Section 1. 1. Except for individuals who meet the definition of medically frail, individuals who qualify for coverage under subsections 2 and 3 of section 208.995 shall receive covered services through health plans offered by managed care entities which are authorized by the department. Health plans authorized by the department:

(1) Shall resemble commercially available health plans while complying with federal Medicaid requirements as authorized by federal law or through a federal waiver, and may include accountable care organizations, administrative service organizations, or managed care organizations paid on a capitated basis;

(2) Shall promote, to the greatest extent possible, the opportunity for children and their parents to be covered under the same plan;

(3) Shall offer plans statewide;

(4) Shall include cost sharing for outpatient services to the maximum extent allowed by federal law;

(5) May include other co-payments and provide incentives that encourage and reward the prudent use of the health benefit provided;

(6) Shall encourage access to care through provider rates that include pay-for-performance and are comparable to commercial rates;

(7) Shall provide incentives, including shared risk and savings, to health plans and providers to encourage cost-effective delivery of care;

(8) May provide multiple plan options and reward participants for choosing a low-cost plan; and

(9) Shall include the services of health providers as defined in 42 U.S.C. Section 1396d(l)(1) and (2) and meet the payment requirements for such health providers as provided in 42 U.S.C. Sections 1396a(a)(15) and 1396a(bb).

2. The department may designate that certain health care services be excluded from such health plans if it is determined cost effective by the department.

3. (1) The department may accept regional plan proposals as an additional option for beneficiaries. Such proposals may be submitted by accountable care organizations or other organizations and entities.

(2) The department shall advance the development of systems of care for medically complex children who are recipients of MO HealthNet benefits by accepting cost-effective regional proposals from and contracting with appropriate pediatric care networks, pediatric centers for excellence, and medical homes for children to provide MO HealthNet benefits when

the department determines it is cost effective to do so. Such entities shall be treated as accountable care organizations.

(3) The provisions of subsection 1 of this section shall not apply to this subsection.

4. The department shall establish, in collaboration with plans and providers, uniform utilization review protocols to be used by all authorized health plans.

5. The department shall establish a competitive bidding process for contracting with managed care plans.

(1) The department shall solicit bids only from bidders who offer, or through an associated company offer, an identical or substantially similar plan, in services provided and network, within a health care exchange in this state, whether federally facilitated, state based, or operated on a partnership basis. The bidder, if the bidder offers an identical or similar plan, in services provided or network, or the bidder and the associated company, if the bidder has formed a partnership for purposes of its bid, shall include a process in its bid by which MO HealthNet recipients who choose its plan will be automatically enrolled in the corresponding plan offered within the health care exchange if the recipient's income increases resulting in the recipient's ineligibility for MO HealthNet benefits. The bidder also shall include in its bid a process by which an individual enrolled in an identical or substantially similar plan, in services provided or network, within a health care exchange in this state, whether federally facilitated, state based, or operated on a partnership basis whose income decreases resulting in eligibility for MO HealthNet benefits shall be enrolled in MO HealthNet after an application is received and the participant is determined eligible for MO HealthNet benefits.

(2) The department shall select a minimum of three winning bids and may select up to a maximum number of bids equal to the quotient derived from dividing the total number of participants anticipated by the department in a region by one hundred thousand.

(3) The department shall accept the lowest conforming bid. For determining other accepted bids, the department shall consider the following factors:

(a) The cost to Missouri taxpayers;

(b) The extent of the network of health care providers offering services within the bidder's plan;

(c) Additional services offered to recipients under the bidder's plan;

(d) The bidder's history of providing managed care plans for similar populations in Missouri or other states;

(e) Any other criteria the department deems relevant to ensuring MO HealthNet benefits are provided to recipients in such manner as to save taxpayer money and improve health outcomes of recipients.

6. Any managed care organization that enters into a contract with the state to provide managed care plans shall be required to fulfill the terms of the contract and provide such plans for at least twelve months, or longer if the contract so provides. The state shall not increase the reimbursement rate provided to the managed care organization during the contract period above the rate included in the contract. If the managed care organization breaches the contract, the state shall be entitled to bring an action against the managed care organization for any remedy allowed by law or equity and shall also recover any and all damages provided by law, including liquidated damages in an amount determined by the department during the bidding process. Nothing in this subsection shall be construed to preclude the department or the state of Missouri from terminating the contract as specified in the terms of the contract, including for breach of contract, lack of appropriated funds, or exercising any remedies for breach as may be provided in the contract.

7. (1) Participants enrolling in managed care plans under this section shall have the ability to choose their plan. In the enrollment process, participants shall be provided a list of all plans available ranked by the relative actuarial value of each plan. Each participant shall be informed in the enrollment process that he or she will be eligible to receive a portion of the amount saved by Missouri taxpayers if he or she chooses a lower cost plan offered in his or her region. The portion received by a participant shall be determined by the department according to the department's best judgment as to the portion which will bring the maximum savings to Missouri taxpayers.

(2) If a participant fails or refuses to choose a plan as set forth in subdivision (1) of this subsection, the department shall determine rules for auto-assignment, which shall include incentives for low-cost bids and improved health outcomes as determined by the department.

8. This section shall not be construed to require the department to terminate any existing managed care contract or to extend any managed care contract.

9. All MO HealthNet plans under this section shall provide coverage for the following services unless they are specifically excluded under subsection 2 of this section and instead are provided by an administrative services organization:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn care;

(5) Mental health and substance abuse treatment, including behavioral health treatment;

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness care, and chronic disease management;

(10) Pediatric services, including oral and vision care; and

(11) Any other services required by federal law.

10. No MO HealthNet plan or program shall provide coverage for an abortion unless a physician certifies in writing 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.

11. The MO HealthNet program shall provide a high deductible health plan option for uninsured adults nineteen years of age or older and under sixty-five years of age with incomes of less than one hundred percent of the federal poverty level. The high deductible health plan shall include:

(1) After meeting a one thousand dollar deductible, coverage for benefits as specified by rule of the department;

(2) An account, funded by the department, of at least one thousand dollars per adult to pay medical costs for the initial deductible funded by the department;

(3) Preventive care, as defined by the department by rule, that is not subject to the deductible and does not require a payment of moneys from the account described in subdivision (2) of this subsection;

(4) A basic benefits package if annual medical costs exceed one thousand dollars;

(5) A minimum deductible of one thousand dollars;

(6) As soon as practicable, the establishment and maintenance of a record-keeping system for each health care visit or service received by recipients under this subsection. The plan shall require that the recipient's prepaid card number be entered, or electronic strip be swiped, by the health care provider for purposes of maintaining a record of every health care visit or service received by the recipient from such provider, regardless of any balance on the recipient's card. Such information shall include only the date, provider name, and general description of the visit or service provided. The plan shall maintain a complete history of all health care visits and services for which the recipient's prepaid card is entered or swiped in accordance with this subdivision. If required under

the federal Health Insurance Portability and Accountability Act (HIPAA) or other relevant state or federal law or regulation, a recipient shall, as a condition of participation in the prepaid card incentive, be required to provide a written waiver for disclosure of any information required under this subdivision;

(7) The determination of a proportion of the amount left in a participant's account described in subdivision (2) of this subsection which shall be paid to the participant for saving taxpayer money. The amount and method of payment shall be determined by the department; and

(8) The determination of a proportion of a participant's account described in subdivision (2) of this subsection which shall be used to subsidize premiums to facilitate a participant's transition from health coverage under MO HealthNet to private health insurance based on cost-effective principles determined by the department.

12. All participants with chronic conditions, as specified by the department, shall be included in an incentive program for MO HealthNet recipients who obtain specified primary care and preventive services, and who participate or refrain from participation in specified activities to improve the overall health of the recipient. Recipients who complete the requirements of the program shall be eligible to receive an annual cash payment for successful completion of the program. The department shall establish, by rule, the specific primary care and preventive services, activities to be included in the incentive program, and the amount of any annual cash payments to recipients.

13. A MO HealthNet recipient shall be eligible for participation in only one of either the high deductible health plan under subsection 11 of this section or the incentive program under subsection 12 of this section.

14. No cash payments, incentives, or credits paid to or on behalf of a MO HealthNet participant under a program established by the department under this section shall be deemed to be income to the participant in any means-tested benefit program unless otherwise specifically required by law or rule of the department.

15. Managed care entities shall inform participants who choose the high deductible health plan under subsection 11 of this section that the participant may lose his or her incentive payment under subdivision (7) of subsection 11 of this section if the participant utilizes visits to the emergency department for non-emergent purposes. Such information shall be included on every electronic and paper correspondence between the managed care plan and the participant.

16. The department shall seek all necessary waivers and state plan amendments from the federal Department of Health and Human Services necessary to implement the provisions of this section. The provisions of this section shall not be implemented unless such waivers and state plan amendments are approved. If this section is approved in part by the federal government, the department is authorized to proceed on those sections for which approval has been granted; except that, any increase in eligibility shall be contingent upon the receipt of all necessary waivers and state plan amendments. The provisions of this section shall not be implemented until eligibility of persons set out in subsection 3 of section 208.995 has been approved by the federal Department of Health and Human Services and has been implemented by the department. However, nothing shall prevent the department from expanding managed care for populations under other granted authority.

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

Section 2. 1. Notwithstanding any other provision of law to the contrary, beginning July 1, 2015, any MO HealthNet recipient who elects to receive medical coverage through a private health insurance plan instead of through the MO HealthNet program shall be eligible for a private insurance premium subsidy to assist the recipient in paying the costs of such private insurance if it is determined to be cost effective by the department. The subsidy shall 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.

Section 3. 1. Managed care organizations shall be required to provide to the department of social services, on at least a quarterly basis, and the department of social services shall publicly report the information within thirty days of receipt, including posting on the department's website, at least the following information:

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

(2) Medical loss ratios of each of a managed care organization's capitated specialized subcontractors, such as mental health or dental health, to make sure that the subcontractors' own administrative costs are not erroneously deemed to be expenditures on health care; and

(3) Total payments to the managed care organization in any form, including but not limited to tax breaks and capitated payments to participate in Medicaid, and total projected state payments for health care for the same population without the managed care organization.

2. Managed care organizations shall be required to maintain medical loss ratios of at least eighty-five percent for Medicaid operations. If a managed care organization's medical loss ratio falls below eighty-five percent in a given month, the managed care plan shall be required to refund to the state the portion of the capitation rates paid to the managed care plan in the amount equal to the difference between the plan's medical loss ratio and eighty-five percent of the capitated payment to the managed care organization.

3. The department of social services shall be required to ensure that managed care organizations establish and maintain adequate provider networks to serve the Medicaid population and to include these standards in its contracts with managed care organizations. Managed care organizations shall be required to establish and maintain health plan provider networks in geographically accessible locations in accordance with travel distances specified by the department of social services in its managed care contracts and as required by the department of insurance, financial institutions and professional registration.

4. Managed care plans' networks must consist of, at minimum, hospitals, physicians, advanced practice nurses, behavioral health providers, substance abuse providers, dentists, emergent and non-emergent transportation services, federally qualified health centers, rural health centers, women's health specialists, local public health agencies, family planning and sexually transmitted disease providers, and all other provider types necessary to ensure sufficient capacity to make available all services in accordance with the service accessibility standards specified by the department of social services.

5. Managed care organizations shall be required to post all of their provider networks online and shall regularly update

their postings of these networks on a timely basis regarding all changes to provider networks. A provider who is seeing only existing patients under a given managed care plan shall not be so listed.

6. The department of social services shall be required to contract with an independent organization that does not contract or consult with managed care plans or insurers to conduct secret shopper surveys of Medicaid managed care plans for compliance with provider network adequacy standards on a regular basis, to be funded by the managed care organizations out of their administrative budgets. Secret shopper surveys are a quality assurance mechanism under which individuals posing as managed care enrollees will test the availability of timely appointments with providers listed as participating in the network of a given plan for new patients. The testing shall be conducted with various categories of providers, with the specific categories rotated for each survey and with no advance notice provided to the managed health plan. If an attempt to obtain a timely appointment is unsuccessful, the survey records the particular reason for the failure, such as the provider not participating in Medicaid at all, not participating in Medicaid under the plan which listed them and was being tested, or participating under that plan but only for existing patients.

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

8. The provider compensation rates for each category of provider shall also be reported by the managed care organizations to help ascertain whether they are paying enough to engage providers comparable to the number of providers available to commercially-insured individuals, as required by federal law, and compared, where applicable, to the state's own provider rates for the same categories of providers.

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

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

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

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

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

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

(1) Plan disenrollment data by cause, number of months with the particular managed care plan prior to disenrollment, and form of enrollment, such as passive enrollment or enrollee election;

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

(3) Consumer satisfaction survey data;

(4) Enrollee telephone access reports including the number of unduplicated calls by enrollees, average wait time before managed care organization or subcontractor response, busy signal rate, and enrollee telephone call abandonment rate;

(5) Data regarding the average cost of care of individuals whose care is reported as having been actively managed by the managed care organization versus the average cost of care of the managed care organization's population generally. For purposes of this section, the phrase "actively managed by the managed care organization" means the managed care organization has actually developed a care plan for the particular individual and is implementing it as opposed to reacting to prior authorization requests as they come in, reviewing usage data, or monitoring doctors with high utilization;

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

(7) Results of network adequacy reviews including geo-mapping and waiting times, stratified by factors including provider type, geographic location, urban or rural area, any findings of adequacy or inadequacy, and any remedial actions taken. This information shall also include any findings with

respect to the accuracy of networks as published by managed care organizations, including providers found to be not participating and not accepting new patients;

(8) Provider change data indicating how many enrollees changed their primary care provider by cause, months of enrollment, and form of enrollment, such as passive enrollment or enrollee election;

(9) Any data related to preventable hospitalizations, hospital acquired infections, preventable adverse events, and emergency room admissions; and

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

12. The managed care organization shall be subject to public disclosure of all documents related to the running of its government-funded managed care plan, as fully as the state itself is subject to the sunshine laws under chapter 610, such that if a public citizen asks for documents about a particular matter concerning the administration of, or performance by, the managed care organization's Medicaid plan from the state agency and the documents are only in the possession of the managed care organization, the managed care organization shall turn the documents over to the state agency to provide to the requester.