

**SENATE . . . . . No. 739**

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**The Commonwealth of Massachusetts**

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PRESENTED BY:

***Michael D. Brady***

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*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 relative to MassHealth rates.**

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PETITION OF:

NAME:

*Michael D. Brady*

DISTRICT/ADDRESS:

*Second Plymouth and Bristol*

**SENATE . . . . . No. 739**

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By Mr. Brady, a petition (accompanied by bill, Senate, No. 739) of Michael D. Brady for legislation relative to MassHealth rates. Health Care Financing.

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[SIMILAR MATTER FILED IN PREVIOUS SESSION  
SEE SENATE, NO. 661 OF 2019-2020.]

**The Commonwealth of Massachusetts**

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**In the One Hundred and Ninety-Second General Court  
(2021-2022)**  
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An Act relative to 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 38 is hereby amended by inserting at the end thereof  
2 of the following new paragraphs:

3 “Within 45 days after the receipt by the Division of completed forms for reimbursement  
4 to a physician who participates in a medical service programs established pursuant to this  
5 chapter, or within 15 days if such claim is received electronically, the Division shall (i) make  
6 payments for such services provided by the physician that are services covered under such  
7 medical assistance program and for which claim is made, or (ii) notify the physician in writing or  
8 by electronic means, within 15 days for written claim forms or 48 hours for electronic claims, of  
9 any and all reasons for non-payment, or (iii) notify the physician in writing or by electronic  
10 means, within 15 days for written claim forms or 48 hours for electronic claims, of all additional

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

20 "The division shall provide written guidelines to providers of medical services that  
21 participate in a medical assistance program established pursuant to this chapter setting forth a  
22 statement of its policies and procedures that is complete, detailed and specific with regard to  
23 what such providers must include in claims for reimbursement in order to qualify as a completed  
24 claim for reimbursement payment for which any such provider is entitled. Such guidelines shall  
25 identify all of the data and documentation that is to accompany each claim for reimbursement  
26 and shall identify all utilization review and other screening policies and procedures employed by  
27 the division in reviewing such claims submitted by a provider of medical services. The Division  
28 shall institute no policy or practice of recoupment, reduction, review or retroactive denial of  
29 payments to any physician or physicians for services provided one year or more prior to the date  
30 of the Division's initiating said policy or practice. Physicians must be given written notice by the  
31 Division specifying any and all policy changes which may result in recoupments, reductions or  
32 reviews of payments for physician services at least 90 days prior to the implementation of such  
33 recoupments, reductions or reviews.

34 SECTION 2. Chapter 176O is hereby amended by deleting the title and inserting in place  
35 thereof the following new title: HEALTH INSURANCE AND DIVISION OF MEDICAL  
36 ASSISTANCE CONSUMER PROTECTIONS.

37 SECTION 3. Said Chapter 176 O Section 1 is further amended by deleting the following  
38 paragraph:

39 "Carrier", an insurer licensed or otherwise authorized to transact accident or health  
40 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter  
41 176A; a nonprofit medical service corporation organized under chapter 176B; a health  
42 maintenance organization organized under chapter 176G; and an organization entering into a  
43 preferred provider arrangement under chapter 176I, but not including an employer purchasing  
44 coverage or acting on behalf of its employees or the employees of one or more subsidiaries or  
45 affiliated corporations of the employer. Unless otherwise noted, the term "carrier" shall not  
46 include any entity to the extent it offers a policy, certificate or contract that provides coverage  
47 solely for dental care services or visions care services.”; And inserting in place thereof the  
48 following new paragraph: "Carrier", an insurer licensed or otherwise authorized to transact  
49 accident or health insurance under chapter 175; a nonprofit hospital service corporation  
50 organized under chapter 176A; a nonprofit medical service corporation organized under chapter  
51 176B; a health maintenance organization organized under chapter 176G, the Primary Care  
52 Clinician Program or any entity providing managed care services under contract to the Division,  
53 or any similar managed care arrangement of the Division of Medical Assistance or its successor  
54 providing medical care coverage to eligible individuals under M. G. L. Chapter 118 E; and an  
55 organization entering into a preferred provider arrangement under chapter 176I, but not including  
56 an employer purchasing coverage or acting on behalf of its employees or the employees of one or

57 more subsidiaries or affiliated corporations of the employer. Unless otherwise noted, the term  
58 "carrier" shall not include any entity to the extent it offers a policy, certificate or contract that  
59 provides coverage solely for dental care services or visions care services.”

60 SECTION 4. Said Chapter 176 O, Section 1 is further amended by deleting the following  
61 definition:

62 "Covered benefits" or "benefits", health care services to which an insured is entitled under  
63 the terms of the health benefit plan.” And inserting in place thereof the following definition:

64 "Covered benefits" or "benefits", health care services to which an insured or a recipient of  
65 services under the Division of Medical Assistance or its successor entity under M. G. L. Chapter  
66 118 E is entitled under the terms of a health benefit plan or program.

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

69 "Grievance", any oral or written complaint submitted to the carrier which has been  
70 initiated by an insured, or on behalf of an insured with the consent of the insured, concerning any  
71 aspect or action of the carrier relative to the insured, including, but not limited to, review of  
72 adverse determinations regarding scope of coverage, denial of services, quality of care and  
73 administrative operations, in accordance with the requirements of this chapter. And inserting in  
74 place thereof the following definition: "Grievance", any oral or written complaint submitted to  
75 the carrier or the Division of Medical Assistance or its successor entity under M. G. L. Chapter  
76 118 E which has been initiated by an insured or a recipient of public assistance, or on behalf of  
77 an insured or recipient of public assistance with the consent of the insured or the recipient,  
78 concerning any aspect or action of the carrier or the Division of Medical Assistance or its

79 successor entity under M. G. L. Chapter 118 E relative to the insured or the recipient, including,  
80 but not limited to, review of adverse determinations regarding scope of coverage, denial of  
81 services, quality of care and administrative operations, in accordance with the requirements of  
82 this chapter.

83 SECTION 6. Said Chapter 176O, Section 1 is further amended by deleting the following  
84 definition:

85 "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or  
86 issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of  
87 health care services. And inserting in place thereof the following definition: "Health benefit  
88 plan", a policy, contract, certificate or agreement entered into, offered or issued by a carrier to  
89 provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services; or a  
90 managed care arrangement of the Division of Medical Assistance or its successor entity under M.  
91 G. L. Chapter 118 E.

92 SECTION 7. Said Chapter 176O, Section 1 is further amended by deleting the following  
93 definition:

94 "Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a  
95 carrier, including an individual whose eligibility as an insured of a carrier is in dispute or under  
96 review, or any other individual whose care may be subject to review by a utilization review  
97 program or entity as described under other provisions of this chapter. And inserting in place  
98 thereof the following definition: "Insured", an enrollee, covered person, insured, member,  
99 policyholder or subscriber of a carrier, including an assistance recipient of the Division of  
100 Medical Assistance, and including an individual whose eligibility as an insured of a carrier is in

101 dispute or under review, or any other individual whose care may be subject to review by a  
102 utilization review program or entity as described under other provisions of this chapter.

103 SECTION 8. Said Chapter 176O, Section 2(a) is hereby amended by striking lines 1  
104 through 3 and inserting in place thereof the following: Section 2. (a) There is hereby established  
105 within the center a bureau of managed care. Said bureau shall by regulation establish minimum  
106 standards for the accreditation of carriers, other than the Division of Medical Assistance or its  
107 successor entity under M. G. L. Chapter 118 E, in the following areas:

108 SECTION 9. Said Chapter 176O, Section 8 is hereby amended by striking said section in  
109 its entirety and inserting in place thereof the following: Section 8. A carrier, other than the  
110 Division of Medical Assistance or its successor entity under M. G. L. Chapter 118 E, neglecting  
111 to make and file its annual statement or the materials required by the commissioner to be filed  
112 with the division under this chapter or under chapter 176G in the form and within the time  
113 required thereby shall be fined \$5,000 for each day during which such neglect continues after  
114 being notified by said commissioner of such neglect, and, after notice and a hearing by the  
115 commissioner to that effect, its authority to do new business shall cease while such neglect  
116 continues.