FIRST REGULAR SESSION

# SENATE BILL NO. 230

**98TH GENERAL ASSEMBLY**

INTRODUCED BY SENATOR ROMINE.

Read 1st time January 13, 2015, and ordered printed.

ADRIANE D. CROUSE, Secretary.

0497S.01I

## AN ACT

To repeal sections 208.151, 208.152, 208.670, 208.952, and 208.955, RSMo, and to enact in lieu thereof twelve new sections relating to the MO HealthNet program, with penalty provisions.

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

Section A. Sections 208.151, 208.152, 208.670, 208.952, and 208.955, RSMo, are repealed and twelve new sections enacted in lieu thereof, to be known as sections 208.151, 208.152, 208.186, 208.661, 208.670, 208.952, 208.997, 208.998, 208.999, 208.1500, 208.1503, and 208.1506, to read as follows:

208.151. 1. Medical assistance on behalf of needy persons shall be known as "MO HealthNet". For the purpose of paying MO HealthNet benefits and to comply with Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.) as amended, the following needy persons shall be eligible to receive MO HealthNet benefits to the extent and in the manner hereinafter provided:

(1) All participants receiving state supplemental payments for the aged, blind and disabled;

(2) All participants receiving aid to families with dependent children benefits, including all persons under nineteen years of age who would be classified as dependent children except for the requirements of subdivision (1) of subsection 1 of section 208.040. Participants eligible under this subdivision who are participating in drug court, as defined in section 478.001, shall have their eligibility automatically extended sixty days from the time their dependent child is removed from the custody of the participant, subject to approval of the Centers for Medicare and Medicaid Services;

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

(3) All participants receiving blind pension benefits;

(4) All persons who would be determined to be eligible for old age assistance benefits, permanent and total disability benefits, or aid to the blind benefits under the eligibility standards in effect December 31, 1973, or less restrictive standards as established by rule of the family support division, who are sixty-five years of age or over and are patients in state institutions for mental diseases or tuberculosis;

(5) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children except for the requirements of subdivision (2) of subsection 1 of section 208.040, and who are residing in an intermediate care facility, or receiving active treatment as inpatients in psychiatric facilities or programs, as defined in 42 U.S.C. 1396d, as amended;

(6) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children benefits except for the requirement of deprivation of parental support as provided for in subdivision (2) of subsection 1 of section 208.040;

(7) All persons eligible to receive nursing care benefits;

(8) All participants receiving family foster home or nonprofit private child-care institution care, subsidized adoption benefits and parental school care wherein state funds are used as partial or full payment for such care;

(9) All persons who were participants receiving old age assistance benefits, aid to the permanently and totally disabled, or aid to the blind benefits on December 31, 1973, and who continue to meet the eligibility requirements, except income, for these assistance categories, but who are no longer receiving such benefits because of the implementation of Title XVI of the federal Social Security Act, as amended;

(10) Pregnant women who meet the requirements for aid to families with dependent children, except for the existence of a dependent child in the home;

(11) Pregnant women who meet the requirements for aid to families with dependent children, except for the existence of a dependent child who is deprived of parental support as provided for in subdivision (2) of subsection 1 of section 208.040;

(12) Pregnant women or infants under one year of age, or both, whose family income does not exceed an income eligibility standard equal to one hundred eighty-five percent of the federal poverty level as established and amended by the federal Department of Health and Human Services, or its

successor agency;

(13) Children who have attained one year of age but have not attained six years of age who are eligible for medical assistance under 6401 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989). The family support division shall use an income eligibility standard equal to one hundred thirty-three percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency;

(14) Children who have attained six years of age but have not attained nineteen years of age. For children who have attained six years of age but have not attained nineteen years of age, the family support division shall use an income assessment methodology which provides for eligibility when family income is equal to or less than equal to one hundred percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency. As necessary to provide MO HealthNet coverage under this subdivision, the department of social services may revise the state MO HealthNet plan to extend coverage under 42 U.S.C. 1396a (a)(10)(A)(I)(III) to children who have attained six years of age but have not attained nineteen years of age as permitted by paragraph (2) of subsection (n) of 42 U.S.C. 1396d using a more liberal income assessment methodology as authorized by paragraph (2) of subsection (r) of 42 U.S.C. 1396a;

(15) The family support division shall not establish a resource eligibility standard in assessing eligibility for persons under subdivision (12), (13) or (14) of this subsection. The MO HealthNet division shall define the amount and scope of benefits which are available to individuals eligible under each of the subdivisions (12), (13), and (14) of this subsection, in accordance with the requirements of federal law and regulations promulgated thereunder;

(16) Notwithstanding any other provisions of law to the contrary, ambulatory prenatal care shall be made available to pregnant women during a period of presumptive eligibility pursuant to 42 U.S.C. Section 1396r-1, as amended;

(17) A child born to a woman eligible for and receiving MO HealthNet benefits under this section on the date of the child's birth shall be deemed to have applied for MO HealthNet benefits and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of time determined in accordance with applicable federal and state law and regulations so long as the child is a member of the

woman's household and either the woman remains eligible for such assistance or for children born on or after January 1, 1991, the woman would remain eligible for such assistance if she were still pregnant. Upon notification of such child's birth, the family support division shall assign a MO HealthNet eligibility identification number to the child so that claims may be submitted and paid under such child's identification number;

(18) Pregnant women and children eligible for MO HealthNet benefits pursuant to subdivision (12), (13) or (14) of this subsection shall not as a condition of eligibility for MO HealthNet benefits be required to apply for aid to families with dependent children. The family support division shall utilize an application for eligibility for such persons which eliminates information requirements other than those necessary to apply for MO HealthNet benefits. The division shall provide such application forms to applicants whose preliminary income information indicates that they are ineligible for aid to families with dependent children. Applicants for MO HealthNet benefits under subdivision (12), (13) or (14) of this subsection shall be informed of the aid to families with dependent children program and that they are entitled to apply for such benefits. Any forms utilized by the family support division for assessing eligibility under this chapter shall be as simple as practicable;

(19) Subject to appropriations necessary to recruit and train such staff, the family support division shall provide one or more full-time, permanent eligibility specialists to process applications for MO HealthNet benefits at the site of a health care provider, if the health care provider requests the placement of such eligibility specialists and reimburses the division for the expenses including but not limited to salaries, benefits, travel, training, telephone, supplies, and equipment of such eligibility specialists. The division may provide a health care provider with a part-time or temporary eligibility specialist at the site of a health care provider if the health care provider requests the placement of such an eligibility specialist and reimburses the division for the expenses, including but not limited to the salary, benefits, travel, training, telephone, supplies, and equipment, of such an eligibility specialist. The division may seek to employ such eligibility specialists who are otherwise qualified for such positions and who are current or former welfare participants. The division may consider training such current or former welfare participants as eligibility specialists for this program;

(20) Pregnant women who are eligible for, have applied for and have received MO HealthNet benefits under subdivision (2), (10), (11) or (12) of this

subsection shall continue to be considered eligible for all pregnancy-related and postpartum MO HealthNet benefits provided under section 208.152 until the end of the sixty-day period beginning on the last day of their pregnancy;

(21) Case management services for pregnant women and young children at risk shall be a covered service. To the greatest extent possible, and in compliance with federal law and regulations, the department of health and senior services shall provide case management services to pregnant women by contract or agreement with the department of social services through local health departments organized under the provisions of chapter 192 or chapter 205 or a city health department operated under a city charter or a combined city-county health department or other department of health and senior services designees. To the greatest extent possible the department of social services and the department of health and senior services shall mutually coordinate all services for pregnant women and children with the crippled children's program, the prevention of intellectual disability and developmental disability program and the prenatal care program administered by the department of health and senior services. The department of social services shall by regulation establish the methodology for reimbursement for case management services provided by the department of health and senior services. For purposes of this section, the term "case management" shall mean those activities of local public health personnel to identify prospective MO HealthNet-eligible high-risk mothers and enroll them in the state's MO HealthNet program, refer them to local physicians or local health departments who provide prenatal care under physician protocol and who participate in the MO HealthNet program for prenatal care and to ensure that said high-risk mothers receive support from all private and public programs for which they are eligible and shall not include involvement in any MO HealthNet prepaid, case-managed programs;

(22) By January 1, 1988, the department of social services and the department of health and senior services shall study all significant aspects of presumptive eligibility for pregnant women and submit a joint report on the subject, including projected costs and the time needed for implementation, to the general assembly. The department of social services, at the direction of the general assembly, may implement presumptive eligibility by regulation promulgated pursuant to chapter 207;

(23) All participants who would be eligible for aid to families with dependent children benefits except for the requirements of paragraph (d) of

subdivision (1) of section 208.150;

(24) (a) All persons who would be determined to be eligible for old age assistance benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f), or less restrictive methodologies as contained in the MO HealthNet state plan as of January 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized by annual appropriation;

(b) All persons who would be determined to be eligible for aid to the blind benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f), or less restrictive methodologies as contained in the MO HealthNet state plan as of January 1, 2005, except that less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to one hundred percent of the federal poverty level;

(c) All persons who would be determined to be eligible for permanent and total disability benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. 1396a(f); or less restrictive methodologies as contained in the MO HealthNet state plan as of January 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized by annual appropriations. Eligibility standards for permanent and total disability benefits shall not be limited by age;

(25) Persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage pursuant to 42 U.S.C. 1396a (a)(10)(A)(ii)(XVIII). Such persons shall be eligible during a period of presumptive eligibility in accordance with 42 U.S.C. 1396r-1;

(26) Effective August 28, 2013, persons who are in foster care under the responsibility of the state of Missouri on the date such persons attain the age of eighteen years, or at any time during the thirty-day period preceding their eighteenth birthday, without regard to income or assets, if such persons:

(a) Are under twenty-six years of age;

(b) Are not eligible for coverage under another mandatory coverage group; and

(c) Were covered by Medicaid while they were in foster care.

2. Rules and regulations to implement this section shall be promulgated in accordance with chapter 536. Any rule or portion of a rule, as that term is

defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2002, shall be invalid and void.

3. After December 31, 1973, and before April 1, 1990, any family eligible for assistance pursuant to 42 U.S.C. 601, et seq., as amended, in at least three of the last six months immediately preceding the month in which such family became ineligible for such assistance because of increased income from employment shall, while a member of such family is employed, remain eligible for MO HealthNet benefits for four calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of income and resource limitation. After April 1, 1990, any family receiving aid pursuant to 42 U.S.C. 601, et seq., as amended, in at least three of the six months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of employment or income from employment of the caretaker relative, shall remain eligible for MO HealthNet benefits for six calendar months following the month of such ineligibility as long as such family includes a child as provided in 42 U.S.C. 1396r-6. Each family which has received such medical assistance during the entire six-month period described in this section and which meets reporting requirements and income tests established by the division and continues to include a child as provided in 42 U.S.C. 1396r-6 shall receive MO HealthNet benefits without fee for an additional six months. The MO HealthNet division may provide by rule and as authorized by annual appropriation the scope of MO HealthNet coverage to be granted to such families.

4. When any individual has been determined to be eligible for MO HealthNet benefits, such medical assistance will be made available to him or her for care and services furnished in or after the third month before the month in which he made application for such assistance if such individual was, or upon application would have been, eligible for such assistance at the time such care and services were furnished; provided, further, that such medical expenses remain unpaid.

5. The department of social services may apply to the federal Department of Health and Human Services for a MO HealthNet waiver amendment to the Section 1115 demonstration waiver or for any additional MO HealthNet waivers necessary not to exceed one million dollars in additional costs to the state, unless subject to appropriation or directed by statute, but in no event shall such waiver applications or amendments seek to waive the services of a rural health clinic or a federally qualified health center as defined in 42 U.S.C. 1396d(l)(1) and (2) or the payment requirements for such clinics and centers as provided in 42 U.S.C. 1396a(a)(15) and 1396a(bb) unless such waiver application is approved by the oversight committee created in section 208.955. A request for such a waiver so submitted shall only become effective by executive order not sooner than ninety days after the final adjournment of the session of the general assembly to which it is submitted, unless it is disapproved within sixty days of its submission to a regular session by a senate or house resolution adopted by a majority vote of the respective elected members thereof, unless the request for such a waiver is made subject to appropriation or directed by statute.

6. Notwithstanding any other provision of law to the contrary, in any given fiscal year, any persons made eligible for MO HealthNet benefits under subdivisions (1) to (22) of subsection 1 of this section shall only be eligible if annual appropriations are made for such eligibility. This subsection shall not apply to classes of individuals listed in 42 U.S.C. Section 1396a(a)(10)(A)(I).

**7. The department shall notify any potential exchange-eligible participant who may be eligible for services due to spenddown that the participant may qualify for more cost-effective private insurance and premium tax credits under Section 36B of the Internal Revenue Code of 1986, as amended, available through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership basis and the benefits that would be potentially covered under such insurance.**

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy persons as defined in section 208.151 who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for

mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the MO HealthNet division shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the MO HealthNet division shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the MO HealthNet division not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for participants, except to persons with more than five hundred thousand dollars equity in their home or except for persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. Section 301, et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The MO HealthNet division when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

(5) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection for those days, which shall not exceed twelve per any period of six consecutive months, during which the participant is on a

temporary leave of absence from the hospital or nursing home, provided that no such participant shall be allowed a temporary leave of absence unless it is specifically provided for in his plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a participant is away from the hospital or nursing home overnight because he is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere;

(7) Drugs and medicines when prescribed by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse; except that no payment for drugs and medicines prescribed on and after January 1, 2006, by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse may be made on behalf of any person who qualifies for prescription drug coverage under the provisions of P.L. 108-173;

(8) Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments;

(9) Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of Section 6403 of P.L. 101-239 and federal regulations promulgated thereunder;

(10) Home health care services;

(11) Family planning as defined by federal rules and regulations; provided, however, that such family planning services shall not include abortions unless such abortions are certified in writing by a physician to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term;

(12) Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C. Section 1396d, et seq.);

(13) Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for

coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

(14) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his or her physician on an outpatient rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the participant's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one participant one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such services, when delivered in a residential care facility or assisted living facility licensed under chapter 198 shall be authorized on a tier level based on the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal physician. Such authorized units of personal care services or tier level shall be transferred with such resident if he or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as to whether the relevant waivers are

approved or a determination of noncompliance is made;

(15) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. Section 301, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(b) Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, mental health professional and alcohol and drug abuse professional shall be defined by the department of mental health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, MO HealthNet division, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental

health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the MO HealthNet division. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

(16) Such additional services as defined by the MO HealthNet division to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. Section 301, et seq.) subject to appropriation by the general assembly;

(17) The services of an advanced practice registered nurse with a collaborative practice agreement to the extent that such services are provided in accordance with chapters 334 and 335, and regulations promulgated thereunder;

(18) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection to reserve a bed for the participant in the nursing home during the time that the participant is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of MO HealthNet certified licensed beds, according to the most recent quarterly census provided to the department of health and senior services which was taken prior to when the participant is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a participant under this subdivision during any period of six consecutive months such participant shall, during the same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the participant or the participant's responsible party that the participant intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the

participant or the participant's responsible party prior to release of the reserved bed;

(19) Prescribed medically necessary durable medical equipment. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(20) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(21) Prescribed medically necessary dental services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(22) Prescribed medically necessary optometric services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(23) Blood clotting products-related services. For persons diagnosed with a bleeding disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section 338.400, such services include:

(a) Home delivery of blood clotting products and ancillary infusion equipment and supplies, including the emergency deliveries of the product when medically necessary;

(b) Medically necessary ancillary infusion equipment and supplies

required to administer the blood clotting products; and

(c) Assessments conducted in the participant's home by a pharmacist, nurse, or local home health care agency trained in bleeding disorders when deemed necessary by the participant's treating physician;

(24) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and for third-party payor average dental reimbursement rates. Such plan shall be subject to appropriation and the division shall include in its annual budget request to the governor the necessary funding needed to complete the four-year plan developed under this subdivision.

2. Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Dental services;

(2) Services of podiatrists as defined in section 330.010;

(3) Optometric services as defined in section 336.010;

(4) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs;

(5) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would

have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this subdivision shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions (14) and (15) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by participants under this section shall be in addition to and not in lieu of payments

made by the state for goods or services described herein except the participant portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a participant is unable to pay a required payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the Missouri MO HealthNet state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

4. The MO HealthNet division shall have the right to collect medication samples from participants in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for MO HealthNet benefits at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. Section 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for MO HealthNet benefits under section 208.151 to the special supplemental food programs for

women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. Section 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the MO HealthNet program shall not increase payments in excess of the increase that would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. Section 1396a (a)(13)(C).

10. The MO HealthNet division, may enroll qualified residential care facilities and assisted living facilities, as defined in chapter 198, as MO HealthNet personal care providers.

11. Any income earned by individuals eligible for certified extended employment at a sheltered workshop under chapter 178 shall not be considered as income for purposes of determining eligibility under this section.

**12. Licensed professional counselors and provisionally licensed professional counselors licensed under sections 337.500 to 337.540 may provide MO HealthNet behavioral health services to adults age twenty-one and older in a federally qualified health center setting.**

**208.186. 1. Any person participating in the MO HealthNet program who has pled guilty to or been found guilty of a crime, or in the case of a juvenile, admitted to allegations or had allegations found to be true, involving alcohol or a controlled substance or any crime in which alcohol or substance abuse was, in the opinion of the court, a contributing factor to the person's commission of the crime shall be required to obtain an assessment by a treatment provider approved by the department of mental health to determine the need for services. Recommendations of the treatment provider may be used by the court in sentencing or rendering a disposition.**

**2. Any person participating in the MO HealthNet program who is a parent of a child subject to proceedings in juvenile court under subsection 1 or 2 of section 211.031, whose misuse of controlled**

**substances or alcohol is found to be a significant, contributing factor to the reason the child was adjudicated, shall be required to obtain an assessment by a treatment provider approved by the department of mental health to determine the need for services. Recommendations of the treatment provider shall be included in the child's permanency plan. The court may order the parent or guardian to successfully complete treatment before the child is reunified with the parent or guardian.**

**3. The MO HealthNet division shall certify a MO HealthNet participant's enrollment in MO HealthNet if requested by the court under this section. A letter signed by the director of the MO HealthNet division or his or her designee or the family support division certifying that the individual is a participant in the MO HealthNet program shall be prima facie evidence of such participation and shall be admissible into evidence without further foundation for that purpose. The letter may specify additional information such as anticipated dates of coverage as may be deemed necessary by the department.**

**208.661. 1. The department of social services shall develop incentive programs, submit state plan amendments, and apply for necessary waivers to permit rural health clinics, federally-qualified health centers, or other primary care practices to co-locate on the property of public elementary and secondary schools with seventy-five percent or more students who are eligible for free or reduced price lunch.**

**2. Any co-location under this section shall require the consent of the school district in the form of a written agreement with the service provider, approved at a public meeting under chapter 610.**

**3. The school district may limit who is eligible to receive services under this section to any one or combination of the following: students, siblings of students, parents or guardians of students, and employees.**

**4. No school-based health care clinic established under this section shall perform or refer for abortion services or provide or refer for contraceptive drugs or devices, consistent with the provisions of section 167.611.**

**5. The consent of a parent or legal guardian shall be required before a minor may receive health care services under this section except as provided in section 431.056.**

**6. The provisions of this section shall be null and void unless and until any waivers necessary to the implementation of this section are granted by the federal government, including waiver of any requirement that federally-qualified health centers and rural health clinics provide or refer for abortion services or contraceptive drugs or devices.**

208.670. 1. As used in this section, these terms shall have the following meaning:

(1) "Provider", any provider of medical services and mental health services, including all other medical disciplines;

(2) "Telehealth", the use of medical information exchanged from one site to another via electronic communications to improve the health status of a patient.

2. The department of social services, in consultation with the departments of mental health and health and senior services, shall promulgate rules governing the practice of telehealth in the MO HealthNet program. Such rules shall address, but not be limited to, appropriate standards for the use of telehealth, certification of agencies offering telehealth, and payment for services by providers. Telehealth providers shall be required to obtain patient consent before telehealth services are initiated and to ensure confidentiality of medical information.

3. Telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law. Reimbursement for such services shall be made in the same way as reimbursement for in-person contacts**;**

**4. In addition to the subjects to be promulgated under subsection 2 of this section, the rules shall set requirements for the use of:**

**(1) Out-of-state health care providers enrolled as MO HealthNet providers to use MO HealthNet telehealth services in collaboration with a licensed Missouri health care provider in order to address provider shortage in a geographic area; and**

**(2) Specialists, including hospitalists, to monitor patients through telehealth services in small and rural or community hospitals**.

208.952. 1. There is hereby established **[**the**] a permanent** "Joint Committee on MO HealthNet". The committee shall have as its purpose the study**, monitoring, and review** of the **efficacy of the program as well as the** resources needed to continue and improve the MO HealthNet program over

time. **The committee shall receive and obtain information from the departments of social services, mental health, health and senior services and elementary and secondary education, as applicable, regarding the projected budget of the entire MO HealthNet program including projected MO HealthNet enrollment growth, categorized by population and geographic area.** The committee shall consist of ten members:

(1) The chair and the ranking minority member of the house committee on the budget;

(2) The chair and the ranking minority member of the senate committee on appropriations **[**committee**]**;

(3) The chair and the ranking minority member of the house committee on appropriations for health, mental health, and social services;

(4) The chair and the ranking minority member of the **standing** senate committee **[**on health and mental health**] assigned to consider MO HealthNet legislation and matters**;

(5) A representative chosen by the speaker of the house of representatives; and

(6) A senator chosen by the president pro tem of the senate. No more than three members from each house shall be of the same political party.

2. A chair of the committee shall be selected by the members of the committee.

3. The committee shall meet **[**as necessary**] at least twice a year. In the event of three consecutive absences on the part of any member, such member may be removed from the committee. The committee shall solicit from state organizations representing health care professionals as to any recommendations they have to improve the quality of health care and its cost**.

4. **[**Nothing in this section shall be construed as authorizing the committee to hire employees or enter into any employment contracts**] The committee is authorized to hire an employee or enter into employment contracts, including an executive director to conduct an audit, special review or investigation of the MO HealthNet program in order to assist the committee with its duties. Such executive director shall have free access to all divisions or offices within the departments of social services, health and senior services or mental health associated with**

**the MO HealthNet program for the inspection of such books, accounts, contracts, data and papers as concern any of the executive director's duties. Any person who willfully makes or causes to be made to the executive director any false, misleading, or unfounded report for the purpose of interfering with the performance of the executive director's duties under this section shall be guilty of a class A misdemeanor. The compensation of such personnel and the expenses of the committee shall be paid from the joint contingent fund or jointly from the senate and house contingent funds until an appropriation is made therefor**.

5. **[**The committee shall receive and study the five-year rolling MO HealthNet budget forecast issued annually by the legislative budget office.

6.**]** The committee shall **annually conduct a rolling five-year MO HealthNet forecast and** make recommendations in a report to the general assembly by January first each year, beginning in **[**2008**]** **2016**, on anticipated growth in the MO HealthNet program, needed improvements, anticipated needed appropriations, and suggested strategies on ways to structure the state budget in order to satisfy the future needs of the program.

**208.997. 1. By July 1, 2018, the MO HealthNet division shall develop and implement the "Health Care Homes Program" as a provider-directed care coordination program for MO HealthNet participants who shall be enrolled in a coordinated care organization under section 208.1503. The health care homes program shall provide payment to primary care clinics, community mental health centers, and other appropriate providers for care coordination for individuals who are deemed medically frail and other individuals as determined appropriate by the department. Clinics shall meet certain criteria, including but not limited to the following:**

**(1) The capacity to develop care plans;**

**(2) A dedicated care coordinator;**

**(3) An adequate number of clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement; and**

**(4) The capability to maintain and use a disease registry.**

**2. For purposes of this section, the following terms shall mean:**

**(1) "Community mental health center", an administrative agent or affiliated provider designated by the department of mental health that meets Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation and other health care home standards of care;**

**(2) "Primary care clinic", a medical clinic designated as the patient's first point of contact for medical care, available twenty-four hours a day, seven days a week, that provides or arranges the patient's comprehensive health care needs and provides overall integration, coordination, and continuity over time and referrals for specialty care. A primary care clinic shall include a community health care center.**

**3. The department may designate that the health care homes program be administered through an organization with a statewide primary care or community mental health center presence, experience with Medicaid population health management, and an established health care homes outcomes monitoring and improvement system.**

**4. This section shall be implemented in such a way that it does not conflict with federal requirements for health care home participation by MO HealthNet participants.**

**5. The department or appropriate divisions of the department may promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly under chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2015, shall be invalid and void.**

**6. Nothing in this section shall be construed to limit the department's ability to create health care homes for participants in a managed care plan.**

**208.998. 1. The department of social services shall seek a state plan amendment to extend the current MO HealthNet managed care program statewide no earlier than January 1, 2016, and no later than July 1, 2016, for all eligibility groups currently enrolled in a managed care plan as of January 1, 2015. Such eligibility groups shall receive covered services through health plans offered by managed care entities which are authorized by the department. Participants in a plan under this section shall choose a primary care provider. Health plans authorized by the department:**

**(1) Shall resemble commercially available health plans while complying with federal Medicaid requirements as authorized by federal law or through a federal waiver, and shall consist of managed care organizations paid on a capitated basis;**

**(2) Shall promote, to the greatest extent possible, the opportunity for children and their parents to be covered under the same plan;**

**(3) Shall offer plans statewide;**

**(4) Shall include cost sharing for outpatient services to the maximum extent allowed by federal law;**

**(5) May include other co-payments and provide incentives that encourage and reward the prudent use of the health benefit provided;**

**(6) Shall encourage access to care through provider rates that include pay-for-performance and are comparable to commercial or Medicare rates, whichever is higher. The department of social services shall determine pay-for-performance provisions that managed care organizations shall execute and shall provide incentives for managed care organizations that meet specified performance goals;**

**(7) Shall provide incentives, including shared risk and savings, to health plans and providers to encourage cost-effective delivery of care;**

**(8) Shall provide incentive programs for participants to encourage healthy behaviors and promote the adoption of healthier personal habits including limiting tobacco use or behaviors that lead to obesity;**

**(9) May provide multiple plan options and reward participants for choosing a low-cost plan;**

**(10) Shall include the services of community mental health centers; and**

**(11) Shall include the services of health providers as defined in 42 U.S.C. Section 1396d(l)(1) and (2) and meet the payment requirements for such health providers as provided in 42 U.S.C. Sections 1396a(a)(15) and 1396a(bb).**

**2. The department may designate that certain health care services be excluded from such health plans if it is determined cost effective by the department.**

**3. The department shall establish, in collaboration with plans**

**and providers, uniform utilization review protocols to be used by all authorized health plans.**

**4. The department shall establish a competitive bidding process for contracting with managed care plans.**

**(1) The department shall solicit bids only from bidders who offer, or through an associated company offer, an identical or substantially similar plan, in services provided and network, within a health care exchange in this state, whether federally facilitated, state based, or operated on a partnership basis. The bidder, if the bidder offers an identical or substantially similar plan, in services provided and network, or the bidder and the associated company, if the bidder has formed a partnership for purposes of its bid, shall include a process in its bid by which MO HealthNet recipients who choose its plan will be automatically enrolled in the corresponding plan offered within the health care exchange if the recipient's income increases resulting in the recipient's ineligibility for MO HealthNet benefits. The bidder also shall include in its bid a process by which an individual enrolled in an identical or substantially similar plan, in services provided and network, within a health care exchange in this state, whether federally facilitated, state based, or operated on a partnership basis whose income decreases resulting in eligibility for MO HealthNet benefits shall be enrolled in MO HealthNet after an application is received and the participant is determined eligible for MO HealthNet benefits.**

**(2) The department shall select a minimum of three conforming bids and may select up to a maximum number of bids equal to the quotient derived from dividing the total number of participants anticipated by the department in a region by one hundred thousand.**

**(3) The department shall accept the lowest conforming bids. For determining the accepted bids, the department shall consider the following factors:**

**(a) The cost to Missouri taxpayers;**

**(b) The extent of the network of health care providers offering services within the bidder's plan;**

**(c) Additional services offered to recipients under the bidder's plan;**

**(d) The bidder's history of providing managed care plans for similar populations in Missouri or other states;**

**(e) Any other criteria the department deems relevant to ensuring MO HealthNet benefits are provided to recipients in such manner as to save taxpayer money and improve health outcomes of recipients.**

**5. Any managed care organization that enters into a contract with the state to provide managed care plans shall be required to fulfill the terms of the contract and provide such plans for at least twelve months, or up to three years if the contract so provides. The department shall annually conduct an actuarial review of the reimbursement rate provided to the managed care organization to determine if the rate is in accordance with past and prospective losses, current and projected loss ratios, past and prospective expenses, health services utilization trend projections, three year rate increase history, and adequacy of contingency reserves. If the managed care organization breaches the contract, the state shall be entitled to bring an action against the managed care organization for any remedy allowed by law or equity and shall also recover any and all damages provided by law, including liquidated damages in an amount determined by the department during the bidding process. Nothing in this subsection shall be construed to preclude the department or the state of Missouri from terminating the contract as specified in the terms of the contract, including for breach of contract, lack of appropriated funds, or exercising any remedies for breach as may be provided in the contract.**

**6. (1) Participants enrolling in managed care plans under this section shall have the ability to choose their plan. In the enrollment process, participants shall be provided a list of all plans available ranked by the relative actuarial value of each plan. Each participant shall be informed in the enrollment process that he or she will be eligible to receive a portion of the amount saved by Missouri taxpayers if he or she chooses a lower cost plan offered in his or her region. The portion received by a participant shall be determined by the department according to the department's best judgment as to the portion which will bring the maximum savings to Missouri taxpayers.**

**(2) If a participant fails or refuses to choose a plan as set forth in subdivision (1) of this subsection, the department shall determine rules for auto-assignment, which shall include performance criteria based on low-cost bids and improved health outcomes as determined by**

**the department. Auto-enrolled participants shall be assigned to the highest performing managed care organization.**

**7. This section shall not be construed to require the department to terminate any existing managed care contract or to extend any managed care contract.**

**8. All MO HealthNet plans under this section shall provide coverage for the following services:**

**(1) Ambulatory patient services;**

**(2) Emergency services;**

**(3) Hospitalization;**

**(4) Maternity and newborn care;**

**(5) Mental health and substance abuse treatment, including behavioral health treatment;**

**(6) Prescription drugs;**

**(7) Habilitative services and devices;**

**(8) Laboratory services;**

**(9) Preventive and wellness care, and chronic disease management;**

**(10) Pediatric services, including oral and vision care;**

**(11) Case management services;**

**(12) Preventive services including mental health services for participants who may be at risk for needing mental health services; and**

**(13) Any other services required by federal law.**

**9. (1) Electronic billing shall be available for all health care providers in the MO HealthNet managed care program. Reimbursement of provider claims shall be paid in accordance with sections 376.383 to 376.384.**

**(2) No MO HealthNet plan or program shall provide coverage for an abortion unless a physician certifies in writing to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term.**

**10. The MO HealthNet managed care program shall provide a high deductible health plan which shall include:**

**(1) A minimum deductible of one thousand dollars;**

**(2) After meeting a one thousand dollar deductible, coverage for benefits as specified by rule of the department;**

**(3) An account, funded by the department, of at least one**

**thousand dollars per adult to pay medical costs for the initial deductible funded by the department;**

**(4) Preventive care, as defined by the department by rule, that is not subject to the deductible and does not require a payment of moneys from the account described in subdivision (2) of this subsection;**

**(5) A basic benefits package if annual medical costs exceed one thousand dollars;**

**(6) As soon as practicable, the establishment and maintenance of a record-keeping system for each health care visit or service received by recipients under this subsection. The plan shall require that the recipient's prepaid card number be entered, or electronic strip be swiped, by the health care provider for purposes of maintaining a record of every health care visit or service received by the recipient from such provider, regardless of any balance on the recipient's card. Such information shall include only the date, provider name, and general description of the visit or service provided. The plan shall maintain a complete history of all health care visits and services for which the recipient's prepaid card is entered or swiped in accordance with this subdivision. If required under the federal Health Insurance Portability and Accountability Act (HIPAA) or other relevant state or federal law or regulation, a recipient shall, as a condition of participation in the prepaid card incentive, be required to provide a written waiver for disclosure of any information required under this subdivision;**

**(7) The determination of a proportion of the amount left in a participant's account described in subdivision (2) of this subsection which shall be paid to the participant for saving taxpayer money. The amount and method of payment shall be determined by the department; and**

**(8) The determination of a proportion of a participant's account described in subdivision (2) of this subsection which shall be used to subsidize premiums to facilitate a participant's transition from health coverage under MO HealthNet to private health insurance based on cost-effective principles determined by the department.**

**11. The department shall require managed care plans under this section to offer an incentive program in which all MO HealthNet participants with chronic conditions, as specified by the department,**

**who are enrolled in managed care plans under this section to enroll in such incentive program. Participants who obtain specified primary care and preventive services, and who participate or refrain from participation in specified activities to improve the overall health of the participant shall be eligible to receive an annual cash payment if federal financial participation is obtained for such a payment, or, if not, a cash-equivalent payment for successful completion of the program. The department shall establish, by rule, the specific primary care and preventive services, activities to be included in the incentive program and the amount of any annual payments to participants.**

**12. A MO HealthNet managed care recipient under this section shall be eligible for participation in only one of either the high deductible health plan under subsection 10 of this section or the incentive program under subsection 11 of this section.**

**13. No cash payments, incentives, or credits paid to or on behalf of a MO HealthNet participant under a program established by the department under this section shall be deemed to be income to the participant in any means-tested benefit program unless otherwise specifically required by law or rule of the department.**

**14. Managed care entities shall inform participants who choose the high deductible health plan under subsection 10 of this section that the participant may lose his or her incentive payment under subdivision (7) of subsection 10 of this section if the participant utilizes visits to the emergency department for non-emergent purposes. Such information shall be included on every electronic and paper correspondence between the managed care plan and the participant.**

**15. The department shall seek all necessary waivers and state plan amendments from the federal Department of Health and Human Services necessary to implement the provisions of this section. The provisions of this section shall not be implemented unless such waivers and state plan amendments are approved. If this section is approved in part by the federal government, the department is authorized to proceed on those sections for which approval has been granted.**

**16. The department may promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as the term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is**

**subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly under chapter 536 to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2015, shall be invalid and void.**

**17. The MO HealthNet division shall develop transitional spending plans prior to January 1, 2016, if necessary, for the purpose of continuing and preserving payments consistent with current Medicaid levels for community mental health centers (CMHCs), which act as administrative entities of the department of mental health and serve as safety net providers. The MO HealthNet division shall create an implementation workgroup consisting of the MO HealthNet division, the department of mental health, CMHCs, and managed care organizations in the MO HealthNet program.**

**208.999. Subject to appropriations, the department shall develop incentive programs to encourage the construction and operation of urgent care clinics which operate outside normal business hours and are in or adjoining emergency room facilities which receive a high proportion of patients who are participating in MO HealthNet, to the extent that the incentives are eligible for federal matching funds.**

**208.1500. 1. As used in this section, the term "managed care organization" or "managed care plan" means a managed care organization or plan that provides benefits to groups or individuals under the MO HealthNet program. Managed care organizations shall be required to provide to the department of social services, on at least an annual basis, and the department of social services shall publicly report the information within thirty days of receipt, including posting on the department's website, at least the following information:**

**(1) Medical loss ratios for each managed care organization compared with the eighty-five percent medical loss ratio for large group commercial plans under Public Law 111-148 and, where applicable, with the state's administrative costs in its fee-for-service MO HealthNet program;**

**(2) Medical loss ratios of each of a managed care organization's capitated specialized subcontractors, such as mental health or dental**

**health, to make sure that the subcontractors' own administrative costs are not erroneously deemed to be expenditures on health care; and**

**(3) Total payments to the managed care organization in any form, including but not limited to tax incentives and capitated payments to participate in MO HealthNet, and total projected state payments for health care for the same population without the managed care organization.**

**2. Managed care organizations shall be required to maintain medical loss ratios of at least eighty-five percent for MO HealthNet operations. If a managed care organization's medical loss ratio falls below eighty-five percent in a given year, the managed care plan shall be required to refund to the state the portion of the capitation rates paid to the managed care plan in the amount equal to the difference between the plan's medical loss ratio and eighty-five percent of the capitated payment to the managed care organization.**

**3. To aid the discovery of how and if MO HealthNet recipients covered under managed care organization health plans are improving in health outcomes and to provide data to the state to target health disparities, the state of Missouri shall:**

**(1) Provide a biannual analysis of each of the state managed care organizations to ensure such organizations are meeting required metrics, goals, and quality measurements as defined in the managed care contract such as costs of managed care services as compared to fee-for-service providers, and to provide the state with needed data for future contract negotiations and incentive management;**

**(2) Meet all state health privacy laws and federal Health Insurance Portability and Accountability Act (HIPAA) requirements; and**

**(3) Meet federal data security requirements.**

**4. The department of social services shall be required to contract with an independent organization that does not contract or consult with managed care plans or insurers to conduct secret shopper surveys of Medicaid managed care plans for compliance with provider network adequacy standards on a regular basis, to be funded by the managed care organizations out of their administrative budgets. Secret shopper surveys are a quality assurance mechanism under which individuals posing as managed care enrollees will test the availability of timely**

**appointments with providers listed as participating in the network of a given plan for new patients. The testing shall be conducted with various categories of providers, with the specific categories rotated for each survey and with no advance notice provided to the managed health plan. If an attempt to obtain a timely appointment is unsuccessful, the survey records the particular reason for the failure, such as the provider not participating in Medicaid at all, not participating in Medicaid under the plan which listed them and was being tested, or participating under that plan but only for existing patients.**

**5. Inadequacy of provider networks, as determined from the secret shopper surveys or the publication of false or misleading information about the composition of health plan provider networks, may be the basis for contract cancellation or sanctions against the offending managed care organization.**

**208.1503. 1. Beginning July 1, 2019, participants in the MO HealthNet fee-for-service program as of January 1, 2015, shall begin enrollment in regionally-based coordinated care organizations except for those participants transitioning to the MO HealthNet managed care program pursuant to section 208.998, those residing in skilled nursing facilities, and those with developmental disabilities receiving state plan services or home- and community-based services through a waiver administered by the department of mental health.**

**2. For purposes of this section, a "coordinated care organization" or "CCO" shall mean an organization of health care providers, including a health care home, that agrees to be accountable for the quality, cost, coordination, and overall care of a defined group of MO HealthNet participants. The regional CCOs shall be built from the current fee-for-service payment system and shall use a shared savings model where over time there is also shared risk, team approaches to care, participant choice of provider, and investment in technology while using analytics based on best clinical practices.**

**3. The department shall engage a wide range of community stakeholders to design a CCO model that functions to meet a variety of regions and patient populations. The regional or statewide CCOs shall be reimbursed through a global payment methodology developed by the department.**

**(1) The global payment methodology may utilize a population-based payment mechanism calculated on a per-member, per-month calculation, and may include risk adjustments, risk sharing, and aligned payment incentives to achieve performance improvement;**

**(2) The department may develop performance incentive payments designed to reward increased quality and decreased cost of care. CCOs under this section may be eligible to receive performance incentive payments as determined by the department beginning in their second full year of operation.**

**4. The department may designate that certain health care services be excluded from the global payment methodology if it is determined cost effective by the department. Health care services provided under paragraph (c) of subdivision (15) of subsection 1 of section 208.152 shall be excluded from the global payment methodology.**

**5. Participants under a CCO shall be placed in a health care home under section 208.997 or in the disease management 3700 project (DM 3700) or any successor collaborative project between the department of mental health and MO HealthNet that targets high cost MO HealthNet participants who have co-occurring chronic medical conditions and serious mental illness.**

**6. Notwithstanding MO HealthNet coverage of children under section 208.998, the department shall advance the development of systems of care for medically complex children who are recipients of MO HealthNet benefits by accepting cost-effective regional proposals from and contracting with appropriate pediatric care networks, pediatric centers for excellence, and medical homes for children to provide MO HealthNet benefits when the department determines it is cost effective to do so. Such entities shall be treated as coordinated care organizations under this section.**

**7. The department shall promulgate rules to implement this section, including rules that:**

**(1) Encourage access to care through provider rates that include pay-for-performance and are comparable to commercial rates;**

**(2) Develop statewide uniform data and analytics integration;**

**(3) Consider developing regional community care organizations as a CCO model for the introduction of the elderly, blind, and disabled population into coordinated care;**

**(4) Require the contracts to adopt mandatory medical loss ratios;**

**(5) Sponsor a variety of community collaboration initiatives to promote cost-saving and health improvement activities at the local level;**

**(6) Ensure that there is an adequate provider network through the CCO agreements;**

**(7) The MO HealthNet division shall develop transitional spending plans prior to January 1, 2016, if necessary, for the purpose of continuing and preserving payments consistent with current Medicaid levels for community mental health centers (CMHCs), which act as administrative entities of the department of mental health and serve as safety net providers. The MO HealthNet division shall create an implementation workgroup consisting of the MO HealthNet Division, the department of mental health, CMHCs, and managed care organizations in the MO HealthNet program.**

**8. By July 1, 2016, the departments of social services, health and senior services and mental health and the division of budget and planning within the office of administration shall jointly conduct a study on the feasibility, practical implications, and risks of integrating all of the aged, blind, and disabled population, including Medicare and Medicaid dual eligibles, skilled nursing facility, health home, home-and community-based waiver, and department of mental health waiver populations into the coordinated care organization model established under this section. The study shall investigate six areas of feasibility:**

**(1) Technical and system, including the technological and human resource capabilities needed for a CCO model;**

**(2) Legal, including what waivers, if any, would be necessary from the federal government;**

**(3) Operational, such as how a CCO model for the populations at issue and with current department policies would work in practice;**

**(4) Economic, identifying what the short, medium, and long terms costs would be and the amount of any potential cost savings to the state general revenue fund;**

**(5) Social and community, including whether the CCO model would foster independence and living in the least restrictive environment and the impact such changes would have on the participants;**

**(6) Schedule, taking into consideration the factors from subdivisions (1) through (5) of this subsection, how long it would take to shift all of the populations at issue into the model.**

**The study shall not be limited to the six areas of feasibility. The departments shall solicit the input of participants, clients, patients, vendors, providers, and other stakeholders affected by the transition to the new model. At the study's conclusion, the departments shall jointly present the findings in public before the joint committee on MO HealthNet created under section 208.952. Stakeholders shall have the opportunity to comment on the study's conclusions. The study shall be released to the public at least sixty days before any public hearings on the study are convened.**

**208.1506. 1. Notwithstanding any other provision of law to the contrary, beginning July 1, 2016, any MO HealthNet recipient who elects to receive medical coverage through a private health insurance plan instead of through the MO HealthNet program shall be eligible for a private insurance premium subsidy to assist the recipient in paying the costs of such private insurance if it is determined to be cost effective by the department. The subsidy shall be provided on a sliding scale based on income, with a graduated reduction in subsidy over a period of time not to exceed two years.**

**2. Nothing in this section shall be construed as being part of a MO HealthNet program, plan, or benefit, and this section shall specifically not apply to or impact premium subsidies or other cost supports enrolling MO HealthNet participants in employer-provided health plans, other private health plans, or plans purchased through a health care exchange.**

**3. The department may promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly under chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking**

**authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.**

**[**208.955. 1. There is hereby established in the department of social services the "MO HealthNet Oversight Committee", which shall be appointed by January 1, 2008, and shall consist of nineteen members as follows:

(1) Two members of the house of representatives, one from each party, appointed by the speaker of the house of representatives and the minority floor leader of the house of representatives;

(2) Two members of the Senate, one from each party, appointed by the president pro tem of the senate and the minority floor leader of the senate;

(3) One consumer representative who has no financial interest in the health care industry and who has not been an employee of the state within the last five years;

(4) Two primary care physicians, licensed under chapter 334, who care for participants, not from the same geographic area, chosen in the same manner as described in section 334.120;

(5) Two physicians, licensed under chapter 334, who care for participants but who are not primary care physicians and are not from the same geographic area, chosen in the same manner as described in section 334.120;

(6) One representative of the state hospital association;

(7) Two nonphysician health care professionals, the first nonphysician health care professional licensed under chapter 335 and the second nonphysician health care professional licensed under chapter 337, who care for participants;

(8) One dentist, who cares for participants, chosen in the same manner as described in section 332.021;

(9) Two patient advocates who have no financial interest in the health care industry and who have not been employees of the state within the last five years;

(10) One public member who has no financial interest in the health care industry and who has not been an employee of the state within the last five years; and

(11) The directors of the department of social services, the department of mental health, the department of health and senior services, or the respective directors' designees, who shall serve as ex officio members of the committee.

2. The members of the oversight committee, other than the members from the general assembly and ex officio members, shall be appointed by the governor with the advice and consent of the senate. A chair of the oversight committee shall be selected by the members of the oversight committee. Of the members first appointed to the oversight committee by the governor, eight members shall serve a term of two years, seven members shall serve a term of one year, and thereafter, members shall serve a term of two years. Members shall continue to serve until their successor is duly appointed and qualified. Any vacancy on the oversight committee shall be filled in the same manner as the original appointment. Members shall serve on the oversight committee without compensation but may be reimbursed for their actual and necessary expenses from moneys appropriated to the department of social services for that purpose. The department of social services shall provide technical, actuarial, and administrative support services as required by the oversight committee. The oversight committee shall:

(1) Meet on at least four occasions annually, including at least four before the end of December of the first year the committee is established. Meetings can be held by telephone or video conference at the discretion of the committee;

(2) Review the participant and provider satisfaction reports and the reports of health outcomes, social and behavioral outcomes, use of evidence-based medicine and best practices as required of the health improvement plans and the department of social services under section 208.950;

(3) Review the results from other states of the relative success or failure of various models of health delivery attempted;

(4) Review the results of studies comparing health plans conducted under section 208.950;

(5) Review the data from health risk assessments collected and reported under section 208.950;

(6) Review the results of the public process input collected under section 208.950;

(7) Advise and approve proposed design and implementation proposals for new health improvement plans submitted by the department, as well as make recommendations and suggest modifications when necessary;

(8) Determine how best to analyze and present the data reviewed under section 208.950 so that the health outcomes, participant and provider satisfaction, results from other states, health plan comparisons, financial impact of the various health improvement plans and models of care, study of provider access, and results of public input can be used by consumers, health care providers, and public officials;

(9) Present significant findings of the analysis required in subdivision (8) of this subsection in a report to the general assembly and governor, at least annually, beginning January 1, 2009;

(10) Review the budget forecast issued by the legislative budget office, and the report required under subsection (22) of subsection 1 of section 208.151, and after study:

(a) Consider ways to maximize the federal drawdown of funds;

(b) Study the demographics of the state and of the MO HealthNet population, and how those demographics are changing;

(c) Consider what steps are needed to prepare for the increasing numbers of participants as a result of the baby boom following World War II;

(11) Conduct a study to determine whether an office of inspector general shall be established. Such office would be responsible for oversight, auditing, investigation, and performance review to provide increased accountability, integrity, and oversight of state medical assistance programs, to assist in improving agency and program operations, and to deter and identify fraud, abuse, and illegal acts. The committee shall review the experience of all

states that have created a similar office to determine the impact of creating a similar office in this state; and

(12) Perform other tasks as necessary, including but not limited to making recommendations to the division concerning the promulgation of rules and emergency rules so that quality of care, provider availability, and participant satisfaction can be assured.

3. The oversight committee shall designate a subcommittee devoted to advising the department on the development of a comprehensive entry point system for long-term care that shall:

(1) Offer Missourians an array of choices including community-based, in-home, residential and institutional services;

(2) Provide information and assistance about the array of long-term care services to Missourians;

(3) Create a delivery system that is easy to understand and access through multiple points, which shall include but shall not be limited to providers of services;

(4) Create a delivery system that is efficient, reduces duplication, and streamlines access to multiple funding sources and programs;

(5) Strengthen the long-term care quality assurance and quality improvement system;

(6) Establish a long-term care system that seeks to achieve timely access to and payment for care, foster quality and excellence in service delivery, and promote innovative and cost-effective strategies; and

(7) Study one-stop shopping for seniors as established in section 208.612.

4. The subcommittee shall include the following members:

(1) The lieutenant governor or his or her designee, who shall serve as the subcommittee chair;

(2) One member from a Missouri area agency on aging, designated by the governor;

(3) One member representing the in-home care profession, designated by the governor;

(4) One member representing residential care facilities, predominantly serving MO HealthNet participants, designated by the governor;

(5) One member representing assisted living facilities or continuing care retirement communities, predominantly serving MO HealthNet participants, designated by the governor;

(6) One member representing skilled nursing facilities, predominantly serving MO HealthNet participants, designated by the governor;

(7) One member from the office of the state ombudsman for long-term care facility residents, designated by the governor;

(8) One member representing Missouri centers for independent living, designated by the governor;

(9) One consumer representative with expertise in services for seniors or persons with a disability, designated by the governor;

(10) One member with expertise in Alzheimer's disease or related dementia;

(11) One member from a county developmental disability board, designated by the governor;

(12) One member representing the hospice care profession, designated by the governor;

(13) One member representing the home health care profession, designated by the governor;

(14) One member representing the adult day care profession, designated by the governor;

(15) One member gerontologist, designated by the governor;

(16) Two members representing the aged, blind, and disabled population, not of the same geographic area or demographic group designated by the governor;

(17) The directors of the departments of social services, mental health, and health and senior services, or their designees; and

(18) One member of the house of representatives and one member of the senate serving on the oversight committee, designated by the oversight committee chair.

Members shall serve on the subcommittee without compensation but may be reimbursed for their actual and necessary expenses from moneys appropriated to the department of health and senior services for that purpose. The department of health and senior services shall provide technical and administrative support services as required by the committee.

5. The provisions of section 23.253 shall not apply to sections 208.950 to 208.955.**]**