HOUSE AMENDMENT NO.____
TO
HOUSE AMENDMENT NO.____

Offered By

AMEND House Amendment No._____ to House Committee Substitute for Senate Substitute for Senate Bill No. 333, Page 2, Line 24, by inserting after the word, "agreement." the following:

"9. Any Medicaid managed care organization defined in 42 U.S.C. 1396b(m) which provides or arranges health care services for MO HealthNet enrollees in Missouri pursuant to this chapter shall not deny coverage of medically necessary services to a MO HealthNet participant for which the participant is eligible and which the health care provider is duly qualified to provide in the regular course of business. Violation of this subsection involving medical diagnosis and treatment services shall incur a civil penalty to the state in the amount of 50 percent of all premium payments made to said plan during the month in which the violation occurred. Violation of this subsection involving behavioral health diagnosis and treatment services shall incur a civil penalty to the state in the amount of 75 percent of all premium payments made to said plan during the month in which the violation occurred. For each successive violation occurring during a month, the amount of civil penalty shall be halved.

10. To expedite efficient enforcement of subsection 9 of this section, all denials of coverage of services issued by a Medicaid managed care organization defined in 42 U.S.C. 1396b(m) which provides or arranges health care services for MO HealthNet enrollees in Missouri shall be compiled and submitted to the department of commerce and insurance, with all necessary documentation and redaction of information to prohibit disclosure of the patient or any heath care provider delivering services to the patient, along with the status of any administrative and or judicial appeals of such denials. The department shall make such information available to the public in electronic format.

11. If a hospital and a Medicaid managed care organization defined in 42 U.S.C. 1396b(m) which provides or arranges health care services for MO HealthNet enrollees in Missouri do not have a contractual agreement to provide services to Medicaid enrollees covered by the managed care organization, the following standards shall govern payment for reimbursable services provided by the hospital to said enrollee:

(1) The hospital shall send any claim for payment to the Medicaid managed care plan c within one hundred eighty days of the delivery of the service.

(2) Within forty-five processing days, as defined in section 376.383, of receiving the hospital's claim, the Medicaid managed care plan shall offer to pay the hospital a reasonable reimbursement for out-of-network care. If the hospital participates in one or more commercial networks which are under common ownership and control of an entity with the Medicaid managed care plan, the offer of reimbursement shall be at least one hundred percent of the Medicaid fee-for-service payment rate for the diagnostic or treatment services rendered to the enrollee of the

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Medicaid managed care organization.

(3) If the hospital declines the Medicaid managed care organization's initial offer of reimbursement, the Medicaid managed care organization and hospital shall have sixty days from the date of the initial offer of reimbursement to negotiate in good faith to attempt to determine the reimbursement for services rendered.

(4) If the Medicaid managed care organization and hospital 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 subdivisions 8 and 9 of this subsection.

(5) To initiate arbitration proceedings, either the Medicaid managed care organization or the hospital must provide written notification to the director of the department of social services and the other party within one hundred twenty 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 claim for payment may be resolved between the parties at any point prior to the commencement of the arbitration proceedings. Claims may be combined for purposes of arbitration, but only to the extent the claims represent similar circumstances and services provided by the same hospital, and the parties attempted to resolve the dispute in accordance with subdivisions (3) to (5) of this subsection.

(6) No hospital who sends a claim to a Medicaid managed care organization under subdivision 2 of this subsection shall send a bill to the patient except as provided in subdivision 7 of this subsection.

(7) When out-of-network care is provided, the hospital that sends a claim to a Medicaid managed care organization subdivision 2 of this subsection may collect cost-sharing requirements as permitted by state and federal law and regulation.

(8) The director of social services shall ensure access to an external arbitration process when a hospital and Medicaid managed care organization cannot agree to a reimbursement under this subsection. In order to ensure access, when notified of a party's intent to arbitrate, the director shall randomly select an arbitrator for each case from the department of commerce and insurance's approved list of arbitrators or entities that provide binding arbitration established pursuant to section 376.690. The costs of arbitration shall be shared equally between and will be directly billed to the hospital and Medicaid managed care organization. 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.

(9) 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 of social services. The initial request for arbitration, all correspondence and documents received by the department and the final arbitration decision shall be considered a closed record. 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 section 536.010."; and

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

AMENDS 1579H04.09H