Basye (1)

1130S06.01F

Mr. Speaker: I am instructed by the Senate to inform the House of Representatives that the Senate has taken up and passed

SS SCS HCS HB 399 entitled:

AN ACT

To repeal sections 192.007, 208.909, 208.918, 208.924, 208.930, 376.427, 376.690, 376.1040, 376.1042, and 376.1224, RSMo, and to enact in lieu thereof eighteen new sections relating to healthcare, with an emergency clause for a certain section.

With SA 1, SA 2, SA 3

EC - Adopted

In which the concurrence of the House is respectfully requested.

Respectfully,

Adriane D. Crouse

Adriane D. Crouse
Secretary of the Senate

RECF
MAY 15 20
CHIE

1130S06.03S

SENATE AMENDMENT NO. 1

Offered by Hoskins of 21

Amend SCS/HCS/House Bill No. 399, Page 3, Section 376.1224, Line 82,

by striking "and" as it appears the third time on said line and inserting in lieu thereof the following: "or".

Offered 5/7/19
Adopted "

1130S06.01F

8125S19.01S

SENATE AMENDMENT NO. 2

Offered by Walsh of 13th

Amend SCS/HCS/HB Bill No. 399, Page 1, Section title, Line 3,

by inserting after "disabilities", ", with an emergency clause for a certain section"; and

Further amend said bill, Page 1, Section A, Line 2, by inserting after all of said line the following:

"208.930. 1. As used in this section, the term "department" shall mean the department of health and senior services.

2. Subject to appropriations, the department may provide financial assistance for consumer-directed personal care assistance services through eligible vendors, as provided in sections 208.900 through 208.927, to each person who was participating as a non-MO HealthNet eligible client pursuant to sections 178.661 through 178.673 on June 30, 2005, and who:

(1) Makes application to the department;

(2) Demonstrates financial need and eligibility under subsection 3 of this section;

(3) Meets all the criteria set forth in sections 208.900 through 208.927, except for subdivision (5) of subsection 1 of section 208.903;

(4) Has been found by the department of social services not to be eligible to participate under guidelines established by the MO HealthNet plan; and

Offered 5/7/13
Adopted "

(5) Does not have access to affordable employer-sponsored health care insurance or other affordable health care coverage for personal care assistance services as defined in section 208.900. For purposes of this section, "access to affordable employer-sponsored health care insurance or other affordable health care coverage" refers to health insurance requiring a monthly premium less than or equal to one hundred thirty-three percent of the monthly average premium required in the state's current Missouri consolidated health care plan.

Payments made by the department under the provisions of this section shall be made only after all other available sources of payment have been exhausted.

3. (1) In order to be eligible for financial assistance for consumer-directed personal care assistance services under this section, a person shall demonstrate financial need, which shall be based on the adjusted gross income and the assets of the person seeking financial assistance and such person's spouse.

(2) In order to demonstrate financial need, a person seeking financial assistance under this section and such person's spouse must have an adjusted gross income, less disability-related medical expenses, as approved by the department, that is equal to or less than three hundred percent of the federal poverty level. The adjusted gross income shall be based on the most recent income tax return.

(3) No person seeking financial assistance for personal care services under this section and such person's spouse shall have assets in excess of two hundred fifty thousand dollars.

4. The department shall require applicants and the

applicant's spouse, and consumers and the consumer's spouse, to provide documentation for income, assets, and disability-related medical expenses for the purpose of determining financial need and eligibility for the program. In addition to the most recent income tax return, such documentation may include, but shall not be limited to:

(1) Current wage stubs for the applicant or consumer and the applicant's or consumer's spouse;

(2) A current W-2 form for the applicant or consumer and the applicant's or consumer's spouse;

(3) Statements from the applicant's or consumer's and the applicant's or consumer's spouse's employers;

(4) Wage matches with the division of employment security;

(5) Bank statements; and

(6) Evidence of disability-related medical expenses and proof of payment.

5. A personal care assistance services plan shall be developed by the department pursuant to section 208.906 for each person who is determined to be eligible and in financial need under the provisions of this section. The plan developed by the department shall include the maximum amount of financial assistance allowed by the department, subject to appropriation, for such services.

6. Each consumer who participates in the program is responsible for a monthly premium equal to the average premium required for the Missouri consolidated health care plan; provided that the total premium described in this section shall not exceed five percent of the consumer's and the consumer's spouse's adjusted gross income for the year involved.

7. (1) Nonpayment of the premium required in subsection 6 shall result in the denial or termination of assistance, unless the person demonstrates good cause for such nonpayment.

(2) No person denied services for nonpayment of a premium shall receive services unless such person shows good cause for nonpayment and makes payments for past-due premiums as well as current premiums.

(3) Any person who is denied services for nonpayment of a premium and who does not make any payments for past-due premiums for sixty consecutive days shall have their enrollment in the program terminated.

(4) No person whose enrollment in the program is terminated for nonpayment of a premium when such nonpayment exceeds sixty consecutive days shall be reenrolled unless such person pays any past-due premiums as well as current premiums prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument.

8. (1) Consumers determined eligible for personal care assistance services under the provisions of this section shall be reevaluated annually to verify their continued eligibility and financial need. The amount of financial assistance for consumer-directed personal care assistance services received by the consumer shall be adjusted or eliminated based on the outcome of the reevaluation. Any adjustments made shall be recorded in the consumer's personal care assistance services plan.

(2) In performing the annual reevaluation of financial need, the department shall annually send a reverification eligibility form letter to the consumer requiring the consumer to respond within ten days of receiving the letter and to provide

income and disability-related medical expense verification documentation. If the department does not receive the consumer's response and documentation within the ten-day period, the department shall send a letter notifying the consumer that he or she has ten days to file an appeal or the case will be closed.

(3) The department shall require the consumer and the consumer's spouse to provide documentation for income and disability-related medical expense verification for purposes of the eligibility review. Such documentation may include but shall not be limited to the documentation listed in subsection 4 of this section.

9. (1) Applicants for personal care assistance services and consumers receiving such services pursuant to this section are entitled to a hearing with the department of social services if eligibility for personal care assistance services is denied, if the type or amount of services is set at a level less than the consumer believes is necessary, if disputes arise after preparation of the personal care assistance plan concerning the provision of such services, or if services are discontinued as provided in section 208.924. Services provided under the provisions of this section shall continue during the appeal process.

(2) A request for such hearing shall be made to the department of social services in writing in the form prescribed by the department of social services within ninety days after the mailing or delivery of the written decision of the department of health and senior services. The procedures for such requests and for the hearings shall be as set forth in section 208.080.

10. Unless otherwise provided in this section, all other

provisions of sections 208.900 through 208.927 shall apply to individuals who are eligible for financial assistance for personal care assistance services under this section.

11. The department may promulgate rules and regulations, including emergency 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. Any provisions of the existing rules regarding the personal care assistance program promulgated by the department of elementary and secondary education in title 5, code of state regulations, division 90, chapter 7, which are inconsistent with the provisions of this section are void and of no force and effect.

[12. The provisions of this section shall expire on June 30, 2019.]"; and

Further amend said bill, Page 8, Section 376.1224, Line 242 by inserting after all of said line the following:

"Section B. Because of the need to ensure continuity of care and stability of necessary services, the repeal and reenactment of section 208.930 of this act is deemed necessary for the immediate preservation of the public health, welfare, peace and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the repeal and reenactment of section 208.930 of this act shall be in full force and effect upon its passage and approval."; and

Further amend the title and enacting clause accordingly.

SENATE AMENDMENT NO. 3

Offered by Schupp of 24th

Amend SCS/HCS/House Bill No. 399, Page 1, Section title, Line 3,

of the title, by striking "health care for persons with disabilities" and inserting in lieu thereof the following: "private health insurance"; and

Further amend said bill and page, Section A, Line 2, by inserting after all of said line the following:

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

(1) "Emergency medical condition", the same meaning given to such term in section 376.1350;

(2) "Facility", the same meaning given to such term in section 376.1350;

(3) "Health care professional", the same meaning given to such term in section 376.1350;

(4) "Health carrier", the same meaning given to such term in section 376.1350;

(5) "Unanticipated out-of-network care", health care services received by a patient in an in-network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged.

2. (1) Health care professionals [may] shall send any claim for charges incurred for unanticipated out-of-network care to the patient's health carrier within one hundred eighty days of

Offered 5/7/19

the delivery of the unanticipated out-of-network care on a U.S. Centers of Medicare and Medicaid Services Form 1500, or its successor form, or electronically using the 837 HIPAA format, or its successor.

(2) Within forty-five processing days, as defined in section 376.383, of receiving the health care professional's claim, the health carrier shall offer to pay the health care professional a reasonable reimbursement for unanticipated out-of-network care based on the health care professional's services. If the health care professional participates in one or more of the carrier's commercial networks, the offer of reimbursement for unanticipated out-of-network care shall be the amount from the network which has the highest reimbursement.

(3) If the health care professional declines the health carrier's initial offer of reimbursement, the health carrier and health care professional shall have sixty days from the date of the initial offer of reimbursement to negotiate in good faith to attempt to determine the reimbursement for the unanticipated out-of-network care.

(4) If the health carrier and health care professional do not agree to a reimbursement amount by the end of the sixty-day negotiation period, the dispute shall be resolved through an arbitration process as specified in subsection 4 of this section.

(5) To initiate arbitration proceedings, either the health carrier or health care professional must provide written notification to the director and the other party within one hundred twenty days of the end of the negotiation period, indicating their intent to arbitrate the matter and notifying the director of the billed amount and the date and amount of the

final offer by each party. A claim for unanticipated out-of-network care may be resolved between the parties at any point prior to the commencement of the arbitration proceedings. Claims may be combined for purposes of arbitration, but only to the extent the claims represent similar circumstances and services provided by the same health care professional, and the parties attempted to resolve the dispute in accordance with subdivisions (3) to (5) of this subsection.

(6) No health care professional who sends a claim to a health carrier under subsection 2 of this section shall send a bill to the patient for any difference between the reimbursement rate as determined under this subsection and the health care professional's billed charge.

3. (1) When unanticipated out-of-network care is provided, the health care professional who sends a claim to a health carrier under subsection 2 of this section may bill a patient for no more than the cost-sharing requirements described under this section.

(2) Cost-sharing requirements shall be based on the reimbursement amount as determined under subsection 2 of this section.

(3) The patient's health carrier shall inform the health care professional of its enrollee's cost-sharing requirements within forty-five processing days of receiving a claim from the health care professional for services provided.

(4) The in-network deductible and out-of-pocket maximum cost-sharing requirements shall apply to the claim for the unanticipated out-of-network care.

4. The director shall ensure access to an external

arbitration process when a health care professional and health carrier cannot agree to a reimbursement under subdivision (3) of subsection 2 of this section. In order to ensure access, when notified of a parties' intent to arbitrate, the director shall randomly select an arbitrator for each case from the department's approved list of arbitrators or entities that provide binding arbitration. The director shall specify the criteria for an approved arbitrator or entity by rule. The costs of arbitration shall be shared equally between and will be directly billed to the health care professional and health carrier. These costs will include, but are not limited to, reasonable time necessary for the arbitrator to review materials in preparation for the arbitration, travel expenses and reasonable time following the arbitration for drafting of the final decision.

5. At the conclusion of such arbitration process, the arbitrator shall issue a final decision, which shall be binding on all parties. The arbitrator shall provide a copy of the final decision to the director. The initial request for arbitration, all correspondence and documents received by the department and the final arbitration decision shall be considered a closed record under section 374.071. However, the director may release aggregated summary data regarding the arbitration process. The decision of the arbitrator shall not be considered an agency decision nor shall it be considered a contested case within the meaning of section 536.010.

6. The arbitrator shall determine a dollar amount due under subsection 2 of this section between one hundred twenty percent of the Medicare-allowed amount and the seventieth percentile of the usual and customary rate for the unanticipated out-of-network

care, as determined by benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations.

7. When determining a reasonable reimbursement rate, the arbitrator shall consider the following factors if the health care professional believes the payment offered for the unanticipated out-of-network care does not properly recognize:

(1) The health care professional's training, education, or experience;

(2) The nature of the service provided;

(3) The health care professional's usual charge for comparable services provided;

(4) The circumstances and complexity of the particular case, including the time and place the services were provided; and

(5) The average contracted rate for comparable services provided in the same geographic area.

8. The enrollee shall not be required to participate in the arbitration process. The health care professional and health carrier shall execute a nondisclosure agreement prior to engaging in an arbitration under this section.

9. [This section shall take effect on January 1, 2019.

10.] The department of insurance, financial institutions and professional registration may promulgate rules and fees as necessary to implement the provisions of this section, including but not limited to procedural requirements for arbitration. 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, 2018, shall be invalid and void."; and

Further amend the title and enacting clause accordingly.