SENATE DOCKET, NO. 1498 FILED ON: 1/17/2019

SENATE . . . . . No. 589

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 limits on insurers' retroactive clawbacks for mental health and substance use disorder services.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
Cindy F. Friedman	*Fourth Middlesex*	
Michael J. Rodrigues	*First Bristol and Plymouth*	
Sean Garballey	*23rd Middlesex*	*1/28/2019*
Maria Duaime Robinson	*6th Middlesex*	*1/28/2019*
Jason M. Lewis	*Fifth Middlesex*	*1/29/2019*
Kenneth I. Gordon	*21st Middlesex*	*1/29/2019*
Rebecca L. Rausch	*Norfolk, Bristol and Middlesex*	*1/30/2019*
Mike Connolly	*26th Middlesex*	*1/30/2019*
Patricia D. Jehlen	*Second Middlesex*	*1/31/2019*
Donald F. Humason, Jr.	*Second Hampden and Hampshire*	*1/31/2019*
Patrick M. O'Connor	*Plymouth and Norfolk*	*1/31/2019*
John F. Keenan	*Norfolk and Plymouth*	*2/1/2019*
Joan B. Lovely	*Second Essex*	*2/1/2019*
Mark C. Montigny	*Second Bristol and Plymouth*	*2/1/2019*
Julian Cyr	*Cape and Islands*	*2/1/2019*
Michael O. Moore	*Second Worcester*	*2/11/2019*
Joanne M. Comerford	*Hampshire, Franklin and Worcester*	*2/22/2019*

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SENATE . . . . . No. 589

The Commonwealth of Massachusetts

In the One Hundred and Ninety-First General Court
(2019-2020)

An Act relative to limits on insurers' retroactive clawbacks for mental health and substance use disorder 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 2016 Official Edition, is hereby amended by inserting after section 4A the following section:-

Section 4B. (a) For the purposes of this section, 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, or a behavioral, substance use disorder, or mental health professional who is licensed under chapter 112 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.

(b) The commission or any entity with which the commission contracts to provide or manage health insurance benefits, including mental health and substance use disorder 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:

(1) less than 12 months have elapsed from the time of submission of the claim by the provider to the commission or other entity responsible for payment;

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

(3) where applicable, the commission or other entity responsible for payment allows the provider 30 days to submit additional documentation or take other corrective actions required for payment of the claim.

(c) Notwithstanding subsection (b), retroactive claim denials may be permitted after 12 months if:

(1) the claim was submitted fraudulently;

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

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

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

(d) In cases in which a retroactive claim denial is imposed because the claim payment is subject to adjustment due to expected payment from another payer other than the commission or any entity with which the commission contracts to provide or manage health insurance benefits, including mental health and addiction services, the commission or other entity shall notify a provider at least 15 days before imposing the retroactive claim denial. The provider shall then

have 12 months to determine whether the claim is subject to payment by a secondary insurer; provided, that if the claim is denied by the secondary insurer due to the insured's transfer or termination of coverage, the commission shall allow for resubmission of the claim.

SECTION 2. Chapter 118E of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after section 38 the following section:-

Section 38A. (a) For the purposes of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Provider", 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 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;

"Retroactive claim denial" the denial of a previously paid claim for services that results in the requirement to repay the claim, or the imposition of a reduction in other payments, or otherwise causes a withholding or affects future payments owed to a provider in order to recoup payment for the denied claim.

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

(1) less than 12 months have elapsed from the time of submission of the claim by the provider to the division or other entity responsible for payment;

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

(3) where applicable, the division or other entity responsible for payment allows the provider 30 days to submit additional documentation or take other corrective actions required for payment of the claim.

(c) Notwithstanding subsection (b), retroactive claim denials may be permitted after 12 months if:

(1) the claim was submitted fraudulently;

(2) the claim payment is subject to adjustment due to expected payment from another payer other than the division or any entity with which the division contracts to provide or manage health insurance benefits, including mental health and addiction services;

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

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

(5) the health care services identified in the claim were not delivered by the provider; or

(6) the services were not delivered in accordance with MassHealth regulations.

(d) In cases in which a retroactive claim denial is imposed under clause (2) of subsection (c), the division or other entity shall notify a provider at least 15 days before imposing the retroactive claim denial. The provider shall then have 12 months to determine whether the claim is subject to payment by a secondary insurer; provided, that if the claim is denied by the secondary insurer due to the insured's transfer or termination of coverage, the division shall allow for resubmission of the claim.

SECTION 3. Section 1 of chapter 175 of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting before the definition of "Commissioner" the following definition:-

"Behavioral health services", 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.

SECTION 4. Said section 1 of said chapter 175, as so appearing, is hereby amended by inserting after the definition of "Resident" the following definition:-

"Retroactive claim denial", an action by an insurer, an entity with which the insurer subcontracts to manage behavioral health services, or an entity with which the Group Insurance Commission has entered into an administrative services contract or a contract to manage behavioral health services, to deny a previously paid claim for services and to require repayment of the claim, or to impose a reduction in other payments or otherwise withhold or affect future payments owed to a provider in order to recoup payment for the denied claim.

SECTION 5. Section 108 of said chapter 175, as so appearing, is hereby amended by adding the following section:-

Section 14. (a) For the purposes of this section, 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, or a behavioral, substance use disorder, or mental health professional who is licensed under chapter 112 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 or other entity.

(b) No insurer or other entity 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:

(1) less than 12 months have elapsed from the time of submission of the claim by the provider to the insurer or other entity responsible for payment;

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

(3) where applicable, the insurer or other entity responsible for payment allows the provider 30 days to submit additional documentation or take other corrective actions required for payment of the claim.

(c) Notwithstanding subsection (b), retroactive claim denials may be permitted after 12 months if:

(1) the claim was submitted fraudulently;

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

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

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

(d) In cases in which a retroactive claim denial is imposed because the claim payment is subject to adjustment due to expected payment from another payer other than the insurer or any entity with which the insurer contracts to provide or manage health insurance benefits, including mental health and addiction services, the insurer or other entity shall notify a provider at least 15 days before imposing the retroactive claim denial. The provider shall then have 12 months to determine whether the claim is subject to payment by a secondary insurer; provided, that if the claim is denied by the secondary insurer due to the insured's transfer or termination of coverage, the insurer shall allow for resubmission of the claim.

SECTION 6. Chapter 176A of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after section 8A the following section:-

Section 8A1/2. (a) For the purposes of this section, 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, or a behavioral, substance use disorder, or mental health

professional who is licensed under chapter 112 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 corporation.

(b) 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:

(1) less than 12 months have elapsed from the time of submission of the claim by the provider to the corporation;

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

(3) where applicable, the corporation allows the provider 30 days to submit additional documentation or take other corrective actions required for payment of the claim.

(c) Notwithstanding subsection (b), retroactive claim denials may be permitted after 12 months if:

(1) the claim was submitted fraudulently;

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

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

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

(d) In cases in which a retroactive claim denial is imposed because the claim payment is subject to adjustment due to expected payment from another payer other than the corporation, including mental health and addiction services, the corporation shall notify a provider at least 15 days before imposing the retroactive claim denial. The provider shall then have 12 months to determine whether the claim is subject to payment by a secondary insurer; provided, that if the claim is denied by the secondary insurer due to the insured's transfer or termination of coverage, the corporation shall allow for resubmission of the claim.

SECTION 7. Chapter 176B of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after section 7C the following section:-

Section 7D. (a) For the purposes of this section, 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, or a behavioral, substance use disorder, or mental health professional who is licensed under chapter 112 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 corporation.

(b) 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:

(1) less than 12 months have elapsed from the time of submission of the claim by the provider to the corporation;

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

(3) where applicable, the corporation allows the provider 30 days to submit additional documentation or take other corrective actions required for payment of the claim.

(c) Notwithstanding subsection (b), retroactive claim denials may be permitted after 12 months if:

(1) the claim was submitted fraudulently;

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

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

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

(d) In cases in which a retroactive claim denial is imposed because the claim payment is subject to adjustment due to expected payment from another payer other than the corporation, including mental health and substance use disorder services, the corporation shall notify a provider at least 15 days before imposing the retroactive claim denial. The provider shall then have 12 months to determine whether the claim is subject to payment by a secondary insurer; provided, that if the claim is denied by the secondary insurer due to the insured's transfer or termination of coverage, the corporation shall allow for resubmission of the claim.

SECTION 8. Chapter 176G of the General Laws, as appearing in the 2016 Official Edition, is hereby amended by inserting after section 6A the following section:-

Section 6B. (a) For the purposes of this section, 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, or a behavioral, substance use disorder, or mental health professional who is licensed under chapter 112 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 insurer or other entity.

(b) The insurer or other entity 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:

(1) less than 12 months have elapsed from the time of submission of the claim by the provider to the insurer or other entity;

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

(3) where applicable, the insurer or other entity allows the provider 30 days to submit additional documentation or take other corrective actions required for payment of the claim.

(c) Notwithstanding subsection (b), retroactive claim denials may be permitted after 12 months if:

(1) the claim was submitted fraudulently;

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

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

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

(d) In cases in which a retroactive claim denial is imposed because the claim payment is subject to adjustment due to expected payment from another payer other than the insurer or other entity, including mental health and substance use disorder services, the insurer or other entity shall notify a provider at least 15 days before imposing the retroactive claim denial. The provider shall then have 12 months to determine whether the claim is subject to payment by a secondary insurer; provided, that if the claim is denied by the secondary insurer due to the insured's transfer or termination of coverage, the insurer shall allow for resubmission of the claim.