SECOND REGULAR SESSION

HOUSE BILL NO. 2156

100TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE NEELY.

4735H.01I DANA RADEMAN MILLER, Chief Clerk

AN ACT

To amend chapter 208, RSMo, by adding thereto three new sections relating to MO HealthNet managed care.

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

Section A. Chapter 208, RSMo, is amended by adding thereto three new sections, to be known as sections 208.1100, 208.1105, and 208.1110, to read as follows:

208.1100. Any contract between the state of Missouri and a vendor of prepaid capitated health services, as described in section 208.166, which is issued, reauthorized, or renewed after August 28, 2020, shall incorporate the following standards:

(1) Each vendor shall use a set of uniform utilization review protocols and standards in determining medical necessity for services and for authorizing payment for services delivered and administered pursuant to the contract. The uniform utilization review protocols and standards shall be established by the department of social services. Uniform utilization review protocols and standards for hospital emergency department coverage shall include, but not be limited to, the standards established for health maintenance organizations as defined in chapter 354 regarding emergency services and emergency medical conditions. The department shall ensure the active engagement of network health care providers, including, but not limited to, providers of behavioral health services, in developing the department's set of uniform utilization review protocols and standards. In developing the uniform utilization review protocols and standards, the department shall give preference to the use of protocols and standards with prevalent use among the Medicare program and health carriers, as defined in section 376.1350;

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.

(2) Decisions regarding appeals of utilization review or payment authorization decisions shall be timely. Data on the number, timing, nature, and disposition of appeals shall be reported to the department as provided by the contract, but no less frequently than quarterly. The contract shall include deadlines and other criteria for making utilization review decisions and resolving disputes of utilization review decisions and shall include financial penalties for consistent failure of a vendor to issue timely decisions pursuant to terms of the contract and state and federal laws and regulations;

(3) Network adequacy standards shall be established and enforced to ensure that vendors provide access to adult and pediatric primary care, specialty medical care, and behavioral health services comparable to those provided to enrollees of private health benefit plans;

(4) Administrative requirements from the state that are imposed on providers and patients by a vendor shall be standardized and uniformly applied to each vendor. For purposes of this section, administrative requirements shall include, but not be limited to, the collection from providers of financial, care delivery, and quality of care data;

(5) To the extent that federal statutory or regulatory requirements directly or indirectly prevent the payment of Medicaid upper-limit payments under 42 CFR 447 that some or all hospitals are eligible to receive, alternative or supplemental payments shall be made in lieu thereof as authorized by appropriation by the general assembly and by federal laws and regulations;

(6) Capitation payments made to a vendor through prepaid capitated coverage arrangements shall not exceed an actuarially sound capitation rate established under paragraph (c) of 42 CFR 438.6. The portion of capitation payments for which the state share is funded by the proceeds of a provider assessment shall be used exclusively to pay for the compensable services of some or all of the providers subject to the applicable tax under state law. This requirement shall not apply to the amounts of each type of provider assessment appropriated and expended to fund MO HealthNet managed care payments during state fiscal year 2019. Contracts described in this section shall ensure the collection and distribution of payments and encounter data necessary to verify continuous compliance with this subdivision. For purposes of this section, the term "provider assessment" shall mean assessments in which payment is mandated by:

(a) Sections 190.800 to 190.839;

(b) Sections 198.401 to 198.439;

(c) Sections 208.453 to 208.480;

(d) Sections 338.500 to 338.550; or

(e) Section 633.401;

(7) A vendor shall be subject to a financial penalty if the vendor fails to meet targets defined by the contract for rates at which participants whose care is being managed by a managed care plan seek to use hospital emergency department services for nonemergency medical conditions. The MO HealthNet division shall convene representatives of vendors, physicians, hospitals, pharmacists, and other applicable health care providers to promote the development and implementation of best practices to reduce the incidence of nonemergency use of hospital emergency departments by MO HealthNet participants;

(8) The vendor shall maintain a medical loss ratio of at least ninety percent or greater;

(9) The vendor shall provide on a monthly basis, or more frequently as specifically required by the contract, all data necessary to allow the department to monitor and implement payments including, but not limited to, any data necessary to determine compliance with any contractual agreements between the vendor and providers of health care services. The data shall be a public record under chapter 610;

(10) The vendor shall permit shared savings and risk- and gain-sharing arrangements between vendors and health care providers;

(11) In accordance with section 1.330, no contract shall compel or coerce, directly or indirectly, health care providers to participate in a health care system including, but not limited to, a MO HealthNet managed care program; and

(12) Timely payment of providers by vendors that is at least as stringent as provided in section 376.383. This subdivision shall not be construed to impede the inclusion of standards regarding timely payment that are more stringent than state statutory standards as permitted or required by federal laws or regulations or the terms of a contract under this section.

208.1105. The department of social services shall accept regional plan proposals from provider-sponsored care management organizations as an option for coverage of beneficiaries. Provider-sponsored care management organizations shall comply with standards established by the department to ensure comparable levels of benefits, quality, and protection to enrollees including, but not limited to, financial solvency and enrollee, fiscal, and quality accountability standards applied to any health maintenance organizations that are vendors of MO HealthNet managed care services. For purposes of this section, regional proposals may be submitted by a "coordinated care organization" or "CCO", which shall be an organization of health care providers, including a health care home, that agrees to be accountable for the quality, cost, coordination, and overall care of a defined group of MO HealthNet participants. The regional CCOs shall use a shared savings model in which, over time, there is also shared risk. The regional or statewide

CCOs shall be reimbursed through a global payment methodology developed by the department. The global payment methodology may utilize a population-based payment mechanism calculated on a per-member, per-month calculation and may include risk adjustments, risk sharing, and aligned payment incentives to achieve performance improvement. The department may develop performance incentive payments designed to reward increased quality and decreased cost of care. CCOs under this section may be eligible to receive performance incentive payments as determined by the department beginning in their second full year of operation.

208.1110. The state auditor shall conduct an annual evaluation of the savings and costs attributable to state government, political subdivisions, health care providers, and MO HealthNet participants pursuant to the expanded implementation of prepaid capitated health services occurring after April 30, 2021. In preparing the evaluation, the state auditor may consult with the department of social services, the department of mental health, and the department of commerce and insurance. The annual evaluation shall include an assessment of the financial implications attributable to the use of subcontractors by prepaid capitated heath service plans to administer the delivery of health services, including behavioral health services, to MO HealthNet participants.

✓