

SECOND REGULAR SESSION
HOUSE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 1662
97TH GENERAL ASSEMBLY

5261H.05C

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 208.166 and 208.952, RSMo, and to enact in lieu thereof four new sections relating to health care coverage.

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

Section A. Sections 208.166 and 208.952, RSMo, are repealed and four new sections enacted in lieu thereof, to be known as sections 191.875, 208.166, 208.952, 208.999, to read as follows:

191.875. 1. By January 1, 2015, any patient or consumer of health care services who requests an estimate of the cost of health care services from a health care provider or the insurance costs from such patient's or consumer's health carrier shall be provided such estimate of cost or insurance costs prior to the provision of such services, if feasible, but in no event later than three business days after such request. The provisions of this subsection shall not apply to emergency health care services.

2. As used in this section, the following terms shall mean:

(1) "Ambulatory surgical center", any ambulatory surgical center as defined in section 197.200;

(2) "Enrollee", shall have the same meaning ascribed to it in section 376.1350;

(3) "Estimate of cost", an estimate based on the information entered and assumptions about typical utilization and costs for health care services. Such estimate of cost shall include the following:

(a) The amount that will be charged to a patient for the health care services if all charges are paid in full without a public or private third party paying for any portion of the charges;

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.

17 **(b) The average negotiated settlement on the amount that will be charged to a**
18 **patient required to be provided in paragraph (a) of this subdivision;**

19 **(c) The amount of any MO HealthNet reimbursement for the health care services,**
20 **including claims and pro rata supplemental payments, if known;**

21 **(d) The amount of any Medicare reimbursement for the medical services, if known;**
22 **and**

23 **(e) The amount of any insurance co-payments for the health benefit plan of the**
24 **patient, if known;**

25 **(4) "Health care provider", any hospital, ambulatory surgical center, physician,**
26 **dentist, clinical psychologist, pharmacist, optometrist, podiatrist, registered nurse,**
27 **physician assistant, chiropractor, physical therapist, nurse anesthetist, long-term care**
28 **facility, or other licensed health care facility or professional providing health care services**
29 **in this state;**

30 **(5) "Health care service", shall have the same meaning ascribed to it in section**
31 **376.1350;**

32 **(6) "Health carrier", an entity as such term is defined under section 376.1350;**

33 **(7) "Insurance costs", an estimate of costs of covered services provided by a health**
34 **carrier based on a specific insured's coverage and health care services to be provided.**
35 **Such insurance cost shall include:**

36 **(a) The reimbursement amount to any health care provider;**

37 **(b) Any deductibles, co-payments, or co-insurance amounts; and**

38 **(c) Any amounts not covered under the health benefit plan;**

39 **(8) "Public or private third party", the state, the federal government, employers,**
40 **health carriers, third-party administrators, and managed care organizations.**

41 **3. (1) Health care providers shall include with any estimate of costs the following:**
42 **"Your estimated cost is based on the information entered and assumptions about typical**
43 **utilization and costs. The actual amount billed to you may be different from the estimate**
44 **of costs provided to you. Many factors affect the actual bill you will receive, and this**
45 **estimate of costs does not account for all of them. Additionally, the estimate of costs is not**
46 **a guarantee of insurance coverage. You will be billed at the provider's charge for any**
47 **service provided to you that is not a covered benefit under your plan. Please check with**
48 **your insurance company if you need help understanding your benefits for the service**
49 **chosen."**

50 **(2) Health carriers shall include with any insurance costs the following: "Your**
51 **insurance costs are based on the information entered and assumptions about typical**
52 **utilization and costs. The actual amount of insurance costs and the amount billed to you**

53 may be different from the insurance costs provided to you. Many factors affect the actual
54 insurance costs, and this insurance costs does not account for all of them. Additionally, the
55 insurance costs provided are limited to the specific information provided and is not a
56 guarantee of insurance coverage for additional services. You will be billed at the
57 provider's charge for any service provided to you that is not a covered benefit under your
58 plan. You may contact us if you need further assistance in understanding your benefits for
59 the service chosen."

60 4. Each health care provider shall also make available the percentage or amount
61 of any discounts for cash payment of any charges incurred by a posting on the provider's
62 website and by making it available at the provider's location.

63 5. No provision in a contract entered into, amended, or renewed on or after August
64 28, 2014, between a health carrier and a health care provider shall be enforceable if such
65 contractual provision prohibits, conditions, or in any way restricts any party to such
66 contract from disclosing to an enrollee, patient, potential patient, or such person's parent
67 or legal guardian the contractual payment amount for a health care service if such
68 payment amount is less than the health care provider's usual charge for the health care
69 service, and if such contractual provision prevents the determination of the potential out-
70 of-pocket cost for the health care service by the enrollee, patient, potential patient, parent,
71 or legal guardian.

72 6. The department may promulgate rules to implement the provisions of this
73 section. Any rule or portion of a rule, as that term is defined in section 536.010, that is
74 created under the authority delegated in this section shall become effective only if it
75 complies with and is subject to all of the provisions of chapter 536 and, if applicable,
76 section 536.028. This section and chapter 536 are nonseverable and if any of the powers
77 vested with the general assembly under chapter 536 to review, to delay the effective date,
78 or to disapprove and annul a rule are subsequently held unconstitutional, then the grant
79 of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be
80 invalid and void.

208.166. 1. As used in this section, the following terms mean:

2 (1) "Department", the Missouri department of social services;

3 (2) "Prepaid capitated", a mode of payment by which the department periodically
4 reimburse a contracted health provider plan or primary care physician sponsor for delivering
5 health care services for the duration of a contract to a maximum specified number of members
6 based on a fixed rate per member, notwithstanding:

7 (a) The actual number of members who receive care from the provider; or

8 (b) The amount of health care services provided to any members;

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

12 (4) "Primary care physician sponsor", a physician licensed pursuant to chapter 334 who
13 is a family practitioner, general practitioner, pediatrician, general internist or an obstetrician or
14 gynecologist;

15 (5) "Specialty physician services arrangement", an arrangement where the department
16 may restrict recipients of specialty services to designated providers of such services, even in the
17 absence of a primary care case-management system.

18 2. The department or its designated division shall maximize the use of prepaid health
19 plans, where appropriate, and other alternative service delivery and reimbursement
20 methodologies, including, but not limited to, individual primary care physician sponsors or
21 specialty physician services arrangements, designed to facilitate the cost-effective purchase of
22 comprehensive health care.

23 3. In order to provide comprehensive health care, the department or its designated
24 division shall have authority to:

25 (1) Purchase medical services for recipients of public assistance from prepaid health
26 plans, health maintenance organizations, health insuring organizations, preferred provider
27 organizations, individual practice associations, local health units, community health centers, or
28 primary care physician sponsors;

29 (2) Reimburse those health care plans or primary care physicians' sponsors who enter
30 into direct contract with the department on a prepaid capitated or primary care case-management
31 basis on the following conditions:

32 (a) That the department or its designated division shall ensure, whenever possible and
33 consistent with quality of care and cost factors, that publicly supported neighborhood and
34 community-supported health clinics shall be utilized as providers;

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

38 (c) That the department shall ensure full freedom of choice for prescription drugs at any
39 [Medicaid] **MO HealthNet** participating pharmacy;

40 (3) Limit providers of medical assistance benefits to those who demonstrate efficient and
41 economic service delivery for the level of service they deliver, and provided that such limitation
42 shall not limit recipients from reasonable access to such levels of service;

43 (4) Provide recipients of public assistance with alternative services as provided for in
44 state law, subject to appropriation by the general assembly;

45 (5) Designate providers of medical assistance benefits to assure specifically defined
46 medical assistance benefits at a reduced cost to the state, to assure reasonable access to all levels
47 of health services and to assure maximization of federal financial participation in the delivery
48 of health related services to Missouri citizens; provided, all qualified providers that deliver such
49 specifically defined services shall be afforded an opportunity to compete to meet reasonable state
50 criteria and to be so designated;

51 (6) Upon mutual agreement with any entity of local government, to elect to use local
52 government funds as the matching share for Title XIX payments, as allowed by federal law or
53 regulation;

54 (7) To elect not to offset local government contributions from the allowable costs under
55 the Title XIX program, unless prohibited by federal law and regulation.

56 4. Nothing in this section shall be construed to authorize the department or its designated
57 division to limit the recipient's freedom of selection among health care plans or primary care
58 physician sponsors, as authorized in this section, who have entered into contract with the
59 department or its designated division to provide a comprehensive range of health care services
60 on a prepaid capitated or primary care case-management basis, except in those instances of
61 overutilization of [Medicaid] **MO HealthNet** services by the recipient.

62 **5. (1) The department of social services shall extend the current MO HealthNet**
63 **managed care program with a procurement effective July 1, 2015, for all eligibility groups**
64 **currently enrolled in a managed care plan as of January 1, 2014, notwithstanding any**
65 **provisions to the contrary, and seek any necessary waivers or state plan amendments from**
66 **the federal Department of Health and Human Services.**

67 **(2) The pharmacy benefit for the managed care population receiving coverage**
68 **under this section shall remain covered under the MO HealthNet fee-for-service program.**

69 **(3) The department shall develop a transitional Medicaid payment plan prior to**
70 **July 1, 2015, if necessary, for the purpose of continuing and preserving payments**
71 **consistent with current Medicaid levels for community mental health centers (CMHCs),**
72 **which act as administrative entities for the department of mental health and serve as safety**
73 **net providers. The department shall create an implementation working group consisting**
74 **of CMHCs, the department of mental health and managed care organizations in the MO**
75 **HealthNet program.**

76 **6. (1) No MO HealthNet managed care organization shall refuse to contract with**
77 **any licensed Missouri medical doctor, doctor of osteopathy, psychiatrist or psychologist**
78 **who is located within the geographic coverage area of a MO HealthNet managed care**
79 **program and is able to meet the credentialing criteria established by the National**

80 **Committee for Quality Assurance, and is willing, as a term of contract, to be paid at rates**
81 **not less than one hundred percent of the MO HealthNet Medicaid fee schedule.**

82 **(2) In the MO HealthNet program, all provisional licensed clinical social workers,**
83 **licensed clinical social workers, provisional licensed professional counselors and licensed**
84 **professional counselors may provide behavioral health services to all participants in any**
85 **setting. No MO HealthNet managed care organization shall refuse to contract with any**
86 **provider under this subdivision so long as the provider is located within the geographic**
87 **coverage area of a MO HealthNet managed care program, is able to meet the credentialing**
88 **criteria established by the National Committee for Quality Assurance, and is willing, as a**
89 **term of contract, to be paid at rates equal to one hundred percent of the MO HealthNet fee**
90 **schedule. Nothing in this subdivision shall be construed to expand the scope of practice of**
91 **provisional licensed clinical social workers, licensed clinical social workers, provisional**
92 **licensed professional counselors, and licensed professional counselors.**

93 **(3) For services provided by MO HealthNet managed care organizations, no prior**
94 **authorization shall be required for the receipt of mental health testing and evaluation up**
95 **to four hours per member per year.**

96 **7. To aid the discovery of how and if MO HealthNet recipients covered under**
97 **managed care organization health plans are improving in health outcomes and to provide**
98 **data to the state to target health disparities, the state of Missouri shall:**

99 **(1) Provide a biannual analysis of each of the state managed care organizations to**
100 **ensure such organizations are meeting required metrics, goals, and quality measurements**
101 **as defined in the managed care contract such as costs of managed care services as**
102 **compared to fee-for-service providers, and to provide the state with needed data for future**
103 **contract negotiations and incentive management;**

104 **(2) Meet all state health privacy laws and federal Health Insurance Portability and**
105 **Accountability Act (HIPAA) requirements; and**

106 **(3) Meet federal data security requirements.**

107 **8. MO HealthNet providers shall be reimbursed within forty days of submitting a**
108 **clean claim as such term is defined under section 376.383.**

208.952. 1. There is hereby established the "Joint Committee on MO HealthNet". The
2 committee shall have as its purpose the study of the resources needed to continue and improve
3 the MO HealthNet program over time. The committee shall consist of ten members:

4 (1) The chair and the ranking minority member of the house committee on the budget;

5 (2) The chair and the ranking minority member of the senate committee on
6 appropriations committee;

7 (3) The chair and the ranking minority member of the house committee on appropriations
8 for health, mental health, and social services;

9 (4) The chair and the ranking minority member of the senate committee on health and
10 mental health;

11 (5) A representative chosen by the speaker of the house of representatives; and

12 (6) A senator chosen by the president pro tem of the senate.

13

14 No more than three members from each house shall be of the same political party.

15 2. A chair of the committee shall be selected by the members of the committee.

16 3. The committee shall [meet as necessary] :

17 **(1) Meet on at least four occasions annually, including at least four before the end**
18 **of December of the first year the committee is established. Meetings can be held by**
19 **telephone or video conference at the discretion of the committee;**

20 **(2) Review participant and provider satisfaction reports and reports of health**
21 **outcomes, social and behavioral outcomes, and the use of evidence-based medicine and best**
22 **practices in the MO HealthNet program;**

23 **(3) Review the results from other states of the relative success or failure of various**
24 **models of health delivery attempted;**

25 **(4) Review the results of studies comparing various health plans;**

26 **(5) Review the data from health risk assessments;**

27 **(6) Review the results of public process input;**

28 **(7) Advise and approve proposed design and implementation proposals for new**
29 **health improvement plans submitted by the department, as well as make recommendations**
30 **and suggest modifications when necessary;**

31 **(8) Determine how best to analyze and present the data reviewed so that the health**
32 **outcomes, participant and provider satisfaction, results from other states, health plan**
33 **comparisons, financial impact of the various health improvement plans and models of care,**
34 **study of provider access, and results of public input can be used by consumers, health care**
35 **providers, and public officials;**

36 **(9) Present significant findings of the analysis required in subdivision (8) of this**
37 **subsection in a report to the general assembly and governor, at least annually, beginning**
38 **January 1, 2016;**

39 **(10) Study the demographics of the state and of the MO HealthNet population, and**
40 **how those demographics are changing; and**

41 **(11) Perform other tasks as necessary including, but not limited to, making**
42 **recommendations to the division concerning the promulgation of rules and emergency**

43 **rules so that quality of care, provider availability, and participant satisfaction can be**
44 **assured.**

45 4. [Nothing in this section shall be construed as authorizing the committee to hire
46 employees or enter into any employment contracts.

47 5. The committee shall receive and study the five-year rolling MO HealthNet budget
48 forecast issued annually by the legislative budget office.

49 6.] The committee shall make recommendations in a report to the general assembly by
50 January first each year, beginning in [2008] **2016**, on anticipated growth in the MO HealthNet
51 program, needed improvements, anticipated needed appropriations, and suggested strategies on
52 ways to structure the state budget in order to satisfy the future needs of the program.

208.999. 1. MO HealthNet managed care organizations shall be required to provide
2 **to the department of social services on at least a yearly basis, and the department of social**
3 **services shall publicly report within thirty days of receipt, including posting on the**
4 **department's website, at least the following information:**

5 (1) **Medical loss ratios for each managed care organization compared with the**
6 **eighty-five percent medical loss ratio for large group commercial plans under Public Law**
7 **111-148 and, if applicable, with the state's administrative costs in its fee-for-service MO**
8 **HealthNet program; and**

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

13 2. **Managed care organizations shall be required to maintain medical loss ratios of**
14 **at least eighty-five percent, as defined by the National Association of Insurance**
15 **Commissioners, for MO HealthNet operations. If a managed care organization's medical**
16 **loss ratio falls below eighty-five percent over a cumulative period of three years, the**
17 **managed care plan shall be required to refund a portion of the capitation rates paid to the**
18 **managed care plan in a tiered amount equal to the difference between the plan's medical**
19 **loss ratio and eighty-five percent of the capitated payment to the managed care**
20 **organization. When the medical loss ratio is between eighty-five percent and eighty**
21 **percent, twenty-five percent of the tier shall be returned to the state; when the medical loss**
22 **ratio is less than eighty percent, seventy-five percent of the tier shall be returned to the**
23 **state.**

24 3. **The department of social services shall be required to ensure that managed care**
25 **organizations establish and maintain adequate provider networks to serve the MO**
26 **HealthNet population and to include these standards in its contracts with managed care**

27 organizations. Managed care organizations shall be required to establish and maintain
28 health plan provider networks in geographically accessible locations in accordance with
29 travel distances specified by the department of social services in its managed care contracts
30 and as required by the department of insurance, financial institutions and professional
31 registration.

32 4. Managed care plans' networks shall consist of, at minimum, hospitals,
33 physicians, advanced practice nurses, behavioral health providers, community mental
34 health centers, substance abuse providers, dentists, emergent and non-emergent
35 transportation services, federally qualified health centers, rural health centers, women's
36 health specialists, local public health agencies, and all other provider types necessary to
37 ensure sufficient capacity to make available all services in accordance with the service
38 accessibility standards specified by the department of social services.

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

43 6. The department of social services shall be required to contract with an
44 independent organization that does not contract or consult with managed care plans or
45 insurers to conduct secret shopper surveys of MO HealthNet plans for compliance with
46 provider network adequacy standards on a regular basis, to be funded by the insurers out
47 of their administrative budgets. In no event shall an insurer be required to pay more than
48 ten thousand dollars per year for such surveys. Secret shopper surveys are a quality
49 assurance mechanism under which individuals posing as MO HealthNet enrollees will test
50 the availability of timely appointments with providers listed as participating in the network
51 of a given plan for new patients. The testing shall be conducted with various categories of
52 providers, with the specific categories rotated for each survey and with no advance notice
53 provided to the plan. If an attempt to obtain a timely appointment is unsuccessful, the
54 survey records the particular reason for the failure, such as the provider not participating
55 in MO HealthNet at all, not participating in MO HealthNet under the plan which listed it
56 and was being tested, or participating under that plan but only for existing patients.

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

61 8. The provider compensation rates for each category of provider shall also be
62 reported by the managed care organizations to help ascertain whether they are paying

63 enough to engage providers comparable to the number of providers available to
64 commercially insured individuals, as required by federal law, and compared, if applicable,
65 to the state's own provider rates for the same categories of providers.

66 **9. Managed care organizations shall be required to ensure sufficient access to out-**
67 **of-network providers if necessary to meet the health needs of enrollees in accordance with**
68 **standards developed by the department of social services and included in the managed care**
69 **contracts.**

70 **10. Managed care organizations shall be required to provide, on a quarterly basis**
71 **and for prompt publication, at least the following information related to service utilization,**
72 **approval, and denial:**

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

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

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

84 **11. Managed care organizations shall be required to disclose the following**
85 **information:**

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

89 **(2) Consumer satisfaction survey data;**

90 **(3) Provider satisfaction survey data;**

91 **(4) Enrollee telephone access reports including average wait time before managed**
92 **care organization or subcontractor response, busy signal rate, and enrollee telephone call**
93 **abandonment rate;**

94 **(5) Data regarding the average cost of care of individuals whose care is reported as**
95 **having been actively managed by the managed care organization versus the average cost**
96 **of care of the managed care organization's population generally. For purposes of this**
97 **section, the phrase "actively managed by the managed care organization" means the**
98 **managed care organization has actually developed a care plan for the particular individual**

99 and is implementing it as opposed to reacting to prior authorization requests as they come
100 in, reviewing usage data, or monitoring doctors with high utilization;

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

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

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

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

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