SENATE DOCKET, NO. FILED ON: 1/13/2009

# SENATE . . . . . . . . . . . . . . No.

## The Commonwealth of Massachusetts

PRESENTED BY:

**James E. Timilty**

*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 passage of the accompanying bill:

An Act to extend patient protections to recipients of MassHealth.

PETITION OF:

| NAME: | DISTRICT/ADDRESS: |
|---|---|
| James E. Timilty | Bristol and Norfolk |

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. S00694 OF 2007-2008.]

# The Commonwealth of Massachusetts

**In the Year Two Thousand and Nine**

## 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 hereby
2 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
5 SECTION 2. Said Chapter 176 O Section 1, as amended by Chapter 162 of the Acts of 2005, is
6 further amended by the deletion of the following paragraph:
7
8 "“Carrier", an insurer licensed or otherwise authorized to transact accident or health insurance
9 under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a
10 nonprofit medical service corporation organized under chapter 176B; a health maintenance
11 organization organized under chapter 176G; and an organization entering into a preferred
12 provider arrangement under chapter 176I, but not including an employer purchasing coverage or

13 acting on behalf of its employees or the employees of one or more subsidiaries or affiliated
14 corporations of the employer. Unless otherwise noted, the term "carrier" shall not include any
15 entity to the extent it offers a policy, certificate or contract that provides coverage solely for
16 dental care services or visions care services.";
17
18 and, the insertion of the following paragraph:
19
20 "Carrier", an insurer licensed or otherwise authorized to transact accident or health insurance
21 under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a
22 nonprofit medical service corporation organized under chapter 176B; a health maintenance
23 organization organized under chapter 176G, the Primary Care Clinician Program or any entity
24 providing managed care services under contract to the Division,  or any similar managed care
25 arrangement of the Division of Medical Assistance or its successor providing medical care
26 coverage to eligible individuals under M. G. L. Chapter 118 E; and an organization entering into
27 a preferred provider arrangement under chapter 176I, but not including an employer purchasing
28 coverage or acting on behalf of its employees or the employees of one or more subsidiaries or
29 affiliated corporations of the employer. Unless otherwise noted, the term "carrier" shall not
30 include any entity to the extent it offers a policy, certificate or contract that provides coverage
31 solely for dental care services or visions care services."
32
33 SECTION 3.Said Chapter 176 O is further amended by the deletion in the first section of the
34 following definition:
35

36 "Covered benefits" or "benefits", health care services to which an insured is entitled under the

37 terms of the health benefit plan.”

38 And, the insertion of the following definition:

39

40 "Covered benefits" or "benefits", health care services to which an insured or a recipient of

41 services under the Division of Medical Assistance or its successor entity under M. G. L. Chapter

42 118 E is entitled under the terms of a health benefit plan or program.

43

44 SECTION 4. Said Chapter 176 O is further amended by the deletion in Section 1 of the

45 following definition:

46

47 "Grievance", any oral or written complaint submitted to the carrier which has been initiated by an

48 insured, or on behalf of an insured with the consent of the insured, concerning any aspect or

49 action of the carrier relative to the insured, 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

53 And, the insertion of the following definition:

54

55 "Grievance", any oral or written complaint submitted to the carrier or the Division of Medical

56 Assistance or its successor entity under M. G. L. Chapter 118 E which has been initiated by an

57 insured or a recipient of public assistance, or on behalf of an insured or recipient of public

58 assistance with the consent of the insured or the recipient, concerning any aspect or action of the

59 carrier or the Division of Medical Assistance or its successor entity under M. G. L. Chapter 118

60 E relative to the insured or the recipient, including, but not limited to, review of adverse

61 determinations regarding scope of coverage, denial of services, quality of care and administrative

62 operations, in accordance with the requirements of this chapter.

63

64 SECTION 5. Said Chapter 176 O is further amended by the deletion in Section 1 of the

65 following definition:

66

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

68 by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care

69 services.

70

71 And, the insertion of the following definition:

72

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

74 by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care

75 services; or a managed care arrangement of the Division of Medical Assistance or its successor

76 entity under M. G. L. Chapter 118 E.

77

78 SECTION 6. Said Chapter 176 O is further amended by the deletion in Section 1 of the

79 following definition:

80

81 "Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a carrier,
82 including an individual whose eligibility as an insured of a carrier is in dispute or under review,
83 or any other individual whose care may be subject to review by a utilization review program or
84 entity as described under other provisions of this chapter.
85
86 And, the insertion of the following definition:
87
88 "Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a carrier,
89 including an assistance recipient of the Division of Medical Assistance, and including an
90 individual whose eligibility as an insured of a carrier is in dispute or under review, or any other
91 individual whose care may be subject to review by a utilization review program or entity as
92 described under other provisions of this chapter.
93
94 SECTION 7. Said Chapter 176 O is further amended by the deletion in Section 2 of lines 1
95 through 3 and the insertion in their place of the following:
96
97 Section 2. (a) There is hereby established within the division a bureau of managed care. Said
98 bureau shall by regulation establish minimum standards for the accreditation of carriers, other
99 than the Division of Medical Assistance or its successor entity under M. G. L. Chapter 118 E, in
100 the following areas:
101
102 SECTION 8. Said Chapter 176 O is further amended by the deletion in Section 8 of lines 1
103 through 8 and the insertion in their place of the following:

104

105 Section 8. A carrier, other than the Division of Medical Assistance or its successor entity under

106 M. G. L. Chapter 118 E, neglecting to make and file its annual statement or the materials

107 required by the commissioner to be filed with the division under this chapter or under chapter

108 176G in the form and within the time required thereby shall be fined $5,000 for each day during

109 which such neglect continues after being notified by said commissioner of such neglect, and,

110 after notice and a hearing by the commissioner to that effect, its authority to do new business

111 shall cease while such neglect continues

112

113 SECTION 9. M.G.L. Chapter 118 E Section 38 as appearing in the 2004 Official Edition is

114 hereby amended by insertion at the end thereof of the following new paragraphs:

115

116 “Within 45 days after the receipt by the Division of completed forms for reimbursement to a

117 physician who participates in a medical service program established pursuant to this chapter, or

118 within 15 days if such claim is received electronically, the Division shall (i) make payments for

119 such services provided by the physician that are services covered under such medical assistance

120 program and for which claim is made, or (ii) notify the physician in writing or by electronic

121 means, within 15 days for written claim forms or 48 hours for electronic claims, of any and all

122 reasons for non-payment, or (iii) notify the physician in writing or by electronic means, within

123 15 days for written claim forms or 48 hours for electronic claims, of all additional information or

124 documentation that is necessary to establish such physician’s entitlement to such reimbursement.

125 If the Division fails to comply with the provisions of this paragraph for any such completed

126 claim, the Division shall pay, in addition to any reimbursement for health care services provided

127 to which the physician is entitled, interest on any unpaid amount of such benefits, which shall
128 accrue beginning 45 days after the Division's receipt of request for reimbursement, or 15 days
129 after the receipt of an electronic claim, at the rate of 1.5 per cent per month, not to exceed 18 per
130 cent per year. The provisions of this paragraph relating to interest payments shall not apply to a
131 claim that the Division is investigating because of suspected fraud."
132
133 "The division shall provide written guidelines to providers of medical services that participate in
134 a medical assistance program established pursuant to this chapter setting forth a statement of its
135 policies and procedures that is complete, detailed and specific with regard to what such providers
136 must include in claims for reimbursement in order to qualify as a completed claim for
137 reimbursement payment for which any such provider is entitled. Such guidelines shall identify all
138 of the data and documentation that is to accompany each claim for reimbursement and shall
139 identify all utilization review and other screening policies and procedures employed by the
140 division in reviewing such claims submitted by a provider of medical services.
141
142 "The Division shall, in its payment to physicians, recognize the use of modifiers to billing codes
143 employed by the Division. Modifiers that indicate that a procedure or service is distinct or
144 separate from other services performed on the same day, including services provided in a
145 separate session or encounter; a different procedure or surgery; a different site, or a separate
146 lesion, or separate injury or site of injury shall be reimbursed in a manner consistent with that of
147 programs providing health coverage under Title XVIII of the Social Security Act. Modifiers that
148 identify a significant, separate evaluation and management service by the same physician on the
149 same day of another, non-comprehensive, billed service or procedure shall be recognized by the

150 Division and be compensated in a manner consistent with that of programs providing health
151 coverage under Title XVIII of the Social Security Act. In implementation of the provisions of
152 this paragraph, the Division shall use the Medicare Correct Coding Initiative standards for
153 modifiers 25 and 59."
154
155 The Division shall institute no policy or practice of recoupment, reduction, review or retroactive
156 denial of payments to any physician or physicians for services provided one year or more prior to
157 the date of the Division's initiating said policy or practice. Physicians must be given written
158 notice by the Division specifying any and all policy changes which may result in recoupments,
159 reductions or reviews of payments for physician services at least 90 days prior to the
160 implementation of such recoupments, reductions or reviews.
161