CHAPTER 182
HB 725-FN - FINAL VERSION

7Mar2019... 0487h

2019 SESSION

19-0737
01/06

HOUSE BILL ***725-FN***

AN ACT relative to certain standards for managed care organizations.

SPONSORS: Rep. Knirk, Carr. 3; Rep. Williams, Hills. 4; Rep. Marsh, Carr. 8; Rep. Woods, Merr. 23; Sen. Sherman, Dist 24

COMMITTEE: Commerce and Consumer Affairs

AMENDED ANALYSIS

This bill establishes certain credentialing standards and claims quality assurance standards for managed care organizations for the purposes of the Medicaid program.

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Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

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STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Nineteen

AN ACT relative to certain standards for managed care organizations.

Be it Enacted by the Senate and House of Representatives in General Court convened:

182:1 New Subparagraphs; Medicaid Managed Care; Standards for Managed Care Organizations. Amend RSA 126-A:5, XIX by inserting after subparagraph (i) the following new subparagraphs:

(j)(1) Managed care organizations shall process credentialing applications from all types of providers within the following prescribed time frames:

(A) For primary care physicians, within 30 calendar days of receipt of clean and complete credentialing applications.

(B) For specialty care providers, within 45 calendar days of receipt of clean and complete credentialing applications.

(2) For the purposes of subparagraph (1), the start time begins when the managed care organization has received a provider's clean and complete application, and ends on the date of the provider's written notice of network status.

(3) For the purposes of this subparagraph, a "clean and complete" application is a claim that is signed and appropriately dated by the provider, and includes:

(A) Evidence of the provider's New Hampshire Medicaid identification; and

(B) Other applicable information to support the provider application, including provider explanations related to quality and clinical competence satisfactory to the managed care organization.

(4) If the managed care organization does not process a provider's credentialing application within the time frames set forth in this subparagraph, the managed care organization shall pay the provider retroactive to 30 calendar days or 45 calendar days after receipt of the provider's clean and complete application, depending on the prescribed time frame for the appropriate provider.

(5) Nothing in this subparagraph shall preclude the commissioner from administering the applicable contract requirements with the managed care organization as necessary to allow for exceptions to credentialing standards under this subparagraph.

(k)(1) For the purposes of this subparagraph regarding claims quality assurance standards, the commissioner shall adopt the claims definitions established by the Centers for Medicare and Medicaid Services under the Medicaid program which are as follows:

(A) "Clean claim" means a claim that does not have any defect, impropriety, lack

of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

(B) "Incomplete claim" means a claim that is denied for the purpose of obtaining additional information from the provider. The managed care organization shall pay or deny 95 percent of clean claims within 30 days of receipt, or receipt of additional information. The managed care organization shall pay 99 percent of clean claims within 90 days of receipt.

(2) Nothing in this subparagraph shall preclude the commissioner from administering the applicable contract requirements with the managed care organization as necessary to allow for exceptions to claims quality assurance standards under this subparagraph.

182:2 Effective Date. This act shall take effect 60 days after its passage.

Approved: July 10, 2019
Effective Date: September 08, 2019