FIRST REGULAR SESSION

SENATE BILL NO. 577

94TH GENERAL ASSEMBLY

INTRODUCED BY SENATORS SHIELDS AND GIBBONS.

Read 1st time February 22, 2007, and ordered printed.

TERRY L. SPIELER, Secretary.

2227S.02I

AN ACT

To repeal sections 208.014, 208.151, 208.152, 208.153, 208.201, 208.631, 660.546, 660.547, 660.549, 660.551, 660.553, 660.555, and 660.557, RSMo, and to enact in lieu thereof sixteen new sections relating to the Missouri health improvement act of 2007.

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

Section A. Sections 208.014, 208.151, 208.152, 208.153, 208.201, 208.631, 660.546, 660.547, 660.549, 660.551, 660.553, 660.555, and 660.557, RSMo, are repealed and sixteen new sections enacted in lieu thereof, to be known as sections 191.990, 208.001, 208.151, 208.152, 208.153, 208.201, 208.202, 208.203, 208.631, 208.690, 208.692, 208.694, 208.696, 208.698, 208.950, and 208.955, to read as follows:

191.990. 1. There is hereby created in the state treasury the "Healthcare Technology Fund" which shall consist of all gifts, donations, transfers, and moneys appropriated by the general assembly, and bequests to the fund. The fund shall be administered by the department of social services.

2. The state treasurer shall be custodian of the fund and may approve disbursements from the fund in accordance with sections 30.170 and 30.180, RSMo. Any moneys remaining in the fund at the end of the biennium shall revert to the credit of the general revenue fund. The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

3. Upon appropriation, moneys in the fund shall be used to

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

promote technological advances to improve patient care, decrease administrative burdens, and increase patient and healthcare provider satisfaction. Such programs or improvements on technology shall include encouragement and implementation of technologies intended to improve the safety, quality, and costs of healthcare services in the state including, but not limited to, the following:

(1) Electronic medical records;

(2) Community health records;

(3) Personal health records;

(4) E-prescribing;

(5) Telemedicine; and

(6) Telemonitoring.

4. The department of social services shall promulgate rules setting forth the procedures and methods implementing the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, 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, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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, 2007, shall be invalid and void.

208.001. 1. Sections 191.990, 208.001, 208.151, 208.152, 208.153, 208.201, 208.202, 208.203, 208.631, 208.690, 208.692, 208.694, 208.696, 208.698, 208.950, and 208.955, RSMo, may be known as and may be cited as the "Missouri Health Improvement Act of 2007".

2. In Missouri, the medical assistance program on behalf of needy persons, Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, 42 U.S.C. Section 301 et seq., shall be known as "MO HealthNet". Where the title Medicaid appears it shall be replaced with MO HealthNet throughout Missouri Revised Statutes. Where the title division of medical services appears it shall be replaced with "MO HealthNet Division".

208.151. 1. For the purpose of paying medical assistance on behalf of needy persons and to comply with Title XIX, Public Law 89-97, 1965 amendments

to the federal Social Security Act (42 U.S.C. Section 301 et seq.) as amended, the following needy persons shall be eligible to receive medical assistance to the extent and in the manner hereinafter provided:

(1) All recipients of state supplemental payments for the aged, blind and disabled;

(2) All recipients of aid to families with dependent children benefits, including all persons under nineteen years of age who would be classified as dependent children except for the requirements of subdivision (1) of subsection 1 of section 208.040;

(3) All recipients of blind pension benefits;

(4) All persons who would be determined to be eligible for old age assistance benefits, permanent and total disability benefits, or aid to the blind benefits under the eligibility standards in effect December 31, 1973, or less restrictive standards as established by rule of the family support division, who are sixty-five years of age or over and are patients in state institutions for mental diseases or tuberculosis;

(5) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children except for the requirements of subdivision (2) of subsection 1 of section 208.040, and who are residing in an intermediate care facility, or receiving active treatment as inpatients in psychiatric facilities or programs, as defined in 42 U.S.C. 1396d, as amended;

(6) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children benefits except for the requirement of deprivation of parental support as provided for in subdivision (2) of subsection 1 of section 208.040;

(7) All persons eligible to receive nursing care benefits;

(8) All recipients of family foster home or nonprofit private child-care institution care, subsidized adoption benefits and parental school care wherein state funds are used as partial or full payment for such care;

(9) All persons who were recipients of old age assistance benefits, aid to the permanently and totally disabled, or aid to the blind benefits on December 31, 1973, and who continue to meet the eligibility requirements, except income, for these assistance categories, but who are no longer receiving such benefits because of the implementation of Title XVI of the federal Social Security Act, as amended;

(10) Pregnant women who meet the requirements for aid to families with dependent children, except for the existence of a dependent child in the home;

(11) Pregnant women who meet the requirements for aid to families with dependent children, except for the existence of a dependent child who is deprived of parental support as provided for in subdivision (2) of subsection 1 of section 208.040;

(12) Pregnant women or infants under one year of age, or both, whose family income does not exceed an income eligibility standard equal to one hundred eighty-five percent of the federal poverty level as established and amended by the federal Department of Health and Human Services, or its successor agency;

(13) Children who have attained one year of age but have not attained six years of age who are eligible for medical assistance under 6401 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989). The family support division shall use an income eligibility standard equal to one hundred thirty-three percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency;

(14) Children who have attained six years of age but have not attained nineteen years of age. For children who have attained six years of age but have not attained nineteen years of age, the family support division shall use an income assessment methodology which provides for eligibility when family income is equal to or less than equal to one hundred percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency. As necessary to provide Medicaid coverage under this subdivision, the department of social services may revise the state Medicaid plan to extend coverage under 42 U.S.C. 1396a (a)(10)(A)(i)(III) to children who have attained six years of age but have not attained nineteen years of age as permitted by paragraph (2) of subsection (n) of 42 U.S.C. 1396d using a more liberal income assessment methodology as authorized by paragraph (2) of subsection (r) of 42 U.S.C. 1396a;

(15) The family support division shall not establish a resource eligibility standard in assessing eligibility for persons under subdivision (12), (13) or (14) of this subsection. The division of medical services shall define the amount and scope of benefits which are available to individuals eligible under each of the subdivisions (12), (13), and (14) of this subsection, in accordance with the requirements of federal law and regulations promulgated thereunder;

(16) Notwithstanding any other provisions of law to the contrary, ambulatory prenatal care shall be made available to pregnant women during a

period of presumptive eligibility pursuant to 42 U.S.C. Section 1396r-1, as amended;

(17) A child born to a woman eligible for and receiving medical assistance under this section on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of time determined in accordance with applicable federal and state law and regulations so long as the child is a member of the woman's household and either the woman remains eligible for such assistance or for children born on or after January 1, 1991, the woman would remain eligible for such assistance if she were still pregnant. Upon notification of such child's birth, the family support division shall assign a medical assistance eligibility identification number to the child so that claims may be submitted and paid under such child's identification number;

(18) Pregnant women and children eligible for medical assistance pursuant to subdivision (12), (13) or (14) of this subsection shall not as a condition of eligibility for medical assistance benefits be required to apply for aid to families with dependent children. The family support division shall utilize an application for eligibility for such persons which eliminates information requirements other than those necessary to apply for medical assistance. The division shall provide such application forms to applicants whose preliminary income information indicates that they are ineligible for aid to families with dependent children. Applicants for medical assistance benefits under subdivision (12), (13) or (14) shall be informed of the aid to families with dependent children program and that they are entitled to apply for such benefits. Any forms utilized by the family support division for assessing eligibility under this chapter shall be as simple as practicable;

(19) Subject to appropriations necessary to recruit and train such staff, the family support division shall provide one or more full-time, permanent case workers to process applications for medical assistance at the site of a health care provider, if the health care provider requests the placement of such case workers and reimburses the division for the expenses including but not limited to salaries, benefits, travel, training, telephone, supplies, and equipment, of such case workers. The division may provide a health care provider with a part-time or temporary case worker at the site of a health care provider if the health care provider requests the placement of such a case worker and reimburses the

division for the expenses, including but not limited to the salary, benefits, travel, training, telephone, supplies, and equipment, of such a case worker. The division may seek to employ such case workers who are otherwise qualified for such positions and who are current or former welfare recipients. The division may consider training such current or former welfare recipients as case workers for this program;

(20) Pregnant women who are eligible for, have applied for and have received medical assistance under subdivision (2), (10), (11) or (12) of this subsection shall continue to be considered eligible for all pregnancy-related and postpartum medical assistance provided under section 208.152 until the end of the sixty-day period beginning on the last day of their pregnancy;

(21) Case management services for pregnant women and young children at risk shall be a covered service. To the greatest extent possible, and in compliance with federal law and regulations, the department of health and senior services shall provide case management services to pregnant women by contract or agreement with the department of social services through local health departments organized under the provisions of chapter 192, RSMo, or chapter 205, RSMo, or a city health department operated under a city charter or a combined city-county health department or other department of health and senior services designees. To the greatest extent possible the department of social services and the department of health and senior services shall mutually coordinate all services for pregnant women and children with the crippled children's program, the prevention of mental retardation program and the prenatal care program administered by the department of health and senior services. The department of social services shall by regulation establish the methodology for reimbursement for case management services provided by the department of health and senior services. For purposes of this section, the term "case management" shall mean those activities of local public health personnel to identify prospective Medicaid-eligible high-risk mothers and enroll them in the state's Medicaid program, refer them to local physicians or local health departments who provide prenatal care under physician protocol and who participate in the Medicaid program for prenatal care and to ensure that said high-risk mothers receive support from all private and public programs for which they are eligible and shall not include involvement in any Medicaid prepaid, case-managed programs;

(22) By January 1, 1988, the department of social services and the

department of health and senior services shall study all significant aspects of presumptive eligibility for pregnant women and submit a joint report on the subject, including projected costs and the time needed for implementation, to the general assembly. The department of social services, at the direction of the general assembly, may implement presumptive eligibility by regulation promulgated pursuant to chapter 207, RSMo;

(23) All recipients who would be eligible for aid to families with dependent children benefits except for the requirements of paragraph (d) of subdivision (1) of section 208.150;

(24) (a) All persons who would be determined to be eligible for old age assistance benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f), or less restrictive methodologies as contained in the Medicaid state plan as of January 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized by annual appropriation;

(b) All persons who would be determined to be eligible for aid to the blind benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f), or less restrictive methodologies as contained in the Medicaid state plan as of January 1, 2005, except that less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to one hundred percent of the federal poverty level;

(c) All persons who would be determined to be eligible for permanent and total disability benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. 1396a(f); or less restrictive methodologies as contained in the Medicaid state plan as of January 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized by annual appropriations. Eligibility standards for permanent and total disability benefits shall not be limited by age;

(25) Persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage pursuant to 42 U.S.C. 1396a (a)(10)(A)(ii)(XVIII). Such persons shall be eligible during a period of presumptive eligibility in accordance with 42 U.S.C. 1396r-1**;**

(26) Persons who are independent foster care adolescents, as defined in 42 U.S.C. 1396d, or who are within reasonable categories of

such adolescents who are under twenty-one years of age as specified by the state, are eligible for coverage under 42 U.S.C. 1396a (a)(10)(A)(ii)(XVII) without regard to income or assets.

2. Rules and regulations to implement this section shall be promulgated in accordance with section 431.064, RSMo, and chapter 536, RSMo. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, 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, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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, 2002, shall be invalid and void.

3. After December 31, 1973, and before April 1, 1990, any family eligible for assistance pursuant to 42 U.S.C. 601 et seq., as amended, in at least three of the last six months immediately preceding the month in which such family became ineligible for such assistance because of increased income from employment shall, while a member of such family is employed, remain eligible for medical assistance for four calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of income and resource limitation. After April 1, 1990, any family receiving aid pursuant to 42 U.S.C. 601 et seq., as amended, in at least three of the six months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of employment or income from employment of the caretaker relative, shall remain eligible for medical assistance for six calendar months following the month of such ineligibility as long as such family includes a child as provided in 42 U.S.C. 1396r-6. Each family which has received such medical assistance during the entire six-month period described in this section and which meets reporting requirements and income tests established by the division and continues to include a child as provided in 42 U.S.C. 1396r-6 shall receive medical assistance without fee for an additional six months. The division of medical services may provide by rule and as authorized by annual appropriation the scope of medical assistance coverage to be granted to such families.

4. When any individual has been determined to be eligible for medical

assistance, such medical assistance will be made available to him or her for care and services furnished in or after the third month before the month in which he made application for such assistance if such individual was, or upon application would have been, eligible for such assistance at the time such care and services were furnished; provided, further, that such medical expenses remain unpaid.

5. The department of social services may apply to the federal Department of Health and Human Services for a Medicaid waiver amendment to the Section 1115 demonstration waiver or for any additional Medicaid waivers necessary not to exceed one million dollars in additional costs to the state. A request for such a waiver so submitted shall only become effective by executive order not sooner than ninety days after the final adjournment of the session of the general assembly to which it is submitted, unless it is disapproved within sixty days of its submission to a regular session by a senate or house resolution adopted by a majority vote of the respective elected members thereof.

6. Notwithstanding any other provision of law to the contrary, in any given fiscal year, any persons made eligible for medical assistance benefits under subdivisions (1) to (22) of subsection 1 of this section shall only be eligible if annual appropriations are made for such eligibility. This subsection shall not apply to classes of individuals listed in 42 U.S.C. Section 1396a(a)(10)(A)(i).

208.152. 1. **[**Benefit**]** **MO HealthNet** payments **[**for medical assistance**]** shall be made on behalf of those eligible needy persons as defined in section 208.151 who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the **[**division of medical services**]** **MO HealthNet division**, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the division of medical services shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the Medicaid children's diagnosis length-of-stay schedule; and provided further that the division of medical services shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts

which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et seq.), but the division of medical services may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the division of medical services not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for recipients, **except to persons with more than five hundred thousand dollars equity in their home or** except **[**to**]** **for** persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. 301, et seq.), as amended, for nursing facilities. The **[**division of medical services**] MO HealthNet division** may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of Medicaid patients. The division of medical services when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

(5) Nursing home costs for recipients of benefit payments under subdivision (4) of this subsection for those days, which shall not exceed twelve per any period of six consecutive months, during which the recipient is on a temporary leave of absence from the hospital or nursing home, provided that no such recipient shall be allowed a temporary leave of absence unless it is specifically provided for in his plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a recipient is away from the hospital or nursing home overnight because he is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere;

(7) Drugs and medicines when prescribed by a licensed physician, dentist, or podiatrist; except that no payment for drugs and medicines prescribed on and after January 1, 2006, by a licensed physician, dentist, or podiatrist may be made on behalf of any person who qualifies for prescription drug coverage under the provisions of P.L. 108-173;

(8) Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments;

(9) Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of Section 6403 of P.L. 101-239 and federal regulations promulgated thereunder;

(10) Home health care services;

(11) Family planning as defined by federal rules and regulations; provided, however, that such family planning services shall not include abortions unless such abortions are certified in writing by a physician to the Medicaid agency that, in his professional judgment, the life of the mother would be endangered if the fetus were carried to term;

(12) Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C. 1396d, et seq.);

(13) Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

(14) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his physician on an outpatient, rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall

be rendered by an individual not a member of the recipient's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one recipient one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time;

(15) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. 301, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097, RSMo. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(b) Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse

professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, "mental health professional" and "alcohol and drug abuse professional" shall be defined by the department of mental health pursuant to duly promulgated rules.

With respect to services established by this subdivision, the department of social services, **[**division of medical services**]** **MO HealthNet division**, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the **[**division of medical services**]** **MO HealthNet division**. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

(16) Such additional services as defined by the **[**division of medical services**]** **MO HealthNet division** to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. 301, et seq.) subject to appropriation by the general assembly;

(17) Beginning July 1, 1990, the services of a certified pediatric or family nursing practitioner to the extent that such services are provided in accordance with chapter 335, RSMo, and regulations promulgated thereunder, regardless of whether the nurse practitioner is supervised by or in association with a physician or other health care provider;

(18) Nursing home costs for recipients of benefit payments under subdivision (4) of this subsection to reserve a bed for the recipient in the nursing home during the time that the recipient is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of Medicaid certified licensed beds, according to the most recent quarterly census provided to the department of health and senior services which was taken prior to when the recipient is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an

anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a recipient pursuant to this subdivision during any period of six consecutive months such recipient shall, during the same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the recipient or the recipient's responsible party that the recipient intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the recipient or the recipient's responsible party prior to release of the reserved bed.

2. Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the division of medical services, unless otherwise hereinafter provided, for the following:

(1) Dental services;

(2) Services of podiatrists as defined in section 330.010, RSMo;

(3) Optometric services as defined in section 336.010, RSMo;

(4) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs;

(5) Hospice care. As used in this subsection, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the division of medical services to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would

have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The division of medical services shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this subdivision shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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, 2005, shall be invalid and void.

3. Benefit payments for medical assistance for surgery as defined by rule duly promulgated by the division of medical services, and any costs related directly thereto, shall be made only when a second medical opinion by a licensed physician as to the need for the surgery is obtained prior to the surgery being performed.

4. The division of medical services may require any recipient of medical assistance to pay part of the charge or cost, as defined by rule duly promulgated by the division of medical services, for all covered services except for those services covered under subdivisions (14) and (15) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, RSMo, and a generic drug is substituted for a name brand drug, the division of medical services may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the

federal Social Security Act. A provider of goods or services described under this section must collect from all recipients the partial payment that may be required by the division of medical services under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by recipients under this section shall be reduced from any payments made by the state for goods or services described herein except the recipient portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a recipient is unable to pay a required cost sharing. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give recipients advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a recipient. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the Missouri Medicaid state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

5. The division of medical services shall have the right to collect medication samples from recipients in order to maintain program integrity.

6. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for medical assistance at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. 1396a and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404 of P.L. 101-239 (Omnibus Budget

Reconciliation Act of 1989) and federal regulations promulgated thereunder.

8. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for medical assistance under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.

9. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. 1396a, as amended, and regulations promulgated thereunder.

10. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the Medicaid program shall not increase payments in excess of the increase that would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. 1396a (a)(13)(C).

11. The **[**department of social services, division of medical services**]** **MO HealthNet division**, may enroll qualified residential care facilities, as defined in chapter 198, RSMo, as **[**Medicaid**]** **MO HealthNet** personal care providers.

208.153. 1. Pursuant to and not inconsistent with the provisions of sections 208.151 and 208.152, the **[**division of medical services**]** **MO HealthNet division** shall by rule and regulation define the reasonable costs, manner, extent, quantity, quality, charges and fees of medical assistance herein provided. The benefits available under these sections shall not replace those provided under other federal or state law or under other contractual or legal entitlements of the persons receiving them, and all persons shall be required to apply for and utilize all benefits available to them and to pursue all causes of action to which they are entitled. Any person entitled to medical assistance may obtain it from any provider of services with which an agreement is in effect under this section and which undertakes to provide the services, as authorized by the **[**division of medical services**]** **MO HealthNet division**. At the discretion of the director of **[**medical services**]** **the MO HealthNet division** and with the approval of the governor, the **[**division of medical services**]** **MO HealthNet division** is authorized to provide medical benefits for recipients of public assistance by expending funds for the payment of federal medical insurance premiums, coinsurance and deductibles pursuant to the provisions of Title XVIII

B and XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301 et seq.), as amended.

2. [Medical assistance] **Subject to appropriations and, pursuant to and not inconsistent with the provisions of sections 208.151, 208.152, and 208.153, the MO HealthNet division shall by rule and regulation develop a pay-for-performance payment program. Providers operating under a risk-bearing care coordination program and an administrative services organization program, as defined in section 208.950, shall be required to participate in a pay-for-performance incentive program, and providers operating under the state care management point of service program, as defined in section 208.950, may participate in the pay-for-performance incentive program.**

3. MO HealthNet shall include benefit payments on behalf of qualified Medicare beneficiaries as defined in 42 U.S.C. section 1396d(p). The [division of family services] **family support division** shall by rule and regulation establish which qualified Medicare beneficiaries are eligible. The [division of medical services] **MO HealthNet division** shall define the premiums, deductible and coinsurance provided for in 42 U.S.C. section 1396d(p) to be provided on behalf of the qualified Medicare beneficiaries.

[3. Beginning July 1, 1990, medical assistance] **4. MO HealthNet** shall include benefit payments for Medicare Part A cost sharing as defined in clause (p)(3)(A)(i) of 42 U.S.C. 1396d on behalf of qualified disabled and working individuals as defined in subsection (s) of section 42 U.S.C. 1396d as required by subsection (d) of section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989). The [division of medical services] **MO HealthNet division** may impose a premium for such benefit payments as authorized by paragraph (d)(3) of section 6408 of P.L. 101-239.

[4. Medical assistance] **5. MO HealthNet** shall include benefit payments for Medicare Part B cost-sharing described in 42 U.S.C. section 1396(d)(p)(3)(A)(ii) for individuals described in subsection 2 of this section, but for the fact that their income exceeds the income level established by the state under 42 U.S.C. section 1396(d)(p)(2) but is less than one hundred and ten percent beginning January 1, 1993, and less than one hundred and twenty percent beginning January 1, 1995, of the official poverty line for a family of the size involved.

[5. Beginning July 1, 1991,] **6.** For an individual eligible for [medical

assistance**] MO HealthNet** under Title XIX of the Social Security Act, **[**medical assistance**] MO HealthNet** shall include payment of enrollee premiums in a group health plan and all deductibles, coinsurance and other cost-sharing for items and services otherwise covered under the state Title XIX plan under section 1906 of the federal Social Security Act and regulations established under the authority of section 1906, as may be amended. Enrollment in a group health plan must be cost effective, as established by the Secretary of Health and Human Services, before enrollment in the group health plan is required. If all members of a family are not eligible for **[**medical assistance under Title XIX**] MO HealthNet** and enrollment of the Title XIX eligible members in a group health plan is not possible unless all family members are enrolled, all premiums for noneligible members shall be treated as payment for **[**medical assistance**] MO HealthNet** of eligible family members. Payment for noneligible family members must be cost effective, taking into account payment of all such premiums. Non-Title XIX eligible family members shall pay all deductible, coinsurance and other cost-sharing obligations. Each individual as a condition of eligibility for medical assistance shall apply for enrollment in the group health plan.

208.201. 1. The **[**"Division of Medical Services"**] "MO HealthNet Division"** is hereby established within the department of social services. The director of the **MO HealthNet** division shall be appointed by the director of the department. **Where the title "Division of Medical Services" is found in Missouri statutes it shall mean "MO HealthNet Division".**

2. The **[**division of medical services**] MO HealthNet division** is an integral part of the department of social services and shall have and exercise all the powers and duties necessary to carry out fully and effectively the purposes assigned to it by law and shall be the state agency to administer payments to providers under the medical assistance program and to carry out such other functions, duties, and responsibilities as the division of medical services may be transferred by law, or by a departmental reorganizational plan pursuant to law.

3. All powers, duties and functions of the division of family services relative to the development, administration and enforcement of the medical assistance programs of this state are transferred by type I transfer as defined in the Omnibus State Reorganization Act of 1974 to the division of medical services. The **[**division of family services**] family support division** shall retain the authority to determine and regulate the eligibility of needy persons for

participation in the medical assistance program.

4. **All state regulations adopted under the authority of the division of medical services shall remain in effect unless withdrawn or amended by authority of the MO HealthNet division.**

5. The director of the **[**division of medical services**]** **MO HealthNet division** shall exercise the powers and duties of an appointing authority under chapter 36, RSMo, to employ such administrative, technical, and other personnel as may be necessary, and may designate subdivisions as needed for the performance of the duties and responsibilities of the division.

[5.**]** **6.** In addition to the powers, duties and functions vested in the **[**division of medical services**]** **MO HealthNet division** by other provisions of this chapter or by other laws of this state, the **[**division of medical services**]** **MO HealthNet division** shall have the power:

(1) To sue and be sued;

(2) To adopt, amend and rescind such rules and regulations necessary or desirable to perform its duties under state law and not inconsistent with the constitution or laws of this state;

(3) To make and enter into contracts and carry out the duties imposed upon it by this or any other law;

(4) To administer, disburse, accept, dispose of and account for funds, equipment, supplies or services, and any kind of property given, granted, loaned, advanced to or appropriated by the state of Missouri or the federal government for any lawful purpose;

(5) To cooperate with the United States government in matters of mutual concern pertaining to any duties of the division of medical services or the department of social services, including the adoption of such methods of administration as are found by the United States government to be necessary for the efficient operation of state medical assistance plans required by federal law, and the modification or amendment of a state medical assistance plan where required by federal law;

(6) To make reports in such form and containing such information as the United States government may, from time to time, require and comply with such provisions as the United States government may, from time to time, find necessary to assure the correctness and verification of such reports;

(7) To create and appoint, when and if it may deem necessary, advisory committees not otherwise provided in any other provision of the law to provide

professional or technical consultation with respect to medical assistance program administration. Each advisory committee shall consult with and advise the division of medical services with respect to policies incident to the administration of the particular function germane to their respective field of competence;

(8) To define, establish and implement the policies and procedures necessary to administer payments to providers under the medical assistance program;

(9) To conduct utilization reviews to determine the appropriateness of services and reimbursement amounts to providers participating in the medical assistance program;

(10) To establish or cooperate in research or demonstration projects relative to the medical assistance programs, including those projects which will aid in effective coordination or planning between private and public medical assistance programs and providers, or which will help improve the administration and effectiveness of medical assistance programs.

208.202. 1. The director of MO HealthNet division, or the director's designee, and the director of the department of insurance, financial and professional regulation or the director's designee, are authorized to implement a premium offset program for making standardized private health insurance coverage available to qualified individuals.

2. The MO HealthNet division shall apply for those state plan amendments or waivers necessary to obtain federal financial participation in the premium offset program.

3. The uninsured employee and spouse are not entitled to MO HealthNet wraparound services.

4. The premium offset from the MO HealthNet division shall only be due if the employer and employee pay their share of the required premium. The premium offset due shall be subject to appropriation.

5. Individuals eligible for this premium offset program who apply after the appropriation authority is depleted to pay for the premium offset shall be placed on a waiting list for that state fiscal year. If additional money is appropriated the MO HealthNet division shall process applications for MO HealthNet Plus services on a first come, first serve basis.

208.203. 1. The department of social services, MO HealthNet

division is authorized to promulgate rules, including emergency rules if necessary, to implement the provisions of the "Missouri Health Improvement Act of 2007" including but not limited to the form and content of any documents required to be filed under the "Missouri Health Improvement Act of 2007";

2. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in the Missouri Health Improvement Act of 2007, sections 208.202 to 208.203 shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. Sections 208.202 to 208.203 and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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 the effective date of the Missouri Health Improvement Act of 2007, shall be invalid and void.

208.631. 1. Notwithstanding any other provision of law to the contrary, the **[**department of social services**]** **MO Healthnet division** shall establish a program to pay for health care for uninsured children. Coverage pursuant to sections 208.631 to 208.660 is subject to appropriation. The provisions of sections 208.631 to **[**208.657**]** **208.660, "Health Care for Uninsured Children"** shall be void and of no **[**effect after June 30, 2008**]** **affect 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 pursuant to the Federal Social Security Act**.

2. For the purposes of sections 208.631 to 208.657, "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 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 medical assistance as authorized in section 208.151 is not uninsured for the purposes of sections 208.631 to 208.657.

208.690. 1. Sections 208.690 to 208.698 shall be known and may be cited as the "Missouri Long-term Care Partnership Program Act".

2. As used in sections 208.690 to 208.698, the following terms shall mean:

(1) "Asset disregard", the disregard of any assets or resources in an amount equal to the insurance benefit payments that are used on behalf of the individual;

(2) "Missouri Qualified Long-term Care Partnership approved policy", a long-term care insurance policy certified by the director of the department of insurance, financial and professional regulation as meeting the requirements of:

(a) The National Association of Insurance Commissioners' Long-term Care Insurance Model Act and Regulation as specified in 42 U.S.C. 1917(b); and

(b) The provisions of Section 6021 of the Federal Deficit Reduction Act of 2005.

(3) "MO HealthNet", the medical assistance program established in this state under Title XIX of the federal Social Security Act;

(4) "State plan amendment", the state MO HealthNet plan amendment to the federal Department of Health and Human Services that, in determining eligibility for state MO HealthNet benefits, provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care insurance partnership policy.

208.692. 1. In accordance with Section 6021 of the Federal Deficit Reduction Act of 2005, there is established the Missouri Long-term Care Partnership Program, which shall be administered by the department of social services in conjunction with the department of insurance, financial and professional regulation. The program shall:

(1) Provide incentives for individuals to insure against the costs of providing for their long-term care needs;

(2) Provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under MO HealthNet without first being required to substantially exhaust their resources; and

(3) Alleviate the financial burden to the MO HealthNet program by encouraging the pursuit of private initiatives.

2. Upon payment under a Missouri qualified long-term care partnership approved policy, certain assets of an individual, as provided in subsection 3 of this section, shall be disregarded when determining any of the following:

(1) MO HealthNet eligibility;

(2) The amount of any MO HealthNet payment; and

(3) Any subsequent recovery by the state of a payment for medical services.

3. The department of social services shall:

(1) Within one hundred eighty days of the effective date of sections 208.690 to 208.698, make application to the federal Department of Health and Human Services for a state plan amendment to establish a program that, in determining eligibility for state MO HealthNet benefits, provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care insurance partnership policy; and

(2) Provide information and technical assistance to the department of insurance, financial and professional regulation to assure that any individual who sells a qualified long-term care insurance partnership policy receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

4. The department of social services shall promulgate rules to implement the provisions of sections 208.690 to 208.698. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, 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, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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, 2007, shall be invalid and void.

208.694. 1. An individual who is beneficiary of a Missouri qualified long-term care partnership approved policy is eligible for

assistance under MO HealthNet using asset disregard under sections 208.690 to 208.698.

2. If the Missouri long-term care partnership program is discontinued, an individual who purchased a qualified long-term care partnership approved policy prior to the date the program was discontinued shall be eligible to receive asset disregard, as provided by Title VI, Section 6021 of the Federal Deficit Reduction Act of 2005.

3. The department of social services may enter into reciprocal agreements with other states that have asset disregard provisions established under Title VI, Section 6021 of the Federal Deficit Reduction Act of 2005 in order to extend the asset disregard to Missouri residents who purchase long-term care policies in another state.

208.696. 1. The director of the department of insurance, financial and professional regulation shall:

(1) Develop requirements to ensure that any individual who sells a qualified long-term care insurance partnership policy receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care;

(2) Impose no requirements affecting the terms or benefits of qualified long-term care partnership policies unless the director imposes such a requirement on all long-term care policies sold in this state, without regard to whether the policy is covered under the partnership or is offered in connection with such partnership;

(a) This subsection shall not apply to inflation protection as required under Section 6021(a)(1)(iii)(iv) of the Federal Deficit Reduction Act of 2005;

(b) The inflation protection required for partnership policies, as stated under Section 6021(a)(1)(iii)(iv) of the Federal Deficit Reduction Act of 2005, shall be no less favorable than the inflation protection offered for all long-term care policies under the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Regulation as specified in 42 U.S.C. 1917(b);

(3) Develop a summary notice in clear, easily understood language for the consumer purchasing qualified long-term care insurance partnership policies on the current law pertaining to asset disregard and asset tests; and

(4) Develop requirements to ensure that any individual who exchanges non-qualified long-term care insurance for a qualified long-term care insurance partnership policy receives equitable treatment for time or value gained.

2. The director of the department of insurance, financial and professional regulation shall promulgate rules to carry out the provisions of this section, and on the process for certifying the qualified long-term care partnership policies. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, 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, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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, 2007, shall be invalid and void.

208.698. The issuers of qualified long-term care partnership policies in this state shall provide regular reports to both the Secretary of the Department of Health and Human Services in accordance with federal law and regulations and to the department of social services and the department of insurance, financial and professional regulation as provided in Section 6021 of the Federal Deficit Reduction Act of 2005.

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

(1) "Administrative services organization", a system of health care delivery providing care management and health plan administration services on a noncapitated basis;

(2) "Health care advocate", an advocate for the participant of a health improvement plan who provides comprehensive coordinated physical and behavioral health in partnership with the patient, their family, and their caregivers to assure optimal consideration of medical, behavioral or psychosocial needs. The services of the health care advocate shall provide a health care home for the participant, where the primary goal is to assist patients and their support system with

accessing more choices in obtaining primary care services, coordinating referrals, and obtaining specialty care. The health care advocate, serving as a health care home for the participant, encourages health-based educational-interventions with related services, both in-home and out-of-home care, family support assistance from both private and public-sector providers;

(3) "Health improvement plan", a health care delivery mechanism which is either risk-bearing care coordination, an administrative services organization, or a state care management point of service program;

(4) "Risk-bearing care coordination", a system of health care delivery providing payment to providers on a prepaid capitated basis, as defined in section 208.166;

(5) "State care management point of service program", a system of health care delivery administered by the department of social services.

2. Beginning no later than July 1, 2008, the MO Healthnet Division shall function as a third party administrator, providing all participants of the medical assistance program on behalf of needy persons, Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, 42 U.S.C. Section 301 et seq., a choice of health improvement plans. The three access choices for a health improvement plan shall include a risk-bearing care coordination program, an administrative services organization program, and a state care management point of service program.

3. The department of social services shall, if required, request the appropriate waiver or state plan amendment from the Secretary of the federal Department of Health and Human Services to permit the establishment of an administrative services organization.

4. By July 1, 2013, all participants of the medical assistance program on behalf of needy persons, Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, 42 U.S.C. Section 301 et seq., shall be enrolled in a health improvement plan. The department shall implement a plan for enrolling all such participants in accordance with the time line specified in subsections 11, 12, and 13 of this section.

5. The department shall implement a risk-bearing care coordination program, an administrative services organization

program, and a state care management point of service program in areas with similar demographics and populations. All models shall be evaluated annually on the basis of cost, quality, health improvement, health outcomes, social and behavioral outcomes, health status, customer satisfaction, use of evidence-based medicine, and use of best practices. The annual evaluation by the department shall be submitted to the oversight committee established under section 208.955. Nothing in this subsection shall be construed to require the department to limit the implementation of these programs as a pilot project.

6. The department shall promulgate rules outlining an exemption process for participants whose current treating physicians are not participating in either a risk-bearing care coordination or administrative services organization network in order to prevent interruption in the continuity of medical care. However, the department shall formulate a plan so that by July 1, 2013, all participants are enrolled in one of the programs mentioned in subsection 1 of this section.

7. The department shall require participants in the risk-bearing care coordination program to select a primary care provider from the approved risk-bearing care coordination plan within thirty days of enrollment in the program. If the participant does not select a primary care provider, a provider will be selected for the participant.

8. The department shall promulgate rules for the implementation of the risk-bearing care coordination program. Under the program there shall be the establishment of risk-based coordinated care with a guaranteed savings level that is actuarially sound while limiting the profit that is generated to the risk-bearing care coordination vendor. The risk-bearing care coordination program shall operate generally under a traditional managed care model, and as outlined in section 208.166, including offering care coordination ensuring the coverage of services as prescribed under section 208.152, RSMo, utilization management, claims adjudication, participant education, primary care case management, and pharmacy management. The program vendor may subcontract pharmacy management to the state.

9. The department shall promulgate rules for the implementation of the administrative service organization program. For the administrative service organization program, the financial terms shall

require that the vendor fees be reduced if savings and quality targets specified by the department are not met. The administrative services organization program shall provide care coordination, utilization management, participant education, and primary care case management. The state shall continue to retain provider reimbursement, pharmacy management, eligibility determination, and provider network management ensuring the coverage of services as prescribed under section 208.152.

10. For the risk-bearing care coordination and administrative service organization programs, there shall be competitive requests for proposals. The department shall establish criteria for award selection to include preference for Missouri-based vendors and prior experience as required by chapter 34, RSMo. The risk-bearing care coordination and administrative service organization programs shall include the elements outlined in this subsection. The state care management point of service program as defined in subsection 1 of this section may include any or all of the elements outlined in this subsection.

(1) For all programs, there shall be an option for participants to choose a health care advocate. The vendor shall assist the participant in choosing the health care advocate. The health care advocate, serving as a health care home, shall coordinate and facilitate, either directly or indirectly through care managers, an individual's health care needs by making referrals, conducting health risk assessments, providing care management, and helping the participant navigate the health care system. The health care advocate shall create a complete physical and behavioral plan of care for the participant. The vendor shall take all steps to ensure that the health care advocate is accessible, continuous, comprehensive, coordinated and family-centered, providing a health care home for participants;

(2) For all programs, the vendors shall issue electronic access cards bearing the vendor's logo to participants. Such cards may be used to satisfy cost-sharing at the hospital, physician's office, pharmacy, or any other health care professional and also allow participants to earn enhanced health improvement points by signing a health improvement participant agreement, participating in healthy practices, and making responsible lifestyle choices. These health improvement points will provide participants the ability to use the card

to pay for approved health care expenditures. The health care advocate shall advise the participant regarding the appropriate health care expenditures for each participant consistent with the participant's plan of care. Participants who engage in a discussion with their health care advocate on the participant's recommended plan of care may access physical therapy, speech therapy, or occupational therapy, or a combination of therapy if the general assembly has passed an appropriation and the governor has signed the appropriation for the therapy and the therapy is part of the participant's plan of care that includes evidenced-based performance measures. The MO HealthNet division shall promulgate regulation designating the format of the plan of care and outcome measures, with preference given to electronic documents;

(3) For all programs, there will be three-year contract terms subject to annual savings and quality targets determined by the department and which shall include consumer and provider satisfaction levels;

(4) For all programs, there shall be mechanisms in place to promote and determine the appropriate use of in-home care for participants prior to admissions in custodial skilled nursing facilities;

(5) For all programs, there shall be at least quarterly reporting of participant and provider quality and satisfaction indicators including, but not limited to, complaints, prompt payment of providers, call center statistics, and denials of care, to be determined by the department, to ensure the highest levels of care;

(6) For all programs, the vendors shall establish participant call centers based in Missouri to receive questions from participants regarding the program and to refer the participants to appropriate state offices, when necessary;

(7) For all programs, the state shall establish a level of copayments to be paid by participants for state-designated services that are not federally mandated, including but not limited to prescription drugs;

(8) For all programs, the vendors shall establish a percentage of coinsurance to be paid by the participant for emergency department visits subsequently determined to be non-emergency; and

(9) For all programs, if the programs are established within a

thirty-mile radius of a federally qualified health center, rural health clinic, or community mental health center, the vendors shall establish partnerships with such health centers and clinics to ensure availability of care.

11. By July 1, 2008, the department shall begin enrollment of parents and children not already enrolled in Missouri Medicaid managed care in a health improvement plan, with complete enrollment by July 1, 2009.

12. By July 1, 2009, the department shall begin enrollment in a health improvement plan one-half of the participants of medical assistance who receive such assistance on the basis of being aged, blind, or disabled, as specified in subdivision (24) of section 208.151, on an opt-out basis, with complete enrollment for participants under this subsection completed by July 1, 2010.

13. By July 1, 2013, enrollment in a health improvement plan shall be completed for the remainder of the recipients of medical assistance who receive such assistance on the basis of being aged, blind, or disabled, as specified in subdivision (24) of section 208.151.

14. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, 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, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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, 2007, shall be invalid and void.

208.955. 1. There is hereby established in the department of social services an "Oversight Committee on Health Improvement Plans". The oversight committee shall consist of thirteen members:

(1) Two members of the house of representatives, one from each party, appointed by the speaker;

(2) Two members of the senate, one from each party, appointed by the president pro tem;

(3) Two consumer representatives, not from the same geographic area or health improvement plan, appointed by the governor;

(4) Two healthcare providers, not from the same geographic area, appointed by the governor;

(5) Two advocates of healthcare, appointed by the governor; and

(6) The directors of the department of social services, the department of mental health, and the department of health and senior services, or the directors' designee.

2. The members of the committee, other than the members from the general assembly and ex-officio members, shall be appointed by the governor with the advice and consent of the senate. Of the members first appointed to the committee by the governor, three members shall serve a term of two years, three members shall serve a term of one year, and thereafter, members shall serve a term of two years. Members shall continue to serve until their successor is duly appointed and qualified. Any vacancy on the committee shall be filled in the same manner as the original appointment. Members shall serve on the committee without compensation but may be reimbursed for their actual and necessary expenses from moneys appropriated by the department of social services for that purpose. The oversight committee shall:

(1) Meet on at least four occasions the first year and then on at least two occasions each year thereafter;

(2) Review the participant and provider satisfaction reports required of the program vendors under subdivision (5) of subsection 10 of section 208.950;

(3) Review the call center statistics required to be maintained by the program vendors under subdivision (5) of subsection 10 of section 208.950;

(4) Determine how the data collected from subdivisions (2) and (3) of this subsection shall be analyzed to determine the health or other outcomes and financial impact from the programs as defined by the state, and how such findings may be communicated to consumers, health care providers, and public officials;

(5) Report significant findings indicating satisfaction or dissatisfaction of the programs to the general assembly;

(6) Perform other tasks as necessary, including making recommendations to the department of social services concerning the promulgation of emergency rules to ensure quality of care, availability,

participant satisfaction and status information on the programs.

3. By July 1, 2013, the oversight committee shall issue findings to the general assembly on the success and failure of the health improvement programs and recommend whether to discontinue any of the programs.

4. The provisions of section 23.253, RSMo, shall not apply to sections 208.950 to 208.955.

[208.014. 1. There is hereby established the "Medicaid Reform Commission". The commission shall have as its purpose the study and review of recommendations for reforms of the state Medicaid system. The commission shall consist of ten members:

(1) Five members of the house of representatives appointed by the speaker; and

(2) Five members of the senate appointed by the pro tem. No more than three members from each house shall be of the same political party. The directors of the department of social services, the department of health and senior services, and the department of mental health or the directors' designees shall serve as ex officio members of the commission.

2. Members of the commission shall be reimbursed for the actual and necessary expenses incurred in the discharge of the member's official duties.

3. A chair of the commission shall be selected by the members of the commission.

4. The commission shall meet as necessary.

5. The commission is authorized to contract with a consultant. The compensation of the consultant and other personnel shall be paid from the joint contingent fund or jointly from the senate and house contingent funds until an appropriation is made therefor.

6. The commission shall make recommendations in a report to the general assembly by January 1, 2006, on reforming, redesigning, and restructuring a new, innovative state Medicaid healthcare delivery system under Title XIX, Public Law 89-97, 1965, amendments to the federal Social Security Act (42 U.S.C. Section 30 et. seq.) as amended, to replace the current state

Medicaid system under Title XIX, Public Law 89-97, 1965, amendments to the federal Social Security Act (42 U.S.C. Section 30, et seq.), which shall sunset on June 30, 2008.**]**

[660.546. 1. The department of social services shall coordinate a program entitled the "Missouri Partnership for Long-term Care" whereby private insurance and Medicaid funds shall be combined to finance long-term care. Under such program, an individual may purchase a precertified long-term care insurance policy in an amount commensurate with his resources as defined pursuant to the Medicaid program. Notwithstanding any provision of law to the contrary, the resources of such an individual, to the extent such resources are equal to the amount of long-term care insurance benefit payments as provided in section 660.547, shall not be considered by the department of social services in a determination of:

(1) His eligibility for Medicaid;

(2) The amount of any Medicaid payment.

Any subsequent recovery of a payment for medical services by the state shall be as provided by federal law.

2. Notwithstanding any provision of law to the contrary, for purposes of recovering any medical assistance paid on behalf of an individual who was allowed an asset or resource disregard based on such long-term care insurance policy, the definition of estate shall be expanded to include any other real or personal property and other assets in which the individual has any legal title or interest at the time of death, to the extent of such interest, including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement.**]**

[660.547. The department of social services shall request appropriate waiver or waivers from the Secretary of the federal Department of Health and Human Services to permit the use of long-term care insurance for the preservation of resources pursuant to section 660.546. Such preservation shall be provided, to the extent approved by the federal Department of Health and Human Services, for any purchaser of a precertified long-term care

insurance policy delivered, issued for delivery or renewed within five years after receipt of the federal approval of the waiver, and shall continue for the life of the original purchaser of the policy, provided that he maintains his obligations pursuant to the precertified long-term care insurance policy. Insurance benefit payments made on behalf of a claimant, for payment of services which would be covered under section 208.152, RSMo, shall be considered to be expenditures of resources as required under chapter 208, RSMo, for eligibility for medical assistance to the extent that such payments are:

(1) For services Medicaid approves or covers for its recipients;

(2) In an amount not in excess of the charges of the health services provider;

(3) For nursing home care, or formal services delivered to insureds in the community as part of a care plan approved by a coordination, assessment and monitoring agency licensed pursuant to chapter 198, RSMo; and

(4) For services provided after the individual meets the coverage requirements for long-term care benefits established by the department of social services for this program.

The director of the department of social services shall adopt regulations in accordance with chapter 536, RSMo, to implement the provisions of sections 660.546 to 660.557, relating to determining eligibility of applicants for Medicaid and the coverage requirements for long-term care benefits.**]**

[660.549. The department of social services shall establish an outreach program to educate consumers to:

(1) The mechanisms for financing long-term; and

(2) The asset protection provided under sections 660.546 to 660.557.**]**

[660.551. 1. The department of insurance shall precertify long-term care insurance policies which are issued by insurers who, in addition to complying with other relevant laws and regulations:

(1) Alert the purchaser to the availability of consumer information and public education provided by the division of aging

and the department of insurance pursuant to sections 660.546 to 660.557;

(2) Offer the option of home- and community-based services in lieu of nursing home care;

(3) Offer automatic inflation protection or optional periodic per diem upgrades until the insured begins to receive long-term care benefits; provided, however, that such inflation protection or upgrades shall not be required of life insurance policies or riders containing accelerated long-term care benefits;

(4) Provide for the keeping of records and an explanation of benefits reports to the insured and the department of insurance on insurance payments which count toward Medicaid resource exclusion; and

(5) Provide the management information and reports necessary to document the extent of Medicaid resource protection offered and to evaluate the Missouri partnership for long-term care including, but not limited to, the information listed in section 660.553.

Included among those policies precertified under this section shall be life insurance policies which offer long-term care either by rider or integrated into the life insurance policy.

2. No policy shall be precertified pursuant to sections 660.546 to 660.557, if it requires prior hospitalization or a prior stay in a nursing home as a condition of providing benefits.

3. The department of insurance may adopt regulations to carry out the provisions of sections 660.546 to 660.557.**]**

[660.553. The department of insurance shall provide public information to assist individuals in choosing appropriate insurance coverage, and shall establish an outreach program to educate consumers as to:

(1) The need for long-term; and

(2) The availability of long-term care insurance.**]**

[660.555. The director of the department of insurance each year, on January first shall report in writing to the department of social services the following information:

(1) The success in implementing the provisions of sections

660.546 to 660.557;

(2) The number of policies precertified pursuant to sections 660.546 to 660.557;

(3) The number of individuals filing consumer complaints with respect to precertified policies; and

(4) The extent and type of benefits paid, in the aggregate, under such policies that could count toward Medicaid resource protection.**]**

[660.557. The director of the department of social services shall request the federal approvals necessary to carry out the purposes of sections 660.546 to 660.557. Each year on January first, the director of the department of social services shall report in writing to the general assembly on the progress of the program. Such report will include, but not be limited to:

(1) The success in implementing the provisions of sections 660.546 to 660.557;

(2) The number of policies precertified pursuant to sections 660.546 to 660.557;

(3) The number of individuals filing consumer complaints with respect to precertified policies;

(4) The extent and type of benefits paid, in the aggregate, under such policies that could count toward Medicaid resource protection;

(5) Estimates of impact on present and future Medicaid expenditures;

(6) The cost effectiveness of the program; and

(7) A recommendation regarding the appropriateness of continuing the program.**]**

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