for inpatient psychiatric services. If the member is still
315 boarded after 96 hours, and the provider and the health maintenance organization agree that all
316 appropriate behavioral health facilities both in our out of the carrier's provider network are at full
317 capacity, then the rate of reimbursement shall reset to the standard rate. Any regulations adopted

318 pursuant to this section shall be utilized and included by a health maintenance organization with
319 a contracted entity in developing future payment reform and alternative contract arrangement.

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

323 Behavioral health services determined to be medically necessary shall be reimbursable
324 regardless of where such services are provided, including services provided using telemedicine.
325 If determined to be medically appropriate, telemedicine services shall be reimbursed to allow for
326 a patient to receive behavioral health treatment at home until an appropriate inpatient placement
327 is identified. For the purposes of this section, "telemedicine" shall mean the use of interactive
328 audio, video or other electronic media for the purpose of diagnosis, consultation, and treatment
329 of a patient's physical and mental health.

330 SECTION 18. Said chapter 176G, as so appearing, is hereby amended by inserting after
331 section 4AA the following new section:--

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

337 SECTION 19. Section 14 of chapter 176J of the General Laws, as so appearing, is hereby
338 amended by adding the following four paragraphs:--

339 Carriers shall conduct searches, including but not limited to the use of a bed finding tool,
340 for inpatient mental health or substance abuse placements for their members of insured if the
341 individuals suffering from a mental health or substance abuse condition remain in a hospital's
342 emergency department two hours after the decision to admit has been made.

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

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

359 Behavioral health services determined to be medically necessary shall be reimbursable
360 regardless of where such services are provided, including services provided using telemedicine.

361 If determined to be medically appropriate, telemedicine services shall be reimbursed to allow for
362 a patient to receive behavioral health treatment at home until an appropriate inpatient placement
363 is identified. For the purposes of this section, “telemedicine” shall mean the use of interactive
364 audio, video or other electronic media for the purpose of diagnosis, consultation, and treatment
365 of a patient's physical and mental health.

366 SECTION 20. Chapter 176T of the General Laws, as so appearing, is hereby amended by
367 adding the following section:--

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

371 SECTION 21. (a) There shall be a Massachusetts Interagency Council on Behavioral
372 Health Integration convened to determine regulatory and payment structure barriers to
373 comprehensive behavioral health integration. The Interagency Council shall: (i) review potential
374 changes to licensing authority of psychiatric units and the impacts of such changes on patient
375 access to behavioral health services; (ii) review regulatory barriers that inhibit behavioral health
376 integration, including but not limited to regulations that impede facilities and units from
377 processing discharge and admissions authorizations on weekends and the reimbursement of
378 behavioral health care and physical health care on the same day; (iii) review regulations and
379 protocols of health care payers that inhibit the ability of locating appropriate behavioral health
380 services for patients following acute inpatient hospitalization; and (iv) review potential funding
381 mechanisms to increase reimbursement rates for community level behavioral health services and
382 inpatient behavioral health services, including but not limited to the establishment of a trust fund

383 to subsidize payments for behavioral health care provided in community settings and at
384 community hospitals.

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

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

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

396 SECTION 22. The health policy commission shall issue a report detailing the effect of
397 health care payers using behavioral health managers. This report should take into account the
398 effect on finances, quality, access, and the integration of behavioral health services with medical
399 services.