SENATE DOCKET, NO. 2089 FILED ON: 2/19/2021

SENATE . . . . . No. 675

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 mental health parity implementation.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
Cindy F. Friedman	*Fourth Middlesex*	
Julian Cyr	*Cape and Islands*	
Susannah M. Whipps	*2nd Franklin*	*3/24/2021*
Sal N. DiDomenico	*Middlesex and Suffolk*	*4/1/2021*
Joanne M. Comerford	*Hampshire, Franklin and Worcester*	*4/1/2021*

SENATE DOCKET, NO. 2089 FILED ON: 2/19/2021

SENATE . . . . . No. 675

By Ms. Friedman, a petition (accompanied by bill, Senate, No. 675) of Cindy F. Friedman, Julian Cyr, Susannah M. Whipps, Sal N. DiDomenico and others for legislation relative to mental health parity implementation. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. *588* OF 2019-2020.]

The Commonwealth of Massachusetts

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

An Act relative to mental health parity implementation.

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. Paragraph (5) of subsection (a) of section 16 of chapter 6D of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the words "established by", in lines 41 and 42, the following words:- section 47B of chapter 118E and.

SECTION 2. Section 18 of chapter 15A of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by adding the following paragraph:-

Any qualifying student health insurance plan authorized under this chapter shall comply with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part

156.115(a)(3), and the benefit mandates and other obligations under section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter 176G, as if the student health insurance plan was issued by such carriers licensed under chapters 175, 176A, 176B and 176G, without regard to any limitation under section 1 of chapter 176J.

SECTION 3. Chapter 26 of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by striking out section 8K and inserting in place thereof the following section:-

Section 8K. (a) The commissioner of insurance shall implement and enforce applicable provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3), and applicable state mental health parity laws, including, but not limited to, section 22 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter 176G, in regard to any carrier licensed under chapters 175, 176A, 176B and 176G, any carrier offering a student health plan issued under section 18 of chapter 15A or the group insurance commission, by:

(i) evaluating all consumer or provider complaints regarding mental health and substance use disorder coverage for possible parity violations within 3 months of receipt;

(ii) performing behavioral health parity compliance market conduct examinations of each carrier at least once every 36 months, or more frequently if noncompliance is suspected, with a focus on: (A) non-quantitative treatment limitations under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and applicable state mental

health and substance use disorder parity laws, including, but not limited to, prior authorization, concurrent review, retrospective review, step-therapy, network admission standards, reimbursement rates, network adequacy and geographic restrictions; (B) denials of authorization, payment and coverage; and (C) any other criteria determined by the division, including factors identified through consumer or provider complaints; provided, however, that: (1) a market conduct examination of a carrier subject to chapters 175, 176A, 176B or 176G and any plans authorized or regulated under chapter 32A shall follow the procedural requirements in subsections 10, 11 and 15 of section 4 of said chapter 175 regarding notice and rebuttal of examination findings, subsequent hearings and conflicts of interest; (2) the commissioner shall publicize the fees for a market conduct examination under section 3B of chapter 7 and said subsection 11 of said section 4 of said chapter 175; and (3) nothing contained in clause (ii) or in said section 4 of said chapter 175, section 7 of said chapter 176A, section 9 of said chapter 176B and section 10 of said chapter 176G shall limit the commissioner's authority to use, and if appropriate, to make public any final or preliminary examination report, any examiner or company work papers or other documents or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the commissioner may, in their sole discretion, deem appropriate;

(iii) requiring that carriers that provide mental health or substance use disorder benefits directly or through a behavioral health manager as defined in section 1 of chapter 176O or any other entity that manages or administers such benefits for the carrier comply with the annual reporting requirements under section 8M;

(iv) updating applicable regulations as necessary to effectuate any provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 that relate to insurance; and

(v) assessing a fee upon any carrier for the costs and expenses incurred in any market conduct examination authorized by law, consistent with the costs associated with the use of division personnel and examiners, the costs of retaining qualified contract examiners necessary to perform an examination, electronic data processing costs, supervision and preparation of an examination report and lodging and travel expenses; provided, however, that the commissioner shall maintain active management and oversight of examination costs and fees to ensure that the examination costs and fees comply with the National Association of Insurance Commissioners market conduct examiners handbook, unless the commissioner demonstrates that the fees prescribed in the handbook are inadequate under the circumstances of the examination; and provided further, that the commissioner or the commissioner's examiners shall not receive or accept any additional emolument on account of any examination.

(b) The division of insurance may impose a penalty against a carrier that provides mental health or substance use disorder benefits, directly or through a behavioral health manager as defined in section 1 of chapter 176O or any other entity that manages or administers such benefits for the carrier, for any violation by the carrier or the entity that manages or administers mental health and substance use disorder benefits for the carrier of state laws related to mental health and substance use disorder parity or provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as amended, and federal guidance or regulations issued under the act.

The amount of any penalty imposed shall be $100 for each day in the noncompliance period per product line with respect to each participant or beneficiary to whom such failure relates; provided, however, that the maximum annual penalty under this subsection shall be $1,000,000. For purposes of this subsection, the term "noncompliance period" shall mean the period beginning on the date a failure first occurs and ending on the date such failure is corrected.

No penalty shall be imposed on any failure if the division of insurance determines that such failure was due to reasonable cause and not to willful neglect or if such failure is corrected within 30 days of the start of the noncompliance period.

(c) In the event that a parity violation was likely to have caused denials of access to behavioral health services, the division of insurance shall require carriers to provide remedies for any failure to meet the requirements of state laws related to mental health and substance use disorder parity or provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), as amended, and federal guidance or regulations issued under the act, including, but not limited to:

(i) requiring the carrier to change the benefit standard or practice, including updating plan language, with notice to plan members;

(ii) providing training to staff on any changes to benefits and practices;

(iii) informing plan members of changes;

(iv) requiring the carrier to reprocess and pay all inappropriately denied claims to affected plan members, notify members of their right to file claims for services previously denied

and for which members paid out-of-pocket and reimburse for services eligible for coverage under corrected standards; and

(v) requiring the carrier to submit to ongoing monitoring to verify compliance.

(d) Any proprietary information submitted to the commissioner by a carrier as a result of the requirements of this section shall not be public records under clause Twenty-sixth of section 7 of chapter 4 or chapter 66; provided, however, that the commissioner may produce reports summarizing any findings.

(e) Nothing in this section shall limit the authority of the commonwealth, through the attorney general, to enforce any state or federal law, regulation or guidance described in this section.

(f) Nothing in this section shall prevent the commissioner of insurance from publishing any illustrative utilization review criteria, medical necessity standard, clinical guideline, or other policy, procedure, criteria or standard, regardless of its origin, as an example of the type of policy, procedure, criteria or standard that contributes to a violation of state or federal law parity requirements, including any document that would normally be subject to disclosure to plan members or their providers under section 16 of chapter 6D, section 16 of chapter 176O or the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended.

SECTION 4. Said chapter 26 is hereby further amended by inserting after Section 8L the following section:-

Section 8M. (a) All carriers licensed under chapters 175, 176A, 176B and 176G that provide mental health or substance use disorder benefits, directly or through a behavioral health manager, as defined in section 1 of chapter 176O or any other entity that manages or administers such benefits for the carrier, and the group insurance commission under chapter 32A, or the carriers the group insurance commission contracts with for the administration of any self-insured plans that provide mental health or substance use disorder benefits, directly or through a behavioral health manager, as defined in section 1 of chapter 176O or any other entity that manages or administers such benefits for the carrier, shall submit an annual report not later than July 1 to the commissioner of insurance that contains:

(i) a description of the process used to develop or select the medical necessity criteria for mental health and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(ii) identification of all non-quantitative treatment limitations that are applied to mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits, as defined in 45 CFR Part 146.136(c)(4)(i); provided, however, that there shall not be separate non-quantitative treatment limitations that apply to mental health and substance use disorder benefits but do not apply to medical and surgical benefits within any classification of benefits; provided further, that the non-quantitative treatment limitations shall include the processes, strategies or methodologies for developing and applying the carrier's reimbursement rates for mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits; and

(iii) the results of an analysis that demonstrates that for the medical necessity criteria described in clause (i) and for each non-quantitative treatment limitation identified in clause (ii), as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to mental health and substance use disorder benefits within each classification of benefits are comparable to, and are not applied more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits; provided, however, that, at a minimum, the results of the analysis shall:

(A) identify the factors used to determine that an non-quantitative treatment limitation will apply to a benefit;

(B) identify any processes, strategies or evidentiary standards used to define the factors identified in subclause (A);

(C) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each non-quantitative treatment limitation, as written, and the as-written processes and strategies used to apply the non-quantitative treatment limitation to mental health and substance use disorder benefits are comparable to, and are not applied more stringently than, the processes and strategies used to design each non-quantitative treatment limitation, as written, and the as-written processes and strategies used to apply the non-quantitative treatment limitation to medical and surgical benefits;

(D) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each non-quantitative treatment limitation, in operation, for mental health and substance use disorder benefits and provider reimbursement rates are comparable to, and are not applied more stringently than, the processes or strategies used to apply each non-quantitative treatment limitation, in operation, for medical and surgical benefits and provider reimbursement rates;

(E) disclose the specific findings and conclusions reached by the carrier or the group insurance commission that the results of the analyses in this clause indicate that the carrier or group insurance commission is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including, but not limited to, 45 CFR Part 146.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3); and

(F) disclose the number of requests for parity documents received under 29 CFR 2590.712(d)(3) or 45 CFR 146.136(d)(3) and the number of any such requests for which the plan refused, declined or was unable to provide documents.

(b) If federal guidance, including, but not limited to, the Self-Compliance Tool for the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, is released that indicates a non-quantitative treatment limitation analysis process and reporting format that is significantly different from, contrary to or more efficient than the non-quantitative treatment limitation analysis process and reporting format requirements described in subsection (a), the commissioner may promulgate regulations that delineate a non-quantitative treatment limitation analysis process and reporting format that may be used in lieu of

the non-quantitative treatment limitation analysis and reporting requirements described in said subsection (a).

(c) Any proprietary portions of information submitted to the commissioner by a carrier as a result of the requirements of this section shall not be public records under clause Twenty-sixth of section 7 of chapter 4 or chapter 66; provided, however, that: (i) the commissioner may produce reports summarizing any findings; (ii) nothing in this section shall limit the authority of the commissioner to use and, if appropriate, make public any final or preliminary examination report, examiner or company work papers or other documents or other information discovered or developed during the course of an examination in the furtherance of any legal or regulatory action that the commissioner may, in their sole discretion, deem appropriate; and (iii) nothing in this section shall prevent the commissioner of insurance from publishing any illustrative utilization review criteria, medical necessity standard, clinical guideline, or other policy, procedure, criteria or standard, regardless of its origin, as an example of the type of policy, procedure, criteria or standard that contributes to a violation of state or federal law parity requirements, including any document that would normally be subject to disclosure to plan members or their providers under section 16 of Chapter 6D, section 16 of Chapter 176O or under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended.

(d) Annually, not later than December 1, the commissioner shall submit a summary of the reports that the commissioner receives from all carriers under subsection (a) to the clerks of the senate and house of representatives, the joint committee on mental health, substance use and recovery and the joint committee on health care financing. The summary report shall include, but not be limited to:

(i) the methodology the commissioner is using to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act;

(ii) the methodology the commissioner is using to check for compliance with section 22 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and section 4M of chapter 176G;

(iii) the report of each market conduct examination conducted or completed during the immediately preceding calendar year regarding access to behavioral health services or compliance with parity in mental health and substance use disorder benefits under state and federal laws and any actions taken as a result of such market conduct examinations;

(iv) a breakdown of treatment authorization data for each carrier for mental health treatment services, substance use disorder treatment services and medical and surgical treatment services for the immediately preceding calendar year indicating for each treatment service: (A) the number of inpatient days, outpatient services and total services requested; (B) the number and per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day requests modified resulting in a lesser amount of inpatient days authorized than requested and the reason for the modification, inpatient day requests denied and the reason for the denial, inpatient day requests where an internal appeal was filed and approved, inpatient day requests where an internal appeal was filed and denied, inpatient day requests where an external appeal was filed and upheld and inpatient day requests where an external appeal was filed and overturned; and (C) the number and per cent of outpatient service requests authorized, outpatient service requests modified, outpatient service requests modified resulting in a lower amount of outpatient service

authorized than requested and the reason for the modification, outpatient service requests denied and the reason for the denial, outpatient service requests where an internal appeal was filed and approved, outpatient service requests where an internal appeal was filed and denied, outpatient service requests where an external appeal was filed and upheld and outpatient service requests where an external appeal was filed and overturned;

(v) the number of complaints the division has received in the immediately preceding calendar year regarding access to behavioral health services or compliance with parity in mental health and substance use disorder benefits under state and federal laws and a summary of all complaints resolved by the division during that time period; and

(vi) information about any educational or corrective actions the commissioner has taken to ensure carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and said section 22 of said chapter 32A, said section 47B of said chapter 175, said section 8A of said chapter 176A, said section 4A of said chapter 176B and said section 4M of said chapter 176G.

The summary report shall be written in non-technical, readily understandable language and shall be made available to the public by posting the report on the division's website.

SECTION 5. Section 47 of chapter 118E of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by inserting after the first paragraph the following paragraphs:-

Any recipient of medical assistance denied authorization or approval for a covered service by the division or its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms or third party administrators under contract

with the division, a Medicaid managed care organization or primary care clinician plan, on the basis of medical necessity shall have the right to pursue an independent external review through the office of patient protection under section 47B. Such review shall be available to the recipient of medical assistance as an optional component of any internal review process conducted by the division and shall not interfere with the recipient's right to a hearing under this section or the recipient's right to a board of hearing under section 48. Upon completion of an independent external review, the recipient of medical assistance shall have 30 days to submit a request for a hearing under this section.

Notwithstanding any general or special law to the contrary, the division shall promulgate regulations that require the division, its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third party administrators under contract with the division, a Medicaid managed care organization or primary care clinician plan, to maintain documentation of all requests for benefits or services, whether the request is submitted by or on behalf of the intended recipient of those benefits or services. Any request that is not fulfilled in full shall be considered a denial, and shall result in the prompt written notification to the recipient through electronic means, if possible. Such notification shall include a description of the requested service, the response by the entity, and the recipient's due process and appeal rights. All such entities shall accept requests for authorized representatives or for appeals by electronic means.

SECTION 6. Said chapter 118E, as so appearing, is hereby further amended by inserting after section 47A the following section:-

Section 47B. (a) Any recipient of medical assistance that is denied authorization or approval for a covered service by the division or its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms or third party administrators under contract with the division, a Medicaid managed care organization or primary care clinician plan, may seek further review of the denial by a review panel established by the office of patient protection pursuant to paragraph (5) of subsection (a) of section 16 of chapter 6D. The division or its applicable contracted health insurers, health plans, health maintenance organizations, behavioral health management firms or third party administrators under contract with the division, a Medicaid managed care organization or primary care clinician plan, shall be responsible for the cost of the review pursuant to regulations promulgated by the executive director of the health policy commission in consultation with the commissioner. The office of patient protection shall contract with at least 3 unrelated and objective review agencies through a bidding process and refer denials of a covered service to 1 of the review agencies on a random selection basis. The review agencies shall be accredited by a national accrediting organization and shall develop review panels appropriate for the given covered service denial, which shall include qualified clinical decision-makers experienced in the determination of medical necessity, utilization management protocols and covered service denial resolution, and shall not have any financial relationship with the division or its applicable contracted health insurers, health plans, health maintenance organizations, behavioral health management firms or third party administrators under contract with the division, a Medicaid managed care organization or primary care clinician plan, making the initial determination to deny a covered service. For denials related to medical necessity, the standard for review of a denial of a covered service by such a panel shall be the determination of whether the requested treatment or service

is medically necessary and a covered benefit under the policy or contract; provided, that the word "medically necessary" shall include a determination of whether access to an out-of-network provider is required when no qualified in-network provider is available. For denials related to a violation of the federal or state mental health parity laws, the standard for review of a grievance by such a panel shall be the legal standards related to QTLs and NQTLs under those statutes, regulations and guidance, including, but not limited to, 45 CFR Part 146.136 and 29 C.F.R. § 2590.712. The panel shall consider, but not be limited to considering: (i) any related right to such treatment or services under any related state statute or regulation; (ii) written documents submitted by the recipient of medical assistance; (iii) medical records and medical opinions regarding medical necessity by the treating provider that requested or provided the disputed service to the recipient of medical assistance, which shall be obtained by the division, or by the panel if the division fails to do so; (iv) additional information from the involved parties or outside sources that the review panel deems necessary or relevant; and (v) information obtained from any informal meeting held by the panel with the parties. The panel shall send final written disposition of the covered service denial and the reasons therefore, to the recipient of medical assistance and the division or its applicable contracted health insurers, health plans, health maintenance organizations, behavioral health management firms or third party administrators under contract with the division, a Medicaid managed care organization or primary care clinician plan, within 45 days of receipt of the request for review; provided, however, that if the panel discovers new facts or a new rationale to deny the treatment or service that was not previously relied upon by the division or its applicable contracted health insurers, health plans, health maintenance organizations, behavioral health management firms or third party administrators under contract with the division, a Medicaid managed care organization or primary care clinician

plan, in their denial of a covered service determination, the panel shall provide the division or its applicable contracted health insurers, health plans, health maintenance organizations, behavioral health management firms or third party administrators under contract with the division, a Medicaid managed care organization or primary care clinician plan, with notice of such rationale and an opportunity to respond to such rationale before issuing a final decision on the denial of a covered service. Notwithstanding the requirements of this section, such review shall be available to the recipient of medical assistance as an optional component of any internal review process conducted by the division and shall not interfere with the recipient's right to a hearing under section 47 or the recipient's right to a board of hearing under section 48.

(b) If a denial of a covered service includes the termination of ongoing coverage or treatment, the recipient of medical assistance may apply to the external review panel to seek continued provision of health care services which are the subject of the denial during the course of an external review upon a showing of substantial harm to the health of the recipient of medical assistance absent such continuation, or other good cause as determined by the panel; provided, that good cause shall include a history or pattern of denials that have been overturned by prior internal or external appeals.

(c) A recipient of medical assistance may request reconsideration of a decision by the review panel within 30 days. A decision shall be reconsidered if the review panel makes a clear error regarding essential facts, demonstrates a lack of adequate medical expertise in an area of specialty, or fails to address an articulated right to health care benefits under state or federal law. Absent such reconsideration, the decision of the review panel shall be binding on the recipient of medical assistance and on the division or its applicable contracted health insurers, health plans, health maintenance organizations, behavioral health management firms or third party

administrators under contract with the division, a Medicaid managed care organization or primary care clinician plan. The office of patient protection, the commissioner, the office of the attorney general, and any aggrieved recipient of medical assistance seeking redress in superior court shall have jurisdiction to enforce the decision of the review panel; provided, that if the recipient of medical assistance prevails in superior court, the court shall order the division or its applicable contracted health insurers, health plans, health maintenance organizations, behavioral health management firms or third party administrators under contract with the division, a Medicaid managed care organization or primary care clinician plan, to pay the recipient of medical assistance for the costs of the action and any reasonable attorneys' fees.

(d) The division or its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms or third party administrators under contract with the division, a Medicaid managed care organization or primary care clinician plan, shall allow a guardian, conservator, holder of a power of attorney, family member, or other responsible party to act as a representative for the recipient of medical assistance in the event that a recipient is unable to pursue a denial of a covered service due to physical or mental disability. A recipient of medical assistance may designate such a representative or, if the recipient of medical assistance is unable to so designate, a guardian, conservator, holder of a power of attorney or family member, in order of priority, may serve as representative or may designate another responsible party to act as representative. The representative shall have the same rights of review of a denial of a covered service as the recipient of medical assistance, including the right to review the recipient's medical file relevant to a dispute concerning coverage or treatment.

(e) The external review panel procedures authorized by this section shall be in addition to any other procedures that may be available to any recipient of medical assistance pursuant to contract or law, and failure to pursue, exhaust or engage in the procedures described in this subsection shall not preclude the use of any other remedy provided by any contract or law.

(f) No health care provider and no agent or employee of a health care provider shall provide information relative to unpaid charges for health care services to a consumer reporting agency, as defined in section 50 of chapter 93, while a review under this section is pending or for 30 days following the resolution of a denial of a covered service.

SECTION 7. Said chapter 118E is hereby further amended by adding the following sections:-

Section 79. (a) The division, its managed care organizations, accountable care organizations or other entity contracting with the division to manage or administer mental health and substance use disorder benefits shall ensure that there are no separate non-quantitative treatment limitations that apply to mental health and substance use disorder benefits but do not apply to medical and surgical benefits within any classification of benefits as defined under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and applicable state mental health parity laws, including, but not limited to, section 80; provided, however, that the non-quantitative treatment limitations shall include the processes, strategies or methodologies for developing and applying the division's reimbursement rates for mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits.

(b) The division shall perform a behavioral health parity compliance examination of each Medicaid managed care organization, accountable care organization or other entity contracted with the agency that manages or administers mental health and substance use disorder benefits for the division at least once every 24 months. The examination shall include examination of entities that manage medical and surgical benefits, as necessary. The examination shall only apply where the division is the primary payer. The examination shall include but not be limited to:

(1) non-quantitative treatment limitations, including, but not limited to, prior authorization, concurrent review, retrospective review, step-therapy, network admission standards, reimbursement rates, and geographic restrictions;

(2) approvals and denials of authorization, payment, and coverage; and

(3) any other specific criteria as may be determined by the division, including factors identified through consumer or provider complaints.

(c) The division shall require each of its managed care organizations, accountable care organizations or other entity contracting with the division to manage or administer mental health and substance use disorder benefits to submit an annual report to the division on or before July 1 that includes:

(i) a description of the process used to develop or select the medical necessity criteria for mental health and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(ii) identification of all non-quantitative treatment limitations that are applied to mental health and substance use disorder benefits and medical and surgical benefits, including, but not limited to, prior authorization, concurrent review, retrospective review, step-therapy, network admission standards, reimbursement rates, network adequacy and geographic restrictions, within each classification of benefits, as defined in 42 CFR Part 457.496(d)(2)(ii); and

(iii) the results of an analysis that demonstrates that for the medical necessity criteria described in clause (i) of this subsection and for each non-quantitative treatment limitation identified in clause (ii) of this subsection, as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to mental health and substance use disorder benefits within each classification of benefits are comparable to, and are not applied more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the medical necessity criteria and each non-quantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits; provided, however, that, at a minimum, the results of the analysis shall:

(A) identify the factors used to determine that a non-quantitative treatment limitation will apply to a benefit;

(B) identify any processes, strategies or evidentiary standards used to define the factors identified in subclause (A);

(C) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each non-quantitative treatment limitation, as written, and the as-written processes and strategies used to apply the non-

quantitative treatment limitation to mental health and substance use disorder benefits are comparable to, and are not applied more stringently than, the processes and strategies used to design each non-quantitative treatment limitation, as written, and the as-written processes and strategies used to apply the non-quantitative treatment limitation to medical and surgical benefits;

(D) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each non-quantitative treatment limitation, in operation, for mental health and substance use disorder benefits and provider reimbursement rates are comparable to, and are not applied more stringently than, the processes or strategies used to apply each non-quantitative treatment limitation, in operation, for medical and surgical benefits; and

(E) disclose the specific findings and conclusions reached by the division that the results of the analyses under this clause indicate compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal guidelines and regulations relevant to the act, including, but not limited to, 42 CFR Part 457.496;

(F) The treatment authorization data for the prior calendar year, which shall include, but not be limited to: the number of inpatient days, outpatient services and total number of services requested; the number and per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day requests modified resulting in a lesser amount of inpatient days authorized than requested and the reason for the modification, inpatient day requests denied and the reason for the denial, inpatient day requests where an internal appeal was filed and approved,

inpatient day requests where an internal appeal was filed and denied, inpatient day requests where an external appeal was filed and upheld and inpatient day requests where an external appeal was filed and overturned; and the number and per cent of outpatient service requests authorized, outpatient service requests modified, outpatient service requests modified resulting in a lower amount of outpatient service authorized than requested and the reason for the modification, outpatient service requests denied and the reason for the denial, outpatient service requests where an internal appeal was filed and approved, outpatient service requests where an internal appeal was filed and denied, outpatient service requests where an external appeal or hearing before the board of hearings was filed and upheld and outpatient service requests where an external appeal was filed and overturned; and

(vii) any other information required by the division.

(d) If federal guidance, including, but not limited to, the Self-Compliance Tool for the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, is released that indicates a non-quantitative treatment limitation analysis process and reporting format that is significantly different from, contrary to or more efficient than the non-quantitative treatment limitation analysis process and reporting format requirements described in subsection (c), the division may promulgate regulations that delineate a non-quantitative treatment limitation analysis process and reporting format that may be used in lieu of the non-quantitative treatment limitation analysis and reporting requirements described in said subsection (c).

(e) Any proprietary information submitted to the general court by the division as a result of the requirements in this section shall not be a public record under clause Twenty-sixth of

section 7 of chapter 4 or chapter 66; provided, however, that nothing in this section shall limit the authority of the director of Medicaid to use and, if appropriate, make public any final or preliminary examination report, examiner or company work papers or other documents or other information discovered or developed during the course of an examination in the furtherance of any legal or regulatory action that the director may, in their sole discretion, deem appropriate; provided, that nothing in this section shall prevent the director of Medicaid from publishing any illustrative utilization review criteria, medical necessity standard, clinical guideline, or other policy, procedure, criteria or standard, regardless of its origin, as an example of the type of policy, procedure, criteria or standard that contributes to a violation of state or federal law parity requirements, including nay information that is subject to disclosure to plan members under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, or under any member right to receive such guideline under applicable federal law.

(f) Not later than 60 days after the completion of the examination, the division shall submit a report of the examination conducted under subsection (b) and any actions taken as a result of such examination to the clerks of the senate and the house of representatives, the joint committee on mental health, substance use and recovery and the joint committee on health care financing.

(g) The division shall file an annual report with the clerks of the senate and house of representatives, the joint committee on mental health, substance use and recovery and the joint committee on health care financing not later than December 1. The report shall include, but not be limited to:

(i) the methodology the division is using to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal regulations or guidance relevant to the act;

(ii) the methodology the division is using to check for compliance with section 80;

(iii) a breakdown of treatment authorization data for the division, and for each Medicaid managed care organization, accountable care organization or other entity that manages or administers benefits for the division, for mental health treatment services, substance use disorder treatment services and medical and surgical treatment services for the immediately preceding calendar year.

The treatment authorization data shall include, but not be limited to: (A) the number of inpatient days, outpatient services and total number of services requested; (B) the number and per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day requests modified resulting in a lesser amount of inpatient days authorized than requested and the reason for the modification, inpatient day requests denied and the reason for the denial, inpatient day requests where an internal appeal was filed and approved, inpatient day requests where an internal appeal was filed and denied, inpatient day requests where an external review under section 47B or hearing before the board of hearings under section 48 was filed and upheld and inpatient day requests where an external review under section 47B or hearing before the board of hearings under section 48 was filed and overturned; and (C) the number and per cent of outpatient service requests authorized, outpatient service requests modified, outpatient service requests modified resulting in a lower amount of outpatient service authorized than requested and the reason for the modification, outpatient service requests denied and the reason for the

denial, outpatient service requests where an internal appeal was filed and approved, outpatient service requests where an internal appeal was filed and denied, outpatient service requests where an external review under section 47B or hearing before the board of hearings under section 48 was filed and upheld and outpatient service requests where an external review under section 47B or hearing before the board of hearings under section 48 was filed and overturned;

(iv) the number of complaints the division, or any Medicaid managed care organization, accountable care organization or other entity contracting with the division to manage or administer mental health and substance use disorder benefits, has received in the immediately preceding calendar year regarding access to behavioral health services or compliance with parity in mental health and substance use disorder benefits under state and federal laws and a summary of all complaints resolved by the division, or any Medicaid managed care organization, accountable care organization or other entity contracting with the division to manage or administer mental health and substance use disorder benefits, during that time period; and

(v) information about any educational or corrective actions the division has taken to ensure carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and section 80.

The summary report shall be written in non-technical, readily understandable language and shall be made publicly available on the division's website.

(h) The division shall evaluate all consumer or provider complaints regarding mental health and substance use disorder coverage for possible parity violations within 3 months of receipt of the complaint.

Section 80. (a) The division and its health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract with the division, a Medicaid managed care organization or a primary care clinician plan shall provide mental health and substance use disorder benefits for the diagnosis and medically necessary treatment of any behavioral health disorder described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, or the most current version of the International Classification of Diseases (ICD). The benefits shall be provided on a nondiscriminatory basis.

(b) In addition to the mental health and substance use disorder benefits established pursuant to this section, the division shall provide benefits on a non-discriminatory basis for children and adolescents under the age of 19 for the diagnosis and treatment of mental, behavioral, emotional or substance use disorders described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders that substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent; provided, however, that the interference or limitation is documented by and the referral for the diagnosis and treatment is made by the primary care provider, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including, but not limited to: (i) an inability to attend school as a result of such a disorder; (ii) the need to hospitalize the child or adolescent as a result of such a disorder; or (iii) a pattern of conduct or behavior caused by such a disorder that poses a serious danger to self or others.

(c) For the purposes of this section, the division shall be deemed to be providing such coverage on a non-discriminatory basis if the plan or coverage does not contain any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of the

mental disorders that is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of physical conditions.

(d) Benefits authorized pursuant to this section shall consist of a range of inpatient, intermediate and outpatient services that shall permit medically necessary and active and noncustodial treatment for the mental disorders to take place in the least restrictive clinically appropriate setting. For purposes of this section, inpatient services may be provided in a general hospital licensed to provide such services, in a facility under the direction and supervision of the department of mental health, in a private mental hospital licensed by the department of mental health or in a substance abuse facility licensed by the department of public health. Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the department of public health or the department of mental health. Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office or as home-based services.

(e) The division and its health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract with the division, a Medicaid managed care organization or a primary care clinician plan shall not require, as a condition to receiving benefits mandated by this section, consent to the disclosure of information regarding services for mental disorders under different terms and conditions than consent is required for disclosure of information for other medical conditions. A determination by the division or its agents that services authorized pursuant to this section are not medically necessary shall only be made by a mental health professional licensed in the appropriate

specialty related to such services and, where applicable, by a provider in the same licensure category as the ordering provider; provided, however, that this subsection shall not apply to denials of service resulting from an enrollee's lack of coverage or use of a facility or professional that has not entered into a negotiated agreement with the division or its agents. The benefits provided by the division or its agents pursuant to this section shall meet all other terms and conditions of the plan not inconsistent with state or federal law.

(f) Nothing in this section shall require the division to pay for mental health or substance use disorder benefits or services that:

(i) are services otherwise covered by third-party insurance;

(ii) are provided to a person who is presently incarcerated, confined or committed to a jail, house of correction, or prison within the commonwealth or a political subdivision of the commonwealth;

(iii) constitute educational services required to be provided by a school committee pursuant to section 5 of chapter 71B;

(iv) constitute services provided by the department of mental health, or the department of public health or the department of developmental services; or

(v) are not eligible for federal financial participation.

Section 81. Notwithstanding any general or special law to the contrary, the office of Medicaid shall seek a waiver and promulgate regulations in order to require the division and its health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract with the division, a Medicaid managed care

organization or primary care clinician plan to meet the parity requirements described under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including 42 CFR 438 Subpart K, 42 CFR 440.395 and 42 CFR 457.496, for all enrollees. For persons under the age of 21, MassHealth and its agents may comply with this section by meeting the obligations related to Early and Periodic Screening, Diagnostic and Treatment benefits under 42 CFR 457.496(b) or 440.395(c).

SECTION 8. Subsection (a) of section 13 of chapter 176O of the General Laws is hereby amended by striking out the first sentence and inserting in place thereof the following sentence:-

A carrier or utilization review organization shall maintain a formal internal grievance process that is compliant with the Patient Protection and Affordable Care Act, Public Law 111–148, as amended from time to time, as well as with any rules, regulations or guidance applicable thereto, and such formal internal grievance process shall provide for adequate consideration and timely resolution of grievances, which shall include but not be limited to: (1) a system for maintaining records of each grievance filed by an insured or on his behalf, and responses thereto, for a period of seven years, which records shall be subject to inspection by the commissioner; (2) the provision of a clear, concise and complete description of the carrier's formal internal grievance process and the procedures for obtaining external review pursuant to section 14 with each notice of an adverse determination; (3) the carrier's toll-free telephone number for assisting insureds in resolving such grievances and the consumer assistance toll-free telephone number maintained by the office of patient protection; (4) a written acknowledgement of the receipt of a grievance within 15 days and a written resolution of each grievance sent to the insured by certified or registered mail, or other express carrier with proof of delivery, within 30 days from

receipt thereof; (5) a procedure to accept grievances by telephone, in person, by mail, and by electronic means; (6) a process for an insured to request the appointment of an authorized representative to act on the insured's behalf; (7) a procedure to accept an insured's request for medical release forms by electronic means, which shall include a designated email address or an online consumer portal accessible by the insured or their family member or authorized representative that can provide the insured's membership identification number.

SECTION 9. Subsection (b) of said section 13 of said chapter 176O, as so appearing, is hereby amended by striking out the third sentence, in lines 55 to 62, inclusive, and inserting in place thereof the following sentence:-

If the expedited review process affirms the denial of coverage or treatment, the carrier shall provide the insured, as soon as possible, including by any electronic means consented to by the insured, (1) a statement setting forth the specific medical and scientific reasons for denying coverage or treatment; (2) a description of alternative treatment, services or supplies covered or provided by the carrier, if any; (3) a description of the insured's rights to any further appeal; and (4) a description of the insured's right to request a conference.

SECTION 10. Subsection (c) of said section 13 of said chapter 176O, as so appearing, is hereby amended by adding the following sentence:-

The office of patient protection shall decide a grievance in favor of the insured unless the carrier provides substantial evidence, such as proof of delivery, that the carrier complied with the time limits required under this section.

SECTION 11. Subsection (a) of section 14 of chapter 176O of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by striking out, in lines 24 to 35,

inclusive, the seventh, eight and nineth sentences and inserting in place thereof the following sentence:-

For denials related to medical necessity, the standard for review of a grievance by such a panel shall be a determination of whether the requested treatment or service is medically necessary, as defined in section 1, and a covered benefit under the policy or contract. For denials related to a violation of the federal or state mental health parity laws, the standard for review of a grievance by such a panel shall be the legal standards related to QTLs and NQTLs under those statutes, regulations and guidance, including, but not limited to, 45 CFR Part 146.136 and 29 C.F.R. § 2590.712. The panel shall consider, but not be limited to considering: (i) any related right to such treatment or services under any related state statute or regulation (ii) written documents submitted by the insured, (iii) medical records and medical opinions regarding medical necessity by the insured's treating provider that requested or provided the disputed service, which shall be obtained by the carrier, or by the panel if the carrier fails to do so, (iv) additional information from the involved parties or outside sources that the review panel deems necessary or relevant, (v) information obtained from any informal meeting held by the panel with the parties. The panel shall send final written disposition of the grievance and the reasons therefore, to the insured and the carrier within 45 days of receipt of the request for review; provided, however, that if the panel discovers new facts or a new rationale to deny the treatment or service that was not previously relied upon by the carrier in their final adverse benefit determination, the panel shall provide the insured with notice of such a rationale, and an opportunity to respond to such rationale before issuing a final decision on the grievance.

SECTION 12. Subsection (b) of said section 14 of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 43 to 47, the second sentence and inserting in place thereof the following sentence:-

An insured may apply to the external review panel to seek continued provision of health care services which are the subject of the grievance during the course of an expedited or non-expedited external review upon a showing of substantial harm to the insured's health absent such continuation, or other good cause as determined by the panel; provided, that good cause shall include a history or pattern of denials that have been overturned by prior internal or external appeals.

SECTION 13. Said section 14 of said chapter 176O, as so appearing, is hereby further amended by striking out subsection (c) and inserting in place thereof the following subsection:-

(c) An insured may request reconsideration of a decision by the review panel within 30 days. A decision shall be reconsidered if the review panel makes a clear error regarding essential facts, demonstrates a lack of adequate medical expertise in an area of specialty, or fails to address an articulated right to health care benefits under state or federal law. Absent such reconsideration, the decision of the review panel shall be binding on the insured and on the carrier. The office of patient protection, the commissioner, the office of the attorney general, and any aggrieved party seeking redress in superior court shall have jurisdiction to enforce the decision of the review panel. A carrier’s failure to promptly comply with a decision of the review panel shall be an unfair and deceptive practice in violation of chapter 93A.

SECTION 14. Subsection (b) of section 16 of chapter 176O of the General Laws, as appearing in the 2018 Official Edition, is hereby amended by striking out the last sentence and inserting in place thereof the following sentence:-

If a carrier or utilization review organization intends 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 guideline 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; and (ii) the carrier or utilization review organization has assessed the limitation to show it is in compliance with state and federal parity requirements under chapter 26.

SECTION 15. The health policy commission, in consultation with the division of insurance, shall conduct an analysis of and issue a report on the effects of behavioral health managers, as defined in section 1 of chapter 176O of the General Laws, on the commonwealth's health care delivery system, including on the accessibility, quality and cost of behavioral health care services. In developing the report, the commission shall seek input from the executive office of health and human services, other state agencies, health care providers and payers, behavioral health and economic experts and patients and caregivers.

The commission shall analyze: (i) a detailed description of the types of services that behavioral health managers provide; (ii) an assessment of the effect of behavioral health managers on patient outcomes and access to behavioral health services; (iii) an inventory of oversight practices by other states on behavioral health managers; (iv) an examination of the effects of behavioral health manager state licensure, regulation or registration on access to

behavioral health services; and (v) other aspects of behavioral health managers as deemed appropriate by the commission.

Not later than January 1, 2023, the health policy commission shall file a report of its findings, together with any recommendations for legislation, with the clerks of the senate and house of representatives, the joint committee on health care financing, the joint committee on mental health, substance use and recovery and the joint committee on financial services.