SENATE DOCKET, NO. 2231 FILED ON: 1/20/2023

SENATE . . . . . No. 1249

The Commonwealth of Massachusetts

PRESENTED BY:

Cindy F. Friedman

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 reducing administrative burden.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Cindy F. Friedman	*Fourth Middlesex*

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SENATE . . . . . No. 1249

By Ms. Friedman, a petition (accompanied by bill, Senate, No. 1249) of Cindy F. Friedman for legislation relative to reducing administrative burden. Mental Health, Substance Use and Recovery.

The Commonwealth of Massachusetts

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

An Act relative to reducing administrative burden.

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 18 of chapter 15A of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by adding the following paragraphs:-

Any qualifying student health insurance plan authorized under this chapter shall adopt utilization review criteria and conduct all utilization review activities under the criteria and in compliance with this section. The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians. Utilization review criteria, including detailed preauthorization requirements and clinical review criteria, shall be applied consistently and made easily accessible and up-to-date on a website by the institutions of higher education or any entity that provides or manages health insurance benefits and to the general public in a searchable electronic format; provided, however, that the institutions of higher education or any entity that contracts to provide or manage health insurance benefits shall not be required to disclose licensed, proprietary criteria purchased by a carrier or

utilization review organization on its website, but shall disclose the licensed, proprietary criteria relevant to particular treatments and services to students and their dependents and health care providers upon request. If the institution of higher education or an entity with which the institution of higher education contracts to provide or manage health insurance benefits intends either to implement a new preauthorization requirement or restriction or amend an existing requirement or restriction, the new or amended requirement or restriction shall not be implemented unless: (i) the appropriate website has been updated to reflect the new or amended requirement or restriction; (ii) students of the institutions of higher education who are affected, and their dependents, are notified of the changes by electronic means via email and any applicable online member portal, or for those without access to electronic means of communication, by mail; and (iii) the institutions of higher education or entity which that contracts to provide or manage health insurance benefits has processes in place to ensure continuation of any previously approved preauthorizations.

The institutions of higher education or any entity that contracts to provide or manage health insurance benefits under this section shall not retrospectively deny authorization for an admission, procedure, treatment, service, or course of medication when an authorization has already been approved for that service unless the approval was based upon fraudulent information material to the review.

SECTION 2. Chapter 26 of the General Laws, as most recently amended by section 23 of chapter 177 of the acts of 2022, is hereby amended by inserting after section 8M the following section:-

8N. (a) All carriers licensed under chapters 175, 176A, 176B and 176G that provide medical or prescription drug benefits subject to utilization review consistent with section 12 of chapter 176O, or any other entity that manages or administers such benefits for the carrier, including a utilization review organization as defined in section 1 of said chapter 176O, shall report annually, not later than July 1, to the division, in a format prescribed by the division:

(i) a list of all admission, items, services, treatments, procedures, and medications that require prior authorization;

(ii) the number and percentage of standard prior authorization requests that were approved, individualized for each admission, item, service, treatment, procedure, and medication;

(iii) the number and percentage of standard prior authorization requests that were denied, individualized for each admission, item, service, treatment, procedure, and medication;

(iv) the number and percentage of standard prior authorization requests that were initially denied and approved after appeal, individualized for each admission, item, service, treatment, procedure, and medication;

(v) the number and percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, individualized for each admission, item, service, treatment, procedure, and medication;

(vi) the number and percentage of expedited prior authorization requests that were approved, individualized for each admission, item, service, treatment, procedure, and medication;

(vii) the number and percentage of expedited prior authorization requests that were denied, individualized for each admission, item, service, treatment, procedure, and medication;

(viii) the average and median time that elapsed between the submission of a request and a determination by the payer, plan, or issuer, for standard prior authorizations, individualized for each admission, item, service, treatment, procedure, and medication; and

(ix) the average and median time that elapsed between the submission of a request and a decision by the payer, plan or issuer, for expedited prior authorizations, individualized for each admission, item, service, treatment, procedure, and medication;

(x) the average and median time that elapsed to process an appeal submitted by a health care provider initially denied by the payer, plan, or issuer, for standard prior authorizations, individualized for each admission, item, service, treatment, procedure, and medication; and

(xi) the average and median time that elapsed to process an appeal submitted by a health care provider initially denied by the payer, plan or issuer, for expedited prior authorizations, individualized for each admission, item, service, treatment, procedure, and medication.

(b) Annually, not later than December 1, the commissioner shall submit a summary of the reports, including all data submitted, that the commissioner receives from each carrier, or any other entity that manages or administers such benefits for the carrier, under subsection (a) to the clerks of the senate and house of representatives, the joint committee on health care financing, the center for health information and analysis, and the health policy commission. The commissioner shall make publicly available, through its website or alternative means, the submitted data, including a listing of all items, services, treatments, procedures, or medications

subject to prior authorization by each individual carrier. The commissioner shall direct each carrier to make said data available through the carrier's website.

(c) The division shall promulgate rules and regulations necessary to implement this section.

SECTION 3. Chapter 32A of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by inserting after section 4B the following section:-

Section 4C. The commission or an entity with which the commission contracts to provide or manage health insurance benefits, shall adopt utilization review criteria and conduct all utilization review activities under the criteria and in compliance with this section. The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians. Utilization review criteria, including detailed preauthorization requirements and clinical review criteria, shall be applied consistently and made easily accessible and up-to-date on a website by the commission or any entity with which the commission contracts to provide or manages health insurance benefits and to the general public in a searchable electronic format; provided, however, that the commission or an entity with which the commission contracts to provide or manage health insurance benefits shall not be required to disclose licensed, proprietary criteria purchased by a carrier or utilization review organization on its website, but shall disclose such licensed, proprietary criteria relevant to particular treatments and services to active or retired employees of the commonwealth and their dependents and health care providers upon request. If the commission or an entity with which the commission contracts to provide or manage health insurance benefits intends either to implement a new preauthorization requirement or restriction or amend an existing requirement or

restriction, the new or amended requirement or restriction shall not be implemented unless: (i) the appropriate website has been updated to reflect the new or amended requirement or restriction; (ii) active or retired employees of the commonwealth and their dependents who are affected are notified of the changes by electronic means via email and any applicable online member portal, or for those without access to electronic means of communication, by mail; and (iii) the commission or an entity with which the commission contracts to provide or manage health insurance benefits has processes in place to ensure continuation of any previously approved preauthorizations.

The commission or an entity with which the commission contracts to provide or manage health insurance benefits shall not retrospectively deny authorization for an admission, procedure, treatment, service, or course of medication when an authorization has already been approved for that service unless the approval was based upon fraudulent information material to the review.

SECTION 4. Section 24B of chapter 175 of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by adding the following paragraphs:-

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, that 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 not deny payment for a claim for medically necessary covered services on the basis of an administrative or technical defect in the claim except in the case where the carrier has a reasonable basis, supported by specific information available for review, that the claim for health care services rendered was submitted fraudulently. A carrier shall have no more than 1 year after the original payment was received by the health care 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. Claims may 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.

SECTION 5. Subsection (a) of section 12 of chapter 176O of the General Laws, as appearing in the 2020 Official Edition, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-

A carrier or utilization review organization shall adopt utilization review criteria and conduct all utilization review activities under the criteria and in compliance with this section. The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians, consistent with the development of medical necessity criteria under section 16. Utilization review criteria, including detailed preauthorization requirements and clinical review criteria, shall be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website and to the general public in a searchable electronic format; provided, however, that a carrier shall not be required to disclose licensed, proprietary criteria purchased by a carrier or utilization review organization on its website, but shall disclose such licensed, proprietary criteria relevant to particular treatments and services to insureds,

prospective insureds and health care providers upon request. If a carrier or utilization review organization intends either to implement a new preauthorization requirement or restriction or amend an existing requirement or restriction, the carrier or utilization review organization shall ensure that the new or amended requirement or restriction shall not be implemented unless: (i) the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction; (ii) insureds who are affected are notified of the changes by electronic means via email and any applicable online member portal, or for those without access to electronic means of communication, by mail; and (iii) the carrier or utilization review organization has processes in place to ensure continuation of any previously approved preauthorizations.

SECTION 6. Said subsection (a) of said section 12 of said chapter 176O, as so appearing, is hereby further amended by inserting after the third paragraph the following paragraphs:-

A carrier or utilization review organization shall not retrospectively deny authorization for an admission, procedure, treatment, service, or course of medication when an authorization has already been approved for that service unless the approval was based upon fraudulent information material to the review.

A carrier or utilization review organization shall accept and respond to utilization review requests made through secure electronic transmissions, using the mandated standards for prior authorization adopted under the federal Health Insurance Portability and Accountability Act standard electronic transactions for pharmacy and medical services benefits or standards compatible therewith. A carrier or utilization review organization shall adopt and implement an HL7 Fast Healthcare Interoperability Resources Application Programming Interface that would

work in combination with or is compatible with the adopted Health Insurance Portability and Accountability Act transaction standard to conduct the prior authorization process, including the National Council for Prescription Drug Programs Telecommunication Standard Implementation Guide Version D.0 for retail pharmacy drugs and the ASC X12N 278 Health Care Service Review Request for Review and Response transactions for medical services benefits.

SECTION 7. Subsection (b) of said section 12 of said chapter 176O of the General Laws, as so appearing, is hereby amended by inserting after the word “information”, in line 38, the following words:-

; provided, however, that if additional delay would result in significant risk to the enrollee’s health or well-being, a carrier or a utilization review organization shall respond not more than 24 hours following the receipt of all necessary information.

SECTION 8. Said section 12 of said chapter 176O, as so appearing, is further amended by adding after subsection (f) the following subsections:-

(g) For an insured member who is stable on a treatment, service or course of medication as determined by a health care provider and approved for coverage by a previous carrier or health benefit plan, a carrier or utilization review organization shall not restrict coverage of such treatment, service, or course of medication for at least 90 days upon the insured member’s enrollment.

(h) Preauthorization approval for a prescribed treatment, service, or course of medication shall be valid for the duration of a prescribed or ordered course of treatment, or at least 1 year.

SECTION 9. Section 25 of said chapter 176O, as so appearing, is hereby amended by striking subsection (e) and inserting in place thereof the following subsection:-

(e) The division, in developing the forms, shall:

(1) ensure that the forms are consistent with existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services; and

(2) consider other national standards pertaining to electronic prior authorization.

SECTION 10. (a) Notwithstanding any general or special law to the contrary, the health policy commission, in collaboration with the center for health information and analysis and the division of insurance, shall conduct an analysis of and issue a report on the use of utilization management tools, including prior authorization, and the effect on patient access to care, administrative burden on health care providers, and system cost. In developing the report, the commission shall consult with members of the Massachusetts Collaborative, the executive office of health and human services, health care providers and payers, and other health care experts as appropriate.

(b) The report shall include, but not be limited to: (i) a review and analysis of the prior authorization data collected by the division of insurance under section 8N of chapter 26 of the General Laws; (ii) total health care expenditures associated with the submission and processing, including appeals, of prior authorization determinations; (iii) an analysis of the impact of prior authorization requirements on patient access to and cost of care by patient demographics, geographic region and type of service; (iv) identification of admissions, items, services, treatments, procedures, and medications subject to prior authorization that have low variation in utilization across providers and carriers or low denial rates across carriers; (v) identification of

admissions, items, services, treatments, procedures, and medications subject to prior authorization for certain chronic disease services that negatively impact chronic disease management; (vi) review and analysis of the integration of standardized electronic prior authorization attachments, standardized forms, requirements and decision support into electronic health records and other practice management software to promote transparency and efficiency; and (vii) recommendations regarding the simplification of health insurance prior authorization standards and processes to improve health care access and reduce the burden on health care providers.

(c) The report, along with a suggested plan to implement its recommendations in order to maximize health care access, quality of care and reduction of administrative burden on health care providers, shall be submitted to the chairs of the joint committee on health care financing, the house and senate committees on ways and means, and the commissioner of the division of insurance, not later than 1 year from the effective date of this act.

SECTION 11. Notwithstanding any general or special law to the contrary, the division of insurance shall develop and implement rules, regulations, bulletins or other guidance that prohibit carriers from imposing prior authorization requirements for any generic medication or on all admissions, items, services, treatments, procedures, and medications that have: (i) low variation in utilization across health care providers; (ii) low denial rates across carriers; and (iii) an evidence-base for the treatment or management of certain chronic diseases. In developing the rules, regulations, bulletins or other guidance, the division shall rely on data submitted by the carriers and shall consult with the health policy commission, including the commission’s report and analysis relative to prior authorization required by Section 10 on this act.

SECTION 12. Notwithstanding any general or special law to the contrary, the division of insurance shall develop and implement a comprehensive set of uniform prior authorization forms for different health care services and benefits, as required by section 25 of chapter 176O of the General Laws, not later than 6 months after the effective date of this act.

SECTION 13. The rules and regulations required by subsection (c) of section 8N of chapter 26 of the General Laws shall be promulgated not later than 6 months after the effective date of this act.

SECTION 14. Sections 1, 2, 3, 4, 5, 7, and 8 shall take effect July 1, 2024.

SECTION 15. Section 6 shall take effect January 1, 2026.

SECTION 16. Section 9 shall take effective immediately upon passage.