HCS SS SB 1007 -- PUBLIC ASSISTANCE PROGRAMS

SPONSOR: Dempsey (Cooper)

COMMITTEE ACTION: Voted "do pass" by the Committee on Health Care Policy by a vote of 8 to 4.

This substitute changes the laws regarding public assistance programs administered by the state.

DRUG TESTING OF ELECTED OFFICIALS AND PUBLIC ASSISTANCE RECIPIENTS (Sections 105.012 and 208.027, RSMo, and Section 1)

A state elected official is required to submit to chemical testing of his or her blood or urine for determining the drug content of the blood before taking office and once every two years thereafter. The person tested will be responsible for the cost of the test and, upon request, will have access to the results. To be considered valid, the test must be administered according to methods and devices approved by the Department of Health and Senior Services and performed by licensed medical personnel or by a person possessing a valid permit issued by the department for this purpose. Refusal to take a drug test will be considered an admission of guilt, and the elected official will be subject to any sanction authorized by law or rule covering the respective official. An official who tests positive for drugs that have not been lawfully prescribed or has shown to have abused the use of drugs based on the testing must participate in a drug treatment program or be subject to any sanction as authorized by law. Anyone administering the test or any other person, firm, or corporation with whom the person is associated will not be civilly liable for damages to the person tested except for negligence or by a willful or wanton act or omission.

By July 1, 2011, the Department of Social Services must develop a program to screen a work-eligible applicant or work-eligible recipient of Temporary Assistance for Needy Families (TANF) Program benefits and test those whom the department has reasonable suspicion to believe, based on the screening, engage in the illegal use of a controlled substance. Any applicant or recipient who refuses to participate in the testing process will be ineligible to receive TANF benefits for one year. If an applicant or recipient tests positive for the illegal use of a controlled substance, the department can, after a departmental administrative hearing, declare the individual ineligible for TANF benefits for one year following the hearing decision. Any member of a household which includes a person who has been declared ineligible for TANF benefits, if otherwise eligible, will continue to receive protective or vendor payments through a third-party payee. By September 30, 2010, the department must

develop, distribute to its staff, implement, and begin enforcement of a policy requiring the immediate termination of an employee who fails to report any suspected illegal use of a controlled substance or the suspected fraudulent reporting of total household size or income under the TANF Program by any applicant or recipient of TANF benefits. The department must submit an annual report to the General Assembly beginning July 1, 2011, that tracks the total number of reported cases of suspected illegal drug use and of suspected fraudulent reporting by participants in the TANF Program.

FREE CLINICS (Section 105.711)

A specialist, a licensed health care professional under the direction of a licensed physician or dentist, a 501(c)(3) tax-exempt charitable health care referral network, and the professional corporation of a physician organized under Chapter 356 are added to the list of health care providers for whom the State Legal Expense Fund is available for the payment of certain claims filed against a provider.

HEALTH INSURANCE PREMIUM TAX (Sections 148.340, 148.350, 148.370, and 148.380)

Every health maintenance organization (HMO) under contract with the state to provide medical assistance services or organized under the laws of this state is required to pay a quarterly tax on the direct insurance premiums received. The provision will only apply as long as the revenue generated by the tax is eligible for federal financial participation and payments. The Managed Care Fund is created for the deposit of the health insurance premium taxes collected from HMOs.

CARE OF TUBERCULOSIS PATIENTS (Sections 172.850, 199.010, 199.200, 199.210, 199.230, 199.240, 199.250, and 199.260)

The Missouri Rehabilitation Center directed by the University of Missouri, under order and appropriation of the General Assembly, must provide care for head injury patients but is no longer required to provide treatment for persons with tuberculosis. The Department of Health and Senior Services must provide treatment to tuberculosis patients at the center. An individual granted an ex parte petition for emergency temporary commitment and an individual considered to be a public health danger will be committed to a facility chosen by Department of Health and Senior Services instead of the University of Missouri. The department may contract with the center to provide treatment to tuberculosis patients, except that the contract will be exempt from the competitive bidding requirements of Chapter 34. The state payment will be available only after benefits from all

third-party payees have been exhausted.

HOME AND COMMUNITY-BASED SERVICES (Section 198.016)

Prior to admission of a MO HealthNet individual into a long-term care facility, a prospective resident or his or her next-of-kin, legally authorized representative, or designee must be informed of the home and community-based services available to him or her. A decline of these services by the prospective resident must be on record.

MO HEALTHNET PROGRAM (Sections 208.010, 208.152, 208.215, 208.895, and 660.300)

The MO HealthNet Program will be exempt from paying Medicare Part B deductible and co-insurance amounts for outpatient hospital services but is required to provide two visits for newly diagnosed diabetics for diabetic education and initial diabetic management training services.

When a MO HealthNet recipient also has a third-party insurer, the third-party administrator, administrative service organization, and pharmacy benefits manager must process and pay all properly submitted medical assistance subrogation claims for up to three years from the date of the services, unless MO HealthNet does not evoke its right to the claim within six years after the claim is submitted. The computerized records of the MO HealthNet Division, certified by the division director or his or her designee, will be prima facie evidence of proof of moneys expended and the amount due the state.

The Department of Health and Senior Services may contract with an independent third party for initial home and community-based assessments. The contract must include:

(1) A requirement that the assessment be conducted by the third-party assessor face-to-face with the patient and an assessment by telephone is not permitted. The contractor must notify the referring entity within five days of receipt of referral if additional information is needed. The contract must also include the same requirements for the assessments as of January 1, 2010, related to timeliness of assessments and the beginning of service. Reassessment visits conducted by a nurse must be reviewed and approved by the independent third-party assessor; and

(2) An assessment of needed care and a plan of care by the contractor within 15 days of receipt of a referral for service.

Currently, all in-home services clients must be advised of their

rights by the Department of Health and Senior Services, including the right to call the department to report dissatisfaction with the provider or services. The substitute specifies that the department's designee can give the notification and that the department may contract for services relating to receiving complaints.

HEALTH CARE PROVIDER TAX (Section 208.453)

The substitute removes public hospitals which are operated primarily for the care and treatment of mental disorders from exemption of a federal reimbursement allowance.

TELEPHONE TRACKING SYSTEM (Sections 208.905, 208.918, and 660.023)

By July 1, 2015, all personal care service vendors must have, maintain, and use a telephone tracking system to report and verify the delivery of consumer-directed care services as authorized by the Department of Health and Senior Services to ensure accurate billing. The department, in collaboration with other appropriate agencies including centers for independent living, must establish a telephone tracking system pilot project in an urban and a rural area. The department must submit a report by December 31, 2013, to the Governor and General Assembly detailing the outcomes of these pilot projects.

In order to be a department-contracted vendor, the vendor must be able to provide fiscal conduit services through a telephone tracking system by July 1, 2015.

By July 1, 2012, all in-home service provider agencies must have, maintain, and use a telephone tracking system to report and verify the delivery of home and community-based services as authorized by the department.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM FUNDING (Section 2)

By January 1, 2011, the Department of Health and Senior Services is required to develop policies and procedures to make it possible for the state to qualify for unrestricted federal bonus funds appropriated in the federal Children's Health Insurance Program Reauthorization Act.

The provisions of the substitute regarding the health insurance premium tax expire June 30, 2012.

The substitute contains an emergency clause for the provisions regarding the health insurance premium tax.

FISCAL NOTE: Estimated Income on General Revenue Fund of $3,287,308 to $6,088,820 in FY 2011, $2,810,402 to $5,480,971 in FY 2012, and $2,943,482 to $19,265,925 in FY 2013. Estimated Income on Other State Funds of Unknown but Less than $24,541,737 in FY 2011, Unknown but Less than $25,541,737 in FY 2012, and Unknown but Greater than $367,100 in FY 2013.

PROPONENTS: Supporters say that the bill will make the state compliant with the federal Deficit Reduction Act and attempts to reduce costs to current programs. These programs are at risk of being eliminated because of rising costs. The bill will properly transfer responsibility for paying claims to a third-party payor instead of the MO HealthNet Program. The telephone tracking system provisions will save the state a substantial amount; however, it will be expensive for smaller providers so the implementation date is set for 2015. The provisions regarding third-party assessments will help to ensure that everyone who needs services will receive them and that there is no overutilization of in-home services.

Testifying for the bill were Representative Cooper for Senator Dempsey; MO HealthNet Division; and Department of Health and Senior Services.

OPPONENTS: Those who oppose the bill say that it is not a satisfactory solution regarding third-party assessments for the in-home provider industry. It would be better to do an audit of each region to see where there is overutilization, instead of revamping the assessment process. The current system is working effectively and is only three years old. The nurse involvement in this program has improved the health of many and provides critical protections for patients who are in declining health. Allowing a third-party assessor will encourage profits for companies who have an incentive to reduce services in a difficult budget year in order to keep a contract. The telephone tracking system pilot project is necessary so that there is an opportunity to see if the system will work with the in-home program because it is unsure if the program can actually save the state money.

Testifying against the bill were Missouri Council for In-Home Services; Missouri Alliance for Home Care; Wayne Lee; Paraquad, Incorporated; Shawn D'Abrea, Center for Independent Living; Jennifer Gandy, On My Own, Incorporated; and Maxine Johnson, Black Alliance Education.