HCS SB 575 -- REIMBURSEMENT OF HEALTH CARE SERVICES

SPONSOR: Wallingford

COMMITTEE ACTION: Voted "Do Pass with HCS" by the Standing Committee on Insurance Policy by a vote of 9 to 0. Voted "Do Pass" by the Standing Committee on Rules- Legislative Oversight by a vote of 13 to 0.

TELEHEALTH

This bill specifies that the Department of Social Services shall reimburse providers for services provided through telehealth if the providers can ensure that services are rendered meeting the standard of care that would be expected if the services were rendered in person. Telehealth services are the delivery of health care using technology to communicate with a health care provider who is at a different location than the patient. Generally, reimbursement for telehealth services must be made in the same way as reimbursement for in-person contact. The Department of Health and Senior Services cannot make rules or restrictions on providing services via telehealth as 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.

The bill specifies that before telehealth services can be provided in a school, the parent or guardian must give authorization.

This bill clarifies that current statute authorizing a health care provider to provide telehealth services shall not be construed to prohibit a health carrier from reimbursing non-clinical staff for services otherwise allowed by law.

This bill repeals several existing provisions relating to telehealth services within MO HealthNet (Sections 191.1145, 208.670, 208.671, 208.673, 208.675, and 208.677, RSMo).

These provisions are the same as HCS HB 1617 (2018).

ACCREDITATION ASSOCIATION FOR AMBULATORY HEALTH CARE

This bill provides that the Director of the Department of Insurance, Financial Institutions and Professional Registration shall determine that a managed care plan's network is adequate if the managed care plan is being offered by a health carrier accredited by the Accreditation Association for Ambulatory Health Care (Section 354.603).

UNANTICIPATED OUT-OF-NETWORK CARE

The bill specifies that health care professionals shall send any U.S. Centers of Medicare and Medicaid Services Form 1500, or its successor form, for charges incurred for unanticipated out-of-network care to the patient's health carrier within 45 processing days. Health carriers shall pay health care professionals a reasonable rate for unanticipated out-of-network care; if the health care professional participates in the health carrier's commercial networks, the offer of reimbursement shall be the amount from the network with the highest reimbursement rate.

Requires carriers and health care professionals to negotiate within 60 days, in good faith to determine a reimbursement amount. If the health care professional declines the carrier's initial offer the bill provides for disputes to be resolved through a binding arbitration process as outlined, and prohibits health care professionals from billing patients for any difference between the payment received and the payment that would have been received based on the rate charged by that professional.

When unanticipated out-of-network care is provided, the health care professional may bill the patient for no more than the cost-sharing requirements as described. The in-network deductible and out-of-pocket maximum, cost sharing requirements shall apply to the claim for the unanticipated out-of-network care.

The Director of the Department of Insurance, Financial Institutions, and Professional Registration shall randomly select an arbitrator from the department's approved list and provide for a binding arbitration process when a health care professional and health carrier cannot agree to a reasonable reimbursement rate. The arbitrator shall determine a reimbursement rate between 120% of the Medicare allowed amount and the 70th percentile of the usual and customary rate based on benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations.

The bill specifies information that the arbitrator shall consider certain information in rendering his or her decision, requires the parties to execute a nondisclosure agreement prior to the arbitration, and specifies that the parties shall share the arbitration costs equally.

This bill requires any health carrier engaged in the act of contracting with providers for the delivery of dental services, or in the act of selling or assigning dental network plans, to update their electronic and paper provider materials made available to plan members or other potential plan members upon receiving written notice of changes by providers.

The Department of Insurance, Financial Institutions, and Professional Registration shall consider violations of the act when conducting a market conduct examination (Section 376.690).

These provisions shall take effect on January 1, 2019.

These provisions are similar to SB 1057 (2018) and to provisions in SCS SB 928 (2018).

ELECTRONIC AND PAPER DENTAL SERVICES PROVIDER MATERIALS

This bill requires any health carrier engaged in the act of contracting with providers for the delivery of dental services, or in the act of selling or assigning dental network plans, to update their electronic and paper provider materials made available to plan members or other potential plan members upon receiving written notice of changes by providers.

The Department of Insurance, Financial Institutions and Professional Registration shall consider violations when conducting a market conduct examination (Section 376.1065).

This provision is the same as SB 852 (2018) and similar to SB 193 (2017) and SB 999 (2016).

EMERGENCY MEDICAL CONDITIONS

This bill specifies that whether an ailment is considered an "emergency medical condition" depends on the person having sufficiently severe symptoms, regardless of what final diagnosis is given (Section 376.1350).

The bill specifies that necessity of emergency services to screen and stabilize a patient shall be determined by the treating health care provider.

Before a health carrier denies payment for an emergency service based on the lack of an emergency medical condition, it shall review the enrollee's medical records regarding the emergency condition at issue. If a health carrier requests records for a potential denial, the provider shall submit the record to the carrier within 45 days or the claim shall be subject to the prompt payment insurance law. The carrier's review of the records shall be completed by a board certified physician licensed to practice in the state.

This bill increases, from 30 minutes to 60 minutes, the amount of time health carriers have to provide authorization decisions for

immediate post evaluation or post stabilization services before the services are deemed approved.

When a patient's health benefit plan does not provide for payment to out-of-network healthcare providers for emergency services, including but not limited to HMO and EPO plans, payment for all emergency services necessary to screen and stabilize the enrollee shall be paid directly to the health care provider by the health carrier. Any service authorized by the health carrier for the enrollee once the enrollee is stabilized shall also be paid by the health carrier directly to the provider (Section 376.1367).

This provision is similar to SCS SB 928 and SB 1057 (2018).

PROPONENTS: Supporters say that this bill will help the department deem managed care plan networks adequate quicker by allowing the department to do so if the network is accredited by the Accreditation Association for Ambulatory Health Care.

Testifying for the bill was Senator Wallingford.

OPPONENTS: There was no opposition voiced to the committee.