CCS SS SCS HCS HB 399 -- HEALTHCARE

(Vetoed by the Governor)

This bill modifies several provisions relating to the health care services.

SUBSTANCE USE DISORDERS

This bill establishes the "Ensuring Access to High Quality Care for the Treatment of Substance Use Disorders Act".

The bill requires that medication-assisted treatment (MAT) services shall include pharmacologic and behavioral therapies.

All MAT medications must be placed on the lowest cost-sharing tier of the formulary managed by the health insurer or the pharmacy benefits manager.

MAT services shall not be subject to:

(1) Annual or lifetime dollar limitations;

(2) Financial requirements and quantitative treatment limitations that do not comply with the Mental Health Parity and Addition Equity Act of 2008;

(3) Step therapy that conflicts with a prescribed course of treatment; and

(4) Prior authorization for MAT services.

The health care benefits and MAT services required by the bill apply to all health insurance plans in the state.

Any treatment program must disclose the MAT services it provides, as well as which of its level of care have been certified.

MO HealthNet must cover the MAT medications and services provided for in this section.

Drug courts and other diversion programs must ensure that all persons under their care are assessed for substance use disorders and make available MAT services (Sections 191.1164 to 191.1168, RSMo).

QUALIFICATIONS OF THE DIRECTOR OF THE DEPARTMENT OF HEALTH AND SENIOR SERVICES

This bill requires the Director of the Department of Health and Senior Services (DHSS) to have specified qualifications regarding education and experience (Section 192.007).

PERSONAL CARE ASSISTANCE VENDORS

Currently, vendors of consumer-directed services are required to monitor the performance of personal care assistance service plans. This bill requires the consumer to permit the vendor to comply with its quality assurance and supervision process, including bi-annual face-to-face home visits and monthly case management activities. During the home visits, the vendor shall document if the attendant was present and providing services as set forth in the plan of care and report to the DHSS if the attendant is not present or providing services, which may result in a suspension of services to the consumer.

The bill repeals language permitting the DHSS to establish certain pilot projects for telephone tracking systems.

This bill requires vendors to notify consumers during orientation that falsification of personal care attendant time sheets shall be considered and reported to the DHSS as fraud.

A vendor shall submit an annual financial statement audit or annual financial statement review performed by a certified public accountant to the DHSS upon request. The DHSS shall require the vendor to maintain a business location in compliance with any and all city, county, state, and federal requirements. Additionally, this bill requires the DHSS to create a consumer-directed services division provider certification manager course. State or federal funds shall not be authorized or expended if the owner, primary operator, certified manager, or any direct employee of the consumer-directed services vendor is also the personal care attendant, unless such person provides services solely on a temporary basis for no more than three days in a 30-day period.

Currently, a consumer's services may be discontinued if the consumer has falsified records. This bill adds language to include providing false information of his or her condition, functional capacity, or level of care needs (Sections 208.909, 208.918, and 208.924).

CONSUMER DIRECTED SERVICES

This bill extends the sunset date for financial assistance for consumer-directed personal care assistance services from June 30, 2019, to June 30, 2025 (Section 208.930).

INTERACTIVE ASSESSMENT TOOL FOR CERTAIN HOME AND COMMUNITY-BASED SERVICES

This bill requires DHSS, subject to appropriations, to develop an interactive assessment tool for utilization by the Division of Senior and Disability Services when implementing the assessment and authorization process for home and community-based services authorized by the division (Section 208.935).

OFFENDER MO HEALTHNET BENEFITS

This bill specifies that MO HealthNet benefits shall be suspended, rather than canceled or terminated, for an offender entering a correctional facility or jail if the Department of Social Services is notified of the person's entry into the correctional center or jail, the person is enrolled in MO HealthNet at the time of his or her incarceration, and the person is otherwise eligible for MO HealthNet benefits but for his or her incarcerated status. Upon release from incarceration, the suspension shall end and the person shall continue to be eligible for MO HealthNet benefits until such time as he or she is otherwise ineligible.

The Department of Corrections shall notify the Department of Social Services within 20 days of receiving information that a person receiving MO HealthNet benefits is or will become an offender in a correctional center or jail and within 45 days prior to the release of such person whose benefits have been suspended under this bill. City, county, and private jails shall likewise notify the Department of Social Services within 10 days of receiving information that a person receiving MO HealthNet benefits is or will be in the custody of the jail (Sections 217.930 and 221.125).

UNANTICIPATED OUT-OF-NETWORK HEALTH CARE SERVICES

Currently, utilizing the unanticipated out-of-network process is optional. This bill requires health care professionals to utilize the process outlined in statute for claims of charges for unanticipated out-of-network care (Section 376.690).

MULTIPLE EMPLOYER WELFARE

The bill allows multiple employer self-insured health plans having a certificate of authority approved by the Director of the Department of Insurance, Financial Institutions and Professional Registration to offer such plans to the public. Health carriers acting as an administrator for a plan shall permit any willing licensed broker to market such plans; provided that such broker is appointed and in good standing with the health carrier and completes all required training (Sections 376.1040 and 376.1042).

HEALTH CARE FOR PERSONS WITH DISABILITIES

This bill adds therapeutic care for "developmental or physical disabilities," as defined in the bill, to the insurance coverage mandate for autism spectrum disorders, and makes the mandate applicable to policies issued or renewed on or after January 1, 2020, rather than to group policies only. The bill specifies that autism spectrum disorder will not be subject to any limits on the number of visits an individual may make to an autism service provider. Coverage for therapeutic care provided under the bill for developmental and physical disabilities may be limited to a number of visits per calendar year, provided that additional visits shall be covered if approved and deemed medically necessary by the health benefit plan. Provisions requiring coverage for autism spectrum disorders and developmental or physical disabilities shall not apply to certain grandfathered, pre-empted, or supplemental plans as described in the bill.

This bill repeals a provision of law directing the Department of Insurance, Financial Institutions and Professional Registration to grant small employers waivers from the coverage requirements under certain circumstances. The bill also repeals a provision requiring the department to submit annual reports to the legislature and requiring health carriers to supply certain diagnosis and coverage information for the report.

These provisions apply to policies issued, delivered, or renewed on or after January 1, 2020 (Section 376.1224).

METHODS OF REIMBURSEMENT

This bill prohibits health carriers from restricting methods of reimbursement which require health care providers to pay a fee to redeem the amount of their claim for reimbursement.

Health carriers changing the reimbursement method used shall notify health care providers whether any fee is required to receive reimbursement through the new or different method. For health benefit plans issued, delivered, or renewed on or after August 28, 2019, the provider will be able to select an alternative method of reimbursement which does not require a fee.

Violation of these provisions shall be deemed an unfair trade practice under the Unfair Trade Practice Act (Section 376.1345).