HCS HB 986 -- MO HEALTHNET (Barnes)

COMMITTEE OF ORIGIN: Committee on Government Oversight and Accountability

This substitute extends the provisions regarding the Ticket to Work Health Assurance Program from August 28, 2013, to August 28, 2019. It specifies that a person in foster care is eligible for MO HealthNet benefits on the date he or she turns 18 years of age, or in the 30 days before turning 18, without regard to income or assets if the person is less 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.

In order to be eligible for MO HealthNet benefits an individual must be a resident 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. The Family Support Division within the Department of Social Services must conduct an annual redetermination of all MO HealthNet participants' eligibility. The department may contract with an administrative service organization to conduct the annual redetermination if it is cost effective. The department or the division must conduct electronic searches to redetermine eligibility on the basis of income, residency, citizenship, identity, and other criteria upon availability of electronic data sources. The department or division may enter into a contract with a vendor to perform the electronic searches of eligibility information not disclosed during the application process and obtain an applicable case management system. The department will retain final authority over eligibility determinations made during the redetermination process.

An individual who is applying for MO HealthNet benefits must submit an application in accordance with federal law, including 42 CFR 435.907, and provide all required information and documentation necessary to make an eligibility determination, resolve discrepancies found during the redetermination process, or for any purpose directly connected to the administration of the medical assistance program.

The department will determine an individual's financial eligibility based on projected annual household income and family size for the remainder of the current year and 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. A pregnant woman's household size is determined 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 the child's parent must pay the required premium. An individual claiming eligibility as an uninsured woman must be uninsured.

The 12-member Joint Committee on Medicaid Transformation is established, with four representatives appointed by the Speaker of the House of Representatives and two by the House Minority Leader, and four senators appointed by the President Pro Tem of the Senate and two appointed by the Senate Minority Leader. The committee must meet by June 27, 2013, and select a chairperson and vice-chairperson.

The committee must make recommendations for legislative action in a report to the Speaker, the President Pro Tem, and the Governor by December 31, 2013, on improvements that can be made to the state medical assistance health care delivery system. The report must include, but not be limited to:

(1) More efficient and cost-effective ways to provide coverage;

(2) How coverage can resemble that of commercially available health plans while complying with federal Medicaid requirements;

(3) Possibilities for promoting healthy behavior by encouraging a patient to take ownership of his or her health care and seek early preventative care;

(4) The best manner in which to provide incentives, including a shared risk and savings to health plans and providers to encourage cost-effective delivery of care; and

(5) Ways that a participant currently receiving coverage can transition to obtaining his or her health coverage through the private sector.

The committee must hold at least one meeting in three urban regions and may gather information from the general public, any state department, political subdivision or anyone else it deems advisable. The staffs of senate research, legislative research, and house research may provide services to the committee. Members of the committee cannot receive any additional compensation but must be eligible for reimbursement for expenses from the joint contingent fund.

Beginning January 1, 2014, those eligible for MO HealthNet benefits must include:

(1) Individuals covered by MO HealthNet for families;

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

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

(4) 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 federal poverty level (FPL);

(5) Children between one year of age and 19 years of age who are eligible for medical assistance and whose family income does not exceed an income eligibility standard equal to 133% of the FPL;

(6) Children eligible for the federal Children's Health Insurance Program (CHIP); and

(7) Uninsured women at least 18 years of age with a net family income equal to or less than 185% of the federal poverty level and with assets less than $250,000 who don't have access to employer-provided health insurance.

The substitute requires the eligibility for these individuals to be determined by the Department of Social Services by converting applicable income standards to the individual's modified adjusted gross income (MAGI) equivalent net income standard.

The substitute contains an emergency clause for the provisions regarding the Joint Committee on Medicaid Transformation, which will expire January 1, 2014.