CONFERENCE COMMITTEE SUBSTITUTE

FOR

SENATE SUBSTITUTE

FOR

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FOR

HOUSE COMMITTEE SUBSTITUTE

FOR

HOUSE BILL NO. 399

AN ACT

To repeal sections 192.007, 208.909, 208.918, 208.924, 208.930, 376.690, 376.1040, 376.1042, and 376.1224, RSMo, and to enact in lieu thereof seventeen new sections relating to healthcare, with an emergency clause for a certain section.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

Section A. Sections 192.007, 208.909, 208.918, 208.924, 208.930, 376.690, 376.1040, 376.1042, and 376.1224, RSMo, are repealed and seventeen new sections enacted in lieu thereof, to be known as sections 191.1164, 191.1165, 191.1167, 191.1168, 192.007, 208.909, 208.918, 208.924, 208.930, 208.935, 217.930, 221.125, 376.690, 376.1040, 376.1042, 376.1224, and 376.1345, to read as follows:

191.1164. 1. Sections 191.1164 to 191.1168 shall be known and may be cited as the "Ensuring Access to High Quality Care for the Treatment of Substance Use Disorders Act".

2. As used in sections 191.1164 to 191.1168, the following terms shall mean:

(1) "Behavioral therapy", individual, family, or group therapy designed to help patients engage in the treatment process, modify their attitudes and behaviors related to substance use, and increase healthy life skills;

(2) "Department of insurance", the department that has jurisdiction regulating health insurers;

(3) "Financial requirements", deductibles, co-payments, coinsurance, or out-of-pocket maximums;

(4) "Health care professional", a physician or other health care practitioner licensed, accredited, or certified by the state of Missouri to perform specified health services;

(5) "Health insurance plan", an individual or group plan that provides, or pays the cost of, health care items or services;

(6) "Health insurer", any person or entity that issues, offers, delivers, or administers a health insurance plan;

(7) "Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)", the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 found at 42 U.S.C. 300gg-26 and its implementing and related regulations found at 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115;

(8) "Nonquantitative treatment limitation" or "NQTL", any limitation on the scope or duration of treatment that is not expressed numerically;

(9) "Pharmacologic therapy", a prescribed course of treatment that may include methadone, buprenorphine, naltrexone,

or other FDA-approved or evidence-based medications for the treatment of substance use disorder;

(10) "Pharmacy benefits manager", an entity that contracts with pharmacies on behalf of health carriers or any health plan sponsored by the state or a political subdivision of the state;

(11) "Prior authorization", the process by which the health insurer or the pharmacy benefits manager determines the medical necessity of otherwise covered health care services prior to the rendering of such health care services. "Prior authorization" also includes any health insurer's or utilization review entity's requirement that a subscriber or health care provider notify the health insurer or utilization review entity prior to receiving or providing a health care service;

(12) "Quantitative treatment limitation" or "QTL", numerical limits on the scope or duration of treatment, which include annual, episode, and lifetime day and visit limits;

(13) "Step therapy", a protocol or program that establishes the specific sequence in which prescription drugs for a medical condition that are medically appropriate for a particular patient are authorized by a health insurer or prescription drug management company;

(14) "Urgent health care service", a health care service with respect to which the application of the time period for making a non-expedited prior authorization, in the opinion of a physician with knowledge of the enrollee's medical condition:

(a) Could seriously jeopardize the life or health of the subscriber or the ability of the enrollee to regain maximum function; or

(b) Could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

3. For the purpose of this section, "urgent health care service" shall include services provided for the treatment of substance use disorders.

191.1165. 1. Medication-assisted treatment (MAT) shall include pharmacologic therapies. A formulary used by a health insurer or managed by a pharmacy benefits manager, or medical benefit coverage in the case of medications dispensed through an opioid treatment program, shall include:

(1) Buprenorphine tablets;

(2) Methadone;

(3) Naloxone;

(4) Extended-release injectable naltrexone; and

(5) Buprenorphine/naloxone combination.

2. All MAT medications required for compliance in this section shall be placed on the lowest cost-sharing tier of the formulary managed by the health insurer or the pharmacy benefits manager.

3. MAT medications provided for in this section shall not be subject to any of the following:

(1) Any annual or lifetime dollar limitations;

(2) Financial requirements and quantitative treatment limitations that do not comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), specifically 45 CFR 146.136(c)(3);

(3) Step therapy or other similar drug utilization strategy

or policy when it conflicts or interferes with a prescribed or recommended course of treatment from a licensed health care professional; and

(4) Prior authorization for MAT medications as specified in this section.

4. MAT medications outlined in this section shall apply to all health insurance plans delivered in the state of Missouri.

5. Any entity that holds itself out as a treatment program or that applies for licensure by the state to provide clinical treatment services for substance use disorders shall be required to disclose the MAT services it provides, as well as which of its levels of care have been certified by an independent, national, or other organization that has competencies in the use of the applicable placement guidelines and level of care standards.

6. The MO HealthNet program shall cover the MAT medications and services provided for in this section and include those MAT medications in its preferred drug lists for the treatment of substance use disorders and prevention of overdose and death. The preferred drug list shall include all current and new formulations and medications that are approved by the U.S. Food and Drug Administration for the treatment of substance use disorders.

7. Drug courts or other diversion programs that provide for alternatives to jail or prison for persons with a substance use disorder shall be required to ensure all persons under their care are assessed for substance use disorders using standard diagnostic criteria by a licensed physician who actively treats patients with substance use disorders. The court or other

diversion program shall make available the MAT services covered under this section, consistent with a treatment plan developed by the physician, and shall not impose any limitations on the type of medication or other treatment prescribed or the dose or duration of MAT recommended by the physician.

8. Requirements under this section shall not be subject to a covered person's prior success or failure of the services provided.

191.1167. Any contract provision, written policy, or written procedure in violation of sections 191.1164 to 191.1168 shall be deemed to be unenforceable and shall be null and void.

191.1168. If any provision of sections 191.1164 to 191.1168 or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of sections 191.1164 to 191.1168 which may be given effect without the invalid provision or application, and to that end the provisions of sections 191.1164 to 191.1168 are severable.

192.007. 1. The director of the department of health and senior services shall be appointed by the governor by and with the advice and consent of the senate. The director shall serve at the pleasure of the governor and the director's salary shall not exceed appropriations made for that purpose.

2. The director shall be a person of recognized character, integrity and executive ability, **[**~~shall be a graduate of an institution of higher education approved by recognized accrediting agencies, and shall have had the administrative experience necessary to enable him to successfully perform the~~

~~duties of his office. He shall have experience in public health management and agency operation and management~~**]** and shall have, at a minimum, one of the following qualifications:

(1) A medical doctor or a doctor of osteopathy degree; or

(2) A Ph.D. in a health-related field, which may include nursing, public health, health policy, environmental health, community health, or health education or a master's degree in public health or an equivalent academic degree from an institution of higher education approved by recognized accrediting agencies.

208.909. 1. Consumers receiving personal care assistance services shall be responsible for:

(1) Supervising their personal care attendant;

(2) Verifying wages to be paid to the personal care attendant;

(3) Preparing and submitting time sheets, signed by both the consumer and personal care attendant, to the vendor on a biweekly basis;

(4) Promptly notifying the department within ten days of any changes in circumstances affecting the personal care assistance services plan or in the consumer's place of residence;

(5) Reporting any problems resulting from the quality of services rendered by the personal care attendant to the vendor. If the consumer is unable to resolve any problems resulting from the quality of service rendered by the personal care attendant with the vendor, the consumer shall report the situation to the department; **[**~~and~~**]**

(6) Providing the vendor with all necessary information to

complete required paperwork for establishing the employer identification number; and

(7) Allowing the vendor to comply with its quality assurance and supervision process, which shall include, but not be limited to, biannual face-to-face home visits and monthly case management activities.

2. Participating vendors shall be responsible for:

(1) Collecting time sheets or reviewing reports of delivered services and certifying the accuracy thereof;

(2) The Medicaid reimbursement process, including the filing of claims and reporting data to the department as required by rule;

(3) Transmitting the individual payment directly to the personal care attendant on behalf of the consumer;

(4) Monitoring the performance of the personal care assistance services plan. Such monitoring shall occur during the biannual face-to-face home visits under section 208.918. The vendor shall document whether the attendant was present and if services are being provided to the consumer as set forth in the plan of care. If the attendant was not present or not providing services, the vendor shall notify the department and the department may suspend services to the consumer.

3. No state or federal financial assistance shall be authorized or expended to pay for services provided to a consumer under sections 208.900 to 208.927, if the primary benefit of the services is to the household unit, or is a household task that the members of the consumer's household may reasonably be expected to share or do for one another when they live in the

same household, unless such service is above and beyond typical activities household members may reasonably provide for another household member without a disability.

4. No state or federal financial assistance shall be authorized or expended to pay for personal care assistance services provided by a personal care attendant who has not undergone the background screening process under section 192.2495. If the personal care attendant has a disqualifying finding under section 192.2495, no state or federal assistance shall be made, unless a good cause waiver is first obtained from the department in accordance with section 192.2495.

5. (1) All vendors shall, by July 1, 2015, have, maintain, and use a telephone tracking system for the purpose of reporting and verifying the delivery of consumer-directed services as authorized by the department of health and senior services or its designee. **[**~~Use of such a system prior to July 1, 2015, shall be voluntary.~~**]** The telephone tracking system shall be used to process payroll for employees and for submitting claims for reimbursement to the MO HealthNet division. At a minimum, the telephone tracking system shall:

(a) Record the exact date services are delivered;

(b) Record the exact time the services begin and exact time the services end;

(c) Verify the telephone number from which the services are registered;

(d) Verify that the number from which the call is placed is a telephone number unique to the client;

(e) Require a personal identification number unique to each

personal care attendant;

(f) Be capable of producing reports of services delivered, tasks performed, client identity, beginning and ending times of service and date of service in summary fashion that constitute adequate documentation of service; and

(g) Be capable of producing reimbursement requests for consumer approval that assures accuracy and compliance with program expectations for both the consumer and vendor.

(2) **[**~~The department of health and senior services, in collaboration with other appropriate agencies, including centers for independent living, shall establish telephone tracking system pilot projects, implemented in two regions of the state, with one in an urban area and one in a rural area. Each pilot project shall meet the requirements of this section and section 208.918. The department of health and senior services shall, by December 31, 2013, submit a report to the governor and general assembly detailing the outcomes of these pilot projects. The report shall take into consideration the impact of a telephone tracking system on the quality of the services delivered to the consumer and the principles of self-directed care.~~

~~(3)~~**]** As new technology becomes available, the department may allow use of a more advanced tracking system, provided that such system is at least as capable of meeting the requirements of this subsection.

[~~(4)~~**]** (3) The department of health and senior services shall promulgate by rule the minimum necessary criteria of the telephone tracking system. Any rule or portion of a rule, as that 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, 2010, shall be invalid and void.

[~~6. In the event that a consensus between centers for independent living and representatives from the executive branch cannot be reached, the telephony report issued to the general assembly and governor shall include a minority report which shall detail those elements of substantial dissent from the main report.~~

~~7. No interested party, including a center for independent living, shall be required to contract with any particular vendor or provider of telephony services nor bear the full cost of the pilot program.~~**]**

208.918. 1. In order to qualify for an agreement with the department, the vendor shall have a philosophy that promotes the consumer's ability to live independently in the most integrated setting or the maximum community inclusion of persons with physical disabilities, and shall demonstrate the ability to provide, directly or through contract, the following services:

(1) Orientation of consumers concerning the responsibilities of being an employer**[**~~,~~**]** and supervision of personal care attendants including the preparation and

verification of time sheets. Such orientation shall include notifying customers that falsification of attendant visit verification records shall be considered fraud and shall be reported to the department. Such orientation shall take place in the presence of the personal care attendant, to the fullest extent possible;

(2) Training for consumers about the recruitment and training of personal care attendants;

(3) Maintenance of a list of persons eligible to be a personal care attendant;

(4) Processing of inquiries and problems received from consumers and personal care attendants;

(5) Ensuring the personal care attendants are registered with the family care safety registry as provided in sections 210.900 to **[**~~210.937~~**]** 210.936; and

(6) The capacity to provide fiscal conduit services through a telephone tracking system by the date required under section 208.909.

2. In order to maintain its agreement with the department, a vendor shall comply with the provisions of subsection 1 of this section and shall:

(1) Demonstrate sound fiscal management as evidenced on accurate quarterly financial reports and an annual financial statement audit **[**~~submitted to the department~~**]** performed by a certified public accountant if the vendor's annual gross revenue is one hundred thousand dollars or more or, if the vendor's annual gross revenue is less than one hundred thousand dollars, an annual financial statement audit or annual financial statement

review performed by a certified public accountant. Such reports, audits, and reviews shall be completed and made available upon request to the department; **[**~~and~~**]**

(2) Demonstrate a positive impact on consumer outcomes regarding the provision of personal care assistance services as evidenced on accurate quarterly and annual service reports submitted to the department;

(3) Implement a quality assurance and supervision process that ensures program compliance and accuracy of records including, but not limited to:

(a) The department of health and senior services shall promulgate by rule a consumer-directed services division provider certification manager course; and

(b) The vendor shall perform with the consumer at least biannual face-to-face home visits to provide ongoing monitoring of the provision of services in the plan of care and assess the quality of care being delivered. The biannual face-to-face home visits do not preclude the vendor's responsibility from its ongoing diligence of case management activity oversight;

(4) Comply with all provisions of sections 208.900 to 208.927, and the regulations promulgated thereunder; and

(5) Maintain a business location which shall comply with any and all applicable city, county, state, and federal requirements.

3. No state or federal funds shall be authorized or expended to pay for personal care assistance services under sections 208.900 to 208.927 if the person providing the personal care is the same person conducting the biannual face-to-face home

visits.

208.924. A consumer's personal care assistance services may be discontinued under circumstances such as the following:

(1) The department learns of circumstances that require closure of a consumer's case, including one or more of the following: death, admission into a long-term care facility, no longer needing service, or inability of the consumer to consumer-direct personal care assistance service;

(2) The consumer has falsified records; provided false information of his or her condition, functional capacity, or level of care needs; or committed fraud;

(3) The consumer is noncompliant with the plan of care. Noncompliance requires persistent actions by the consumer which negate the services provided in the plan of care;

(4) The consumer or member of the consumer's household threatens or abuses the personal care attendant or vendor to the point where their welfare is in jeopardy and corrective action has failed;

(5) The maintenance needs of a consumer are unable to continue to be met because the plan of care hours exceed availability; and

(6) The personal care attendant is not providing services as set forth in the personal care assistance services plan and attempts to remedy the situation have been unsuccessful.

208.930. 1. As used in this section, the term "department" shall mean the department of health and senior services.

2. Subject to appropriations, the department may provide financial assistance for consumer-directed personal care

assistance services through eligible vendors, as provided in sections 208.900 through 208.927, to each person who was participating as a non-MO HealthNet eligible client pursuant to sections 178.661 through 178.673 on June 30, 2005, and who:

(1) Makes application to the department;

(2) Demonstrates financial need and eligibility under subsection 3 of this section;

(3) Meets all the criteria set forth in sections 208.900 through 208.927, except for subdivision (5) of subsection 1 of section 208.903;

(4) Has been found by the department of social services not to be eligible to participate under guidelines established by the MO HealthNet plan; and

(5) Does not have access to affordable employer-sponsored health care insurance or other affordable health care coverage for personal care assistance services as defined in section 208.900. For purposes of this section, "access to affordable employer-sponsored health care insurance or other affordable health care coverage" refers to health insurance requiring a monthly premium less than or equal to one hundred thirty-three percent of the monthly average premium required in the state's current Missouri consolidated health care plan.

Payments made by the department under the provisions of this section shall be made only after all other available sources of payment have been exhausted.

3. (1) In order to be eligible for financial assistance for consumer-directed personal care assistance services under

this section, a person shall demonstrate financial need, which shall be based on the adjusted gross income and the assets of the person seeking financial assistance and such person's spouse.

(2) In order to demonstrate financial need, a person seeking financial assistance under this section and such person's spouse must have an adjusted gross income, less disability-related medical expenses, as approved by the department, that is equal to or less than three hundred percent of the federal poverty level. The adjusted gross income shall be based on the most recent income tax return.

(3) No person seeking financial assistance for personal care services under this section and such person's spouse shall have assets in excess of two hundred fifty thousand dollars.

4. The department shall require applicants and the applicant's spouse, and consumers and the consumer's spouse, to provide documentation for income, assets, and disability-related medical expenses for the purpose of determining financial need and eligibility for the program. In addition to the most recent income tax return, such documentation may include, but shall not be limited to:

(1) Current wage stubs for the applicant or consumer and the applicant's or consumer's spouse;

(2) A current W-2 form for the applicant or consumer and the applicant's or consumer's spouse;

(3) Statements from the applicant's or consumer's and the applicant's or consumer's spouse's employers;

(4) Wage matches with the division of employment security;

(5) Bank statements; and

(6) Evidence of disability-related medical expenses and proof of payment.

5. A personal care assistance services plan shall be developed by the department pursuant to section 208.906 for each person who is determined to be eligible and in financial need under the provisions of this section. The plan developed by the department shall include the maximum amount of financial assistance allowed by the department, subject to appropriation, for such services.

6. Each consumer who participates in the program is responsible for a monthly premium equal to the average premium required for the Missouri consolidated health care plan; provided that the total premium described in this section shall not exceed five percent of the consumer's and the consumer's spouse's adjusted gross income for the year involved.

7. (1) Nonpayment of the premium required in subsection 6 shall result in the denial or termination of assistance, unless the person demonstrates good cause for such nonpayment.

(2) No person denied services for nonpayment of a premium shall receive services unless such person shows good cause for nonpayment and makes payments for past-due premiums as well as current premiums.

(3) Any person who is denied services for nonpayment of a premium and who does not make any payments for past-due premiums for sixty consecutive days shall have their enrollment in the program terminated.

(4) No person whose enrollment in the program is terminated for nonpayment of a premium when such nonpayment exceeds sixty

consecutive days shall be reenrolled unless such person pays any past-due premiums as well as current premiums prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument.

8. (1) Consumers determined eligible for personal care assistance services under the provisions of this section shall be reevaluated annually to verify their continued eligibility and financial need. The amount of financial assistance for consumer-directed personal care assistance services received by the consumer shall be adjusted or eliminated based on the outcome of the reevaluation. Any adjustments made shall be recorded in the consumer's personal care assistance services plan.

(2) In performing the annual reevaluation of financial need, the department shall annually send a reverification eligibility form letter to the consumer requiring the consumer to respond within ten days of receiving the letter and to provide income and disability-related medical expense verification documentation. If the department does not receive the consumer's response and documentation within the ten-day period, the department shall send a letter notifying the consumer that he or she has ten days to file an appeal or the case will be closed.

(3) The department shall require the consumer and the consumer's spouse to provide documentation for income and disability-related medical expense verification for purposes of the eligibility review. Such documentation may include but shall not be limited to the documentation listed in subsection 4 of this section.

9. (1) Applicants for personal care assistance services

and consumers receiving such services pursuant to this section are entitled to a hearing with the department of social services if eligibility for personal care assistance services is denied, if the type or amount of services is set at a level less than the consumer believes is necessary, if disputes arise after preparation of the personal care assistance plan concerning the provision of such services, or if services are discontinued as provided in section 208.924. Services provided under the provisions of this section shall continue during the appeal process.

(2) A request for such hearing shall be made to the department of social services in writing in the form prescribed by the department of social services within ninety days after the mailing or delivery of the written decision of the department of health and senior services. The procedures for such requests and for the hearings shall be as set forth in section 208.080.

10. Unless otherwise provided in this section, all other provisions of sections 208.900 through 208.927 shall apply to individuals who are eligible for financial assistance for personal care assistance services under this section.

11. The department may promulgate rules and regulations, including emergency rules, to implement the provisions of this section. Any rule or portion of a rule, as that 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. Any provisions of the existing rules regarding the personal care assistance program promulgated

by the department of elementary and secondary education in title 5, code of state regulations, division 90, chapter 7, which are inconsistent with the provisions of this section are void and of no force and effect.

12. The provisions of this section shall expire on June 30, **[**~~2019~~**]** 2025.

208.935. Subject to appropriations, the department of health and senior services shall develop, or contract with a state agency or third party to develop an interactive assessment tool, which may include mobile as well as centralized functionality, for utilization when implementing the assessment and authorization process for MO HealthNet home and community-based services authorized by the division of senior and disability services.

217.930. 1. (1) Medical assistance under MO HealthNet shall be suspended, rather than canceled or terminated, for a person who is an offender in a correctional center if:

(a) The department of social services is notified of the person's entry into the correctional center;

(b) On the date of entry, the person was enrolled in the MO HealthNet program; and

(c) The person is eligible for MO HealthNet except for institutional status.

(2) A suspension under this subsection shall end on the date the person is no longer an offender in a correctional center.

(3) Upon release from incarceration, such person shall continue to be eligible for receipt of MO HealthNet benefits

until such time as the person is otherwise determined to no longer be eligible for the program.

2. The department of corrections shall notify the department of social services:

(1) Within twenty days after receiving information that a person receiving benefits under MO HealthNet is or will be an offender in a correctional center; and

(2) Within forty-five days prior to the release of a person who is qualified for suspension under subsection 1 of this section.

221.125. 1. (1) Medical assistance under MO HealthNet shall be suspended, rather than canceled or terminated, for a person who is an offender in a county jail, a city jail, or a private jail if:

(a) The department of social services is notified of the person's entry into the jail;

(b) On the date of entry, the person was enrolled in the MO HealthNet program; and

(c) The person is eligible for MO HealthNet except for institutional status.

(2) A suspension under this subsection shall end on the date the person is no longer an offender in a jail.

(3) Upon release from incarceration, such person shall continue to be eligible for receipt of MO HealthNet benefits until such time as the person is otherwise determined to no longer be eligible for the program.

2. City, county, and private jails shall notify the department of social services within ten days after receiving

information that a person receiving medical assistance under MO HealthNet is or will be an offender in the jail.

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

(1) "Emergency medical condition", the same meaning given to such term in section 376.1350;

(2) "Facility", the same meaning given to such term in section 376.1350;

(3) "Health care professional", the same meaning given to such term in section 376.1350;

(4) "Health carrier", the same meaning given to such term in section 376.1350;

(5) "Unanticipated out-of-network care", health care services received by a patient in an in-network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged.

2. (1) Health care professionals **[**~~may~~**]** shall send any claim for charges incurred for unanticipated out-of-network care to the patient's health carrier within one hundred eighty days of the delivery of the unanticipated out-of-network care on a U.S. Centers of Medicare and Medicaid Services Form 1500, or its successor form, or electronically using the 837 HIPAA format, or its successor.

(2) Within forty-five processing days, as defined in section 376.383, of receiving the health care professional's claim, the health carrier shall offer to pay the health care professional a reasonable reimbursement for unanticipated

out-of-network care based on the health care professional's services. If the health care professional participates in one or more of the carrier's commercial networks, the offer of reimbursement for unanticipated out-of-network care shall be the amount from the network which has the highest reimbursement.

(3) If the health care professional declines the health carrier's initial offer of reimbursement, the health carrier and health care professional shall have sixty days from the date of the initial offer of reimbursement to negotiate in good faith to attempt to determine the reimbursement for the unanticipated out-of-network care.

(4) If the health carrier and health care professional do not agree to a reimbursement amount by the end of the sixty-day negotiation period, the dispute shall be resolved through an arbitration process as specified in subsection 4 of this section.

(5) To initiate arbitration proceedings, either the health carrier or health care professional must provide written notification to the director and the other party within one hundred twenty days of the end of the negotiation period, indicating their intent to arbitrate the matter and notifying the director of the billed amount and the date and amount of the final offer by each party. A claim for unanticipated out-of-network care may be resolved between the parties at any point prior to the commencement of the arbitration proceedings. Claims may be combined for purposes of arbitration, but only to the extent the claims represent similar circumstances and services provided by the same health care professional, and the parties attempted to resolve the dispute in accordance with

subdivisions (3) to (5) of this subsection.

(6) No health care professional who sends a claim to a health carrier under subsection 2 of this section shall send a bill to the patient for any difference between the reimbursement rate as determined under this subsection and the health care professional's billed charge.

3. (1) When unanticipated out-of-network care is provided, the health care professional who sends a claim to a health carrier under subsection 2 of this section may bill a patient for no more than the cost-sharing requirements described under this section.

(2) Cost-sharing requirements shall be based on the reimbursement amount as determined under subsection 2 of this section.

(3) The patient's health carrier shall inform the health care professional of its enrollee's cost-sharing requirements within forty-five processing days of receiving a claim from the health care professional for services provided.

(4) The in-network deductible and out-of-pocket maximum cost-sharing requirements shall apply to the claim for the unanticipated out-of-network care.

4. The director shall ensure access to an external arbitration process when a health care professional and health carrier cannot agree to a reimbursement under subdivision (3) of subsection 2 of this section. In order to ensure access, when notified of a parties' intent to arbitrate, the director shall randomly select an arbitrator for each case from the department's approved list of arbitrators or entities that provide binding

arbitration. The director shall specify the criteria for an approved arbitrator or entity by rule. The costs of arbitration shall be shared equally between and will be directly billed to the health care professional and health carrier. These costs will include, but are not limited to, reasonable time necessary for the arbitrator to review materials in preparation for the arbitration, travel expenses and reasonable time following the arbitration for drafting of the final decision.

5. At the conclusion of such arbitration process, the arbitrator shall issue a final decision, which shall be binding on all parties. The arbitrator shall provide a copy of the final decision to the director. The initial request for arbitration, all correspondence and documents received by the department and the final arbitration decision shall be considered a closed record under section 374.071. However, the director may release aggregated summary data regarding the arbitration process. The decision of the arbitrator shall not be considered an agency decision nor shall it be considered a contested case within the meaning of section 536.010.

6. The arbitrator shall determine a dollar amount due under subsection 2 of this section between one hundred twenty percent of the Medicare-allowed amount and the seventieth percentile of the usual and customary rate for the unanticipated out-of-network care, as determined by benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations.

7. When determining a reasonable reimbursement rate, the arbitrator shall consider the following factors if the health

care professional believes the payment offered for the unanticipated out-of-network care does not properly recognize:

(1) The health care professional's training, education, or experience;

(2) The nature of the service provided;

(3) The health care professional's usual charge for comparable services provided;

(4) The circumstances and complexity of the particular case, including the time and place the services were provided; and

(5) The average contracted rate for comparable services provided in the same geographic area.

8. The enrollee shall not be required to participate in the arbitration process. The health care professional and health carrier shall execute a nondisclosure agreement prior to engaging in an arbitration under this section.

9. **[**~~This section shall take effect on January 1, 2019.~~

~~10.~~**]** The department of insurance, financial institutions and professional registration may promulgate rules and fees as necessary to implement the provisions of this section, including but not limited to procedural requirements for arbitration. Any rule or portion of a rule, as that 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, 2018, shall be invalid and void.

376.1040. 1. No multiple employer self-insured health plan shall be offered or advertised to the public **[**~~generally~~**]**. No plan shall be sold, solicited, or marketed by persons or entities defined in section 375.012 or sections 376.1075 to 376.1095. Multiple employer self-insured health plans with a certificate of authority approved by the director under section 376.1002 shall be exempt from the restrictions set forth in this section.

2. A health carrier acting as an administrator for a multiple employer self-insured health plan shall permit any willing licensed broker to quote, sell, solicit, or market such plan to the extent permitted by this section; provided that such broker is appointed and in good standing with the health carrier and completes all required training.

376.1042. The sale, solicitation or marketing of any plan in violation of section 376.1040 by an agent, agency or broker shall constitute a violation of section 375.141.

376.1224. 1. For purposes of this section, the following terms shall mean:

(1) "Applied behavior analysis", the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the

relationships between environment and behavior;

(2) "Autism service provider":

(a) Any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri; or

(b) Any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst;

(3) "Autism spectrum disorders", a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;

(4) "Developmental or physical disability", a severe chronic disability that:

(a) Is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness or autism spectrum disorder which results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services;

(b) Manifests before the individual reaches age nineteen;

(c) Is likely to continue indefinitely; and

(d) Results in substantial functional limitations in three or more of the following areas of major life activities:

a. Self-care;

b. Understanding and use of language;

c. Learning;

d. Mobility;

e. Self-direction; or

f. Capacity for independent living;

(5) "Diagnosis **[**~~of autism spectrum disorders~~**]**", medically necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder or a developmental or physical disability;

[~~(5)~~**]** (6) "Habilitative or rehabilitative care", professional, counseling, and guidance services and treatment programs, including applied behavior analysis for those diagnosed with autism spectrum disorder, that are necessary to develop the functioning of an individual;

[~~(6)~~**]** (7) "Health benefit plan", shall have the same meaning ascribed to it as in section 376.1350;

[~~(7)~~**]** (8) "Health carrier", shall have the same meaning ascribed to it as in section 376.1350;

[~~(8)~~**]** (9) "Line therapist", an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst;

[~~(9)~~**]** (10) "Pharmacy care", medications used to address symptoms of an autism spectrum disorder or a developmental or physical disability prescribed by a licensed physician, and any health-related services deemed medically necessary to determine

the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan;

[~~(10)~~**]** (11) "Psychiatric care", direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

[~~(11)~~**]** (12) "Psychological care", direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

[~~(12)~~**]** (13) "Therapeutic care", services provided by licensed speech therapists, occupational therapists, or physical therapists;

[~~(13)~~**]** (14) "Treatment **[**~~for autism spectrum disorders~~**]**", care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist, or for an individual diagnosed with a developmental or physical disability by a licensed physician or licensed psychologist, including equipment medically necessary for such care, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, including, but not limited to:

(a) Psychiatric care;

(b) Psychological care;

(c) Habilitative or rehabilitative care, including applied behavior analysis therapy for those diagnosed with autism spectrum disorder;

(d) Therapeutic care;

(e) Pharmacy care.

2. Except as otherwise provided in subsection 12 of this section, all **[**~~group~~**]** health benefit plans that are delivered, issued for delivery, continued, or renewed on or after January 1, **[**~~2011~~**]** 2020, if written inside the state of Missouri, or written outside the state of Missouri but insuring Missouri residents, shall provide coverage for the diagnosis and treatment of autism spectrum disorders and for the diagnosis and treatment of developmental or physical disabilities to the extent that such diagnosis and treatment is not already covered by the health benefit plan.

3. With regards to a health benefit plan, a health carrier shall not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on an individual or their dependent because the individual is diagnosed with autism spectrum disorder or developmental or physical disabilities.

4. (1) Coverage provided under this section for autism spectrum disorder or developmental or physical disabilities is limited to medically necessary treatment that is ordered by the insured's treating licensed physician or licensed psychologist, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, in accordance with a treatment plan.

(2) The treatment plan, upon request by the health benefit plan or health carrier, shall include all elements necessary for the health benefit plan or health carrier to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and

goals.

(3) Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder or developmental or physical disability, a health carrier shall have the right to review the treatment plan not more than once every six months unless the health carrier and the individual's treating physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall only apply to a particular individual **[**~~being treated for an autism spectrum disorder~~**]** receiving applied behavior analysis and shall not apply to all individuals **[**~~being treated for autism spectrum disorders by a~~**]** receiving applied behavior analysis from that autism service provider, physician, or psychologist. The cost of obtaining any review or treatment plan shall be borne by the health benefit plan or health carrier, as applicable.

5. (1) Coverage provided under this section for applied behavior analysis shall be subject to a maximum benefit of forty thousand dollars per calendar year for individuals through eighteen years of age. Such maximum benefit limit may be exceeded, upon prior approval by the health benefit plan, if the provision of applied behavior analysis services beyond the maximum limit is medically necessary for such individual. Payments made by a health carrier on behalf of a covered individual for any care, treatment, intervention, service or item, the provision of which was for the treatment of a health condition unrelated to the covered individual's autism spectrum disorder, shall not be applied toward any maximum benefit

established under this subsection. Any coverage required under this section, other than the coverage for applied behavior analysis, shall not be subject to the age and dollar limitations described in this subsection.

[~~6.~~**]** (2) The maximum benefit limitation for applied behavior analysis described in **[**~~subsection 5~~**]** subdivision (1) of this **[**~~section~~**]** subsection shall be adjusted by the health carrier at least triennially for inflation to reflect the aggregate increase in the general price level as measured by the Consumer Price Index for All Urban Consumers for the United States, or its successor index, as defined and officially published by the United States Department of Labor, or its successor agency. Beginning January 1, 2012, and annually thereafter, the current value of the maximum benefit limitation for applied behavior analysis coverage adjusted for inflation in accordance with this subsection shall be calculated by the director of the department of insurance, financial institutions and professional registration. The director shall furnish the calculated value to the secretary of state, who shall publish such value in the Missouri Register as soon after each January first as practicable, but it shall otherwise be exempt from the provisions of section 536.021.

[~~7.~~**]** (3) Subject to the provisions set forth in subdivision (3) of subsection 4 of this section, coverage provided for autism spectrum disorders under this section shall not be subject to any limits on the number of visits an individual may make to an autism service provider, except that the maximum total benefit for applied behavior analysis set forth in subdivision (1) of

this subsection [~~5 of this section~~] shall apply to this [~~subsection~~] subdivision.

6. Coverage for therapeutic care provided under this section for developmental or physical disabilities may be limited to a number of visits per calendar year, provided that upon prior approval by the health benefit plan, coverage shall be provided beyond the maximum calendar limit if such therapeutic care is medically necessary as determined by the health care plan.

[~~8.~~] 7. This section shall not be construed as limiting benefits which are otherwise available to an individual under a health benefit plan. The health care coverage required by this section shall not be subject to any greater deductible, coinsurance, or co-payment than other physical health care services provided by a health benefit plan. Coverage of services may be subject to other general exclusions and limitations of the contract or benefit plan, not in conflict with the provisions of this section, such as coordination of benefits, exclusions for services provided by family or household members, and utilization review of health care services, including review of medical necessity and care management; however, coverage for treatment under this section shall not be denied on the basis that it is educational or habilitative in nature.

[~~9.~~] 8. To the extent any payments or reimbursements are being made for applied behavior analysis, such payments or reimbursements shall be made to either:

(1) The autism service provider, as defined in this section; or

(2) The entity or group for whom such supervising person,

who is certified as a board-certified behavior analyst by the Behavior Analyst Certification Board, works or is associated.

Such payments or reimbursements under this subsection to an autism service provider or a board-certified behavior analyst shall include payments or reimbursements for services provided by a line therapist under the supervision of such provider or behavior analyst if such services provided by the line therapist are included in the treatment plan and are deemed medically necessary.

[~~10.~~**]** 9. Notwithstanding any other provision of law to the contrary, health carriers shall not be held liable for the actions of line therapists in the performance of their duties.

[~~11.~~**]** 10. The provisions of this section shall apply to any health care plans issued to employees and their dependents under the Missouri consolidated health care plan established pursuant to chapter 103 that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, **[**~~2011~~**]** 2020. The terms "employees" and "health care plans" shall have the same meaning ascribed to them in section 103.003.

[~~12.~~**]** 11. The provisions of this section shall also apply to the following types of plans that are established, extended, modified, or renewed on or after January 1, **[**~~2011~~**]** 2020:

(1) All self-insured governmental plans, as that term is defined in 29 U.S.C. Section 1002(32);

(2) All self-insured group arrangements, to the extent not preempted by federal law;

(3) All plans provided through a multiple employer welfare

arrangement, or plans provided through another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, or any waiver or exception to that act provided under federal law or regulation; and

(4) All self-insured school district health plans.

[~~13. The provisions of this section shall not automatically apply to an individually underwritten health benefit plan, but shall be offered as an option to any such plan.~~

~~14.~~**]** 12. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy of six months or less duration, or any other supplemental policy. The provisions of this section requiring coverage for autism spectrum disorders shall not apply to an individually underwritten health benefit plan issued prior to January 1, 2011. The provisions of this section requiring coverage for a developmental or physical disability shall not apply to a health benefit plan issued prior to January 1, 2014.

[~~15.~~**]** 13. Any health carrier or other entity subject to the provisions of this section shall not be required to provide reimbursement for the applied behavior analysis delivered to a person insured by such health carrier or other entity to the extent such health carrier or other entity is billed for such services by any Part C early intervention program or any school district for applied behavior analysis rendered to the person covered by such health carrier or other entity. This section

shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education plan, or an individualized service plan. This section shall not be construed as affecting any obligation to provide reimbursement pursuant to section 376.1218.

[~~16.~~**]** 14. The provisions of sections 376.383, 376.384, and 376.1350 to 376.1399 shall apply to this section.

[~~17. The director of the department of insurance, financial institutions and professional registration shall grant a small employer with a group health plan, as that term is defined in section 379.930, a waiver from the provisions of this section if the small employer demonstrates to the director by actual claims experience over any consecutive twelve-month period that compliance with this section has increased the cost of the health insurance policy by an amount of two and a half percent or greater over the period of a calendar year in premium costs to the small employer.~~

~~18.~~**]** 15. The provisions of this section shall not apply to the Mo HealthNet program as described in chapter 208.

[~~19. (1) By February 1, 2012, and every February first thereafter, the department of insurance, financial institutions and professional registration shall submit a report to the general assembly regarding the implementation of the coverage required under this section. The report shall include, but shall not be limited to, the following:~~

~~(a) The total number of insureds diagnosed with autism spectrum disorder;~~

~~(b) The total cost of all claims paid out in the immediately preceding calendar year for coverage required by this section;~~

~~(c) The cost of such coverage per insured per month; and~~

~~(d) The average cost per insured for coverage of applied behavior analysis;~~

~~(2) All health carriers and health benefit plans subject to the provisions of this section shall provide the department with the data requested by the department for inclusion in the annual report.~~**]**

376.1345. 1. As used in this section, unless the context clearly indicates otherwise, terms shall have the same meaning as ascribed to them in section 376.1350.

2. No health carrier, nor any entity acting on behalf of a health carrier, shall restrict methods of reimbursement to health care providers for health care services to a reimbursement method requiring the provider to pay a fee, discount the amount of their claim for reimbursement, or remit any other form of remuneration in order to redeem the amount of their claim for reimbursement.

3. If a health carrier initiates or changes the method used to reimburse a health care provider to a method of reimbursement that will require the health care provider to pay a fee, discount the amount of its claim for reimbursement, or remit any other form of remuneration to the health carrier or any entity acting on behalf of the health carrier in order to redeem the amount of its claim for reimbursement, the health carrier or an entity acting on its behalf shall:

(1) Notify such health care provider of the fee, discount,

or other remuneration required to receive reimbursement through the new or different reimbursement method; and

(2) In such notice, provide clear instructions to the health care provider as to how to select an alternative payment method.

4. For health benefit plans issued, delivered, or renewed on or after August 28, 2019, a health carrier shall allow the provider to select to be reimbursed by an electronic funds transfer through the Automated Clearing House Network as required pursuant to 45 C.F.R. Sections 162.925, 162.1601, and 162.1602, and if the provider makes such selection, the health carrier shall use such reimbursement method to reimburse the provider until the provider requests otherwise.

5. Violation of this section shall be deemed an unfair trade practice under sections 375.930 to 375.948.

Section B. Because of the need to ensure continuity of care and stability of necessary services, the repeal and reenactment of section 208.930 of this act is deemed necessary for the immediate preservation of the public health, welfare, peace and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the repeal and reenactment of section 208.930 of this act shall be in full force and effect upon its passage and approval.

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Representative Chuck Basye Senator Denny Hoskins