HCS#2 HB 1490 -- HEALTH CARE

SPONSOR: Sater (Frederick)

COMMITTEE ACTION: Voted "do pass" by the Committee on Health Care Policy by a vote of 10 to 1.

This substitute changes laws regarding health care.

RADIATION 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.

NEWBORN SCREENING REQUIREMENTS (Section 191.332)

The Department of Health and Senior Services is required, by January 1, 2013, to expand, subject to appropriations, the newborn screening requirements to include severe combined immune deficiency disease (SCID), also known as bubble boy disease, prior to the newborn being discharged from a health care facility.

TUBERCULOSIS TESTING (Sections 199.170 - 199.340)

The substitute changes the laws regarding the requirements for the testing of persons with tuberculosis (TB). The substitute:

(1) Allows the local public health authority to institute proceedings by petition for directly observed therapy (DOT) or commitment when a person with TB violates state rules and regulations. A general allegation that the public health requires therapy or commitment of the person with TB is sufficient;

(2) Allows the Department of Health and Senior Services to contract for the care of a person with TB. The contract must provide that state payment will be available for the treatment and care of the patients only after benefits from all third-party payers have been exhausted;

(3) Specifies that a person with TB cannot be required to submit to medical or surgical treatment without his or her consent unless a circuit court authorizes treatment by a written order or as otherwise permitted by law;

(4) Specifies that if a person with TB who is committed to a facility for treatment leaves the facility without a proper discharge, he or she can be prosecuted if appropriate;

(5) Allows a patient with TB or the patient's next of kin to petition the circuit court that originally issued the commitment order if he or she believes the contagious TB no longer exists and that discharging the patient from the facility is not a public health danger;

(6) Prohibits any person who is knowingly infected with TB from acting in a reckless manner to expose another person who has not consented to being exposed, reporting to work with active contagious TB, or violating the requirements of a commitment order. A person who violates these provisions is guilty of a class D felony unless the victim contracts TB, in which case it is a class C felony;

(7) Authorizes the department to respond to TB cases, outbreaks, and disease investigations;

(8) Authorizes the department or the local public health authority to investigate and examine suspected TB cases, require the administration of TB treatments, and make the necessary contractual arrangements with health care providers to care and treat persons with TB as resources permit;

(9) Requires the department or local public health authority to immediately initiate an investigation when notified of an active TB case within its jurisdiction. In order to prevent or control TB, the department or the local public health authority can enter and inspect public places, any public or commercial means of transportation, and private property with the consent of the property owner or by an ex parte order; and

(10) Requires all volunteers and employees of health care facilities to receive a tuberculin skin test or interferon gamma release assay test upon employment as recommended in the most recent version of the Centers for Disease Control and Prevention guidelines. All college and university campuses in the state must implement testing for all on-campus students upon matriculation and any student who does not comply with the testing cannot be permitted to maintain enrollment in the subsequent semester.

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 48 hours after receipt of an electronically filed credentialing application, access to the health carrier's website to verify the receipt of the practitioner's application or send a notice of receipt within five days after the receipt of a paper application;

(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 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.

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 will 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.

FISCAL NOTE: Estimated Net Cost on General Revenue Fund of Unknown more than $571,572 in FY 2013, Unknown Greater than $57,945 in FY 2014, and Unknown Greater than $57,945 in FY 2015. Estimated Net Cost on Other State Funds of Unknown more than $7,220 in FY 2013, Unknown more than $7,603 in FY 2014, and Unknown more than $21,917 in 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 Representative Frederick; Kathleen McCarry, MSMA/MGMA/St. Louis Management Group; Becky York, Sound Health Services, PC and Metro Ent/MGMA St. Louis; Michael Hunt; Missouri State Chiropractors Association; Missouri Psychiatric Society; Missouri Academy of Family Physicians; Dr. Frances Atkins; Missouri Association of Osteopathic Physicians; Missouri Ambulatory Surgery Center Association; Signature Health Services; Missouri Association of Rural Health Clinics; Missouri Psychological Association; and Missouri Hospital Association.

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 America's Health Insurance Plans; Missouri Insurance Coalition; Coventry Healthcare Services, Incorporated; United Healthcare Services, Incorporated; Anthem Blue Cross Blue Shield of Missouri; and Humana, Incorporated.