House _____ **Amendment NO.____**

Offered By

_____ _____

AMEND House Committee Substitute for House Bill No. 1662, Page 3, Section 191.875, Line 80, by inserting after all of said section and line the following:

"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;

(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

Action Taken_____ Date _____

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 of social services 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 potentially covered under such insurance."; and

Further amend said bill and page, Section 208.166, Lines 1 through 108, by deleting all of said section from the bill; and

Further amend said bill, Page 6, Section 208.166, Line 108, by inserting after all of said section and line the following:

"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 a juvenile case 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 of a disposition.

2. Any person participating in the MO HealthNet program who is a parent or guardian 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 juvenile court record. 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, 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 of social services.

208.189. 1. As used in this section, the following terms shall mean:

(1) "Health information exchange" or "HIE", the electronic movement of health-related information among organizations in accordance with nationally recognized standards, with the goal of facilitating access to and retrieval of clinical data to provide safe, timely, efficient, effective, equitable, patient-centered care;

(2) "HIPAA", the federal Health Insurance Portability and Accountability Act.

2. The MO HealthNet division shall contract for a system that shall:

(1) Support an interoperable data analytics platform for analyzing clinical data for defined populations, such as mothers at risk of premature birth, frequent utilizers of emergency departments, and those suffering from chronic pain conditions. The system shall be able to leverage cloud-based technology and be hosted remotely by the vendor of the application services system with interoperability capabilities to connect with disparate systems;

(2) Have the ability to interoperate using accepted industry standards, collect and aggregate data from disparate systems, and include, but not be limited to, clinical data, electronic medical records, claims and eligibility databases, state-managed registries, and health information exchanges;

(3) Provide a member portal to beneficiaries to view and manage their personal health information, wellness plans, and overall health, and a HIPAA-compliant provider portal that allows providers access to patient information;

(4) Allow for real-time patient queries and present clinical information to providers for the purpose of avoiding duplicate tests and improving care coordination;

(5) Have the ability to create condition-specific registries for managing populations and provide predictive modeling or alerting functionality which alerts providers of at-risk patients and is able to communicate between various systems to provide electronic medical record (EMR) workflow integration or similar tools to communicate with a health care provider's workflow; and

(6) Operate on a statewide, regional, or community-wide basis.

3. All MO HealthNet providers providing services to MO HealthNet recipients shall be required to participate in the system described in this section for their MO HealthNet recipient patients.

208.662. 1. There is hereby established within the department of social services the "Show-Me Healthy Babies Program" as a separate children's health insurance program (CHIP) for any low-income unborn child. The program shall be established under the authority of Title XXI of the federal Social Security Act, the State Children's Health Insurance Program, as amended, and 42 CFR 457.1.

2. For an unborn child to be enrolled in the show-me healthy babies program, his or her mother shall not be eligible for coverage under Title XIX of the federal Social Security Act, the Medicaid program as it is administered by the state, and shall not have access to affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. In addition, the unborn child shall be in a family with income eligibility of no more than three hundred percent of the federal poverty level, or the equivalent modified adjusted gross income, unless the income eligibility is set lower by the general assembly through appropriations. In calculating family size as it relates to income eligibility, the family shall include, in addition to other family members, all unborn children.

3. Coverage for an unborn child enrolled in the show-me healthy babies program shall include all prenatal care and pregnancy-related services that benefit the health of the unborn child and that promote healthy labor, delivery, and birth. Coverage need not include services that are solely for the benefit of the pregnant mother, that are unrelated to maintaining or promoting a healthy pregnancy, or that provide no benefit to the unborn child. However, the department may include pregnancy-related assistance as defined in 42 U.S.C. Section 1397ll.

4. There shall be no waiting period before an unborn child may be enrolled in the show-me healthy babies program. In accordance with the definition of child in 42 CFR 457.10, coverage shall include the period from conception to birth. The department shall develop a presumptive eligibility procedure for enrolling an unborn child, which shall include verification of the pregnancy.

5. Coverage for the child shall continue for up to one year after birth, unless otherwise prohibited by law or limited by the general assembly through appropriations.

6. Pregnancy-related and postpartum coverage for the mother shall begin on the day the pregnancy ends and extend through the last day of the month that includes the sixtieth day after the pregnancy ends, unless otherwise prohibited by law or limited by the general assembly through appropriations. The department may include pregnancy-related assistance as defined in 42 U.S.C. 1397ll.

7. The department may provide coverage for an unborn child enrolled in the show-me healthy babies program through:

(1) Direct coverage whereby the state pays health care providers directly, by contracting with a managed care organization or with a group or individual health insurance provider;

(2) A premium assistance program whereby the state assists in payment of the premiums, co-payments, coinsurance, or deductibles for a person who is eligible for health coverage through an employer, former employer, labor union, credit union, church, spouse, other organization, other individual, or through an individual health insurance policy that includes coverage for the unborn child when such person needs assistance in paying such premiums, co-payments, coinsurance, or deductibles;

(3) A combination of direct coverage when the unborn child is first enrolled and premium assistance after the child is born; or

(4) Any other similar arrangement whereby there:

(a) Are lower program costs without sacrificing health care coverage for the unborn child or the child up to one year after birth;

(b) Are greater covered services for the unborn child or the child up to one year after birth;

(c) Is also coverage for siblings or other family members, including the unborn child's mother, such as by providing pregnancy-related assistance under 42 U.S.C. 1397ll, relating to coverage of targeted low-income pregnant women through the children's health insurance program (CHIP); or

(d) Will be an ability for the child to transition more easily to non-government or less government-subsidized group or individual health insurance coverage after the child is no longer enrolled in the show-me healthy babies program.

8. The department shall provide information about the show-me healthy babies program to maternity homes as defined in section 135.600, pregnancy resource centers as defined in section 135.630, and other similar agencies and programs in the state that assist unborn children and their mothers. The department shall consider allowing such agencies and programs to assist in the enrollment of unborn children in the program and in making determinations about presumptive eligibility and verification of the pregnancy.

9. Within sixty days after the effective date of this section, the department shall submit a state plan amendment or seek any necessary waivers from the federal Department of Health and Human Services requesting approval for the show-me healthy babies program.

10. At least annually, the department shall prepare and submit a report to the governor, the speaker of the house of representatives, and the president pro tempore of the senate analyzing and projecting the cost savings and benefits, if any, to the state, counties, local communities, school districts, law enforcement agencies, correctional centers, health care providers, employers, other public and private entities, and persons by enrolling unborn children in the show-me healthy babies program. The analysis and projection of cost savings and benefits, if any, may include, but need not be limited to:

(1) The higher federal matching rate for having an unborn child enrolled in the show-me healthy babies program versus the lower federal matching rate for a pregnant woman being enrolled in MO HealthNet or other federal programs;

(2) The efficacy in providing services to unborn children through managed care organizations, group or individual health insurance providers, premium assistance, or through other nontraditional arrangements of providing health care;

(3) The change in the proportion of unborn children who receive care in the first trimester of pregnancy due to a lack of waiting periods, by allowing presumptive eligibility, or by removal of other barriers, and any resulting or projected decrease in health problems and other problems for unborn children and women throughout pregnancy; at labor, delivery, and birth; and during infancy and childhood;

(4) The change in healthy behaviors by pregnant women, such as the cessation of the use of tobacco, alcohol, illicit drugs, or other harmful practices, and any resulting or projected short-term and long-term decrease in birth defects; poor motor skills; vision, speech, and hearing problems; breathing and respiratory problems; feeding and digestive problems; and other physical, mental, educational, and behavioral problems; and

(5) The change in infant and maternal mortality, pre-term births and low birth weight babies,

and any resulting or projected decrease in short-term and long-term medical and other interventions.

11. The show-me healthy babies program shall not be deemed an entitlement program, but instead shall be subject to a federal allotment or other federal appropriations and matching state appropriations.

12. Nothing in this section shall be construed as obligating the state to continue the show-me healthy babies program if the allotment or payments from the federal government end, are not sufficient for the program to operate, or if the general assembly does not appropriate funds for the program.

13. Nothing in this section shall be construed as expanding MO HealthNet or fulfilling a mandate imposed by the federal government on the state.

208.790. 1. The applicant shall have or intend to have a fixed place of residence in Missouri, with the present intent of maintaining a permanent home in Missouri for the indefinite future. The burden of establishing proof of residence within this state is on the applicant. The requirement also applies to persons residing in long-term care facilities located in the state of Missouri.

2. The department shall promulgate rules outlining standards for documenting proof of residence in Missouri. Documents used to show proof of residence shall include the applicant's name and address in the state of Missouri.

3. Applicant household income limits for eligibility shall be subject to appropriations, but in no event shall applicants have household income that is greater than one hundred eighty-five percent of the federal poverty level for the applicable family size for the applicable year as converted to the MAGI equivalent net income standard.

4. The department shall promulgate rules outlining standards for documenting proof of household income.

208.798. The provisions of sections 208.780 to 208.798 shall terminate on August 28, **[**2014**]** 2017."; and

Further amend said bill, Page 8, Section 208.952, Line 52, by inserting after all of said section and line the following:

"208.990. 1. Notwithstanding any other provisions of law to the contrary, to be eligible for MO HealthNet coverage individuals shall meet the eligibility criteria set forth in 42 CFR 435, including but not limited to the requirements that:

(1) The individual is a resident of the state of Missouri;

(2) The individual has a valid Social Security number;

(3) The individual is a citizen of the United States or a qualified alien as described in Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C. Section 1641, who has provided satisfactory documentary evidence of qualified alien status which has been verified with the Department of Homeland Security under a declaration required by Section 1137(d) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 that the applicant or beneficiary is an alien in a satisfactory immigration status; and

(4) An individual claiming eligibility as a pregnant woman shall verify pregnancy.

2. Notwithstanding any other provisions of law to the contrary, effective January 1, 2014, the family support division shall conduct an annual redetermination of all MO HealthNet participants' eligibility as provided in 42 CFR 435.916. The department may contract with an administrative service organization to conduct the annual redeterminations if it is cost effective.

3. The department, or family support division, shall conduct electronic searches to redetermine eligibility on the basis of income, residency, citizenship, identity and other criteria as described in 42 CFR 435.916 upon availability of federal, state, and commercially available electronic data sources. The department, or family support division, may enter into a contract with a vendor to perform the electronic search of eligibility information not disclosed during the application process and obtain an applicable case management system. The department shall retain final authority over eligibility determinations made during the redetermination process.

4. Notwithstanding any other provisions of law to the contrary, applications for MO HealthNet benefits shall be submitted in accordance with the requirements of 42 CFR 435.907 and other applicable federal law. The individual shall provide all required information and documentation necessary to make an eligibility determination, resolve discrepancies found during the redetermination process, or for a purpose directly connected to the administration of the medical assistance program.

5. Notwithstanding any other provisions of law to the contrary, to be eligible for MO HealthNet coverage under section 208.991, individuals shall meet the eligibility requirements set forth in subsection 1 of this section and all other eligibility criteria set forth in 42 CFR 435 and 457, including, but not limited to, the requirements that:

(1) The department of social services shall determine the individual's financial eligibility based on projected annual household income and family size for the remainder of the current calendar year;

(2) The department of social services shall determine household income for the purpose of determining the modified adjusted gross income by including all available cash support provided by the person claiming such individual as a dependent for tax purposes;

(3) The department of social services shall determine a pregnant woman's household size by counting the pregnant woman plus the number of children she is expected to deliver;

(4) CHIP-eligible children shall be uninsured, shall not have access to affordable insurance, and their parent shall pay the required premium;

(5) An individual claiming eligibility as an uninsured woman shall be uninsured.

6. The MO HealthNet program shall not provide MO HealthNet coverage under subsection 4 of section 208.991 to a parent or other caretaker relative living with a dependent child unless the child is receiving benefits as required by a court order, under the MO HealthNet program, the Children's Health Insurance Program (CHIP) under 42 CFR Chapter IV, Subchapter D, or otherwise is enrolled in minimum essential coverage as defined in 42 CFR 435.4.

7. (1) The provisions of subsection 7 of section 208.151, section 208.186, section 208.662, subsection 6 of this section, subdivisions (1) and (7) of subsection 1 of section 208.991, subsections 3 to 11, 13, and 14 of section 208.991, and sections 208.997, 208.998, 208.999, 208.1000, and 208.1001 shall be null and void unless and until:

(a) Any necessary waivers or state plan amendments have been granted by the federal government to implement the provisions of subsection 6 of section 208.991 and subsection 11 of section 208.998;

(b) Eligibility of persons set out in subsection 4 of section 208.991 has been approved by the federal Department of Health and Human Services and notice has been provided by the director of the department of social services to the revisor of statutes;

(c) The federal Department of Health and Human Services grants the required waivers, state plan amendments, and enhanced federal funding rate for persons newly eligible under subsection 4 of section 208.991 whereby the federal government agrees to pay the percentages specified in Section 2001 of P.L. 111-148, as that section existed on March 23, 2010; and

(d) The federal Department of Health and Human Services grants the enhanced federal funding rate whereby the federal government agrees to pay the percentages specified in Section 2001 of P.L. 111-148, as that section existed on March 23, 2010, for the department to provide coverage for persons under subsection 8 of section 208.991.

(2) Upon receipt and approval of all necessary waivers and state plan amendments and the enhanced federal funding rate, the director of the department of social services shall notify the revisor of statutes.

(3) If the federal funds at the disposal of the state shall at any time become less than ninety percent of the funds necessary to cover the cost of benefits provided to MO HealthNet participants eligible for coverage under subsection 4 of section 208.991 or are not appropriated to pay the percentages specified in Section 2001 of P. L. 111-148, as that section existed on March 23, 2010, the provisions listed in subdivision (1) of this subsection shall be null and void. If the director of the department of social services is notified that federal funding will fall below ninety percent of the funds necessary to cover the cost of benefits provided to MO HealthNet participants eligible for coverage under subsection 4 of section 208.991, participants will be notified as soon as practicable that the benefits they receive will terminate on the date that federal funding falls below ninety percent.

208.991. 1. For purposes of **[**this section and section 208.990**]** sections 208.990 to 208.998, the following terms mean:

(1) "Caretaker relative", a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, which may, but is not required to, be indicated by claiming the child as a tax dependent for federal income tax purposes, and who is one of the following:

(a) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece; or

(b) The spouse of such parent or relative, even after the marriage is terminated by death or divorce;

(2) "Child" or "children", a person or persons who are under nineteen years of age;

[(2)**]** (3) "CHIP-eligible children", children who meet the eligibility standards for Missouri's children's health insurance program as provided in sections 208.631 to 208.658, including paying the premiums required under sections 208.631 to 208.658;

[(3)**]** (4) "Department", the Missouri department of social services, or a division or unit within the department as designated by the department's director;

[(4)**]** (5) "MAGI", the individual's modified adjusted gross income as defined in Section 36B(d)(2) of the Internal Revenue Code of 1986, as amended, and:

(a) Any foreign earned income or housing costs;

(b) Tax-exempt interest received or accrued by the individual; and

(c) Tax-exempt Social Security income;

[(5)**]** (6) "MAGI equivalent net income standard", an income eligibility threshold based on modified adjusted gross income that is not less than the income eligibility levels that were in effect prior to the enactment of Public Law 111-148 and Public Law 111-152;

(7) "Medically frail", individuals:

(a) Described in 42 CFR 438.50(d)(3);

(b) With disabling mental disorders;

(c) With chronic substance use disorders;

(d) With serious and complex medical conditions;

(e) With a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; or

(f) With a disability determination based on Social Security criteria.

2. (1) Effective January 1, 2014, notwithstanding any other provision of law to the contrary, the following individuals shall be eligible for MO HealthNet coverage as provided in this section:

(a) Individuals covered by MO HealthNet for families as provided in section 208.145;

(b) Individuals covered by transitional MO HealthNet as provided in 42 U.S.C. Section 1396r-6;

(c) Individuals covered by extended MO HealthNet for families on child support closings as provided in 42 U.S.C. Section 1396r-6;

(d) Pregnant women as provided in subdivisions (10), (11), and (12) of subsection 1 of section 208.151;

(e) Children under one year of age as provided in subdivision (12) of subsection 1 of section 208.151;

(f) Children under six years of age as provided in subdivision (13) of subsection 1 of section 208.151;

(g) Children under nineteen years of age as provided in subdivision (14) of subsection 1 of section 208.151;

(h) CHIP-eligible children; and

(i) Uninsured women as provided in section 208.659.

(2) Effective January 1, 2014, the department shall determine eligibility for individuals eligible for MO HealthNet under subdivision (1) of this subsection based on the following income eligibility standards, unless and until they are changed:

(a) For individuals listed in paragraphs (a), (b), and (c) of subdivision (1) of this subsection, the department shall apply the July 16, 1996, Aid to Families with Dependent Children (AFDC) income standard as converted to the MAGI equivalent net income standard;

(b) For individuals listed in paragraphs (f) and (g) of subdivision (1) of this subsection, the department shall apply one hundred thirty-three percent of the federal poverty level converted to the MAGI equivalent net income standard;

(c) For individuals listed in paragraph (h) of subdivision (1) of this subsection, the department shall convert the income eligibility standard set forth in section 208.633 to the MAGI equivalent net income standard;

(d) For individuals listed in paragraphs (d), (e), and (i) of subdivision (1) of this subsection, the department shall apply one hundred eighty-five percent of the federal poverty level converted to the MAGI equivalent net income standard;

(3) Individuals eligible for MO HealthNet under subdivision (1) of this subsection shall receive all applicable benefits under section 208.152.

3. The department shall implement an automated process to ensure applicants applying for benefit programs are eligible for such programs. The automated process shall be designed to periodically review current beneficiaries to ensure that they remain eligible for benefits they are receiving. The system shall check applicant and recipient information against multiple sources of information through an automated process.

4. (1) As soon as practicable upon receipt and approval of all necessary waivers and state plan amendments, but in no event later than one hundred eighty days after receipt and approval of such waivers and state plan amendments, the director of the department shall notify the revisor of statutes, and individuals who meet the following qualifications shall be eligible for alternative benefit plans as set forth in section 208.998, subject to the other requirements of this section:

(a) Are nineteen years of age or older and under sixty-five years of age;

(b) Are not pregnant;

(c) Are not entitled to or enrolled for Medicare benefits under Part A or B of Title XVIII of the Social Security Act;

(d) Are not otherwise eligible for and enrolled in mandatory coverage under the MO HealthNet program in accordance with 42 CFR 435, Subpart B; and

(e) Have household income that is at or below one hundred thirty-three percent of the federal poverty level for the applicable family size for the applicable year as converted to the MAGI equivalent net income standard except the household income may be reduced by a dollar amount equivalent to five percent of the federal poverty level for the applicable family size.

(2) The department shall immediately seek any necessary waivers from the federal Department of Health and Human Services to implement the provisions of this subsection. The waivers shall:

(a) Promote healthy behavior and allow reasonable requirements that patients take ownership of their health care by seeking early preventive care in appropriate settings, including no co-payments for preventive care services;

(b) Require personal responsibility in the payment of health care by establishing appropriate co-payments based on family income that shall discourage the use of emergency department visits for non-emergent health situations and promote responsible use of other health care services;

(c) Promote the adoption of healthier personal habits including limiting tobacco use or

behaviors that lead to obesity;

(d) Allow recipients to receive an annual cash incentive if federal financial participation is obtained for such an incentive, or a cash equivalent if not, to promote responsible behavior and encourage efficient use of health care services;

(e) Allow health plans to offer a health savings account option; and

(f) Include a request for an enhanced federal funding rate consistent with subsection 14 of this section for newly eligible participants.

(3) If such waivers, state plan amendments, and enhanced federal funding rate are not granted by the federal government, the provisions of this subsection shall be null and void.

5. Except for those individuals who meet the definition of medically frail, individuals eligible for MO HealthNet benefits under subsection 4 of this section shall receive only an alternative benefit plan. Notwithstanding the provisions of chapter 536, the MO HealthNet division shall promulgate regulations to be effective upon implementation of subsection 4 of this section that provide an alternative benefit plan that complies with the requirements of federal law and is subject to limitations.

6. The department shall require cost sharing to the maximum extent allowed by law including, but not limited to, cost sharing of no less than one percent of the individual's income as converted to the MAGI equivalent net income standard if the individual fails to participate in healthy behaviors as specified by the department. Cost sharing shall not occur during the individual's first year of participation in MO HealthNet. Any use of an emergency department by an individual for a non-emergent purpose and that does not result in a hospital admission shall result in cost sharing by the individual under this subsection. In order to collect the required cost sharing under this subsection, the department may garnish the individual's state income tax returns through any method available to the department.

7. The department shall provide premium subsidy and other cost supports for individuals eligible for MO HealthNet under subsections 2 and 4 of this section to enroll in employer-provided health plans or other private health plans based on cost-effective principles determined by the department.

8. Upon implementation of subsection 4 of this section, the department shall obtain health care coverage for persons who have an income between one hundred percent and one hundred thirty-three percent of the federal poverty level for the applicable family size, for the applicable year as converted to the MAGI equivalent net income standard, who meet all other requirements of subsection 4 of this section and have not been determined to be medically frail by the department, through a health care exchange operating in this state, whether federally facilitated, state based, or operated on a partnership basis, or an employer. The department shall ensure the participants receive the minimum services required to ensure federal reimbursement at the percentages specified in Section 2001 of Public Law 111-148. The department shall require cost sharing to the maximum extent allowed by law.

9. Upon implementation of subsection 4 of this section, all persons who have an income up to one hundred thirty-three percent of the federal poverty level for the applicable family size, for the applicable year as converted to the MAGI equivalent net income standard, who are eligible for MO

HealthNet benefits under subsection 4 of this section who meet the definition of medically frail shall receive all benefits they are eligible to receive under sections 208.152, 208.900, 208.903, 208.909, and 208.930.

10. The department shall establish a screening process in conjunction with the department of mental health and the department of health and senior services for determining whether an individual is medically frail and shall enroll all eligible individuals who meet the definition of medically frail and whose care management would benefit from being assigned a health home in the health home program or other care coordination as established by the department. Any eligible individual may opt out of the health home program.

11. For individuals who meet the definition of medically frail, the department shall develop an incentive program to promote the adoption of healthier personal habits including limiting tobacco use or behaviors that lead to obesity and for those individuals who utilize the health home program in subsection 11 of this section.

12. The department or appropriate divisions of the department shall 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 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, 2013, shall be invalid and void.

[4.**]** 13. The department shall submit such state plan amendments and waivers to the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services as the department determines are necessary to implement the provisions of this section. The department shall request of the federal government an enhanced federal funding rate for persons newly eligible under subsection 4 of this section whereby the federal government agrees to pay the percentages specified in Section 2001 of P.L. 111-148, as that section existed on March 23, 2010. The provisions of subsections 4 to 12 of this section shall not be implemented unless such waivers and enhanced federal funding rates are granted by the federal government.

14. If at any time the director receives notice that the federal funds at the disposal of the state for payments of money benefits to or on behalf of any persons under subsection 4 of this section shall at any time become less than ninety percent of the funds necessary to cover the cost of benefits provided to MO HealthNet participants eligible for coverage under subsections 4, 5, 8, 9, 10, and 12 of this section or are not appropriated to pay the percentages specified in Section 2001 of Public Law 111-148, as that section existed on March 23, 2010, subsections 4 to 12 of this section shall no longer be effective for the individuals whose benefits are no longer matchable at the specified percentages. The date benefits cease shall be stated in a notice sent to the affected individuals.

15. The department may seek and apply for grants to educate MO HealthNet recipients how to:

(1) Increase their overall health and well-being;

(2) Improve health outcomes; and

(3) Properly utilize health care providers and services.

208.997. 1. The MO HealthNet division shall develop and implement the "Health Care Homes Program" as a provider-directed care coordination program for MO HealthNet recipients who are not enrolled in a prepaid MO HealthNet benefits option and who are receiving services on a fee-for-service basis or are otherwise identified by the department. 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. 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, "primary care clinic" means 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.

3. The department may designate that the health care homes program be administered through an organization with a statewide primary care 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, 2014, 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. Except for individuals who meet the definition of medically frail, individuals who qualify for coverage under subsections 2 and 4 of section 208.991 shall receive covered services through health plans offered by managed care entities which are authorized by the department. 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 may include risk-bearing accountable care organizations and 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 rates. 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 perform well;

(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. (1) The department may accept regional proposals as an additional option for beneficiaries. Such proposals may be submitted by accountable care organizations or other organizations and entities.

(2) 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 accountable care organizations.

(3) The provisions of subsection 1 of this section shall not apply to this subsection.

4. The department shall establish, in collaboration with plans and providers, uniform utilization review protocols to be used by all authorized health plans.

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 longer if the contract so provides. The state shall not increase the reimbursement rate provided to the managed care organization during the contract period above the rate included in the contract. 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 incentives for 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 unless they are specifically excluded under subsection 2 of this section:

(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) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

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

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

(11) Any other services required by federal law.

9. 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 program shall require managed care plans under this section to provide a high deductible health plan option for uninsured adults nineteen years of age or older and under sixty-five years of age with incomes of less than one hundred percent of the federal poverty level as converted to the MAGI equivalent net income standard who are enrolled in managed care plans under this section. The high deductible health plan shall include:

(1) A minimum deductible of one thousand dollars and upon meeting the deductible, coverage for benefits as specified by rule of the department;

(2) An account, funded by the department, of at least one thousand dollars per adult to pay

medical costs for the initial deductible in the form of a prepaid card;

(3) 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;

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

(5) Primary care provider visits, as defined by the department by rule, that are not subject to the deductible and do not require a payment of moneys from the account described in subdivision (2) of this subsection;

(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 at the end of the plan year, 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 shall enroll. 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 recipient shall be eligible to receive an annual cash payment if federal financial participation is obtained for such a payment, or a cash equivalent if not, 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 recipients.

12. A MO HealthNet recipient shall be eligible for participation in only one of either the high deductible health plan under subsection 11 of this section or the incentive program under subsection 12 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 11 of this section that the participant may lose his or her incentive payment under subdivision (7) of subsection 11 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; except that, any increase in eligibility shall be contingent upon the receipt of all necessary waivers and state plan amendments. The provisions of this section shall not be implemented until eligibility of persons set out in subsection 4 of section 208.991 has been approved by the federal Department of Health and Human Services and has been implemented by the department. However, nothing shall prevent the department from expanding managed care for populations under other granted authority.

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, 2014, shall be invalid and void."; and

Further amend said bill, Page 11, Section 208.999, Line 115, by inserting after all of said section and line the following:

"208.1000. Subject to appropriations, the department of social services 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 department 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.

208.1001. 1. Notwithstanding any other provision of law to the contrary, beginning July 1, 2015, 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 of social services. 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 under subsection 9 of section 208.991.

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.

208.1002. 1. The department of social services shall develop regional care coordination models among networks of health care providers to meet the needs of and reduce the costs incurred by MO HealthNet beneficiaries who frequently or inefficiently utilize emergency department services. The objectives of such models shall include, but not be limited to:

(1) Reducing emergency department utilization;

(2) Reducing unnecessary utilization of diagnostic services, pharmacy costs, inpatient encounters, and admissions;

(3) Increasing quality and coordination of care through leveraging community resources and care management;

(4) Improving the patient experience and quality of care; and

(5) Achieving net savings of ten to thirteen percent over a three-year period for MO HealthNet participants.

2. The regional care coordination models shall require the development of an algorithm that uses analytical approaches to identify prospective participants who have a history of presenting in an emergency department for care on at least ten occasions over a twelve-month period. Prospective participants also shall be screened based on claims and other available data to predict the likely value of intense care coordination to reduce costs and improve care. The regional care coordination models shall incorporate the following strategies:

(1) Utilization of a multi-disciplinary, team-based approach that adapts health care and community resources to the participant's individual needs;

(2) Utilization of resources and sharing of information among the care management team to develop a comprehensive care management program based on social, clinical, and behavioral assessments. The care management team shall include medical direction from a physician supported by additional health care professionals and community resources as necessary; and

(3) Creation of a sustainable program in coordination with the regional networks of health care providers whereby the department measures and tracks baseline expenditures on a per-member, per-month basis for the target population. The department shall develop a shared savings funding

model that may be adapted to a wider array of health payment models.

3. The department also shall develop additional innovative programs that seek to address the cost and quality of care for individuals who disproportionately utilize emergency departments for care. Health care providers participating in the regional care coordination models shall be encouraged to include uninsured individuals who frequently utilize the emergency department for care in this program to the greatest extent possible."; and

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