

SENATE No. 645

The Commonwealth of Massachusetts

PRESENTED BY:

John J. Cronin

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 for Medical Necessity Fairness.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
<i>John J. Cronin</i>	<i>Worcester and Middlesex</i>	
<i>Michael P. Kushmerek</i>	<i>3rd Worcester</i>	
<i>Meghan Kilcoyne</i>	<i>12th Worcester</i>	
<i>Susannah M. Whipps</i>	<i>2nd Franklin</i>	<i>2/26/2021</i>
<i>Paul A. Schmid, III</i>	<i>8th Bristol</i>	<i>3/5/2021</i>
<i>Joanne M. Comerford</i>	<i>Hampshire, Franklin and Worcester</i>	<i>3/31/2021</i>
<i>Adam G. Hinds</i>	<i>Berkshire, Hampshire, Franklin and Hampden</i>	<i>4/2/2021</i>
<i>John C. Velis</i>	<i>Second Hampden and Hampshire</i>	<i>4/9/2021</i>
<i>Walter F. Timilty</i>	<i>Norfolk, Bristol and Plymouth</i>	<i>4/15/2021</i>
<i>Danillo A. Sena</i>	<i>37th Middlesex</i>	<i>5/7/2021</i>
<i>Natalie M. Higgins</i>	<i>4th Worcester</i>	<i>9/3/2021</i>

SENATE No. 645

By Mr. Cronin, a petition (accompanied by bill, Senate, No. 645) of John Cronin, Michael P. Kushmerek, Meghan Kilcoyne, Susannah M. Whipps and other members of the General Court for legislation relative to medical necessity fairness. Financial Services.

The Commonwealth of Massachusetts

**In the One Hundred and Ninety-Second General Court
(2021-2022)**

An Act for Medical Necessity Fairness.

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. Section 16 of chapter 176O, as so appearing, is amended by striking
2 subsection (b), and replacing it with the following:-

3 (b) A carrier shall be required to pay for health care services ordered by a treating
4 physician or a primary care provider if: (1) the services are a covered benefit under the insured's
5 health benefit plan; and (2) the services are medically necessary. Except as otherwise required
6 under subsections (d) and (e) of this section, a carrier may develop guidelines to be used in
7 applying the standard of medical necessity, as defined in this subsection. Any such medical
8 necessity guidelines utilized by a carrier in making coverage determinations shall be: (i)
9 developed in accordance with the requirements under this section; (ii) developed with input from
10 practicing physicians and participating providers in the carrier's or utilization review
11 organization's service area; (ii) developed under the standards adopted by national accreditation
12 organizations; (iii) updated at least biennially or more often as new treatments, applications and

13 technologies are adopted as generally accepted professional medical practice; and (iv) evidence-
14 based, if practicable. In applying such guidelines, a carrier shall consider the individual health
15 care needs of the insured. Any such medical necessity guidelines shall be applied consistently by
16 a carrier or a utilization review organization and made easily accessible and up-to-date on a
17 carrier or utilization review organization's website to insureds, prospective insureds and health
18 care providers consistent with subsection (a) of section 12. If a carrier or utilization review
19 organization intends either to implement a new medical necessity guideline or amend an existing
20 requirement or restriction, the carrier or utilization review organization shall ensure that the new
21 or amended requirement or restriction shall not be implemented unless the carrier's or utilization
22 review organization's website has been updated to reflect the new or amended requirement or
23 restriction.

24

25 SECTION 2. Section 16 of said chapter 176O, as so appearing, is hereby further amended
26 by adding the following subsection:-

27 (d) Medical necessity and utilization management determinations for treatments for
28 substance use disorder or co-occurring mental illness and substance use disorder shall be made in
29 accordance with the level of care placement criteria and practice guidelines established by the
30 American Society of Addiction Medicine, or by any comparable current criteria and practice
31 guidelines developed by a comparable nonprofit professional association for the relevant clinical
32 specialty of addiction medicine, if available, including age group specific guidelines for children,
33 adolescents and young adults, if available. No additional criteria may be used to make medical
34 necessity or utilization management determinations for treatments for substance use disorder or

35 co-occurring mental illness and substance use disorder, unless such criteria are less restrictive. A
36 carrier, or any entity that manages or administers mental health and substance use disorder
37 benefits for the carrier, shall not deny authorization or coverage for treatment for substance use
38 disorder or co-occurring mental illness and substance use disorder on the basis that such
39 treatment was authorized or ordered by a court of law or other law enforcement agency. Such
40 authorization shall be considered a factor in support of coverage for such treatment, including as
41 allowed under clause (4) of subsection (a) of section 6 and clause (7) of subsection (a) of section
42 7. Nothing in this section shall be construed to affect the authority of the treating clinician to
43 determine medical necessity as provided under section 47GG of chapter 175, section 8II of
44 chapter 176A, section 4LL of chapter 176B, or section 4AA of chapter 176G.

45

46

47 SECTION 3: Section 16 of chapter 176O, as so appearing, is hereby further amended by
48 adding the following subsections:-

49 (e) Appropriate medical necessity standards for behavioral health condition services

50 (1) Definitions. The following definitions apply for purposes of this subsection:

51 (i) “Generally accepted standards of behavioral health condition care” means standards of
52 care and clinical practice that are generally recognized by health care providers practicing in
53 relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction
54 medicine and counseling, and behavioral health treatment. Valid, evidence-based sources
55 reflecting generally accepted standards of mental health and substance use disorder care include

56 peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care
57 provider professional associations and specialty societies, including but not limited to patient
58 placement criteria and clinical practice guidelines, recommendations of federal government
59 agencies, and drug labeling approved by the United States Food and Drug Administration.

60 (ii) “Medically necessary treatment of a behavioral health condition” means a service or
61 product addressing the specific needs of that patient, for the purpose of screening, preventing,
62 diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including
63 minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is
64 all of the following:

65 (A) In accordance with the generally accepted standards of mental health and substance
66 use disorder care.

67 (B) Clinically appropriate in terms of type, frequency, extent, site, and duration.

68 (C) Not primarily for the economic benefit of the carrier, purchaser, or for the
69 convenience of the patient, treating physician, or other health care provider.

70 (iii) “Behavioral health condition ” means a mental health condition, developmental
71 disorder or substance use disorder that falls under any of the diagnostic categories listed in the
72 mental and behavioral disorders chapter of the most recent edition of the World Health
73 Organization’s International Statistical Classification of Diseases and Related Health Problems,
74 or that is listed in the most recent version of the American Psychiatric Association’s Diagnostic
75 and Statistical Manual of Mental Disorders. Changes in terminology, organization, or
76 classification of mental health and substance use disorders in future versions of the American
77 Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders or the World

78 Health Organization’s International Statistical Classification of Diseases and Related Health
79 Problems shall not affect the conditions covered by this subsection as long as a condition is
80 commonly understood to be a mental health or substance use disorder by health care providers
81 practicing in relevant clinical specialties.

82 (iv) “Utilization review” means either of the following:

83 (A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying,
84 delaying, or denying, based in whole or in part on medical necessity, requests by health care
85 providers, insureds, or their authorized representatives for coverage of health care services prior
86 to, retrospectively or concurrent with the provision of health care services to insureds.

87 (B) Evaluating the medical necessity, appropriateness, level of care, service intensity,
88 efficacy, or efficiency of health care services, benefits, procedures, or settings, under any
89 circumstances, to determine whether a health care service or benefit subject to a medical
90 necessity coverage requirement in an insurance policy is covered as medically necessary for an
91 insured.

92 (v) “Utilization review criteria” means any criteria, standards, protocols, or guidelines
93 used by a carrier to conduct utilization review.

94 (2) Coverage for medically necessary behavioral health condition Services

95 (ii) A carrier shall not limit benefits or coverage for chronic or pervasive behavioral
96 health conditions to short-term or acute treatment at any level of care placement.

97 (iii) All medical necessity determinations made by the carrier concerning service
98 intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed

99 with behavioral health conditions shall be conducted in accordance with the requirements of this
100 subsection.

101 (iv) A carrier shall not limit benefits or coverage for medically necessary services for
102 behavioral health conditions on the basis that those services should be or could be covered by a
103 public entitlement program, including, but not limited to, a special education or an individualized
104 education program, Medicaid, Medicare, Supplemental Security Income, or Social Security
105 Disability Insurance, and shall not include or enforce a contract term that excludes otherwise
106 covered benefits on the basis that those services should be or could be covered by a public
107 entitlement program.

108 (v) A carrier shall not deny authorization or coverage for treatment for substance use
109 disorder or co-occurring mental illness and substance use disorder on the basis that such
110 treatment was authorized or ordered by a court of law or other law enforcement agency, except
111 to the extent that such treatment is for an incarcerated person with access to coverage from
112 public programs.

113 (vi) A carrier shall not adopt, impose, or enforce terms in its policies or provider
114 agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of
115 this subsection.

116 (3) Medical necessity determinations must follow generally accepted standards

117 (i) Carriers shall base any medical necessity determination or the utilization review
118 criteria that the carrier, and any entity acting on the carrier's behalf, applies to determine the
119 medical necessity of health care services and benefits for the diagnosis, prevention, and

120 treatment of behavioral health conditions on current generally accepted standards of behavioral
121 health condition care as defined in this subsection.

122 (ii) In conducting utilization review of all covered health care services and benefits for
123 the diagnosis, prevention, and treatment of behavioral health conditions in children, adolescents,
124 and adults, a carrier shall apply the level of care placement criteria and practice guidelines set
125 forth in the most recent versions of such criteria and practice guidelines developed by the
126 nonprofit professional association for the relevant clinical specialty, if available, including age
127 group specific guidelines for children, adolescents and young adults, if available.

128 (iii) In conducting utilization review involving level of care placement decisions or any
129 other patient care decisions that are within the scope of the sources specified in this subsection, a
130 carrier shall not apply different, additional, conflicting, or more restrictive utilization review
131 criteria than the criteria and guidelines set forth in those sources. For all level of care placement
132 decisions, the insurer shall authorize placement at the level of care consistent with the insured's
133 score using the relevant level of care placement criteria and guidelines as specified in this
134 subsection. If that level of placement is not available, the insurer shall authorize the next higher
135 level of care. In the event of disagreement, the carrier shall provide full detail of its scoring using
136 the relevant level of care placement criteria and guidelines as specified in this subsection to the
137 provider of the service.

138 (iv) A carrier shall not deny authorization or coverage for a service to treat a chronic
139 behavioral health condition on the basis that the service will not cure the condition, and a carrier
140 shall approve services that are appropriate to prevent a chronic behavioral health condition from
141 deteriorating.

142 (4) Implementation. To ensure the proper use of the criteria described in this subsection,
143 every carrier shall do all of the following in relation to behavioral health conditions:

144 (i) Sponsor a formal education program by nonprofit clinical specialty associations to
145 educate the carrier's staff, including any third parties contracted with the insurer to review
146 claims, conduct utilization reviews, or make medical necessity determinations about the clinical
147 review criteria.

148 (ii) Make the education program available to other stakeholders, including the carrier's
149 participating providers and covered lives.

150 (iii) Provide, at no cost, the clinical review criteria and any training material or resources
151 to providers and insured patients.

152 (iv) Track, identify, and analyze how the clinical review criteria are used to certify care,
153 deny care, and support the appeals process.

154 (v) Conduct interrater reliability testing to ensure consistency in utilization review
155 decision making covering how medical necessity decisions are made. This assessment shall
156 cover all aspects of utilization review for behavioral health conditions as defined in this
157 subsection

158 (vi) Run interrater reliability reports about how the clinical guidelines are used in
159 conjunction with the utilization management process and mental health parity compliance
160 activities.

161 (vii) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is
162 not met, immediately provide for the remediation of poor interrater reliability and interrater
163 reliability testing for all new staff before they can conduct utilization review without supervision.

164 (5) Enforcement

165 (i) This subsection applies to all health care services and benefits for the diagnosis,
166 prevention, and treatment and management of behavioral health conditions covered by a carrier,
167 including prescription drugs.

168 (ii) This subsection applies to carriers that conduct utilization review for behavioral
169 health conditions as defined in this subsection, and any entity or contracting provider that
170 performs utilization review or utilization management functions for behavioral health conditions
171 on a carrier's behalf.

172 (iii) If the commissioner determines that a carrier or other entity has violated this
173 subsection, the commissioner may, after appropriate notice and opportunity for hearing in
174 accordance with the procedural requirements of subsections a through c of section 3 of chapter
175 176O, by order, assess a civil penalty not to exceed five thousand dollars (\$5,000) for each
176 violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars
177 (\$10,000) for each violation. The civil penalties available to the commissioner pursuant to this
178 subsection are not exclusive and may be sought and employed in combination with any other
179 remedies available to the commissioner under this code.

180 (iv) If, after said hearing the commissioner of insurance determines that noncompliance
181 has been substantiated, the commissioner shall have the authority to investigate whether any
182 insureds were denied access or coverage due to a violation of this subsection, and to issue an

183 order a carrier to implement a corrective action plan and timeline to require the carrier to cover
184 any services that were denied due to a violation of this subsection. In the event that an
185 inappropriate denial by a carrier led an insured to seek treatment at an out-of-network provider,
186 the carrier may be ordered to indemnify the insured for their costs.

187 (v) A carrier shall not adopt, impose, or enforce terms in its policies or provider
188 agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of
189 this subsection.

190 (6) Discretionary Clauses Prohibited

191 (i) If a contract offered, issued, delivered, amended, or renewed on or after January 1,
192 2022, by a carrier contains a provision that reserves discretionary authority to the carrier, or an
193 agent of the carrier, to determine eligibility for benefits or coverage, to interpret the terms of the
194 contract, or to provide standards of interpretation or review that are inconsistent with the laws of
195 this state, that provision is void and unenforceable.

196 (ii) For purposes of this subsection, the term “discretionary authority” means a contract
197 provision that has the effect of conferring discretion on a carrier or other claims administrator to
198 determine entitlement to benefits or interpret contract language that, in turn, could lead to a
199 deferential standard of review by a reviewing court.

200 (iii) This subsection does not prohibit a carrier from including a provision in a contract
201 that informs an insured that, as part of its routine operations, the plan applies the terms of its
202 contracts for making decisions, including making determinations regarding eligibility, receipt of
203 benefits and claims, or explaining policies, procedures, and processes, so long as the provision
204 could not give rise to a deferential standard of review by a reviewing court.

205

206 SECTION 4. Chapter 118E as so appearing is hereby amended by adding the following
207 two sections:-

208 Section 79. Mental necessity for substance use disorder or co-occurring conditions. (a)
209 Medical necessity and utilization management determinations for treatments for substance use
210 disorder or co-occurring mental illness and substance use disorder shall be made in accordance
211 with the level of care placement criteria and practice guidelines established by the American
212 Society of Addiction Medicine, or by any comparable current criteria and practice guidelines
213 developed by a comparable nonprofit professional association for the relevant clinical specialty
214 of addiction medicine, if available, including age group specific guidelines for children,
215 adolescents and young adults, if available. No additional criteria may be used to make medical
216 necessity or utilization management determinations for treatments for substance use disorder or
217 co-occurring mental illness and substance use disorder, unless such criteria are less restrictive. A
218 carrier, or any entity that manages or administers mental health and substance use disorder
219 benefits for the carrier, shall not deny authorization or coverage for treatment for substance use
220 disorder or co-occurring mental illness and substance use disorder on the basis that such
221 treatment was authorized or ordered by a court of law or other law enforcement agency. Such
222 authorization shall be considered a factor in support of coverage for such treatment, including as
223 allowed under clause (4) of subsection (a) of section 6 and clause (7) of subsection (a) of section
224 7.

225 Section 80. (a) Appropriate medical necessity standards for behavioral health condition
226 services

227 (1) Definitions. The following definitions apply for purposes of this section:

228 (i) “Generally accepted standards of behavioral health condition care” means standards of
229 care and clinical practice that are generally recognized by health care providers practicing in
230 relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction
231 medicine and counseling, and behavioral health treatment. Valid, evidence-based sources
232 reflecting generally accepted standards of mental health and substance use disorder care include
233 peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care
234 provider professional associations and specialty societies, including but not limited to patient
235 placement criteria and clinical practice guidelines, recommendations of federal government
236 agencies, and drug labeling approved by the United States Food and Drug Administration.

237 (ii) “Medically necessary treatment of a behavioral health condition” means a service or
238 product addressing the specific needs of that patient, for the purpose of screening, preventing,
239 diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including
240 minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is
241 all of the following:

242 (A) In accordance with the generally accepted standards of mental health and substance
243 use disorder care.

244 (B) Clinically appropriate in terms of type, frequency, extent, site, and duration.

245 (C) Not primarily for the economic benefit of the carrier, purchaser, or for the
246 convenience of the patient, treating physician, or other health care provider.

247 (iii) “Behavioral health condition ” means a mental health condition, developmental
248 disorder or substance use disorder that falls under any of the diagnostic categories listed in the
249 mental and behavioral disorders chapter of the most recent edition of the World Health
250 Organization’s International Statistical Classification of Diseases and Related Health Problems,
251 or that is listed in the most recent version of the American Psychiatric Association’s Diagnostic
252 and Statistical Manual of Mental Disorders. Changes in terminology, organization, or
253 classification of mental health and substance use disorders in future versions of the American
254 Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders or the World
255 Health Organization’s International Statistical Classification of Diseases and Related Health
256 Problems shall not affect the conditions covered by this section as long as a condition is
257 commonly understood to be a mental health or substance use disorder by health care providers
258 practicing in relevant clinical specialties.

259 (iv) “Utilization review” means either of the following:

260 (A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying,
261 delaying, or denying, based in whole or in part on medical necessity, requests by health care
262 providers, insureds, or their authorized representatives for coverage of health care services prior
263 to, retrospectively or concurrent with the provision of health care services to insureds.

264 (B) Evaluating the medical necessity, appropriateness, level of care, service intensity,
265 efficacy, or efficiency of health care services, benefits, procedures, or settings, under any
266 circumstances, to determine whether a health care service or benefit subject to a medical
267 necessity coverage requirement in an insurance policy is covered as medically necessary for an
268 insured.

269 (v) "Utilization review criteria" means any criteria, standards, protocols, or guidelines
270 used by a carrier to conduct utilization review.

271 (2) Coverage for medically necessary behavioral health condition Services. The division,
272 its managed care organizations, accountable care organizations or other entity contracting with
273 the division to manage or administer behavioral health condition services:

274 (i) Shall not limit benefits or coverage for chronic or pervasive behavioral health
275 conditions to short-term or acute treatment at any level of care placement.

276 (iii) Shall make all medical necessity determinations concerning service intensity, level of
277 care placement, continued stay, and transfer or discharge of insureds diagnosed with behavioral
278 health conditions shall be conducted in accordance with the requirements of this section.

279 (iv) Shall not limit benefits or coverage for medically necessary services for behavioral
280 health conditions on the basis that those services should be or could be covered by another public
281 entitlement program, including, but not limited to, a special education or an individualized
282 education program, Medicare, Supplemental Security Income, or Social Security Disability
283 Insurance, and shall not include or enforce a contract term that excludes otherwise covered
284 benefits on the basis that those services should be or could be covered by a public entitlement
285 program.

286 (v) Shall not deny authorization or coverage for treatment for substance use disorder or
287 co-occurring mental illness and substance use disorder on the basis that such treatment was
288 authorized or ordered by a court of law or other law enforcement agency, except to the extent
289 that such treatment is for an incarcerated person with access to coverage from public programs.

290 (vi) Shall not adopt, impose, or enforce terms in any health plan coverage policy or
291 provider agreement, in writing or in operation, that undermine, alter, or conflict with the
292 requirements of this section.

293 (3) Medical Necessity Determinations Must Follow Generally Accepted Standards. The
294 division, its managed care organizations, accountable care organizations or other entity
295 contracting with the division to manage or administer behavioral health condition services:

296 (i) Shall base any medical necessity determination or the utilization review decision for
297 the diagnosis, prevention, and treatment of behavioral health conditions on current generally
298 accepted standards of behavioral health condition care as defined in this section.

299 (ii) Shall apply the level of care placement criteria and practice guidelines set forth in the
300 most recent versions of such criteria and practice guidelines developed by the nonprofit
301 professional association for the relevant clinical specialty, if available, including age group
302 specific guidelines for children, adolescents and young adults, if available.

303 (iii) Shall not apply different, additional, conflicting, or more restrictive utilization review
304 criteria when conducting utilization review involving level of care placement decisions or any
305 other patient care decisions that are within the scope of the sources specified in this section.

306 (iv) Shall authorize placement at the level of care consistent with the insured's score
307 using the relevant level of care placement criteria and guidelines as specified in this section.,
308 however if that level of placement is not available, the next higher level of care shall be
309 authorized.

310 (v) Shall, in the event of a disagreement with a treating provider, furnish the provider
311 with the full detail of its scoring using the relevant level of care placement criteria and guidelines
312 as specified in this section.

313 (iv) Shall not deny authorization or coverage for a service to treat a chronic behavioral
314 health condition on the basis that the service will not cure the condition, and a carrier shall
315 approve services that are appropriate to prevent a chronic behavioral health condition from
316 deteriorating.

317 (4) Implementation. To ensure the proper use of the criteria described in this section, the
318 division, its managed care organizations, accountable care organizations or other entity
319 contracting with the division to manage or administer behavioral health condition services shall
320 do all of the following in relation to authorization and utilization of behavioral health condition
321 services:

322 (i) Sponsor a formal education program by nonprofit clinical specialty associations to
323 educate utilization review and appeals staff (including any third parties contracted to review
324 claims, conduct utilization reviews, or make medical necessity determinations) about the clinical
325 review criteria.

326 (ii) Make the education program available to other stakeholders, including the
327 participating providers, advocates and covered members.

328 (iii) Provide, at no cost, the clinical review criteria and any training material or resources
329 to providers, advocates and covered members.

330 (iv) Track, identify, and analyze how the clinical review criteria are used to certify care,
331 deny care, and support the appeals process.

332 (v) Conduct interrater reliability testing to ensure consistency in utilization review
333 decision making covering how medical necessity decisions are made. This assessment shall
334 cover all aspects of utilization review for behavioral health conditions as defined in this section

335 (vi) Run interrater reliability reports about how the clinical guidelines are used in
336 conjunction with the utilization management process and mental health parity compliance
337 activities.

338 (vii) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is
339 not met, immediately provide for the remediation of poor interrater reliability and interrater
340 reliability testing for all new staff before they can conduct utilization review without supervision.

341 (5) Enforcement

342 (i) This section applies to all health care services and benefits for the diagnosis,
343 prevention, treatment and management of behavioral health conditions covered by the division,
344 including prescription drugs.

345 (ii) This section applies to the division's managed care organizations, accountable care
346 organizations or other entity contracting with the division to manage or administer behavioral
347 health condition services, or to conduct utilization review for behavioral health conditions as
348 defined in this section.

349 (iii) If the division determines that a contracting entity described in this section has
350 violated this section, the division may, after appropriate notice and opportunity for hearing in

351 accordance with current contracting practices, by order assess a civil penalty not to exceed five
352 thousand dollars (\$5,000) for each violation, or, if a violation was willful, a civil penalty not to
353 exceed ten thousand dollars (\$10,000) for each violation. The civil penalties available to the
354 division pursuant to this section are not exclusive and may be sought and employed in
355 combination with any other remedies available to the division.

356 (iv) If, after said hearing the division determines that noncompliance has been
357 substantiated, the division shall have the authority to investigate whether any covered members
358 were denied access or coverage due to a violation of this section, and to issue an order any
359 contracting entity to implement a corrective action plan and timeline to require coverage of any
360 services that were denied due to a violation of this section. In the event that an inappropriate
361 denial by a contracting entity led a covered member to seek treatment at an out-of-network
362 provider, the contracting entity may be ordered to indemnify the covered member for their costs.

363 (v) The division's managed care organizations, accountable care organizations or other
364 entity contracting with the division to manage or administer behavioral health condition services,
365 or to conduct utilization review for behavioral health conditions as defined in this section shall
366 not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in
367 operation, that undermine, alter, or conflict with the requirements of this section.

368 Page Break

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370

371 SECTION 5. Chapter 32A is hereby further amended by adding at the end the following
372 two sections:-

373 Section 29. (a) The commission shall provide to any active or retired employee of the
374 commonwealth who is insured under the group insurance commission coverage for behavioral
375 health condition services that ensures that medical necessity and utilization management
376 determinations for treatments for substance use disorder or co-occurring mental illness and
377 substance use disorder made by any health plan or entity contracting with the commission to
378 provide, administer or manage behavioral health condition benefits shall be made in accordance
379 with the level of care placement criteria and practice guidelines established by the American
380 Society of Addiction Medicine, or by any comparable current criteria and practice guidelines
381 developed by a comparable nonprofit professional association for the relevant clinical specialty
382 of addiction medicine, if available, including age group specific guidelines for children,
383 adolescents and young adults, if available. No additional criteria may be used to make medical
384 necessity or utilization management determinations for treatments for substance use disorder or
385 co-occurring mental illness and substance use disorder, unless such criteria are less restrictive.
386 No health plan or health coverage authorized by the group insurance commission, nor any entity
387 that manages or administers mental health and substance use disorder benefits such a health plan
388 shall not deny authorization or coverage for treatment for substance use disorder or co-occurring
389 mental illness and substance use disorder on the basis that such treatment was authorized or
390 ordered by a court of law or other law enforcement agency. Such authorization shall be
391 considered a factor in support of coverage for such treatment, including as allowed under clause
392 (4) of subsection (a) of section 6 and clause (7) of subsection (a) of section 7. Nothing in this

393 section shall be construed to affect the authority of the treating clinician to determine medical
394 necessity as provided under section 17N.

395

396 Section 30. (a) Appropriate medical necessity standards for behavioral health condition
397 services

398 (1) Definitions. The following definitions apply for purposes of this section:

399 (i) “Generally accepted standards of behavioral health condition care” means standards of
400 care and clinical practice that are generally recognized by health care providers practicing in
401 relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction
402 medicine and counseling, and behavioral health treatment. Valid, evidence-based sources
403 reflecting generally accepted standards of mental health and substance use disorder care include
404 peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care
405 provider professional associations and specialty societies, including but not limited to patient
406 placement criteria and clinical practice guidelines, recommendations of federal government
407 agencies, and drug labeling approved by the United States Food and Drug Administration.

408 (ii) “Medically necessary treatment of a behavioral health condition” means a service or
409 product addressing the specific needs of that patient, for the purpose of screening, preventing,
410 diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including
411 minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is
412 all of the following:

413 (A) In accordance with the generally accepted standards of mental health and substance
414 use disorder care.

415 (B) Clinically appropriate in terms of type, frequency, extent, site, and duration.

416 (C) Not primarily for the economic benefit of the carrier, purchaser, or for the
417 convenience of the patient, treating physician, or other health care provider.

418 (iii) “Behavioral health condition ” means a mental health condition, developmental
419 disorder or substance use disorder that falls under any of the diagnostic categories listed in the
420 mental and behavioral disorders chapter of the most recent edition of the World Health
421 Organization’s International Statistical Classification of Diseases and Related Health Problems,
422 or that is listed in the most recent version of the American Psychiatric Association’s Diagnostic
423 and Statistical Manual of Mental Disorders. Changes in terminology, organization, or
424 classification of mental health and substance use disorders in future versions of the American
425 Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders or the World
426 Health Organization’s International Statistical Classification of Diseases and Related Health
427 Problems shall not affect the conditions covered by this section as long as a condition is
428 commonly understood to be a mental health or substance use disorder by health care providers
429 practicing in relevant clinical specialties.

430 (iv) “Utilization review” means either of the following:

431 (A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying,
432 delaying, or denying, based in whole or in part on medical necessity, requests by health care
433 providers, insureds, or their authorized representatives for coverage of health care services prior
434 to, retrospectively or concurrent with the provision of health care services to insureds.

435 (B) Evaluating the medical necessity, appropriateness, level of care, service intensity,
436 efficacy, or efficiency of health care services, benefits, procedures, or settings, under any
437 circumstances, to determine whether a health care service or benefit subject to a medical
438 necessity coverage requirement in an insurance policy is covered as medically necessary for an
439 insured.

440 (v) "Utilization review criteria" means any criteria, standards, protocols, or guidelines
441 used by a carrier to conduct utilization review.

442 (2) Coverage for medically necessary behavioral health condition Services. The
443 commission shall provide to any active or retired employee of the commonwealth who is insured
444 under the group insurance commission coverage for medically necessary evaluation, diagnosis,
445 treatment and management of behavioral health condition services that:

446 (i) Shall not limit benefits or coverage for chronic or pervasive behavioral health
447 conditions to short-term or acute treatment at any level of care placement.

448 (iii) Shall make all medical necessity determinations concerning service intensity, level of
449 care placement, continued stay, and transfer or discharge of insureds diagnosed with behavioral
450 health conditions shall be conducted in accordance with the requirements of this section.

451 (iv) Shall not limit benefits or coverage for medically necessary services for behavioral
452 health conditions on the basis that those services should be or could be covered by another public
453 entitlement program, including, but not limited to, a special education or an individualized
454 education program, Medicaid, Medicare, Supplemental Security Income, or Social Security
455 Disability Insurance, and shall not include or enforce a contract term that excludes otherwise

456 covered benefits on the basis that those services should be or could be covered by a public
457 entitlement program.

458 (v) Shall not deny authorization or coverage for treatment for substance use disorder or
459 co-occurring mental illness and substance use disorder on the basis that such treatment was
460 authorized or ordered by a court of law or other law enforcement agency, except to the extent
461 that such treatment is for an incarcerated person with access to coverage from public programs.

462 (vi) Shall not adopt, impose, or enforce terms in any health plan coverage policy or
463 provider agreement, in writing or in operation, that undermine, alter, or conflict with the
464 requirements of this section.

465 (3) Medical Necessity Determinations Must Follow Generally Accepted Standards. The
466 commission and any entity contracting with the commission directly or indirectly to manage or
467 administer behavioral health condition services:

468 (i) Shall base any medical necessity determination or the utilization review decision for
469 the diagnosis, prevention, and treatment of behavioral health conditions on current generally
470 accepted standards of behavioral health condition care as defined in this section.

471 (ii) Shall apply the level of care placement criteria and practice guidelines set forth in the
472 most recent versions of such criteria and practice guidelines developed by the nonprofit
473 professional association for the relevant clinical specialty, if available, including age group
474 specific guidelines for children, adolescents and young adults, if available.

475 (iii) Shall not apply different, additional, conflicting, or more restrictive utilization review
476 criteria when conducting utilization review involving level of care placement decisions or any
477 other patient care decisions that are within the scope of the sources specified in this section.

478 (iv) Shall authorize placement at the level of care consistent with the insured's score
479 using the relevant level of care placement criteria and guidelines as specified in this section.,
480 however if that level of placement is not available, the next higher level of care shall be
481 authorized.

482 (v) Shall, in the event of a disagreement with a treating provider, furnish the provider
483 with the full detail of its scoring using the relevant level of care placement criteria and guidelines
484 as specified in this section.

485 (iv) Shall not deny authorization or coverage for a service to treat a chronic behavioral
486 health condition on the basis that the service will not cure the condition, and a carrier shall
487 approve services that are appropriate to prevent a chronic behavioral health condition from
488 deteriorating.

489 (4) Implementation. To ensure the proper use of the criteria described in this section, the
490 commission and any entity contracting with the commission directly or indirectly to manage or
491 administer behavioral health condition services shall do all of the following in relation to
492 authorization and utilization of behavioral health condition services:

493 (i) Sponsor a formal education program by nonprofit clinical specialty associations to
494 educate utilization review and appeals staff (including any third parties contracted to review
495 claims, conduct utilization reviews, or make medical necessity determinations) about the clinical
496 review criteria.

497 (ii) Make the education program available to other stakeholders, including the
498 participating providers, advocates and covered members.

499 (iii) Provide, at no cost, the clinical review criteria and any training material or resources
500 to providers, advocates and covered members.

501 (iv) Track, identify, and analyze how the clinical review criteria are used to certify care,
502 deny care, and support the appeals process.

503 (v) Conduct interrater reliability testing to ensure consistency in utilization review
504 decision making covering how medical necessity decisions are made. This assessment shall
505 cover all aspects of utilization review for behavioral health conditions as defined in this section

506 (vi) Run interrater reliability reports about how the clinical guidelines are used in
507 conjunction with the utilization management process and mental health parity compliance
508 activities.

509 (vii) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is
510 not met, immediately provide for the remediation of poor interrater reliability and interrater
511 reliability testing for all new staff before they can conduct utilization review without supervision.

512 (5) Enforcement

513 (i) This section applies to all health care services and benefits for the diagnosis,
514 prevention, treatment and management of behavioral health conditions covered by the division,
515 including prescription drugs.

516 (ii) This section applies to the commission and any entity contracting with the
517 commission directly or indirectly to manage or administer behavioral health condition services,
518 or to conduct utilization review for behavioral health conditions as defined in this section.

519 (iii) If the commission determines that a contracting entity described in this section has
520 violated this section, the commission may, after appropriate notice and opportunity for hearing in
521 accordance with current contracting practices, assess a civil penalty not to exceed five thousand
522 dollars (\$5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten
523 thousand dollars (\$10,000) for each violation. The civil penalties available to the division
524 pursuant to this section are not exclusive and may be sought and employed in combination with
525 any other remedies available to the commission.

526 (iv) If, after said hearing the commission determines that noncompliance has been
527 substantiated, the commission shall have the authority to investigate whether any covered
528 members were denied access or coverage due to a violation of this section, and to issue an order
529 any contracting entity to implement a corrective action plan and timeline to require coverage of
530 any services that were denied due to a violation of this section. In the event that an inappropriate
531 denial by a contracting entity led a covered member to seek treatment at an out-of-network
532 provider, the contracting entity may be ordered to indemnify the covered member for their costs.

533 (v) The commission and any entity contracting with the commission directly or indirectly
534 to manage or administer behavioral health condition services or to conduct utilization review for
535 behavioral health conditions as defined in this section shall not adopt, impose, or enforce terms
536 in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict
537 with the requirements of this section.

538 (6) Discretionary Clauses Prohibited

539 (i) If a contract offered, issued, delivered, amended, or renewed on or after January 1,
540 2022, by the commission to any member contains a provision that reserves discretionary
541 authority to the commission, or an agent of the commission to determine eligibility for benefits
542 or coverage, to interpret the terms of the contract, or to provide standards of interpretation or
543 review that are inconsistent with the laws of this state, that provision is void and unenforceable.

544 (ii) For purposes of this subsection, the term “discretionary authority” means a contract
545 provision that has the effect of conferring discretion on a carrier or other claims administrator to
546 determine entitlement to benefits or interpret contract language that, in turn, could lead to a
547 deferential standard of review by a reviewing court.

548 (iii) This subsection does not prohibit the commission or an entity contracting with the
549 commission from including a provision in a contract that informs an insured that, as part of its
550 routine operations, the plan applies the terms of its contracts for making decisions, including
551 making determinations regarding eligibility, receipt of benefits and claims, or explaining
552 policies, procedures, and processes, so long as the provision could not give rise to a deferential
553 standard of review by a reviewing court.

554

555 SECTION 6. Section 18 of chapter 15A of the General Laws is hereby amended by
556 adding the following paragraph:-

557 Notwithstanding any general or special law to the contrary, any qualifying student health
558 insurance plan authorized under this chapter shall comply with the requirements regarding

559 medical necessity determinations of behavioral health condition services as provided under
560 subsections d and e of section 16 of chapter 176O. The connector shall issue regulations to
561 implement this section, and the connector shall have the authority to implement civil penalties
562 and corrective orders upon carriers of student health insurance as described in subsection e of
563 section 16 of chapter 176O.

564