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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2019

A N A C T

RELATING TO INSURANCE -- PROMPT PROCESSING OF CLAIMS

Introduced By: Senators DiPalma, Miller, Goldin, Archambault, and Picard

Date Introduced: January 31, 2019

Referred To: Senate Health & Human Services

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 of 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 (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 2. Chapter 27-18 of the General Laws entitled "Accident and Sickness
17 Insurance Policies" is hereby amended by adding thereto the following section:

18 **27-18-61.1. Prompt processing of Medicaid 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 policy holder within fifteen (15) calendar days following the date of receipt of a
22 complete written claim or within fifteen (15) calendar days following the date of receipt of a
23 complete electronic claim. The executive office of health and human services (EOHHS) shall
24 establish a written standard defining what constitutes a complete claim and shall distribute this
25 standard to all participating providers within three (3) months of passage.

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

32 (c) If denial of a claim results from an error on the part of the health care entity or health
33 plan, the health care entity or health plan shall have fifteen (15) calendar days to notify in writing
34 the health care provider or policyholder of any and all errors that result in denial or pending the

1 claim and will reprocess the claim and forward payment in fifteen (15) calendar days or interest
2 will accrue at the rate of fifteen percent (15%) per annum commencing on the sixteenth day and
3 ending on the date the payment is issued to the health care provider or policyholder.

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

7 (e) A health care entity or health plan which fails to notify the health care provider or
8 policyholder of any and all reasons for denying or pending the claim, and/or fails to reimburse the
9 health care provider or policyholder after receipt by the health care entity or health plan of a
10 complete claim within the required timeframes shall pay to the health care provider or the
11 policyholder who submitted the claim, in addition to any reimbursement for health care services
12 provided, interest which shall accrue at the rate of twenty-five percent (25%) per annum
13 commencing on the sixteenth day after receipt of a complete electronic claim or on the sixteenth
14 day after receipt of a complete written claim, and ending on the date the payment is issued to the
15 health care provider or policyholder except as outlined in subsection (e)(1) of this section.

16 (1) 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 licensed by the department of behavioral
19 healthcare, developmental disabilities and hospitals providing treatment to individuals with
20 behavioral health care needs pursuant to §§ 40.1-24-1, 40.1-8.5-1, and 40.1-1-13 or the
21 policyholder who submitted the claim, in addition to any reimbursement for health care services
22 provided, interest which shall accrue at the rate of twenty-five percent (25%) per annum
23 commencing on the sixteenth day after receipt of a complete electronic claim or on the sixteenth
24 day after receipt of a complete written claim, and ending on the date the payment is issued to the
25 health care provider or the policyholder.

26 (f) For purposes of this section, the following definition applies:

27 (1) "Substantial compliance" means that the ratio of the number of claims paid or
28 processed by a subject entity within the timeframes set forth in subsections (a) and (b) of this
29 section to the number of claims received, is ninety-five percent (95%) or greater.

30 SECTION 3. Section 27-19-52 of the General Laws in Chapter 27-19 entitled "Nonprofit
31 Hospital Service Corporations" is hereby amended to read as follows:

32 **27-19-52. Prompt processing of claims.**

33 (a) A health care entity or health plan operating in the state shall pay all complete claims
34 for covered health care services submitted to the health care entity or health plan by a health care

1 provider or by a policyholder within forty (40) calendar days following the date of receipt of a
2 complete written claim or within thirty (30) calendar days following the date of receipt of a
3 complete electronic claim. Each health plan shall establish a written standard defining what
4 constitutes a complete claim and shall distribute this standard to all participating providers.

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

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

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

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

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

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

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

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

30 (2) No health care entity or health plan operating in the state shall be in violation of this
31 section for any claim: (i) initially submitted more than ninety (90) days after the service is
32 rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider
33 received the notice provided for in ~~§ 27-18-61(b)~~ [subsection \(b\) of this section](#); provided, this
34 exception shall not apply in the event compliance is rendered impossible due to matters beyond

1 the control of the health care provider and were not caused by the health care provider.

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

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

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

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

18 (1) "Claim" means:

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

20 (ii) A line item of service; or

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

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

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

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

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

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

1 (i) Arrangements with selected providers to furnish health care services; ~~and/or~~
2 (ii) Financial incentive for persons enrolled in the plan to use the participating providers
3 and procedures provided for by the health plan; or

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

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

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

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 4. Chapter 27-19 of the General Laws entitled "Nonprofit Hospital Service
33 Corporations" is hereby amended by adding thereto the following section:

34 **27-19-52.1. Prompt processing of Medicaid 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 policy holder within fifteen (15) calendar days following the date of receipt of a
4 complete written claim or within fifteen (15) calendar days following the date of receipt of a
5 complete electronic claim. The executive office of health and human services (EOHHS) shall
6 establish a written standard defining what constitutes a complete claim and shall distribute this
7 standard to all participating providers within three (3) months of passage.

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

14 (c) If denial of a claim results from an error on the part of the health care entity or health
15 plan, the health care entity or health plan shall have fifteen (15) calendar days to notify in writing
16 the health care provider or policyholder of any and all errors that result in denial or pending the
17 claim and will reprocess the claim and forward payment in fifteen (15) calendar days or interest
18 will accrue at the rate of fifteen percent (15%) per annum commencing on the sixteenth day and
19 ending on the date the payment is issued to the health care provider or policyholder.

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

23 (e) A health care entity or health plan which fails to notify the health care provider or
24 policyholder of any and all reasons for denying or pending the claim, and/or fails to reimburse the
25 health care provider or policyholder after receipt by the health care entity or health plan of a
26 complete claim within the required timeframes shall pay to the health care provider or the
27 policyholder who submitted the claim, in addition to any reimbursement for health care services
28 provided, interest which shall accrue at the rate of twenty-five percent (25%) per annum
29 commencing on the sixteenth day after receipt of a complete electronic claim or on the sixteenth
30 day after receipt of a complete written claim, and ending on the date the payment is issued to the
31 health care provider or policyholder except as outlined in subsection (e)(1) of this section.

32 (1) 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 licensed by the department of behavioral

1 healthcare, developmental disabilities and hospitals providing treatment to individuals with
2 behavioral health care needs pursuant to §§ 40.1-24-1, 40.1-8.5-1, and 40.1-1-13 or the
3 policyholder who submitted the claim, in addition to any reimbursement for health care services
4 provided, interest which shall accrue at the rate of twenty-five percent (25%) per annum
5 commencing on the sixteenth day after receipt of a complete electronic claim or on the sixteenth
6 day after receipt of a complete written claim, and ending on the date the payment is issued to the
7 health care provider or the policyholder.

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

9 (1) "Substantial compliance" means that the ratio of the number of claims paid or
10 processed by a subject entity within the timeframes set forth in subsections (a) and (b) of this
11 section to the number of claims received, is ninety-five percent (95%) or greater.

12 SECTION 5. Section 27-20-47 of the General Laws in Chapter 27-20 entitled "Nonprofit
13 Medical Service Corporations" is hereby amended to read as follows:

14 **27-20-47. Prompt processing of claims.**

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

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

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

30 (d) A health care entity or health plan which fails to reimburse the health care provider or
31 policyholder after receipt by the health care entity or health plan of a complete claim within the
32 required timeframes shall pay to the health care provider or the policyholder who submitted the
33 claim, in addition to any reimbursement for health care services provided, interest which shall
34 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day

1 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a
2 complete written claim, and ending on the date the payment is issued to the health care provider
3 or the policyholder.

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

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

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

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

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

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

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

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

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

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

34 (1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or

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

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

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

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

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

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

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

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

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

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

22 (8) "Substantial compliance" means that the health care entity or health plan is processing
23 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in
24 § 27-18-61(a) and (b).

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

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

33 The pre-payment reimbursement plan shall require the health plan to pay a health care
34 provider rendering opioid treatment program health home services; integrated health home

1 services (IHH) including vocational and therapy services, assertive community treatment (ACT),
2 mental health psychiatric rehabilitation residences (MHPRR), and substance use disorder
3 residential treatment services.

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

10 SECTION 6. Chapter 27-20 of the General Laws entitled "Nonprofit Medical Service
11 Corporations" is hereby amended by adding thereto the following section:

12 **27-20-47.1. Prompt processing of Medicaid claims.**

13 (a) A health care entity or health plan operating in the state shall pay all complete claims
14 for covered health care services submitted to the health care entity or health plan by a health care
15 provider or by a policy holder within fifteen (15) calendar days following the date of receipt of a
16 complete written claim or within fifteen (15) calendar days following the date of receipt of a
17 complete electronic claim. The executive office of health and human services (EOHHS) shall
18 establish a written standard defining what constitutes a complete claim and shall distribute this
19 standard to all participating providers within three (3) months of passage.

20 (b) If the health care entity or health plan denies or pends a claim, the health care entity
21 or health plan shall have fifteen (15) calendar days from receipt of the claim to notify in writing
22 the health care provider or policyholder of any and all reasons for denying or pending the claim
23 and what, if any, additional information is required to process the claim. No health care entity or
24 health plan may limit the time period in which additional information may be submitted to
25 complete a claim.

26 (c) If denial of a claim results from an error on the part of the health care entity or health
27 plan, the health care entity or health plan shall have fifteen (15) calendar days to notify in writing
28 the health care provider or policyholder of any and all errors that result in denial or pending the
29 claim and will reprocess the claim and forward payment in fifteen (15) calendar days or interest
30 will accrue at the rate of fifteen percent (15%) per annum commencing on the sixteenth day and
31 ending on the date the payment is issued to the health care provider or policyholder.

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

1 (e) A health care entity or health plan which fails to notify the health care provider or
2 policyholder of any and all reasons for denying or pending the claim, and/or fails to reimburse the
3 health care provider or policyholder after receipt by the health care entity or health plan of a
4 complete claim within the required timeframes shall pay to the health care provider or the
5 policyholder who submitted the claim, in addition to any reimbursement for health care services
6 provided, interest which shall accrue at the rate of twenty-five percent (25%) per annum
7 commencing on the sixteenth day after receipt of a complete electronic claim or on the sixteenth
8 day after receipt of a complete written claim, and ending on the date the payment is issued to the
9 health care provider or policyholder except as outlined in subsection (e)(1) of this section.

10 (1) A health care entity or health plan which fails to reimburse the health care provider or
11 policyholder after receipt by the health care entity or health plan of a complete claim within the
12 required timeframes shall pay to the health care provider licensed by the department of behavioral
13 healthcare, developmental disabilities and hospitals providing treatment to individuals with
14 behavioral health care needs pursuant to §§ 40.1-24-1, 40.1-8.5-1, and 40.1-1-13 or the
15 policyholder who submitted the claim, in addition to any reimbursement for health care services
16 provided, interest which shall accrue at the rate of twenty-five percent (25%) per annum
17 commencing on the sixteenth day after receipt of a complete electronic claim or on the sixteenth
18 day after receipt of a complete written claim, and ending on the date the payment is issued to the
19 health care provider or the policyholder.

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

21 (1) "Substantial compliance" means that the ratio of the number of claims paid or
22 processed by a subject entity within the timeframes set forth in subsections (a) and (b) of this
23 section to the number of claims received, is ninety-five percent (95%) or greater.

24 SECTION 7. Section 27-41-64 of the General Laws in Chapter 27-41 entitled "Health
25 Maintenance Organizations" is hereby amended to read as follows:

26 **27-41-64. Prompt processing of claims.**

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

33 (b) If the health care entity or health plan denies or pends a claim, the health care entity
34 or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing

1 the health care provider or policyholder of any and all reasons for denying or pending the claim
2 and what, if any, additional information is required to process the claim. No health care entity or
3 health plan may limit the time period in which additional information may be submitted to
4 complete a claim.

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

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

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

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

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

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

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

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

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

32 (4) No health care entity or health plan operating in the state shall be obligated under this
33 section to pay interest to any health care provider or policyholder for any claim if the ~~director of~~
34 ~~the department of business regulation~~ office of the health insurance commissioner

1 (commissioner) finds that the entity or plan is in substantial compliance with this section. A
2 health care entity or health plan seeking that finding from the ~~director~~ commissioner shall submit
3 any documentation that the ~~director~~ commissioner shall require. A health care entity or health
4 plan which is found to be in substantial compliance with this section shall submit any
5 documentation the ~~director~~ commissioner may require on ~~an annual~~ a quarterly basis for the
6 ~~director~~ commissioner to assess ongoing compliance with this section.

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

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

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

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

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

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

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

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

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

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

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

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

34 (8) "Substantial compliance" means that the ~~health care entity or health plan is processing~~

1 ~~and paying ninety five percent (95%) or more of all claims within the time frame provided for in~~
2 ~~§ 27-18-61(a) and (b)~~ ratio by the number of claims paid or processed by a subject entity within
3 the timeframes set forth in subsection (a) of this section to the number of claims received, is
4 ninety-five percent (95%) or greater.

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

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

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

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

24 SECTION 8. Chapter 27-41 of the General Laws entitled "Health Maintenance
25 Organizations" is hereby amended by adding thereto the following section:

26 **27-41-64.1. Prompt processing of Medicaid claims.**

27 (a) A health care entity or health plan operating in the state shall pay all complete claims
28 for covered health care services submitted to the health care entity or health plan by a health care
29 provider or by a policy holder within fifteen (15) calendar days following the date of receipt of a
30 complete written claim or within fifteen (15) calendar days following the date of receipt of a
31 complete electronic claim. The executive office of health and human services (EOHHS) shall
32 establish a written standard defining what constitutes a complete claim and shall distribute this
33 standard to all participating providers within three (3) months of passage.

34 (b) If the health care entity or health plan denies or pends a claim, the health care entity

1 or health plan shall have fifteen (15) calendar days from receipt of the claim to notify in writing
2 the health care provider or policyholder of any and all reasons for denying or pending the claim
3 and what, if any, additional information is required to process the claim. No health care entity or
4 health plan may limit the time period in which additional information may be submitted to
5 complete a claim.

6 (c) If denial of a claim results from an error on the part of the health care entity or health
7 plan, the health care entity or health plan shall have fifteen (15) calendar days to notify in writing
8 the health care provider or policyholder of any and all errors that result in denial or pending the
9 claim and will reprocess the claim and forward payment in fifteen (15) calendar days or interest
10 will accrue at the rate of fifteen percent (15%) per annum commencing on the sixteenth day and
11 ending on the date the payment is issued to the health care provider or policyholder.

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

15 (e) A health care entity or health plan which fails to notify the health care provider or
16 policyholder of any and all reasons for denying or pending the claim, and/or fails to reimburse the
17 health care provider or policyholder after receipt by the health care entity or health plan of a
18 complete claim within the required timeframes shall pay to the health care provider or the
19 policyholder who submitted the claim, in addition to any reimbursement for health care services
20 provided, interest which shall accrue at the rate of twenty-five percent (25%) per annum
21 commencing on the sixteenth day after receipt of a complete electronic claim or on the sixteenth
22 day after receipt of a complete written claim, and ending on the date the payment is issued to the
23 health care provider or policyholder except as outlined in subsection (e)(1) of this section.

24 (1) A health care entity or health plan which fails to reimburse the health care provider or
25 policyholder after receipt by the health care entity or health plan of a complete claim within the
26 required timeframes shall pay to the health care provider licensed by the department of behavioral
27 healthcare, developmental disabilities and hospitals providing treatment to individuals with
28 behavioral health care needs pursuant to §§ 40.1-24-1, 40.1-8.5-1, and 40.1-1-13 or the
29 policyholder who submitted the claim, in addition to any reimbursement for health care services
30 provided, interest which shall accrue at the rate of twenty-five percent (25%) per annum
31 commencing on the sixteenth day after receipt of a complete electronic claim or on the sixteenth
32 day after receipt of a complete written claim, and ending on the date the payment is issued to the
33 health care provider or the policyholder.

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

1 (1) "Substantial compliance" means that the ratio of the number of claims paid or
2 processed by a subject entity within the timeframes set forth in subsections (a) and (b) of this
3 section to the number of claims received, is ninety-five percent (95%) or greater.

4 SECTION 9. This act shall take effect upon passage.

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LC001003/SUB A
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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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LC001003/SUB A
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