MISSISSIPPI LEGISLATURE REGULAR SESSION 1999

By: Senator(s) Bean

To: Public Health and Welfare

SENATE BILL NO. 2150

AN ACT TO AMEND SECTION 83-41-409, MISSISSIPPI CODE OF 1972, TO REQUIRE MANAGED HEALTH CARE PLANS TO MAINTAIN AND ADMINISTER A GRIEVANCE PROCEDURE FOR ENROLLEES AND PARTICIPATING PROVIDERS AND TO REPORT TO THE MISSISSIPPI DEPARTMENT OF INSURANCE THE NUMBER OF COMPLAINTS RECEIVED, TO REQUIRE MANAGED HEALTH CARE PLANS TO PROVIDE FOR A DUE PROCESS HEARING AND REVIEW PROCESS FOR A PROVIDER WHO IS INVOLUNTARILY DELETED FROM A PROVIDER NETWORK OR DENIED PARTICIPATION IN THE NETWORK, TO PROHIBIT MANAGED HEALTH CARE PLANS FROM OFFERING PROVIDERS A FINANCIAL INCENTIVE BASED SOLELY ON THE NUMBER OF SERVICES OR REFERRALS DENIED BY THE PROVIDER, TO REQUIRE MANAGED HEALTH CARE PLANS TO ANNUALLY REPORT THE PERCENTAGE OF REVENUES EXPENDED ON HEALTH CARE SERVICES AND ADMINISTRATION, TO REQUIRE ADVANCE DISCLOSURE OF PRE-AUTHORIZATION REQUIREMENTS BY MANAGED HEALTH CARE PLANS FOR MEDICAL SERVICES OR SUPPLIES, TO PROHIBIT THE EXCLUSION OF A PHYSICIAN FROM A MANAGED HEALTH CARE PLAN'S PROVIDER NETWORK BASED SOLELY ON THE PHYSICIAN'S ECONOMIC PROFILE, TO REQUIRE MANAGED HEALTH CARE PLANS TO COVER EMERGENCY ROOM VISITS BASED UPON THE "PRUDENT LAY PERSON" STANDARD, TO REQUIRE MANAGED HEALTH CARE PLANS CONTRACTING WITH THE DIVISION OF MEDICAID TO SPEND A MINIMUM PERCENTAGE OF REVENUE ON DIRECT PATIENT CARE, AND TO PROVIDE FOR A MANAGED HEALTH CARE PLAN "POINT-OF-SERVICE" OPTION; TO CODIFY SECTION 83-41-410, MISSISSIPPI CODE OF 1972, TO PROHIBIT ANY MANAGED CARE ENTITY FROM RESTRICTING OR RETALIATING AGAINST ANY PARTICIPATING MEDICAL PROVIDER FOR DISCLOSING TO ANY MEMBER IN THE MANAGED CARE PLAN APPROPRIATE MEDICAL INFORMATION REGARDING TREATMENT OR SERVICES UNDER THE PLAN; TO REPEAL SECTION 83-41-415, MISSISSIPPI CODE OF 1972, WHICH PROVIDES THAT THE PROVISIONS OF THE PATIENT PROTECTION ACT OF 1995 AND THE HEALTH MAINTENANCE ORGANIZATION-PREFERRED PROVIDER ORGANIZATION-PREPAID HEALTH BENEFIT PLAN PROTECTION ACT DO NOT APPLY TO THE MISSISSIPPI MEDICAID PROGRAM; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. Section 83-41-409, Mississippi Code of 1972, is amended as follows:

83-41-409. In order to be certified and recertified under this act, a managed care plan shall:

(a) Provide enrollees or other applicants with written information on the terms and conditions of coverage in easily understandable language including, but not limited to, information on the following:

(i) Coverage provisions, benefits, limitations, exclusions and restrictions on the use of any providers of care;

(ii) Summary of utilization review and quality assurance policies; and

(iii) Enrollee financial responsibility for copayments, deductibles and payments for out-of-plan services or supplies;

(b) Demonstrate that its provider network has providers of sufficient number throughout the service area to assure reasonable access to care with minimum inconvenience by plan enrollees;

(c) File a summary of the plan credentialing criteria and process and policies with the State Department of Insurance to be available upon request;

(d) Provide a participating provider with a copy of his/her individual profile if economic or practice profiles, or both, are used in the credentialing process upon request;

(e) When any provider application for participation is denied or contract is terminated, the reasons for denial or termination shall be reviewed by the managed care plan upon the request of the provider; * * *

(f) Establish procedures to ensure that all applicable state and federal laws designed to protect the confidentiality of medical records are followed;

(g) Maintain and administer a grievance procedure whereby an enrollee or participating provider may file a complaint regarding administration of the plan. Enrollees and providers shall have the right to protest decisions which may have an adverse impact on the enrollee or provider, and shall have the due process right to appeal an adverse decision in a manner acceptable to the State Department of Insurance. A managed care plan shall annually report to the Department of Insurance the number of complaints received from enrollees, the nature of each complaint

and the manner in which each complainant was resolved.

(h) Establish mechanisms to assure basic fairness in processing applications for initial provider participation and for making decisions that adversely affect participation status. These mechanisms shall include: (i) provisions for giving reasonably prompt consideration to each applicant for initial participation and for biennial renewal of participation; (ii) provisions for a physician to receive a written statement of reasons, and to have an opportunity to respond, either in writing or at a formal meeting, before a final decision is made to deny an application for initial participation or renewal, terminate or permanently restrict participation. If the action that is under consideration is of a type that must be reported to the national Practitioner Data Bank or to a state medical board under federal or state law, the physician's procedural rights, at a minimum, must meet the standards of fairness contemplated by the federal Health Care Quality Improvement Act of 1986, 42 U.S.C. Sections 11101-11152; (iii) provisions to ensure that prior to initiation of termination, denial or restriction of participation in the plan based on utilization of services or economic criteria, the physician shall receive a written statement of reasons, which must take into consideration and recognize the physician's practice that may account for higher or lower than expected costs. The physician shall have the opportunity to respond either in writing or at a meeting, and the opportunity to enter into and complete a corrective action plan, except in cases where there is imminent harm to patient health or an action by the State Board of Medical Licensure or other government agency that effectively impairs the physician's ability to practice medicine within the jurisdiction.

(2) Any managed care plan that operates a physician incentive plan must meet the following requirements: (a) no specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit

medically necessary services provided with respect to an individual patient; (b) if the plan places a physician or physician group at financial risk for services not provided by the physician or physician group, the plan provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Mississippi Department of Insurance, that take into account the number of physicians placed at such financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or physician group.

For purposes of this subsection, the term "physician incentive plan" means any compensation arrangement between the plan and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled in the plan.

(3) A managed care plan shall annually report to the Mississippi Department of Insurance the company's medical benefit/loss ratios and an explanation that they reflect the percentage of premiums expended for health services.

(4) Prospective enrollees in managed care plans shall be provided information as to the terms and conditions of the plan so that they can make informed decisions about accepting a certain system of health care delivery. Where the plan is described orally to enrollees, easily understood, truthful and objective terms must be used. All written plan descriptions must be in readable and understandable format, consistent with standards developed for supplemental insurance coverage under Title XVIII of the Social Security Act. This format must be standardized so that customers can compare the attributes of the plans. Specific items that must be included are any and all prior authorization or other review requirements including pre-authorization review, concurrent review, post-service review, post-payment review and any procedures that may lead the patient to be denied coverage for or

not be provided a particular service.

(5) When the economics and capacity of a physician's practice are used as a credentialing factor for a managed care plan, the applicable criteria must be documented, made available to the applying physician, physicians participating in the plan and enrollees. Any economic or capacity profiling of a physician must be adjusted to recognize case mix, severity of illness, age of patients and other features of a physician's practice that may account for higher than or lower than expected costs. Managed care plans shall not discriminate against enrollees with expensive, long-term or chronic medical conditions by excluding practitioners with practices containing a substantial number of such patients. Managed care plans shall not discriminate against members of high-risk, vulnerable or other similar patient populations by excluding practitioners with practices containing a substantial number of such patients.

(6) Managed care plans shall cover emergency room services based upon the prudent lay person standard and shall sufficiently educate enrollees regarding appropriate times to utilize emergency facilities. For purposes of this subsection, "emergency room services based upon the prudent lay person standard" means those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in: (a) placing the patient's health in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

(7) Any managed care plan contracting with the State of Mississippi to provide medical services to recipients of Medicaid benefits shall expend a minimum of ninety percent (90%) of state

revenues for patient care and services to include direct patient care, wellness programs and educational programs.

(8) Any managed care entity whose plan restricts a patient's choice of physicians or hospitals shall offer, at the time of enrollment and at least for a continuous one-month period annually thereafter, an optional "point-of-service" type feature so that patients who choose such plans may elect to self-refer to physicians outside the plan at additional cost to themselves.

SECTION 2. The following provision shall be codified as Section 83-41-410, Mississippi Code of 1972:

83-41-410. (1) No managed care plan, health maintenance organization, independent practice association, other entity contracting for the provision of health care services, or any other entity, shall prohibit or restrict any participating provider from disclosing to any subscriber, enrollee or member any medically appropriate health care information that such participating provider deems appropriate regarding (a) the nature of treatment, risks or alternatives thereto; (b) the availability of alternate therapies, consultation or tests; (c) the decision of any plan to authorize or deny services; or (d) the process the plan or any person contracting with the plan uses, or proposes to use, to authorize or deny health care services or benefits. Any such prohibition or restriction contained in a contract with a participating provider shall be void and unenforceable.

(2) A managed care entity shall be prohibited from denying an application, terminating employment or refusing to renew employment or other contractual relationship with a participating physician, surgeon or medical provider, principally for advocating medically appropriate health care that is consistent with the degree of learning and skill ordinarily possessed by reputable physicians, surgeons and medical providers practicing according to the applicable legal standard of care.

(3) This section shall not be construed to prohibit a

managed care plan from making a determination not to pay for a particular medical treatment or service, or to prohibit a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff, hospital governing body, or payor from enforcing reasonable peer review or utilization review protocols or determining whether a physician, surgeon or medical provider has complied with those protocols.

(4) For the purpose of this section, "to advocate medically appropriate health care" shall mean to appeal a payor's decision to deny payment for a service pursuant to the reasonable grievance or appeal procedure established by a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff and governing body, or payor as required by Section 41-83-1 et seq., Mississippi Code of 1972, or to protest a decision policy, or practice that the physician, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care, reasonably believes impairs the physician's ability to provide medically appropriate health care to his or her patients.

SECTION 3. Section 83-41-415, Mississippi Code of 1972, which provides that the provisions of the Patient Protection Act of 1995 and the Health Maintenance Organization-Preferred Provider Organization-Prepaid Health Benefit Plan Protection Act do not apply to the Mississippi Medicaid Program, is hereby repealed.

SECTION 4. This act shall take effect and be in force from and after July 1, 1999.