

FIRST REGULAR SESSION

SENATE BILL NO. 153

98TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR WALLINGFORD.

Pre-filed December 16, 2014, and ordered printed.

ADRIANE D. CROUSE, Secretary.

0893S.011

AN ACT

To repeal section 354.603, RSMo, and to enact in lieu thereof one new section relating to the accreditation of managed care plans.

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

Section A. Section 354.603, RSMo, is repealed and one new section
2 enacted in lieu thereof, to be known as section 354.603, to read as follows:

354.603. 1. A health carrier shall maintain a network that is sufficient
2 in number and types of providers to assure that all services to enrollees shall be
3 accessible without unreasonable delay. In the case of emergency services,
4 enrollees shall have access twenty-four hours per day, seven days per week. The
5 health carrier's medical director shall be responsible for the sufficiency and
6 supervision of the health carrier's network. Sufficiency shall be determined by
7 the director in accordance with the requirements of this section and by reference
8 to any reasonable criteria, including but not limited to provider-enrollee ratios by
9 specialty, primary care provider-enrollee ratios, geographic accessibility,
10 reasonable distance accessibility criteria for pharmacy and other services, waiting
11 times for appointments with participating providers, hours of operation, and the
12 volume of technological and specialty services available to serve the needs of
13 enrollees requiring technologically advanced or specialty care.

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

19 (2) The health carrier shall establish and maintain adequate

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

20 arrangements to ensure reasonable proximity of participating providers, including
21 local pharmacists, to the business or personal residence of enrollees. In
22 determining whether a health carrier has complied with this provision, the
23 director shall give due consideration to the relative availability of health care
24 providers in the service area under, especially rural areas, consideration.

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

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

35 2. A health carrier shall file with the director, in a manner and form
36 defined by rule of the department of insurance, financial institutions and
37 professional registration, an access plan meeting the requirements of sections
38 354.600 to 354.636 for each of the managed care plans that the health carrier
39 offers in this state. The health carrier may request the director to deem sections
40 of the access plan as proprietary or competitive information that shall not be
41 made public. For the purposes of this section, information is proprietary or
42 competitive if revealing the information will cause the health carrier's
43 competitors to obtain valuable business information. The health carrier shall
44 provide such plans, absent any information deemed by the director to be
45 proprietary, to any interested party upon request. The health carrier shall
46 prepare an access plan prior to offering a new managed care plan, and shall
47 update an existing access plan whenever it makes any change as defined by the
48 director to an existing managed care plan. The director shall approve or
49 disapprove the access plan, or any subsequent alterations to the access plan,
50 within sixty days of filing. The access plan shall describe or contain at a
51 minimum the following:

52 (1) The health carrier's network;

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

55 (3) The health carrier's process for monitoring and assuring on an ongoing

56 basis the sufficiency of the network to meet the health care needs of enrollees of
57 the managed care plan;

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

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

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

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

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

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

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

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

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

90 (3) The managed care plan's network has been accredited by the Joint
91 Commission on the Accreditation of Health Organizations for Network Adequacy,

92 and such accreditation is in effect at the time the access plan is filed. If the
93 accreditation applies to only a portion of the managed care plan's network, only
94 the accredited portion will be deemed adequate; [or]

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

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

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Bill

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