# HOUSE . . . . . No. 4315

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, March 22, 2018.

The committee on Financial Services to whom were referred the petition (accompanied by bill, House, No. 2193) of James J. O'Day and others for legislation to limit retroactive denials of health insurance claims for mental health and substance abuse services and the petition (accompanied by bill, House, No. 2974) of James J. O'Day and others for legislation to limit retroactive denials of health insurance claims for behavioral health and substance abuse services, reports recommending that the accompanying bill (House, No. 4315) ought to pass.

For the committee,

AARON MICHLEWITZ.

FILED ON: 2/7/2018

# HOUSE . . . . . No. 4315

## The Commonwealth of Massachusetts

**In the One Hundred and Ninetieth General Court**
**(2017-2018)**

An Act to limit retroactive denials of health insurance claims for behavioral health and substance abuse services.

*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. Chapter 32A of the General Laws, as appearing in the 20XX Official Edition, is hereby amended by inserting after section 4A the following new section: -

Section 4B. (a) The commission or any entity with which the commission contracts to provide or manage health insurance benefits, including mental health services, shall not impose a retroactive claims denial, as defined in section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on a provider unless:

(i) Less than twelve months have elapsed from the time of submission of the claim by the provider to the commission or other entity responsible for payment;

(ii) The commission or other entity has furnished the provider with a written explanation of the reason for the retroactive claim denial, and a description of additional documentation or other corrective actions required for payment of the claim.

(b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be permitted after twelve months if:

(i) The claim was submitted fraudulently;

(ii) The claim payment is subject to adjustment due to expected payment from another payer and not more than 12 months have elapsed since submission of the claim; or

(iii) The claims, or services for which the claim has been submitted, is the subject of legal action.

(iv) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim; or

(v) the health care services identified in the claim were not delivered by the provider.

(c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph (b), the commission or other entity shall notify a provider at least 15 days before imposing the retroactive claim denial and the provider shall have twelve months to determine whether the claim is subject to payment by a secondary insurer. Notwithstanding the contractual terms between the provider and insurer, an insurer shall allow for submission of a claim that was previously denied by another insurer due to the insured's transfer or termination of coverage.

(d) For the purposes of this subsection, provider shall mean a mental health clinic or substance use disorder program licensed by the department of public health under Chapters 18, 111, 111B, or 111E , a behavioral, substance use disorder, or mental health professional who is licensed under Chapter 112 of the General Laws and accredited or certified to provide services consistent with law and who has provided services under an express or implied contract or with

the expectation of receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly from the commission or other entity.

SECTION 2. Chapter 118E of the General Laws, as so appearing, is amended by inserting after section 38 the following new section: -

38A. (a) The division or any entity with which the division contracts to provide or manage health insurance benefits, including mental health services, shall not impose a retroactive claims denial, as defined in section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on a provider unless:

(i) Less than twelve months have elapsed from the time of submission of the claim by the provider to the division or other entity responsible for payment;

(ii) The division or other entity has furnished the provider with a written explanation of the reason for the retroactive claim denial, and a description of additional documentation or other corrective actions required for payment of the claim.

(b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be permitted after twelve months if:

(i) The claim was submitted fraudulently;

(ii) The claim payment is subject to adjustment due to expected payment from another payer and not more than 12 months have elapsed since submission of the claim;

(iii) The claims, or services for which the claim has been submitted, is the subject of legal action;

(iv) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim;

(v) the health care services identified in the claim were not delivered by the provider.

(c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph (b), the division or other entity shall notify a provider at least 15 days before imposing the retroactive claim denial and the provider shall have twelve months to determine whether the claim is subject to payment by a secondary insurer. Notwithstanding the contractual terms between the provider and insurer, an insurer shall allow for submission of a claim that was previously denied by another insurer due to the insured's transfer or termination of coverage.

(d) For the purposes of this subsection, provider shall mean a mental health clinic or substance use disorder program licensed by the department of public health under Chapters 18, 111, 111B, or 111E, a behavioral, substance use disorder, or mental health professional who is licensed under Chapter 112 of the General Laws and accredited or certified to provide services consistent with law and who has provided services under an express or implied contract or with the expectation of receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly from the division or managed care entity.

SECTION 3. Section 1 of Chapter 175 of the General Laws, as so appearing, is amended by inserting before the definition of "Commissioner" the following new definition:

"Behavioral Health", mental health and substance use disorder prevention, recovery and treatment services including but not limited to inpatient 24 hour levels of care, 24 hour and non 24 hour diversionary levels of care, intermediate levels of care and outpatient services

and by inserting after the definition of "Resident" the following new definition:

"Retroactive Claim Denial", an action by a) an insurer, b) an entity with which the insurer subcontracts to manage behavioral health services, c) an entity with which the Group Insurance Commission has entered into an administrative services contract or a contract to manage behavioral health services, or d) the executive office of health and human services acting as the singe state agency under section 1902(a)(5) of the Social Security Act authorized to administer programs under title XIX, to deny a previously paid claim for services and to require repayment of the claim, impose a reduction in other payments, or otherwise withhold or affect future payments owed a provider in order to recoup payment for the denied claim.

SECTION 4. Section 108 of chapter 175 of the General Laws, as so appearing, is hereby amended by adding the following new subsection at the end thereof: -

(a) No insurer shall impose a retroactive claims denial, as defined in section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on a provider unless:

(i) Less than twelve months have elapsed from the time of submission of the claim by the provider to the insurer or other entity responsible for payment;

(ii) The insurer or other entity has furnished the provider with a written explanation of the reason for the retroactive claim denial, and a description of additional documentation or other corrective actions required for payment of the claim.

(b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be permitted after twelve months if:

(i) The claim was submitted fraudulently;

(ii) The claim payment is subject to adjustment due to expected payment from another payer and not more than 12 months have elapsed since submission of the claim; or

(iii) The claims, or services for which the claim has been submitted, is the subject of legal action.

(iv) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim; or

(v) the health care services identified in the claim were not delivered by the provider.

(c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph (b), the insurer shall notify a provider at least 15 days before imposing the retroactive claim denial and the provider shall have twelve months to determine whether the claim is subject to payment by a secondary insurer. Notwithstanding the contractual terms between the provider and insurer, an insurer shall allow for submission of a claim that was previously denied by another insurer due to the insured's transfer or termination of coverage.

(d) For the purposes of this subsection, provider shall mean a mental health clinic or substance use disorder program licensed by the department of public health under Chapters 18, 111, 111B, or 111E, a behavioral, substance use disorder, or mental health professional who is licensed under Chapter 112 of the General Laws and accredited or certified to provide services consistent with law and who has provided services under an express or implied contract or with the expectation of receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly from an insurer.

SECTION 5. Chapter 176A of the General Laws, as so appearing, is amended by inserting after section 8 the following new section:-

Section 8A (a) The corporation shall not impose a retroactive claims denial, as defined in section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on a provider unless:

(i) Less than twelve months have elapsed from the time of submission of the claim by the provider to the corporation;

(ii) The corporation has furnished the provider with a written explanation of the reason for the retroactive claim denial, and a description of additional documentation or other corrective actions required for payment of the claim.

(b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be permitted after twelve months if:

(i) The claim was submitted fraudulently;

(ii) The claim payment is subject to adjustment due to expected payment from another payer and not more than 12 months have elapsed since submission of the claim; or

(iii) The claims, or services for which the claim has been submitted, is the subject of legal action.

(iv) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim; or

(v) the health care services identified in the claim were not delivered by the provider.

(c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph (b), the corporation shall notify a provider at least 15 days before imposing the retroactive claim denial and the provider shall have twelve months to determine whether the claim is subject to

payment by a secondary payer. Notwithstanding the contractual terms between the provider and secondary payer, the payer shall allow for submission of a claim that was previously denied by the corporation due to the insured's transfer or termination of coverage.

(d) For the purposes of this subsection, provider shall mean a mental health clinic or substance use disorder program licensed by the department of public health under Chapters 18, 111, 111B, or 111E, a behavioral, substance use disorder, or mental health professional who is licensed under Chapter 112 of the General Laws and accredited or certified to provide services consistent with law and who has provided services under an express or implied contract or with the expectation of receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly from an insurer.

SECTION 6. Chapter 176B of the General Laws, as so appearing is hereby amended by inserting after section 7C the following new section:-

Section 7D (a) The corporation shall not impose a retroactive claims denial, as defined in section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on a provider unless:

(i) Less than twelve months have elapsed from the time of submission of the claim by the provider to the corporation;

(ii) The corporation has furnished the provider with a written explanation of the reason for the retroactive claim denial, and a description of additional documentation or other corrective actions required for payment of the claim.

(b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be permitted after twelve months if:

(i) The claim was submitted fraudulently;

(ii) The claim payment is subject to adjustment due to expected payment from another payer and not more than 12 months have elapsed since submission of the claim; or

(iii) The claims, or services for which the claim has been submitted, is the subject of legal action.

(iv) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim; or

(v) the health care services identified in the claim were not delivered by the provider.

(c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph (b), the corporation shall notify a provider at least 15 days before imposing the retroactive claim denial and the provider shall have twelve months to determine whether the claim is subject to payment by a secondary payer. Notwithstanding the contractual terms between the provider and secondary payer, the payer shall allow for submission of a claim that was previously denied by the corporation due to the insured's transfer or termination of coverage.

(d) For the purposes of this subsection, provider shall mean a mental health clinic or substance use disorder program licensed by the department of public health under Chapters 18, 111, 111B, or 111E , a behavioral, substance use disorder, or mental health professional who is licensed under Chapter 112 of the General Laws and accredited or certified to provide services consistent with law and who has provided services under an express or implied contract or with

the expectation of receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly from an insurer.

SECTION 7. Chapter 176G of the General Laws, as so appearing, is hereby amended by inserting after section 6A the following new section:-

Section 6B. (a) No insurer shall impose a retroactive claims denial, as defined in section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on a provider unless:

(i) Less than twelve months have elapsed from the time of submission of the claim by the provider to the insurer or other entity responsible for payment;

(ii) The insurer or other entity has furnished the provider with a written explanation of the reason for the retroactive claim denial, and a description of additional documentation or other corrective actions required for payment of the claim.

(b) Notwithstanding clauses (i) of paragraph (d), retroactive claim denials may be permitted after twelve months if:

(i) The claim was submitted fraudulently;

(ii) The claim payment is subject to adjustment due to expected payment from another payer and not more than 12 months have elapsed since submission of the claim; or

(iii) The claims, or services for which the claim has been submitted, is the subject of legal action.

(iv) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim; or

(v) the health care services identified in the claim were not delivered by the provider.

(c) In cases in which a retroactive claim denial is imposed under clause (ii) of paragraph (b), the insurer shall notify a provider at least 15 days before imposing the retroactive claim denial and the provider shall have twelve months to determine whether the claim is subject to payment by a secondary insurer. Notwithstanding the contractual terms between the provider and insurer, an insurer shall allow for submission of a claim that was previously denied by another insurer due to the insured's transfer or termination of coverage.

(d) For the purposes of this subsection, provider shall mean a mental health clinic or substance use disorder program licensed by the department of public health under Chapters 18, 111, 111B, or 111E, a behavioral, substance use disorder, or mental health professional who is licensed under Chapter 112 of the General Laws and accredited or certified to provide services consistent with law and who has provided services under an express or implied contract or with the expectation of receiving payment, other than co- payment, deductible or co-insurance, directly or indirectly from an insurer.

SECTION 8. The Division of Medical Assistance is hereby authorized and directed to develop an internal process for the reconciliation of claims due to retroactive eligibility changes and/or duplicate enrollments in cases that involve multiple payers for services provided to MassHealth enrollees. This process shall not require provider involvement. The division shall report to the senate and house committees on ways and means on this process no longer than five months after enactment of this legislation.