**Department of Mental Health**

**Medical Necessity Commission Minutes of Meeting**

**January 20, 2023, 2:00-3:00p.m.**

**Location: In-Person at DMH or via Zoom**

Meeting #3 Summary:

1. Commissioner Brooke Doyle called the meeting to order. Due to network technical issues, the meeting started approximately 15 minutes late.
2. Roll Call of Commission Members (See attached attendance sheet)
3. Motion was made to accept 12/16/22 meeting minutes. Seconded and unanimously approved.
4. Commissioner Doyle reviewed the meeting agenda:

* Presentation from DOI on the MA regulatory framework.
* Discussion of the role health payers’ medical directors play in establishing medical necessity standards.
* For purposes of developing a survey to be distributed to health payers, need to concretely define and identify service “lines” (level of care, type of treatment) the commission wants to prioritize.

1. MA Medical Necessity Regulatory Framework

* Commission member Niels Puetthoff of the Division of Insurance (DOI) gave a PowerPoint presentation (see attached) highlighting state statutes and regulations that govern medical necessity requirements:
  + MGL 176O, §16(b): Consumer Protections
  + 211 CMR 52.02: Medical Necessity Legal Definition
  + 211 CMR 52.05 Accreditation
  + 958 CMR 3.101: Health Insurance Consumer Protection
  + 211 CMR 154: Mental Health Parity
  + DOI Bulletin 2013-06: Mental Health Parity
* DOI is not involved in the development of medical necessity standards but rather, by reviewing and validating a health payer’s detailed response to survey questions regarding state and federal parity compliance (publicly available upon request) and verifying that the health payer has gone through an accreditation process, DOI ensures medical necessity standards are applied appropriately.
* Health payers are required to develop medical necessity standards with input from physicians and participating providers in the health payer’s service area and under the standards adopted by national accreditation organizations. Commission members expressed an interest in understanding how local physicians are involved in the process.
* Health payers must be accredited by the Bureau of Managed Care with the DOI every 2 years and demonstrate evidence of accreditation by a national organization such as the National Council on Quality Assurance (NCQA), Utilization Review Accreditation Commission (URAC) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
* A commission member asked where a complaint is filed and how is it’s managed. Niels stated violations/complaints can be filed with the DOI consumer complaint office or any DOI office. Medical necessity complaints may be referred to the Office of Patient Protection. Individuals filing complaints may do so by contacting the hotline or submitting a complaint through an online portal. DOI would process the complaint and review for compliance.
* Commission members expressed concerns with health payers who argue that they are not denying a service but rather providing a “modification” or alternative. Members can appeal by filing a complaint with the Office of Patient Protection. Concerns though that insureds ability to appeal affected by health payers treating “modifications” differently than denials. Commission members may want to include a question on the health payer survey.

1. Role of Health Plan Medical Directors

* Commission member Dr. Gregory Harris of Blue Cross Blue Shield (BCBS) lead a discussion of how BCBS approaches medical necessity.
* BCBS business: 60% self-insured versus fully insured. Operate in MA and other states.
* Integrated behavioral and medical health.
* Covered versus not covered. BCBS and other health payers cover medically necessary treatment that is generally accepted and FDA approved. What is the level of evidence for the service? Alternatives? Improvements only in investigatory or widely seen? What do professional organizations use?
* BCBS obtains local physician input for development of clinical policies: re-occurring monthly meetings, ad hoc meetings, provider organization meetings.
* BCBS utilizes both local and national clinical policies. For example, BCBS developed and issued its own Applied Behavioral Health Policy but uses InterQual medical standards for Skilled Nursing Facility (SNF).
* Clinical policies are written for the “typical” patient, not the “unusual” patient. Health payers may still provide services when atypical but the burden shifts. If evidence not there, safety concerns- would need to justify why.
* Levels of control over use of a service: prior authorization, concurrent reviews, post service review. More deference to medical directors.
* Lots of variation in medical practice. For example, ASAM does not include any medical standards for frequency of urine drug testing. Wide variability in provider practice. Electric Convulsive Treatment (ECT) is another example.

1. Next Steps

* For the next commission meeting, start to prioritize service lines and questions that commission members want included on a health payer medical necessity survey. What do we want prioritized? What do we need to know from health payers to help us better understand how they apply medical necessity standards?

1. Adjournment
   * The Commission agreed to adjourn and will meet next on Friday, February 17, 2:00-3:00.