SECOND REGULAR SESSION

HOUSE BILL NO. 1972

97TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES ALLEN (Sponsor) AND FLANIGAN (Co-sponsor).

6180H.01I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal section 208.166, RSMo, and to enact in lieu thereof one new section relating to medical assistance.

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

Section A. Section 208.166, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 208.166, to read as follows:

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

(1) **"Accountable care organization", an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of beneficiaries who are enrolled in a traditional fee-for-service health care delivery system;**

(2) "Department", the Missouri department of social services;

[(2)**] (3)** "Prepaid capitated", a mode of payment by which the department periodically **[**reimburse**] reimburses** a contracted health provider plan or primary care physician sponsor for delivering health care services for the duration of a contract to a maximum specified number of members based on a fixed rate per member, notwithstanding:

(a) The actual number of members who receive care from the provider; or

(b) The amount of health care services provided to any members;

[(3)**] (4) "Prepaid health plan", a health plan that is licensed or certified as a risk-bearing entity or is a provider service network approved by the MO HealthNet division, and is paid a prospective per-member, per-month payment by the division;**

(5) "Primary care case-management", a mode of payment by which the department reimburses a contracted primary care physician sponsor **or community mental health center** on a fee-for-service schedule plus a monthly fee to manage each recipient's case;

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

[(4)**] (6)** "Primary care physician sponsor", a physician licensed pursuant to chapter 334 who is a family practitioner, general practitioner, pediatrician, general internist or an obstetrician or gynecologist;

[(5)**] (7)** "Specialty physician services arrangement", an arrangement where the department may restrict recipients of specialty services to designated providers of such services, even in the absence of a primary care case-management system.

2. **(1)** The department or its designated division shall maximize the use of prepaid health plans, where appropriate, and other alternative service delivery and reimbursement methodologies, including, but not limited to, individual primary care physician sponsors or specialty physician services arrangements, designed to facilitate the cost-effective purchase of comprehensive health care**, but shall not include pharmacy benefits and services**.

(2) The following shall not be provided by a prepaid health plan:

(a) Pharmacy benefits;

(b) All benefits and services currently provided by a community psychiatric rehabilitation provider or a comprehensive substance abuse treatment and rehabilitation provider under the Medicaid rehabilitation state plan option which includes mental health rehabilitation services and substance abuse rehabilitation services; and

(c) All benefits and services subject to the clinic upper payment limit under the clinic upper payment limit state plan approved by the Centers for Medicare and Medicaid Services (CMS) that are provided by privately owned and operated community mental health centers which act as administrative entities of the department of mental health. Such community mental health centers may be designated entry and exit points for department of mental health services and are required to provide a comprehensive array of services to any department of mental health patients in their designated service areas who seek care.

(3) For the purposes of care coordination and disease management, prepaid health plans or other alternative service delivery entities shall be required to provide MO HealthNet with:

(a) An electronic notice of any authorization or denial of an initial request of coverage of inpatient admission within twenty-four hours of receiving the request; and

(b) An electronic copy of all other claims within ten days of both initial submission of the claim and upon payment of the claim.

3. In order to provide comprehensive health care, the department or its designated division shall have authority to:

(1) Purchase medical services for recipients of public assistance from prepaid health plans, **accountable care organizations,** health maintenance organizations, health insuring

organizations, preferred provider organizations, individual practice associations, local health units, community health centers, **community mental health centers,** or primary care physician sponsors;

(2) Reimburse those health care plans or primary care physicians' sponsors who enter into direct contract with the department on a prepaid capitated or primary care case-management basis on the following conditions:

(a) That the department or its designated division shall ensure, whenever possible and consistent with quality of care and cost factors, that publicly supported neighborhood and community-supported health clinics **and community mental health centers** shall be utilized as providers;

(b) That the department or its designated division shall ensure reasonable access to medical services in **all** geographic areas **[**where managed or coordinated care programs are initiated**] of the state**; and

(c) That the department shall ensure full freedom of choice for prescription drugs at any Medicaid participating pharmacy;

(3) Limit providers of medical assistance benefits to those who demonstrate efficient and economic service delivery for the level of service they deliver, and provided that such limitation shall not limit recipients from reasonable access to such levels of service;

(4) Provide recipients of public assistance with alternative services as provided for in state law, subject to appropriation by the general assembly;

(5) Designate providers of medical assistance benefits to assure specifically defined medical assistance benefits at a reduced cost to the state, to assure reasonable access to all levels of health services and to assure maximization of federal financial participation in the delivery of health related services to Missouri citizens; provided, all qualified providers that deliver such specifically defined services shall be afforded an opportunity to compete to meet reasonable state criteria and to be so designated;

(6) Upon mutual agreement with any entity of local government, to elect to use local government funds as the matching share for Title XIX payments, as allowed by federal law or regulation;

(7) To elect not to offset local government contributions from the allowable costs under the Title XIX program, unless prohibited by federal law and regulation.

4. **Consistent with the department of mental health's constitutional role as the state's mental health authority, MO HealthNet and the department of mental health shall collaborate to determine, by mutual consent:**

(1) A sub-capitation rate for behavioral health within the overall capitation rate at a level sufficient to support reasonable access to service, good quality of care, and consistent with the rate for similar populations nationally;

(2) All requests for proposal language for managed care procurement related to behavioral health benefits;

(3) The definition of medical necessity for behavioral health benefits; and

(4) Protocols mutually developed by MO HealthNet and the department of mental health to assure the quality of behavioral health services delivered through capitated managed care plans.

5. Nothing in this section shall be construed to authorize the department or its designated division to limit the recipient's freedom of selection among health care plans or primary care physician sponsors, as authorized in this section, who have entered into contract with the department or its designated division to provide a comprehensive range of health care services on a prepaid capitated or primary care case-management basis, except in those instances of overutilization of Medicaid services by the recipient.

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