

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

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:

1 SECTION 1. Chapter 32A of the General Laws, as appearing in the 2016 Official
2 Edition, is hereby amended by inserting after section 4A the following section:-

3 Section 4B. (a) For the purposes of this section, provider shall mean a mental health
4 clinic or substance use disorder program licensed by the department of public health under
5 chapters 18, 111, 111B, or 111E, or a behavioral, substance use disorder, or mental health
6 professional who is licensed under chapter 112 and accredited or certified to provide services
7 consistent with law and who has provided services under an express or implied contract or with
8 the expectation of receiving payment, other than co-payment, deductible or co-insurance, directly
9 or indirectly from the commission or other entity.

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

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

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

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

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

24 (1) the claim was submitted fraudulently;

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

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

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

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

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

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

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

42 "Provider", a mental health clinic or substance use disorder program licensed by the
43 department of public health under chapters 18, 111, 111B, or 111E, a behavioral, substance use
44 disorder, or mental health professional who is licensed under chapter 112 and accredited or
45 certified to provide services consistent with law and who has provided services under an express
46 or implied contract or with the expectation of receiving payment, other than co- payment,
47 deductible or co-insurance, directly or indirectly from the division or managed care entity;

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

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

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

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

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

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

66 (1) the claim was submitted fraudulently;

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

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

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

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

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

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

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

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

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

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

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

99 Section 14. (a) For the purposes of this section, provider shall mean a mental health clinic
100 or substance use disorder program licensed by the department of public health under chapters 18,
101 111, 111B, or 111E, or a behavioral, substance use disorder, or mental health professional who
102 is licensed under chapter 112 and accredited or certified to provide services consistent with law
103 and who has provided services under an express or implied contract or with the expectation of
104 receiving payment, other than co-payment, deductible or co-insurance, directly or indirectly from
105 an insurer or other entity.

106 (b) No insurer or other entity shall impose a retroactive claims denial, as defined in
107 section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on
108 a provider unless:

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

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

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

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

119 (1) the claim was submitted fraudulently;

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

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

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

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

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

135 Section 8A1/2. (a) For the purposes of this section, provider shall mean a mental health
136 clinic or substance use disorder program licensed by the department of public health under
137 chapters 18, 111, 111B, or 111E, or a behavioral, substance use disorder, or mental health

138 professional who is licensed under chapter 112 and accredited or certified to provide services
139 consistent with law and who has provided services under an express or implied contract or with
140 the expectation of receiving payment, other than co-payment, deductible or co-insurance, directly
141 or indirectly from the corporation.

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

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

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

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

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

154 (1) the claim was submitted fraudulently;

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

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

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

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

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

169 Section 7D. (a) For the purposes of this section, provider shall mean a mental health
170 clinic or substance use disorder program licensed by the department of public health under
171 chapters 18, 111, 111B, or 111E, or a behavioral, substance use disorder, or mental health
172 professional who is licensed under chapter 112 and accredited or certified to provide services
173 consistent with law and who has provided services under an express or implied contract or with
174 the expectation of receiving payment, other than co-payment, deductible or co-insurance, directly
175 or indirectly from the corporation.

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

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

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

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

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

188 (1) the claim was submitted fraudulently;

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

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

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

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

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

203 Section 6B. (a) For the purposes of this section, provider shall mean a mental health
204 clinic or substance use disorder program licensed by the department of public health under
205 chapters 18, 111, 111B, or 111E, or a behavioral, substance use disorder, or mental health
206 professional who is licensed under chapter 112 and accredited or certified to provide services
207 consistent with law and who has provided services under an express or implied contract or with
208 the expectation of receiving payment, other than co-payment, deductible or co-insurance, directly
209 or indirectly from the insurer or other entity.

210 (b) The insurer or other entity shall not impose a retroactive claims denial, as defined in
211 section 1 of chapter 175, for behavioral health services, as defined in section 1 of chapter 175, on
212 a provider unless:

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

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

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

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

222 (1) the claim was submitted fraudulently;

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

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

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

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