HCS SCS SB 524 -- HEALTH AND WELFARE

SPONSOR: Cunningham (Molendorp)

COMMITTEE ACTION: Voted "Do Pass" by the Committee on Health Insurance by a vote of 6 to 2.

BENEFITS FOR ELECTED OFFICIALS (Section 67.150, RSMo)

Currently, a political subdivision may elect to contribute to a health insurance plan or similar benefit for its elected officials and employees as part of their compensation. When a county elects to furnish all or part of medical expenses then it must provide the benefit to all elected officials.

This bill specifies that if a county elects to furnish all or part of the medical expenses, then it must do so only for those elected officials who are compensated by the county. The county may, but is not required, to furnish medical expenses to other elected officials not compensated by the county.

HEALTH CARE COST TRANSPARENCY (Section 191.870)

Upon request from a patient, potential patient, or the person's parent or guardian, a health care provider must provide an estimated cost, if known, for a health care service based on the patient or potential patient's health benefit plan coverage, Medicaid coverage, Medicare coverage, or uninsured status. If covered by a health benefit plan, Medicaid, or Medicare, the health care provider must provide the contractual reimbursement rate for the service, if known, and, if applicable, the amount the patient or potential patient would pay as a result of a deductible, coinsurance, or co-payment. If a patient or potential patient is uninsured, the health care provider must provide the estimated out-of-pocket cost and information regarding any payment plan or other financial assistance that may be available. The health care provider's response does not need to be in writing unless so requested by those authorized to receive the response. Health care providers providing estimated costs under these provisions must include with any price quote a specified statement.

No provision in a contract entered into, amended, or renewed on or after August 28, 2014, between a health carrier and a health care provider must be enforceable if the contractual provision prohibits, conditions, or in any way restricts any party to the contract from disclosing to an enrollee, patient, potential patient, or the person’s parent or legal guardian the contractual reimbursement rate for a health care service if the payment amount is less than the health care provider’s usual charge for the health

care service and if the contractual provision prevents the determination of the potential out-of-pocket cost for the health care service by the enrollee, patient, potential patient, parent, or legal guardian.

Any violation of these provisions will result in a fine not to exceed $1,000 for each instance of violation.

PRICE TRANSPARENCY (Section 191.875)

By July 1, 2015, this bill requires all health care providers and insurers to provide cost estimates prior to the provision of the services, if feasible, but in no event later than 5 business days after the request. These provisions must not apply to emergency health care services.

Health care providers and health carriers must include with any estimate a specified disclaimer stating that the estimated cost is an estimate and must also make available the percentage or amount of any discounts for cash payment of any charges incurred by a posting on the provider's website or in person.

Nothing in these provisions will be construed as violating any provider contract provision with a health carrier that prohibits disclosure of the provider's fee schedule with a health carrier to third parties.

REPORTING OF PRICES FOR MOST COMMON PROCEDURES (Sections 197.170 & 197.173)

This bill requires hospitals and ambulatory surgical centers to submit to the Department of Health and Senior Services prices for 140 of the most common procedures, including 100 of the most common procedures in hospital inpatient settings as well as 20 of the most common surgery and 20 of the most common imaging procedures conducted in both outpatient hospital and ambulatory surgical settings.

The department must provide the information on its Internet website in a manner that is easily understood by the public. Information for each hospital must be listed separately and hospitals must be listed in groups by category as determined by the department through the promulgation of rules. Information for each hospital outpatient department and each ambulatory surgical center must also be listed separately.

The information regarding hospital inpatient procedures must be submitted beginning with the quarter ending June 30, 2015, and quarterly thereafter. The information regarding outpatient

surgical and imaging procedures must be submitted beginning with the quarter ending September 30, 2015, and quarterly thereafter.

CERTIFICATE OF NEED (Sections 197.305 to 197.330)

This bill amends the certificate of need (CON) law as follows:

(1) Limits the radius area for "affected persons" to a 5 mile radius of proposed new development as well as when consideration must be given to the facilities located within the 5 mile radius when determining if a CON will be issued;

(2) Provides that a certificate of need will not be required for a proposed project which creates 10 or more new full-time jobs;

(3) Raises the expenditure minimum for falling under CON review for capital expenditures to $1 million and for major medical equipment to $2 million;

(4) Requires all testimony and other evidence taken during the hearings to be under oath and subject to penalty of perjury;

(5) Changes the procedures and evidentiary standard at the certificate of need hearing;

(6) Prohibits all ex parte communications between members of the committee and any interested party or witness regarding the subject matter of the hearing at any time prior to, during, or after the hearing; and

(7) Modifies the membership and requirements for Missouri Health Facilities Review Committee for the Certificate of Need Program.

ASSET LIMITS INCREASE FOR MEDICAID (Section 208.010)

This bill modifies the amount of cash, securities, or other total non-exempt assets an aged or disabled participant is allowed to retain in order to qualify for MO HealthNet benefits from less than $1,000 to $2,000 for a single person and from $2,000 to $4,000 for a married couple.

SNAP REQUIREMENTS (Section 208.023)

This bill requires the Department of Social Services to imprint a photograph of a recipient on all EBT cards distributed for Supplemental Nutrition Assistance Program (SNAP) benefits. The card must expire and be subject to renewal every three years (Section 208.023(1)).

Under these provisions, certain SNAP applicants are required to sign an affidavit stating that the individual will follow certain requirements such as registering to work, providing sufficient information of job status and availability, accepting suitable jobs if offered, continuing employment if hired, and to not voluntarily reduce employment hours and failure to comply with requirements may result in loss of SNAP benefits (Section 208.023(2)).

SNAP recipients are required to participate in any one or a combination of certain activities such as a condition of eligibility, secondary education, job search and readiness, community service, job training or employment (Section 208.023(3)).

SNAP recipients must report any time their monthly gross income is over the maximum allowed for household size and shall also complete recertification once every 12 months (Section 208.023(4) and (5)).

EBT USE BY TANF RECIPIENTS IN CERTAIN ESTABLISHMENTS (Section 208.024, subsection 1 & 2)

This bill changes the prohibition on the use of EBT cards in specified establishments to the prohibition on the purchase of alcoholic beverages, lottery tickets, or tobacco products in those establishments and repeals the prohibition on using the EBT card in places and for items that are primarily marketed for use or by adults. This bill prohibits the owner or proprietor of a specified business from adopting any policy that encourages, permits, or acquiesces in its employees knowingly accepting EBT cards for prohibited purchases.

OUT-OF-STATE USE OF EBT CARDS (Section 208.024, subsections 3 & 4)

This bill also requires recipients of benefits who do not make at least one transaction in the state during a 90 day period to have his or her benefit payments to the EBT account temporarily suspended, pending an investigation by the Department of Social Services to determine if he or she no longer is a Missouri resident. If the department finds that the recipient is no longer a Missouri resident, it must close the recipient's benefits. To ensure that benefits are not erroneously closed, a recipient must notify the department of the reasons why he or she cannot be within the state for more than 90 days. A recipient who does not make an EBT transaction within the state for 60 days will be given notice of the possibility of suspension of funds.

DRUG TESTING OF TANF RECIPIENTS (Section 208.027)

This bill repeals the provision requiring an automatic administrative hearing after an applicant or recipient of temporary

assistance for needy families benefits tests positive for a controlled substance or refuses to submit to a test. The applicant may request an administrative hearing. This bill adds "other information" in addition to information from the screening to the provision regarding requiring an applicant or recipient to test for drug use.

NOTIFICATION TO SPENDDOWN PARTICIPANTS (Section 208.151)

The Department of Social Services is required to 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 the insurance.

AUTOMATIC ELIGIBILITY VERIFICATION PROCESS FOR BENEFIT PROGRAMS (Section 208.238)

Under this bill, the Department of Social Services is required to implement an automated process to ensure an applicant is eligible to apply for a benefit program. The automated process must be designed to periodically review any current beneficiary to ensure he or she is still eligible for any benefit he or she is receiving. The system must check applicant and recipient information against multiple sources of information through an automated process.

PUBLIC ASSISTANCE FRAUD (Section 208.249)

This bill specifies that any person who knowingly commits fraud in obtaining or attempting to obtain public assistance benefits will permanently lose eligibility for the benefits.

CHILDREN'S HEALTH INSURANCE PROGRAM (Sections 208.631 to 208.659)

Under this bill, a child eligible for the current Children's Health Insurance Program (CHIP) must only remain eligible if, in addition to other requirements, his or her parents do not have access to health insurance coverage for the child through their employment or through a health insurance plan in a health care exchange because the parents are not eligible for a premium subsidy for the child through the exchange.

These provisions must not go into effect unless and until federal health insurance premium tax credits are available for children and family coverage to purchase a health insurance plan from a health

care exchange and the credits are available for six months prior to the discontinuation of CHIP eligibility. The department must inform participants of the possibility of insurance coverage via the purchase of subsidized health insurance plan available through a health care exchange six months before CHIP coverage is discontinued.

SHOW-ME HEALTHY BABIES PROGRAM (Section 208.662)

This bill establishes the Show-Me Healthy Babies Program within the Department of Social Services as a separate children's health insurance program for any low-income unborn child. For an unborn child to be eligible for enrollment in the program, the mother of the child must not be eligible for coverage under the Medicaid Program as administered by the state and must not have access to affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. The unborn child must be in a family with income eligibility of no more than 300% 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. The act delineates all of the parameters of the program. The department must provide coverage for an unborn child under this program in the same manner in which the department provides CHIP coverage in the county of the primary residence of the mother.

CHIROPRACTIC SERVICES (Section 208.960)

This bill requires the MO HealthNet Division within the Department of Social Services to reimburse licensed chiropractors for specific services. These services include examinations, diagnoses, adjustments, manipulations and treatments in both inpatient and outpatient settings. If a chiropractor is specially certified by the Missouri Board of Chiropractic Examiners in the Division of Professional Registration within the Department of Insurance, Financial Institutions and Professional Registration, covered services may also include meridian therapy, acupressure, or acupuncture.

REVISED JOINT COMMITTEE ON MO HEALTHNET AND REPEAL OF MO HEALTHNET OVERSIGHT COMMITTEE (Sections 208.950; 208.952; 208.975; and 208.985)

This bill amends the Joint Committee on MO HealthNet to have as its purpose of study the efficacy of the program as well as the resources needed to continue and improve the MO HealthNet program over time. The committee must receive and obtain information from the departments of Social Services, Mental Health, Health and

Senior Services and Elementary and Secondary Education as applicable, regarding the projected budget of the entire MO HealthNet program including projected MO HealthNet enrollment growth, categorized by population and geographic area.

The committee must meet at least twice a year. The committee is authorized to hire an employee or enter into employment contracts. The compensation of the personnel and the expenses of the committee will be paid as specified in the bill. The committee may also hire or contract for an executive director to conduct investigations to fulfill the duties of the committee.

This bill also repeals the MO HealthNet Oversight Committee and references made to it.

MO HEALTHNET ELIGIBILITY (Section 208.991)

Effective January 1, 2015, and subject to the receipt of all appropriate waivers and approval of state plan amendments, individuals who meet the following qualifications must be eligible for the alternative package of MO HealthNet benefits:

(1) Are 19 years of age or older and younger than 65 years of age;

(2) Are not pregnant;

(3) Are not entitled to or enrolled for federal Medicare benefits;

(4) Are not otherwise eligible for and enrolled for mandatory MO HealthNet Program coverage; and

(5) Have a household income that is at or below 133% of the Federal Poverty Level (FPL) for the applicable family size for the applicable year under the MAGI equivalent net income standard, except the household income may be reduced by a dollar amount equivalent to 5% of the FPL for the applicable family size.

The Department of Social Services is required to immediately seek any waivers necessary to implement these provisions. The waivers must promote healthy behavior and include no co-payment for preventive care, require personal responsibility in the payment of health care by establishing appropriate co-payments based on family income that will discourage the use of emergency room visits for non-emergent care and promote responsible use of other health care services, promote the adoption of healthier personal habits including limiting tobacco use or behaviors that lead to obesity, allow recipients to receive an annual cash incentive or cash equivalent if federal financial participation is not obtained to promote responsible behavior and encourage efficient use of health

care services, allow health plans to offer a health savings account option, and include a request for an enhanced federal funding rate for newly eligible participants. If the waivers and enhanced federal funding rates are not granted, these provisions must be null and void.

The MO HealthNet Division within the Department of Social Services must establish regulations to be effective January 1, 2015, that provide an alternative benefit package that complies with the requirements of federal law and is subject to the limitations as established in division regulations.

The department must require cost sharing to the maximum extent allowed by law, including but not limited to a premium of no less than 1% of the individual's income as converted to the MAGI equivalent net income standard. In order to collect the required cost sharing the department may garnish the individual's state income tax returns.

The department is required to apply for a waiver to require workforce participation of individuals otherwise eligible for MO HealthNet. Individuals who are not elderly, disabled, or medically frail must provide proof of workforce participation and individuals who fail to provide proof of workforce participation must be deemed ineligible.

The department must provide premium subsidy and other cost supports for individuals eligible for MO HealthNet benefits to enroll in employer-provided health plans or other private health plans based on cost-effective principles determined by the department.

Beginning January 1, 2015, the department must obtain health care coverage for persons who have an income between 100% and 133% percent of the FPL for the applicable family size, for the applicable year as converted to the MAGI equivalent net income standard, who meet all other requirements for the alternative benefits package, and have not been determined to be medically frail by the department, through a health care exchange operating in this state or an employer. The department must 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 must require cost sharing to the maximum extent allowed by law.

All individuals who meet the definition of medically frail must receive all benefits that they are eligible to receive under Sections 208.152, 208.900, 208.903, 208.909, and 208.930. The Department of Social Services, in conjunction with the Department of Mental Health and the Department of Health and Human Services,

must establish a screening process for determining whether an individual is medically frail and must enroll all eligible individuals who are deemed 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 of Social Services. However, any eligible individual may opt out of the health home program.

HEALTH CARE HOMES PROGRAM (Section 208.997)

The division must 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. The program must provide payment to primary care clinics, community mental health centers, and other appropriate providers for care coordination for individuals deemed medically frail. Clinics must meet certain specified criteria, including the capacity to develop care plans; a dedicated care coordinator; an adequate number of clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement; and the capability to maintain and use a disease registry. 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 homes outcomes monitoring and improvement system. These provisions must be implemented in a way that it does not conflict with federal requirements for health care home participation by MO HealthNet Program recipients and must not be construed to limit the department's ability to create health care homes for participants in a managed care plan.

MO HEALTHNET MANAGED CARE (Sections 208.998 and 208.999)

Except for those individuals deemed medically frail, recipients of the alternative package of MO HealthNet benefits must receive covered services through health plans offered by managed care entities authorized by the department.

The health plans must resemble commercially available health plans while complying with federal Medicaid Program requirements as authorized by federal law or through a federal waiver and may include accountable care organizations, administrative service organizations, and managed care organizations paid on a capitated basis; must promote, to the greatest extent possible, the opportunity for children and their parents to be covered under the same plan; must offer plans statewide; must include cost sharing for out patient services to the maximum extent allowed by federal law; may include other co-payments and provide incentives that

encourage and reward the prudent use of the health benefit provided; must encourage access to care through provider rates that include pay-for-performance and are comparable to commercial rates and the department must determine pay-for-performance provisions that managed care organizations must execute and must provide incentives for managed care organizations that perform well; must provide incentives, including shared risk and savings, to health plans and providers to encourage cost-effective delivery of care; must 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; may provide multiple plan options and reward participants for choosing a low-cost plan; must include the services of community mental health centers; and must include the services of health providers as required by federal law and must meet the payment requirements for the health providers as required by federal law.

The department may designate that certain health care services be excluded from the health plans if it is determined cost effective by the department. The department may accept regional proposals as an additional option for beneficiaries. The proposals may be submitted by accountable care organizations or other organizations and entities. The department must advance the development of systems of care for medically complex children who are MO HealthNet benefit recipients 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. The entities must be treated as accountable care organizations. The department, in collaboration with plans and providers, must establish uniform utilization review protocols to be used by all authorized health plans.

The department must establish a competitive bidding process for contracting with managed care plans. The bill requires:

(1) The department to solicit bids only from bidders who offer, or through an associated company offer, an identical or substantially similar plan, in services provided and network, within a health care exchange in the state;

(2) The bidder, or the bidder and the associated company, if the bidder has formed a partnership for purposes of its bid, to include in its bid a process to allow MO HealthNet recipients who choose its plan to be automatically enrolled in the corresponding exchange plan if the recipient's income increases resulting in his or her ineligibility for MO HealthNet benefits. The bidder must also include in its bid a process to allow an individual enrolled in an

identical or substantially similar exchange plan in the state, in the event his or her income decreases resulting in eligibility for MO HealthNet, to be enrolled in MO HealthNet after an application is received and the applicant is deemed eligible;

(3) The department to select a minimum of two conforming bids and may select up to a maximum number of bids equal to the number of anticipated participants in a region by 100,000;

(4) The department to consider, in determining other accepted bids, the cost to Missouri taxpayers, the extent of the network of health care providers offering services within the bidder's plan, additional services offered to recipients under the bidder's plan, the bidder's history of providing managed care plans for similar populations in Missouri or other states, and any other criteria that the department deems relevant to ensure MO HealthNet benefits are provided to recipients in a way that saves taxpayer money and improves the health outcomes of recipients;

(5) The department to accept the lowest conforming bid; and

(6) Any managed care organization that enters into a contract with the state to provide managed care plans to be required to fulfill the terms of the contract and provide the plans for at least 12 months or longer if provided in the contract. The state must not increase the reimbursement rate provided to the managed care organization during the contract period above the rate included in the contract. If the organization breaches the contract, the state must be entitled to bring an action against the organization for any remedy allowed by law or equity and must also recover any and all damages provided by law, including liquidated damages in an amount determined by the department during the bidding process. These provisions cannot be construed to preclude the department or the state 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.

Any participant enrolling in a managed care plan must have the ability to choose his or her plan. In the enrollment process, a participant must be provided a list of all plans available ranked by the relative actuarial value of each plan and each participant must be informed 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 amount received will be determined by the department according to the department's best judgment as to the portion that will bring the maximum savings to Missouri taxpayers. If a participant fails or refuses to select a plan, the department must determine rules for

auto-assignment that must include incentives for low-cost bids and improved health outcomes as determined by the department. Auto-enrolled participants must be assigned to the highest performing managed care organization. These provisions cannot be construed to require the department to terminate any existing managed care contract or to extend any managed care contract.

All MO HealthNet managed care plans must provide coverage for ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse treatment, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness care, and chronic disease management; pediatric services, including oral and vision care; and any other services required by federal law. No MO HealthNet plan or program may 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.

The division must require managed care plans to provide a high-deductible health plan option for uninsured adults 19 years of age or older and younger than 65 years of age with an income of less than 100% of the FPL as converted to the MAGI equivalent net income standard who are enrolled in managed care plans under these provisions. The plan must include a minimum deductible of $1,000 and coverage for benefits as specified by department rule after meeting the $1,000 deductible; an account, funded by the department, of at least $1,000 per adult to pay the medical costs for the initial deductible in the form of a prepaid card; preventative care, as defined by department rule, that is not subject to the deductible and does not require a payment of money from the account; a basic benefits package if annual medical costs exceed $1,000; and primary care provider visits, as defined by the department by rule, that are not subject to the deductible and do not require a payment from the prepaid card.

As soon as practicable, the health plan must establish and maintain a record keeping system for each health care visit or service received by recipients. The plan must require that the recipient's prepaid card number be entered or the electronic strip must be swiped by the health care provider for every health care visit or service received by the recipient regardless of the balance on the card. The information may only include the date of service, the name of the provider, and a general description of the visit or service provided. The plan must keep a complete history of all health care visits and services for which the recipient's prepaid card is entered or swiped. If necessary under state or federal law, a recipient must be required to provide a written waiver for

disclosure of this information as a condition of participation in the prepaid card incentive. The department must determine the proportion of the amount left in a participant's account at the end of the plan year that must be paid to the participant for saving taxpayer money and the method of payment. The department must determine the proportion of a participant's account that must be used to subsidize premiums to facilitate a participant's transition from health coverage under MO HealthNet to private insurance based on cost-effective principles determined by the department.

The department must require managed care plans under these provisions 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 these provisions must enroll. Participants who obtain specified primary care and preventive services and who participate or refrain from specified activities to improve the recipient's overall health are eligible to receive an annual cash payment. The department must establish by rule the specific primary care and preventive services and activities to be included in the program and the amount of any annual cash payments or cash equivalents if federal financial participation is not obtained for the cash payments.

A MO HealthNet recipient is eligible to participate in only one of either the high deductible health plan or the incentive program for chronic conditions. No cash payments, incentives, or credits paid to or on behalf of a participant under a MO HealthNet Program are to be considered income in any means-tested benefit program unless otherwise required by law or department rule.

Managed care entities must inform a participant who chooses the high-deductible health plan that the participant may lose his or her incentive payment if he or she utilizes emergency services for non-emergent purposes and requires the information to be included on every electronic and paper correspondence between the managed care plan and the participant.

The department must seek all necessary waivers and state plan amendments from the federal Department of Health and Human Services that are necessary to implement the provisions of the bill. No provisions of the bill may be implemented unless the waivers and state plan amendments are approved.

Managed care organizations must be required to provide to the department, on at least a yearly basis, and the department must publicly report within 30 days of receipt, including posting on the department’s website, at least the following information:

(1) Medical loss ratios for each managed care organization

compared with the 85% medical loss ratio for large group commercial plans under Public Law 111-148 and, where applicable, with the state's administrative costs in its fee-for-service MO HealthNet program;

(2) Medical loss ratios of each of a managed care organization's capitated specialized subcontractors, such as mental health or dental health, to make sure that the subcontractors' own administrative costs are not erroneously deemed to be expenditures on health care; and

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

Managed care organizations must be required to maintain medical loss ratios of at least 85% for MO HealthNet operations. If a managed care organization's medical loss ratio falls below 85% in a given year, the managed care plan must be required to refund to the state the portion of the capitation rates paid to the managed care plan in the amount equal to the difference between the plan's medical loss ratio and 85% of the capitated payment to the managed care organization.

The department must be required to ensure that managed care organizations establish and maintain adequate provider networks to serve the Medicaid population and to include these standards in its contracts with managed care organizations. Managed care organizations must be required to establish and maintain health plan provider networks in geographically accessible locations in accordance with travel distances specified by the department in its managed care contracts and as required by the Department of Insurance, Financial Institutions and Professional Registration.

Managed care plans' networks must consist of, at minimum, hospitals, physicians, advanced practice nurses, behavioral health providers, community mental health centers, substance abuse providers, dentists, emergent and non-emergent transportation services, federally qualified health centers, rural health centers, women's health specialists, local public health agencies, and all other provider types necessary to ensure sufficient capacity to make available all services in accordance with the service accessibility standards specified by the Department of Social Services.

Managed care organizations must be required to post all of their provider networks on-line and must regularly update their postings

of these networks on a timely basis regarding all changes to provider networks. A provider who is seeing only existing patients under a given managed care plan must not be listed.

The Department of Social Services must be required to contract with an independent organization that does not contract or consult with managed care plans or insurers to conduct secret shopper surveys of Medicaid managed care plans for compliance with provider network adequacy standards on a regular basis, to be funded by the managed care organizations out of their administrative budgets. Secret shopper surveys are a quality assurance mechanism under which individuals posing as managed care enrollees will test the availability of timely appointments with providers listed as participating in the network of a given plan for new patients. The testing must be conducted with various categories of providers, with the specific categories rotated for each survey and with no advance notice provided to the managed care plan. If an attempt to obtain a timely appointment is unsuccessful, the survey records the particular reason for the failure, such as the provider not participating in Medicaid at all, not participating in Medicaid under the plan that listed it and was being tested, or participating under that plan but only for existing patients.

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

The provider compensation rates for each category of provider must also be reported by the managed care organizations to help ascertain whether they are paying enough to engage providers comparable to the number of providers available to commercially insured individuals, as required by federal law, and compared, where applicable, to the state’s own provider rates for the same categories of providers.

Managed care organizations must be required to ensure sufficient access to out-of-network providers when necessary to meet the health needs of enrollees in accordance with standards developed by the department and included in the managed care contracts.

Managed care organizations must be required to provide, on a quarterly basis and for prompt publication, at least the following information related to service utilization, approval, and denial:

(1) Service utilization data, including how many of each type of service was requested and delivered, subtotaled by age, race, gender, geographic location, and type of service;

(2) Data regarding denials and partial denials by managed care organizations or their subcontractors each month for each category of services provided to Medicaid enrollees. Denials include partial denials whereby a requested service is approved but in a different amount, duration, scope, frequency, or intensity than requested; and

(3) Data regarding complaints, grievances, and appeals, including numbers of complaints, grievances, and appeals filed, subtotaled by race, age, gender, geographic location, and type of service, including the time frame data for hearings and decisions made and the dispositions and resolutions of complaints, grievances, or appeals.

Managed care organizations must be required to disclose the following information:

(1) Plan disenrollment data by cause, number of months with the particular managed care plan prior to disenrollment, and form of enrollment such as passive enrollment or enrollee election;

(2) Quality measurement data including, at minimum, all health plan employer data and information set (HEDIS) measures, early periodic screening, diagnosis, and treatment (EPSDT) screening data, and other appropriate utilization measures;

(3) Consumer satisfaction survey data;

(4) Enrollee telephone access reports including the number of unduplicated calls by enrollees, average wait time before managed care organization or subcontractor response, busy signal rate, and enrollee telephone call abandonment rate;

(5) Data regarding the average cost of care of individuals whose care is reported as having been actively managed by the managed care organization versus the average cost of care of the managed care organization's population generally. For purposes of this section, the phrase "actively managed by the managed care organization" means the managed care organization has actually developed a care plan for the particular individual and is implementing it as opposed to reacting to prior authorization requests as they come in, reviewing usage data, or monitoring doctors with high utilization;

(6) Data regarding the number of enrollees whose care is being actively managed by the managed care organization, broken down by whether the individuals are hospitalized, have been hospitalized in the last 30 days, or have not recently been hospitalized;

(7) Results of network adequacy reviews including geo-mapping and waiting times, stratified by factors including provider type, geographic location, urban or rural areas, any findings of adequacy or inadequacy, and any remedial actions taken. This information must also include any findings with respect to the accuracy of networks as published by managed care organizations, including providers found to be not participating and not accepting new patients;

(8) Provider change data indicating how many enrollees changed their primary care provider by cause, months of enrollment, and form of enrollment such as passive enrollment or enrollee election;

(9) Any data related to preventable hospitalizations, hospital-acquired infections, preventable adverse events, and emergency department admissions; and

(10) Any additional reported data obtained from the managed care plans that relates to the performance of the plans in terms of cost, quality, access to providers or services, or other measures.

HEALTH INSURANCE COVERAGE (Section 376.998)

This bill prohibits any health insurance mandate that is applicable to health benefit plans written by a health carrier from applying to excepted benefit plans. For purposes of the exemption under this section, a "health insurance mandate" means a state requirement for a health carrier to offer or provide coverage for:

(1) A treatment by a particular type of health care provider;

(2) A certain treatment or service, including procedures, medical equipment, or drugs that are used in connection with a treatment or service; and

(3) Screening, diagnosis, or treatment of a particular disease or condition.

The bill requires that all excepted benefit plans issued on or after January 1, 2015, must include a disclaimer printed in no less than 12-point font on the front of the policy, certificate, application and enrollment form, and all advertising materials which states:

"NOTICE TO CONSUMER: THIS PLAN IS NOT CONSIDERED "MINIMUM ESSENTIAL COVERAGE" AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. THIS PLAN HAS LIMITS AND EXCLUSIONS AND MAY NOT COVER ALL HEALTH BENEFITS OR SERVICES."

If plan identification cards are issued to enrollees of excepted benefit plans, the cards must clearly and conspicuously state on the front of the card: "THIS IS NOT MINIMUM ESSENTIAL COVERAGE."

These provisions apply to all insurers that provide coverage to residents of this state that is issued or renewed on or after January 1, 2015.

INSURANCE FOR DENTAL SERVICES (Section 376.1060)

This bill prohibits a contracting entity from selling, assigning, or otherwise granting access to the dental services of a participating provider under a health care contract unless expressly authorized by the health care contract. The health care contract must specifically provide that one purpose of the contract is the selling, assigning, or giving the contracting entity rights to the services of the participating provider, including network plans.

Upon entering into a contract with a participating provider and upon request by a participating provider, a contracting entity must properly identify any third party that has been granted access to the dental services of the participating provider. Any contracts entered into or renewed on or after the effective date of these provisions must require that at any time a contracting entity sells, assigns, or otherwise grants access to the dental services of a participating provider, it must allow the participating provider the option to refuse to continue to provide services to third party entities that have purchased, been assigned, or otherwise been granted access to the dental services of a participating provider by the contracting entity.

A contracting entity that sells, assigns, or otherwise grants access to the dental services of a participating provider must maintain an Internet website or a toll-free telephone number through which the participating provider may obtain a listing, updated at least every 90 days, of the third parties that have been granted access to the participating provider's dental services. Any third party entity within 30 days of purchasing, being assigned, or otherwise accessing the dental services of a participating provider must provide to the participating provider a listing of the 100 most frequently reimbursed American Dental Association Current Dental Terminology codes by the third party entity and the amount by which the third party entity reimburses a participating provider.

A contracting entity that sells, assigns, or otherwise grants access to a participating provider's dental services must ensure

that an explanation of benefits or remittance advice furnished to the participating provider that delivers dental services under the health care contract identifies the contractual source of any applicable discount. All third parties that have contracted with a contracting entity to purchase, be assigned, or otherwise be granted access to the participating provider's discounted rate must comply with the participating provider's contract including all requirements to encourage access to the participating provider and pay the participating provider pursuant to the rates of payment and methodology set forth in that contract unless otherwise agreed to by a participating provider. A contracting entity is deemed in compliance with these provisions when the insured's identification card provides information which identifies the insurance carrier to be used to reimburse the participating provider for the covered dental services.

MEDICAID SAVINGS BUDGET AND TAXPAYER PROTECTION FUND (Section 660.013)

This bill creates the "Medicaid Savings Budget and Taxpayer Protection Fund." The Office of Administration (OA) in conjunction with the Departments of Social Services and Mental Health must track the general revenue savings achieved due to the reduction in the number of participants determined eligible under other MO HealthNet categories such as CHIP and Ticket to Work or state programs paid for with state-only funds as a result of expansion of Medicaid eligibility to 133% of the federal poverty level and as a result of federal subsidies available under the federal health care exchange, whether federally facilitated, state based, or operated on a partnership basis.

The Department of Social Services (DSS) must determine the additional pharmacy provider assessment revenue generated as a result of expansion of Medicaid eligibility to 133% of the federal poverty level. DSS must determine the amount of that additional pharmacy provider assessment that is needed to make payments to pharmacies for services. Any amount generated that is not needed for the payments must be reported as excess and may be transferred to the Medicaid Savings State Budget and Taxpayer Protection Fund ("The fund").

DSS must also determine the additional hospital provider assessment revenue generated as a result of expansion of Medicaid eligibility to 133% of the federal poverty level. DSS must determine the amount of the additional hospital provider assessment that is needed to make payments to hospitals for services to newly eligible participants. Any amount generated that is not needed for the payment must be reported as excess and may be transferred to the fund.

By October 1 of each year, OA must report the amounts pursuant in this fund in the prior fiscal year to the Governor and the appropriate committees in the General Assembly. OA must, subject to appropriation, transfer the amounts reported to the fund. The transfers must be made in three installments of relatively equal size no later than November, February, and May of each fiscal year.

Subject to appropriation, moneys in the fund must be used solely to pay the general revenue share of costs for individuals eligible for Medicaid services as a result of expansion of eligibility to 133% of the federal poverty level under this bill.

If revenue in the fund is not sufficient to cover the general revenue share of the costs outlined in this bill, rates paid to providers for those services must be reduced accordingly. Provider rates that must be subject to reduction under this bill must include rates paid to hospitals, federally qualified health centers, rural health clinics, community mental health centers, pharmacies, physicians, chiropractors, and Medicaid managed care plans.

Also, if, due to federal requirements, rates to one or more of the provider types listed in this bill cannot be reduced sufficiently to cover the costs outlined in this bill, rates to the remaining providers listed in this bill must be reduced by no more than an additional 5% percent.

This bill also provides that if the United States Congress passes legislation to convert the Medicaid program into a block grant program, DSS must seek the necessary approval to operate Missouri's Medicaid program under a block grant program within six months of federal implementation of such program.

PROPONENTS: Supporters say that currently, if a person is an elected official the county is required to provide medical insurance coverage for that official, regardless of whether the official receives compensation. Many county surveyors are not compensated but under current law the counties are required to provide insurance anyway. In some counties this has resulted in having surveyors who are not cooperating with the counties and are running for office just to obtain free medical insurance. The bill requires the counties to only provide insurance to compensated elected officials, but still allows the counties to provide insurance to uncompensated elected officials if the county so chooses.

Testifying for the bill was Senator Cunningham.

OPPONENTS: There was no opposition voiced to the committee.