HOUSE DOCKET, NO. 3818 FILED ON: 1/18/2019

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:
Mark J. Cusack	*5th Norfolk*

HOUSE DOCKET, NO. 3818 FILED ON: 1/18/2019

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:

SECTION 1. Chapter 118 E, Section 13 is hereby amended by inserting at the end of the second sentence, after the words "ways and means" the following:

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

SECTION 2. Chapter 118 E, Section 38 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, within 15 days for written claim forms or 48 hours for electronic claims, of all additional information or documentation that is necessary to establish such physician's entitlement to such reimbursement. If the Division fails to comply with the provisions of this paragraph for any such completed claim, the Division shall pay, in addition to any reimbursement for health care services provided to which the physician is entitled, interest on any unpaid amount of such benefits, which shall accrue beginning 45 days after the Division's receipt of request for reimbursement, or 15 days after the receipt of an electronic claim, at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the Division is investigating because of suspected fraud."

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

The Division shall institute no policy or practice of recoupment, reduction, review or 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

maintenance organization organized under chapter 176G, the Primary Care Clinician Program or any entity providing managed care services under contract to the Division, or any similar managed care arrangement of the Division of Medical Assistance or its successor providing medical care coverage to eligible individuals under M. G. L. Chapter 118 E; 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."

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

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

And inserting in place thereof the following definition:

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

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

"Grievance", any oral or written complaint submitted to the carrier which has been 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

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

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

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

And inserting in place thereof the following definition:

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

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

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

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

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