

2019 -- H 5347

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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2019

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A N A C T

RELATING TO INSURANCE -- PROMPT PROCESSING OF CLAIMS

Introduced By: Representatives Craven, Bennett, Shanley, McEntee, and Caldwell

Date Introduced: February 07, 2019

Referred To: House Judiciary

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 27-18-61 of the General Laws in Chapter 27-18 entitled "Accident
2 and Sickness Insurance Policies" is hereby amended to read as follows:

3 **27-18-61. Prompt processing of claims.**

4 (a) A health care entity or health plan operating in the state shall pay all complete claims
5 for covered health care services submitted to the health care entity or health plan by a health care
6 provider or by a policyholder within forty (40) calendar days following the date of receipt of a
7 complete written claim or within thirty (30) calendar days following the date of receipt of a
8 complete electronic claim. Each health plan shall establish a written standard defining what
9 constitutes a complete claim and shall distribute this standard to all participating providers.

10 (b) If the health care entity or health plan denies or pends a claim, the health care entity
11 or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing
12 the health care provider or policyholder of any and all reasons for denying or pending the claim
13 and what, if any, additional information is required to process the claim. No health care entity or
14 health plan may limit the time period in which additional information may be submitted to
15 complete a claim.

16 (c) Any claim that is resubmitted by a health care provider or policyholder shall be
17 treated by the health care entity or health plan pursuant to the provisions of subsection (a) of this
18 section.

19 (d) A health care entity or health plan which fails to reimburse the health care provider or

1 policyholder after receipt by the health care entity or health plan of a complete claim within the
2 required timeframes shall pay to the health care provider or the policyholder who submitted the
3 claim, in addition to any reimbursement for health care services provided, interest which shall
4 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day
5 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a
6 complete written claim, and ending on the date the payment is issued to the health care provider
7 or the policyholder.

8 (e) Exceptions to the requirements of this section are as follows:

9 (1) No health care entity or health plan operating in the state shall be in violation of this
10 section for a claim submitted by a health care provider or policyholder if:

11 (i) Failure to comply is caused by a directive from a court or federal or state agency;

12 (ii) The health care entity or health plan is in liquidation or rehabilitation or is operating
13 in compliance with a court-ordered plan of rehabilitation; or

14 (iii) The health care entity or health plan's compliance is rendered impossible due to
15 matters beyond its control that are not caused by it.

16 (2) No health care entity or health plan operating in the state shall be in violation of this
17 section for any claim: (i) initially submitted more than ninety (90) days after the service is
18 rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider
19 received the notice provided for in subsection (b) of this section; provided, this exception shall
20 not apply in the event compliance is rendered impossible due to matters beyond the control of the
21 health care provider and were not caused by the health care provider.

22 (3) No health care entity or health plan operating in the state shall be in violation of this
23 section while the claim is pending due to a fraud investigation by a state or federal agency.

24 (4) No health care entity or health plan operating in the state shall be obligated under this
25 section to pay interest to any health care provider or policyholder for any claim if the ~~director of~~
26 ~~business regulation~~ office of the health insurance commissioner (commissioner) finds that the
27 entity or plan is in substantial compliance with this section. A health care entity or health plan
28 seeking such a finding from the ~~director~~ commissioner shall submit any documentation that the
29 ~~director~~ commissioner shall require. A health care entity or health plan which is found to be in
30 substantial compliance with this section shall thereafter submit any documentation that the
31 ~~director~~ commissioner may require on ~~an annual~~ a quarterly basis for the ~~director~~ commissioner
32 to assess ongoing compliance with this section.

33 (5) A health care entity or health plan may petition the ~~director~~ commissioner for a
34 waiver of the provision of this section for a period not to exceed ninety (90) days in the event the

1 health care entity or health plan is converting or substantially modifying its claims processing
2 systems.

3 (f) For purposes of this section, the following definitions apply:

4 (1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or
5 (iii) all services for one patient or subscriber within a bill or invoice.

6 (2) "Date of receipt" means the date the health care entity or health plan receives the
7 claim whether via electronic submission or as a paper claim.

8 (3) "Health care entity" means a licensed insurance company or nonprofit hospital or
9 medical or dental service corporation or plan or health maintenance organization, or a contractor
10 as described in § 23-17.13-2(2), which operates a health plan.

11 (4) "Health care provider" means an individual clinician, either in practice independently
12 or in a group, ~~who provides health care services, and otherwise referred to as a non-institutional~~
13 ~~provider~~ or a certified community mental health center, opioid treatment provider or other non-
14 CMHC providers of Medicaid services.

15 (5) "Health care services" include, but are not limited to, medical, mental health,
16 substance abuse, dental and any other services covered under the terms of the specific health plan.

17 (6) "Health plan" means a plan operated by a health care entity that provides for the
18 delivery of health care services to persons enrolled in those plans through:

19 (i) Arrangements with selected providers to furnish health care services; ~~and/or~~

20 (ii) Financial incentive for persons enrolled in the plan to use the participating providers
21 and procedures provided for by the health plan; ~~or~~ or

22 (iii) All persons enrolled and approved via the department of behavioral healthcare,
23 developmental disabilities and hospitals (BHDDH), portal.

24 (7) "Policyholder" means a person covered under a health plan or a representative
25 designated by that person.

26 (8) "Substantial compliance" means that the ~~health care entity or health plan is processing~~
27 ~~and paying ninety-five percent (95%) or more of all claims within the time frame provided for in~~
28 ~~subsections (a) and (b) of this section~~ ratio by the number of claims paid or processed by a subject
29 entity within the timeframes set forth in subsection (a) of this section to the number of claims
30 received, is ninety-five percent (95%) or greater.

31 (i) To measure the level of substantial compliance with the parity statute, any health plan
32 contracting with the executive office of health and human services (EOHHS) must report prompt
33 Medicaid claims processing of data by service line on a quarterly basis, and include the following
34 information:

- 1 (A) Total number of claims received within the quarter;
2 (B) Total number of claims paid within statutory timeframes;
3 (C) Total number of claims paid outside of statutory timeframes;
4 (D) Average processing time (in days) for all claims paid within statutory timeframes;
5 (E) Average processing time (in days) for all claims paid outside of statutory timeframes;
6 and
7 (F) Total interest paid on claims paid outside of statutory timeframes.

8 (ii) All data must be submitted within thirty (30) days following the close of the quarter.

9 (iii) If the health plan is meeting the federal and/or contractual Medicaid reimbursement
10 requirements, but is processing and paying behavioral health claims in an unequitable manner, it
11 will qualify as a non-quantitative insurer practice and sanctions will be applied through the office
12 of the health insurance commissioner.

13 (g) Any provision in a contract between a health care entity or a health plan and a health
14 care provider which is inconsistent with this section shall be void and of no force and effect.

15 (h) Pre-payment and timely payment. The executive office of health and human services
16 (EOHHS) shall impose a timely claims processing and payment procedure for Medicaid services.
17 If the health plan fails to reimburse the health care provider or policy holder within the required
18 timeframes as outlined under subsection (a) of this section, EOHHS, office of Medicaid, will
19 mandate under contractual agreement that the health plan execute a pre-payment reimbursement
20 plan with agreement of the health care provider.

21 The pre-payment reimbursement plan shall require the health plan to pay a health care
22 provider rendering opioid treatment program health home services; integrated health home
23 services (IHH) including vocational and therapy services, assertive community treatment (ACT),
24 mental health psychiatric rehabilitation residences (MHPRR), and substance use disorder
25 residential treatment services.

26 Payment on a pre-payment basis shall require payment by the health plan on the first
27 business day of each month with each payment amount equal to the average monthly payment
28 received for individuals on the attribution list during the immediate preceding six (6) months.
29 The health care provider and health plan shall undertake a reconciliation within one hundred
30 eighty (180) days of the close of each quarter with any overpayment repaid by the health care
31 provider or underpayment paid by the health plan within thirty (30) days.

32 SECTION 2. Section 27-19-52 of the General Laws in Chapter 27-19 entitled "Nonprofit
33 Hospital Service Corporations" is hereby amended to read as follows:

34 **27-19-52. Prompt processing of claims.**

1 (a) A health care entity or health plan operating in the state shall pay all complete claims
2 for covered health care services submitted to the health care entity or health plan by a health care
3 provider or by a policyholder within forty (40) calendar days following the date of receipt of a
4 complete written claim or within thirty (30) calendar days following the date of receipt of a
5 complete electronic claim. Each health plan shall establish a written standard defining what
6 constitutes a complete claim and shall distribute this standard to all participating providers.

7 (b) If the health care entity or health plan denies or pends a claim, the health care entity
8 or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing
9 the health care provider or policyholder of any and all reasons for denying or pending the claim
10 and what, if any, additional information is required to process the claim. No health care entity or
11 health plan may limit the time period in which additional information may be submitted to
12 complete a claim.

13 (c) Any claim that is resubmitted by a health care provider or policyholder shall be
14 treated by the health care entity or health plan pursuant to the provisions of subsection (a) of this
15 section.

16 (d) A health care entity or health plan which fails to reimburse the health care provider or
17 policyholder after receipt by the health care entity or health plan of a complete claim within the
18 required timeframes shall pay to the health care provider or the policyholder who submitted the
19 claim, in addition to any reimbursement for health care services provided, interest which shall
20 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day
21 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a
22 complete written claim, and ending on the date the payment is issued to the health care provider
23 or the policyholder.

24 (e) Exceptions to the requirements of this section are as follows:

25 (1) No health care entity or health plan operating in the state shall be in violation of this
26 section for a claim submitted by a health care provider or policyholder if:

27 (i) Failure to comply is caused by a directive from a court or federal or state agency;

28 (ii) The health care provider or health plan is in liquidation or rehabilitation or is
29 operating in compliance with a court-ordered plan of rehabilitation; or

30 (iii) The health care entity or health plan's compliance is rendered impossible due to
31 matters beyond its control that are not caused by it.

32 (2) No health care entity or health plan operating in the state shall be in violation of this
33 section for any claim: (i) initially submitted more than ninety (90) days after the service is
34 rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider

1 received the notice provided for in ~~§ 27-18-61(b)~~ subsection (b) of this section; provided, this
2 exception shall not apply in the event compliance is rendered impossible due to matters beyond
3 the control of the health care provider and were not caused by the health care provider.

4 (3) No health care entity or health plan operating in the state shall be in violation of this
5 section while the claim is pending due to a fraud investigation by a state or federal agency.

6 (4) No health care entity or health plan operating in the state shall be obligated under this
7 section to pay interest to any health care provider or policyholder for any claim if the ~~director of~~
8 ~~the department of business regulation~~ office of the health insurance commissioner
9 (commissioner) finds that the entity or plan is in substantial compliance with this section. A
10 health care entity or health plan seeking such a finding from the ~~director~~ commissioner shall
11 submit any documentation that the ~~director~~ commissioner shall require. A health care entity or
12 health plan which is found to be in substantial compliance with this section shall ~~after this~~
13 ~~thereafter~~ submit any documentation that the ~~director~~ commissioner may require on ~~an annual~~
14 quarterly basis for the ~~director~~ commissioner to assess ongoing compliance with this section.

15 (5) A health care entity or health plan may petition the ~~director~~ commissioner for a
16 waiver of the provision of this section for a period not to exceed ninety (90) days in the event the
17 health care entity or health plan is converting or substantially modifying its claims processing
18 systems.

19 (f) For purposes of this section, the following definitions apply:

20 (1) "Claim" means:

21 (i) A bill or invoice for covered services;

22 (ii) A line item of service; or

23 (iii) All services for one patient or subscriber within a bill or invoice.

24 (2) "Date of receipt" means the date the health care entity or health plan receives the
25 claim whether via electronic submission or has a paper claim.

26 (3) "Health care entity" means a licensed insurance company or nonprofit hospital or
27 medical or dental service corporation or plan or health maintenance organization, or a contractor
28 as described in § 23-17.13-2(2), that operates a health plan.

29 (4) "Health care provider" means an individual clinician, either in practice independently
30 or in a group, ~~who provides health care services, and referred to as a non-institutional provider or~~
31 a certified community mental health center, opioid treatment provider or other non-CMHC
32 providers of Medicaid services.

33 (5) "Health care services" include, but are not limited to, medical, mental health,
34 substance abuse, dental and any other services covered under the terms of the specific health plan.

1 (6) "Health plan" means a plan operated by a health care entity that provides for the
2 delivery of health care services to persons enrolled in those plans through:

3 (i) Arrangements with selected providers to furnish health care services; ~~and/or~~

4 (ii) Financial incentive for persons enrolled in the plan to use the participating providers
5 and procedures provided for by the health plan; or

6 (iii) All persons enrolled and approved via the department of behavioral healthcare,
7 developmental disabilities and hospitals (BHDDH) portal.

8 (7) "Policyholder" means a person covered under a health plan or a representative
9 designated by that person.

10 (8) "Substantial compliance" means that the ~~health care entity or health plan is processing~~
11 ~~and paying ninety-five percent (95%) or more of all claims within the time frame provided for in~~
12 ~~§ 27-18-61(a) and (b)~~ ratio by the number of claims paid or processed by a subject entity within
13 the timeframes set forth in subsection (a) of this section to the number of claims received, is
14 ninety-five percent (95%) or greater.

15 (i) To measure the level of substantial compliance with the parity statute, any health plan
16 contracting with the executive office of health and human services (EOHHS) must report prompt
17 Medicaid claims processing of data by service line on a quarterly basis, and include the following
18 information:

19 (A) Total number of claims received within the quarter;

20 (B) Total number of claims paid within statutory timeframes;

21 (C) Total number of claims paid outside of statutory timeframes;

22 (D) Average processing time (in days) for all claims paid within statutory timeframes;

23 (E) Average processing time (in days) for all claims paid outside of statutory timeframes;

24 and

25 (F) Total interest paid on claims paid outside of statutory timeframes.

26 (ii) All data must be submitted within thirty (30) days following the close of the quarter.

27 (iii) If the health plan is meeting the federal and/or contractual Medicaid reimbursement
28 requirements, but is processing and paying behavioral health claims in an inequitable manner, it
29 will qualify as a non-quantitative insurer practice and sanctions will be applied through the office
30 of the health insurance commissioner.

31 (g) Any provision in a contract between a health care entity or a health plan and a health
32 care provider which is inconsistent with this section shall be void and of no force and effect.

33 (h) Pre-payment and timely payment. The executive office of health and human services
34 (EOHHS) shall impose a timely claims processing and payment procedure for Medicaid services.

1 If the health plan fails to reimburse the health care provider or policy holder within the required
2 timeframes as outlined under subsection (a) of this section, EOHHS, office of Medicaid, will
3 mandate under contractual agreement that the health plan execute a pre-payment reimbursement
4 plan with agreement of the health care provider.

5 The pre-payment reimbursement plan shall require the health plan to pay a health care
6 provider rendering opioid treatment program health home services; integrated health home
7 services (IHH) including vocational and therapy services, assertive community treatment (ACT),
8 mental health psychiatric rehabilitation residences (MHPRR), and substance use disorder
9 residential treatment services.

10 Payment on a pre-payment basis shall require payment by the health plan on the first
11 business day of each month with each payment amount equal to the average monthly payment
12 received for individuals on the attribution list during the immediate preceding six (6) months.

13 The health care provider and health plan shall undertake a reconciliation within one hundred
14 eighty (180) days of the close of each quarter with any overpayment repaid by the health care
15 provider or underpayment paid by the health plan within thirty (30) days.

16 SECTION 3. Section 27-20-47 of the General Laws in Chapter 27-20 entitled "Nonprofit
17 Medical Service Corporations" is hereby amended to read as follows:

18 **27-20-47. Prompt processing of claims.**

19 (a) A health care entity or health plan operating in the state shall pay all complete claims
20 for covered health care services submitted to the health care entity or health plan by a health care
21 provider or by a policyholder within forty (40) calendar days following the date of receipt of a
22 complete written claim or within thirty (30) calendar days following the date of receipt of a
23 complete electronic claim. Each health plan shall establish a written standard defining what
24 constitutes a complete claim and shall distribute the standard to all participating providers.

25 (b) If the health care entity or health plan denies or pends a claim, the health care entity
26 or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing
27 the health care provider or policyholder of any and all reasons for denying or pending the claim
28 and what, if any, additional information is required to process the claim. No health care entity or
29 health plan may limit the time period in which additional information may be submitted to
30 complete a claim.

31 (c) Any claim that is resubmitted by a health care provider or policyholder shall be
32 treated by the health care entity or health plan pursuant to the provisions of subsection (a) of this
33 section.

34 (d) A health care entity or health plan which fails to reimburse the health care provider or

1 policyholder after receipt by the health care entity or health plan of a complete claim within the
2 required timeframes shall pay to the health care provider or the policyholder who submitted the
3 claim, in addition to any reimbursement for health care services provided, interest which shall
4 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day
5 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a
6 complete written claim, and ending on the date the payment is issued to the health care provider
7 or the policyholder.

8 (e) Exceptions to the requirements of this section are as follows:

9 (1) No health care entity or health plan operating in the state shall be in violation of this
10 section for a claim submitted by a health care provider or policyholder if:

11 (i) Failure to comply is caused by a directive from a court or federal or state agency;

12 (ii) The health care entity or health plan is in liquidation or rehabilitation or is operating
13 in compliance with a court-ordered plan of rehabilitation; or

14 (iii) The health care entity or health plan's compliance is rendered impossible due to
15 matters beyond its control that are not caused by it.

16 (2) No health care entity or health plan operating in the state shall be in violation of this
17 section for any claim: (i) initially submitted more than ninety (90) days after the service is
18 rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider
19 received the notice provided for in § 27-18-61(b); provided, this exception shall not apply in the
20 event compliance is rendered impossible due to matters beyond the control of the health care
21 provider and were not caused by the health care provider.

22 (3) No health care entity or health plan operating in the state shall be in violation of this
23 section while the claim is pending due to a fraud investigation by a state or federal agency.

24 (4) No health care entity or health plan operating in the state shall be obligated under this
25 section to pay interest to any health care provider or policyholder for any claim if the ~~director of~~
26 ~~the department of business regulation~~ office of the health insurance commissioner
27 (commissioner) finds that the entity or plan is in substantial compliance with this section. A
28 health care entity or health plan seeking such a finding from the ~~director~~ commissioner shall
29 submit any documentation that the ~~director~~ commissioner shall require. A health care entity or
30 health plan which is found to be in substantial compliance with this section shall ~~after this~~
31 thereafter submit any documentation that the ~~director~~ commissioner may require on ~~an annual a~~
32 quarterly basis for the ~~director~~ commissioner to assess ongoing compliance with this section.

33 (5) A health care entity or health plan may petition the ~~director~~ commissioner for a
34 waiver of the provision of this section for a period not to exceed ninety (90) days in the event the

1 health care entity or health plan is converting or substantially modifying its claims processing
2 systems.

3 (f) For purposes of this section, the following definitions apply:

4 (1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or
5 (iii) all services for one patient or subscriber within a bill or invoice.

6 (2) "Date of receipt" means the date the health care entity or health plan receives the
7 claim whether via electronic submission or has a paper claim.

8 (3) "Health care entity" means a licensed insurance company or nonprofit hospital or
9 medical or dental service corporation or plan or health maintenance organization, or a contractor
10 as described in § 23-17.13-2(2), that operates a health plan.

11 (4) "Health care provider" means an individual clinician, either in practice independently
12 or in a group, ~~who provides health care services, and referred to as a non-institutional provider~~ or
13 a certified community mental health center, opioid treatment provider or other non-CMHC
14 providers of Medicaid services.

15 (5) "Health care services" include, but are not limited to, medical, mental health,
16 substance abuse, dental and any other services covered under the terms of the specific health plan.

17 (6) "Health plan" means a plan operated by a health care entity that provides for the
18 delivery of health care services to persons enrolled in the plan through:

19 (i) Arrangements with selected providers to furnish health care services; ~~and/or~~

20 (ii) Financial incentive for persons enrolled in the plan to use the participating providers
21 and procedures provided for by the health plan; ~~or~~ or

22 (iii) All persons enrolled and approved via the department of behavioral healthcare,
23 developmental disabilities and hospitals (BHDDH) portal.

24 (7) "Policyholder" means a person covered under a health plan or a representative
25 designated by that person.

26 (8) "Substantial compliance" means that the health care entity or health plan is processing
27 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in
28 § 27-18-61(a) and (b).

29 (g) Any provision in a contract between a health care entity or a health plan and a health
30 care provider which is inconsistent with this section shall be void and of no force and effect.

31 (h) Pre-payment and timely payment. The executive office of health and human services
32 (EOHHS) shall impose a timely claims processing and payment procedure for Medicaid services.
33 If the health plan fails to reimburse the health care provider or policy holder within the required
34 timeframes as outlined under subsection (a) of this section, EOHHS, office of Medicaid, will

1 mandate under contractual agreement that the health plan execute a pre-payment reimbursement
2 plan with agreement of the health care provider.

3 The pre-payment reimbursement plan shall require the health plan to pay a health care
4 provider rendering opioid treatment program health home services; integrated health home
5 services (IHH) including vocational and therapy services, assertive community treatment (ACT),
6 mental health psychiatric rehabilitation residences (MHPRR), and substance use disorder
7 residential treatment services.

8 Payment on a pre-payment basis shall require payment by the health plan on the first
9 business day of each month with each payment amount equal to the average monthly payment
10 received for individuals on the attribution list during the immediate preceding six (6) months.
11 The health care provider and health plan shall undertake a reconciliation within one hundred
12 eighty (180) days of the close of each quarter with any overpayment repaid by the health care
13 provider or underpayment paid by the health plan within thirty (30) days.

14 SECTION 4. Section 27-41-64 of the General Laws in Chapter 27-41 entitled "Health
15 Maintenance Organizations" is hereby amended to read as follows:

16 **27-41-64. Prompt processing of claims.**

17 (a) A health care entity or health plan operating in the state shall pay all complete claims
18 for covered health care services submitted to the health care entity or health plan by a health care
19 provider or by a policyholder within forty (40) calendar days following the date of receipt of a
20 complete written claim or within thirty (30) calendar days following the date of receipt of a
21 complete electronic claim. Each health plan shall establish a written standard defining what
22 constitutes a complete claim and shall distribute this standard to all participating providers.

23 (b) If the health care entity or health plan denies or pends a claim, the health care entity
24 or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing
25 the health care provider or policyholder of any and all reasons for denying or pending the claim
26 and what, if any, additional information is required to process the claim. No health care entity or
27 health plan may limit the time period in which additional information may be submitted to
28 complete a claim.

29 (c) Any claim that is resubmitted by a health care provider or policyholder shall be
30 treated by the health care entity or health plan pursuant to the provisions of subsection (a) of this
31 section.

32 (d) A health care entity or health plan which fails to reimburse the health care provider or
33 policyholder after receipt by the health care entity or health plan of a complete claim within the
34 required timeframes shall pay to the health care provider or the policyholder who submitted the

1 claim, in addition to any reimbursement for health care services provided, interest which shall
2 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day
3 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a
4 complete written claim, and ending on the date the payment is issued to the health care provider
5 or the policyholder.

6 (e) Exceptions to the requirements of this section are as follows:

7 (1) No health care entity or health plan operating in the state shall be in violation of this
8 section for a claim submitted by a health care provider or policyholder if:

9 (i) Failure to comply is caused by a directive from a court or federal or state agency;

10 (ii) The health care entity or health plan is in liquidation or rehabilitation or is operating
11 in compliance with a court-ordered plan of rehabilitation; or

12 (iii) The health care entity or health plan's compliance is rendered impossible due to
13 matters beyond its control, which are not caused by it.

14 (2) No health care entity or health plan operating in the state shall be in violation of this
15 section for any claim: (i) initially submitted more than ninety (90) days after the service is
16 rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider
17 received the notice provided for in § 27-18-61(b); provided, this exception shall not apply in the
18 event compliance is rendered impossible due to matters beyond the control of the health care
19 provider and were not caused by the health care provider.

20 (3) No health care entity or health plan operating in the state shall be in violation of this
21 section while the claim is pending due to a fraud investigation by a state or federal agency.

22 (4) No health care entity or health plan operating in the state shall be obligated under this
23 section to pay interest to any health care provider or policyholder for any claim if the ~~director of~~
24 ~~the department of business regulation~~ office of the health insurance commissioner
25 (commissioner) finds that the entity or plan is in substantial compliance with this section. A
26 health care entity or health plan seeking that finding from the ~~director~~ commissioner shall submit
27 any documentation that the ~~director~~ commissioner shall require. A health care entity or health
28 plan which is found to be in substantial compliance with this section shall submit any
29 documentation the ~~director~~ commissioner may require on ~~an annual~~ a quarterly basis for the
30 ~~director~~ commissioner to assess ongoing compliance with this section.

31 (5) A health care entity or health plan may petition the ~~director~~ commissioner for a
32 waiver of the provision of this section for a period not to exceed ninety (90) days in the event the
33 health care entity or health plan is converting or substantially modifying its claims processing
34 systems.

1 (f) For purposes of this section, the following definitions apply:

2 (1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or
3 (iii) all services for one patient or subscriber within a bill or invoice.

4 (2) "Date of receipt" means the date the health care entity or health plan receives the
5 claim whether via electronic submission or as a paper claim.

6 (3) "Health care entity" means a licensed insurance company or nonprofit hospital or
7 medical or dental service corporation or plan or health maintenance organization, or a contractor
8 as described in § 23-17.13-2(2) that operates a health plan.

9 (4) "Health care provider" means an individual clinician, either in practice independently
10 or in a group, ~~who provides health care services, and is referred to as a non-institutional provider~~
11 or a certified community mental health center, opioid treatment provider or other non-CMHC
12 providers of Medicaid services.

13 (5) "Health care services" include, but are not limited to, medical, mental health,
14 substance abuse, dental and any other services covered under the terms of the specific health plan.

15 (6) "Health plan" means a plan operated by a health care entity that provides for the
16 delivery of health care services to persons enrolled in the plan through:

17 (i) Arrangements with selected providers to furnish health care services; ~~and/or~~

18 (ii) Financial incentive for persons enrolled in the plan to use the participating providers
19 and procedures provided for by the health plan; ~~or~~

20 (iii) All persons enrolled and approved via the department of behavioral healthcare,
21 developmental disabilities and hospitals (BHDDH) portal.

22 (7) "Policyholder" means a person covered under a health plan or a representative
23 designated by that person.

24 (8) "Substantial compliance" means that the ~~health care entity or health plan is processing~~
25 ~~and paying ninety-five percent (95%) or more of all claims within the time frame provided for in~~
26 ~~§ 27-18-61(a) and (b)~~ ratio by the number of claims paid or processed by a subject entity within
27 the timeframes set forth in subsection (a) of this section to the number of claims received, is
28 ninety-five percent (95%) or greater.

29 (i) To measure the level of substantial compliance with the parity statute, any health plan
30 contracting with the executive office of health and human services (EOHHS) must report prompt
31 Medicaid claims processing of data by service line on a quarterly basis, and include the following
32 information:

33 (A) Total number of claims received within the quarter;

34 (B) Total number of claims paid within statutory timeframes;

1 (C) Total number of claims paid outside of statutory timeframes;
2 (D) Average processing time (in days) for all claims paid within statutory timeframes;
3 (E) Average processing time (in days) for all claims paid outside of statutory timeframes;
4 and
5 (F) Total interest paid on claims paid outside of statutory timeframes.
6 (ii) All data must be submitted within thirty (30) days following the close of the quarter.
7 (iii) If the health plan is meeting the federal and/or contractual Medicaid reimbursement
8 requirements, but is processing and paying behavioral health claims in an inequitable manner, it
9 will qualify as a non-quantitative insurer practice and sanctions will be applied through the office
10 of the health insurance commissioner.

11 (g) Any provision in a contract between a health care entity or a health plan and a health
12 care provider which is inconsistent with this section shall be void and of no force and effect.

13 (h) Pre-payment and timely payment. The executive office of health and human services
14 (EOHHS) shall impose a timely claims processing and payment procedure for Medicaid services.
15 If the health plan fails to reimburse the health care provider or policy holder within the required
16 timeframes as outlined under subsection (a) of this section, EOHHS, office of Medicaid, will
17 mandate under contractual agreement that the health plan execute a pre-payment reimbursement
18 plan with agreement of the health care provider.

19 The pre-payment reimbursement plan shall require the health plan to pay a health care
20 provider rendering opioid treatment program health home services; integrated health home
21 services (IHH) including vocational and therapy services, assertive community treatment (ACT),
22 mental health psychiatric rehabilitation residences (MHPRR), and substance use disorder
23 residential treatment services.

24 Payment on a pre-payment basis shall require payment by the health plan on the first
25 business day of each month with each payment amount equal to the average monthly payment
26 received for individuals on the attribution list during the immediate preceding six (6) months. The
27 health care provider and health plan shall undertake a reconciliation within one hundred eighty
28 (180) days of the close of each quarter with any overpayment repaid by the health care provider
29 or underpayment paid by the health plan within thirty (30) days.

30 SECTION 5. This act shall take effect upon passage.

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LC001327
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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO INSURANCE -- PROMPT PROCESSING OF CLAIMS

1 This act would provide greater details to be considered when deciding if there has been
2 substantial compliance with the statutes requiring the prompt processing and payment of health
3 insurance claims. It would include certain instances where prepayment of health insurance claims
4 would be required. The act would also require a quarterly report of Medicaid claims processing.
5 In addition compliance with the statute would no longer be determined by the director of business
6 regulations, but rather the commissioner of the office of health insurance.

7 This act would take effect upon passage.

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