SENATE DOCKET, NO. 1578 FILED ON: 1/14/2009

SENATE . . . . . No. 541

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:

SECTION 1. Section 38 of chapter 118E of the General Laws is hereby amended by inserting at the end thereof the following new paragraphs:-

Within 45 days after the receipt by the Division of completed forms for reimbursement to a physician who participates in a medical service program established pursuant to this chapter the Division shall (i) make payments for such services provided by the physician that are services covered under such medical assistance program and for which claim is made, or (ii) fully notify the provider in writing or by electronic means of any and all reason or reasons for nonpayment, or (iii) notify the provider within 15 days in writing or by electronic means of all additional information or documentation that is necessary to establish such physician’s entitlement to such reimbursement. If the Division fails to comply with the provisions of this paragraph for any such completed claim, the Division shall pay, in addition to any reimbursement for health care services provided to which the physician is entitled, interest on any unpaid amount of such benefits, which shall accrue beginning 45 days after the Division's receipt of request for reimbursement, or 15 days after the receipt of an electronic claim, at the rate of 1.5 per cent per

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

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

SECTION 2. Section 108, subsection 4 (c) of chapter 175 of the General Laws is hereby amended in the second sentence by striking out the words “forty five days” and inserting in place thereof the following:- fifteen days.

SECTION 3. Section 110 (G) of chapter 175 of the General Laws is hereby amended in the second sentence of the second paragraph by striking the words “forty five days” and inserting in place thereof the following:- fifteen days,

SECTION 4. Section 8 of chapter 176A is hereby amended in the first sentence of clause (e) by striking the words “within forty five days,”

SECTION 5. Section 7 of chapter 176 B of the General Laws is hereby amended in the second sentence of the second paragraph by striking out the words “forty five days” and inserting in place thereof the following:- fifteen days,

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

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

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

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

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

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

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

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

SECTION 9. Subsection (b) of Section 10 of chapter 176O of the General Laws is hereby amended by adding the following paragraphs:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Access the physician’s discounted rate; or

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) After the effective date of this act, where the covered entity, contracting agent, or payer issues member or subscriber identification cards, the cards shall, in a clear and legible manner, identify any third-party entity, including any contracting agent, responsible for paying

claims and any third-party entity, including a contracting agent, whose contract with a payer controls or otherwise affects reimbursement for claims filed pursuant to the subscriber contract.

(12) No payer, payer representative, administrator of claims payment, or other third party acting on behalf of a payer shall be eligible to claim or otherwise proffer a physician's specific contracted rate for services except to the extent that the rate is based on the contract that directly controls payment for services provided to that patient and is reflected on the explanation of benefits and/or remittance advice and on any patient identification card issued to the patient.

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

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

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

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

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