HB 700 -- Show-Me Transformation Act

Sponsor: Barnes

This bill establishes the Show-Me Transformation Act and changes the laws regarding the MO HealthNet Program. In its main provisions, the bill:

(1) Specifies that MO HealthNet benefits are provided to any person who is in foster care under the responsibility of the State of Missouri on the date he or she turns 18 years old without regard to income or assets if the person is younger than 26 years of age, is not eligible for coverage under another mandatory coverage group, and was covered by the Missouri Medicaid Program while he or she was in foster care;

(2) Specifies that beginning July 1, 2014:

(a) Any person receiving blind pension benefits and any person deemed eligible due to a diagnosis of breast or cervical cancer will no longer be eligible for MO HealthNet benefits; and

(b) Eligibility for coverage of pregnant women is changed from 185% of the federal poverty level (FPL) to 133% of the FPL and limits, beginning October 1, 2019, the eligibility of infants under one year of age to those infants whose family income does not exceed 133% of the FPL;

(3) Prohibits any of the changes in (2) from occurring unless and until:

(a) There are federal health insurance premium tax credits available to persons through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state-based, or operated on a partnership basis;

(b) The United States Department of Health and Human Services has approved eligibility of certain populations and the Department of Social Services has implemented eligibility for the population; and

(c) The United States Department of Health and Human Services grants all necessary waivers and state plan amendments to implement these provisions;

(4) Specifies that beginning October 1, 2019, the current Children's Health Insurance Plan (CHIP) is no longer in effect unless and until federal health insurance premium tax credits available for children and family coverage to purchase a health insurance plan from a health care exchange and the credits are

available for six months prior to the discontinuation of CHIP benefits. The department must inform participants of the possibility of insurance coverage via the purchase of a subsidized health insurance plan available through a health care exchange at least six months before CHIP coverage is discontinued;

(5) Requires the Department of Social Services to notify any potential exchange-eligible participant who may be eligible for services due to spenddown of the participant's potential ability to qualify for more cost-effective private insurance and federal premium tax credits available through the purchase of a health insurance plan in a health care exchange and the benefits that would be potentially covered under the insurance;

(6) Specifies that beginning July 1, 2014, the Uninsured Women's Health Program will no longer be in effect. The change in eligibility will not take place unless and until for a six-month period preceding the discontinuance of benefits, there are federal health insurance premium tax credits available for children and family coverage through the purchase a health insurance plan in a health care exchange. The department must inform participants of the possibility of insurance coverage via the purchase of a subsidized health insurance plan through a health care exchange at least six months before coverage is discontinued;

(7) Specifies that in order to be eligible for MO HealthNet benefits an individual must be a resident of the State of Missouri; have a valid Social Security number; be a citizen of the United States or a qualified alien with satisfactory documentary evidence of qualified alien status that has been verified by the federal Department of Homeland Security; and if claiming eligibility as a pregnant woman, she must verify the pregnancy;

(8) Requires the Family Support Division within the Department of Social Services to conduct an annual review of all MO HealthNet participants' eligibility;

(9) Requires an individual who is applying for MO HealthNet benefits to submit an application in accordance with federal law, including 42 CFR 435.907, and to provide all required information and documentation necessary to make an eligibility determination or for any purpose directly connected to the administration of the medical assistance program;

(10) Requires the department to determine an individual's financial eligibility based on projected annual household income and family size for the remainder of the current year; to determine the modified adjusted gross household by including all actually available cash support provided by the person claiming the applying

individual as a tax dependent; and to determine a pregnant woman's household size by counting the pregnant woman plus the number of children she is expected to deliver. A CHIP-eligible child must be uninsured and not have access to affordable insurance and must pay the required premium. An individual claiming eligibility as an uninsured woman must be uninsured;

(11) Prohibits the MO HealthNet Program from providing coverage to a parent or other caretaker relative living with a dependent child who is classified as medically frail unless the child is receiving benefits under MO HealthNet or CHIP or is enrolled in minimum essential coverage;

(12) Specifies that beginning January 1, 2014, those eligible for MO HealthNet benefits under Section 208.152, RSMo, must include:

(a) Individuals covered by MO HealthNet for families under Section 208.145;

(b) Individuals covered by transitional MO HealthNet under 42 U.S.C. Section 1396r-6;

(c) Individuals covered by extended MO HealthNet for families on child support closings under 42 U.S.C. Section 1396r-6;

(d) Pregnant women who meet the requirements for aid to families with dependent children benefits except for the existence of a dependent child in the home; pregnant women who meet the requirements for aid to families with dependent children except for the existence of a dependent child who is deprived of parental support; and pregnant women or infants under one year of age, or both, whose family income does not exceed an income eligibility standard equal to 133% of the FPL;

(e) Children between the ages of one year old and six years old who are eligible for medical assistance and whose family income does not exceed an income eligibility standard equal to 133% of the FPL;

(f) Children between the ages of six years old and 19 years old whose family income is equal to or less than equal to 100% of the FPL;

(g) CHIP-eligible children; and

(h) Uninsured women under Section 208.659;

(13) Specifies that eligibility for those listed in (12) must be determined by the department by converting applicable income

standards to the individual's modified adjusted gross income (MAGI) equivalent net income standard;

(14) Specifies that effective January 1, 2014, and subject to the receipt of all appropriate waivers and approval of state plan amendments, individuals who meet the following qualifications must be eligible for the alternative package of MO HealthNet benefits:

(a) Are between the ages of 19 and 64 years;

(b) Are not pregnant;

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

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

(e) Have a household income that is at or below 100% of the FPL for the applicable family size for the applicable year under the MAGI equivalent net income standard;

(15) Requires the department to immediately seek any waivers necessary to implement these provisions. The waivers must promote healthy behavior, contain requirements that patients take ownership of their health and seek early preventative care, promote the adoption of healthier personal habits, and allow recipients to receive an annual cash incentive to promote responsible behavior and encourage efficient use of health care services. The division must establish regulations to be effective January 1, 2014, that provide an alternative benefit package that complies with the requirements of federal law and is subject to the limitations as established in division regulations;

(16) Requires the department to provide premium subsidy and other cost supports for individuals eligible for MO HealthNet benefits to enroll in employer-provided health plans or other private health plans based on cost-effective principles determined by the department. All individuals who meet the definition of medically frail must receive all coverage that they are eligible to receive under Section 208.152. The department, in conjunction with the Department of Mental Health and the Department of Health and Human Services, must establish a screening process for determining whether an individual is medically frail;

(17) Requires the division to develop and implement the Health Care Homes Program as a provider-directed care coordination program for MO HealthNet recipients who are not enrolled in a prepaid MO HealthNet benefits option and who are receiving services on a fee-for-service basis. The program must provide payment to primary

care clinics for care coordination for people who have complex and chronic medical conditions. Clinics must meet certain criteria, including the capacity to develop care plans; having a dedicated care coordinator; and maintaining an adequate number of clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement. These provisions must be implemented in a way that it does not conflict with federal requirements for health care home participation by MO HealthNet Program recipients;

(18) Requires, except for those individuals deemed medically frail, recipients of the alternative package of MO HealthNet benefits to receive covered services through health plans offered by managed care entities authorized by the department. The health plans must resemble commercially available health plans while complying with federal Medicaid Program requirements; must promote the opportunity for children and their parents to be covered under the same plan; may offer plans regionally, statewide, or both, but must ensure that all regions have adequate coverage through managed care contracts; must include cost-sharing for out-patient services as allowed by federal law; must provide incentives to health plans and providers to encourage cost-effective delivery of care; and may provide multiple plan options and reward participants for choosing a low-cost plan. The department may designate that certain health care services be excluded from the health plans if it is determined cost effective by the department. The department must establish uniform utilization review protocols to be used by all authorized health plans;

(19) Requires the department to establish the following requirements for contracting with managed care plans:

(a) Managed care plans utilizing capitation arrangements between the managed care plan and providers must submit a blind bid on each of two levels of coverage with the department establishing the levels of coverage and the maximum capitation rate for each level. The department must not disclose its maximum capitation rate during the initial bidding process;

(b) Each bidder must include all actuarial and other relevant information utilized by the bidder in determining the bidder's capitation rate. The plan that submits the lowest bid below the undisclosed maximum capitation rate must be guaranteed participation;

(c) The department must contract with those plans and no further bidding is required if at least two bids are equal to or less than the undisclosed maximum capitation rate;

(d) All bids in excess of the undisclosed maximum capitation rate

must not be considered; however, if no capitation managed care plans submit a bid equal to or less than the undisclosed maximum capitation rate or if less than two or three if the department elects to include an additional plan, capitation managed care plans submit bids equal to or less than the undisclosed maximum capitation rate, the department may select any plans with the lowest bid within 125% of the undisclosed maximum capitation rate; and

(e) The department may select any plan or plans with the lowest bids within 125% of the undisclosed maximum capitation rate or the department may reevaluate and adjust the maximum capitation rate, discard all previous nonconforming bids, disclose to all bidders the adjusted maximum capitation rate, and open a second bidding process if no bids are equal to or less than the disclosed maximum capitation rate;

(20) Specifies that when awarding contracts for managed care plans, the department must consider the cost to Missouri taxpayers, the extent of the network of health care providers offering services within the bidder's plan, additional services offered to recipients under the bidder's plan, the bidder's history of providing managed care plans for similar populations in Missouri or other states, whether the bidder offers an identical or similar plan in a health care exchange in Missouri and if so whether MO HealthNet recipients who choose the plan will be automatically enrolled in the exchange plan if the recipient's income increases resulting in the recipient's ineligibility for MO HealthNet benefits, and any other criteria the department deems relevant to ensure MO HealthNet benefits are provided to recipients in a way that saves taxpayer money and improves the health outcomes of recipients;

(21) Specifies that if a recipient enrolls in a managed care plan with a capitation rate that is less than the maximum capitation rate established by the department, the recipient must be eligible to receive a portion of the difference between the plan's capitation rate and the established maximum capitation rate;

(22) Requires the department to select a minimum of three plans from the conforming bids for each region. The department must select all or none of the bidders' plans, and the lowest conforming bid in each region must be accepted by the department;

(23) Requires all MO HealthNet managed care plans to provide coverage for ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and

devices; laboratory services; preventive and wellness and chronic disease management; pediatric services, including oral and vision care; and any other service required by federal law. No Mo HealthNet plan may provide coverage for abortion unless the abortion is certified in writing by a physician to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term;

(24) Requires the MO HealthNet Program to provide a high-deductible health plan option for uninsured adults between 19 and 64 years of age with an income of less than 100% of the FPL. The plan must include high-deductible coverage and after meeting a $1,000 deductible, individuals must be covered for benefits as specified by regulation of the department. The plan must include an account of at least $1,000 per adult, funded by the department, to pay the medical costs for the initial deductible. Preventative care may not be subject to the deductible and does not require a payment of money from the account. The plan must include a basic benefits package once annual medical costs exceed $1,000. As soon as practicable, the health plan must establish and maintain a record keeping system for each health care visit or service received by recipients. The plan must require that the recipient's prepaid card number be entered or the electronic strip must be swiped by the health care provider for every health care visit or service received by the recipient regardless of the balance on the card. The information may only include the date of service, the name of the provider, and a general description of the visit or service provided. The plan must keep a complete history of all health care visits and services for which the recipient's prepaid card is entered or swiped. If necessary under state or federal law, a recipient must be required to provide a written waiver for disclosure of this information as a condition of participation in the prepaid card incentive. The department must determine by rule the amount credited to a co-payment card, and the amount must be no less than 40% of the minimum deductible required for the high-deductible plan. No recipient can be eligible unless the recipient receives a yearly checkup with his or her primary care physician;

(25) Requires the department to establish and implement a co-payment cost-sharing program for MO HealthNet recipients not otherwise participating in a high-deductible health plan. A participant will receive a prepaid card that will be used to cover the costs of co-payments required under the MO HealthNet Program. The department must require recipients to fund the prepaid card with the maximum cost-share allowed under federal law with the remainder to be funded by the MO HealthNet Program. Primary care services must not have a co-payment and recipients must be eligible to receive a portion of the remaining card balance at the end of

the coverage year in an amount as determined by the department by rule. The amount must be electronically transferred to the recipient's electronic benefits transfer (EBT) card and are subject to the use requirements and restrictions of EBT cards;

(26) Requires all recipients with chronic conditions to be included in an incentive program for MO HealthNet recipients who obtain specified primary care and preventive services and who participate or refrain from specified activities to improve the recipient's overall health. Those recipients who successfully complete the requirements of the program are eligible to receive an annual cash payment. The department must establish by rule the specific primary care and preventive services and activities to be included in the program and the amount of any annual cash payments;

(27) Specifies that MO HealthNet recipients are eligible to participate in only one of the high deductible health plans, the co-payment cost-sharing program or the incentive program for chronic conditions. Any cash payments, incentives, or credits paid to or on behalf of a participant under a MO HealthNet Program are not to be considered income in any means-tested benefit program unless otherwise required by law or department rule;

(28) Requires a participant who chooses the high-deductible plan or the co-payment cost-sharing program to be notified that the participant may lose his or her payment if he or she utilizes emergency services for nonemergency purposes and requires the information to be included on every electronic and paper correspondence between the managed care plan and the participant;

(29) Requires the department to seek all waivers and state plan amendments from the United States Department of Health and Human Services that are necessary to implement the provisions of the bill. No provisions of the bill may be implemented unless the necessary waivers are granted. If the federal funds at the disposal of the state for payments of money benefits to or on behalf of any MO HealthNet recipients at any time become less than 90% of the funds necessary to pay the percentages specified in Section 2001 of Public Law 111-148 as that section existed on March 28, 2010, the provisions of the bill will no longer be effective for individuals whose benefits are no longer matchable at the specified percentages;

(30) Specifies that beginning August 28, 2013, the Board of Directors of the Missouri Health Insurance Pool, the executive director, and any other employees of the pool will have the authority to provide assistance or resources to any department, agency, public official, employee, or agent of the federal government for the specific purpose of transitioning individuals

enrolled in the pool to coverage outside of the pool beginning on or before January 1, 2014. This authority does not extend to authorizing the pool to implement, establish, create, administer, or otherwise operate a state-based exchange. On or before September 1, 2013, the board must submit the amendments to the plan of operation as are necessary or suitable to ensure a reasonable transition period to allow for the termination of issuance of policies by the pool. The amendments to the plan of operation submitted by the board must include all current requirements under Section 376.962.2, including the selection of an administering insurer or third-party administrator, and must address the transition of individuals covered under the pool to alternative health insurance coverage as it is available after January 1, 2014. The plan of operation must also address procedures for finalizing the financial matters of the pool, including assessments, claims expenses, and other specified matters. The Director of the Department of Insurance, Financial Institutions and Professional Registration must review the plan of operation and must establish rules to effectuate the transitional plan of operation. The rules must be effective no later than October 1, 2013;

(31) Specifies that prior to January 1, 2014, the board of directors and administering insurers may issue policies of insurance from the Missouri Health Insurance Pool; however, they are prohibited from issuing new insurance policies on or after January 1, 2014. All coverage under the pool must expire on January 1, 2014;

(32) Requires, on or before September 1, 2013, the board to invite all insurers and third-party administrators, including the current administering insurer, to submit bids to serve as the administering insurer or third-party administrator for the pool. Selection of the administering insurer or third-party administrator must be made prior to January 1, 2014. Beginning January 1, 2014, the administering insurer or third-party administrator must:

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

(b) Perform all administrative claim-payment functions relating to the pool;

(c) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including making available information relating to the proper manner of submitting a claim for benefits to the pool, distributing forms upon which submission must be made, and evaluating the eligibility of each

claim for payment by the pool;

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

(e) Determine, following the close of each calendar year, the expense of administration and the paid and incurred losses for the year and report the information to the board and department on a form prescribed by the department director; and

(f) Be paid as provided in the plan of operation for its expenses incurred in the performance of its services;

(33) Requires Missouri Health Insurance Pool assessments to continue until the executive director of the pool provides notice to the board and the department director that all claims have been paid. Any assessment funds remaining at the time the executive director provides notice that all claims have been paid must be deposited in the General Revenue Fund; and

(34) Specifies that 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 will be eligible for a private insurance premium subsidy to assist the recipient in paying the costs of the private insurance. The subsidy must be provided on a sliding scale based on income with a graduated reduction in subsidy over a period of time not to exceed two years.