SENATE DOCKET, NO. 01376 FILED ON: 01/21/2011

SENATE . . . . . No. 00526

The Commonwealth of Massachusetts

PRESENTED BY:

Michael O. Moore

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 passage of the accompanying bill:

An Act relative to equitable reimbursement rates..

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Michael O. Moore	*Second Worcester*

SENATE . . . . . No. 00526

By Mr. Moore, petition (accompanied by bill, Senate, No. 526) of Moore for legislation relative to equitable reimbursement rates [Joint Committee on Health Care Financing].

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to equitable reimbursement rates..

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 12 of Chapter 118E of the General Laws is hereby amended by inserting at the beginning of the section the following new definitions:

“Managed Care Organization”, any entity with which the Commonwealth contracts to provide managed care services to eligible MassHealth enrollees on a capitated basis.

"Network", a grouping of health care providers who contract with a managed care organization to provide services to MassHealth enrollees covered by the managed care organization’s plans, policies, contracts or other arrangements.

“Non-network provider”, a health care provider who has not entered into a contract with a managed care organization to provide services to MassHealth enrollees.

SECTION 2. Section 12 of Chapter 118E of the General Laws is further amended by inserting at the end of the section the following new language:

For emergency, post-stabilization, and certain other services that have received a prior approval by a managed care organization contracting with the Commonwealth to provide managed care services to MassHealth enrollees, health care providers not included in a managed care organization's network, must accept a rate equal to the rate paid by Medicaid for the same or similar services. Nothing in this section shall prohibit a managed care organization from denying payment for unapproved services conducted by a non-network provider.

SECTION 3. Chapter 118G is hereby amended by adding the following new Section:

As used in this section, the following words shall have the following meanings:

"Payor", carrier, as defined by M.G.L. Chapter 176O, the group insurance commission established under chapter 32A; and to the extent legally feasible and otherwise not prohibited by any applicable provision of the Employee Retirement Income Security Act of 1974, other employee welfare benefit plans.

Every acute care hospital, health care facility, ambulatory surgical center, or outpatient facility licensed in the commonwealth that does not agree to participate in a payor's network must accept a rate equal 110% of the rate paid by Medicare for the same or similar services. Nothing in this section shall prohibit a payor from denying payment for unapproved services conducted by a non-network provider. Every acute care hospital, health care facility, ambulatory surgical center, or outpatient facility licensed in the commonwealth shall be prohibited from attempting to charge or to collect from the enrollee, or persons acting on the enrollee's behalf, any amount in excess of the amount paid by the payor for that service pursuant to the requirements of this section, other than applicable co-payments, co-insurance and deductibles.

SECTION 4. Chapter 118H of the General Laws is hereby amended by the addition of a new Section 7, as follows:

Section 7. For emergency, post-stabilization, and certain other services that have received a prior approval by a carrier or managed care organization contracting with the Connector to provide managed care services to Commonwealth Care Health Insurance Program enrollees, health care providers not included in a managed care organization's network, must accept a rate equal to the rate paid by Medicaid for the same or similar services. Nothing in this section shall prohibit a carrier or managed care organization from denying payment for unapproved services conducted by a non-network provider.