SENATE DOCKET, NO. 1785 FILED ON: 2/18/2021

SENATE . . . . . No. 645

The Commonwealth of Massachusetts

PRESENTED BY:

John Cronin

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 for Medical Necessity Fairness.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
John Cronin	*Worcester and Middlesex*	
Michael P. Kushmerek	*3rd Worcester*	
Meghan Kilcoyne	*12th Worcester*	
Susannah M. Whipps	*2nd Franklin*	*2/26/2021*
Paul A. Schmid, III	*8th Bristol*	*3/5/2021*
Joanne M. Comerford	*Hampshire, Franklin and Worcester*	*3/31/2021*
Adam G. Hinds	*Berkshire, Hampshire, Franklin and Hampden*	*4/2/2021*
John C. Velis	*Second Hampden and Hampshire*	*4/9/2021*

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SENATE . . . . . No. 645

By Mr. Cronin, a petition (accompanied by bill, Senate, No. 645) of John Cronin, Michael P. Kushmerek, Meghan Kilcoyne, Susannah M. Whipps and other members of the General Court for legislation relative to medical necessity fairness. Financial Services.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Second General Court
(2021-2022)

An Act for Medical Necessity Fairness.

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 16 of chapter 176O, as so appearing, is amended by striking subsection (b), and replacing it with the following:-

(b) A carrier shall be required to pay for health care services ordered by a treating physician or a primary care provider if: (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary. Except as otherwise required under subsections (d) and (e) of this section, a carrier may develop guidelines to be used in applying the standard of medical necessity, as defined in this subsection. Any such medical necessity guidelines utilized by a carrier in making coverage determinations shall be: (i) developed in accordance with the requirements under this section; (ii) developed with input from practicing physicians and participating providers in the carrier's or utilization review organization's service area; (ii) developed under the standards adopted by national accreditation organizations; (iii) updated at least biennially or more often as new treatments, applications and

technologies are adopted as generally accepted professional medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier shall consider the individual health care needs of the insured. Any such medical necessity guidelines 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 to insureds, prospective insureds and health care providers consistent with subsection (a) of section 12. If a carrier or utilization review organization intends either to implement a new medical necessity guideline 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 the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction.

SECTION 2. Section 16 of said chapter 176O, as so appearing, is hereby further amended by adding the following subsection:-

(d) Medical necessity and utilization management determinations for treatments for substance use disorder or co-occurring mental illness and substance use disorder shall be made in accordance with the level of care placement criteria and practice guidelines established by the American Society of Addiction Medicine, or by any comparable current criteria and practice guidelines developed by a comparable nonprofit professional association for the relevant clinical specialty of addiction medicine, if available, including age group specific guidelines for children, adolescents and young adults, if available. No additional criteria may be used to make medical necessity or utilization management determinations for treatments for substance use disorder or

co-occurring mental illness and substance use disorder, unless such criteria are less restrictive. A carrier, or any entity that manages or administers mental health and substance use disorder benefits for the carrier, shall not deny authorization or coverage for treatment for substance use disorder or co-occurring mental illness and substance use disorder on the basis that such treatment was authorized or ordered by a court of law or other law enforcement agency. Such authorization shall be considered a factor in support of coverage for such treatment, including as allowed under clause (4) of subsection (a) of section 6 and clause (7) of subsection (a) of section 7. Nothing in this section shall be construed to affect the authority of the treating clinician to determine medical necessity as provided under section 47GG of chapter 175, section 8II of chapter 176A, section 4LL of chapter 176B, or section 4AA of chapter 176G.

SECTION 3: Section 16 of chapter 176O, as so appearing, is hereby further amended by adding the following subsections:-

(e) Appropriate medical necessity standards for behavioral health condition services

(1) Definitions. The following definitions apply for purposes of this subsection:

(i) "Generally accepted standards of behavioral health condition care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health and substance use disorder care include

peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including but not limited to patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(ii) "Medically necessary treatment of a behavioral health condition" means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(A) In accordance with the generally accepted standards of mental health and substance use disorder care.

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(C) Not primarily for the economic benefit of the carrier, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

(iii) "Behavioral health condition " means a mental health condition, developmental disorder or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World

Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this subsection as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(iv) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.

(v) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a carrier to conduct utilization review.

(2) Coverage for medically necessary behavioral health condition Services

(ii) A carrier shall not limit benefits or coverage for chronic or pervasive behavioral health conditions to short-term or acute treatment at any level of care placement.

(iii) All medical necessity determinations made by the carrier concerning service intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed

with behavioral health conditions shall be conducted in accordance with the requirements of this subsection.

(iv) A carrier shall not limit benefits or coverage for medically necessary services for behavioral health conditions on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, a special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(v) A carrier shall not deny authorization or coverage for treatment for substance use disorder or co-occurring mental illness and substance use disorder on the basis that such treatment was authorized or ordered by a court of law or other law enforcement agency, except to the extent that such treatment is for an incarcerated person with access to coverage from public programs.

(vi) A carrier shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this subsection.

(3) Medical necessity determinations must follow generally accepted standards

(i) Carriers shall base any medical necessity determination or the utilization review criteria that the carrier, and any entity acting on the carrier's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and

treatment of behavioral health conditions on current generally accepted standards of behavioral health condition care as defined in this subsection.

(ii) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of behavioral health conditions in children, adolescents, and adults, a carrier shall apply the level of care placement criteria and practice guidelines set forth in the most recent versions of such criteria and practice guidelines developed by the nonprofit professional association for the relevant clinical specialty, if available, including age group specific guidelines for children, adolescents and young adults, if available.

(iii) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in this subsection, a carrier shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. For all level of care placement decisions, the insurer shall authorize placement at the level of care consistent with the insured's score using the relevant level of care placement criteria and guidelines as specified in this subsection. If that level of placement is not available, the insurer shall authorize the next higher level of care. In the event of disagreement, the carrier shall provide full detail of its scoring using the relevant level of care placement criteria and guidelines as specified in this subsection to the provider of the service.

(iv) A carrier shall not deny authorization or coverage for a service to treat a chronic behavioral health condition on the basis that the service will not cure the condition, and a carrier shall approve services that are appropriate to prevent a chronic behavioral health condition from deteriorating.

(4) Implementation. To ensure the proper use of the criteria described in this subsection, every carrier shall do all of the following in relation to behavioral health conditions:

(i) Sponsor a formal education program by nonprofit clinical specialty associations to educate the carrier's staff, including any third parties contracted with the insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(ii) Make the education program available to other stakeholders, including the carrier's participating providers and covered lives.

(iii) Provide, at no cost, the clinical review criteria and any training material or resources to providers and insured patients.

(iv) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(v) Conduct interrater reliability testing to ensure consistency in utilization review decision making covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review for behavioral health conditions as defined in this subsection

(vi) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and mental health parity compliance activities.

(vii) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(5) Enforcement

(i) This subsection applies to all health care services and benefits for the diagnosis, prevention, and treatment and management of behavioral health conditions covered by a carrier, including prescription drugs.

(ii) This subsection applies to carriers that conduct utilization review for behavioral health conditions as defined in this subsection, and any entity or contracting provider that performs utilization review or utilization management functions for behavioral health conditions on a carrier's behalf.

(iii) If the commissioner determines that a carrier or other entity has violated this subsection, the commissioner may, after appropriate notice and opportunity for hearing in accordance with the procedural requirements of subsections a through c of section 3 of chapter 176O, by order, assess a civil penalty not to exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each violation. The civil penalties available to the commissioner pursuant to this subsection are not exclusive and may be sought and employed in combination with any other remedies available to the commissioner under this code.

(iv) If, after said hearing the commissioner of insurance determines that noncompliance has been substantiated, the commissioner shall have the authority to investigate whether any insureds were denied access or coverage due to a violation of this subsection, and to issue an

order a carrier to implement a corrective action plan and timeline to require the carrier to cover any services that were denied due to a violation of this subsection. In the event that an inappropriate denial by a carrier led an insured to seek treatment at an out-of-network provider, the carrier may be ordered to indemnify the insured for their costs.

(v) A carrier shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this subsection.

(6) Discretionary Clauses Prohibited

(i) If a contract offered, issued, delivered, amended, or renewed on or after January 1, 2022, by a carrier contains a provision that reserves discretionary authority to the carrier, or an agent of the carrier, to determine eligibility for benefits or coverage, to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

(ii) For purposes of this subsection, the term “discretionary authority” means a contract provision that has the effect of conferring discretion on a carrier or other claims administrator to determine entitlement to benefits or interpret contract language that, in turn, could lead to a deferential standard of review by a reviewing court.

(iii) This subsection does not prohibit a carrier from including a provision in a contract that informs an insured that, as part of its routine operations, the plan applies the terms of its contracts for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures, and processes, so long as the provision could not give rise to a deferential standard of review by a reviewing court.

SECTION 4. Chapter 118E as so appearing is hereby amended by adding the following two sections:-

Section 79. Mental necessity for substance use disorder or co-occurring conditions. (a) Medical necessity and utilization management determinations for treatments for substance use disorder or co-occurring mental illness and substance use disorder shall be made in accordance with the level of care placement criteria and practice guidelines established by the American Society of Addiction Medicine, or by any comparable current criteria and practice guidelines developed by a comparable nonprofit professional association for the relevant clinical specialty of addiction medicine, if available, including age group specific guidelines for children, adolescents and young adults, if available. No additional criteria may be used to make medical necessity or utilization management determinations for treatments for substance use disorder or co-occurring mental illness and substance use disorder, unless such criteria are less restrictive. A carrier, or any entity that manages or administers mental health and substance use disorder benefits for the carrier, shall not deny authorization or coverage for treatment for substance use disorder or co-occurring mental illness and substance use disorder on the basis that such treatment was authorized or ordered by a court of law or other law enforcement agency. Such authorization shall be considered a factor in support of coverage for such treatment, including as allowed under clause (4) of subsection (a) of section 6 and clause (7) of subsection (a) of section 7.

Section 80. (a) Appropriate medical necessity standards for behavioral health condition services

(1) Definitions. The following definitions apply for purposes of this section:

(i) "Generally accepted standards of behavioral health condition care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including but not limited to patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(ii) "Medically necessary treatment of a behavioral health condition" means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(A) In accordance with the generally accepted standards of mental health and substance use disorder care.

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(C) Not primarily for the economic benefit of the carrier, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

(iii) “Behavioral health condition ” means a mental health condition, developmental disorder or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(iv) “Utilization review” means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.

(v) “Utilization review criteria” means any criteria, standards, protocols, or guidelines used by a carrier to conduct utilization review.

(2) Coverage for medically necessary behavioral health condition Services. The division, its managed care organizations, accountable care organizations or other entity contracting with the division to manage or administer behavioral health condition services:

(i) Shall not limit benefits or coverage for chronic or pervasive behavioral health conditions to short-term or acute treatment at any level of care placement.

(iii) Shall make all medical necessity determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed with behavioral health conditions shall be conducted in accordance with the requirements of this section.

(iv) Shall not limit benefits or coverage for medically necessary services for behavioral health conditions on the basis that those services should be or could be covered by another public entitlement program, including, but not limited to, a special education or an individualized education program, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(v) Shall not deny authorization or coverage for treatment for substance use disorder or co-occurring mental illness and substance use disorder on the basis that such treatment was authorized or ordered by a court of law or other law enforcement agency, except to the extent that such treatment is for an incarcerated person with access to coverage from public programs.

(vi) Shall not adopt, impose, or enforce terms in any health plan coverage policy or provider agreement, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(3) Medical Necessity Determinations Must Follow Generally Accepted Standards. The division, its managed care organizations, accountable care organizations or other entity contracting with the division to manage or administer behavioral health condition services:

(i) Shall base any medical necessity determination or the utilization review decision for the diagnosis, prevention, and treatment of behavioral health conditions on current generally accepted standards of behavioral health condition care as defined in this section.

(ii) Shall apply the level of care placement criteria and practice guidelines set forth in the most recent versions of such criteria and practice guidelines developed by the nonprofit professional association for the relevant clinical specialty, if available, including age group specific guidelines for children, adolescents and young adults, if available.

(iii) Shall not apply different, additional, conflicting, or more restrictive utilization review criteria when conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in this section.

(iv) Shall authorize placement at the level of care consistent with the insured's score using the relevant level of care placement criteria and guidelines as specified in this section., however if that level of placement is not available, the next higher level of care shall be authorized.

(v) Shall, in the event of a disagreement with a treating provider, furnish the provider with the full detail of its scoring using the relevant level of care placement criteria and guidelines as specified in this section.

(iv) Shall not deny authorization or coverage for a service to treat a chronic behavioral health condition on the basis that the service will not cure the condition, and a carrier shall approve services that are appropriate to prevent a chronic behavioral health condition from deteriorating.

(4) Implementation. To ensure the proper use of the criteria described in this section, the division, its managed care organizations, accountable care organizations or other entity contracting with the division to manage or administer behavioral health condition services shall do all of the following in relation to authorization and utilization of behavioral health condition services:

(i) Sponsor a formal education program by nonprofit clinical specialty associations to educate utilization review and appeals staff (including any third parties contracted to review claims, conduct utilization reviews, or make medical necessity determinations) about the clinical review criteria.

(ii) Make the education program available to other stakeholders, including the participating providers, advocates and covered members.

(iii) Provide, at no cost, the clinical review criteria and any training material or resources to providers, advocates and covered members.

(iv) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(v) Conduct interrater reliability testing to ensure consistency in utilization review decision making covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review for behavioral health conditions as defined in this section

(vi) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and mental health parity compliance activities.

(vii) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(5) Enforcement

(i) This section applies to all health care services and benefits for the diagnosis, prevention, treatment and management of behavioral health conditions covered by the division, including prescription drugs.

(ii) This section applies to the division's managed care organizations, accountable care organizations or other entity contracting with the division to manage or administer behavioral health condition services, or to conduct utilization review for behavioral health conditions as defined in this section.

(iii) If the division determines that a contracting entity described in this section has violated this section, the division may, after appropriate notice and opportunity for hearing in

accordance with current contracting practices, by order assess a civil penalty not to exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each violation. The civil penalties available to the division pursuant to this section are not exclusive and may be sought and employed in combination with any other remedies available to the division.

(iv) If, after said hearing the division determines that noncompliance has been substantiated, the division shall have the authority to investigate whether any covered members were denied access or coverage due to a violation of this section, and to issue an order any contracting entity to implement a corrective action plan and timeline to require coverage of any services that were denied due to a violation of this section. In the event that an inappropriate denial by a contracting entity led a covered member to seek treatment at an out-of-network provider, the contracting entity may be ordered to indemnify the covered member for their costs.

(v) The division's managed care organizations, accountable care organizations or other entity contracting with the division to manage or administer behavioral health condition services, or to conduct utilization review for behavioral health conditions as defined in this section shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

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SECTION 5. Chapter 32A is hereby further amended by adding at the end the following two sections:-

Section 29. (a) The commission shall provide to any active or retired employee of the commonwealth who is insured under the group insurance commission coverage for behavioral health condition services that ensures that medical necessity and utilization management determinations for treatments for substance use disorder or co-occurring mental illness and substance use disorder made by any health plan or entity contracting with the commission to provide, administer or manage behavioral health condition benefits shall be made in accordance with the level of care placement criteria and practice guidelines established by the American Society of Addiction Medicine, or by any comparable current criteria and practice guidelines developed by a comparable nonprofit professional association for the relevant clinical specialty of addiction medicine, if available, including age group specific guidelines for children, adolescents and young adults, if available. No additional criteria may be used to make medical necessity or utilization management determinations for treatments for substance use disorder or co-occurring mental illness and substance use disorder, unless such criteria are less restrictive. No health plan or health coverage authorized by the group insurance commission, nor any entity that manages or administers mental health and substance use disorder benefits such a health plan shall not deny authorization or coverage for treatment for substance use disorder or co-occurring mental illness and substance use disorder on the basis that such treatment was authorized or ordered by a court of law or other law enforcement agency. Such authorization shall be considered a factor in support of coverage for such treatment, including as allowed under clause (4) of subsection (a) of section 6 and clause (7) of subsection (a) of section 7. Nothing in this

section shall be construed to affect the authority of the treating clinician to determine medical necessity as provided under section 17N.

Section 30. (a) Appropriate medical necessity standards for behavioral health condition services

(1) Definitions. The following definitions apply for purposes of this section:

(i) "Generally accepted standards of behavioral health condition care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including but not limited to patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(ii) "Medically necessary treatment of a behavioral health condition" means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(A) In accordance with the generally accepted standards of mental health and substance use disorder care.

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(C) Not primarily for the economic benefit of the carrier, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

(iii) "Behavioral health condition " means a mental health condition, developmental disorder or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(iv) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.

(v) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a carrier to conduct utilization review.

(2) Coverage for medically necessary behavioral health condition Services. 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 evaluation, diagnosis, treatment and management of behavioral health condition services that:

(i) Shall not limit benefits or coverage for chronic or pervasive behavioral health conditions to short-term or acute treatment at any level of care placement.

(iii) Shall make all medical necessity determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed with behavioral health conditions shall be conducted in accordance with the requirements of this section.

(iv) Shall not limit benefits or coverage for medically necessary services for behavioral health conditions on the basis that those services should be or could be covered by another public entitlement program, including, but not limited to, a special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise

covered benefits on the basis that those services should be or could be covered by a public entitlement program.

(v) Shall not deny authorization or coverage for treatment for substance use disorder or co-occurring mental illness and substance use disorder on the basis that such treatment was authorized or ordered by a court of law or other law enforcement agency, except to the extent that such treatment is for an incarcerated person with access to coverage from public programs.

(vi) Shall not adopt, impose, or enforce terms in any health plan coverage policy or provider agreement, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(3) Medical Necessity Determinations Must Follow Generally Accepted Standards. The commission and any entity contracting with the commission directly or indirectly to manage or administer behavioral health condition services:

(i) Shall base any medical necessity determination or the utilization review decision for the diagnosis, prevention, and treatment of behavioral health conditions on current generally accepted standards of behavioral health condition care as defined in this section.

(ii) Shall apply the level of care placement criteria and practice guidelines set forth in the most recent versions of such criteria and practice guidelines developed by the nonprofit professional association for the relevant clinical specialty, if available, including age group specific guidelines for children, adolescents and young adults, if available.

(iii) Shall not apply different, additional, conflicting, or more restrictive utilization review criteria when conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in this section.

(iv) Shall authorize placement at the level of care consistent with the insured's score using the relevant level of care placement criteria and guidelines as specified in this section., however if that level of placement is not available, the next higher level of care shall be authorized.

(v) Shall, in the event of a disagreement with a treating provider, furnish the provider with the full detail of its scoring using the relevant level of care placement criteria and guidelines as specified in this section.

(iv) Shall not deny authorization or coverage for a service to treat a chronic behavioral health condition on the basis that the service will not cure the condition, and a carrier shall approve services that are appropriate to prevent a chronic behavioral health condition from deteriorating.

(4) Implementation. To ensure the proper use of the criteria described in this section, the commission and any entity contracting with the commission directly or indirectly to manage or administer behavioral health condition services shall do all of the following in relation to authorization and utilization of behavioral health condition services:

(i) Sponsor a formal education program by nonprofit clinical specialty associations to educate utilization review and appeals staff (including any third parties contracted to review claims, conduct utilization reviews, or make medical necessity determinations) about the clinical review criteria.

(ii) Make the education program available to other stakeholders, including the participating providers, advocates and covered members.

(iii) Provide, at no cost, the clinical review criteria and any training material or resources to providers, advocates and covered members.

(iv) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(v) Conduct interrater reliability testing to ensure consistency in utilization review decision making covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review for behavioral health conditions as defined in this section

(vi) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and mental health parity compliance activities.

(vii) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(5) Enforcement

(i) This section applies to all health care services and benefits for the diagnosis, prevention, treatment and management of behavioral health conditions covered by the division, including prescription drugs.

(ii) This section applies to the commission and any entity contracting with the commission directly or indirectly to manage or administer behavioral health condition services, or to conduct utilization review for behavioral health conditions as defined in this section.

(iii) If the commission determines that a contracting entity described in this section has violated this section, the commission may, after appropriate notice and opportunity for hearing in accordance with current contracting practices, assess a civil penalty not to exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each violation. The civil penalties available to the division pursuant to this section are not exclusive and may be sought and employed in combination with any other remedies available to the commission.

(iv) If, after said hearing the commission determines that noncompliance has been substantiated, the commission shall have the authority to investigate whether any covered members were denied access or coverage due to a violation of this section, and to issue an order any contracting entity to implement a corrective action plan and timeline to require coverage of any services that were denied due to a violation of this section. In the event that an inappropriate denial by a contracting entity led a covered member to seek treatment at an out-of-network provider, the contracting entity may be ordered to indemnify the covered member for their costs.

(v) The commission and any entity contracting with the commission directly or indirectly to manage or administer behavioral health condition services or to conduct utilization review for behavioral health conditions as defined in this section shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(6) Discretionary Clauses Prohibited

(i) If a contract offered, issued, delivered, amended, or renewed on or after January 1, 2022, by the commission to any member contains a provision that reserves discretionary authority to the commission, or an agent of the commission to determine eligibility for benefits or coverage, to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

(ii) For purposes of this subsection, the term "discretionary authority" means a contract provision that has the effect of conferring discretion on a carrier or other claims administrator to determine entitlement to benefits or interpret contract language that, in turn, could lead to a deferential standard of review by a reviewing court.

(iii) This subsection does not prohibit the commission or an entity contracting with the commission from including a provision in a contract that informs an insured that, as part of its routine operations, the plan applies the terms of its contracts for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures, and processes, so long as the provision could not give rise to a deferential standard of review by a reviewing court.

SECTION 6. Section 18 of chapter 15A of the General Laws is hereby amended by adding the following paragraph:-

Notwithstanding any general or special law to the contrary, any qualifying student health insurance plan authorized under this chapter shall comply with the requirements regarding

medical necessity determinations of behavioral health condition services as provided under subsections d and e of section 16 of chapter 176O. The connector shall issue regulations to implement this section, and the connector shall have the authority to implement civil penalties and corrective orders upon carriers of student health insurance as described in subsection e of section 16 of chapter 176O.