SECOND REGULAR SESSION

[P E R F E C T E D**]**

SENATE BILL NO. 856

90TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR MAXWELL.

Read 1st time January 18, 2000, and 1,000 copies ordered printed.

Read 2nd time January 31, 2000, and referred to the Committee on Aging, Families and Mental Health.

Reported from the Committee February 8, 2000, with recommendation that the bill do pass and be placed on the Consent Calendar.

Taken up February 17, 2000. Read 3rd time and placed upon its final passage; bill passed.

TERRY L. SPIELER, Secretary.

3821S.01P

AN ACT

To repeal section 198.530, RSMo Supp. 1999, relating to long-term care facilities, and to enact in lieu thereof one new section relating to the same subject.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Section 198.530, RSMo Supp. 1999, is repealed and one new section enacted in lieu thereof, to be known as section 198.530, to read as follows:

198.530. 1. If an enrollee in a managed care organization is also a resident in a long-term care facility licensed pursuant to chapter 198, or a continuing care retirement community, as defined in section 197.305, RSMo, such enrollee's managed care organization shall provide the enrollee with the option of receiving the covered service in the long-term care facility which serves as the enrollee's primary residence. For purposes of this section, "managed care organization" means any organization that offers any health plan certified by the department of **[**health**]** **insurance** designed to provide incentives to medical care providers to manage the cost and use of care associated with claims, including, but not limited to, a health maintenance organization and preferred provider organization. The resident enrollee's managed care organization shall reimburse the resident facility for those services which would otherwise be covered by the managed care organization if the following conditions apply:

EXPLANATION--Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

(1) The facility is willing and able to provide the services to the resident; and

(2) The facility and those health care professionals delivering services to residents pursuant to this section meet the licensing and training standards as prescribed by law; and

(3) The facility is certified through Medicare; and

(4) The facility and those health care professionals delivering services to residents pursuant to this section agree to abide by the terms and conditions of the health carrier's contracts with similar providers, abide by patient protection standards and requirements imposed by state or federal law for plan enrollees and meet the quality standards established by the health carrier for similar providers.

2. The managed care organization shall reimburse the resident facility at a rate of reimbursement not less than the Medicare allowable rate pursuant to Medicare rules and regulations.

3. The services in subsection 1 of this section shall include, but are not limited to, skilled nursing care, rehabilitative and other therapy services, and postacute care, as needed. Nothing in this section shall limit the managed care organization from utilizing contracted providers to deliver the services in the enrollee's resident facility.

4. A resident facility shall not prohibit a health carrier's participating providers from providing covered benefits to an enrollee in the resident facility. A resident facility or health care professional shall not impose any charges on an enrollee for any service that is ancillary to, a component of, or in support of the services provided under this section when the services are provided by a health carrier's participating provider, or otherwise create a disincentive for the use of the health carrier's participating providers. Any violation of the requirements of this subsection by the resident facility shall be considered abuse or neglect of the resident enrollee.