HOUSE DOCKET, NO. 3473 FILED ON: 1/20/2023

HOUSE . . . . . No. 941

The Commonwealth of Massachusetts

PRESENTED BY:

Ruth B. Balser

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 relative to utilization review.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Ruth B. Balser	*12th Middlesex*	*1/20/2023*
Bud L. Williams	*11th Hampden*	*12/3/2023*

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HOUSE . . . . . No. 941

By Representative Balser of Newton, a petition (accompanied by bill, House, No. 941) of Ruth B. Balser relative to healthcare carrier utilization review. Financial Services.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Third General Court
(2023-2024)

An Act relative to utilization review.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 176O of the General Laws, as appearing in the 2020 official edition, is hereby amended by inserting after section 29 the following 2 sections:-

Section 30: (a) A carrier or utilization review organization shall not perform prior authorization on health care services or benefits under the following circumstances:

(1) For generic prescription drugs that are not listed within any of the schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or schedules 1 through 5 of the schedules of controlled substances established under Chapter 94C.

(2) For any prescription drug, generic or brand name, that is not listed within any of the schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or schedules 1 through 5 of the schedules of controlled substances established under Chapter 94C after an insured has been prescribed the drug without interruption for six months.

(3) For any prescription drug or drugs, generic or brand name, on the grounds of therapeutic duplication if the insured has already been subject to prior authorization on the grounds of therapeutic duplication for the same dosage of such prescription drug or drugs and coverage of such prescription drug or drugs was approved.

(4) For any prescription drug, generic or brand name, solely because the dosage of the medication for the insured has been adjusted by the prescriber of such prescription drug.

(5) For any prescription drug, generic or brand name, that is a long-acting injectable antipsychotic.

(6) For any prescription drug, generic or brand name, approved by the federal Food and Drug Administration for the treatment of opioid use disorders.

(b) Any adverse determination for a prescription drug made during the course of prior authorization by a carrier or utilization review organization shall be made by a physician who is in the same specialty as the prescriber of the prescription drug subject to prior authorization, or shall be made by a physician whose specialty focuses on the diagnosis and treatment of the condition for which the prescription drug was prescribed to treat, provided that prior authorization that does not result in an adverse determination shall not require the involvement of a physician on the part of a carrier or utilization review organization.

(c) A carrier or utilization review organization shall not perform retrospective review on any health care services or benefits under the following circumstances:

(1) When payment has already been furnished to the provider of a health care service or benefit unless the carrier or utilization review organization has a credible reason or reasons to

believe that fraud or other illegal activity may have occurred involving such health care service or benefit for which payment has been furnished.

(2) When a health care service or benefit has been previously approved and deemed medically necessary during prior authorization or concurrent review, provided that the carrier or utilization review organization may perform retrospective review if such health care service or benefit was delivered in a manner that exceeded the scope or duration of what was approved during prior authorization or concurrent review

(3) Reviewing approved, paid, or pending claims or authorizations of health care services or benefits for the purposes of informing future utilization review activities shall not be considered a form of retrospective review.

Section 31: (a) Any adverse determination for a prescription drug made during the course of prior authorization shall be eligible for an expedited internal grievance process if the prescriber of the prescription drug subject to the prior authorization believes that, in his or her professional judgment, the insured will suffer serious harm without access to the prescription drug subject to prior authorization.

(b) Upon initiation of the expedited internal grievance process by the prescriber of the prescription drug subject to prior authorization, a carrier or utilization review organization shall render a decision on the expedited internal grievance within 48 hours and provide written notice.

(c) If a carrier or utilization review organization does not render a decision on the expedited internal grievance initiated by the prescriber of the prescription drug subject to prior authorization within 48 hours of initiation, the initial adverse determination shall be

automatically overturned and the insured shall be granted immediate approval for coverage of the prescription drug subject to prior authorization.

(d) The decision rendered during the expedited grievance process by the carrier or utilization review organization shall be made by a physician who is in the same specialty as the prescriber of the prescription drug subject to prior authorization, or shall be made by a physician whose specialty focuses on the diagnosis and treatment of the condition for which the prescription drug was prescribed to treat, but shall not be the same physician that rendered the initial adverse determination for the prescription drug subject to prior authorization.

SECTION 2. Chapter 118E of the General Laws, as appearing in the 2020 official edition, is hereby amended by inserting after section 79 the following 2 sections:-

Section 80: (a) The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization, accountable care organization or primary care clinician plan shall not perform prior authorization on health care services or benefits under the following circumstances:

(1) For generic prescription drugs that are not listed within any of the schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or schedules 1 through 5 of the schedules of controlled substances established under Chapter 94C.

(2) For any prescription drug, generic or brand name, that is not listed within any of the schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or schedules 1 through 5 of the schedules of controlled substances established under Chapter 94C after an enrollee has been prescribed the drug without interruption for six months.

(3) For any prescription drug or drugs, generic or brand name, on the grounds of therapeutic duplication if the enrollee has already been subject to prior authorization on the grounds of therapeutic duplication for the same dosage of such prescription drug or drugs and coverage of such prescription drug or drugs was approved.

(4) For any prescription drug, generic or brand name, solely because the dosage of the medication for the enrollee has been adjusted by the prescriber of such prescription drug.

(5) For any prescription drug, generic or brand name, that is a long-acting injectable antipsychotic.

(6) For any prescription drug, generic or brand name, approved by the federal Food and Drug Administration for the treatment of opioid use disorders.

(b) Any adverse determination for a prescription drug made during the course of prior authorization by the division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization, accountable care organization or primary care clinician plan shall be made by a physician who is in the same specialty as the prescriber of the prescription drug subject to prior authorization, or shall be made by a physician whose specialty focuses on the diagnosis and treatment of the condition for which the prescription drug was prescribed to treat, provided that prior authorization that does not result in an adverse determination shall not require the involvement of a physician on the part of the division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization, accountable care organization or primary care clinician plan.

(c) The division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization, accountable care organization or primary care clinician plan shall not perform retrospective review on any health care services or benefits under the following circumstances:

(1) When payment has already been furnished to the provider of a health care service or benefit unless the division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization, accountable care organization or primary care clinician plan has a credible reason or reasons to believe that fraud or other illegal activity may have occurred involving such health care service or benefit for which payment has been furnished.

(2) When a health care service or benefit has been previously approved and deemed medically necessary during prior authorization or concurrent review, provided that the division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization, accountable care organization or primary care clinician plan may perform retrospective review if such health care service or benefit was delivered in a manner that exceeded the scope or duration of what was approved during prior authorization or concurrent review.

(3) Reviewing approved, paid, or pending claims or authorizations of health care services or benefits for the purposes of informing future utilization review activities shall not be considered a form of retrospective review.

Section 81: (a) Any adverse determination for a prescription drug made during the course of prior authorization shall be eligible for an expedited grievance process if the prescriber of the prescription drug subject to the prior authorization believes that, in his or her professional judgment, the enrollee will suffer serious harm without access to the prescription drug subject to prior authorization.

(b) Upon initiation of the expedited grievance process by the prescriber of the prescription drug subject to prior authorization, the division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization, accountable care organization or primary care clinician plan shall render a decision on the expedited internal grievance within 48 hours and provide written notice.

(c) If the division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization, accountable care organization or primary care clinician plan does not render a decision on the expedited internal grievance initiated by the prescriber of the prescription drug subject to prior authorization within 48 hours of initiation, the initial adverse determination shall be automatically overturned and the enrollee shall be granted immediate approval for coverage of the prescription drug subject to prior authorization.

(d) The decision rendered during the expedited grievance process by the division and its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization, accountable care organization or primary care clinician plan shall be made by a physician who is in the same specialty as the prescriber of the prescription drug subject to prior authorization, or shall be made by a physician whose specialty focuses on the diagnosis and treatment of the condition for which the prescription drug was prescribed to treat, but shall not be the same physician that rendered the initial adverse determination for the prescription drug subject to prior authorization.

SECTION 3. Chapter 32A of the General Laws, as appearing in the 2020 official edition, is hereby amended by inserting after section 30 the following 2 sections:-

Section 31: (a) Coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission shall not include prior authorization on health care services or benefits under the following circumstances:

(1) For generic prescription drugs that are not listed within any of the schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or schedules 1 through 5 of the schedules of controlled substances established under Chapter 94C.

(2) For any prescription drug, generic or brand name, that is not listed within any of the schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or schedules 1 through 5 of the schedules of controlled substances established under Chapter 94C after an insured has been prescribed the drug without interruption for six months.

(3) For any prescription drug or drugs, generic or brand name, on the grounds of therapeutic duplication if the insured has already been subject to prior authorization on the grounds of therapeutic duplication for the same dosage of such prescription drug or drugs and coverage of such prescription drug or drugs was approved.

(4) For any prescription drug, generic or brand name, solely because the dosage of the medication for the insured has been adjusted by the prescriber of such prescription drug.

(5) For any prescription drug, generic or brand name, that is a long-acting injectable antipsychotic.

(6) For any prescription drug, generic or brand name, approved by the federal Food and Drug Administration for the treatment of opioid use disorders.

(b) Any adverse determination for a prescription drug made during the course of prior authorization shall be made by a physician who is in the same specialty as the prescriber of the prescription drug subject to prior authorization, or shall be made by a physician whose specialty focuses on the diagnosis and treatment of the condition for which the prescription drug was prescribed to treat, provided that prior authorization that does not result in an adverse determination shall not require the involvement of a physician.

(c) Coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission shall not include retrospective review on any health care services or benefits under the following circumstances:

(1) When payment has already been furnished to the provider of a health care service or benefit unless there is a credible reason or reasons to believe that fraud or other illegal activity

may have occurred involving such health care service or benefit for which payment has been furnished.

(2) When a health care service or benefit has been previously approved and deemed medically necessary during prior authorization or concurrent review, provided that retrospective review is allowed if such health care service or benefit was delivered in a manner that exceeded the scope or duration of what was approved during prior authorization or concurrent review.

(3) Reviewing approved, paid, or pending claims or authorizations of health care services or benefits for the purposes of informing future utilization review activities shall not be considered a form of retrospective review.

Section 32: (a) Any adverse determination for a prescription drug made during the course of prior authorization shall be eligible for an expedited grievance process if the prescriber of the prescription drug subject to the prior authorization believes that, in his or her professional judgment, the insured will suffer serious harm without access to the prescription drug subject to prior authorization.

(b) Upon initiation of the expedited grievance process by the prescriber of the prescription drug subject to prior authorization, coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission shall render a decision on the expedited internal grievance within 48 hours and provide written notice.

(c) If Coverage offered by the commission to an active or retired employee of the commonwealth insured under the group insurance commission does not render a decision on the expedited internal grievance initiated by the prescriber of the prescription drug subject to prior authorization within 48 hours of initiation, the initial adverse determination shall be

automatically overturned and the insured shall be granted immediate approval for coverage of the prescription drug subject to prior authorization.

(d) The decision rendered during the expedited grievance process shall be made by a physician who is in the same specialty as the prescriber of the prescription drug subject to prior authorization, or shall be made by a physician whose specialty focuses on the diagnosis and treatment of the condition for which the prescription drug was prescribed to treat, but shall not be the same physician that rendered the initial adverse determination for the prescription drug subject to prior authorization.