2019 -- H 5347

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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2019

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:

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

27-18-61. Prompt processing of claims.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27-19-52. Prompt processing of claims.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) "Claim" means:

(i) A bill or invoice for covered services;

(ii) A line item of service; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27-20-47. Prompt processing of claims.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27-41-64. Prompt processing of claims.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 5. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- PROMPT PROCESSING OF CLAIMS

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

This act would take effect upon passage.

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