HOUSE DOCKET, NO. 605 FILED ON: 1/13/2023

HOUSE . . . . . No. 1145

The Commonwealth of Massachusetts

PRESENTED BY:

Adam Scanlon and Kate Donaghue

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 removing barriers to behavioral health services.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Adam Scanlon	*14th Bristol*	*1/13/2023*
Kate Donaghue	*19th Worcester*	*1/17/2023*
Bud L. Williams	*11th Hampden*	*1/20/2023*
Patrick Joseph Kearney	*4th Plymouth*	*2/16/2023*

HOUSE DOCKET, NO. 605 FILED ON: 1/13/2023

HOUSE . . . . . No. 1145

By Representatives Scanlon of North Attleborough and Donaghue of Westborough, a petition (accompanied by bill, House, No. 1145) of Adam Scanlon, Kate Donaghue and others relative to healthcare insurance coverage for certain behavioral health services. Financial Services.

The Commonwealth of Massachusetts

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

An Act removing 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:

SECTION 1. Section 17S of chapter 32A of the General Laws, as inserted by chapter 177 of the acts of 2022, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection: -

(b) The commission shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage for medically necessary mental health services within an inpatient psychiatric facility, a community health center, a community behavioral health center, a community mental health center, an outpatient substance use disorder provider, a hospital outpatient department, a community based acute treatment program, or an intensive community based acute treatment program and shall not require a preauthorization before obtaining treatment; provided, however, that the facility shall notify the carrier of the admission and the initial treatment plan not more than three business days of admission; provided further that notification shall be limited to patient's name, facility

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

SECTION 2. Section 10O of chapter 118E of the General Laws, as so appearing, is hereby amended by striking out the last paragraph and inserting in place thereof the following new paragraph:-

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 or primary care clinician plan shall cover the cost of medically necessary mental health services within an inpatient psychiatric facility, a community health center, a community mental health center, a community behavioral health center, an outpatient substance use disorder provider, a hospital outpatient department, a community based acute treatment program, or an intensive community based acute treatment program and shall not require a preauthorization before obtaining treatment; provided, however, that the facility shall notify the carrier of the admission and the initial treatment plan within three business days of admission; provided further that notification shall be limited to patient's name, facility name, time of admission, diagnosis, and initial treatment plan; and provided further that services administered prior to notification must be covered. Medical necessity shall be determined by the treating clinician in consultation with the patient and noted in the member's medical record.

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

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

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

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

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

(b) A contract between a subscriber and the corporation under an individual or group hospital service plan that is delivered, issued or renewed within the commonwealth shall provide coverage for medically necessary mental health services within an inpatient psychiatric facility, a

community health center, a community mental health center, an outpatient substance use disorder provider, a hospital outpatient department, a community based acute treatment program, or an intensive community based acute treatment program and shall not require a preauthorization before the administration of any such treatment; provided, however, that the facility shall notify the carrier of the admission and the initial treatment plan within three business days of admission; provided further that notification shall be limited to patient's name, facility name, time of admission, diagnosis, and initial treatment plan; and provided further that services administered prior to notification must be covered. Medical necessity shall be determined by the treating clinician in consultation with the patient and noted in the patient's medical record.

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

(b) A subscription certificate under an individual or group medical service agreement delivered, issued or renewed within the commonwealth shall provide coverage for medically necessary mental health services within an inpatient psychiatric facility, a community health center, a community mental health center, an outpatient substance use disorder provider, a hospital outpatient department, a community based acute treatment program, or an intensive community based acute treatment program and shall not require a preauthorization before obtaining treatment; provided, however, that the facility shall notify the carrier of the admission and the initial treatment plan within three business days of admission; provided further that notification shall be limited to patient's name, facility name, time of admission, diagnosis, and initial treatment plan; and provided further that services administered prior to notification must

be covered. Medical necessity shall be determined by the treating clinician in consultation with the patient and noted in the patient's medical record.

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

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