

FIRST REGULAR SESSION
HOUSE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 700
97TH GENERAL ASSEMBLY

0714H.04C

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 208.146, 208.151, 208.631, 208.659, 376.961, 376.962, 376.964, 376.966, 376.968, 376.970, and 376.973, RSMo, and to enact in lieu thereof twenty-one new sections relating to the show-me transformation act.

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

Section A. Sections 208.146, 208.151, 208.631, 208.659, 376.961, 376.962, 376.964, 2 376.966, 376.968, 376.970, and 376.973, RSMo, are repealed and twenty-one new sections 3 enacted in lieu thereof, to be known as sections 208.146, 208.151, 208.186, 208.631, 208.659, 4 208.661, 208.662, 208.990, 208.995, 208.997, 208.998, 208.999, 376.961, 376.962, 376.964, 5 376.966, 376.968, 376.970, 376.973, 1 and 2, to read as follows:

208.146. 1. The program established under this section shall be known as the "Ticket 2 to Work Health Assurance Program". Subject to appropriations and in accordance with the 3 federal Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIA), Public Law 4 106-170, the medical assistance provided for in section 208.151 may be paid for a person who 5 is employed and who:

6 (1) Except for earnings, meets the definition of disabled under the Supplemental Security 7 Income Program or meets the definition of an employed individual with a medically improved 8 disability under TWWIA;

9 (2) Has earned income, as defined in subsection 2 of this section;

10 (3) Meets the asset limits in subsection 3 of this section;

11 (4) Has net income, as defined in subsection 3 of this section, that does not exceed the 12 limit for permanent and totally disabled individuals to receive nonspenddown MO HealthNet 13 under subdivision (24) of subsection 1 of section 208.151; and

14 (5) Has a gross income of two hundred fifty percent or less of the federal poverty level, 15 excluding any earned income of the worker with a disability between two hundred fifty and three 16 hundred percent of the federal poverty level. For purposes of this subdivision, "gross income" 17 includes all income of the person and the person's spouse that would be considered in

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.

18 determining MO HealthNet eligibility for permanent and totally disabled individuals under
19 subdivision (24) of subsection 1 of section 208.151. Individuals with gross incomes in excess
20 of one hundred percent of the federal poverty level shall pay a premium for participation in
21 accordance with subsection 4 of this section.

22 2. For income to be considered earned income for purposes of this section, the
23 department of social services shall document that Medicare and Social Security taxes are
24 withheld from such income. Self-employed persons shall provide proof of payment of Medicare
25 and Social Security taxes for income to be considered earned.

26 3. (1) For purposes of determining eligibility under this section, the available asset limit
27 and the definition of available assets shall be the same as those used to determine MO HealthNet
28 eligibility for permanent and totally disabled individuals under subdivision (24) of subsection
29 1 of section 208.151 except for:

30 (a) Medical savings accounts limited to deposits of earned income and earnings on such
31 income while a participant in the program created under this section with a value not to exceed
32 five thousand dollars per year; and

33 (b) Independent living accounts limited to deposits of earned income and earnings on
34 such income while a participant in the program created under this section with a value not to
35 exceed five thousand dollars per year. For purposes of this section, an "independent living
36 account" means an account established and maintained to provide savings for transportation,
37 housing, home modification, and personal care services and assistive devices associated with
38 such person's disability.

39 (2) To determine net income, the following shall be disregarded:

40 (a) All earned income of the disabled worker;

41 (b) The first sixty-five dollars and one-half of the remaining earned income of a
42 nondisabled spouse's earned income;

43 (c) A twenty dollar standard deduction;

44 (d) Health insurance premiums;

45 (e) A seventy-five dollar a month standard deduction for the disabled worker's dental and
46 optical insurance when the total dental and optical insurance premiums are less than seventy-five
47 dollars;

48 (f) All Supplemental Security Income payments, and the first fifty dollars of SSDI
49 payments;

50 (g) A standard deduction for impairment-related employment expenses equal to one-half
51 of the disabled worker's earned income.

52 4. Any person whose gross income exceeds one hundred percent of the federal poverty
53 level shall pay a premium for participation in the medical assistance provided in this section.
54 Such premium shall be:

55 (1) For a person whose gross income is more than one hundred percent but less than one
56 hundred fifty percent of the federal poverty level, four percent of income at one hundred percent
57 of the federal poverty level;

58 (2) For a person whose gross income equals or exceeds one hundred fifty percent but is
59 less than two hundred percent of the federal poverty level, four percent of income at one hundred
60 fifty percent of the federal poverty level;

61 (3) For a person whose gross income equals or exceeds two hundred percent but less
62 than two hundred fifty percent of the federal poverty level, five percent of income at two hundred
63 percent of the federal poverty level;

64 (4) For a person whose gross income equals or exceeds two hundred fifty percent up to
65 and including three hundred percent of the federal poverty level, six percent of income at two
66 hundred fifty percent of the federal poverty level.

67 5. Recipients of services through this program shall report any change in income or
68 household size within ten days of the occurrence of such change. An increase in premiums
69 resulting from a reported change in income or household size shall be effective with the next
70 premium invoice that is mailed to a person after due process requirements have been met. A
71 decrease in premiums shall be effective the first day of the month immediately following the
72 month in which the change is reported.

73 6. If an eligible person's employer offers employer-sponsored health insurance and the
74 department of social services determines that it is more cost effective, such person shall
75 participate in the employer-sponsored insurance. The department shall pay such person's portion
76 of the premiums, co-payments, and any other costs associated with participation in the
77 employer-sponsored health insurance.

78 7. The provisions of this section shall expire [six years after August 28, 2007] **July 1,**
79 **2014.**

208.151. 1. Medical assistance on behalf of needy persons shall be known as "MO
2 HealthNet". For the purpose of paying MO HealthNet benefits and to comply with Title XIX,
3 Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301,
4 et seq.) as amended, the following needy persons shall be eligible to receive MO HealthNet
5 benefits to the extent and in the manner hereinafter provided, **unless otherwise provided in**
6 **subsection 2 of this section:**

7 (1) All participants receiving state supplemental payments for the aged, blind and
8 disabled;

9 (2) All participants receiving aid to families with dependent children benefits, including
10 all persons under nineteen years of age who would be classified as dependent children except for
11 the requirements of subdivision (1) of subsection 1 of section 208.040. Participants eligible
12 under this subdivision who are participating in drug court, as defined in section 478.001, shall
13 have their eligibility automatically extended sixty days from the time their dependent child is

14 removed from the custody of the participant, subject to approval of the Centers for Medicare and
15 Medicaid Services;

16 (3) All participants receiving blind pension benefits;

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

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

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

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

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

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

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

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

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

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

53 (14) Children who have attained six years of age but have not attained nineteen years of
54 age. For children who have attained six years of age but have not attained nineteen years of age,
55 the family support division shall use an income assessment methodology which provides for
56 eligibility when family income is equal to or less than equal to one hundred percent of the federal
57 poverty level established by the Department of Health and Human Services, or its successor
58 agency. As necessary to provide MO HealthNet coverage under this subdivision, the department
59 of social services may revise the state MO HealthNet plan to extend coverage under 42 U.S.C.
60 1396a (a)(10)(A)(i)(III) to children who have attained six years of age but have not attained
61 nineteen years of age as permitted by paragraph (2) of subsection (n) of 42 U.S.C. 1396d using
62 a more liberal income assessment methodology as authorized by paragraph (2) of subsection (r)
63 of 42 U.S.C. 1396a;

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

69 (16) Notwithstanding any other provisions of law to the contrary, ambulatory prenatal
70 care shall be made available to pregnant women during a period of presumptive eligibility
71 pursuant to 42 U.S.C. Section 1396r-1, as amended;

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

82 (18) Pregnant women and children eligible for MO HealthNet benefits pursuant to
83 subdivision (12), (13) or (14) of this subsection shall not as a condition of eligibility for MO
84 HealthNet benefits be required to apply for aid to families with dependent children. The family
85 support division shall utilize an application for eligibility for such persons which eliminates
86 information requirements other than those necessary to apply for MO HealthNet benefits. The
87 division shall provide such application forms to applicants whose preliminary income
88 information indicates that they are ineligible for aid to families with dependent children.
89 Applicants for MO HealthNet benefits under subdivision (12), (13) or (14) of this subsection
90 shall be informed of the aid to families with dependent children program and that they are

91 entitled to apply for such benefits. Any forms utilized by the family support division for
92 assessing eligibility under this chapter shall be as simple as practicable;

93 (19) Subject to appropriations necessary to recruit and train such staff, the family support
94 division shall provide one or more full-time, permanent eligibility specialists to process
95 applications for MO HealthNet benefits at the site of a health care provider, if the health care
96 provider requests the placement of such eligibility specialists and reimburses the division for the
97 expenses including but not limited to salaries, benefits, travel, training, telephone, supplies, and
98 equipment of such eligibility specialists. The division may provide a health care provider with
99 a part-time or temporary eligibility specialist at the site of a health care provider if the health care
100 provider requests the placement of such an eligibility specialist and reimburses the division for
101 the expenses, including but not limited to the salary, benefits, travel, training, telephone,
102 supplies, and equipment, of such an eligibility specialist. The division may seek to employ such
103 eligibility specialists who are otherwise qualified for such positions and who are current or
104 former welfare participants. The division may consider training such current or former welfare
105 participants as eligibility specialists for this program;

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

111 (21) Case management services for pregnant women and young children at risk shall be
112 a covered service. To the greatest extent possible, and in compliance with federal law and
113 regulations, the department of health and senior services shall provide case management services
114 to pregnant women by contract or agreement with the department of social services through local
115 health departments organized under the provisions of chapter 192 or chapter 205 or a city health
116 department operated under a city charter or a combined city-county health department or other
117 department of health and senior services designees. To the greatest extent possible the
118 department of social services and the department of health and senior services shall mutually
119 coordinate all services for pregnant women and children with the crippled children's program,
120 the prevention of intellectual disability and developmental disability program and the prenatal
121 care program administered by the department of health and senior services. The department of
122 social services shall by regulation establish the methodology for reimbursement for case
123 management services provided by the department of health and senior services. For purposes
124 of this section, the term "case management" shall mean those activities of local public health
125 personnel to identify prospective MO HealthNet-eligible high-risk mothers and enroll them in
126 the state's MO HealthNet program, refer them to local physicians or local health departments
127 who provide prenatal care under physician protocol and who participate in the MO HealthNet
128 program for prenatal care and to ensure that said high-risk mothers receive support from all

129 private and public programs for which they are eligible and shall not include involvement in any
130 MO HealthNet prepaid, case-managed programs;

131 (22) By January 1, 1988, the department of social services and the department of health
132 and senior services shall study all significant aspects of presumptive eligibility for pregnant
133 women and submit a joint report on the subject, including projected costs and the time needed
134 for implementation, to the general assembly. The department of social services, at the direction
135 of the general assembly, may implement presumptive eligibility by regulation promulgated
136 pursuant to chapter 207;

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

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

145 (b) All persons who would be determined to be eligible for aid to the blind benefits
146 under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section
147 1396a(f), or less restrictive methodologies as contained in the MO HealthNet state plan as of
148 January 1, 2005, except that less restrictive income methodologies, as authorized in 42 U.S.C.
149 Section 1396a(r)(2), shall be used to raise the income limit to one hundred percent of the federal
150 poverty level;

151 (c) All persons who would be determined to be eligible for permanent and total disability
152 benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C.
153 1396a(f); or less restrictive methodologies as contained in the MO HealthNet state plan as of
154 January 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as
155 authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if
156 authorized by annual appropriations. Eligibility standards for permanent and total disability
157 benefits shall not be limited by age;

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

161 (26) **Effective August 28, 2013**, persons who are [independent foster care adolescents,
162 as defined in 42 U.S.C. Section 1396d, or who are within reasonable categories of such
163 adolescents who are under twenty-one years of age as specified by the state, are eligible for
164 coverage under 42 U.S.C. Section 1396a (a)(10)(A)(ii)(XVII) without regard to income or assets]
165 **in foster care under the responsibility of the state of Missouri on the date such persons**
166 **attain the age of eighteen years, or at any time during the thirty-day period preceding their**
167 **eighteenth birthday, without regard to income or assets, if such persons:**

- 168 (a) Are under twenty-six years of age;
- 169 (b) Are not eligible for coverage under another mandatory coverage group; and
- 170 (c) Were covered by Medicaid while they were in foster care.
- 171 2. Beginning July 1, 2014, eligibility for MO HealthNet benefits shall be amended
- 172 as follows:
- 173 (1) Persons eligible under subdivisions (3) and (25) of subsection 1 of this section
- 174 shall no longer be eligible for MO HealthNet benefits as provided in this section, except for
- 175 those persons eligible under subdivision (25) who do not have access to employer-sponsored
- 176 health insurance coverage or subsidized insurance coverage through an exchange at any
- 177 point after diagnosis, whose income is between one hundred percent and two hundred
- 178 percent of the federal poverty level;
- 179 (2) Pregnant women who are eligible under subdivision (12) of subsection 1 of this
- 180 section, with income between one hundred thirty-three and one hundred eighty-five
- 181 percent of the federal poverty level shall be eligible for MO HealthNet in the form of a
- 182 premium subsidy as established by rule of the department in order for them to enroll in
- 183 a plan offered by a health care exchange, whether federally facilitated, state based, or
- 184 operated on a partnership basis. The pregnant women shall be directed to choose an
- 185 exchange plan and shall be eligible for a premium subsidy equal to the amount of the
- 186 percentage of income required for premium payments or coinsurance to the pregnant
- 187 women by federal rule;
- 188 (3) Beginning October 1, 2019, infants under one year of age who are eligible under
- 189 subdivision (12) of subsection 1 of this section shall be limited to those infants whose family
- 190 income does not exceed one hundred eighty-five percent of the federal poverty level as
- 191 established and amended by the federal Department of Health and Human Services or its
- 192 successor agency. Infants under one year of age born to women who were covered under
- 193 subdivision (2) of this subsection with family income between one hundred thirty-three and
- 194 one hundred eighty-five percent of the federal poverty level shall only be eligible if, in
- 195 addition to the other requirements, his or her parents do not have access to health
- 196 insurance coverage for the child through a health insurance plan in a health care exchange,
- 197 whether federally facilitated, state based, or operated on a partnership basis, and the
- 198 parents are not eligible for a premium subsidy for the child or family through such
- 199 exchange because the parents have been determined to have access to affordable health
- 200 insurance as defined by the exchange;
- 201 (4) The changes in eligibility under subdivisions (1) to (3) of this subsection shall
- 202 not take place unless and until:
- 203 (a) There are health insurance premium tax credits under Section 36B of the
- 204 Internal Revenue Code of 1986, as amended, available to persons through the purchase of
- 205 a health insurance plan in a health care exchange, whether federally facilitated, state
- 206 based, or operated on a partnership basis. The director of the department of revenue shall

207 **certify to the director of the department that health insurance premium tax credits are**
208 **available, and the director of the department shall notify the revisor of statutes;**

209 **(b) Eligibility of persons set out in subsection 3 of section 208.995 has been**
210 **approved by the federal Department of Health and Human Services, has been implemented**
211 **by the department, and notice of implementation has been provided to the revisor of**
212 **statutes; and**

213 **(c) The federal Department of Health and Human Services grants any necessary**
214 **waivers and state plan amendments to implement this subsection, federal funding is**
215 **received for the premium subsidies to be paid, and notice has been provided to the revisor**
216 **of statutes.**

217 **3.** Rules and regulations to implement this section shall be promulgated in accordance
218 with [section 431.064 and] chapter 536. Any rule or portion of a rule, as that term is defined in
219 section 536.010, that is created under the authority delegated in this section shall become
220 effective only if it complies with and is subject to all of the provisions of chapter 536 and, if
221 applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the
222 powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective
223 date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of
224 rulemaking authority and any rule proposed or adopted after August 28, 2002, shall be invalid
225 and void.

226 [3.] **4.** After December 31, 1973, and before April 1, 1990, any family eligible for
227 assistance pursuant to 42 U.S.C. 601, et seq., as amended, in at least three of the last six months
228 immediately preceding the month in which such family became ineligible for such assistance
229 because of increased income from employment shall, while a member of such family is
230 employed, remain eligible for MO HealthNet benefits for four calendar months following the
231 month in which such family would otherwise be determined to be ineligible for such assistance
232 because of income and resource limitation. After April 1, 1990, any family receiving aid
233 pursuant to 42 U.S.C. 601, et seq., as amended, in at least three of the six months immediately
234 preceding the month in which such family becomes ineligible for such aid, because of hours of
235 employment or income from employment of the caretaker relative, shall remain eligible for MO
236 HealthNet benefits for six calendar months following the month of such ineligibility as long as
237 such family includes a child as provided in 42 U.S.C. 1396r-6. Each family which has received
238 such medical assistance during the entire six-month period described in this section and which
239 meets reporting requirements and income tests established by the division and continues to
240 include a child as provided in 42 U.S.C. 1396r-6 shall receive MO HealthNet benefits without
241 fee for an additional six months. The MO HealthNet division may provide by rule and as
242 authorized by annual appropriation the scope of MO HealthNet coverage to be granted to such
243 families.

244 [4.] **5.** When any individual has been determined to be eligible for MO HealthNet
245 benefits, such medical assistance will be made available to him or her for care and services

246 furnished in or after the third month before the month in which he made application for such
247 assistance if such individual was, or upon application would have been, eligible for such
248 assistance at the time such care and services were furnished; provided, further, that such medical
249 expenses remain unpaid.

250 [5.] 6. The department of social services may apply to the federal Department of Health
251 and Human Services for a MO HealthNet waiver amendment to the Section 1115 demonstration
252 waiver or for any additional MO HealthNet waivers necessary not to exceed one million dollars
253 in additional costs to the state, unless subject to appropriation or directed by statute, but in no
254 event shall such waiver applications or amendments seek to waive the services of a rural health
255 clinic or a federally qualified health center as defined in 42 U.S.C. 1396d(l)(1) and (2) or the
256 payment requirements for such clinics and centers as provided in 42 U.S.C. 1396a(a)(15) and
257 1396a(bb) unless such waiver application is approved by the oversight committee created in
258 section 208.955. A request for such a waiver so submitted shall only become effective by
259 executive order not sooner than ninety days after the final adjournment of the session of the
260 general assembly to which it is submitted, unless it is disapproved within sixty days of its
261 submission to a regular session by a senate or house resolution adopted by a majority vote of the
262 respective elected members thereof, unless the request for such a waiver is made subject to
263 appropriation or directed by statute.

264 [6.] 7. Notwithstanding any other provision of law to the contrary, in any given fiscal
265 year, any persons made eligible for MO HealthNet benefits under subdivisions (1) to (22) of
266 subsection 1 of this section shall only be eligible if annual appropriations are made for such
267 eligibility. This subsection shall not apply to classes of individuals listed in 42 U.S.C. Section
268 1396a(a)(10)(A)(i).

269 **8. The department shall notify any potential exchange-eligible participant who may**
270 **be eligible for services due to spenddown that the participant may qualify for more cost-**
271 **effective private insurance and premium tax credits under Section 36B of the Internal**
272 **Revenue Code of 1986, as amended, available through the purchase of a health insurance**
273 **plan in a health care exchange, whether federally facilitated, state based, or operated on**
274 **a partnership basis and the benefits that would be potentially covered under such**
275 **insurance.**

2 **208.186. 1. Any person participating in the MO HealthNet program who has pled**
3 **guilty to or been found guilty of a crime involving alcohol or a controlled substance or any**
4 **crime in which alcohol or substance abuse was, in the opinion of the court, a contributing**
5 **factor to the person's commission of the crime shall be required to obtain an assessment**
6 **by a treatment provider approved by the department of mental health to determine the**
7 **need for services. Recommendations of the treatment provider may be used by the court**
8 **in sentencing.**

9 **2. Any person participating in the MO HealthNet program who is a parent of a**
10 **child subject to proceedings in juvenile court under subsection 1 or 2 of section 211.031,**

10 **whose misuse of controlled substances or alcohol is found to be a significant, contributing**
11 **factor to the reason the child was adjudicated, shall be required to obtain an assessment**
12 **by a treatment provider approved by the department of mental health to determine the**
13 **need for services. Recommendations of the treatment provider shall be included in the**
14 **child's permanency plan. The court may order the parent or guardian to successfully**
15 **complete treatment before the child is reunified with the parent or guardian.**

16 **3. The MO HealthNet division shall certify a MO HealthNet participant's**
17 **enrollment in MO HealthNet if requested by the court under this section. A letter signed**
18 **by the director of the MO HealthNet division or his or her designee or the family support**
19 **division certifying that the individual is a participant in the MO HealthNet program shall**
20 **be prima facie evidence of such participation and shall be admissible into evidence without**
21 **further foundation for that purpose. The letter may specify additional information such**
22 **as anticipated dates of coverage as may be deemed necessary by the department.**

208.631. 1. Notwithstanding any other provision of law to the contrary, the MO
2 HealthNet division shall establish a program to pay for health care for uninsured children.
3 Coverage pursuant to sections 208.631 to 208.659 is subject to appropriation. The provisions
4 of sections 208.631 to 208.569, health care for uninsured children, shall be void and of no effect
5 if there are no funds of the United States appropriated by Congress to be provided to the state
6 on the basis of a state plan approved by the federal government under the federal Social Security
7 Act. If funds are appropriated by the United States Congress, the department of social services
8 is authorized to manage the state children's health insurance program (SCHIP) allotment in order
9 to ensure that the state receives maximum federal financial participation. Children in households
10 with incomes up to one hundred fifty percent of the federal poverty level may meet all Title XIX
11 program guidelines as required by the Centers for Medicare and Medicaid Services. Children
12 in households with incomes of one hundred fifty percent to three hundred percent of the federal
13 poverty level shall continue to be eligible as they were and receive services as they did on June
14 30, 2007, unless changed by the Missouri general assembly.

15 2. For the purposes of sections 208.631 to 208.659, "children" are persons up to nineteen
16 years of age. "Uninsured children" are persons up to nineteen years of age who are emancipated
17 and do not have access to affordable employer-subsidized health care insurance or other health
18 care coverage or persons whose parent or guardian have not had access to affordable
19 employer-subsidized health care insurance or other health care coverage for their children for six
20 months prior to application, are residents of the state of Missouri, and have parents or guardians
21 who meet the requirements in section 208.636. A child who is eligible for MO HealthNet
22 benefits as authorized in section 208.151 is not uninsured for the purposes of sections 208.631
23 to 208.659.

24 **3. Beginning October 1, 2019, a child eligible under sections 208.631 to 208.658**
25 **shall only remain eligible if, in addition to the other requirements, his or her parents do not**
26 **have access to health insurance coverage for the child through their employment or**

27 **through a health insurance plan in a health care exchange, whether federally facilitated,**
28 **state based, or operated on a partnership basis because the parents are not eligible for a**
29 **premium subsidy for the child or family through such exchange. This subsection shall not**
30 **go into effect unless and until, for a six-month period preceding the additional**
31 **requirements, there are health insurance premium tax credits available for children and**
32 **family coverage under Section 36B of the Internal Revenue Code of 1986, as amended,**
33 **available to persons through the purchase of a health insurance plan in a health care**
34 **exchange, whether federally facilitated, state based, or operated on a partnership basis,**
35 **which have been in place for a six-month period.**

36 **4. The department shall inform participants six months prior to coverage being**
37 **discontinued under subsection 3 of this section as to the possibility of insurance coverage**
38 **through the purchase of a subsidized health insurance plan available through a health care**
39 **exchange.**

208.659. 1. The MO HealthNet division shall revise the eligibility requirements for the
2 uninsured women's health program, as established in 13 CSR Section 70-4.090, to include
3 women who are at least eighteen years of age and with a net family income of at or below one
4 hundred eighty-five percent of the federal poverty level. In order to be eligible for such program,
5 the applicant shall not have assets in excess of two hundred and fifty thousand dollars, nor shall
6 the applicant have access to employer-sponsored health insurance. Such change in eligibility
7 requirements shall not result in any change in services provided under the program.

8 **2. Beginning July 1, 2014, the provisions of this section shall no longer be in effect.**
9 **Such change in eligibility shall not take place unless and until:**

10 **(1) For a six-month period preceding the discontinuance of benefits under this**
11 **subsection there are health insurance premium tax credits available for children and**
12 **family coverage under Section 36B of the Internal Revenue Code of 1986, as amended,**
13 **available to persons through the purchase of a health insurance plan in a health care**
14 **exchange, whether federally facilitated, state based, or operated on a partnership basis,**
15 **which have been in place for a six-month period, and notice has been provided to the**
16 **revisor of statutes; and**

17 **(2) Eligibility of persons set out in subsection 3 of section 208.995 has received any**
18 **necessary approvals from the federal Department of Health and Human Services, has been**
19 **implemented by the department, and notice has been provided to the revisor of statutes.**

20 **3. The department shall inform participants six months prior to coverage being**
21 **discontinued under subsection 2 of this section as to the possibility of insurance coverage**
22 **through the purchase of a subsidized health insurance plan available through a health care**
23 **exchange.**

208.661. 1. The department shall develop incentive programs, submit state plan
2 amendments and apply for necessary waivers to permit rural health clinics, federally-
3 qualified health centers, or other primary care practices to co-locate on the property of

4 public elementary and secondary schools with fifty percent or more students who are
5 eligible for free or reduced price lunch.

6 2. No school-based health care clinic established under this section shall perform
7 or refer for abortion services, or provide or refer for contraceptive drugs or devices.

8 3. The consent of a parent or legal guardian shall be required before a minor may
9 receive health care services under this section.

10 4. The provisions of this section shall be null and void unless and until any waivers
11 necessary to the implementation of subsections 2 and 3 of this section are granted by the
12 federal government.

208.662. 1. There is hereby established within the department of social services the
2 “Show-Me Healthy Babies Program” as a separate children’s health insurance program
3 (CHIP) for any low-income, unborn child, neither of whose parents have access to
4 affordable health insurance coverage for the unborn child through his or her employment
5 or through a health insurance plan in a health care exchange, whether federally facilitated,
6 state based, or operated on a partnership basis. The program shall be established under
7 the authority of Title XXI of the federal Social Security Act, the State Children’s Health
8 Insurance Program, as amended, and 42 CFR 457.1.

9 2. For an unborn child to be enrolled in the show-me healthy babies program, his
10 or her mother shall not be eligible for coverage under Title XIX of the federal Social
11 Security Act, the Medicaid program, as it is administered by the state, and shall not have
12 access to affordable employer-subsidized health care insurance or other affordable health
13 care coverage that includes coverage for the unborn child including any health insurance
14 plan in a health care exchange, whether federally facilitated, state based, or operated on
15 a partnership basis.

16 3. Coverage for an unborn child enrolled in the show-me healthy babies program
17 shall include all prenatal care and pregnancy-related services that benefit the health of the
18 unborn child and that promote healthy labor, delivery, and birth, as determined by
19 regulations of the department. Coverage shall not include services that are solely for the
20 benefit of the pregnant mother, that are unrelated to maintaining or promoting a healthy
21 pregnancy, and that provide no benefit to the unborn child.

22 4. There shall be no waiting period before an unborn child may be enrolled in the
23 show-me healthy babies program. In accordance with the definition of child in 42 CFR
24 457.10, coverage shall include the period from conception to birth. The department shall
25 develop a presumptive eligibility procedure for enrolling an unborn child.

26 5. Coverage for the child shall continue for up to one year after birth, unless
27 otherwise prohibited by law or unless otherwise limited by the general assembly through
28 appropriations.

29 6. Pregnancy-related and postpartum coverage for the mother shall begin on the
30 day the pregnancy ends and extend through the last day of the month that includes the

31 sixtieth day after the pregnancy ends, unless otherwise prohibited by law or unless
32 otherwise limited by the general assembly through appropriations. Coverage for the
33 mother shall be limited to pregnancy-related and postpartum care.

34 7. Nothing in this section shall be construed to prohibit an unborn child from being
35 enrolled in the show-me healthy babies program at the same time his or her mother is
36 enrolled in MO HealthNet, the children's health insurance program (CHIP), Medicare, or
37 other governmental or government-subsidized health care program. The department shall
38 ensure that there is no duplication of payments for services for an unborn child enrolled
39 in the show-me healthy babies program that are payable under a governmental or
40 nongovernmental health care program for services to an eligible pregnant woman.

41 8. The department may provide coverage for an unborn child enrolled in the show-
42 me healthy babies program through:

43 (1) Direct coverage whereby the state pays health care providers directly or by
44 contracting with a managed care organization or with a group or individual health
45 insurance provider;

46 (2) A premium assistance program whereby the state assists in payment of the
47 premiums, co-payments, coinsurance, or deductibles for a person who is eligible for health
48 coverage through an employer, former employer, labor union, credit union, church,
49 spouse, other organizations, other individuals, or through an individual health insurance
50 policy that includes coverage for the unborn child, when such person needs assistance in
51 paying such premiums, co-payments, coinsurance, or deductibles;

52 (3) A combination of direct coverage, such as when the unborn child is first
53 enrolled, and premium assistance, such as after the child is born; or

54 (4) Any other similar arrangement whereby there:

55 (a) Are lower program costs without sacrificing health care coverage for the
56 unborn child or the child up to one year after birth;

57 (b) Are greater covered services for the unborn child or the child up to one year
58 after birth;

59 (c) Is a similar cost for coverage of the participant and also will provide coverage
60 for siblings or other family members; or

61 (d) Will be an ability for the child to transition more easily to nongovernment or
62 less government-subsidized group or individual health insurance coverage after the child
63 is no longer enrolled in the show-me healthy babies program.

64 9. The department shall provide information about the show-me healthy babies
65 program to maternity homes as defined in section 135.600, pregnancy resource centers as
66 defined in section 135.630, and other similar agencies and programs in the state that assist
67 unborn children and their mothers. The department shall consider allowing such agencies
68 and programs to assist in the enrollment of unborn children in the program and in making
69 determinations about presumptive eligibility.

70 **10. Within sixty days after the effective date of this section, the department shall**
71 **submit a state plan amendment or seek any necessary waivers from the federal Department**
72 **of Health and Human Services requesting approval for the show-me healthy babies**
73 **program.**

74 **11. At least annually, the department shall prepare and submit a report to the**
75 **governor, the speaker of the house of representatives, and the president pro tem of the**
76 **senate analyzing the cost savings and benefits, if any, to the state, counties, local**
77 **communities, school districts, law enforcement agencies, health care providers, employers,**
78 **other public and private entities, and persons by enrolling unborn children in the show-me**
79 **healthy babies program. The analysis of cost savings and benefits, if any, shall include but**
80 **not be limited to:**

81 **(1) The higher federal matching rate for having an unborn child enrolled in the**
82 **show-me healthy babies program versus the lower federal matching rate for a pregnant**
83 **woman being enrolled in MO HealthNet or other federal programs;**

84 **(2) The efficacy in providing services through managed care organizations, group**
85 **or individual health insurance providers or premium assistance, or through other**
86 **nontraditional arrangements of providing health care;**

87 **(3) The change in the proportion of unborn children who receive care in the first**
88 **trimester of pregnancy due to a lack of waiting periods, presumptive eligibility, or removal**
89 **of other barriers, and the attendant decrease in health problems and other problems for**
90 **unborn children and women throughout pregnancy; at labor, delivery, and birth; and**
91 **during infancy and childhood;**

92 **(4) The change in healthy behaviors by pregnant women, such as the cessation of**
93 **the use of tobacco, alcohol, illicit drugs, or other harmful practices, and the attendant**
94 **short-term and long-term decrease in birth defects; poor motor skills; vision, speech, and**
95 **hearing problems; breathing and respiratory problems; feeding and digestive problems;**
96 **and other physical, mental, educational, and behavioral problems; and**

97 **(5) The change in infant and maternal mortality, preterm births and low birth**
98 **weight babies and the attendant decrease in short-term and long-term medical and other**
99 **interventions.**

100 **12. The show-me healthy babies program shall not be deemed an entitlement**
101 **program, but instead shall be subject to a federal allotment or other federal appropriations**
102 **and matching state appropriations.**

103 **13. Nothing in this section shall be construed as obligating the state to continue the**
104 **show-me healthy babies program if the allotment or payments from the federal**
105 **government end or are not sufficient for the program to operate, or if the general assembly**
106 **does not appropriate funds for the program.**

107 **14. Nothing in this section shall be construed as expanding MO HealthNet or**
108 **fulfilling a mandate imposed by the federal government on the state.**

208.990. 1. The provisions of sections 208.146, 208.151, 208.186, 208.631, 208.659,
2 208.661, 208.662, 208.990, 208.995, 208.997, 208.998, 208.999, 376.961, 376.962, 376.964,
3 376.966, 376.968, 376.970, 376.973, 1 and 2 shall be known and may be cited as the "Show-
4 Me Transformation Act".

5 2. Notwithstanding any other provisions of law to the contrary, to be eligible for
6 MO HealthNet coverage individuals shall meet the eligibility criteria set forth in 42 CFR
7 435, including but not limited to the requirements that:

8 (1) The individual is a resident of the state of Missouri;

9 (2) The individual has a valid Social Security number;

10 (3) The individual is a citizen of the United States or a qualified alien as described
11 in Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act
12 of 1996, 8 U.S.C. Section 1641, who has provided satisfactory documentary evidence of
13 qualified alien status which has been verified with the Department of Homeland Security
14 under a declaration required by Section 1137(d) of the Personal Responsibility and Work
15 Opportunity Reconciliation Act of 1996 that the applicant or beneficiary is an alien in a
16 satisfactory immigration status; and

17 (4) An individual claiming eligibility as a pregnant woman shall verify pregnancy.

18 3. Notwithstanding any other provisions of law to the contrary, effective January 1,
19 2014, the family support division shall conduct an annual redetermination of all MO
20 HealthNet participants' eligibility as provided in 42 CFR 435.916. The department may
21 contract with an administrative service organization to conduct the annual
22 redeterminations if it is cost effective.

23 4. The department, or family support division, shall conduct electronic searches to
24 redetermine eligibility on the basis of income, residency, citizenship, identity and other
25 criteria as described in 42 CFR 435.916 upon availability of federal, state, and
26 commercially available electronic data sources. The department, or family support
27 division, may enter into a contract with a vendor to perform the electronic search of
28 eligibility information not disclosed during the application process and obtain an
29 applicable case management system. The department shall retain final authority over
30 eligibility determinations made during the redetermination process.

31 5. Notwithstanding any other provisions of law to the contrary, applications for
32 MO HealthNet benefits shall be submitted in accordance with the requirements of 42 CFR
33 435.907 and other applicable federal law. The individual shall provide all required
34 information and documentation necessary to make an eligibility determination, resolve
35 discrepancies found during the redetermination process, or for a purpose directly
36 connected to the administration of the medical assistance program.

37 6. Notwithstanding any other provisions of law to the contrary, to be eligible for
38 MO HealthNet coverage under section 208.995, individuals shall meet the eligibility

39 requirements set forth in subsection 2 of this section and all other eligibility criteria set
40 forth in 42 CFR 435 and 457, including, but not limited to, the requirements that:

41 (1) The department of social services shall determine the individual's financial
42 eligibility based on projected annual household income and family size for the remainder
43 of the current calendar year;

44 (2) The department of social services shall determine household income for the
45 purpose of determining the modified adjusted gross income by including all available cash
46 support provided by the person claiming such individual as a dependent for tax purposes;

47 (3) The department of social services shall determine a pregnant woman's
48 household size by counting the pregnant woman plus the number of children she is
49 expected to deliver;

50 (4) CHIP-eligible children shall be uninsured, shall not have access to affordable
51 insurance, and their parent shall pay the required premium;

52 (5) An individual claiming eligibility as an uninsured woman shall be uninsured.

53 7. The MO HealthNet program shall not provide MO HealthNet coverage under
54 subsection 3 of section 208.995 to a parent or other caretaker relative living with a
55 dependent child unless the child is receiving benefits under the MO HealthNet program,
56 the Children's Health Insurance Program (CHIP) under 42 CFR Chapter IV, Subchapter
57 D, or otherwise is enrolled in minimum essential coverage as defined in 42 CFR 435.4.

58 8. (1) The provisions of the show-me transformation act shall be null and void
59 unless and until:

60 (a) There are health insurance premium tax credits under Section 36B of the
61 Internal Revenue Code of 1986, as amended, available to persons through the purchase of
62 a health insurance plan in a health care exchange, whether federally facilitated, state based,
63 or operated on a partnership basis;

64 (b) Eligibility of persons set out in subsection 3 of section 208.995 has been
65 approved by the federal Department of Health and Human Services and has been
66 implemented by the department;

67 (c) The federal Department of Health and Human Services grants the required
68 waivers, state plan amendments, and enhanced federal funding rate for persons newly
69 eligible under subsection 3 of section 208.995 whereby the federal government agrees to
70 pay the percentages specified in Section 2001 of PL 111-148, as that section existed on
71 March 23, 2010. The provisions of subsections 3 to 8 of section 208.995 shall not be
72 implemented unless such waivers and enhanced federal funding rates are granted by the
73 federal government;

74 (2) If the federal funds at the disposal of the state shall at any time become less than
75 ninety percent of the funds necessary or are not appropriated to pay the percentages
76 specified in Section 2001 of Public Law 111-148, as that section existed on March 23, 2010,
77 the provisions of this act shall be null and void. If the director is notified that federal

78 funding will fall below ninety percent of the funds necessary, participants will be notified
79 as soon as practicable that the benefits they receive will terminate on the date that federal
80 funding falls below ninety percent.

81 (3) The provisions of subdivisions (1) and (2) of this subsection shall not apply to:
82 the MO HealthNet transformation task force under section 2; subdivision (26) of
83 subsection 1 of section 208.151; subsections 2, 3, 4, 5, and 6 of this section; and subdivision
84 (2) of subsection 2 of section 208.995.

85 9. As MO HealthNet or other expenditures are reduced or savings achieved
86 pursuant to the show-me transformation act, the portion of the state share of those
87 expenditures that is funded by provider taxes described in 42 CFR 433.56 shall be credited
88 or otherwise shall accrue to the depository account in which the proceeds of such a
89 provider tax are deposited.

208.995. 1. For purposes of sections 208.990 to 208.998, the following terms mean:

2 (1) "Caretaker relative", a relative of a dependent child by blood, adoption, or
3 marriage with whom the child is living, who assumes primary responsibility for the child's
4 care, which may, but is not required to, be indicated by claiming the child as a tax
5 dependent for federal income tax purposes, and who is one of the following:

6 (a) The child's father, mother, grandfather, grandmother, brother, sister,
7 stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;
8 or

9 (b) The spouse of such parent or relative, even after the marriage is terminated by
10 death or divorce;

11 (2) "Child" or "children", a person or persons who are under nineteen years of
12 age;

13 (3) "CHIP-eligible children", children who meet the eligibility standards for
14 Missouri's children's health insurance program as provided in sections 208.631 to 208.658,
15 including paying the premiums required under sections 208.631 to 208.658;

16 (4) "Department", the Missouri department of social services, or a division or unit
17 within the department as designated by the department's director;

18 (5) "MAGI", the individual's modified adjusted gross income as defined in Section
19 36B(d)(2) of the Internal Revenue Code of 1986, as amended, and:

20 (a) Any foreign earned income or housing costs;

21 (b) Tax-exempt interest received or accrued by the individual; and

22 (c) Tax-exempt Social Security income;

23 (6) "MAGI equivalent net income standard", an income eligibility threshold based
24 on modified adjusted gross income that is not less than the income eligibility levels that
25 were in effect prior to the enactment of Public Law 111-148 and Public Law 111-152;

26 (7) "Medically frail", individuals with:

27 (a) Serious emotional disturbances;

- 28 **(b) Disabling mental disorders;**
29 **(c) Substance use disorders or chronic medical conditions who are at high risk for**
30 **significant medical and social costs;**
31 **(d) Serious and complex medical conditions, including children who are deemed**
32 **medically complex;**
33 **(e) Physical or mental disabilities that significantly impair the person’s ability to**
34 **perform one or more activities of daily living; or**
35 **(f) An adjudicated level of care of twenty-one points or greater as determined by**
36 **the screening process under 42 CFR 483.100 to 483.138, or deemed eligible for skilled**
37 **nursing facility placement, but who are not currently residing in a nursing facility.**
- 38 **2. (1) Effective January 1, 2014, notwithstanding any other provision of law to the**
39 **contrary, the following individuals shall be eligible for MO HealthNet coverage as provided**
40 **in this section:**
- 41 **(a) Individuals covered by MO HealthNet for families as provided in section**
42 **208.145;**
43 **(b) Individuals covered by transitional MO HealthNet as provided in 42 U.S.C.**
44 **Section 1396r-6;**
45 **(c) Individuals covered by extended MO HealthNet for families on child support**
46 **closings as provided in 42 U.S.C. Section 1396r-6;**
47 **(d) Pregnant women as provided in subdivisions (10), (11), and (12) of subsection**
48 **1 of section 208.151;**
49 **(e) Children under one year of age as provided in subdivision (12) of subsection 1**
50 **of section 208.151;**
51 **(f) Children under six years of age as provided in subdivision (13) of subsection 1**
52 **of section 208.151;**
53 **(g) Children under nineteen years of age as provided in subdivision (14) of**
54 **subsection 1 of section 208.151;**
55 **(h) CHIP-eligible children; and**
56 **(i) Uninsured women as provided in section 208.659.**
- 57 **(2) Effective January 1, 2014, the department shall determine eligibility for**
58 **individuals eligible for MO HealthNet under subdivision (1) of this subsection based on the**
59 **following income eligibility standards, unless and until they are changed under subsection**
60 **2 of section 208.151:**
- 61 **(a) For individuals listed in paragraphs (a), (b) and (c) of subdivision (1) of this**
62 **subsection, the department shall apply the July 16, 1996, Aid to Families with Dependent**
63 **Children (AFDC) income standard as converted to the MAGI equivalent net income**
64 **standard;**

65 (b) For individuals listed in paragraphs (f) and (g) of subdivision (1) of this
66 subsection, the department shall apply one hundred thirty-three percent of the federal
67 poverty level converted to the MAGI equivalent net income standard;

68 (c) For individuals listed in paragraph (h) of subdivision (1) of this subsection, the
69 department shall convert the income eligibility standard set forth in section 208.633 to the
70 MAGI equivalent net income standard;

71 (d) For individuals listed in paragraphs (d), (e) and (i) of subdivision (1) of this
72 subsection, the department shall apply one hundred eighty-five percent of the federal
73 poverty level converted to the MAGI equivalent net income standard;

74 (3) Individuals eligible for MO HealthNet under subdivision (1) of this subsection
75 shall receive all applicable benefits under section 208.152.

76 3. (1) Effective January 1, 2014, and subject to the receipt of appropriate waivers
77 and approval of state plan amendments, individuals who meet the following qualifications
78 shall be eligible for the alternative package of MO HealthNet benefits as set forth in
79 subsection 5 of this section, subject to the other requirements of this section:

80 (a) Are nineteen years of age or older and under sixty-five years of age;

81 (b) Are not pregnant;

82 (c) Are not entitled to or enrolled for Medicare benefits under Part A or B of Title
83 XVIII of the Social Security Act;

84 (d) Are not otherwise eligible for and enrolled in mandatory coverage under
85 Missouri's MO HealthNet program in accordance with 42 CFR 435, Subpart B; and

86 (e) Have household income that is at or below one hundred percent of the federal
87 poverty level for the applicable family size for the applicable year under the MAGI
88 equivalent net income standard.

89 (2) The department shall immediately seek any necessary waivers from the federal
90 Department of Health and Human Services to implement the provisions of this subsection.
91 The waivers shall:

92 (a) Promote healthy behavior and reasonable requirements that patients take
93 ownership of their health care by seeking early preventative care in appropriate settings,
94 including no co-payments for preventive care services;

95 (b) Require personal responsibility in the payment of health care by establishing
96 appropriate co-payments based on family income that shall discourage the use of
97 emergency room visits for non-emergent health situations and promote responsible use of
98 other health care services;

99 (c) Promote the adoption of healthier personal habits including limiting tobacco use
100 or behaviors that lead to obesity;

101 (d) Allow recipients to receive an annual cash incentive to promote responsible
102 behavior and encourage efficient use of health care services; and

103 (e) Allow health plans to offer a health savings account option.

104 (f) Include a request for an enhanced federal funding rate consistent with
105 subsection 10 of this section for newly eligible participants.

106 (3) If such waivers and enhanced federal funding rate are not granted by the
107 federal government, the provisions of this subsection shall be null and void.

108 4. Except for those individuals who meet the definition of medically frail,
109 individuals eligible for MO HealthNet benefits under subsection 3 of this section shall
110 receive only a package of alternative minimum benefits. The MO HealthNet division of the
111 department of social services shall promulgate regulations to be effective January 1, 2014,
112 that provide an alternative benefit package that complies with the requirements of federal
113 law and is subject to limitations as established in regulations of the MO HealthNet division.

114 5. Except for those individuals who meet the definition of medically frail,
115 individuals who qualify for coverage under subsections 2 and 3 of this section shall receive
116 covered services through health plans authorized by the department under section 208.998.

117 6. The department shall provide premium subsidy and other cost supports for
118 individuals eligible for MO HealthNet under subsections 2 and 3 of this section to enroll
119 in employer-provided health plans or other private health plans based on cost-effective
120 principles determined by the department.

121 7. Individuals eligible for MO HealthNet benefits under subsections 2 and 3 of this
122 section who meet the definition of medically frail shall receive all benefits they are eligible
123 to receive under sections 208.152, 208.900, 208.903, 208.909, and 208.930.

124 8. The department shall establish a screening process in conjunction with the
125 department of mental health and the department of health and senior services for
126 determining whether an individual is medically frail and shall enroll all eligible individuals
127 who meet the definition of medically frail and whose care management would benefit from
128 being assigned a health home in the health home program or other care coordination as
129 established by the department. Any eligible individual may opt out of the health home
130 program.

131 9. The department or appropriate divisions of the department shall promulgate
132 rules to implement the provisions of this section. Any rule or portion of a rule, as the term
133 is defined in section 536.010, that is created under the authority delegated in this section
134 shall become effective only if it complies with and is subject to all of the provisions of
135 chapter 536 and, if applicable, section 536.028. This section and chapter 536 are
136 nonseverable and if any of the powers vested with the general assembly pursuant to
137 chapter 536 to review, to delay the effective date or to disapprove and annul a rule are
138 subsequently held unconstitutional, then the grant of rulemaking authority and any rule
139 proposed or adopted after August 28, 2013, shall be invalid and void.

140 10. The department shall submit such state plan amendments and waivers to the
141 Centers for Medicare and Medicaid Services of the federal Department of Health and
142 Human Services as the department determines are necessary to implement the provisions

143 of this section. The department shall request of the federal government an enhanced
144 federal funding rate for persons newly eligible under subsection 3 of this section whereby
145 the federal government agrees to pay the percentages specified in Section 2001 of PL 111-
146 148, as that section existed on March 23, 2010. The provisions of subsections 3 to 8 of this
147 section shall not be implemented unless such waivers and enhanced federal funding rates
148 are granted by the federal government.

149 **11. If at any time the director receives notice that the federal funds at the disposal**
150 **of the state for payments of money benefits to or on behalf of any persons under subsection**
151 **3 of this section shall at any time become less than ninety percent of the funds necessary**
152 **or are not appropriated to pay the percentages specified in Section 2001 of Public Law**
153 **111-148, as that section existed on March 23, 2010, subsections 3 to 8 of this section shall**
154 **no longer be effective for the individuals whose benefits are no longer matchable at the**
155 **specified percentages. The date benefits cease shall be stated in a notice sent to the affected**
156 **individuals.**

208.997. 1. The MO HealthNet division shall develop and implement the "Health
2 **Care Homes Program" as a provider-directed care coordination program for MO**
3 **HealthNet recipients who are not enrolled in a prepaid MO HealthNet benefits option and**
4 **who are receiving services on a fee-for-service basis. The health care homes program shall**
5 **provide payment to primary care clinics for care coordination for individuals who are**
6 **deemed medically frail. Clinics shall meet certain criteria, including but not limited to the**
7 **following:**

8 **(1) The capacity to develop care plans;**

9 **(2) A dedicated care coordinator;**

10 **(3) An adequate number of clients, evaluation mechanisms, and quality**
11 **improvement processes to qualify for reimbursement; and**

12 **(4) The capability to maintain and use a disease registry.**

13 **2. For purposes of this section, "primary care clinic" means a medical clinic**
14 **designated as the patient's first point of contact for medical care, available twenty-four**
15 **hours a day, seven days a week, that provides or arranges the patient's comprehensive**
16 **health care needs and provides overall integration, coordination, and continuity over time**
17 **and referrals for specialty care. A primary care clinic shall include a community health**
18 **care center.**

19 **3. The health care home for recipients of MO HealthNet services defined in**
20 **paragraph (f) of subdivision (7) of subsection 1 of section 208.995 shall be the primary**
21 **provider of home- and community-based services received by the recipient if such provider**
22 **has a qualified, licensed designee to serve as the recipient's care coordinator and the**
23 **provider can demonstrate the ability to meet the requirements in subsections 1 and 2 of this**
24 **section. The qualifications for such designees shall be defined by the department by rule.**

25 **4. Providers of behavioral, social, and psychophysiological services for the**
26 **prevention, treatment, or management of physical health problems and screening and brief**
27 **intervention shall be reimbursed for utilizing the behavior assessment and intervention,**
28 **and screening and brief intervention reimbursement codes 96150 to 96155 and 99408 to**
29 **99409 or their successor codes under the Current Procedural Terminology (CPT) coding**
30 **system. Location of service may be limited to NCQA Level 3 Patient-Centered Medical**
31 **Homes and CARF-accredited health homes.**

32 **5. The department may designate that the health care homes program be**
33 **administered through an organization with a statewide primary care presence, experience**
34 **with Medicaid population health management, and an established health homes outcomes**
35 **monitoring and improvement system.**

36 **6. This section shall be implemented in such a way that it does not conflict with**
37 **federal requirements for health care home participation by MO HealthNet participants.**

38 **7. The department or appropriate divisions of the department may promulgate**
39 **rules to implement the provisions of this section. Any rule or portion of a rule, as that term**
40 **is defined in section 536.010, that is created under the authority delegated in this section**
41 **shall become effective only if it complies with and is subject to all of the provisions of**
42 **chapter 536 and, if applicable, section 536.028. This section and chapter 536 are**
43 **nonseverable and if any of the powers vested with the general assembly pursuant to**
44 **chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are**
45 **subsequently held unconstitutional, then the grant of rulemaking authority and any rule**
46 **proposed or adopted after August 28, 2013, shall be invalid and void.**

47 **8. Nothing in this section shall be construed to limit the department's ability to**
48 **create health care homes for participants in a managed care plan.**

208.998. 1. Except for individuals who meet the definition of medically frail,
2 **individuals who qualify for coverage under subsections 2 and 3 of section 208.995 shall**
3 **receive covered services through health plans offered by managed care entities which are**
4 **authorized by the department. Health plans authorized by the department:**

5 **(1) Shall resemble commercially available health plans while complying with**
6 **federal Medicaid requirements as authorized by federal law or through a federal waiver,**
7 **and may include accountable care organizations, administrative service organizations, or**
8 **managed care organizations paid on a capitated basis;**

9 **(2) Shall promote, to the greatest extent possible, the opportunity for children and**
10 **their parents to be covered under the same plan;**

11 **(3) Shall offer plans statewide;**

12 **(4) Shall include cost sharing for outpatient services to the maximum extent allowed**
13 **by federal law;**

14 **(5) May include other co-payments and provide incentives that encourage and**
15 **reward the prudent use of the health benefit provided;**

16 **(6) Shall encourage access to care through provider rates that include pay-for-**
17 **performance and are comparable to commercial rates;**

18 **(7) Shall provide incentives, including shared risk and savings, to health plans and**
19 **providers to encourage cost-effective delivery of care;**

20 **(8) May provide multiple plan options and reward participants for choosing a low-**
21 **cost plan; and**

22 **(9) Shall include the services of health providers as defined in 42 U.S.C. Section**
23 **1396d(l)(1) and (2) and meet the payment requirements for such health providers as**
24 **provided in 42 U.S.C. Sections 1396a(a)(15) and 1396a(bb).**

25 **2. The department may designate that certain health care services be excluded from**
26 **such health plans if it is determined cost effective by the department.**

27 **3. (1) The department may accept regional plan proposals as an additional option**
28 **for beneficiaries. Such proposals may be submitted by accountable care organizations or**
29 **other organizations and entities.**

30 **(2) The department shall advance the development of systems of care for medically**
31 **complex children who are recipients of MO HealthNet benefits by accepting cost-effective**
32 **regional proposals from and contracting with appropriate pediatric care networks,**
33 **pediatric centers for excellence, and medical homes for children to provide MO HealthNet**
34 **benefits when the department determines it is cost effective to do so. Such entities shall be**
35 **treated as accountable care organizations.**

36 **(3) The provisions of subsection 1 of this section shall not apply to this subsection.**

37 **4. The department shall establish, in collaboration with plans and providers,**
38 **uniform utilization review protocols to be used by all authorized health plans.**

39 **5. The department shall establish a competitive bidding process for contracting**
40 **with managed care plans.**

41 **(1) The department shall solicit bids only from bidders who offer, or through an**
42 **associated company offer, an identical or substantially similar plan, in services provided**
43 **and network, within a health care exchange in this state, whether federally facilitated, state**
44 **based, or operated on a partnership basis. The bidder, if the bidder offers an identical or**
45 **similar plan, in services provided or network, or the bidder and the associated company,**
46 **if the bidder has formed a partnership for purposes of its bid, shall include a process in its**
47 **bid by which MO HealthNet recipients who choose its plan will be automatically enrolled**
48 **in the corresponding plan offered within the health care exchange if the recipient's income**
49 **increases resulting in the recipient's ineligibility for MO HealthNet benefits. The bidder**
50 **also shall include in its bid a process by which an individual enrolled in an identical or**
51 **substantially similar plan, in services provided or network, within a health care exchange**
52 **in this state, whether federally facilitated, state based, or operated on a partnership basis**
53 **whose income decreases resulting in eligibility for MO HealthNet benefits shall be enrolled**

54 in MO HealthNet after an application is received and the participant is determined eligible
55 for MO HealthNet benefits.

56 (2) The department shall select a minimum of three winning bids and may select
57 up to a maximum number of bids equal to the quotient derived from dividing the total
58 number of participants anticipated by the department in a region by one hundred
59 thousand.

60 (3) The department shall accept the lowest conforming bid. For determining other
61 accepted bids, the department shall consider the following factors:

62 (a) The cost to Missouri taxpayers;

63 (b) The extent of the network of health care providers offering services within the
64 bidder's plan;

65 (c) Additional services offered to recipients under the bidder's plan;

66 (d) The bidder's history of providing managed care plans for similar populations
67 in Missouri or other states;

68 (e) Any other criteria the department deems relevant to ensuring MO HealthNet
69 benefits are provided to recipients in such manner as to save taxpayer money and improve
70 health outcomes of recipients.

71 6. Any managed care organization that enters into a contract with the state to
72 provide managed care plans shall be required to fulfill the terms of the contract and
73 provide such plans for at least twelve months, or longer if the contract so provides. The
74 state shall not increase the reimbursement rate provided to the managed care organization
75 during the contract period above the rate included in the contract. If the managed care
76 organization breaches the contract, the state shall be entitled to bring an action against the
77 managed care organization for any remedy allowed by law or equity and shall also recover
78 any and all damages provided by law, including liquidated damages in an amount
79 determined by the department during the bidding process. Nothing in this subsection shall
80 be construed to preclude the department or the state of Missouri from terminating the
81 contract as specified in the terms of the contract, including for breach of contract, lack of
82 appropriated funds, or exercising any remedies for breach as may be provided in the
83 contract.

84 7. (1) Participants enrolling in managed care plans under this section shall have
85 the ability to choose their plan. In the enrollment process, participants shall be provided
86 a list of all plans available ranked by the relative actuarial value of each plan. Each
87 participant shall be informed in the enrollment process that he or she will be eligible to
88 receive a portion of the amount saved by Missouri taxpayers if he or she chooses a lower
89 cost plan offered in his or her region. The portion received by a participant shall be
90 determined by the department according to the department's best judgment as to the
91 portion which will bring the maximum savings to Missouri taxpayers.

92 **(2) If a participant fails or refuses to choose a plan as set forth in subdivision (1)**
93 **of this subsection, the department shall determine rules for auto-assignment, which shall**
94 **include incentives for low-cost bids and improved health outcomes as determined by the**
95 **department.**

96 **8. This section shall not be construed to require the department to terminate any**
97 **existing managed care contract or to extend any managed care contract.**

98 **9. All MO HealthNet plans under this section shall provide coverage for the**
99 **following services unless they are specifically excluded under subsection 2 of this section**
100 **and instead are provided by an administrative services organization:**

101 **(1) Ambulatory patient services;**

102 **(2) Emergency services;**

103 **(3) Hospitalization;**

104 **(4) Maternity and newborn care;**

105 **(5) Mental health and substance abuse treatment, including behavioral health**
106 **treatment;**

107 **(6) Prescription drugs;**

108 **(7) Rehabilitative and habilitative services and devices;**

109 **(8) Laboratory services;**

110 **(9) Preventive and wellness care, and chronic disease management;**

111 **(10) Pediatric services, including oral and vision care; and**

112 **(11) Any other services required by federal law.**

113 **10. No MO HealthNet plan or program shall provide coverage for an abortion**
114 **unless a physician certifies in writing to the MO HealthNet agency that, in the physician's**
115 **professional judgment, the life of the mother would be endangered if the fetus were carried**
116 **to term.**

117 **11. The MO HealthNet program shall provide a high deductible health plan option**
118 **for uninsured adults nineteen years of age or older and under sixty-five years of age with**
119 **incomes of less than one hundred percent of the federal poverty level. The high deductible**
120 **health plan shall include:**

121 **(1) After meeting a one thousand dollar deductible, coverage for benefits as**
122 **specified by rule of the department;**

123 **(2) An account, funded by the department, of at least one thousand dollars per**
124 **adult to pay medical costs for the initial deductible funded by the department;**

125 **(3) Preventive care, as defined by the department by rule, that is not subject to the**
126 **deductible and does not require a payment of moneys from the account described in**
127 **subdivision (2) of this subsection;**

128 **(4) A basic benefits package if annual medical costs exceed one thousand dollars;**

129 **(5) A minimum deductible of one thousand dollars;**

130 **(6) As soon as practicable, the establishment and maintenance of a record-keeping**
131 **system for each health care visit or service received by recipients under this subsection.**
132 **The plan shall require that the recipient's prepaid card number be entered, or electronic**
133 **strip be swiped, by the health care provider for purposes of maintaining a record of every**
134 **health care visit or service received by the recipient from such provider, regardless of any**
135 **balance on the recipient's card. Such information shall include only the date, provider**
136 **name, and general description of the visit or service provided. The plan shall maintain a**
137 **complete history of all health care visits and services for which the recipient's prepaid card**
138 **is entered or swiped in accordance with this subdivision. If required under the federal**
139 **Health Insurance Portability and Accountability Act (HIPAA) or other relevant state or**
140 **federal law or regulation, a recipient shall, as a condition of participation in the prepaid**
141 **card incentive, be required to provide a written waiver for disclosure of any information**
142 **required under this subdivision;**

143 **(7) The determination of a proportion of the amount left in a participant's account**
144 **described in subdivision (2) of this subsection which shall be paid to the participant for**
145 **saving taxpayer money. The amount and method of payment shall be determined by the**
146 **department; and**

147 **(8) The determination of a proportion of a participant's account described in**
148 **subdivision (2) of this subsection which shall be used to subsidize premiums to facilitate a**
149 **participant's transition from health coverage under MO HealthNet to private health**
150 **insurance based on cost-effective principles determined by the department.**

151 **12. All participants with chronic conditions, as specified by the department, shall**
152 **be included in an incentive program for MO HealthNet recipients who obtain specified**
153 **primary care and preventive services, and who participate or refrain from participation**
154 **in specified activities to improve the overall health of the recipient. Recipients who**
155 **complete the requirements of the program shall be eligible to receive an annual cash**
156 **payment for successful completion of the program. The department shall establish, by**
157 **rule, the specific primary care and preventive services, activities to be included in the**
158 **incentive program, and the amount of any annual cash payments to recipients.**

159 **13. A MO HealthNet recipient shall be eligible for participation in only one of**
160 **either the high deductible health plan under subsection 11 of this section or the incentive**
161 **program under subsection 12 of this section.**

162 **14. No cash payments, incentives, or credits paid to or on behalf of a MO HealthNet**
163 **participant under a program established by the department under this section shall be**
164 **deemed to be income to the participant in any means-tested benefit program unless**
165 **otherwise specifically required by law or rule of the department.**

166 **15. Managed care entities shall inform participants who choose the high deductible**
167 **health plan under subsection 11 of this section that the participant may lose his or her**
168 **incentive payment under subdivision (7) of subsection 11 of this section if the participant**

169 **utilizes visits to the emergency department for non-emergent purposes. Such information**
170 **shall be included on every electronic and paper correspondence between the managed care**
171 **plan and the participant.**

172 **16. The department shall seek all necessary waivers and state plan amendments**
173 **from the federal Department of Health and Human Services necessary to implement the**
174 **provisions of this section. The provisions of this section shall not be implemented unless**
175 **such waivers and state plan amendments are approved. If this section is approved in part**
176 **by the federal government, the department is authorized to proceed on those sections for**
177 **which approval has been granted; except that, any increase in eligibility shall be contingent**
178 **upon the receipt of all necessary waivers and state plan amendments. The provisions of**
179 **this section shall not be implemented until eligibility of persons set out in subsection 3 of**
180 **section 208.995 has been approved by the federal Department of Health and Human**
181 **Services and has been implemented by the department. However, nothing shall prevent**
182 **the department from expanding managed care for populations under other granted**
183 **authority.**

184 **17. The department may promulgate rules to implement the provisions of this**
185 **section. Any rule or portion of a rule, as the term is defined in section 536.010, that is**
186 **created under the authority delegated in this section shall become effective only if it**
187 **complies with and is subject to all of the provisions of chapter 536 and, if applicable,**
188 **section 536.028. This section and chapter 536 are nonseverable and if any of the powers**
189 **vested with the general assembly pursuant to chapter 536 to review, to delay the effective**
190 **date or to disapprove and annul a rule are subsequently held unconstitutional, then the**
191 **grant of rulemaking authority and any rule proposed or adopted after August 28, 2013,**
192 **shall be invalid and void.**

208.999. Subject to appropriations, the department shall develop incentive
2 **programs to encourage the construction and operation of urgent care clinics which operate**
3 **outside normal business hours and are in or adjoining emergency room facilities which**
4 **receive a high proportion of patients who are participating in MO HealthNet, to the extent**
5 **that the incentives are eligible for federal matching funds.**

376.961. 1. There is hereby created a nonprofit entity to be known as the "Missouri
2 Health Insurance Pool". All insurers issuing health insurance in this state and insurance
3 arrangements providing health plan benefits in this state shall be members of the pool.

4 2. Beginning January 1, 2007, the board of directors shall consist of the director of the
5 department of insurance, financial institutions and professional registration or the director's
6 designee, and eight members appointed by the director. Of the initial eight members appointed,
7 three shall serve a three-year term, three shall serve a two-year term, and two shall serve a
8 one-year term. All subsequent appointments to the board shall be for three-year terms. Members
9 of the board shall have a background and experience in health insurance plans or health
10 maintenance organization plans, in health care finance, or as a health care provider or a member

11 of the general public; except that, the director shall not be required to appoint members from
12 each of the categories listed. The director may reappoint members of the board. The director
13 shall fill vacancies on the board in the same manner as appointments are made at the expiration
14 of a member's term and may remove any member of the board for neglect of duty, misfeasance,
15 malfeasance, or nonfeasance in office.

16 3. Beginning August 28, 2007, the board of directors shall consist of fourteen members.
17 The board shall consist of the director and the eight members described in subsection 2 of this
18 section and shall consist of the following additional five members:

19 (1) One member from a hospital located in Missouri, appointed by the governor, with
20 the advice and consent of the senate;

21 (2) Two members of the senate, with one member from the majority party appointed by
22 the president pro tem of the senate and one member of the minority party appointed by the
23 president pro tem of the senate with the concurrence of the minority floor leader of the senate;
24 and

25 (3) Two members of the house of representatives, with one member from the majority
26 party appointed by the speaker of the house of representatives and one member of the minority
27 party appointed by the speaker of the house of representatives with the concurrence of the
28 minority floor leader of the house of representatives.

29 4. The members appointed under subsection 3 of this section shall serve in an ex officio
30 capacity. The terms of the members of the board of directors appointed under subsection 3 of
31 this section shall expire on December 31, 2009. On such date, the membership of the board shall
32 revert back to nine members as provided for in subsection 2 of this section.

33 **5. Beginning on August 28, 2013, the board of directors on behalf of the pool, the**
34 **executive director, and any other employees of the pool shall have the authority to provide**
35 **assistance or resources to any department, agency, public official, employee, or agent of the**
36 **federal government for the specific purpose of transitioning individuals enrolled in the pool**
37 **to coverage outside of the pool beginning on or before January 1, 2014. Such authority**
38 **does not extend to authorizing the pool to implement, establish, create, administer, or**
39 **otherwise operate a state-based exchange.**

376.962. 1. The board of directors on behalf of the pool shall submit to the director a
2 plan of operation for the pool and any amendments thereto necessary or suitable to assure the
3 fair, reasonable and equitable administration of the pool. After notice and hearing, the director
4 shall approve the plan of operation, provided it is determined to be suitable to assure the fair,
5 reasonable and equitable administration of the pool, and it provides for the sharing of pool gains
6 or losses on an equitable proportionate basis. The plan of operation shall become effective upon
7 approval in writing by the director consistent with the date on which the coverage under sections
8 376.960 to 376.989 becomes available. If the pool fails to submit a suitable plan of operation
9 within one hundred eighty days after the appointment of the board of directors, or at any time
10 thereafter fails to submit suitable amendments to the plan, the director shall, after notice and

11 hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate
12 the provisions of this section. Such rules shall continue in force until modified by the director
13 or superseded by a plan submitted by the pool and approved by the director.

14 2. In its plan, the board of directors of the pool shall:

15 (1) Establish procedures for the handling and accounting of assets and moneys of the
16 pool;

17 (2) Select an administering insurer **or third-party administrator** in accordance with
18 section 376.968;

19 (3) Establish procedures for filling vacancies on the board of directors; **and**

20 (4) Establish procedures for the collection of assessments from all members to provide
21 for claims paid under the plan and for administrative expenses incurred or estimated to be
22 incurred during the period for which the assessment is made. The level of payments shall be
23 established by the board pursuant to the provisions of section 376.973. Assessment shall occur
24 at the end of each calendar year and shall be due and payable within thirty days of receipt of the
25 assessment notice[;

26 (5) Develop and implement a program to publicize the existence of the plan, the
27 eligibility requirements, and procedures for enrollment, and to maintain public awareness of the
28 plan].

29 **3. On or before September 1, 2013, the board shall submit such amendments to the**
30 **plan of operation as are necessary or suitable to ensure a reasonable transition period to**
31 **allow for the termination of issuance of policies by the pool.**

32 **4. The amendments to the plan of operation submitted by the board shall include**
33 **all of the requirements outlined in subsection 2 of this section and shall address the**
34 **transition of individuals covered under the pool to alternative health insurance coverage**
35 **as it is available after January 1, 2014. The plan of operation shall also address procedures**
36 **for finalizing the financial matters of the pool, including assessments, claims expenses, and**
37 **other matters identified in subsection 2 of this section.**

38 **5. The director shall review the plan of operation submitted under subsection 3 of**
39 **this section and shall promulgate rules to effectuate the transitional plan of operation.**
40 **Such rule shall be effective no later than October 1, 2013. Any rule or portion of a rule,**
41 **as that term is defined in section 536.010, that is created under the authority delegated in**
42 **this section shall become effective only if it complies with and is subject to all of the**
43 **provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536**
44 **are nonseverable and if any of the powers vested with the general assembly pursuant to**
45 **chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are**
46 **subsequently held unconstitutional, then the grant of rulemaking authority and any rule**
47 **proposed or adopted after August 28, 2013, shall be invalid and void.**

376.964. The board of directors and administering insurers of the pool shall have the
2 general powers and authority granted under the laws of this state to insurance companies licensed

3 to transact health insurance as defined in section 376.960, and, in addition thereto, the specific
4 authority to:

5 (1) Enter into contracts as are necessary or proper to carry out the provisions and
6 purposes of sections 376.960 to 376.989, including the authority, with the approval of the
7 director, to enter into contracts with similar pools of other states for the joint performance of
8 common administrative functions, or with persons or other organizations for the performance
9 of administrative functions;

10 (2) Sue or be sued, including taking any legal actions necessary or proper for recovery
11 of any assessments for, on behalf of, or against pool members;

12 (3) Take such legal actions as necessary to avoid the payment of improper claims against
13 the pool or the coverage provided by or through the pool;

14 (4) Establish appropriate rates, rate schedules, rate adjustments, expense allowances,
15 agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the
16 operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the
17 risk experience and expenses of providing the coverage. Rates and rate schedules may be
18 adjusted for appropriate risk factors such as age and area variation in claim costs and shall take
19 into consideration appropriate risk factors in accordance with established actuarial and
20 underwriting practices;

21 (5) Assess members of the pool in accordance with the provisions of this section, and
22 to make advance interim assessments as may be reasonable and necessary for the organizational
23 and interim operating expenses. Any such interim assessments are to be credited as offsets
24 against any regular assessments due following the close of the fiscal year;

25 (6) **Prior to January 1, 2014**, issue policies of insurance in accordance with the
26 requirements of sections 376.960 to 376.989. **In no event shall new policies of insurance be**
27 **issued on or after January 1, 2014;**

28 (7) Appoint, from among members, appropriate legal, actuarial and other committees as
29 necessary to provide technical assistance in the operation of the pool, policy or other contract
30 design, and any other function within the authority of the pool;

31 (8) Establish rules, conditions and procedures for reinsuring risks of pool members
32 desiring to issue pool plan coverages in their own name. Such reinsurance facility shall not
33 subject the pool to any of the capital or surplus requirements, if any, otherwise applicable to
34 reinsurers;

35 (9) Negotiate rates of reimbursement with health care providers on behalf of the
36 association and its members;

37 (10) Administer separate accounts to separate federally defined eligible individuals and
38 trade act eligible individuals who qualify for plan coverage from the other eligible individuals
39 entitled to pool coverage and apportion the costs of administration among such separate
40 accounts.

376.966. 1. No employee shall involuntarily lose his or her group coverage by decision of his or her employer on the grounds that such employee may subsequently enroll in the pool. The department shall have authority to promulgate rules and regulations to enforce this subsection.

2. **Prior to January 1, 2014**, the following individual persons shall be eligible for coverage under the pool if they are and continue to be residents of this state:

(1) An individual person who provides evidence of the following:

(a) A notice of rejection or refusal to issue substantially similar health insurance for health reasons by at least two insurers; or

(b) A refusal by an insurer to issue health insurance except at a rate exceeding the plan rate for substantially similar health insurance;

(2) A federally defined eligible individual who has not experienced a significant break in coverage;

(3) A trade act eligible individual;

(4) Each resident dependent of a person who is eligible for plan coverage;

(5) Any person, regardless of age, that can be claimed as a dependent of a trade act eligible individual on such trade act eligible individual's tax filing;

(6) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium or fraud, and who is not otherwise ineligible under subdivision (4) of subsection 3 of this section. If application for pool coverage is made not later than sixty-three days after the involuntary termination, the effective date of the coverage shall be the date of termination of the previous coverage;

(7) Any person whose premiums for health insurance coverage have increased above the rate established by the board under paragraph (a) of subdivision (1) of subsection 3 of this section;

(8) Any person currently insured who would have qualified as a federally defined eligible individual or a trade act eligible individual between the effective date of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the effective date of this act.

3. The following individual persons shall not be eligible for coverage under the pool:

(1) Persons who have, on the date of issue of coverage by the pool, or obtain coverage under health insurance or an insurance arrangement substantially similar to or more comprehensive than a plan policy, or would be eligible to have coverage if the person elected to obtain it, except that:

(a) This exclusion shall not apply to a person who has such coverage but whose premiums have increased to one hundred fifty percent to two hundred percent of rates established by the board as applicable for individual standard risks;

(b) A person may maintain other coverage for the period of time the person is satisfying any preexisting condition waiting period under a pool policy; and

40 (c) A person may maintain plan coverage for the period of time the person is satisfying
41 a preexisting condition waiting period under another health insurance policy intended to replace
42 the pool policy;

43 (2) Any person who is at the time of pool application receiving health care benefits under
44 section 208.151;

45 (3) Any person having terminated coverage in the pool unless twelve months have
46 elapsed since such termination, unless such person is a federally defined eligible individual;

47 (4) Any person on whose behalf the pool has paid out one million dollars in benefits;

48 (5) Inmates or residents of public institutions, unless such person is a federally defined
49 eligible individual, and persons eligible for public programs;

50 (6) Any person whose medical condition which precludes other insurance coverage is
51 directly due to alcohol or drug abuse or self-inflicted injury, unless such person is a federally
52 defined eligible individual or a trade act eligible individual;

53 (7) Any person who is eligible for Medicare coverage.

54 4. Any person who ceases to meet the eligibility requirements of this section may be
55 terminated at the end of such person's policy period.

56 5. If an insurer issues one or more of the following or takes any other action based
57 wholly or partially on medical underwriting considerations which is likely to render any person
58 eligible for pool coverage, the insurer shall notify all persons affected of the existence of the
59 pool, as well as the eligibility requirements and methods of applying for pool coverage:

60 (1) A notice of rejection or cancellation of coverage;

61 (2) A notice of reduction or limitation of coverage, including restrictive riders, if the
62 effect of the reduction or limitation is to substantially reduce coverage compared to the coverage
63 available to a person considered a standard risk for the type of coverage provided by the plan.

64 **6. Coverage under the pool shall expire on January 1, 2014.**

376.968. The board shall select an insurer [or], insurers, **or third-party administrators**
2 through a competitive bidding process to administer the pool. The board shall evaluate bids
3 submitted based on criteria established by the board which shall include:

4 (1) The insurer's proven ability to handle individual accident and health insurance;

5 (2) The efficiency of the insurer's claim-paying procedures;

6 (3) An estimate of total charges for administering the plan;

7 (4) The insurer's ability to administer the pool in a cost-efficient manner.

376.970. 1. The administering insurer shall serve for a period of three years subject to
2 removal for cause. At least one year prior to the expiration of each three-year period of service
3 by an administering insurer, the board shall invite all insurers, including the current
4 administering insurer, to submit bids to serve as the administering insurer for the succeeding
5 three-year period. Selection of the administering insurer for the succeeding period shall be made
6 at least six months prior to the end of the current three-year period.

7 2. The administering insurer shall:

8 (1) Perform all eligibility and administrative claim-payment functions relating to the
9 pool;

10 (2) Establish a premium billing procedure for collection of premium from insured
11 persons. Billings shall be made on a period basis as determined by the board;

12 (3) Perform all necessary functions to assure timely payment of benefits to covered
13 persons under the pool including:

14 (a) Making available information relating to the proper manner of submitting a claim for
15 benefits to the pool and distributing forms upon which submission shall be made;

16 (b) Evaluating the eligibility of each claim for payment by the pool;

17 (4) Submit regular reports to the board regarding the operation of the pool. The
18 frequency, content and form of the report shall be determined by the board;

19 (5) Following the close of each calendar year, determine net written and earned
20 premiums, the expense of administration, and the paid and incurred losses for the year and report
21 this information to the board and the department on a form prescribed by the director;

22 (6) Be paid as provided in the plan of operation for its expenses incurred in the
23 performance of its services.

24 **3. On or before September 1, 2013, the board shall invite all insurers and third-**
25 **party administrators, including the current administering insurer, to submit bids to serve**
26 **as the administering insurer or third-party administrator for the pool. Selection of the**
27 **administering insurer or third-party administrator shall be made prior to January 1, 2014.**

28 **4. Beginning January 1, 2014, the administering insurer or third-party**
29 **administrator shall:**

30 (1) **Submit to the board and director a detailed plan outlining the winding down**
31 **of operations of the pool. The plan shall be submitted no later than January 31, 2014, and**
32 **shall be updated quarterly thereafter;**

33 (2) **Perform all administrative claim-payment functions relating to the pool;**

34 (3) **Perform all necessary functions to assure timely payment of benefits to covered**
35 **persons under the pool including:**

36 (a) **Making available information relating to the proper manner of submitting a**
37 **claim for benefits to the pool and distributing forms upon which submission shall be made;**
38 **and**

39 (b) **Evaluating the eligibility of each claim for payment by the pool;**

40 (4) **Submit regular reports to the board regarding the operation of the pool. The**
41 **frequency, content and form of the report shall be determined by the board;**

42 (5) **Following the close of each calendar year, determine the expense of**
43 **administration, and the paid and incurred losses for the year, and report such information**
44 **to the board and department on a form prescribed by the director; and**

45 (6) **Be paid as provided in the plan of operation for its expenses incurred in the**
46 **performance of its services.**

376.973. 1. Following the close of each fiscal year, the pool administrator shall determine the net premiums (premiums less administrative expense allowances), the expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums and benefits paid by an insurance arrangement that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments. The total cost of pool operation shall be the amount by which all program expenses, including pool expenses of administration, incurred losses for the year, and other appropriate losses exceeds all program revenues, including net premiums, investment income, and other appropriate gains.

2. Each insurer's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges written in the state and one hundred ten percent of all claims paid by insurance arrangements in the state during the preceding calendar year; provided, however, that the assessment for each health maintenance organization shall be determined through the application of an equitable formula based upon the value of services provided in the preceding calendar year.

3. Each insurance arrangement's assessment shall be determined by multiplying the total cost of pool operation calculated under subsection 1 of this section by a fraction, the numerator of which equals one hundred ten percent of the benefits paid by that insurance arrangement on behalf of insureds in this state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges and one hundred ten percent of all benefits paid by insurance arrangements made on behalf of insureds in this state during the preceding calendar year. Insurance arrangements shall report to the board claims payments made in this state on an annual basis on a form prescribed by the director.

4. If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" include reserves for incurred but not paid claims.

5. Assessments shall continue until such time as the director of the pool provides notice to the board and director that all claims have been paid.

6. Any assessment funds remaining at the time the director provides notice that all claims have been paid shall be deposited in the state general revenue fund.

Section 1. 1. Notwithstanding any other provision of law to the contrary, beginning July 1, 2014, any MO HealthNet recipient who elects to receive medical coverage through a private health insurance plan instead of through the MO HealthNet program shall be eligible for a private insurance premium subsidy to assist the recipient in paying the costs of such private insurance if it is determined to be cost effective by the department. The subsidy shall 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.

8 **2. The department may promulgate rules to implement the provisions of this**
9 **section. Any rule or portion of a rule, as that term is defined in section 536.010, that is**
10 **created under the authority delegated in this section shall become effective only if it**
11 **complies with and is subject to all of the provisions of chapter 536 and, if applicable,**
12 **section 536.028. This section and chapter 536 are nonseverable and if any of the powers**
13 **vested with the general assembly pursuant to chapter 536 to review, to delay the effective**
14 **date, or to disapprove and annul a rule are subsequently held unconstitutional, then the**
15 **grant of rulemaking authority and any rule proposed or adopted after August 28, 2013,**
16 **shall be invalid and void.**

Section 2. 1. There is hereby established in the department of social services the
2 **“MO HealthNet Transformation Task Force”, which shall consist of sixteen members as**
3 **follows:**

- 4 **(1) The director of the department of social services, or his or her designee;**
- 5 **(2) The director of the department of health and senior services, or his or her**
6 **designee;**
- 7 **(3) The director of the department of mental health, or his or her designee;**
- 8 **(4) Four members of the house of representatives, including two from each political**
9 **party;**
- 10 **(5) Four members of the senate, including two from each political party; and**
- 11 **(6) Five members from the Missouri health care community who shall be appointed**
12 **by the governor with senate approval.**

13 **2. The task force shall make recommendations in a report to the general assembly**
14 **on improvements that can be made to the state medical assistance health care delivery**
15 **system. The report shall include, but not be limited to, the following:**

- 16 **(1) Advice on more efficient and cost-effective ways to provide coverage for MO**
17 **HealthNet participants;**
- 18 **(2) An evaluation of how coverage for MO HealthNet participants can resemble**
19 **that of commercially available health plans while complying with federal Medicaid**
20 **requirements;**
- 21 **(3) Possibilities for promoting healthy behavior by encouraging patients to take**
22 **ownership of their health care and seek early preventative care;**
- 23 **(4) Advice on the best manner in which to provide incentives, including a shared**
24 **risk and savings to health plans and providers to encourage cost-effective delivery of care;**
25 **and**
- 26 **(5) Ways that individuals who currently receive medical care coverage through the**
27 **MO HealthNet program can transition to obtaining their health coverage through the**
28 **private sector.**

29 **3. The task force shall meet at least quarterly and shall submit its recommendations**
30 **and statewide plan for improvements to the MO HealthNet plan to the governor, the**

31 **general assembly, and the director of the department of social services by December thirty-**
32 **first of each year.**

33 **4. Members of the task force shall receive no additional compensation, but shall be**
34 **eligible for reimbursement for expenses directly related to the performance of task force**
35 **duties.**

36 **5. The provisions of this section shall expire on May 31, 2024.**

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