

HOUSE No. 1231

The Commonwealth of Massachusetts

PRESENTED BY:

Vincent A. Pedone

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:	DATE ADDED:
<i>Vincent A. Pedone</i>	<i>15th Worcester</i>	<i>1/20/2011</i>
<i>John W. Scibak</i>	<i>2nd Hampshire</i>	<i>2/3/2011</i>

HOUSE No. 1231

By Mr. Pedone of Worcester, a petition (accompanied by bill, House, No. 1231) of Vincent A. Pedone and John W. Scibak for legislation to extend patient protections to recipients of MassHealth. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. 1092 OF 2009-2010.]

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

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:

1 SECTION 1. M.G.L. CHAPTER 176O as Appearing in the 2004 Official Edition is
2 hereby amended by the deletion of the title and insertion of the following new title. HEALTH
3 INSURANCE AND DIVISION OF MEDICAL ASSISTANCE CONSUMER PROTECTIONS.

4 SECTION 2. Said Chapter 176 O Section 1, as amended by Chapter 162 of the Acts of
5 2005, is further amended by the deletion of the following paragraph:

6 ““Carrier”, an insurer licensed or otherwise authorized to transact accident or health
7 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
8 176A; a nonprofit medical service corporation organized under chapter 176B; a health
9 maintenance organization organized under chapter 176G; and an organization entering into a
10 preferred provider arrangement under chapter 176I, but not including an employer purchasing

11 coverage or acting on behalf of its employees or the employees of one or more subsidiaries or
12 affiliated corporations of the employer. Unless otherwise noted, the term "carrier" shall not
13 include any entity to the extent it offers a policy, certificate or contract that provides coverage
14 solely for dental care services or visions care services.”;

15 and, the insertion of the following paragraph:

16 "Carrier", an insurer licensed or otherwise authorized to transact accident or health
17 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
18 176A; a nonprofit medical service corporation organized under chapter 176B; a health
19 maintenance organization organized under chapter 176G, the Primary Care Clinician Program or
20 any entity providing managed care services under contract to the Division, or any similar
21 managed care arrangement of the Division of Medical Assistance or its successor providing
22 medical care coverage to eligible individuals under M. G. L. Chapter 118 E; and an organization
23 entering into a preferred provider arrangement under chapter 176I, but not including an employer
24 purchasing coverage or acting on behalf of its employees or the employees of one or more
25 subsidiaries or affiliated corporations of the employer. Unless otherwise noted, the term "carrier"
26 shall not include any entity to the extent it offers a policy, certificate or contract that provides
27 coverage solely for dental care services or visions care services.”

28 SECTION 3. Said Chapter 176 O is further amended by the deletion in the first section
29 of the following definition:

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

32 And, the insertion of the following definition:

33 "Covered benefits" or "benefits", health care services to which an insured or a recipient of
34 services under the Division of Medical Assistance or its successor entity under M. G. L. Chapter
35 118 E is entitled under the terms of a health benefit plan or program.

36 SECTION 4. Said Chapter 176 O is further amended by the deletion in Section 1 of the
37 following definition:

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

43 And, the insertion of the following definition:

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

52 SECTION 5. Said Chapter 176 O is further amended by the deletion in Section 1 of the
53 following definition:

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

57 And, the insertion of the following definition:

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

62 SECTION 6. Said Chapter 176 O is further amended by the deletion in Section 1 of the
63 following definition:

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

68 And, the insertion of the following definition:

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

74 SECTION 7. Said Chapter 176 O is further amended by the deletion in Section 2 of lines
75 1 through 3 and the insertion in their place of the following:

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

80 Section 8.

81 Said Chapter 176 O is further amended by the deletion in Section 8 of lines 1 through 8
82 and the insertion in their place of the following:

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

90 SECTION 9. M.G.L. Chapter 118 E Section 38 as appearing in the 2004 Official
91 Edition is hereby amended by insertion at the end thereof of the following new paragraphs:

92 “Within 45 days after the receipt by the Division of completed forms for reimbursement
93 to a physician who participates in a medical service program established pursuant to this chapter,
94 or within 15 days if such claim is received electronically, the Division shall (i) make payments

95 for such services provided by the physician that are services covered under such medical
96 assistance program and for which claim is made, or (ii) notify the physician in writing or by
97 electronic means, within 15 days for written claim forms or 48 hours for electronic claims, of any
98 and all reasons for non-payment, or (iii) notify the physician in writing or by electronic means,
99 within 15 days for written claim forms or 48 hours for electronic claims, of all additional
100 information or documentation that is necessary to establish such physician's entitlement to such
101 reimbursement. If the Division fails to comply with the provisions of this paragraph for any such
102 completed claim, the Division shall pay, in addition to any reimbursement for health care
103 services provided to which the physician is entitled, interest on any unpaid amount of such
104 benefits, which shall accrue beginning 45 days after the Division's receipt of request for
105 reimbursement, or 15 days after the receipt of an electronic claim, at the rate of 1.5 per cent per
106 month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest
107 payments shall not apply to a claim that the Division is investigating because of suspected
108 fraud.”

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

117 “The Division shall, in its payment to physicians, recognize the use of modifiers to billing
118 codes employed by the Division. Modifiers that indicate that a procedure or service is distinct or
119 separate from other services performed on the same day, including services provided in a
120 separate session or encounter; a different procedure or surgery; a different site, or a separate
121 lesion, or separate injury or site of injury shall be reimbursed in a manner consistent with that of
122 programs providing health coverage under Title XVIII of the Social Security Act. Modifiers that
123 identify a significant, separate evaluation and management service by the same physician on the
124 same day of another, non-comprehensive, billed service or procedure shall be recognized by the
125 Division and be compensated in a manner consistent with that of programs providing health
126 coverage under Title XVIII of the Social Security Act. In implementation of the provisions of
127 this paragraph, the Division shall use the Medicare Correct Coding Initiative standards for
128 modifiers 25 and 59.”

129 The Division shall institute no policy or practice of recoupment, reduction, review or
130 retroactive denial of payments to any physician or physicians for services provided one year or
131 more prior to the date of the Division’s initiating said policy or practice. Physicians must be
132 given written notice by the Division specifying any and all policy changes which may result in
133 recoupments, reductions or reviews of payments for physician services at least 90 days prior to
134 the implementation of such recoupments, reductions or reviews.