HOUSE DOCKET, NO. 978 FILED ON: 1/14/2015

HOUSE . . . . . No. 974

The Commonwealth of Massachusetts

PRESENTED BY:

Mark J. Cusack

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 to extend patient protections to recipients of MassHealth.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Mark J. Cusack	*5th Norfolk*

HOUSE DOCKET, NO. 978 FILED ON: 1/14/2015

HOUSE . . . . . No. 974

By Mr. Cusack of Braintree, a petition (accompanied by bill, House, No. 974) of Mark J. Cusack relative to health insurance consumer protections. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. *1014* OF 2013-2014.]

The Commonwealth of Massachusetts

In the One Hundred and Eighty-Ninth General Court
(2015-2016)

An Act to extend patient protections to recipients of MassHealth.

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 118 E, Section 38 as appearing in the 2010 Official Edition of the Mass General Laws is hereby amended by inserting at the end thereof of 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, or within 15 days if such claim is received electronically, 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) notify the physician in writing or by electronic means, within 15 days for written claim forms or 48 hours for electronic claims, of any and all reasons for non-payment, or (iii) notify the physician in writing or by electronic means,

11 within 15 days for written claim forms or 48 hours for electronic claims, of all additional
12 information or documentation that is necessary to establish such physician's entitlement to such
13 reimbursement. If the Division fails to comply with the provisions of this paragraph for any such
14 completed claim, the Division shall pay, in addition to any reimbursement for health care
15 services provided to which the physician is entitled, interest on any unpaid amount of such
16 benefits, which shall accrue beginning 45 days after the Division's receipt of request for
17 reimbursement, or 15 days after the receipt of an electronic claim, at the rate of 1.5 per cent per
18 month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest
19 payments shall not apply to a claim that the Division is investigating because of suspected
20 fraud."

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

29 The Division shall institute no policy or practice of recoupment, reduction, review or
30 retroactive denial of payments to any physician or physicians for services provided one year or
31 more prior to the date of the Division's initiating said policy or practice. Physicians must be
32 given written notice by the Division specifying any and all policy changes which may result in

33 recoupments, reductions or reviews of payments for physician services at least 90 days prior to
34 the implementation of such recoupments, reductions or reviews.

35 SECTION 2.

36 CHAPTER 176O, as most recently amended by Chapter 224 of the Acts of 2012, is
37 hereby amended by the deletion of the title and inserting in place thereof the following new title:
38 HEALTH INSURANCE AND DIVISION OF MEDICAL ASSISTANCE CONSUMER
39 PROTECTIONS.

40 SECTION 3.

41 Said Chapter 176 O Section 1 is further amended by the deletion of the following
42 paragraph:

43 ““Carrier", an insurer licensed or otherwise authorized to transact accident or health
44 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
45 176A; a nonprofit medical service corporation organized under chapter 176B; a health
46 maintenance organization organized under chapter 176G; and an organization entering into a
47 preferred provider arrangement under chapter 176I, but not including an employer purchasing
48 coverage or acting on behalf of its employees or the employees of one or more subsidiaries or
49 affiliated corporations of the employer. Unless otherwise noted, the term "carrier" shall not
50 include any entity to the extent it offers a policy, certificate or contract that provides coverage
51 solely for dental care services or visions care services.”;

52 And inserting in place thereof the following new paragraph:

53 "Carrier", an insurer licensed or otherwise authorized to transact accident or health
54 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
55 176A; a nonprofit medical service corporation organized under chapter 176B; a health
56 maintenance organization organized under chapter 176G, the Primary Care Clinician Program or
57 any entity providing managed care services under contract to the Division, or any similar
58 managed care arrangement of the Division of Medical Assistance or its successor providing
59 medical care coverage to eligible individuals under M. G. L. Chapter 118 E; and an organization
60 entering into a preferred provider arrangement under chapter 176I, but not including an employer
61 purchasing coverage or acting on behalf of its employees or the employees of one or more
62 subsidiaries or affiliated corporations of the employer. Unless otherwise noted, the term "carrier"
63 shall not include any entity to the extent it offers a policy, certificate or contract that provides
64 coverage solely for dental care services or visions care services."

65 SECTION 4.

66 Said Chapter 176 O, Section 1 is further amended by the deletion of the following
67 definition:

68 "Covered benefits" or "benefits", health care services to which an insured is entitled
69 under the terms of the health benefit plan."

70 And inserting in place thereof the following definition:

71 "Covered benefits" or "benefits", health care services to which an insured or a recipient of
72 services under the Division of Medical Assistance or its successor entity under M. G. L. Chapter
73 118 E is entitled under the terms of a health benefit plan or program.

74 SECTION 5.

75 Said Chapter 176O, Section 1 is further amended by the deletion of the following
76 definition:

77 "Grievance", any oral or written complaint submitted to the carrier which has been
78 initiated by an insured, or on behalf of an insured with the consent of the insured, concerning any
79 aspect or action of the carrier relative to the insured, including, but not limited to, review of
80 adverse determinations regarding scope of coverage, denial of services, quality of care and
81 administrative operations, in accordance with the requirements of this chapter.

82 And inserting in place thereof the following definition:

83 "Grievance", any oral or written complaint submitted to the carrier or the Division of
84 Medical Assistance or its successor entity under M. G. L. Chapter 118 E which has been initiated
85 by an insured or a recipient of public assistance, or on behalf of an insured or recipient of public
86 assistance with the consent of the insured or the recipient, concerning any aspect or action of the
87 carrier or the Division of Medical Assistance or its successor entity under M. G. L. Chapter 118
88 E relative to the insured or the recipient, including, but not limited to, review of adverse
89 determinations regarding scope of coverage, denial of services, quality of care and administrative
90 operations, in accordance with the requirements of this chapter.

91 SECTION 6.

92 Said Chapter 176 O, Section 1 is further amended by the deletion of the following
93 definition:

94 "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or
95 issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of
96 health care services.

97 And inserting in place thereof the following definition:

98 "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or
99 issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of
100 health care services; or a managed care arrangement of the Division of Medical Assistance or its
101 successor entity under M. G. L. Chapter 118 E.

102 SECTION 7.

103 Said Chapter 176 O, Section 1 is further amended by the deletion of the following
104 definition:

105 "Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a
106 carrier, including an individual whose eligibility as an insured of a carrier is in dispute or under
107 review, or any other individual whose care may be subject to review by a utilization review
108 program or entity as described under other provisions of this chapter.

109 And inserting in place thereof the following definition:

110 "Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a
111 carrier, including an assistance recipient of the Division of Medical Assistance, and including an
112 individual whose eligibility as an insured of a carrier is in dispute or under review, or any other
113 individual whose care may be subject to review by a utilization review program or entity as
114 described under other provisions of this chapter.

115 SECTION 8.

116 Said Chapter 176 O, Section 2(a) is hereby amended by the deletion of lines 1 through 3
117 and inserting in place thereof the following:

118 Section 2. (a) There is hereby established within the center a bureau of managed care.
119 Said bureau shall by regulation establish minimum standards for the accreditation of carriers,
120 other than the Division of Medical Assistance or its successor entity under M. G. L. Chapter 118
121 E, in the following areas:

122 SECTION 9.

123 Said Chapter 176 O, Section 8 is hereby amended by striking said section in its entirety
124 and inserting in place thereof the following:

125 Section 8. A carrier, other than the Division of Medical Assistance or its successor entity
126 under M. G. L. Chapter 118 E, neglecting to make and file its annual statement or the materials
127 required by the commissioner to be filed with the division under this chapter or under chapter
128 176G in the form and within the time required thereby shall be fined $5,000 for each day during
129 which such neglect continues after being notified by said commissioner of such neglect, and,
130 after notice and a hearing by the commissioner to that effect, its authority to do new business
131 shall cease while such neglect continues