SECOND REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 575

99TH GENERAL ASSEMBLY

4516H.02C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 191.1145, 208.670, 208.671, 208.673, 208.675, 208.677, 354.603, 376.427, 376.1350, and 376.1367, RSMo, and to enact in lieu thereof nine new section relating to reimbursement of health care services.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 191.1145, 208.670, 208.671, 208.673, 208.675, 208.677, 354.603, 376.427, 376.1350, and 376.1367, RSMo, is repealed and nine new sections enacted in lieu thereof, to be known as sections 191.1145, 208.670, 208.677, 354.603, 376.427, 376.690, 376.1065, 376.1350, and 376.1367, to read as follows:

191.1145. 1. As used in sections 191.1145 and 191.1146, the following terms shall mean:

(1) "Asynchronous store-and-forward transfer", the collection of a patient's relevant health information and the subsequent transmission of that information from an originating site to a health care provider at a distant site without the patient being present;

(2) "Clinical staff", any health care provider licensed in this state;

(3) "Distant site", a site at which a health care provider is located while providing health care services by means of telemedicine;

(4) "Health care provider", as that term is defined in section 376.1350;

(5) "Originating site", a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine. For the purposes of asynchronous store-and-forward transfer, originating site shall also mean the location at which the health care provider transfers information to the distant site;

(6) "Telehealth" or "telemedicine", the delivery of health care services by means of information and communication technologies which facilitate the assessment, diagnosis,

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

consultation, treatment, education, care management, and self-management of a patient's health care while such patient is at the originating site and the health care provider is at the distant site. Telehealth or telemedicine shall also include the use of asynchronous store-and-forward technology.

2. Any licensed health care provider shall be authorized to provide telehealth services if such services are within the scope of practice for which the health care provider is licensed and are provided with the same standard of care as services provided in person. **This section shall not be construed to prohibit a health carrier, as defined in section 376.1350, from reimbursing non-clinical staff for services otherwise allowed by law.**

3. In order to treat patients in this state through the use of telemedicine or telehealth, health care providers shall be fully licensed to practice in this state and shall be subject to regulation by their respective professional boards.

4. Nothing in subsection 3 of this section shall apply to:

(1) Informal consultation performed by a health care provider licensed in another state, outside of the context of a contractual relationship, and on an irregular or infrequent basis without the expectation or exchange of direct or indirect compensation;

(2) Furnishing of health care services by a health care provider licensed and located in another state in case of an emergency or disaster; provided that, no charge is made for the medical assistance; or

(3) Episodic consultation by a health care provider licensed and located in another state who provides such consultation services on request to a physician in this state.

5. Nothing in this section shall be construed to alter the scope of practice of any health care provider or to authorize the delivery of health care services in a setting or in a manner not otherwise authorized by the laws of this state.

6. No originating site for services or activities provided under this section shall be required to maintain immediate availability of on-site clinical staff during the telehealth services, except as necessary to meet the standard of care for the treatment of the patient's medical condition if such condition is being treated by an eligible health care provider who is not at the originating site, has not previously seen the patient in person in a clinical setting, and is not providing coverage for a health care provider who has an established relationship with the patient.

7. Nothing in this section shall be construed to alter any collaborative practice requirement as provided in chapters 334 and 335.

208.670. 1. As used in this section, these terms shall have the following meaning:

(1) **"Consultation", a type of evaluation and management service as defined by the most recent edition of the Current Procedural Terminology published annually by the American Medical Association;**

(2) "Distant site", the same meaning as such term is defined in section 191.1145;

(3) "Originating site", the same meaning as such term is defined in section 191.1145;

(4) "Provider", **[**~~any provider of medical services and mental health services, including all other medical disciplines~~**] the same meaning as the term "health care provider" is defined in section 191.1145, and such provider meets all other MO HealthNet eligibility requirements**;

[~~(2)~~**] (5)** "Telehealth", the same meaning as such term is defined in section 191.1145.

2. **[**~~Reimbursement for the use of asynchronous store-and-forward technology in the practice of telehealth in the MO HealthNet program shall be allowed for orthopedics, dermatology, ophthalmology and optometry, in cases of diabetic retinopathy, burn and wound care, dental services which require a diagnosis, and maternal-fetal medicine ultrasounds.~~

~~3. The department of social services, in consultation with the departments of mental health and health and senior services, shall promulgate rules governing the practice of telehealth in the MO HealthNet program. Such rules shall address, but not be limited to, appropriate standards for the use of telehealth, certification of agencies offering telehealth, and payment for services by providers. Telehealth providers shall be required to obtain participant consent before telehealth services are initiated and to ensure confidentiality of medical information.~~

~~4. Telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law. Reimbursement for such services shall be made in the same way as reimbursement for in-person contacts.~~

~~5. The provisions of section 208.671 shall apply to the use of asynchronous store-and-forward technology in the practice of telehealth in the MO HealthNet program~~**] The department of social services shall reimburse providers for services provided through telehealth if such providers can ensure services are rendered meeting the standard of care that would otherwise be expected should such services be provided in person. The department shall not restrict the originating site through rule or payment so long as the provider can ensure services are rendered meeting the standard of care that would otherwise be expected should such services be provided in person. Payment for services rendered via telehealth shall not depend on any minimum distance requirement between the originating and distant site. Reimbursement for telehealth services shall be made in the same way as reimbursement for in-person contact; however, consideration shall also be made for reimbursement to the originating site. Reimbursement for asynchronous store-and-**

forward may be capped at the reimbursement rate had the service been provided in person.

208.677. **[**~~1. For purposes of the provision of telehealth services in the MO HealthNet program, the term "originating site" shall mean a telehealth site where the MO HealthNet participant receiving the telehealth service is located for the encounter. The standard of care in the practice of telehealth shall be the same as the standard of care for services provided in person. An originating site shall be one of the following locations:~~

~~(1) An office of a physician or health care provider;~~

~~(2) A hospital;~~

~~(3) A critical access hospital;~~

~~(4) A rural health clinic;~~

~~(5) A federally qualified health center;~~

~~(6) A long-term care facility licensed under chapter 198;~~

~~(7) A dialysis center;~~

~~(8) A Missouri state habilitation center or regional office;~~

~~(9) A community mental health center;~~

~~(10) A Missouri state mental health facility;~~

~~(11) A Missouri state facility;~~

~~(12) A Missouri residential treatment facility licensed by and under contract with the children's division. Facilities shall have multiple campuses and have the ability to adhere to technology requirements. Only Missouri licensed psychiatrists, licensed psychologists, or provisionally licensed psychologists, and advanced practice registered nurses who are MO HealthNet providers shall be consulting providers at these locations;~~

~~(13) A comprehensive substance treatment and rehabilitation (CSTAR) program;~~

~~(14) A school;~~

~~(15) The MO HealthNet recipient's home;~~

~~(16) A clinical designated area in a pharmacy; or~~

~~(17) A child assessment center as described in section 210.001.~~

~~2. If the originating site is a school, the school shall obtain permission from the parent or guardian of any student receiving telehealth services prior to each provision of service.~~**] Prior to the provision of telehealth services in a school, the parent or guardian of the child shall provide authorization for the provision of such service. Such authorization shall include the ability for the parent or guardian to authorize services via telehealth in the school for the remainder of the school year.**

354.603. 1. A health carrier shall maintain a network that is sufficient in number and types of providers to assure that all services to enrollees shall be accessible without unreasonable

delay. In the case of emergency services, enrollees shall have access twenty-four hours per day, seven days per week. The health carrier's medical director shall be responsible for the sufficiency and supervision of the health carrier's network. Sufficiency shall be determined by the director in accordance with the requirements of this section and by reference to any reasonable criteria, including but not limited to provider-enrollee ratios by specialty, primary care provider-enrollee ratios, geographic accessibility, reasonable distance accessibility criteria for pharmacy and other services, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

(1) In any case where the health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit was obtained from a participating provider, or shall make other arrangements acceptable to the director.

(2) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers, including local pharmacists, to the business or personal residence of enrollees. In determining whether a health carrier has complied with this provision, the director shall give due consideration to the relative availability of health care providers in the service area under, especially rural areas, consideration.

(3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its providers to furnish all contracted benefits to enrollees. The provisions of this subdivision shall not be construed to require any health care provider to submit copies of such health care provider's income tax returns to a health carrier. A health carrier may require a health care provider to obtain audited financial statements if such health care provider received ten percent or more of the total medical expenditures made by the health carrier.

(4) A health carrier shall make its entire network available to all enrollees unless a contract holder has agreed in writing to a different or reduced network.

2. A health carrier shall file with the director, in a manner and form defined by rule of the department of insurance, financial institutions and professional registration, an access plan meeting the requirements of sections 354.600 to 354.636 for each of the managed care plans that the health carrier offers in this state. The health carrier may request the director to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information will cause the health carrier's competitors to obtain valuable business information. The health carrier shall provide such plans, absent any information deemed by the director to be proprietary, to any interested party upon request. The health carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it

makes any change as defined by the director to an existing managed care plan. The director shall approve or disapprove the access plan, or any subsequent alterations to the access plan, within sixty days of filing. The access plan shall describe or contain at a minimum the following:

(1) The health carrier's network;

(2) The health carrier's procedures for making referrals within and outside its network;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of enrollees of the managed care plan;

(4) The health carrier's methods for assessing the health care needs of enrollees and their satisfaction with services;

(5) The health carrier's method of informing enrollees of the plan's services and features, including but not limited to the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(6) The health carrier's system for ensuring the coordination and continuity of care for enrollees referred to specialty physicians, for enrollees using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(7) The health carrier's process for enabling enrollees to change primary care professionals;

(8) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, in the event of a reduction in service area or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how enrollees shall be notified of the contract termination, reduction in service area or the health carrier's insolvency or other modification or cessation of operations, and transferred to other health care professionals in a timely manner; and

(9) Any other information required by the director to determine compliance with the provisions of sections 354.600 to 354.636.

3. In reviewing an access plan filed pursuant to subsection 2 of this section, the director shall deem a managed care plan's network to be adequate if it meets one or more of the following criteria:

(1) The managed care plan is a Medicare + Choice coordinated care plan offered by the health carrier pursuant to a contract with the federal Centers for Medicare and Medicaid Services;

(2) The managed care plan is being offered by a health carrier that has been accredited by the National Committee for Quality Assurance at a level of "accredited" or better, and such accreditation is in effect at the time the access plan is filed;

(3) The managed care plan's network has been accredited by the Joint Commission on the Accreditation of Health Organizations for Network Adequacy, and such accreditation is in effect at the time the access plan is filed. If the accreditation applies to only a portion of the managed care plan's network, only the accredited portion will be deemed adequate; **[**~~or~~**]**

(4) The managed care plan is being offered by a health carrier that has been accredited by the Utilization Review Accreditation Commission at a level of "accredited" or better, and such accreditation is in effect at the time the access plan is filed**; or**

(5) The managed care plan is being offered by a health carrier that has been accredited by the Accreditation Association for Ambulatory Health Care, and such accreditation is in effect at the time the access plan is filed.

376.427. 1. As used in this section, the following terms mean:

(1) **"Health benefit plan", as such term is defined in section 376.1350;**

(2) "Health care services", medical, surgical, dental, podiatric, pharmaceutical, chiropractic, licensed ambulance service, and optometric services;

(3) "Health carrier" or "carrier", as such term is defined in section 376.1350;

[~~(2)~~**] (4)** "Insured", any person entitled to benefits under a contract of accident and sickness insurance, or medical-payment insurance issued as a supplement to liability insurance but not including any other coverages contained in a liability or a workers' compensation policy, issued by an insurer;

[~~(3)~~**] (5)** "Insurer", any person, reciprocal exchange, interinsurer, fraternal benefit society, health services corporation, self-insured group arrangement to the extent not prohibited by federal law, or any other legal entity engaged in the business of insurance;

[~~(4)~~**] (6)** "Provider", a physician, hospital, dentist, podiatrist, chiropractor, pharmacy, licensed ambulance service, or optometrist, licensed by this state.

2. Upon receipt of an assignment of benefits made by the insured to a provider, the insurer shall issue the instrument of payment for a claim for payment for health care services in the name of the provider. All claims shall be paid within thirty days of the receipt by the insurer of all documents reasonably needed to determine the claim.

3. Nothing in this section shall preclude an insurer from voluntarily issuing an instrument of payment in the single name of the provider.

4. **Except as provided in subsection 5 of this section,** this section shall not require any insurer, health services corporation, health maintenance corporation or preferred provider organization which directly contracts with certain members of a class of providers for the delivery of health care services to issue payment as provided pursuant to this section to those members of the class which do not have a contract with the insurer.

5. When a patient's health benefit plan does not include or require payment to out-of-network providers for all or most covered services, which would otherwise be covered if the patient received such services from a provider in the carrier's network, including but not limited to health maintenance organization plans, as such term is defined in section 354.400, or a health benefit plan offered by a carrier consistent with subdivision (19) of section 376.426, payment for all services shall be made directly to the providers when the health carrier has authorized such services to be received from a provider outside the carrier's network.

376.690. 1. As used in this section, the following terms shall mean:

(1) "Emergency medical condition", the same meaning given to such term in section 376.1350;

(2) "Facility", the same meaning given to such term in section 376.1350;

(3) "Health care professional", the same meaning given to such term in section 376.1350;

(4) "Health carrier", the same meaning given to such term in section 376.1350;

(5) "Unanticipated out-of-network care", health care services received by a patient in an in-network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged;

2. Health care professionals shall send any claim for charges incurred for unanticipated out-of-network care to the patient's health carrier on a U.S. Centers of Medicare and Medicaid Services Form 1500, or its successor form, or electronically using the 837 HIPAA format, or its successor.

(1) Within forty-five processing days, as defined in 376.383, of receiving the health care professional's claim, the health carrier shall offer to pay the health care professional a reasonable reimbursement for unanticipated out-of-network care based on the health care professional's services. If the health care professional participates in one or more of the carrier's commercial networks, the offer of reimbursement for unanticipated out-of-network care shall be the amount from the network which has the highest reimbursement.

(2) If the health care professional declines the health carrier's initial offer of reimbursement, the health carrier and health care professional shall have sixty days to negotiate in good faith to attempt to determine the reimbursement for the unanticipated out-of-network care.

(3) If the health carrier and health care professional do not agree to a reimbursement amount by the end of the sixty day negotiation period, the dispute shall be resolved through an arbitration process as specified in subsection 4 of this section.

(4) To initiate arbitration proceedings, either the health carrier or health care professional must provide written notification to the director and the other party within 120 days of the end of the negotiation period, indicating their intent to arbitrate the matter and notifying the director of the billed amount and the date and amount of the final offer by each party. A bill for unanticipated out of network care may be resolved between the parties at any point prior to the commencement of the arbitration proceedings. Bills may be combined for purposes of arbitration, but only to the extent the bills represent similar circumstances and services provided by the same health care professional, and the parties attempted to resolve the dispute in accordance with subdivisions (2) through (4) of this subsection.

(5) No health care professional shall send a bill to the patient for any difference between the reimbursement rate as determined under this subsection and the health care professional's billed charge.

3. When unanticipated out-of-network care is provided, the health care professional may bill a patient for no more than the cost-sharing requirements described under this section.

(1) Cost-sharing requirements shall be based on the reimbursement amount as determined under subsection 2 of this section.

(2) The patient's health carrier shall inform the health care professional of its enrollee's cost-sharing requirements within forty-five processing days of receiving a claim from the health care professional for services provided.

(3) The in-network deductible and out-of-pocket maximum cost-sharing requirements shall apply to the claim for the unanticipated out-of-network care.

4. The director shall ensure access to an external arbitration process when a health care professional and health carrier cannot agree to a reimbursement under subdivision (2) of subsection 2 of this section. In order to ensure access, when notified of a parties' intent to arbitrate, the director shall randomly select an arbitrator for each case from the department's approved list of arbitrators or entities that provide binding arbitration. The director shall specify the criteria for an approved arbitrator or entity by rule. The costs of arbitration shall be shared equally between and will be directly billed to the health care professional and health carrier. These costs will include, but are not limited to, reasonable time necessary for the arbitrator to review materials in preparation for the arbitration, travel expenses and reasonable time following the arbitration for drafting of the final decision.

5. At the conclusion of such arbitration process, the arbitrator shall issue a final decision, which shall be binding on all parties. The arbitrator shall provide a copy of the

final decision to the director. The initial request for arbitration, all correspondence and documents received by the Department and the final arbitration decision shall be considered a closed record under section 374.071. However, the director may release aggregated summary data regarding the arbitration process. The decision of the arbitrator shall not be considered an agency decision nor shall it be considered a contested case within the meaning of 536.010.

6. The arbitrator shall determine a dollar amount due under subsection 2 of this section between one hundred twenty percent of the Medicare allowed amount and the seventieth percentile of the usual and customary rate for the unanticipated out-of-network care, as determined by benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations.

7. When determining a reasonable reimbursement rate, the arbitrator shall consider the following factors if the health care professional believes the payment offered for the unanticipated out-of-network care does not properly recognize:

(1) The health care professional's training, education, or experience;

(2) The nature of the service provided;

(3) The health care professional's usual charge for comparable services provided;

(4) The circumstances and complexity of the particular case, including the time and place the services were provided; and

(5) The average contracted rate for comparable services provided in the same geographic area.

8. The enrollee shall not be required to participate in the arbitration process. The health care professional and health carrier shall execute a nondisclosure agreement prior to engaging in an arbitration under this section.

9. This section shall take effect on January 1, 2019.

10. The department of insurance, financial institutions and professional registration may promulgate rules and fees as necessary to implement the provisions of this section, including but not limited to, procedural requirements for arbitration. Any rule or portion of a rule, as that term is defined in section 536.010 that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2018, shall be invalid and void.

376.1065. 1. As used in this section, the following terms shall mean:

(1) "Contracting entity", any health carrier, as such term is defined in section 376.1350, subject to the jurisdiction of the department engaged in the act of contracting with providers for the delivery of dental services, or the selling or assigning of dental network plans to other entities under the jurisdiction of the department;

(2) "Department", the department of insurance, financial institutions and professional registration;

(3) "Official notification," written communication by a provider or participating provider to a contracting entity describing such provider's or participating provider's change in contact information or participation status with the contracting entity;

(4) "Participating provider", a provider who has an agreement with a contracting entity to provide dental services with an expectation of receiving payment, other than coinsurance, co-payments, or deductibles, directly or indirectly from such contracting entity;

(5) "Provider", any person licensed under chapter 332.

2. A contracting entity shall, upon official notification, make changes contained in the official notification to their electronic provider material and their next edition of paper material made available to plan members or other potential plan members.

3. The department, when determining the result of a market conduct examination under sections 374.202 to 374.207, shall consider violations of this section by a contracting entity.

376.1350. For purposes of sections 376.1350 to 376.1390, the following terms mean:

(1) "Adverse determination", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated;

(2) "Ambulatory review", utilization review of health care services performed or provided in an outpatient setting;

(3) "Case management", a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions;

(4) "Certification", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's

requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness;

(5) "Clinical peer", a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review;

(6) "Clinical review criteria", the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services;

(7) "Concurrent review", utilization review conducted during a patient's hospital stay or course of treatment;

(8) "Covered benefit" or "benefit", a health care service that an enrollee is entitled under the terms of a health benefit plan;

(9) "Director", the director of the department of insurance, financial institutions and professional registration;

(10) "Discharge planning", the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(11) "Drug", any substance prescribed by a licensed health care provider acting within the scope of the provider's license and that is intended for use in the diagnosis, mitigation, treatment or prevention of disease. The term includes only those substances that are approved by the FDA for at least one indication;

(12) "Emergency medical condition", the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity**, regardless of the final diagnosis that is given,** that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(a) Placing the person's health in significant jeopardy;

(b) Serious impairment to a bodily function;

(c) Serious dysfunction of any bodily organ or part;

(d) Inadequately controlled pain; or

(e) With respect to a pregnant woman who is having contractions:

a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

b. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child;

(13) "Emergency service", a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider;

(14) "Enrollee", a policyholder, subscriber, covered person or other individual participating in a health benefit plan;

(15) "FDA", the federal Food and Drug Administration;

(16) "Facility", an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

(17) "Grievance", a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and a health carrier;

(18) "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services; except that, health benefit plan shall not include any coverage pursuant to liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(19) "Health care professional", a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law;

(20) "Health care provider" or "provider", a health care professional or a facility;

(21) "Health care service", a service for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease;

(22) "Health carrier", an entity subject to the insurance laws and regulations of this state that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services; except that such plan shall not include any coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(23) "Health indemnity plan", a health benefit plan that is not a managed care plan;

(24) "Managed care plan", a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use, health care providers managed, owned, under contract with or employed by the health carrier;

(25) "Participating provider", a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the health carrier;

(26) "Peer-reviewed medical literature", a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that has been determined by the International Committee of Medical Journal Editors to have met the uniform requirements for manuscripts submitted to biomedical journals or is published in a journal specified by the United States Department of Health and Human Services pursuant to Section 1861(t)(2)(B) of the Social Security Act, as amended, as acceptable peer-reviewed medical literature. Peer-reviewed medical literature shall not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier;

(27) "Person", an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing;

(28) "Prospective review", utilization review conducted prior to an admission or a course of treatment;

(29) "Retrospective review", utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment;

(30) "Second opinion", an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service;

(31) "Stabilize", with respect to an emergency medical condition, that no material deterioration of the condition is likely to result or occur before an individual may be transferred;

(32) "Standard reference compendia":

(a) The American Hospital Formulary Service-Drug Information; or

(b) The United States Pharmacopoeia-Drug Information;

(33) "Utilization review", a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage;

(34) "Utilization review organization", a utilization review agent as defined in section 374.500.

376.1367. When conducting utilization review or making a benefit determination for emergency services:

(1) A health carrier shall cover emergency services necessary to screen and stabilize an enrollee**, as determined by the treating emergency department health care provider,** and shall not require prior authorization of such services;

(2) Coverage of emergency services shall be subject to applicable co-payments, coinsurance and deductibles;

(3) **Before a health carrier denies payment for an emergency medical service based on the absence of an emergency medical condition, it shall review the enrollee's medical record regarding the emergency medical condition at issue. If a health carrier requests records for a potential denial where emergency services were rendered, the health care provider shall submit the record of the emergency services to the carrier within forty-five processing days, or the claim shall be subject to section 376.383. The health carrier's review of emergency services shall be completed by a board-certified physician licensed under chapter 334 to practice medicine in this state;**

(4) When an enrollee receives an emergency service that requires immediate post evaluation or post stabilization services, a health carrier shall provide an authorization decision within sixty minutes of receiving a request; if the authorization decision is not made within **[**~~thirty~~**] sixty** minutes, such services shall be deemed approved**;**

(5) When a patient's health benefit plan does not include or require payment to out-of-network health care providers for emergency services including but not limited to health maintenance organization plans, as defined in section 354.400, or a health benefit plan offered by a health carrier consistent with subdivision (19) of section 376.426, payment for all emergency services as defined in section 376.1350 necessary to screen and stabilize an enrollee shall be paid directly to the health care provider by the health carrier. Additionally, any services authorized by the health carrier for the enrollee once the enrollee is stabilized shall also be paid by the health carrier directly to the health care provider.

[208.671. 1. As used in this section and section 208.673, the following terms shall mean:

(1) "Asynchronous store-and-forward", the transfer of a participant's clinically important digital samples, such as still images, videos, audio, text files, and relevant data from an originating site through the use of a camera or similar recording device that stores digital samples that are forwarded via telecommunication to a distant site for consultation by a consulting provider without requiring the simultaneous presence of the participant and the participant's treating provider;

(2) "Asynchronous store-and-forward technology", cameras or other recording devices that store images which may be forwarded via telecommunication devices at a later time;

(3) "Consultation", a type of evaluation and management service as defined by the most recent edition of the Current Procedural Terminology published annually by the American Medical Association;

(4) "Consulting provider", a provider who, upon referral by the treating provider, evaluates a participant and appropriate medical data or images delivered through asynchronous store-and-forward technology. If a consulting provider is unable to render an opinion due to insufficient information, the consulting provider may request additional information to facilitate the rendering of an opinion or decline to render an opinion;

(5) "Distant site", the site where a consulting provider is located at the time the consultation service is provided;

(6) "Originating site", the site where a MO HealthNet participant receiving services and such participant's treating provider are both physically located;

(7) "Provider", any provider of medical, mental health, optometric, or dental health services, including all other medical disciplines, licensed and providing MO HealthNet services who has the authority to refer participants for medical, mental health, optometric, dental, or other health care services within the scope of practice and licensure of the provider;

(8) "Telehealth", as that term is defined in section 191.1145;

(9) "Treating provider", a provider who:

(a) Evaluates a participant;

(b) Determines the need for a consultation;

(c) Arranges the services of a consulting provider for the purpose of diagnosis and treatment; and

(d) Provides or supplements the participant's history and provides pertinent physical examination findings and medical information to the consulting provider.

2. The department of social services, in consultation with the departments of mental health and health and senior services, shall promulgate rules governing the use of asynchronous store-and-forward technology in the practice of

~~telehealth in the MO HealthNet program. Such rules shall include, but not be limited to:~~

~~(1) Appropriate standards for the use of asynchronous store-and-forward technology in the practice of telehealth;~~

~~(2) Certification of agencies offering asynchronous store-and-forward technology in the practice of telehealth;~~

~~(3) Timelines for completion and communication of a consulting provider's consultation or opinion, or if the consulting provider is unable to render an opinion, timelines for communicating a request for additional information or that the consulting provider declines to render an opinion;~~

~~(4) Length of time digital files of such asynchronous store-and-forward services are to be maintained;~~

~~(5) Security and privacy of such digital files;~~

~~(6) Participant consent for asynchronous store-and-forward services; and~~

~~(7) Payment for services by providers; except that, consulting providers who decline to render an opinion shall not receive payment under this section unless and until an opinion is rendered.~~

~~Telehealth providers using asynchronous store-and-forward technology shall be required to obtain participant consent before asynchronous store-and-forward services are initiated and to ensure confidentiality of medical information.~~

~~3. Asynchronous store-and-forward technology in the practice of telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law. The total payment for both the treating provider and the consulting provider shall not exceed the payment for a face-to-face consultation of the same level.~~

~~4. The standard of care for the use of asynchronous store-and-forward technology in the practice of telehealth shall be the same as the standard of care for services provided in person.~~**]**

[~~208.673. 1. There is hereby established the "Telehealth Services Advisory Committee" to advise the department of social services and propose rules regarding the coverage of telehealth services in the MO HealthNet program utilizing asynchronous store-and-forward technology.~~

~~2. The committee shall be comprised of the following members:~~

~~(1) The director of the MO HealthNet division, or the director's designee;~~

~~(2) The medical director of the MO HealthNet division;~~

~~(3) A representative from a Missouri institution of higher education with expertise in telehealth;~~

~~(4) A representative from the Missouri office of primary care and rural health;~~

~~(5) Two board-certified specialists licensed to practice medicine in this state;~~

~~(6) A representative from a hospital located in this state that utilizes telehealth;~~

~~(7) A primary care physician from a federally qualified health center (FQHC) or rural health clinic;~~

~~(8) A primary care physician from a rural setting other than from an FQHC or rural health clinic;~~

~~(9) A dentist licensed to practice in this state; and~~

~~(10) A psychologist, or a physician who specializes in psychiatry, licensed to practice in this state.~~

~~3. Members of the committee listed in subdivisions (3) to (10) of subsection 2 of this section shall be appointed by the governor with the advice and consent of the senate. The first appointments to the committee shall consist of three members to serve three-year terms, three members to serve two-year terms, and three members to serve a one-year term as designated by the governor. Each member of the committee shall serve for a term of three years thereafter.~~

~~4. Members of the committee shall not receive any compensation for their services but shall be reimbursed for any actual and necessary expenses incurred in the performance of their duties.~~

~~5. Any member appointed by the governor may be removed from office by the governor without cause. If there is a vacancy for any cause, the governor shall make an appointment to become effective immediately for the unexpired term.~~

~~6. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2016, shall be invalid and void.~~**]**

[~~208.675. For purposes of the provision of telehealth services in the MO HealthNet program, the following individuals, licensed in Missouri, shall be considered eligible health care providers:~~

~~(1) Physicians, assistant physicians, and physician assistants;~~

~~(2) Advanced practice registered nurses;~~

~~(3) Dentists, oral surgeons, and dental hygienists under the supervision of a currently registered and licensed dentist;~~

~~(4) Psychologists and provisional licensees;~~

~~(5) Pharmacists;~~

~~(6) Speech, occupational, or physical therapists;~~

~~(7) Clinical social workers;~~

~~(8) Podiatrists;~~

~~(9) Optometrists;~~

~~(10) Licensed professional counselors; and~~

~~(11) Eligible health care providers under subdivisions (1) to (10) of this section practicing in a rural health clinic, federally qualified health center, or community mental health center.~~**]**

✓