

**HOUSE . . . . . No. 941**

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**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 increase MassHealth rates.**

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
<i>Mark J. Cusack</i>	<i>5th Norfolk</i>	<i>1/15/2019</i>

**HOUSE . . . . . No. 941**

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By Mr. Cusack of Braintree, a petition (accompanied by bill, House, No. 941) of Mark J. Cusack relative to MassHealth rates and health insurance consumer protections. Financial Services.

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**The Commonwealth of Massachusetts**

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

An Act to increase MassHealth rates.

*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 118 E, Section 13 is hereby amended by inserting at the end of the  
2 second sentence, after the words “ways and means” the following:

3           “; provided further that said rates shall be equal to or greater than the federal Medicare  
4 rates for the same services, and that there shall be one reimbursement fee schedule for all Title  
5 XIX Accountable Care Organizations rendering care to recipients of said Title XIX state  
6 program.”

7           SECTION 2. Chapter 118 E, Section 38 is hereby amended by inserting at the end thereof  
8 of the following new paragraphs:

9           “Within 45 days after the receipt by the Division of completed forms for reimbursement  
10 to a physician who participates in a medical service program established pursuant to this chapter,  
11 or within 15 days if such claim is received electronically, the Division shall (i) make payments  
12 for such services provided by the physician that are services covered under such medical

13 assistance program and for which claim is made, or (ii) notify the physician in writing or by  
14 electronic means, within 15 days for written claim forms or 48 hours for electronic claims, of any  
15 and all reasons for non-payment, or (iii) notify the physician in writing or by electronic means,  
16 within 15 days for written claim forms or 48 hours for electronic claims, of all additional  
17 information or documentation that is necessary to establish such physician's entitlement to such  
18 reimbursement. If the Division fails to comply with the provisions of this paragraph for any such  
19 completed claim, the Division shall pay, in addition to any reimbursement for health care  
20 services provided to which the physician is entitled, interest on any unpaid amount of such  
21 benefits, which shall accrue beginning 45 days after the Division's receipt of request for  
22 reimbursement, or 15 days after the receipt of an electronic claim, at the rate of 1.5 per cent per  
23 month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest  
24 payments shall not apply to a claim that the Division is investigating because of suspected  
25 fraud.”

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

34 The Division shall institute no policy or practice of recoupment, reduction, review or  
35 retroactive denial of payments to any physician or physicians for services provided one year or

36 more prior to the date of the Division’s initiating said policy or practice. Physicians must be  
37 given written notice by the Division specifying any and all policy changes which may result in  
38 recoupments, reductions or reviews of payments for physician services at least 90 days prior to  
39 the implementation of such recoupments, reductions or reviews.

40 SECTION 3. CHAPTER 176O is hereby amended by the deletion of the title and  
41 inserting in place thereof the following new title: HEALTH INSURANCE AND DIVISION OF  
42 MEDICAL ASSISTANCE CONSUMER PROTECTIONS.

43 SECTION 4. Said Chapter 176 O Section 1 is further amended by the deletion of the  
44 following paragraph:

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

54 And inserting in place thereof the following new paragraph:

55 "Carrier", an insurer licensed or otherwise authorized to transact accident or health  
56 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter  
57 176A; a nonprofit medical service corporation organized under chapter 176B; a health

58 maintenance organization organized under chapter 176G, the Primary Care Clinician Program or  
59 any entity providing managed care services under contract to the Division, or any similar  
60 managed care arrangement of the Division of Medical Assistance or its successor providing  
61 medical care coverage to eligible individuals under M. G. L. Chapter 118 E; and an organization  
62 entering into a preferred provider arrangement under chapter 176I, but not including an employer  
63 purchasing coverage or acting on behalf of its employees or the employees of one or more  
64 subsidiaries or affiliated corporations of the employer. Unless otherwise noted, the term "carrier"  
65 shall not include any entity to the extent it offers a policy, certificate or contract that provides  
66 coverage solely for dental care services or visions care services.”

67 SECTION 5. Said Chapter 176 O, Section 1 is further amended by the deletion of the  
68 following definition:

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

71 And inserting in place thereof the following definition:

72 "Covered benefits" or "benefits", health care services to which an insured or a recipient of  
73 services under the Division of Medical Assistance or its successor entity under M. G. L. Chapter  
74 118 E is entitled under the terms of a health benefit plan or program.

75 SECTION 6. Said Chapter 176O, Section 1 is further amended by the deletion of the  
76 following 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 7. Said Chapter 176O, Section 1 is further amended by the deletion of the  
92 following definition:

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

96 And inserting in place thereof the following definition:

97 "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or  
98 issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of

99 health care services; or a managed care arrangement of the Division of Medical Assistance or its  
100 successor entity under M. G. L. Chapter 118 E.

101 SECTION 8. Said Chapter 176 O, Section 1 is further amended by the deletion of the  
102 following definition:

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

107 And inserting in place thereof the following definition:

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

113 SECTION 9. Said Chapter 176 O, Section 2(a) is hereby amended by the deletion of lines  
114 1 through 3 and inserting in place thereof the following:

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

119           SECTION 10. Said Chapter 176O, Section 8 is hereby amended by striking said section  
120 in its entirety and inserting in place thereof the following:

121           Section 8. A carrier, other than the Division of Medical Assistance or its successor entity  
122 under M. G. L. Chapter 118 E, neglecting to make and file its annual statement or the materials  
123 required by the commissioner to be filed with the division under this chapter or under chapter  
124 176G in the form and within the time required thereby shall be fined \$5,000 for each day during  
125 which such neglect continues after being notified by said commissioner of such neglect, and,  
126 after notice and a hearing by the commissioner to that effect, its authority to do new business  
127 shall cease while such neglect continues