

SENATE No. 677

The Commonwealth of Massachusetts

PRESENTED BY:

Paul W. Mark

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 prescription-drug utilization review.

PETITION OF:

NAME:

Paul W. Mark

DISTRICT/ADDRESS:

*Berkshire, Hampden, Franklin and
Hampshire*

SENATE No. 677

By Mr. Mark, a petition (accompanied by bill, Senate, No. 677) of Paul W. Mark for legislation relative to prescription-drug utilization review. Financial Services.

The Commonwealth of Massachusetts

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

An Act relative to prescription-drug 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:

1 SECTION 1. Chapter 176O of the General Laws is hereby amended by inserting after
2 section 29 the following 2 sections:-

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

5 (1) For generic prescription drugs that are not listed within any of the schedules of
6 controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or schedules 1 through
7 5 of the schedules of controlled substances established under Chapter 94C.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

62 SECTION 2. Chapter 118E of the General Laws is hereby amended by inserting after
63 section 79 the following 2 sections:-

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

69 (1) For generic prescription drugs that are not listed within any of the schedules of
70 controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or schedules 1 through
71 5 of the schedules of controlled substances established under Chapter 94C.

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

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

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

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

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

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

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

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

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

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

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

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

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

140 health insurers, health plans, health maintenance organizations, behavioral health management
141 firms and third-party administrators under contract to a Medicaid managed care organization,
142 accountable care organization or primary care clinician plan shall be made by a physician who is
143 in the same specialty as the prescriber of the prescription drug subject to prior authorization, or
144 shall be made by a physician whose specialty focuses on the diagnosis and treatment of the
145 condition for which the prescription drug was prescribed to treat, but shall not be the same
146 physician that rendered the initial adverse determination for the prescription drug subject to prior
147 authorization.

148 SECTION 3. Chapter 32A of the General Laws is hereby amended by inserting after
149 section 30 the following 2 sections:-

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

153 (1) For generic prescription drugs that are not listed within any of the schedules of
154 controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or schedules 1 through
155 5 of the schedules of controlled substances established under Chapter 94C.

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

160 (3) For any prescription drug or drugs, generic or brand name, on the grounds of
161 therapeutic duplication if the insured has already been subject to prior authorization on the

162 grounds of therapeutic duplication for the same dosage of such prescription drug or drugs and
163 coverage of such prescription drug or drugs was approved.

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

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

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

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

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

179 (1) When payment has already been furnished to the provider of a health care service or
180 benefit unless there is a credible reason or reasons to believe that fraud or other illegal activity
181 may have occurred involving such health care service or benefit for which payment has been
182 furnished.

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

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

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

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

199 (c) If Coverage offered by the commission to an active or retired employee of the
200 commonwealth insured under the group insurance commission does not render a decision on the
201 expedited internal grievance initiated by the prescriber of the prescription drug subject to prior
202 authorization within 48 hours of initiation, the initial adverse determination shall be
203 automatically overturned and the insured shall be granted immediate approval for coverage of
204 the prescription drug subject to prior authorization.

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