

SENATE No. 1253

The Commonwealth of Massachusetts

PRESENTED BY:

John F. Keenan

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act to remove administrative barriers to behavioral health services.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
<i>John F. Keenan</i>	<i>Norfolk and Plymouth</i>	
<i>Adam J. Scanlon</i>	<i>14th Bristol</i>	<i>1/24/2023</i>
<i>James B. Eldridge</i>	<i>Middlesex and Worcester</i>	<i>3/6/2023</i>

SENATE No. 1253

By Mr. Keenan, a petition (accompanied by bill, Senate, No. 1253) of John F. Keenan, Adam Scanlon and James B. Eldridge for legislation to remove administrative barriers to behavioral health services. Mental Health, Substance Use and Recovery.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. 1295 OF 2021-2022.]

The Commonwealth of Massachusetts

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

An Act to remove administrative barriers to behavioral health services.

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 17S of chapter 32A of the General Laws, as inserted by Chapter
2 177 of the acts of 2022, is hereby amended by striking out subsection (b) and inserting in place
3 thereof the following subsection:-

4 (b) The commission shall provide to any active or retired employee of the
5 commonwealth who is insured under the group insurance commission coverage for medically
6 necessary mental health services within an inpatient psychiatric facility, a community health
7 center, a community behavioral health center, a community mental health center, an outpatient
8 substance use disorder provider, a hospital outpatient department, a community based acute
9 treatment program or an intensive community based acute treatment program and shall not
10 require a preauthorization before obtaining treatment; provided, however, that the facility shall

11 notify the carrier of the admission and the initial treatment plan not more than three business
12 days of admission; provided further, that notification shall be limited to patient's name, facility
13 name, time of admission, diagnosis and initial treatment plan; and, provided further, that services
14 administered prior to notification must be covered. Medical necessity shall be determined by the
15 treating clinician in consultation with the patient and noted in the member's medical record.

16 SECTION 2. Section 100 of chapter 118E of the General Laws, as so appearing, is
17 hereby amended by striking out the last paragraph and inserting in place thereof the following
18 new paragraph:-

19 The division and its contracted health insurers, health plans, health maintenance
20 organizations, behavioral health management firms and third-party administrators under contract
21 to a Medicaid managed care organization or primary care clinician plan shall cover the cost of
22 medically necessary mental health services within an inpatient psychiatric facility, a community
23 health center, a community mental health center, a community behavioral health center, an
24 outpatient substance use disorder provider, a hospital outpatient department, a community based
25 acute treatment program or an intensive community based acute treatment program and shall not
26 require a preauthorization before obtaining treatment; provided, however, that the facility shall
27 notify the carrier of the admission and the initial treatment plan within three business days of
28 admission; provided further, that notification shall be limited to patient's name, facility name,
29 time of admission, diagnosis and initial treatment plan; and, provided further, that services
30 administered prior to notification must be covered. Medical necessity shall be determined by the
31 treating clinician in consultation with the patient and noted in the member's medical record.

32 SECTION 3. Section 24B of chapter 175 of the General Laws, as appearing in the 2020
33 Official Edition, is hereby amended by inserting after the first paragraph the following
34 paragraph:

35 A carrier, as defined in section 1 of chapter 176O, shall be required to pay for health care
36 services ordered by the treating health care provider if (1) the services are a covered benefit
37 under the insured's health benefit plan and (2) the services follow the carrier's clinical review
38 criteria; provided, however, a claim for treatment of medically necessary services may not be
39 denied if the treating health care provider follows the carrier's approved method for securing
40 authorization for a covered service for the insured at the time the service was provided. A carrier
41 shall have no more than twelve months after the original payment was received by the provider
42 to recoup a full or partial payment for a claim for services rendered, or to adjust a subsequent
43 payment to reflect a recoupment of a full or partial payment; provided, however, a carrier shall
44 not recoup payments more than ninety days after the original payment was received by a
45 provider for services provided to an insured that the carrier deems ineligible for coverage
46 because the insured was retroactively terminated or retroactively disenrolled for services;
47 provided further, that the provider can document that it received verification of an insured's
48 eligibility status using the carrier's approved method for verifying eligibility at the time service
49 was provided. Claims may also not be recouped for utilization review purposes if the services
50 were already deemed medically necessary or the manner in which the services were accessed or
51 provided were previously approved by the carrier or its contractor. A carrier that seeks to make
52 an adjustment pursuant to this section shall provide the health care provider with written notice
53 that explains in detail the reasons for the recoupment, identifies each previously paid claim for
54 which a recoupment is sought and provides the health care provider with thirty days to challenge

55 the request for recoupment. Such written notice shall be made to the health provider not less than
56 thirty days prior to the seeking of a recoupment or the making of an adjustment.

57 SECTION 4. Section 47SS of chapter 175 of the General Laws, as inserted by chapter
58 177 of the acts of 2022, is hereby amended by striking out subsection (b) and inserting in place
59 thereof the following subsection:-

60 (b) A policy, contract, agreement, plan or certificate of insurance issued, delivered or
61 renewed within or without the commonwealth, which is considered creditable coverage under
62 section 1 of chapter 111M, shall provide coverage for medically necessary mental health services
63 within an inpatient psychiatric facility, a community health center, a community mental health
64 center, a community behavioral health center, an outpatient substance use disorder provider, a
65 hospital outpatient department, a community based acute treatment program or an intensive
66 community based acute treatment program and shall not require a preauthorization before the
67 administration of such treatment; provided, however, that the facility shall notify the carrier of
68 the admission and the initial treatment plan within three business days of admission; provided
69 further, that notification shall be limited to patient's name, facility name, time of admission,
70 diagnosis and initial treatment plan; and, provided further, that services administered prior to
71 notification must be covered. Medical necessity shall be determined by the treating clinician in
72 consultation with the patient and noted in the patient's medical record.

73 SECTION 5. Section 8SS of chapter 176A of the General Laws, as inserted by chapter
74 177 of the acts of 2022, is hereby amended by striking out subsection (b) and inserting in place
75 thereof the following subsection:-

76 (b) A contract between a subscriber and the corporation under an individual or group
77 hospital service plan that is delivered, issued or renewed within the commonwealth shall provide
78 coverage for medically necessary mental health services within an inpatient psychiatric facility, a
79 community health center, a community mental health center, an outpatient substance use disorder
80 provider, a hospital outpatient department, a community based acute treatment program or an
81 intensive community based acute treatment program and shall not require a preauthorization
82 before the administration of any such treatment; provided, however, that the facility shall notify
83 the carrier of the admission and the initial treatment plan within three business days of
84 admission; provided further, that notification shall be limited to patient's name, facility name,
85 time of admission, diagnosis and initial treatment plan; and, provided further, that services
86 administered prior to notification must be covered. Medical necessity shall be determined by the
87 treating clinician in consultation with the patient and noted in the patient's medical record.

88 SECTION 6. Section 4SS of chapter 176B of the General Laws, as inserted by chapter
89 177 of the acts of 2022, is hereby amended by striking out subsection (b) and inserting in place
90 thereof the following subsection:-

91 (b) A subscription certificate under an individual or group medical service agreement
92 delivered, issued or renewed within the commonwealth shall provide coverage for medically
93 necessary mental health services within an inpatient psychiatric facility, a community health
94 center, a community mental health center, an outpatient substance use disorder provider, a
95 hospital outpatient department, a community based acute treatment program or an intensive
96 community based acute treatment program and shall not require a preauthorization before
97 obtaining treatment; provided, however, that the facility shall notify the carrier of the admission
98 and the initial treatment plan within three business days of admission; provided further, that

99 notification shall be limited to patient's name, facility name, time of admission, diagnosis and
100 initial treatment plan; and, provided further, that services administered prior to notification must
101 be covered. Medical necessity shall be determined by the treating clinician in consultation with
102 the patient and noted in the patient's medical record.

103 SECTION 7. Section 4KK of chapter 176G of said General Laws, as inserted by chapter
104 177 of the acts of 2022, is hereby amended by striking out subsection (b) and inserting in place
105 thereof the following subsection:-

106 (b) An individual or group health maintenance contract that is issued or renewed within
107 or without the commonwealth shall provide coverage for medically necessary mental health
108 services within an inpatient psychiatric facility, a community health center, a community mental
109 health center, an outpatient substance use disorder provider, a hospital outpatient department, a
110 community based acute treatment program, or an intensive community based acute treatment
111 program and shall not require a preauthorization before obtaining treatment; provided, however,
112 that the facility shall notify the carrier of the admission and the initial treatment plan within three
113 business days of admission; provided further, that notification shall be limited to patient's name,
114 facility name, time of admission, diagnosis and initial treatment plan; and, provided further, that
115 services administered prior to notification must be covered. Medical necessity shall be
116 determined by the treating clinician in consultation with the patient and noted in the patient's
117 medical record.