HCS SS SB 742 -- HEALTH CARE

SPONSOR: Brown (Frederick)

COMMITTEE ACTION: Voted "do pass" by the Committee on Health Care Policy by a vote of 11 to 0.

This substitute changes the laws regarding health care.

MEDICAL RADIATION SAFETY AWARENESS DAY (Section 9.179, RSMo)

The substitute designates March 27 of each year as Medical Radiation Safety Awareness Day in Missouri to educate and enhance the awareness of the benefits of radiographic medical procedures and the potential dangers of overexposure to radiation during diagnostic imaging and radiation therapy to reduce the frequency of adverse events and allow citizens to make informed decisions about their medical care.

MEDICAL RECORD STORAGE AND RETRIEVAL FEES (Section 191.227)

Currently, a health care provider may charge a patient a fee for copying his or her health care records in an amount of not more than $21.36 plus 50 cents per page or if the provider stores records in an electronic or digital format and provides the requested records and affidavit, if requested, in an electronic or digital format, the provider may not charge more than $5 plus 50 cents per page or $25 total, whichever is less. The bill allows a provider to charge a fee for search and retrieval of the records in an amount of not more than $22.01 plus copying in an amount of 52 cents per page or to furnish the records electronically for the amount of the copying fees at the time of the request or $100 total, whichever is less.

PHARMACIES (Section 338.255)

A licensed pharmacy cannot be required to carry or maintain in inventory any specific prescription or nonprescription drug or device.

LEGEND DRUGS SOLD BY PHARMACIES (Sections 338.315 and 338.333)

A pharmacy is allowed to sell, purchase, or trade legend drugs to other pharmacies if the dollar amount of the sale, purchase, or trade is in compliance with the rules of the Board of Pharmacy within the Department of Insurance, Financial Institutions and Professional Registration and does not exceed 5% of the pharmacy’s total annual prescription drug sales. Pharmacies must establish and maintain inventories and records of all transactions regarding the receipt and distribution or other

disposition of legend drugs for two years and the information must be readily available upon request by the board or its representatives.

CREDENTIALING AND PAYMENT OF HEALTH CARE PRACTITIONERS (Sections 376.1575 - 376.1580)

The substitute establishes a process for a health insurance carrier to credential a health practitioner within 60 days of receiving a completed application from the practitioner. A health insurance carrier must:

(1) Provide a practitioner, within five business days after receipt of an electronically filed credentialing application, the health carrier must send an electronic notice of receipt of the application to the practitioner;

(2) Assess a health practitioner's credentialing information and make a decision to approve or deny his or her application within 90 days unless the verifying application information indicates that the practitioner has a history of behavioral disorders or impairments; had licensure disciplinary actions imposed; had hospital admitting or surgical privileges revoked, restricted, or suspended based on clinical performance; or has incurred a medical malpractice judgement; and

(3) Permit a health practitioner to bill and be paid directly for treatment services provided to the carrier's health plan enrollees while the initial application is under review unless the health practitioner is not affiliated with an entity that has a current contractual relationship with the health insurance carrier. Reimbursement rates for the health practitioner can be limited to the same fee schedule paid to out-of-network providers. The health insurance carrier may refuse to list the health practitioner in its provider directory or to allow the practitioner to be designated as a primary care provider for its enrollees while the application is pending. If a practitioner's credentialing application is denied, the carrier's obligation to be billed by and reimburse the health practitioner ceases upon the carrier's notice to the practitioner of the denied application.

The Department of Insurance, Financial Institutions and Professional Registration must establish a mechanism for reporting a health insurance carrier's violation of untimely credentialing of a health practitioner.

Specified provisions regarding health care claim reimbursements will not apply to a health carrier until 15 business days after the carrier receives a practitioner's initial credentialing

application.

These provisions will not apply to any practitioner who fails to sign, complete, and return to the health carrier within 10 business days a contract offered by the carrier in response to the practitioner's application for credentialing. Any claim made by the provider prior to the 10 business days after a contract is offered by the carrier must be covered under the provisions of the substitute. The provisions will also not apply at any time the contractual relationship with the entity with whom the provider is affiliated and the health carrier is not in force or effect.

These provisions cannot be construed to require a health carrier to accept or add a practitioner to its provider network.

FISCAL NOTE: No impact on state funds in FY 2013, FY 2014, and FY 2015.

PROPONENTS: Supporters say that the current provider credentialing process can be quite cumbersome and often delays care being provided to patients because they are waiting for approval of insurance coverage which is bad public policy practice for patient care. There is no continuity in the process or within the practices of an insurer. The process established in the bill provides needed changes to facilitate improved and faster care to a patient. The bill applies to only licensed providers who are in good standing with the state. It takes a great effort to maintain a certification for a licensed health care practitioner in the state, which hurts physician practices because they cannot make a practice complete with a full panel of practitioners for almost a year due to the requirements it takes to get any new provider fully credentialed by several insurers. Since practitioners are already paying for medical malpractice insurance, the insurers are not at risk, but the delay in the credentialing practice means the practitioner is not making money but still having to pay the expensive insurance premiums. The long waiting period bankrupts smaller companies.

Testifying for the bill were Senator Brown; Kathleen McCarry, MSMA/MGMA/St. Louis Management Group; Becky York, Sound Health Services, PC and Metro Ent/MGMA St. Louis; Missouri Hospital Association; Missouri Nurses Association; BJC Healthcare Systems; CoxHealth; Missouri Association of Rural Health Clinics; Signature Health Services; Missouri Academy of Family Physicians; Missouri Association of Physicians and Surgeons; and Missouri AFL-CIO.

OPPONENTS: Those who oppose the bill say that the concept of the bill was discussed over the past summer but no agreement was

reached between practitioners and carriers. The credentialing process is not simple and it is not taken lightly by health carriers because of the risks involved. The larger a provider is, the longer it takes to be credentialed. Incomplete applications and background checks also delay the process. The most important thing a health plan does is credential providers due to the great liability. Unfortunately, the process can take a long time. The need for income and reimbursement cannot override the necessity to do a complete review to fully protect consumers and the insurer. The process is not always fully automated, it does include personal contact which often slows down the process. There are provisions in the bill that undermine the insurer's panel of network providers which are unfair and undermine network-based healthcare that employers buy and provide for their employees. There is an incentive and a benefit to being in an insurer network. Insurers need to be able to make business decisions about credentialing without government intrusion. The reason insurers don't directly reimburse for out-of-network providers and services is because they want to encourage members to seek in-network providers where they will have savings. This is a payment and contracting issue not a credentialing process issue. This is government intruding on a contract between two parties.

Testifying against the bill were United HealthCare Services, Incorporated; America's Health Insurance Plans; Missouri Insurance Coalition; Luxottica Retail; Coventry Health Care; Anthem Blue Cross Blue Shield of Missouri; and Humana, Incorporated.