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## **Missouri Medicaid Becomes MO HealthNet** *A Summary of the Truly Agreed to and Finally Passed SB577*

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- **Amends the State Legal Expense Fund**

Money available in the State Legal Expense Fund shall be payable to any physician or dentist who provides uncompensated care to an individual referred by a community health center [§105.711.2(3)(f), p.7] and to members of any social welfare board that provide uncompensated medical care §105.711.2(6), p.8].

- **Increases the Allowed Deductible for Long-Term Care Insurance Premiums**

Starting December 31, 2006, individuals may deduct from their taxable Missouri income an amount equal to 100% of the non-reimbursed amounts paid toward long-term care insurance premiums [§135.096.1, p. 14]. This amends current law which allowed for deductions equal to 50% of non-reimbursed long-term care insurance premium payments.

- **Modifies the Role of Long-Term Care Insurance Companies in Establishing Rates**

Prohibits long-term care insurance companies from working together on establishing rates and rating systems [§135.096.3, p. 15].

- **Creates the Missouri Healthcare Access Fund**

- Creates the Missouri Healthcare Access Fund in the Missouri Treasury. This fund shall be used to pay for costs associated with providing primary healthcare in areas of defined need such as recruiting health care professionals, purchasing or renting facilities, or paying for facility expansions [§191.1056, p. 37]. The state of Missouri shall match the donations in an amount equal to one-half the total donations into the fund. Individual donations to the fund shall not exceed \$50,000 per year.

- Beginning January 1, 2007, individuals who make donations in excess of \$100 to the Missouri Healthcare Access Fund will be eligible for a tax credit. The tax credit shall equal one-half of the total donation made and shall not exceed \$25,000 annually [§135.575.2, p.16]. The tax credit is subject to the approval of the Senate Appropriations Committee and the House Budget Committee. This program shall sunset six years after its effective date and if reauthorized at that time, it shall sunset twelve years after that effective date [§135.575.4, p.17].

- **Amends the False Claims Act Provisions**

Adds some additional definitions and requirements to the Medicaid fraud provisions [Starts at §191.900 p. 19-35]. New provisions of the fraud and abuse legislation include:

- Money that remains in the MO HealthNet Fraud Reimbursement Fund after payment to all state and federal agencies shall be used to increase provider reimbursement until it is at least 100% of the Medicare reimbursement rates [§191.905.11, p.25].
- A person who discovers a violation committed by himself/herself, or his/her organization and reports it shall not be prosecuted for a criminal violation [§191.905.15, p. 27].
- An individual who is the original source of the information about the fraud shall receive 10% of the recovery attained by the Attorney General [§191.907.1, p. 27-28].
- Employers may not harass, threaten, discharge, demote, suspend, or discriminate against any employee who participates in the court proceedings related to fraud and abuse allegations [§191.908.1, p. 28].
- By January 1, 2008, the Attorney General’s office shall report to the General Assembly, the Governor’s Office, and the Department of Social Services on various fraud and abuse measures [§191.909, p. 29-31].

- **Creates the Authority to Establish Areas of Defined Need and Eligible Facilities**

The Department of Health and Senior Services may designate eligible facilities in “areas of defined need”. The factors that will contribute to the establishment of these eligible facilities will include: the health status of the local population, the ability of the population to pay for health care services, the accessibility of health care services, and the availability of health care professionals in the area. These facilities will be eligible to receive funds from the Healthcare Access Fund [§191.1053, p.36].

- **Creates the Chronic Kidney Disease Task Force**

Establishes the Chronic Kidney Disease Task Force. This task force will educate the public and the provider community on the benefits of early screening for kidney disease, make recommendations for a cost-effective implementation of the education plan, identify barriers to the implementation of best practices, and submit a report to the general assembly by August 30, 2008 [§192.632, p. 38-40].

- **Ensures Implementation of Plan of Care Change Following Hospitalization**

When a resident of a residential care facility (RCF) is admitted and released from a hospital or skilled nursing facility (SNF), and returns to the RCF, the RCF must implement the doctor's plan of care relating to the hospital or SNF discharge within 24 hours of return to the RCF [§198.069, p. 40].

- **Strengthens Provisions to Ensure Facilities Receive Adequate Payments**

Any person who is financially responsible for an elderly or disabled person who resides in any facility shall be guilty of a Class D felony if s/he fails to pay appropriate funds (e.g. Social Security income, pension, or other income) to the facility. This provision also provides examples of what evidence qualifies as proof for misappropriating funds [§198.097, p. 41]. This changes current law which included only the elderly and nursing homes in this provision.

- **Establishes the “Missouri Continuing Health Improvement Act”**

Changes “Medicaid” to “MO HealthNet” [§208.101.2, p. 42].

- **Creates the Ticket to Work Health Assurance Program**

Creates the Ticket to Work Health Assurance Program [§208.146, p. 43-47]. This program will allow individuals who meet the definition of disabled under the federal guidelines for the Supplemental Security Income (SSI) program to be eligible for medical assistance if s/he is employed. To be eligible, an individual must have a gross income less than or equal to 250% of the Federal Poverty Level (FPL), excluding any earned income between 250 and 300% FPL. Any person whose gross income exceeds 100% FPL shall be required to pay a premium. Certain deductions and asset limits apply to eligibility determinations. If an individual who is eligible for this program is also eligible for employer-sponsored insurance (ESI) that is determined to be more cost-effective, the individual must participate in ESI. In this case, the state shall pay premiums, co-payments and other costs associated with ESI. The Ticket to Work Health Assurance Program is subject to appropriations.

- **Extends Eligibility for Participants Participating in Drug Court**

Extends MO HealthNet eligibility of individuals receiving aid to families with dependent children who are participating in drug court. Individuals who meet these criteria will have their MO HealthNet eligibility automatically extended 60 days from the date that his/her dependent child is removed from his/her custody [§208.151.1(2), p. 47].

- **Extends Eligibility to Foster Care Adolescents Aging Out of Foster Care**

Provides MO HealthNet benefits to persons who are independent foster care adolescents and are under twenty-one years of age [§208.151.1(26), p. 55]. There are no asset or income limits for this group.

- **Protects Rural Health Clinics and Federally Qualified Health Centers in Waivers**

Allows the Department of Social Services to apply to the federal government for 1115 waivers to implement provisions of this law. However, such waivers cannot waive the services of a Rural Health Clinic (RHC) or a Federally Qualified Health Center (FQHC) unless such a waiver of services is approved by the MO HealthNet Oversight Committee [§208.151.5, p. 57].

- **Limits Home Equity for MO HealthNet Payment of Nursing Home Services**  
MO HealthNet benefit payments for nursing home facilities shall not be paid for MO HealthNet participants who have more than \$500,000 equity in their home [§208.152.1(4), p. 59]. *Note: This change reflects mandatory provisions in the Federal Deficit Reduction Act (DRA) of 2005. However, the DRA allows states the option to extend that limit to \$750,000 of home equity.*

- **Changes the Way Payment Is Made for Personal Care Services in an RCF or ALF**

When personal care services are delivered in a residential care facility (RCF) or assisted living facility (ALF) the payment level shall be based on the tier-level of the services provided [§208.152.1(14), p. 62-63].

- **Provides Durable Medical Equipment as a Covered MO HealthNet Benefit**  
Covers prescribed durable medical equipment as a MO HealthNet benefit. Adds that an electronic, web-based system will be used to ensure prior authorization [§208.152.1(19), p. 67].

- **Hospice Care Is a Covered MO HealthNet Benefit** [§208.152.1(20), p. 67-68].

- **Dental Care is a Covered MO HealthNet Benefit Subject to Appropriations**  
Prescribed medically necessary dental care is covered, subject to appropriations [§208.152.1(21), p. 68].

- **Optometric Care Is a Covered MO HealthNet Benefit Subject to Appropriations**  
Prescribed medically necessary optometric care is covered, subject to appropriations [§208.152.1(22), p. 68].

- **Requires Reports on the Status of Medicaid Provider Reimbursement Rates**  
The MO HealthNet Division shall report on the status of Medicaid provider rates as they compare to 100% of Medicare provider rates starting January 1, 2008 [§208.152.1(23), p. 68]. By July 1, 2008, the MO HealthNet Division shall provide a four-year plan to the general assembly for increasing Medicaid provider reimbursement rates to 100% of Medicare reimbursement rates.

- **The MO HealthNet Division May Require Additional Co-payments**

Starting July 1, 2008, the MO HealthNet Division pay require additional co-payments for covered MO HealthNet benefits [§208.152.4, p. 71].

- **Excludes Income Earned in a Sheltered Workshop in Determining Eligibility**

[§208.152.11, p. 74].

- **Requires a Pay-For-Performance Program**

A “professional services” committee will design and maintain the guidelines for a pay-for-performance program. Providers operating under a risk-based (managed care) plan and under administrative services organization plans are required to participate in pay-for-performance. Providers operating under the State’s coordinated fee-for-service plan “shall” participate. (It is not clear why the distinction was made between managed care, ASO’s and coordinated fee-for-service, since they are all required to participate). The employers of physicians whose work earns the pay-for-performance reward must pass on the pertinent portion to the physician, without any corresponding decrease in the compensation to which they would otherwise be entitled [208.153.2, p. 75].

- **Sets up the Professional Services Payment Committee**

The Governor, with approval by the Senate, will appoint this committee to develop and oversee the pay-for-performance program. The Committee is composed of nine physicians, two patient advocates, the attorney general or his/her designee, and six persons actively engaged in hospital or nursing home administration, dentistry or pharmaceuticals. The Committee is to be appointed by December 31, 2007 [208.197.1, p. 78].

- **Provides Guidelines for the Pay-For-Performance Program**

Pay-for-performance shall ensure quality of care, foster the relationship between the patient and provider, use accurate data, evidence-based measures, provide fair and equitable program incentives, and not discourage providers from caring for those with complex/high-risk conditions [§208.197.2, p.78].

- **Simplifies Medicaid Eligibility Determination for Seniors**

Allows Social Security cost of living increases to be disregarded until the federal poverty level for such year is updated. COLAs are implemented before the federal poverty level is updated [§208.153.7, p. 77].

- **Allows Limited Carry-Over of Income “Spent Down”**

Participants in the spend-down program who have met the required spend down, may carry over additional out-of pocket spending for up to three months from the additional expense [§208.153.8, p. 78].

- **Authorizes a Premium Offset Program**

Authorizes a pilot premium offset program in one rural and one urban area, subject to appropriations to make standardized private insurance available to qualified individuals. This is subject to approval by the oversight committee [§208.202.1, p. 82].

- To be eligible, an individual has to: be uninsured for one year; have income less than 185% of FPL; and pay their share of the premium. If the employer opts not to participate, the employee and spouse may directly enroll in the premium offset program. (No mention of what portion of the premium the employee will pay in this scenario). The statute specifies that the employee is not entitled to wrap around Medicaid services [§208.202.1, p. 82].
- An employer may only participate in the program for 5 years [§208.202.3 p. 82].
- The Department of Social Services is authorized to do this by seeking a waiver or a state plan amendment [§208.202.4, p. 83]

- **Changes Resources Excluded in MO HealthNet Eligibility Determinations**

The stream of income from an annuity is excluded as an available resource for annuities that name and pay the MO HealthNet claimant as the primary beneficiary [§208.212.1, p. 83].

- **Makes Efforts to Prohibit Individuals From Sheltering Their Assets When They Apply for Medicaid to Cover Long Term Care**

When institutionalized individuals apply for Medicaid the Department of Social Services looks at their assets over the five previous years. If it appears that they have sheltered assets to avoid using them to pay for long term care, the individual is ineligible for Medicaid for a period of time based on the amount of those assets. This clarifies the conditions under which a personal care contract is a legitimate expense, and thus will not be considered “sheltering” [§208.213, p. 84].

- **Assures Recovery of Third-Party Benefits**

- Medicaid participants who receive third-party benefits or proceeds for an illness/injury are required to pay the division the full amount of MO HealthNet benefits received within 60 days of receiving the settlement, or must place the full amount in a trust account for the benefit of the division [§208.215.4, p. 87].
- The department is not required to seek reimbursement from a liable third-party for claims that it reasonable expects to be less than the cost of recovery [§209.215.18, p. 98].

- **Establishes the Public Assistance Beneficiary Employer Disclosure Act**

The Department of Social Services must prepare a quarterly report that documents the number of individuals who are a beneficiary, or the financially responsible spouse or custodial parent of a MO HealthNet beneficiary of each employer with more than 50 employees. The report also must include whether the employees are full or part time, whether the employer offers insurance as a benefit, and the cost of MO HealthNet benefits being provided to the employer's employees [§208.230.3, p. 102].

- **Improves the State Children's Health Insurance Program (SCHIP)**

- Clarifies that the state will fund the SCHIP program IF funds are appropriated by the federal government. The State is instructed to maximize available federal funding [208.631.1, p. 104].
- States that insurance that does not cover an eligible children's pre-existing condition shall not be considered "affordable" [208.640.1, p. 106].
- Mitigates the affordability test. "Affordable" is defined as:
  - *For families with incomes of 151 to 185% FPL: 3% of 150% FPL for a family of three*
  - *For families with incomes of 186 to 225% FPL: 4% of 185% FPL for a family of three*
  - *For families with incomes of 225 to 300% FPL: 5% of 225% FPL for a family of three [208.641.1, p. 106].*
- The department shall study the expansion of presumptive eligibility for children [§208.640.2, p. 107].

- **Revises eligibility for the Women's Health Program**

Women are eligible if they are at least 18 years of age, have incomes at or below 185% FPL, assets less than \$250,000, and do not have access to employer sponsored insurance [§208.659, p. 107].

- **Clarifies the Use of Telehealth**

The Departments of Social Services, Mental Health and Health & Senior Services will promulgate rules governing the practice of telehealth [§208.690, p. 108].

- **Establishes the Long Term Care Partnership Program**
  - Allows individuals who purchase long term care insurance to disregard assets or resources in an amount equal to the insurance benefits made on their behalf under a qualified long term care partnership policy [§208.692, p. 109].
  - If the Missouri Long Term Care Partnership program is discontinued, an individual who purchased a qualified long term care policy shall be eligible to receive the asset disregard [§208.694.2, p.111].
  - Missouri may enter into reciprocal agreements with other states that have asset disregards for those who purchase long term care insurance [§208.694.3, p. 112].
  - Designates the director of the Department of Insurance, Financial Institutions and Professional Registration to development requirements for the program and promulgate rules for certifying qualified long term care partnership policies [§208.696, p. 112].
  - Requires regular reports to the federal government and to the Department of Social Services and the Department of Insurance, Financial Institutions and Professional Registration [§208.698, p. 113].
  
- **Extends the Sunset for the Consumer Directed Health Program to 2019**  
[§208.930 p. 115]
  
- **Changes the MO HealthNet Delivery System**
  - The Department of Social Services, with approval by the oversight committee will establish Health Improvement Plans (HIPs) to include, but not limited to risk-bearing coordinated plans, Administrative services organization, and coordinated fee-for-service plans [§208.950.1, p. 120].
  - Enrollment in plans to begin July 1, 2008 and be complete by July 1, 2011 taking into account the appropriateness of enrolling particular participants into each plan [§208.950.1, p. 121].
  - Risk-bearing and ASO plans will suffer financial penalties if quality targets aren't met. These targets will include, but are not limited to, the use of hospital emergency room for non-emergency needs [§208.950.1, p. 121].
  - Every participant shall be enrolled in a plan and be provided a health care home [§208.950.2, p. 121].
  - All HIPs are required to help participants remain in the least restrictive setting [§208.950.2, p. 121].
  - HIPs shall use domestic-based call centers and nurse help lines [§208.950.2, p. 121].
  - HIPs shall report on provider and participant satisfaction annually [§208.950.2, p. 121].
  - HIPs shall use evidence-based best practices [§208.950.2, p. 121].

- The Department of Social Services shall evaluate and compare all HIPs on the basis of cost, quality, health improvement, health outcomes, social and behavioral outcomes, health status, consumer satisfaction, use of evidence based medicine and use of best practices and report findings to the oversight committee [§208.950.2, p. 121].
  - HIPs are to be consistent with principles of transparency, personal responsibility, prevention and wellness, performance-based assessments, achievement of improved health outcomes, increasing access and cost effective delivery through the use of technology and coordination of care [§208.950.3, p. 122] .
  - No provision shall be construed as to require any aged, blind or disabled person to enroll in a risk-bearing plan [§208.950.4, p. 122].
  - The Department of Social Services shall commission an independent survey by July 1, 2008 to assess health and wellness outcomes of MO HealthNet participants. Results to be completed by December 2008 and be submitted to the Governor, the General Assembly and the oversight committee [§208.950.5, p. 122].
  - The Department of Social Services shall engage in a public process for the design, development and implementation of the HIPs and other aspects of MO HealthNet [§208.950.6, p. 123].
  - By July 1, 2008 all HIPs shall complete a health risk assessment for enrolled participants and develop a plan of care for each [§208.950.7, p. 123].
  - All contracts related to MO HealthNet shall be competitively bid [§208.950.7, p. 123].
- **Creates the Joint Committee on MO HealthNet**
    - Purpose is to study of resources needed to continue and improve MO HealthNet over time [§208.952.1, p. 123].
    - The committee is composed of [§208.952.1, p. 123]:
      - Chair and ranking minority member of House Budget Committee and Senate Committee on Appropriations.
      - Chair and ranking minority member of House Committee on Appropriations for Health, Mental Health and Social Services.
      - Chair and ranking minority member of the Senate Committee on Health and Mental Health.
      - A representative chosen by the Speaker of the House.
      - A senator chosen by the President Pro Tem of the Senate.
    - The Committee shall study the five year rolling budget forecast issued annually by the legislative budget office [§208.952.5, p 124].
    - The Committee shall make recommendations to the General Assembly by January 1 of each year, beginning in January, 2008 on ways to satisfy the future needs of the program [§208.952.6, p. 124].
- **Creates the MO HealthNet Oversight Committee**
    - Shall be appointed by January 1, 2008 [§208.955, p. 124].

- Composed of 18 members [§208.955, p 125].
    - Two members of the House and two from the Senate, one from each party.
    - One consumer representative.
    - Four physicians.
    - One representative of each of the following: state hospital association, non-physician health care provider, dentist, and one public member.
    - Two patient advocates.
    - Directors of the Departments of Social Services, Mental Health, Health & Senior Services, or their designees to serve as ex officio members.
  - Duties include reviewing satisfaction reports, reports on health outcomes and other collected information under §208.950, other states' experience, data from health risk assessments, input from the public process collected under §208.950, and advise and approve proposed design and implementation of HIPs. Determine how to analyze and present collected data, present significant findings (at least annually) to the Governor and General Assembly beginning in 2009, review the budget forecasts, consider ways to maximize federal drawdown of funds, study demographics of MO HealthNet participants, consider ways to prepare for the growing elderly population, study whether an office of inspector general should be established, and make recommendations to the division regarding rules.
  - Make recommendations by July 1, 2011 on the success/failure of HIPs and whether any or all should be discontinued [§208.955.2, p. 127].
  - The oversight committee shall establish a sub-committee to advise the Department on developing a comprehensive entry point for long term care [§208.955.4, p. 129].
    - The Subcommittee has 22 designated members, two of whom are consumers and one who is a consumer representative. Ten are representatives of professions with interests related to long term care [§208.955, p. 129].
    - The Subcommittee shall make recommendations by October 1, 2008.
  - Report and make recommendations relating to expenditures in the HealthCare Technology Fund [§208.978, p. 136].
- **Creates the Healthcare Technology Fund**  
§208.975 p. 132]
  - **Requires Personal Representatives to Evidence Payment of Costs Due to MO HealthNet From a Probate Estate Prior to Closing**  
§473.398 p. 137]
  - **Requires the Legislative Budget Office to Prepare a Five-Year Rolling Forecast of MO HealthNet Costs**  
Section 1, p. 139]

- **Protects Access to Psychotropic Medications for those in Fee-For-Service Plans**  
Section 2, p. 140]
- **Requires Proposals for HIPs for at Least Six Regions of the State**  
Prohibits a single statewide contract [Section 3, 140].

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