HOUSE AMENDMENT NO.__1__
TO
HOUSE AMENDMENT NO.__2__

Offered By

_____ _____

AMEND House Amendment No.__2___ to House Committee Substitute for House Bill No. 1898 Page __3___Line __17___, by inserting after all of said line the following:

"Further amend said bill, page and section, Line 78, by inserting after all of said line the following:

"208.164. 1. As used in this section, unless the context clearly requires otherwise, the following terms mean:

(1) "Abuse", a documented pattern of inducing, furnishing, or otherwise causing a recipient to receive services or merchandise not otherwise required or requested by the recipient, attending physician or appropriate utilization review team; a documented pattern of performing and billing tests, examinations, patient visits, surgeries, drugs or merchandise that exceed limits or frequencies determined by the department for like practitioners for which there is no demonstrable need, or for which the provider has created the need through ineffective services or merchandise previously rendered. The decision to impose any of the sanctions authorized in this section shall be made by the director of the department, following a determination of demonstrable need or accepted medical practice made in consultation with medical or other health care professionals, or qualified peer review teams;

(2) "Credible allegation of fraud", reliable evidence that overpayments or other violations discovered in the provider's operations are the product, in whole or in part, of fraud committed by the provider or one or more of the provider's staff, contractors, or agents. Reliable evidence is evidence that has been corroborated, is based upon information from a person whose relationship with the suspected perpetrator is such that the person could reasonably be expected to have knowledge of the misconduct, such as an employee, ex-employee, or MO HealthNet participant, or is based on data analysis that reveals aberrant billing practices that appear unjustifiable based on normal business practices;

(3) "Department", the department of social services;

[(3)**]** (4) "Excessive use", the act, by a person eligible for services under a contract or provider agreement between the department of social services or its divisions and a provider, of seeking and/or obtaining medical assistance benefits from a number of like providers and in quantities which exceed the levels that are considered medically necessary by current medical practices and standards for the eligible person's needs;

[(4)**]** (5) "Fraud", **[**a known false representation, including the concealment of a material fact that provider knew or should have known through the usual conduct of his profession or occupation, upon which the provider claims reimbursement under the terms and conditions of a contract or

Action Taken_____ Date _____

provider agreement and the policies pertaining to such contract or provider agreement of the department or its divisions in carrying out the providing of services, or under any approved state plan authorized by the federal Social Security Act**]** an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person. It includes any act that constitutes fraud under applicable federal and state laws, regulations, and policies;

[(5)**]** (6) "Health plan", a group of services provided to recipients of medical assistance benefits by providers under a contract with the department;

[(6)**]** (7) "Medical assistance benefits", those benefits authorized to be provided by sections 208.152 and 208.162;

[(7)**]** (8) "Prior authorization", approval to a provider to perform a service or services for an eligible person required by the department or its divisions in advance of the actual service being provided or approved for a recipient to receive a service or services from a provider, required by the department or its designated division in advance of the actual service or services being received;

[(8)**]** (9) "Provider", any person, partnership, corporation, not-for-profit corporation, professional corporation, or other business entity that enters into a contract or provider agreement with the department or its divisions for the purpose of providing services to eligible persons, and obtaining from the department or its divisions reimbursement therefor;

[(9)**]** (10) "Recipient", a person who is eligible to receive medical assistance benefits allocated through the department;

[(10)**]** (11) "Service", the specific function, act, successive acts, benefits, continuing benefits, requested by an eligible person or provided by the provider under contract with the department or its divisions.

2. The department or its divisions shall have the authority to suspend, revoke, or cancel any contract or provider agreement or refuse to enter into a new contract or provider agreement with any provider where it is determined the provider has committed or allowed its agents, servants, or employees to commit acts defined as abuse or fraud in this section.

3. The department or its divisions shall have the authority to impose prior authorization as defined in this section:

(1) When it has reasonable cause to believe a provider or recipient has knowingly followed a course of conduct which is defined as abuse or fraud or excessive use by this section; or

(2) When it determines by rule that prior authorization is reasonable for a specified service or procedure.

4. If a provider or recipient reports to the department or its divisions the name or names of providers or recipients who, based upon their personal knowledge has reasonable cause to believe an act or acts are being committed which are defined as abuse, fraud or excessive use by this section, such report shall be confidential and the reporter's name shall not be divulged to anyone by the department or any of its divisions, except at a judicial proceeding upon a proper protective order being entered by the court.

5. Payments for services or supplies under any contract or provider agreement between the department or its divisions and a provider may be **[**withheld**]** suspended by the department or its divisions from the provider for acts or omissions defined as abuse or fraud by this section, until such time as an agreement between the parties is reached or the dispute is adjudicated under the laws of this state. In addition, as required by 42 CFR 455.23, the department shall suspend payment for services or supplies under any contract or provider agreement between the department and a provider upon a finding by the department of a credible allegation of fraud as defined in subdivision (2) of subsection 1 of this section unless the department has good cause not to suspend payments as defined in 42 CFR 455.23(e) or to suspend payments only in part as defined in 42 CFR 455.23(f).

6. The department or its designated division shall have the authority to review all cases and claim records for any recipient of public assistance benefits and to determine from these records if the recipient has, as defined in this section, committed excessive use of such services by seeking or obtaining services from a number of like providers of services and in quantities which exceed the levels considered necessary by current medical or health care professional practice standards and policies of the program.

7. The department or its designated division shall have the authority with respect to recipients of medical assistance benefits who have committed excessive use to limit or restrict the use of the recipient's Medicaid identification card to designated providers and for designated services; the actual method by which such restrictions are imposed shall be at the discretion of the department of social services or its designated division.

8. The department or its designated division shall have the authority with respect to any recipient of medical assistance benefits whose use has been restricted under subsection 7 of this section and who obtains or seeks to obtain medical assistance benefits from a provider other than one of the providers for designated services to terminate medical assistance benefits as defined by this chapter, where allowed by the provisions of the federal Social Security Act.

9. The department or its designated division shall have the authority with respect to any provider who knowingly allows a recipient to violate subsection 7 of this section or who fails to report a known violation of subsection 7 of this section to the department of social services or its designated division to terminate or otherwise sanction such provider's status as a participant in the medical assistance program. Any person making such a report shall not be civilly liable when the report is made in good faith.

208.631. 1. Notwithstanding any other provision of law to the contrary, the MO HealthNet division shall establish a program to pay for health care for uninsured children. Coverage pursuant to sections 208.631 to **[**208.659**]** 208.658 is subject to appropriation. The provisions of sections 208.631 to **[**208.569**]** 208.658, health care for uninsured children, shall be void and of no effect if there are no funds of the United States appropriated by Congress to be provided to the state on the basis of a state plan approved by the federal government under the federal Social Security Act. If funds are appropriated by the United States Congress, the department of social services is authorized to manage the state children's health insurance program (SCHIP) allotment in order to ensure that the state receives maximum federal financial participation. Children in households with incomes up to one hundred fifty percent of the federal poverty level may meet all Title XIX program guidelines as required by the Centers for Medicare and Medicaid Services. Children in households with incomes of one hundred fifty percent to three hundred percent of the federal poverty level shall continue to be eligible as they were and receive services as they did on June 30, 2007, unless changed by the Missouri general assembly.

2. For the purposes of sections 208.631 to **[**208.659**]** 208.658, "children" are persons up to nineteen years of age. "Uninsured children" are persons up to nineteen years of age who are emancipated and do not have access to affordable employer-subsidized health care insurance or other health care coverage or persons whose parent or guardian have not had access to affordable employer-subsidized health care insurance or other health care coverage for their children for **[**six months**]** thirty days prior to application, are residents of the state of Missouri, and have parents or guardians who meet the requirements in section 208.636. A child who is eligible for MO HealthNet benefits as authorized in section 208.151 is not uninsured for the purposes of sections 208.631 to **[**208.659**]** 208.658.

208.636. Parents and guardians of uninsured children eligible for the program established in sections 208.631 to **[**208.657**]** 208.658 shall:

(1) Furnish to the department of social services the uninsured child's Social Security number

or numbers, if the uninsured child has more than one such number;

(2) Cooperate with the department of social services in identifying and providing information to assist the state in pursuing any third-party insurance carrier who may be liable to pay for health care;

(3) Cooperate with the department of social services, division of child support enforcement in establishing paternity and in obtaining support payments, including medical support; and

(4) Demonstrate upon request their child's participation in wellness programs including immunizations and a periodic physical examination. This subdivision shall not apply to any child whose parent or legal guardian objects in writing to such wellness programs including immunizations and an annual physical examination because of religious beliefs or medical contraindications**[**; and

(5) Demonstrate annually that their total net worth does not exceed two hundred fifty thousand dollars in total value**]**.

208.640. 1. Parents and guardians of uninsured children with incomes of more than one hundred fifty but less than three hundred percent of the federal poverty level who do not have access to affordable employer-sponsored health care insurance or other affordable health care coverage may obtain coverage for their children under this section. Health insurance plans that do not cover an eligible child's preexisting condition shall not be considered affordable employer-sponsored health care insurance or other affordable health care coverage. For the purposes of sections 208.631 to **[**208.659**]** 208.658, "affordable employer-sponsored health care insurance or other affordable health care coverage" refers to health insurance requiring a monthly premium of:

(1) Three percent of one hundred fifty percent of the federal poverty level for a family of three for families with a gross income of more than one hundred fifty and up to one hundred eighty-five percent of the federal poverty level for a family of three;

(2) Four percent of one hundred eighty-five percent of the federal poverty level for a family of three for a family with a gross income of more than one hundred eighty-five and up to two hundred twenty-five percent of the federal poverty level;

(3) Five percent of two hundred twenty-five percent of the federal poverty level for a family of three for a family with a gross income of more than two hundred twenty-five but less than three hundred percent of the federal poverty level.

The parents and guardians of eligible uninsured children pursuant to this section are responsible for a monthly premium as required by annual state appropriation; provided that the total aggregate cost sharing for a family covered by these sections shall not exceed five percent of such family's income for the years involved. No co-payments or other cost sharing is permitted with respect to benefits for well-baby and well-child care including age-appropriate immunizations. Cost-sharing provisions for their children under sections 208.631 to **[**208.659**]** 208.658 shall not exceed the limits established by 42 U.S.C. Section 1397cc(e). If a child has exceeded the annual coverage limits for all health care services, the child is not considered insured and does not have access to affordable health insurance within the meaning of this section.

2. The department of social services shall study the expansion of a presumptive eligibility process for children for medical assistance benefits.

208.643. 1. The department of social services shall implement policies establishing a program to pay for health care for uninsured children by rules promulgated pursuant to chapter 536, either statewide or in certain geographic areas, subject to obtaining necessary federal approval and appropriation authority. The rules may provide for a health care services package that includes all medical services covered by section 208.152, except nonemergency transportation.

2. Available income shall be determined by the department of social services by rule, which

shall comply with federal laws and regulations relating to the state's eligibility to receive federal funds to implement the insurance program established in sections 208.631 to **[**208.657**]** 208.658.

208.646. There shall be a thirty-day waiting period after enrollment for uninsured children in families with an income of more than two hundred twenty-five percent of the federal poverty level before the child becomes eligible for insurance under the provisions of sections 208.631 to **[**208.660**]** 208.658. If the parent or guardian with an income of more than two hundred twenty-five percent of the federal poverty level fails to meet the co-payment or premium requirements, the child shall not be eligible for coverage under sections 208.631 to **[**208.660**]** 208.658 for **[**six months**]** thirty days after the department provides notice of such failure to the parent or guardian.

208.647. Any child identified as having "special health care needs", defined as a condition which left untreated would result in the death or serious physical injury of a child, that does not have access to affordable employer-subsidized health care insurance shall not be required to be without health care coverage for six months in order to be eligible for services under sections 208.631 to **[**208.657**]** 208.658 and shall not be subject to the waiting period required under section 208.646, as long as the child meets all other qualifications for eligibility.

208.650. 1. The department of social services shall commission a study on the impact of this program on providing a comprehensive array of community-based wraparound services for seriously emotionally disturbed children and children affected by substance abuse. The department shall issue a report to the general assembly within forty-five days of the twelve-month anniversary of the beginning of this program and yearly thereafter. This report shall include recommendations to the department on how to improve access to the provisions of community-based wraparound services pursuant to sections 208.631 to **[**208.660**]** 208.658.

2. The department of social services shall prepare an annual report to the governor and the general assembly on the effect of this program. The report shall include, but is not limited to:

(1) The number of children participating in the program in each income category;

(2) The effect of the program on the number of children covered by private insurers;

(3) The effect of the program on medical facilities, particularly emergency rooms;

(4) The overall effect of the program on the health care of Missouri residents;

(5) The overall cost of the program to the state of Missouri; and

(6) The methodology used to determine availability for the purpose of enrollment, as established by rule.

3. The department of social services shall establish an identification program to identify children not participating in the program though eligible for extended medical coverage. The department's efforts to identify these uninsured children shall include, but not be limited to:

(1) Working closely with hospitals and other medical facilities; and

(2) Establishing a statewide education and information program.

4. The department of social services shall commission a study on any negative impact this program may have on the number of children covered by private insurance as a result of expanding health care coverage to children with a gross family income above one hundred eighty-five percent of the federal poverty level. The department shall issue a report to the general assembly within forty-five days of the twelve-month anniversary of the beginning of this program and annually thereafter. If this study demonstrates that a measurable negative impact on the number of privately insured children is occurring, the department shall take one or more of the following measures targeted at eliminating the negative impact:

(1) Implementing additional co-payments, sliding scale premiums or other cost-sharing provisions;

(2) Adding an insurability test to preclude participation;

(3) Increasing the length of the required period of uninsured status prior to application;

(4) Limiting enrollment to an annual open enrollment period for children with gross family incomes above one hundred eighty-five percent of the federal poverty level; and

(5) Any other measures designed to efficiently respond to the measurable negative impact.

208.655. No funds used to pay for insurance or for services pursuant to sections 208.631 to **[**208.657**]** 208.658 may be expended to encourage, counsel or refer for abortion unless the abortion is done to save the life of the mother or if the unborn child is the result of rape or incest. No funds may be paid pursuant to sections 208.631 to **[**208.657**]** 208.658 to any person or organization that performs abortions or counsels or refers for abortion unless the abortion is done to save the life of the mother or if the unborn child is the result of rape or incest.

208.657. Any rule or portion of a rule, as that term is defined in section 536.010, that is promulgated under the authority delegated in this chapter shall become effective only if the agency has fully complied with all of the requirements of chapter 536, including but not limited to, section 536.028, if applicable, after August 28, 1998. All rulemaking authority delegated prior to August 28, 1998, is of no force and effect and repealed as of August 28, 1998, however, nothing in sections 208.631 to **[**208.657**]** 208.658 shall be interpreted to repeal or affect the validity of any rule adopted or promulgated prior to August 28, 1998. If the provisions of section 536.028, apply, the provisions of sections 208.631 to **[**208.657**]** 208.658 are nonseverable and if any of the powers vested with the general assembly pursuant to section 536.028 to review, to delay the effective date, or to disapprove and annul a rule or portion of a rule are held unconstitutional or invalid, the purported grant of rulemaking authority and any rule so proposed and contained in the order of rulemaking shall be invalid and void, except that nothing in sections 208.631 to **[**208.660**]** 208.658 shall affect the validity of any rule adopted and promulgated prior to August 28, 1998.

208.658. 1. For each school year beginning July 1, 2010, the department of social services shall provide all state licensed child-care providers who receive state or federal funds under section 210.027 and all public school districts in this state with written information regarding eligibility criteria and application procedures for the state children's health insurance program (SCHIP) authorized in sections 208.631 to **[**208.657**]** 208.658, to be distributed by the child-care providers or school districts to parents and guardians at the time of enrollment of their children in child care or school, as applicable.

2. The department of elementary and secondary education shall add an attachment to the application for the free and reduced lunch program for a parent or guardian to check a box indicating yes or no whether each child in the family has health care insurance. If any such child does not have health care insurance, and the parent or guardian's household income does not exceed the highest income level under 42 U.S.C. Section 1397CC, as amended, the school district shall provide a notice to such parent or guardian that the uninsured child may qualify for health insurance under SCHIP.

3. The notice described in subsection 2 shall be developed by the department of social services and shall include information on enrolling the child in the program. No notices relating to the state children's health insurance program shall be provided to a parent or guardian under this section other than the notices developed by the department of social services under this section.

4. Notwithstanding any other provision of law to the contrary, no penalty shall be assessed upon any parent or guardian who fails to provide or provides any inaccurate information required under this section.

5. The department of elementary and secondary education and the department of social services may adopt 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 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, 2010, shall be invalid and void.

6. The department of elementary and secondary education, in collaboration with the department of social services, shall report annually to the governor and the house budget committee chair and the senate appropriations committee chair on the following:

(1) The number of families in each district receiving free lunch and reduced lunches;

(2) The number of families who indicate the absence of health care insurance on the application for free and reduced lunches;

(3) The number of families who received information on the state children's health insurance program under this section; and

(4) The number of families who received the information in subdivision (3) of this subsection and applied to the state children's health insurance program."; and"; and

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