FIRST REGULAR SESSION

HOUSE BILL NO. 926

97TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES ALLEN (Sponsor), FLANIGAN, DIEHL, TORPEY, ZERR, KELLY (45), GOSEN, HAEFNER, CONWAY (104), LICHTENEGGER, MOLENDORP, RICHARDSON AND JONES (50) (Co-sponsors).

2189L.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Section A. Section 208.166, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 208.166, to read as follows: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) "Department", the Missouri department of social services;

(2) "Prepaid capitated", a mode of payment by which the department periodically reimburse 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) "Primary care case-management", a mode of payment by which the department reimburses a contracted primary care physician sponsor on a fee-for-service schedule plus a monthly fee to manage each recipient's case;

(4) "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;

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.

(5) "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 **existing contracted** 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**, which shall include pharmacy benefit and services. The department shall provide for each prepaid health plan to have full control over its formulary and preferred drug list (PDL) in order to develop the necessary pharmacy benefit and services to plan members.**

(2) The department or its designated division shall apply to and seek a waiver from the Centers for Medicare and Medicaid Services (CMS) as is necessary to provide for the following services in a pilot program and as a demonstration project, with the terms and length of time and other terms of specific performance to be determined by the department or its designated division in selected service areas to include Phelps County in the Eastern Region and Jackson County in the Western Region:

(a) Persons certified by the MO HealthNet division who are patients in a medical facility, including nursing homes, hospitals, tuberculosis sanatoriums, or institutions for treatment of mental diseases, and who, except for the fact that they are patients in such medical facility, would qualify for grants under Title IV, Supplemental Security Income (SSI) benefits under Title XVI or state supplements, and those aged, blind and disabled persons who would not be eligible for Supplemental Security Income (SSI) benefits under Title XVI or state supplements if they were not institutionalized in a medical facility but whose income is below the maximum standard set by the MO HealthNet division, which standard shall not exceed that prescribed by federal regulation;

(b) Individuals who are qualified Medicare beneficiaries (QMB) entitled to Medicare Part A as defined in Section 301 of the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, and whose income does not exceed one hundred percent of the nonfarm official poverty level as defined by the federal Office of Management and Budget (OMB) and revised annually. The eligibility of individuals covered under this paragraph shall be determined by the department or its designated division, and those individuals determined eligible shall receive Medicare cost-sharing expenses only as more fully defined by the Medicare Catastrophic Coverage Act of 1988 and the Balanced Budget Act of 1997;

(c) a. Individuals who are entitled to Medicare Part A as defined in Section 4501 of the Omnibus Budget Reconciliation Act of 1990 and whose income does not exceed one

hundred twenty percent of the nonfarm official poverty level as defined by the federal Office of Management and Budget (OMB) and revised annually. Eligibility for MO HealthNet benefits is limited to full payment of Medicare Part B premiums.

b. Individuals entitled to Medicare Part A with an income of more than one hundred twenty percent but less than one hundred thirty-five percent of the federal poverty level and not otherwise eligible for MO HealthNet benefits. Eligibility for MO HealthNet benefits is limited to full payment of Medicare Part B premiums. The number of eligible individuals is limited by the availability of the federal capped allocation at one hundred percent of federal matching funds, as more fully defined in the Balanced Budget Act of 1997;

(d) Disabled workers who are eligible to enroll in Medicare Part A as required by the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, and whose income does not exceed two hundred percent of the federal poverty level as determined in accordance with the Supplemental Security Income (SSI) Program. The eligibility of individuals covered under this paragraph shall be determined by the department or its designated division and those individuals shall be entitled to buy-in coverage of Medicare Part A premiums only under the provisions of this paragraph;

(e) a. Persons who are workers with a potentially severe disability as determined by the department or its designated division. Such persons shall be allowed to purchase MO HealthNet coverage. "Worker with a potentially severe disability" means a person who is at least sixteen years of age, but less than sixty-five years of age who has a physical or mental impairment that is reasonably expected to cause the person to become blind or disabled under Section 1614(a) of the federal Social Security Act, as amended, if the person does not receive items and services provided under MO HealthNet.

b. The eligibility of persons under this paragraph shall be conducted as a demonstration project that is consistent with Section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170, for a certain number of persons as specified by the department or its designated division. The eligibility of individuals covered under this paragraph shall be determined by the department or its designated division;

(f) Individuals who are sixty-five years of age or older, who are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, and whose income does not exceed one hundred thirty-five percent of the nonfarm official poverty level as defined by the federal Office of Management and Budget (OMB) and the MO HealthNet program, and who are not otherwise covered by Medicare. Nothing in this

paragraph shall entitle an individual to benefits. The eligibility of individuals covered under this paragraph shall be determined by the department or its designated division;

(g) Individuals:

a. Who are sixty-five years of age or older;

b. Who are disabled as determined by Section 1614(a)(3) of the federal Social Security Act, as amended;

c. Who are end-stage renal disease patients on dialysis, cancer patients on chemotherapy, or organ transplant recipients on anti-rejection drugs;

d. Whose income does not exceed one hundred thirty-five percent of the nonfarm official poverty level as defined by the federal Office of Management and Budget (OMB) and revised annually; and

(e) Whose resources do not exceed those established by the department or its designated division.

Nothing contained in this paragraph shall entitle an individual to benefits. The eligibility of individuals covered under this paragraph shall be determined by the department or its designated division; and

(h) Individuals who are entitled to Medicare Part D and whose income does not exceed one hundred fifty percent of the nonfarm official poverty level as defined by the federal Office of Management and Budget (OMB) and revised annually. Eligibility for payment of the Medicare Part D subsidy under this paragraph shall be determined by the department and its designated division.

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, health maintenance organizations, health insuring organizations, preferred provider organizations, individual practice associations, local health units, community 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 shall be utilized as providers;

(b) That the department or its designated division shall ensure reasonable access to medical services in geographic areas where managed or coordinated care programs are initiated; 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. 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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