

**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:

*Mark J. Cusack*

DISTRICT/ADDRESS:

*5th Norfolk*

**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.