

HOUSE No. 1012

The Commonwealth of Massachusetts

In the Year Two Thousand Nine

An Act relative to fair and equitable managed care contracting standards..

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 SECTION 1. Section thirty eight of chapter one hundred and eighteen E of the general
2 laws is hereby amended by inserting at the end thereof of the following new paragraphs:

3 “Within 45 days after the receipt by the Division of completed forms for reimbursement
4 to a physician who participates in a medical service program established pursuant to this chapter
5 the Division shall (i) make payments for such services provided by the physician that are
6 services covered under such medical assistance program and for which claim is made, or (ii)
7 fully notify the provider in writing or by electronic means of any and all reason or reasons for
8 nonpayment, or (iii) notify the provider within 15 days in writing or by electronic means of all
9 additional information or documentation that is necessary to establish such physician’s
10 entitlement to such reimbursement. If the Division fails to comply with the provisions of this
11 paragraph for any such completed claim, the Division shall pay, in addition to any
12 reimbursement for health care services provided to which the physician is entitled, interest on
13 any unpaid amount of such benefits, which shall accrue beginning 45 days after the Division's
14 receipt of request for reimbursement, or 15 days after the receipt of an electronic claim, at the

15 rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this
16 paragraph relating to interest payments shall not apply to a claim that the Division is
17 investigating because of suspected fraud.”

18 “The division shall provide written guidelines to providers of medical services that
19 participate in a medical assistance program established pursuant to this chapter setting forth a
20 statement of its policies and procedures that is complete, detailed and specific with regard to
21 what such providers must include in claims for reimbursement in order to qualify as a completed
22 claim for reimbursement payment for which any such provider is entitled. Such guidelines shall
23 identify all of the data and documentation that is to accompany each claim for reimbursement
24 and shall identify all utilization review and other screening policies and procedures employed by
25 the division in reviewing such claims submitted by a provider of medical services.”

26 SECTION 2. Section one hundred and eight, subsection 4 (c) of chapter one hundred and
27 seventy-five of the General Laws is hereby amended in the second sentence by striking out the
28 words “forty five days” and inserting in place thereof the following: “fifteen days”.

29 SECTION 3. Section one hundred and ten (G) of chapter one hundred and seventy-five
30 of the General Laws is hereby amended in the second sentence of the second paragraph by
31 striking the words “forty five days” and inserting in place thereof the following: “fifteen days,”

32 SECTION 4. Section eight of chapter one hundred and seventy-six A is hereby amended
33 in the first sentence of clause (e) by striking the words “within forty five days,”

34 SECTION 5. Section 7 of chapter one hundred and seventy-six B of the General Laws is
35 hereby amended in the second sentence of the second paragraph by striking out the words “forty
36 five days” and inserting in place thereof the following: “fifteen days,”

37 SECTION 6. Section 6 of chapter 176G is hereby amended in the first sentence of the
38 second paragraph by striking out the words “45 days” and inserting in place thereof the
39 following: “fifteen days,”

40 SECTION 7. Section 2 of chapter 176I is hereby amended in the first sentence of the
41 third paragraph by striking the words “45 days” and inserting in place thereof the following:
42 “fifteen days,”

43 SECTION 8. The General Laws are hereby amended in section 1 of chapter 176O by
44 inserting after the definition of “concurrent review” the following:

45 “contracting agent” , a covered entity engaged, for monetary or other consideration, in the
46 act of leasing, selling, transferring, aggregating, assigning or conveying, a physician or physician
47 panel to provide health care services to beneficiaries.

48 And further, by inserting after the definition of “covered benefit”, the following:

49 “covered entity” includes, but is not limited to, any entity responsible for payment or
50 coordination of health care services, including but not limited to all entities that pay or
51 administer claims on behalf of other entities.

52 And further, by inserting after the definition of “participating provider”, the following:

53 “payer”, a self-insured employer, health care service plan, insurer, or other entity that
54 assumes the risk for payment of claims or reimbursement for services provided by contracted
55 physicians.

56 SECTION 9. Subsection (b) of Section 10 of chapter one hundred and seventy six 0 of
57 the General Laws is hereby amended by adding the following paragraphs:

58 (4) a requirement that physician group budgets be based on an accepted per member per
59 month cost determined y actuarial input from a collaboration of representatives including
60 physicians, business groups, employers, carriers and the Division of Insurance.

61 (5) a requirement that reinsurance amounts be determined according to an actuarial
62 standard estimate of catastrophic events in a provider unit.

63 (6) a requirement that carriers provide the physician or physician group with detailed
64 expense descriptions, including but not limited to member name, dates of service, primary care
65 and referring physician information, the physician and/or facility performing the services,
66 amount paid, and, where applicable, amount withheld. Physicians should also receive specific
67 information on the company's provider units and/or contracted physicians reconciliation process
68 so that the provider can review the information at least three months prior to the corporation's
69 declaring the provider unit above, under, or at budget."

70 (7) a provision permitting the provider to refuse participation in one or more such other
71 plans at the time the contract is executed without affecting the provider's status as a member of
72 or for eligibility in the plan which is the subject of such contract or other plans."

73 (8) a prohibition against modification of the contract without the express, written consent
74 of all parties.

75 (9) a requirement that claims which may involve other carriers or future settlements,
76 including but not limited to auto accidents involving legal cases, be extracted from year end
77 budget and settlement information

78 SECTION 10. The General Laws are hereby amended by inserting after section 10 (c) of
79 chapter 176O the following:

80 (d) (1) A contracting agent shall be registered with the Division of Insurance. Provided
81 further that all contracts between a physician and a contracting agent shall comply with all of the
82 following requirements:

83 (a) Contain within the contract itself all material terms consistent with the general laws.

84 (b) Clearly and in a separate section, name any payer eligible to claim a discounted rate.

85 1. Any payers seeking eligibility to claim a discounted rate, directly or indirectly,
86 subsequent to the original execution of the contract must be added to the contract through a
87 separate amendment to the contract that is signed by the physician.

88 2. Any amendment naming additional payers shall be presented to the physician for
89 signature ninety (90) days prior to any anticipated disclosure, lease, sale, transfer, aggregation,
90 assignment, or conveyance of the physician's discounted rate.

91 (c) Identify and highlight all amendments made to the contract.

92 (d) Contain a provision identifying the right of the physician to affirmatively opt in
93 and/or opt out of any agreements to lease, sell, transfer, aggregate, assign or convey a physician
94 panel and associated discounts without penalty, sanction, or retaliation of any kind.

95 (e) Contain provisions informing the physician of his or her contracting and payment
96 rights, as specified in this section and all other relevant provisions of the general laws.

97 (f) Contain a provision fully disclosing any access fee or other remuneration the
98 contracting agent may receive and the specific benefits and service the contracting agent will
99 provide.

100 (g) Contain a provision that requires the contracting agent to obligate any payer or
101 covered entity, through contract, to not further disclose, lease, sell, transfer, aggregate, assign or
102 convey the physician panel and associated discounts to any other payer or entity; and

103 (h) Contain a provision that requires upon the termination of the physician-contracting
104 agent contract, the contracting agent to notify each payer or covered entity that the payer or
105 covered entity, is no longer authorized to:

106 1. Access the physician's discounted rate; or

107 2. Disclose, lease, sell, transfer, aggregate, assign, or convey the physician's discounted
108 rate.

109 (2) A contracting agent that proposes to sell, lease, assign, transfer or convey a
110 physician's name, contracted rate or any other information must have a direct contract with the
111 physician.

112 (3) A contracting agent shall ensure through contract terms that all payers to which it has
113 leased, sold, transferred, aggregated, assigned or conveyed a physician panel and its associated
114 discounts comply with the underlying contract between the contracting agent and the physician
115 and pay the physician pursuant to the rates of payment and methodology set forth in the
116 underlying contract.

117 (4) A contracting agent shall not lease, sell, transfer, aggregate, assign or convey its
118 physician panel and associated discounts or any other contractual obligation to any entity that is
119 not a payer.

120 (5) The contract between the contacting agent and physician will neither authorize nor
121 require the physician to consent to the sale of his or her name and contracted rates for use with
122 more than a single product or line of business.

123 (6) The contract between the contracting agent and the physician will neither authorize
124 nor require the physician to consent to the sale of his or her name and contracted rate more than
125 once.

126 (7) After receiving information from a contracted physician that a payer to whom a
127 contracting agent has leased, sold, transferred, aggregated, assigned or conveyed its physician
128 panel and associated discounts is not complying with the terms of the underlying contract,
129 including, but not limited to, statutory requirements for timely and accurate payment of claims,
130 and the contracted physician has fulfilled the appeal or grievance process described in the
131 underlying agreement, if any, without satisfaction, the contracting agent shall, within 45 days, do
132 at least one of the following:

133 (a) Ensure the payer causes correct payment to be made to the physician.

134 (b) Ensure the payer otherwise complies with the terms of the underlying contract or
135 terminate the contracting agent's agreement with the payer.

136 (c) Assume direct responsibility for the payment of the claim in question by paying
137 the physician the amount owed under the contract and in the manner required by general laws.

138 (8) A contracting agent shall require those payers and covered entities that are by
139 contract eligible to claim a physician's contracted rates to cease claiming entitlement to those
140 rates upon termination of the underlying contract between the contracting agent and the
141 physician or upon termination of the physician's authorization for the payer to pay the contracted
142 reimbursement rate as permitted under the terms of the contract between the contracting agent
143 and the physician.

144 (9) Any explanation of benefits and/or remittance advice issued in the Commonwealth
145 after the effective date of this act, in electronic or paper format, shall include the identity of the
146 entity authorized to have leased, sold, transferred, aggregated, assigned or conveyed the
147 physician's name and associated discount.

148 (10) After the effective date of this act, a payer, or any representative of the payer,
149 processing claims or claims payments, shall clearly identify, in electronic or paper format, on the
150 explanation of benefits and/or remittance advice, the entity assuming financial risk for services
151 and the identity of the contracting agent through which the payment rate and any discount are
152 claimed. A copy of the underlying contract must be provided to the physician upon request.

153 (11) After the effective date of this act, where the covered entity, contracting agent, or
154 payer issues member or subscriber identification cards, the cards shall, in a clear and legible
155 manner, identify any third-party entity, including any contracting agent, responsible for paying
156 claims and any third-party entity, including a contracting agent, whose contract with a payer
157 controls or otherwise affects reimbursement for claims filed pursuant to the subscriber contract.

158 (12) No payer, payer representative, administrator of claims payment, or other third party
159 acting on behalf of a payer shall be eligible to claim or otherwise proffer a physician's specific

160 contracted rate for services except to the extent that the rate is based on the contract that directly
161 controls payment for services provided to that patient and is reflected on the explanation of
162 benefits and/or remittance advice and on any patient identification card issued to the patient.

163 (13) Nothing in the contract between the contracting agent and the physician shall
164 supersede the provisions of this act.

165 (14) In coordination with relevant state law, no covered entity may retaliate against a
166 physician for exercising the right of action provided under this Act.

167 (15) The Division of Insurance shall adopt regulations as necessary for the
168 implementation and administration of this Act. Upon finding a contracting agent, insurer, or
169 other entity in violation of this Act, the Commissioner of Insurance may issue a cease and desist
170 order to prevent violation of this Act and shall issue fines and penalties of no less than \$1,000
171 per violation. The Division shall adopt an administrative remedy process for parties to pursue
172 their rights, including but not limited to the recoupment of payment lost, by a physician, due to
173 an unauthorized agreement to lease, sell, transfer, aggregate, assign or convey a physician panel
174 and associated discount arrangement in violation with this Act.

175 (16) Nothing in this Act prohibits or limits any claim or action for a claim that the
176 physician has against a covered entity or contracting agent. All applicable administrative fines
177 and penalties apply.

178 (17) If any provision of this Act is held by a court to be invalid, such invalidity shall not
179 affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby
180 declared severable.