HB 1901 -- HEALTH CARE COVERAGE

SPONSOR: Torpey

This bill changes the laws regarding health care coverage.

HEALTH CARE COST TRANSPARENCY (Section 191.870, RSMo)

Upon request from a patient, potential patient, or the person's parent or guardian, a health care provider must provide an estimated cost for a health care service based on the patient or potential patient's health benefit plan coverage, Medicaid coverage, Medicare coverage, or uninsured status. If covered by a health benefit plan, Medicaid, or Medicare, the health care provider must provide the contractual reimbursement rate for the service and, if applicable, the amount the patient or potential patient would pay as a result of a deductible, coinsurance, or co-payment. If a patient or potential patient is uninsured, the health care provider must provide the estimated out-of-pocket cost and information regarding any payment plan or other financial assistance that may be available. Health care providers providing estimated costs under these provisions must include with any price quote a specified statement.

No provision in a contract entered into, amended, or renewed on or after August 28, 2014, between a health carrier and a health care provider must be enforceable if the contractual provision prohibits, conditions, or in any way restricts any party to the contract from disclosing to an enrollee, patient, potential patient, or the person’s parent or legal guardian the contractual reimbursement rate for a health care service if the payment amount is less than the health care provider’s usual charge for the health care service and if the contractual provision prevents the determination of the potential out-of-pocket cost for the health care service by the enrollee, patient, potential patient, parent, or legal guardian.

Any violation of these provisions must result in a fine not to exceed $1,000 for each instance of violation.

NOTIFICATION TO SPENDDOWN PARTICIPANTS (Section 208.151)

The Department of Social Services is required to notify any potential exchange-eligible participant who may be eligible for services due to spenddown that the participant may qualify for more cost-effective private insurance and premium tax credits under Section 36B of the Internal Revenue Code of 1986, as amended, available through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state based,

or operated on a partnership basis and the benefits potentially covered under the insurance.

SUBSTANCE ABUSE (Section 208.186)

Any MO HealthNet participant who has pled guilty to or been found guilty of a crime involving alcohol or a controlled substance or any crime in which alcohol or substance abuse was, in the opinion of the court, a contributing factor to the commission of the crime is required to obtain an assessment by a treatment provider approved by the Department of Mental Health to determine the need for services. Recommendations of the treatment provider may be used by the court in sentencing.

A MO HealthNet Program participant who is a parent of a child subject to proceedings in juvenile court because the child is alleged to be in need of care and treatment under 211.031, RSMo, whose misuse of controlled substances or alcohol is found to be a significant, contributing factor to the reason the child was adjudicated, must be required to obtain an assessment by a treatment provider approved by the Department of Mental Health to determine the need for services. Recommendations of the treatment provider must be included in the child's permanency plan, and the court may order the parent or guardian to successfully complete treatment before the child is reunified with the parent or guardian.

If requested by the court, the MO HealthNet Division within the Department of Social Services must certify a MO HealthNet participant's enrollment in MO HealthNet. A letter signed by the division director or his or her designee, or the Family Support Division in the department certifying that the individual is a participant in the program must be prima facie evidence of the participation and must be admissible into evidence without further foundation for that purpose. The letter may specify additional information such as anticipated dates of coverage as may be deemed necessary by the department.

SCHOOL-BASED HEALTH CARE CLINICS (Section 208.661)

The Department of Social Services is required to develop incentive programs, submit state plan amendments, and apply for necessary waivers to permit rural health clinics, federally-qualified health centers, or other primary care practices to co-locate on the property of public elementary and secondary schools with 50% or more students who are eligible for free or reduced-price lunch. Any school-based health care clinic is prohibited from performing or referring for abortion services or providing or referring for contraceptive drugs or devices. The consent of a parent or

guardian must be required before a minor can receive health care services from a school-based health care clinic. These provisions will be null and void unless and until any necessary waivers are granted by the federal government.

SHOW-ME HEALTHY BABIES PROGRAM (Section 208.662)

The bill establishes the Show-Me Healthy Babies Program within the Department of Social Services as a separate children's health insurance program for any low-income unborn child.

For an unborn child to be eligible for enrollment in the program, the mother of the child must not be eligible for coverage under Title XIX of the federal Social Security Act or the Medicaid Program as administered by the state and must not have access to affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. The unborn child must be in a family with income eligibility of no more than 300% of the federal poverty level or the equivalent modified adjusted gross income unless the income eligibility is set lower by the General Assembly through appropriations. When calculating family size as it relates to income eligibility, the family must include in addition to other family members, the unborn child, or in the case of a mother with a multiple pregnancy, all unborn children.

Coverage for an unborn child enrolled in the program must include all prenatal care and pregnancy-related services that benefit the health of the unborn child and promote healthy labor, delivery, and birth. Coverage does not need to include services that are solely for the benefit of the pregnant mother, are unrelated to maintaining or promoting a healthy pregnancy, and provide no benefit to the unborn child.

The bill specifies that there must not be a waiting period before an unborn child may be enrolled in the program. Coverage must include the period from conception to birth and the department must develop a presumptive eligibility procedure for enrolling an unborn child.

Coverage for the child must continue for up to one year after birth unless otherwise prohibited by law or limited by the General Assembly through appropriations. Coverage for the mother is limited to pregnancy-related and postpartum care beginning on the day the pregnancy ends and extends through the last day of the month that includes the sixtieth day after the pregnancy ends unless otherwise prohibited by law or limited by the General Assembly through appropriations.

The bill specifies how the department may provide coverage for an unborn child enrolled in the program. The department must provide information about the program to maternity homes as defined in Section 135.600, pregnancy resource centers as defined in Section 135.630, and other similar agencies and programs in the state that assist unborn children and their mothers. The department must consider allowing these agencies and programs to assist in enrolling unborn children in the program and in making determinations about presumptive eligibility and verification of the pregnancy.

Within 60 days after the effective date of these provisions, the department must submit a state plan amendment or seek any necessary waivers from the federal Department of Health and Human Services requesting approval for the program.

At least annually, the Department of Social Services must prepare and submit a report to the Governor, the Speaker of the House of Representatives, and the President Pro Tem of the Senate analyzing and projecting the cost savings and benefits, if any, to the state, counties, local communities, school districts, law enforcement agencies, correctional centers, health care providers, employers, other public and private entities and persons by enrolling unborn children in the program. The bill specifies the information that must be included in this analysis.

The program is not to be deemed an entitlement program, but instead is subject to a federal allotment or other federal appropriations and matching state appropriations.

The state is not obligated to continue the program if the allotment or payments from the federal government end or are not sufficient for the program to operate or if the General Assembly does not appropriate funds for the program.

These provisions must not be construed as expanding MO HealthNet or fulfilling a mandate imposed by the federal government on the state.

DEPENDENT CARETAKER COVERAGE AND CONTINGENCIES (Section 208.990)

The MO HealthNet Program must not provide MO HealthNet coverage under these provisions to a parent or other caretaker relative living with a dependent child unless the child is receiving benefits under the MO HealthNet program, the Children's Health Insurance Program (CHIP), or otherwise is enrolled in minimum essential coverage.

The provisions of the bill must be null and void unless and until:

(1) Any necessary waivers or state plan amendments have been granted by the federal Department of Health and Human Services to implement the participant cost sharing provisions, the participant work requirement provisions, and the high deductible health plan offered by managed care organizations provisions;

(2) Eligibility for the alternative package population has been approved by the federal government and has been implemented by the Department of Social Services;

(3) The federal department grants the required waivers, state plan amendments, and enhanced federal funding rate for persons newly eligible for the alternative package and the alternative package enhanced federal funding rates are granted by the federal government;

(4) The federal Department of Health and Human Services grants the enhanced federal funding rate for the department to provide coverage for persons newly eligible for the alternative package; and

(5) The federal funds at the disposal of the state at any time is not at least 90% of the funds necessary or are not appropriated to pay the promised enhanced matching rates under Section 2001 of Public Law 111-48 as it existed on March 23, 2010.

MO HEALTHNET ELIGIBILITY (Section 208.991)

Effective January 1, 2015, and subject to the receipt of all appropriate waivers and approval of state plan amendments, individuals who meet the following qualifications must be eligible for the alternative package of MO HealthNet benefits:

(1) Are 19 years of age or older and younger than 65 years of age;

(2) Are not pregnant;

(3) Are not entitled to or enrolled for federal Medicare benefits;

(4) Are not otherwise eligible for and enrolled for mandatory MO HealthNet Program coverage; and

(5) Have a household income that is at or below 133% of the Federal Poverty Level (FPL) for the applicable family size for the applicable year under the MAGI equivalent net income standard, except the household income may be reduced by a dollar amount equivalent to 5% of the FPL for the applicable family size.

The Department of Social Services is required to immediately seek any waivers necessary to implement these provisions. The waivers must promote healthy behavior and include no co-payment for preventive care, require personal responsibility in the payment of health care by establishing appropriate co-payments based on family income that will discourage the use of emergency room visits for non-emergent care and promote responsible use of other health care services, promote the adoption of healthier personal habits including limiting tobacco use or behaviors that lead to obesity, allow recipients to receive an annual cash incentive or cash equivalent if federal financial participation is not obtained to promote responsible behavior and encourage efficient use of health care services, allow health plans to offer a health savings account option, and include a request for an enhanced federal funding rate for newly eligible participants. If the waivers and enhanced federal funding rates are not granted, these provisions must be null and void.

The MO HealthNet Division within the Department of Social Services must establish regulations to be effective January 1, 2015, that provide an alternative benefit package that complies with the requirements of federal law and is subject to the limitations as established in division regulations.

The department must require cost sharing to the maximum extent allowed by law, including but not limited to a premium of no less than 1% of the individual's income as converted to the MAGI equivalent net income standard. In order to collect the required cost sharing the department may garnish the individual's state income tax returns.

The department is required to apply for a waiver to require workforce participation of individuals otherwise eligible for MO HealthNet. Individuals who are not elderly, disabled, or medically frail must provide proof of workforce participation and individuals who fail to provide proof of workforce participation must be deemed ineligible.

The department must provide premium subsidy and other cost supports for individuals eligible for MO HealthNet benefits to enroll in employer-provided health plans or other private health plans based on cost-effective principles determined by the department.

Beginning January 1, 2015, the department must obtain health care coverage for persons who have an income between 100% and 133% percent of the FPL for the applicable family size, for the applicable year as converted to the MAGI equivalent net income standard, who meet all other requirements for the alternative benefits package, and have not been determined to be medically

frail by the department, through a health care exchange operating in this state or an employer. The department must ensure the participants receive the minimum services required to ensure federal reimbursement at the percentages specified in Section 2001 of Public Law 111-148. The department must require cost sharing to the maximum extent allowed by law.

All individuals who meet the definition of medically frail must receive all benefits that they are eligible to receive under Sections 208.152, 208.900, 208.903, 208.909, and 208.930. The Department of Social Services, in conjunction with the Department of Mental Health and the Department of Health and Human Services, must establish a screening process for determining whether an individual is medically frail and must enroll all eligible individuals who are deemed medically frail and whose care management would benefit from being assigned a health home in the health home program or other care coordination as established by the Department of Social Services. However, any eligible individual may opt out of the health home program.

HEALTH CARE HOMES PROGRAM (Section 208.997)

The division must develop and implement the Health Care Homes Program as a provider-directed care coordination program for MO HealthNet recipients who are not enrolled in a prepaid MO HealthNet benefits option and who are receiving services on a fee-for-service basis. The program must provide payment to primary care clinics, community mental health centers, and other appropriate providers for care coordination for individuals deemed medically frail. Clinics must meet certain specified criteria, including the capacity to develop care plans; a dedicated care coordinator; an adequate number of clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement; and the capability to maintain and use a disease registry. The department may designate that the health care homes program be administered through an organization with a statewide primary care presence, experience with Medicaid population health management, and an established health homes outcomes monitoring and improvement system. These provisions must be implemented in a way that it does not conflict with federal requirements for health care home participation by MO HealthNet Program recipients and must not be construed to limit the department's ability to create health care homes for participants in a managed care plan.

MO HEALTHNET MANAGED CARE (Sections 208.998 and 208.999)

Except for those individuals deemed medically frail, recipients of the alternative package of MO HealthNet benefits must receive covered services through health plans offered by managed care

entities authorized by the department.

The health plans must resemble commercially available health plans while complying with federal Medicaid Program requirements as authorized by federal law or through a federal waiver and may include accountable care organizations, administrative service organizations, and managed care organizations paid on a capitated basis; must promote, to the greatest extent possible, the opportunity for children and their parents to be covered under the same plan; must offer plans statewide; must include cost sharing for out patient services to the maximum extent allowed by federal law; may include other co-payments and provide incentives that encourage and reward the prudent use of the health benefit provided; must encourage access to care through provider rates that include pay-for-performance and are comparable to commercial rates and the department must determine pay-for-performance provisions that managed care organizations must execute and must provide incentives for managed care organizations that perform well; must provide incentives, including shared risk and savings, to health plans and providers to encourage cost-effective delivery of care; must provide incentive programs for participants to encourage healthy behaviors and promote the adoption of healthier personal habits including limiting tobacco use or behaviors that lead to obesity; may provide multiple plan options and reward participants for choosing a low-cost plan; must include the services of community mental health centers; and must include the services of health providers as required by federal law and must meet the payment requirements for the health providers as required by federal law.

The department may designate that certain health care services be excluded from the health plans if it is determined cost effective by the department. The department may accept regional proposals as an additional option for beneficiaries. The proposals may be submitted by accountable care organizations or other organizations and entities. The department must advance the development of systems of care for medically complex children who are MO HealthNet benefit recipients by accepting cost-effective regional proposals from and contracting with appropriate pediatric care networks, pediatric centers for excellence, and medical homes for children to provide MO HealthNet benefits when the department determines it is cost effective to do so. The entities must be treated as accountable care organizations. The department, in collaboration with plans and providers, must establish uniform utilization review protocols to be used by all authorized health plans.

The department must establish a competitive bidding process for contracting with managed care plans. The bill requires:

(1) The department to solicit bids only from bidders who offer, or through an associated company offer, an identical or substantially similar plan, in services provided and network, within a health care exchange in the state;

(2) The bidder, or the bidder and the associated company, if the bidder has formed a partnership for purposes of its bid, to include in its bid a process to allow MO HealthNet recipients who choose its plan to be automatically enrolled in the corresponding exchange plan if the recipient's income increases resulting in his or her ineligibility for MO HealthNet benefits. The bidder must also include in its bid a process to allow an individual enrolled in an identical or substantially similar exchange plan in the state to, in the event his or her income decreases resulting in eligibility for MO HealthNet, to be enrolled in MO HealthNet after an application is received and the applicant is deemed eligible;

(3) The department to select a minimum of two conforming bids and may select up to a maximum number of bids equal to the number of anticipated participants in a region by 100,000;

(4) The department to consider, in determining other accepted bids, the cost to Missouri taxpayers, the extent of the network of health care providers offering services within the bidder's plan, additional services offered to recipients under the bidder's plan, the bidder's history of providing managed care plans for similar populations in Missouri or other states, and any other criteria that the department deems relevant to ensure MO HealthNet benefits are provided to recipients in a way that saves taxpayer money and improves the health outcomes of recipients;

(5) The department to accept the lowest conforming bid; and

(6) Any managed care organization that enters into a contract with the state to provide managed care plans to be required to fulfill the terms of the contract and provide the plans for at least 12 months or longer if provided in the contract. The state must not increase the reimbursement rate provided to the managed care organization during the contract period above the rate included in the contract. If the organization breaches the contract, the state must be entitled to bring an action against the organization for any remedy allowed by law or equity and must also recover any and all damages provided by law, including liquidated damages in an amount determined by the department during the bidding process. These provisions cannot be construed to preclude the department or the state from terminating the contract as specified in the terms of the contract, including for breach of contract, lack of appropriated funds, or exercising any remedies for breach as may be provided in the contract.

Any participant enrolling in a managed care plan must have the ability to choose his or her plan. In the enrollment process, a participant must be provided a list of all plans available ranked by the relative actuarial value of each plan and each participant must be informed that he or she will be eligible to receive a portion of the amount saved by Missouri taxpayers if he or she chooses a lower cost plan offered in his or her region. The amount received will be determined by the department according to the department's best judgment as to the portion that will bring the maximum savings to Missouri taxpayers. If a participant fails or refuses to select a plan, the department must determine rules for auto-assignment that must include incentives for low-cost bids and improved health outcomes as determined by the department. Auto-enrolled participants must be assigned to the highest performing managed care organization. These provisions cannot be construed to require the department to terminate any existing managed care contract or to extend any managed care contract.

All MO HealthNet managed care plans must provide coverage for ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse treatment, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness care, and chronic disease management; pediatric services, including oral and vision care; and any other services required by federal law. No MO HealthNet plan or program may provide coverage for an abortion unless a physician certifies in writing to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term.

The division must require managed care plans to provide a high-deductible health plan option for uninsured adults 19 years of age or older and younger than 65 years of age with an income of less than 100% of the FPL as converted to the MAGI equivalent net income standard who are enrolled in managed care plans under these provisions. The plan must include a minimum deductible of $1,000 and coverage for benefits as specified by department rule after meeting the $1,000 deductible; an account, funded by the department, of at least $1,000 per adult to pay the medical costs for the initial deductible in the form of a prepaid card; preventative care, as defined by department rule, that is not subject to the deductible and does not require a payment of money from the account; a basic benefits package if annual medical costs exceed $1,000; and primary care provider visits, as defined by the department by rule, that are not subject to the deductible and do not require a payment from the prepaid card.

As soon as practicable, the health plan must establish and maintain a record keeping system for each health care visit or service received by recipients. The plan must require that the recipient's prepaid card number be entered or the electronic strip must be swiped by the health care provider for every health care visit or service received by the recipient regardless of the balance on the card. The information may only include the date of service, the name of the provider, and a general description of the visit or service provided. The plan must keep a complete history of all health care visits and services for which the recipient's prepaid card is entered or swiped. If necessary under state or federal law, a recipient must be required to provide a written waiver for disclosure of this information as a condition of participation in the prepaid card incentive. The department must determine the proportion of the amount left in a participant's account at the end of the plan year that must be paid to the participant for saving taxpayer money and the method of payment. The department must determine the proportion of a participant's account that must be used to subsidize premiums to facilitate a participant's transition from health coverage under MO HealthNet to private insurance based on cost-effective principles determined by the department.

The department must require managed care plans under these provisions to offer an incentive program in which all MO HealthNet participants with chronic conditions, as specified by the department, who are enrolled in managed care plans under these provisions must enroll. Participants who obtain specified primary care and preventive services and who participate or refrain from specified activities to improve the recipient's overall health are eligible to receive an annual cash payment. The department must establish by rule the specific primary care and preventive services and activities to be included in the program and the amount of any annual cash payments or cash equivalents if federal financial participation is not obtained for the cash payments.

A MO HealthNet recipient is eligible to participate in only one of either the high deductible health plan or the incentive program for chronic conditions. No cash payments, incentives, or credits paid to or on behalf of a participant under a MO HealthNet Program are to be considered income in any means-tested benefit program unless otherwise required by law or department rule.

Managed care entities must inform a participant who chooses the high-deductible health plan that the participant may lose his or her incentive payment if he or she utilizes emergency services for non-emergent purposes and requires the information to be included on every electronic and paper correspondence between the managed care plan and the participant.

The department must seek all necessary waivers and state plan amendments from the federal Department of Health and Human Services that are necessary to implement the provisions of the bill. No provisions of the bill may be implemented unless the waivers and state plan amendments are approved.

Managed care organizations must be required to provide to the department, on at least a yearly basis, and the department must publicly report within 30 days of receipt, including posting on the department's website, at least the following information:

(1) Medical loss ratios for each managed care organization compared with the 85% medical loss ratio for large group commercial plans under Public Law 111-148 and, where applicable, with the state's administrative costs in its fee-for-service MO HealthNet program;

(2) Medical loss ratios of each of a managed care organization's capitated specialized subcontractors, such as mental health or dental health, to make sure that the subcontractors' own administrative costs are not erroneously deemed to be expenditures on health care; and

(3) Total payments to the managed care organization in any form, including but not limited to tax breaks and capitated payments to participate in MO HealthNet, and total projected state payments for health care for the same population without the managed care organization.

Managed care organizations must be required to maintain medical loss ratios of at least 85% for MO HealthNet operations. If a managed care organization's medical loss ratio falls below 85% in a given year, the managed care plan must be required to refund to the state the portion of the capitation rates paid to the managed care plan in the amount equal to the difference between the plan's medical loss ratio and 85% of the capitated payment to the managed care organization.

The department must be required to ensure that managed care organizations establish and maintain adequate provider networks to serve the Medicaid population and to include these standards in its contracts with managed care organizations. Managed care organizations must be required to establish and maintain health plan provider networks in geographically accessible locations in accordance with travel distances specified by the department in its managed care contracts and as required by the Department of Insurance, Financial Institutions and Professional Registration.

Managed care plans' networks must consist of, at minimum,

hospitals, physicians, advanced practice nurses, behavioral health providers, community mental health centers, substance abuse providers, dentists, emergent and non-emergent transportation services, federally qualified health centers, rural health centers, women's health specialists, local public health agencies, and all other provider types necessary to ensure sufficient capacity to make available all services in accordance with the service accessibility standards specified by the Department of Social Services.

Managed care organizations must be required to post all of their provider networks online and must regularly update their postings of these networks on a timely basis regarding all changes to provider networks. A provider who is seeing only existing patients under a given managed care plan must not be listed.

The Department of Social Services must be required to contract with an independent organization that does not contract or consult with managed care plans or insurers to conduct secret shopper surveys of Medicaid managed care plans for compliance with provider network adequacy standards on a regular basis, to be funded by the managed care organizations out of their administrative budgets. Secret shopper surveys are a quality assurance mechanism under which individuals posing as managed care enrollees will test the availability of timely appointments with providers listed as participating in the network of a given plan for new patients. The testing must be conducted with various categories of providers, with the specific categories rotated for each survey and with no advance notice provided to the managed care plan. If an attempt to obtain a timely appointment is unsuccessful, the survey records the particular reason for the failure, such as the provider not participating in Medicaid at all, not participating in Medicaid under the plan that listed it and was being tested, or participating under that plan but only for existing patients.

Inadequacy of provider networks, as determined from the secret shopper surveys or the publication of false or misleading information about the composition of health plan provider networks, may be the basis for contract cancellation or sanctions against the offending managed care organization.

The provider compensation rates for each category of provider must also be reported by the managed care organizations to help ascertain whether they are paying enough to engage providers comparable to the number of providers available to commercially insured individuals, as required by federal law, and compared, where applicable, to the state's own provider rates for the same categories of providers.

Managed care organizations must be required to ensure sufficient access to out-of-network providers when necessary to meet the health needs of enrollees in accordance with standards developed by the department and included in the managed care contracts.

Managed care organizations must be required to provide, on a quarterly basis and for prompt publication, at least the following information related to service utilization, approval, and denial:

(1) Service utilization data, including how many of each type of service was requested and delivered, subtotaled by age, race, gender, geographic location, and type of service;

(2) Data regarding denials and partial denials by managed care organizations or their subcontractors each month for each category of services provided to Medicaid enrollees. Denials include partial denials whereby a requested service is approved but in a different amount, duration, scope, frequency, or intensity than requested; and

(3) Data regarding complaints, grievances, and appeals, including numbers of complaints, grievances, and appeals filed, subtotaled by race, age, gender, geographic location, and type of service, including the timeframe data for hearings and decisions made and the dispositions and resolutions of complaints, grievances, or appeals.

Managed care organizations must be required to disclose the following information:

(1) Plan disenrollment data by cause, number of months with the particular managed care plan prior to disenrollment, and form of enrollment such as passive enrollment or enrollee election;

(2) Quality measurement data including, at minimum, all health plan employer data and information set (HEDIS) measures, early periodic screening, diagnosis, and treatment (EPSDT) screening data, and other appropriate utilization measures;

(3) Consumer satisfaction survey data;

(4) Enrollee telephone access reports including the number of unduplicated calls by enrollees, average wait time before managed care organization or subcontractor response, busy signal rate, and enrollee telephone call abandonment rate;

(5) Data regarding the average cost of care of individuals whose care is reported as having been actively managed by the managed care organization versus the average cost of care of the managed

care organization's population generally. For purposes of this section, the phrase "actively managed by the managed care organization" means the managed care organization has actually developed a care plan for the particular individual and is implementing it as opposed to reacting to prior authorization requests as they come in, reviewing usage data, or monitoring doctors with high utilization;

(6) Data regarding the number of enrollees whose care is being actively managed by the managed care organization, broken down by whether the individuals are hospitalized, have been hospitalized in the last 30 days, or have not recently been hospitalized;

(7) Results of network adequacy reviews including geo-mapping and waiting times, stratified by factors including provider type, geographic location, urban or rural areas, any findings of adequacy or inadequacy, and any remedial actions taken. This information must also include any findings with respect to the accuracy of networks as published by managed care organizations, including providers found to be not participating and not accepting new patients;

(8) Provider change data indicating how many enrollees changed their primary care provider by cause, months of enrollment, and form of enrollment such as passive enrollment or enrollee election;

(9) Any data related to preventable hospitalizations, hospital-acquired infections, preventable adverse events, and emergency department admissions; and

(10) Any additional reported data obtained from the managed care plans that relates to the performance of the plans in terms of cost, quality, access to providers or services, or other measures.

URGENT CARE CLINICS (Section 208.1000)

Subject to appropriations, the Department of Social Services is required to develop incentive programs to encourage the construction and operation of urgent care clinics that operate outside normal business hours and are in or adjoining emergency department facilities that receive a high proportion of patients who are participating in MO HealthNet to the extent that the incentives are eligible for federal matching funds.

PRIVATE HEALTH INSURANCE SUBSIDY (Section 208.1001)

Beginning July 1, 2015, any MO HealthNet recipient who elects to receive medical coverage through a private health insurance plan instead of through the MO HealthNet program must be eligible for a

private insurance premium subsidy to assist the recipient in paying the costs of the private insurance if it is determined to be cost effective by the Department of Social Services. The subsidy must be provided on a sliding scale based on income with a graduated reduction in subsidy over a period of time not to exceed two years.

These provisions must not be construed as being part of a MO HealthNet program, plan, or benefit and these provisions must specifically not apply to or impact premium subsidies or other cost supports enrolling MO HealthNet participants in employer-provided health plans, other private health plans, or plans purchased through a health care exchange.