

# SUMMARY OF THE BEHAVIORAL HEALTH PROVISIONS OF GOVERNOR BAKER'S 2019 HEALTH CARE BILL

House Bill 4134: “An Act to Improve  
Health Care by Investing in Value”

MARCH 2020

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## INTRODUCTION

Like many states across the nation, Massachusetts has long faced challenges ensuring access to high-quality behavioral health services (inclusive of mental health and substance use disorder [SUD] services) for its residents. Attuned to these challenges, state policymakers have incrementally expanded access to these critical services through increased state appropriations to its mental health and SUD service agencies; expansion of its Medicaid-funded community-based residential treatment, care management, and recovery supports for members with SUDs; and targeted investments in the behavioral health system infrastructure and workforce. Despite these efforts, a recent Blue Cross Blue Shield of Massachusetts Foundation report, *Ready for Reform: Behavioral Health Care in Massachusetts*, found that individuals with behavioral health needs continue to experience significant difficulties accessing services and treatment in settings across the behavioral health care continuum.

Advancing a comprehensive set of policies designed to break through barriers to behavioral health care access in Massachusetts, on October 18, 2019, Governor Charlie Baker submitted to the Massachusetts Legislature House Bill 4134, “**An Act to Improve Health Care by Investing in Value**” (H 4134 or “the bill”). The centerpiece of the bill is the establishment of a new system that would incentivize providers and health plans to spend more of their funds on primary care and behavioral health services while rebalancing spending in other areas. H 4134 includes a number of additional proposals intended to expand access to behavioral health care, including:

- Increasing health plans’ payment for certain behavioral health services;
- Requiring coverage and payment for a behavioral health visit that occurs on the same day as a primary care visit;
- Requiring that licensed clinics, including mental health, substance use, and urgent care clinics, offer behavioral health services;
- Requiring that hospitals arrange for behavioral health clinicians to evaluate, stabilize, and refer to appropriate treatment patients admitted to an emergency department with a behavioral health presentation;
- Requiring that health plans accept a standard form for credentialing behavioral health and other providers;
- Ensuring that health plans maintain accurate provider directories, including information on the behavioral health specialties of network providers;
- Expanding the use of telehealth.

Many of the provisions that impose requirements on health plans focus on commercial plans, not MassHealth or plans operating under MassHealth. However, as described below in several cases, MassHealth has already adopted many of the practices that Governor Baker is seeking to expand to the commercial market.

In his letter to the legislature, Governor Baker emphasized that his reform proposal is intended to move the Commonwealth’s health care system away from a system that “rewards those providers that invest in technology and transactional specialty services, at the expense of those that choose to invest in primary care, geriatrics, addiction services, and behavioral health care.”

**A summary of the provisions of H 4134 that target behavioral health care delivery and access** is provided below. Appendix A provides a catalog of the behavioral health related provisions of the bill. Note that this is not a comprehensive bill summary, but rather a summary focused on the behavioral health related provisions of the bill.

## SHIFTING SPENDING TOWARD PRIMARY CARE AND BEHAVIORAL HEALTH

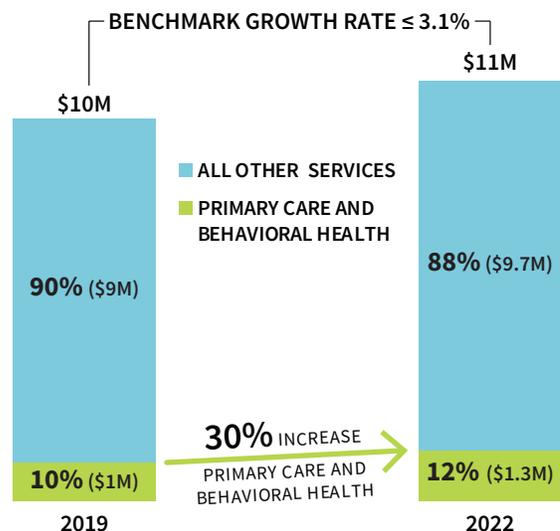
H 4134 proposes to require providers and health plans, including MassHealth, to increase their investments in primary care and behavioral health services by 30 percent over three years, while keeping total health care spending within the parameters of the state’s overall “health care cost growth benchmark” (see sidebar for background on the health care cost growth benchmark).

Within the context of the health care cost growth benchmark, the Governor proposes to add a restriction on how providers and health plans allocate their spending. Specifically, this would require them to increase spending on primary care and behavioral health services. Under the proposal, the Health Policy Commission (HPC) would establish an aggregate primary care and behavioral health expenditure target, which would set a goal for total spending, inclusive of all payers, on primary care and behavioral health services throughout the Commonwealth. For the three-year period ending with calendar year 2022, the target would be a 30 percent increase above total calendar year 2019 expenditures on primary care and behavioral health services. The HPC would similarly establish targets for provider organizations and health plans, which would also reflect a 30 percent increase in spending on primary care and behavioral health services. (The aggregate target and provider-specific/health-plan-specific targets would remain the same for 2023 and beyond unless the HPC decides to modify such targets [Section 8].)

Since providers and health plans would remain subject to spending benchmarks, the new targets effectively mean that these entities would have to spend more on primary care and behavioral health services, while reducing or slowing the growth in spending in other areas such as hospital services and specialty care. For example, if a physician group provided \$10 million in services in 2019, with 10 percent (\$1 million) dedicated to primary care and behavioral health and 90 percent (\$9 million) dedicated to all other services, the increase in the spending benchmark would allow total spending to grow to \$11 million in 2022 (at the current benchmark growth rate of 3.1 percent). However, since the physician group would need to increase its primary care and behavioral health spending by at least 30 percent to \$1.3 million by 2022, spending on other services could be no more than \$9.7 million (see Figure 1).

Under current law, the Massachusetts Health Policy Commission (HPC), a quasi-independent agency, annually sets a “health care cost growth benchmark,” a dollar figure intended to be the limit on health care spending in the Commonwealth. The Center for Health Information and Analysis (CHIA), an independent agency, reviews data on annual changes in providers’ and health plans’ spending. Additionally, CHIA may refer a particular provider or health plan to the HPC if CHIA determines that the provider or health plan had an “excessive” increase in spending that threatens the ability of the Commonwealth to meet the health care cost growth benchmark. Spending is risk-adjusted to avoid penalizing an entity whose costs increased due to enrollment or treatment of sicker individuals. The HPC, in turn, can require such provider or health plan to file a performance improvement plan that identifies cost-saving measures that the entity can take to reduce spending. If the entity fails to file a performance improvement plan or does not implement such a plan in good faith, the HPC can assess a penalty of up to \$500,000.

**FIGURE 1. EXAMPLE: SHIFTING SPENDING TO PRIMARY CARE AND BEHAVIORAL HEALTH SERVICES**



If a specific provider or health plan failed to meet its primary care and behavioral health target, the Center for Health Information and Analysis (CHIA) would refer the entity to the HPC. As in the case of a provider or health plan that exceeds the cost growth benchmark, the HPC could require the entity to file a performance improvement plan and could impose financial penalties on entities that failed to adopt a performance improvement plan or implement such a plan in good faith [Section 9]. The performance improvement plan is required to include identifiable and measurable expected outcomes and a timetable for implementation.

The bill does not provide details on how this framework would be put into effect. If the bill passes, providers and payers may seek guidance from the Commonwealth as to how the law should be applied in specific circumstances. In theory, such guidance could either come from CHIA or from the HPC, assuming a similar implementation process to that which was used for Chapter 224.<sup>1</sup>

Under this framework, CHIA would be required to include an analysis of the growth in spending in primary care and behavioral health expenditures in its annual report [Section 17] and the HPC would be required to include an analysis of primary care and behavioral health spending in its annual health care cost trends hearings [Section 5].

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## REFORMS TO EXPAND SCOPE OF PRACTICE

Governor Baker's proposal would result in several significant changes to the scope of practice of various health care practitioners. Generally, these reforms would allow non-physician practitioners to perform tasks that they are not permitted to perform under current law, with the aim of increasing availability of primary care and behavioral health services.

Nurse practitioners, psychiatric nurse mental health clinical specialists, and nurse anesthetists would be able to obtain independent practice authority, allowing them to write prescriptions and order tests without being supervised by a physician [Sections 98 and 99]. Advanced practice registered nurses who obtain a certification in the field of psychiatric mental health would have the authority to admit patients to psychiatric facilities and allow the use of a restraint on a person with mental illness in the case of an emergency [Sections 114–119].

The bill would also establish a board of registration of recovery coaches. Recovery coaches—individuals who have experienced addiction and recovery who help others get treatment for and recover from a substance use disorder—would be required to register with the new board in order to practice in the Commonwealth. The board would be charged with establishing the standards of practice for recovery coaches, as well as standards for education, experience, training, and oversight [Section 110]. This differs from current practice in that a state agency would oversee the certification of recovery coaches. Currently, a nonprofit organization, the Massachusetts Board of Substance Abuse Counselor Certification, typically provides certification of recovery coaches.<sup>2</sup>

In addition, Massachusetts would join the Nurse Licensure Compact<sup>3</sup> [Section 111]. Under that compact, a nurse who did not hold a Massachusetts license could practice in Massachusetts if the nurse was licensed in another state that is a member of the compact. Likewise, nurses licensed in Massachusetts could practice in any of the

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1 Chapter 224 is the law that established the state's health care cost growth benchmark. Again, these cost growth targets for primary care and behavioral health spending must occur within this overall spending benchmark.

2 Massachusetts Recovery Coach Commission Report (Aug. 2019), <https://www.mass.gov/doc/recovery-coach-commission-report-8-1-2019/download>.

3 For more information, see: <https://www.ncsbn.org/nurse-licensure-compact.htm>.

34 other states that are members of the compact. The law would therefore make it easier for nurses to provide services, including behavioral health care services, via telehealth. However, the nurses would still be required to meet any credentialing requirements imposed by the applicable payer.

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## BEHAVIORAL HEALTH CARE COVERAGE, PAYMENT, AND ACCESS PROVISIONS

In addition to the expenditure target for primary care and behavioral health services and the new scope of practice rules for certain behavioral health providers, H 4134 aims to improve access to behavioral health care in other ways.

Two provisions focus on the coverage of and reimbursement for behavioral health services under commercial health plans. Under the proposed bill, the Division of Insurance would issue regulations requiring health plans to pay licensed mental health professionals at least as much for office visits as they pay to primary care providers [Section 33]. Licensed mental health professionals would include psychiatrists, psychologists, social workers, mental health counselors, nurse mental health clinical specialists, alcohol and drug counselors, and marriage and family therapists [Section 120]. The intent of this provision is to establish rate parity for certain behavioral health care services for which the same service is provided on the physical health side. The bill would also prohibit health plans from denying coverage of a behavioral health service or evaluation and management services solely because the two services were delivered on the same day in the same practice or facility [Sections 120, 128, 130, 132]. Providers such as federally qualified health centers (FQHC), therefore, could be reimbursed for both a primary care visit and a behavioral health visit when a patient received both services from the FQHC on the same day. Although these requirements do not apply to MassHealth or plans operating under MassHealth, MassHealth has separately adopted a policy of allowing reimbursement for both a physical health and behavioral health visit provided on the same day.

Several other behavioral health provisions aim to change provider behaviors or protocols. The Department of Public Health (DPH) would issue regulations requiring hospitals to arrange for behavioral health clinicians to evaluate and stabilize patients admitted to an emergency department with a behavioral health need, and refer those patients for appropriate treatment or inpatient admission [Section 63].

The proposed bill also seeks to provide a standard definition of urgent care services and requires any entity providing urgent care services to be subject to uniform clinic licensure. The proposed bill then establishes three licensure requirements for urgent care clinics. These include: 1) that the clinic accepts MassHealth members; 2) that the clinic provides some level of behavioral health services as defined by DPH and the Department of Mental Health; and 3) that the clinic has protocols for coordinating with a patient's primary care provider. Urgent care clinics can be either for-profit or nonprofit and cannot serve as a patient's primary care provider [Section 67].

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## TELEHEALTH

The bill seeks to expand the use of telehealth within the Commonwealth. Providers, including behavioral health providers, would be allowed to provide telehealth services to a patient whether or not the provider had previously conducted an in-person examination of the patient [Section 62]. Commercial health plans would be

prohibited from denying coverage of a service solely because the service was provided via telehealth, so long as the service in question “may be appropriately provided through the use of telehealth” [Sections 121, 129, 131, 133]. Group health insurance plans that cover state employees would also be required to cover telehealth [Section 35]. Although the provision does not apply to MassHealth, MassHealth has already adopted a policy mandating coverage of telehealth for behavioral health services, and it does not require a prior in-person examination except when the provider is prescribing a Scheduled II controlled substance.<sup>4</sup>

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## COMMERCIAL HEALTH PLAN REGULATION: CREDENTIALING, PROVIDER DIRECTORIES, AND PAIN MANAGEMENT POLICIES

Under the bill, the Bureau of Managed Care within the Division of Insurance would develop a standard credentialing form for health care providers, including behavioral health providers. Commercial health plans would be required to accept this standard form from their providers. The Bureau of Managed Care would be authorized to issue regulations requiring health plans to adopt uniform credentialing policies [Section 142]. The aim of these requirements is to reduce the administrative burden of credentialing on providers.

The bill would also increase the regulation of commercial health plans’ provider directories in an effort to make the directories more accurate and useful. Directories would be required to provide details on the medical and behavioral health specialties of listed practitioners. Health plans would have to update their directories at least monthly, and they would be required to audit the accuracy of their directories at least quarterly. Health plans would need to make a searchable version of their directories available to the public electronically [Section 143].

In addition, the bill would also require commercial insurers to reimburse clinicians working under the supervision of a licensed professional and toward licensure in clinic settings [Sections 128, 130, 132]. Currently, MassHealth is the only payer that reimburses for services provided by these clinicians.

Finally, the bill would require health plans to report on the requests, approvals, and denials for utilization of behavioral health services to help inform the Division of Insurance’s review of a health plan’s network adequacy for behavioral health services [Section 33].

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## CONCLUSION

The Massachusetts House and Senate leadership show early signs of supporting the Governor’s plan, which substantially mirrors provisions that advanced in either the House or the Senate in the last legislative session.<sup>5</sup> (Both chambers passed comprehensive health reform bills in 2019 but failed to reach agreement before the end of the session.) In February 2020, the Senate issued a comprehensive mental health care reform bill<sup>6</sup> and the House is expected to take up a behavioral health care reform proposal this year as well.

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4 Executive Office of Health and Human Services, All Provider Bulletin 281 (Jan. 2019), <https://www.mass.gov/files/documents/2019/01/23/all-provider-bulletin-281.pdf>.

5 Commonwealth Magazine (Oct. 2019). Lawmakers: Baker’s health care bill a good start, <https://commonwealthmagazine.org/health-care/lawmakers-bakers-health-care-bill-a-good-start/>.

6 Massachusetts Senate Bill S.2519 (2020), *An Act Addressing Barriers to Care for Mental Health*, <https://malegislature.gov/Bills/191/S2519.pdf>.

## APPENDIX A. PROVISIONS RELATED TO BEHAVIORAL HEALTH

SECTION(S) OF GOVERNOR'S BILL	SUMMARY	APPLICABLE SECTION(S) OF GENERAL LAW
2, 3, 4	Adds definitions relevant to the establishment of a primary care and behavioral health expenditure target.	Ch. 6D, § 1
5	Requires annual public hearings of the Health Policy Commission to address the primary care and behavioral health expenditure target.	Ch. 6D, § 8
8	Requires the Health Policy Commission to establish a primary care and behavioral health expenditure target that will be 30 percent higher than baseline expenditures by the end of 2022.	Ch. 6D, § 9A
9	Allows the Health Policy Commission to require a performance improvement plan from a health care entity that does not meet its primary care and behavioral health expenditure target.	Ch. 6D, § 10, 10A
13	Renames "Community Hospital Reinvestment Trust Fund" as "Community Hospital and Health Center Investment Trust Fund."	Ch. 12C, § 7
17	Requires the annual report of the Center for Health Information and Analysis to compare costs and cost trends with the aggregate primary care and behavioral health expenditure target.	Ch. 12C, § 16
18	Requires the Center for Health Information and Analysis to identify providers and health plans whose expenditures fail to meet their primary care and behavioral health expenditure target.	Ch. 12C, § 18
25	Revises membership of board of registration of social workers.	Ch. 13, § 80
32	Creates board of registration of recovery coaches.	Ch. 13, § 110
33	Requires the commissioner of insurance to promulgate regulations for provider reimbursement parity rules regarding office visits provided by licensed mental health professionals. Also requires additional reporting by health plans in regard to mental health parity compliance.	Ch. 26, § 8K
34	Requires at least 50 percent of funds in the Community Hospital and Health Center Investment Trust Fund to be directed toward health centers.	Ch. 29, § 2TTTT
40	Adds nurse practitioners, psychiatric nurse mental health clinical specialists, and nurse anesthetists to the definition of "practitioner" under the Controlled Substances Act.	Ch. 94C, § 1

*continued*

<b>SECTION(S) OF GOVERNOR'S BILL</b>	<b>SUMMARY</b>	<b>APPLICABLE SECTION(S) OF GENERAL LAW</b>
44	Requires the Department of Public Health to issue to nurse practitioners, psychiatric nurse mental health clinical specialists, and nurse anesthetists a registration to dispense controlled substances under certain circumstances.	Ch. 94C, § 7
63	Requires the Department of Public Health to issue regulations requiring acute care hospitals to provide or arrange for qualified behavioral health clinicians to evaluate and stabilize a person admitted to an emergency room with a behavioral health presentation.	Ch. 111, § 51 3/4
67	Requires the Department of Public Health and the Department of Mental Health to issue regulations requiring the provision of behavioral health care in licensed clinics.	Ch. 111, § 52B
98, 99	Permits nurse practitioners, psychiatric nurse mental health clinical specialists, and nurse anesthetists to obtain independent practice authority and issue prescriptions and medication orders.	Ch. 112, §§ 80E, 80H
110	Establishes rules governing the regulation of recovery coaches and the board of registration of recovery coaches.	Ch. 112, §§ 275–278
114	Defines a “qualified advanced practice registered nurse” as an advanced practice registered nurse who holds a certification in the field of psychiatric mental health.	Ch. 123, § 1
115, 116	Permits a qualified advanced practice registered nurse to admit a patient to a psychiatric hospital.	Ch. 123, §§ 11, 12
117	Permits a qualified advanced practice registered nurse to authorize, in the case of an emergency, the use of restraint on a patient who is being transported.	Ch. 123, § 21
118, 119	Indicates that qualified advanced practice registered nurses will be immune from liability regarding restraining or admitting a patient to a psychiatric hospital if they adhere to the applicable statutory requirements.	Ch. 123, § 22
120, 128, 130, 132	Prohibits health plans from denying coverage of a behavioral health and evaluation and management office visit on the basis that the two services were provided on the same day in the same practice or facility.	Ch. 175, § 47B Ch. 176A, § 8A Ch. 176B, § 4A Ch. 176G, § 4M



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