

HOUSE No. 941

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>1/18/2019</i>

HOUSE No. 941

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.

The Commonwealth of Massachusetts

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

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

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

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

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

And inserting in place thereof the following new paragraph:

"Carrier", an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 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

aspect or action of the carrier relative to the insured, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, quality of care and administrative operations, in accordance with the requirements of this chapter.

And inserting in place thereof the following definition:

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

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

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

And inserting in place thereof the following definition:

"Health benefit plan", a policy, contract, certificate or agreement entered into, offered or 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