House _____ **Amendment NO.**____

Offered By

_____ _____

AMEND House Committee Substitute for Senate Substitute for Senate Bill No. 580, Page 23, Section 191.116, Line 59, by inserting after all of said line the following:

"191.236. As used in sections 191.236 to 191.238 the following terms shall mean:

(1) "Health information exchange activities", the electronic exchange of individually identifiable information among unaffiliated organizations according to nationally recognized standards. The following activities are not considered "health information exchange activities":

(a) Electronic exchange of individually identifiable information among unaffiliated organizations solely for the purposes of an organized health care arrangement as defined under the HIPAA Laws; and

(b) Electronic exchange of individually identifiable information among unaffiliated organizations solely for research purposes;

(2) "Health information organization", any organization that oversees and governs health information exchange activities;

(3) "HIPAA laws", the Health Insurance Portability and Accountability Act of 1996, as amended, the Health Information Technology for Economic and Clinical Health Act, as amended, and implementing regulations;

(4) "Individual", the person who is the subject of the individually identifiable information;

(5) "Individually identifiable information", any information that identifies an individual or there is a reasonable basis to believe can be used to identify the individual including, but not limited to, information created or received by health care providers, health benefit plans, organizations providing social services or assessing social determinants of health, and organizations that provide services to or on behalf of any of the foregoing and health care clearinghouses, and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual;

(6) "Participant", an individual or entity who accesses, uses, or discloses individually identifiable information through a health information exchange operated by a health information organization including, but not limited to, health care providers, health benefit plans, organizations providing social services or assessing social determinants of health, and organizations that provide services to or on behalf of any of the foregoing.

191.238 1. (1) Notwithstanding any other provision of law to the contrary, any participant may disclose, access, or use individually identifiable information through a health information exchange operated by a health information organization pursuant to this chapter and in accordance with applicable federal laws including, but not limited to, the HIPAA laws, without obtaining individual consent or authorization.

Action Taken_____ Date _____

(2) Except as otherwise provided in state or federal law, an individual has the right to opt out of having the individual's individually identifiable information accessible through a health information exchange operated by a health information organization under this chapter.

(3) A health information organization shall implement policies that meet the requirements under the HIPAA laws governing the privacy and security of individually identifiable information that is accessible through the health information exchange.

(4) All participants in a health information organization under this section shall comply with the HIPAA laws, if such participant is subject to the HIPAA laws, and all policies and procedures of the health information organization with respect to the health information exchange.

(5) To the extent any provision of state law, rule or regulation is contrary to, or is more stringent than the provisions of this section, the provisions of this section shall control with respect to a participant's disclosure, access, or use of individually identifiable information through a health information exchange operated by a health information organization under this section.

(6) This section shall not limit, change, or otherwise affect the use or disclosure of individually identifiable information outside of a health information exchange operated by a health information organization under this section.

2. (1) Participants shall maintain a written notice of privacy practices for the health information exchange that describes all of the following:

(a) The categories of individually identifiable information that are accessible through the health information exchange;

(b) The purposes for which access to individually identifiable information is provided through the health information exchange;

(c) Except as otherwise provided in state or federal law, that an individual has the right to opt out of having the individual's individually identifiable information accessible through the health information exchange; and

(d) An explanation as to how an individual may opt out of having the individual's individually identifiable information accessible through the health information exchange.

(2) The notice of privacy practices maintained by participants may reference a publicly accessible website or websites that contain some or all of the information described in subdivision (1) of this subsection, such as a current list of participants and the permitted purposes for accessing individually identifiable information through the health information exchange.

(3) Participants shall post their current notice of privacy practices on its website in a conspicuous manner.

3. (1) A health information organization shall not be considered a health care provider, as that term is defined in section 538.205, based on its health information exchange activities and shall not be subject to liability for damages or costs of any nature, in law or in equity, arising out of chapter 538 and the common law of Missouri when carrying out health information exchange activities pursuant to this section.

(2) Participants in a health information exchange operated by a health information organization pursuant to this chapter shall not be liable in any action for damages or costs of any nature, in law or equity, which result solely from that participant's use or failure to use the health information exchange or participant's disclosure of individually identifiable information through the health information exchange in accordance with the requirements of this chapter.

(3) No person shall be subject to antitrust or unfair competition liability based solely on participation in a health information exchange operated by a health information organization under this chapter and performs health information exchange activities under this section.

(4) All employees, officers, and members of the governing board of a health information organization that operates a health information exchange under this chapter, whether temporary or permanent, shall not be subject to and shall be immune from any claim, suit, liability, damages, or

any other recourse, civil or criminal, arising from any act or proceeding, decision, or determination undertaken, performed, or reached in good faith and without malice by any such member or members acting individually or jointly in carrying out the responsibilities, authority, duties, powers, and privileges of the offices conferred by law upon them under this chapter, or any other state law, or policies and procedures of the health information exchange, good faith being presumed until proven otherwise, with malice required to be shown by a complainant.

(5) Individually identifiable information accessible through a health information exchange operated by a health information organization under this chapter is not subject to discovery, subpoena, or other means of legal compulsion for the release of such individually identifiable information to any person or entity. Such a health information organization shall not be compelled by a request for production, subpoena, court order, or otherwise, to disclose individually identifiable health information."; and

Further amend said bill, Page 35, Section 195.070, Line 26, by inserting after the word "prescribed" the words "as authorized by federal law"; and

Further amend said bill, Page 68, Section 338.200, Line 41, by inserting after all of said section and line the following:

"376.383. 1. For purposes of this section and section 376.384, the following terms shall mean:

(1) "Claimant", any individual, corporation, association, partnership or other legal entity asserting a right to payment arising out of a contract or a contingency or loss covered under a health benefit plan as defined in section 376.1350;

(2) "Clean claim", a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment;

(3) "Deny" or "denial", when the health carrier refuses to reimburse all or part of the claim;

(4) "Health care provider", health care provider as defined in section 376.1350;

(5) "Health care services", health care services as defined in section 376.1350;

(6) "Health carrier", health carrier as defined in section 376.1350 and any self-insured health plan, to the extent allowed by federal law; except that health carrier shall not include a workers' compensation carrier providing benefits to an employee pursuant to chapter 287. For the purposes of this section and section 376.384, third-party contractors are health carriers;

(7) "Processing days", number of days the health carrier or any of its agents, subsidiaries, contractors, subcontractors, or third-party contractors has the claim in its possession. Processing days shall not include days in which the health carrier is waiting for a response to a request for additional information from the claimant;

(8) "Request for additional information", a health carrier's electronic or facsimile request for additional information from the claimant specifying all of the documentation or information necessary to process all of the claim, or all of the claim on a multi-claim form, as a clean claim for payment;

(9) "Third-party contractor", a third party contracted with the health carrier to receive or process claims for reimbursement of health care services.

2. Within forty-eight hours after receipt of an electronically filed claim by a health carrier or a third-party contractor, a health carrier shall send an electronic acknowledgment of the date of receipt.

3. Within thirty processing days after receipt of a filed claim by a health carrier or a third-party contractor, a health carrier shall send an electronic or facsimile notice of the status of the claim

that notifies the claimant:

(1) Whether the claim is a clean claim as defined under this section; or

(2) The claim requires additional information from the claimant.

If the claim is a clean claim, then the health carrier shall pay or deny the claim. If the claim requires additional information, the health carrier shall include in the notice a request for additional information. If a health carrier pays the claim, this subsection shall not apply.

4. Within ten processing days after receipt of additional information by a health carrier or a third-party contractor, a health carrier shall pay the claim or any undisputed part of the claim in accordance with this section or send an electronic or facsimile notice of receipt and status of the claim:

(1) That denies all or part of the claim and specifies each reason for denial; or

(2) That makes a final request for additional information.

5. Within five processing days after the day on which the health carrier or a third-party contractor receives the additional requested information in response to a final request for information, it shall pay the claim or any undisputed part of the claim or deny the claim.

6. If the health carrier has not paid the claimant on or before the forty-fifth processing day from the date of receipt of the claim, the health carrier shall pay the claimant one percent interest per month and a penalty in an amount equal to one percent of the claim per day. The interest and penalty shall be calculated based upon the unpaid balance of the claim as of the forty-fifth processing day. On claims where the amount owed by the health carrier exceeds thirty five thousand dollars on the unpaid balance of a claim, the health carrier shall pay the claimant one percent interest per month and a penalty in an amount equal to one percent of the claim per day for a maximum of one-hundred days, and thereafter shall pay the claimant two percent interest per month. The interest and penalty paid pursuant to this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest and penalty. A health carrier may combine interest payments and make payment once the aggregate amount reaches one hundred dollars. Any claim or portion of a claim which has been properly denied before the forty-fifth processing day under this section and section 376.384 shall not be subject to interest or penalties. For a claim or any portion of such claim that was denied before the forty-fifth processing day, interest and penalties shall begin to accrue beginning on the day the first appeal is filed by the claimant with the health carrier until such claim is paid if the claim or portion of the claim is approved. If any appeal filed with the health carrier does not result in the disputed claim or portion of such claim being approved for payment to the claimant, and a petition is filed in a court of competent jurisdiction to recover payment of all or part of such claim, interest and penalties shall continue to accrue for no more than one hundred days from the day the first appeal was filed by the claimant with the health carrier, and such interest and penalties shall [~~cease to~~] continue to accrue [~~on the day~~] ten days after [~~a petition is filed in~~] a court of competent jurisdiction [~~to recover payment of such claim~~] finds that the claim or portion of the claim shall be paid to the claimant. Upon a finding by a court of competent jurisdiction that the health carrier failed to pay a claim, interest, or penalty without good cause, the court shall enter judgment for reasonable attorney fees for services necessary for recovery. Upon a finding that a health care provider filed suit without reasonable grounds to recover a claim, the court shall award the health carrier reasonable attorney fees necessary to the defense.

7. The department of commerce and insurance shall monitor denials and determine whether the health carrier acted reasonably.

8. If a health carrier or third-party contractor has reasonable grounds to believe that a fraudulent claim is being made, the health carrier or third-party contractor shall notify the department of commerce and insurance of the fraudulent claim pursuant to sections 375.991 to

375.994.

9. Denial of a claim shall be communicated to the claimant and shall include the specific reason why the claim was denied. Any claim for which the health carrier has not communicated a specific reason for the denial shall not be considered denied under this section or section 376.384.

10. Requests for additional information shall specify all of the documentation and additional information that is necessary to process all of the claim, or all of the claims on a multi-claim form, as a clean claim for payment. Information requested shall be reasonable and pertain solely to the health carrier's liability. The health carrier shall acknowledge receipt of the requested additional information to the claimant within five calendar days or pay the claim."; and

Further amend said bill, Pages 68-71, Section 376.455, Lines 1-103, by removing all of said section and lines from the bill; and

Further amend said bill, Page 71, Section 376.1345, Line 29, by inserting after all of said section and line the following:

"376.1578. 1. Within two working days after receipt of a [~~faxed or mailed completed~~] credentialing application, the health carrier shall send a notice of receipt to the practitioner. A health carrier shall provide access to a provider web portal that allows the practitioner to receive notice of the status of an electronically submitted application.

2. If a health carrier determines the application is not a completed application the health carrier shall have ten days from the date of the notice of receipt in subsection 1 of this section to request any additional information from the practitioner. The application shall be considered a completed application upon receipt of the requested additional information from the practitioner. Within two working days of receipt of the requested additional information, the health carrier shall send a notice to the practitioner informing them that they have submitted a completed application. If the health carrier does not request additional information, the application shall be deemed completed as of the date of the notice of receipt required by subsection 1 of this section.

3. A health carrier shall assess a health care practitioner's completed credentialing [~~information~~] application and make a decision as to whether to approve or deny the practitioner's credentialing application and notify the practitioner of such decision within sixty [~~business~~]days of the date of receipt of the completed application. The sixty-day deadline established in this section shall not apply if the application or subsequent verification of information indicates that the practitioner has:

(1) A history of behavioral disorders or other impairments affecting the practitioner's ability to practice, including but not limited to substance abuse;

(2) Licensure disciplinary actions against the practitioner's license to practice imposed by any state or territory or foreign jurisdiction;

(3) Had the practitioner's hospital admitting or surgical privileges or other organizational credentials or authority to practice revoked, restricted, or suspended based on the practitioner's clinical performance; or

(4) A judgment or judicial award against the practitioner arising from a medical malpractice liability lawsuit.

4. If a practitioner's application is approved, the health carrier shall provide payments for covered health services performed by the practitioner during the credentialing period if the provision of services were on behalf of an entity that had a contract with such health carrier during the Credentialing Period. The contracted entity for whom the practitioner is providing services shall submit to the health carrier all claims for services provided by such practitioner during the credentialing period, within six months after the health carrier has approved that practitioner's

credentialing application. Claims submitted for reimbursement under this section shall be sent to the carrier by the provider in a single request or as few requests as practical subject to any technical constraints or other issues out of the contracted provider's control. "Credentialing Period" shall mean the time between the date the practitioner submits a completed application to the health carrier to be credentialed and the date the practitioner's credentialing is approved by the health carrier.

5. A health carrier shall not require a practitioner to be credentialed in order to receive payments for covered health services if the practitioner is providing coverage for an absent credentialed practitioner during a temporary period of time not to exceed sixty days. Any practitioner authorized to receive payments for covered services under this section shall provide notice to the health carrier, including but not limited to name, medical license information, estimated duration of absence, and practitioner's name and medical license information providing coverage for such absent credentialed practitioner. A health carrier may deny payments if the practitioner providing services in lieu of the credentialed provider meets one of the conditions in subdivisions 1 to 4 in subsection 3 of this section.

6. For the purposes of this section "covered health services" shall mean any services provided by a practitioner that would otherwise be covered if provided by a credentialed provider.

7. All claims eligible for payment as described in subsections 4 and 5 of this section shall be subject to section 376.383.

[~~3~~] 8. The department of commerce and insurance shall establish a mechanism for reporting alleged violations of this section to the department."; and

Further amend said bill, Page 73, Section 579.076, Line 12, by inserting after all of said line the following:

"**[**~~191.237. 1. No law or rule promulgated by an agency of the state of Missouri may impose a fine or penalty against a health care provider, hospital, or health care system for failing to participate in any particular health information organization.~~

~~2. A health information organization shall not restrict the exchange of state agency data or standards-based clinical summaries for patients for federal Health Insurance Portability and Accountability Act (HIPAA) allowable uses. Charges for such service shall not exceed the cost of the actual technology connection or recurring maintenance thereof.~~

~~3. As used in this section, the following terms shall mean:~~

~~(1) "Fine or penalty", any civil or criminal penalty or fine, tax, salary or wage withholding, or surcharge established by law or by rule promulgated by a state agency pursuant to chapter 536;~~

~~(2) "Health care system", any public or private entity whose function or purpose is the management of, processing of, or enrollment of individuals for or payment for, in full or in part, health care services or health care data or health care information for its participants;~~

~~(3) "Health information organization", an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.~~**]**"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.