SECOND REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED**]**

CONFERENCE COMMITTEE SUBSTITUTE FOR

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 607

98TH GENERAL ASSEMBLY

2016

4547S.04T

AN ACT

To repeal sections 208.152, 208.952, and 208.985, RSMo, and to enact in lieu thereof five new sections relating to public assistance programs.

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

Section A. Sections 208.152, 208.952, and 208.985, RSMo, are repealed and five new sections enacted in lieu thereof, to be known as sections 208.065, 208.152, 208.952, 208.1030, and 208.1032, to read as follows:

208.065. 1. No later than January 1, 2017, the department of social services shall procure and enter into a competitively bid contract with a contractor to provide verification of initial and ongoing eligibility data for assistance under the supplemental nutrition assistance program (SNAP); temporary assistance for needy families (TANF) program; child care assistance program; and MO HealthNet program. The contractor shall conduct data matches using the name, date of birth, address, and Social Security number of each applicant and recipient, and additional data provided by the applicant or recipient relevant to eligibility against public records and other data sources to verify eligibility data.

2. The contractor shall evaluate the income, resources, and assets of each applicant and recipient no less than quarterly. In addition to quarterly eligibility data verification, the contractor shall identify on a monthly basis any program participants who have died, moved out of state, or have been incarcerated longer than ninety days.

EXPLANATION–Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

3. The contractor, upon completing an eligibility data verification of an applicant or recipient, shall notify the department of the results; except that, the contractor shall not verify the eligibility data of persons residing in long-term care facilities or persons receiving home- and community-based services whose income and resources were at or below the applicable financial eligibility standards at the time of their last review. Within twenty business days of such notification, the department shall make an eligibility determination. The department shall retain final authority over eligibility determinations. The contractor shall keep a record of all eligibility data verifications communicated to the department. Nothing in this subsection shall be construed to affect any obligation or requirement under state or federal law or regulation that the department verify the eligibility data of persons residing in long-term care facilities or persons receiving home- and community-based services.

4. Within thirty days of the end of each calendar year, the department and contractor shall file a joint report to the governor, the speaker of the house of representatives, and the president pro tempore of the senate. The report shall include, but shall not be limited to, the number of applicants and recipients determined ineligible for assistance programs based on the eligibility data verification by the contractor and the stated reasons for the determination of ineligibility by the department.

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy persons as **[**defined**]** **described** in section 208.151 who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the MO HealthNet division shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the MO HealthNet division shall take into

account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the MO HealthNet division not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for participants, except to persons with more than five hundred thousand dollars equity in their home or except for persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. Section 301, et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The MO HealthNet division when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

(5) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection for those days, which shall not exceed twelve per any period of six consecutive months, during which the participant is on a temporary leave of absence from the hospital or nursing home, provided that no such participant shall be allowed a temporary leave of absence unless it is specifically provided for in his plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a participant is away from the hospital or nursing home overnight because he is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital,

nursing home, or elsewhere;

(7) Drugs and medicines when prescribed by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse; except that no payment for drugs and medicines prescribed on and after January 1, 2006, by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse may be made on behalf of any person who qualifies for prescription drug coverage under the provisions of P.L. 108-173;

(8) Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments;

(9) Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of Section 6403 of P.L. 101-239 and federal regulations promulgated thereunder;

(10) Home health care services;

(11) Family planning as defined by federal rules and regulations; provided, however, that such family planning services shall not include abortions unless such abortions are certified in writing by a physician 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;

(12) Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C. Section 1396d, et seq.);

(13) Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

(14) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his or her physician on an outpatient rather than on an inpatient or residential basis in a hospital,

intermediate care facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the participant's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one participant one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such services, when delivered in a residential care facility or assisted living facility licensed under chapter 198 shall be authorized on a tier level based on the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal physician. Such authorized units of personal care services or tier level shall be transferred with such resident if he or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as to whether the relevant waivers are approved or a determination of noncompliance is made;

(15) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. Section 301, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097. The department of mental health shall

establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(b) Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, mental health professional and alcohol and drug abuse professional shall be defined by the department of mental health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, MO HealthNet division, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the MO HealthNet division. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

(16) Such additional services as defined by the MO HealthNet division to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. Section 301, et seq.) subject to appropriation by the general assembly;

(17) The services of an advanced practice registered nurse with a

collaborative practice agreement to the extent that such services are provided in accordance with chapters 334 and 335, and regulations promulgated thereunder;

(18) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection to reserve a bed for the participant in the nursing home during the time that the participant is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of MO HealthNet certified licensed beds, according to the most recent quarterly census provided to the department of health and senior services which was taken prior to when the participant is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a participant under this subdivision during any period of six consecutive months such participant shall, during the same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the participant or the participant's responsible party that the participant intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the participant or the participant's responsible party prior to release of the reserved bed;

(19) Prescribed medically necessary durable medical equipment. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(20) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive

care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(21) Prescribed medically necessary dental services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(22) Prescribed medically necessary optometric services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(23) Blood clotting products-related services. For persons diagnosed with a bleeding disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section 338.400, such services include:

(a) Home delivery of blood clotting products and ancillary infusion equipment and supplies, including the emergency deliveries of the product when medically necessary;

(b) Medically necessary ancillary infusion equipment and supplies required to administer the blood clotting products; and

(c) Assessments conducted in the participant's home by a pharmacist, nurse, or local home health care agency trained in bleeding disorders when deemed necessary by the participant's treating physician;

(24) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and for third-party payor average dental reimbursement rates. Such plan shall be subject to appropriation and the division shall include

in its annual budget request to the governor the necessary funding needed to complete the four-year plan developed under this subdivision.

2. Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Dental services;

(2) Services of podiatrists as defined in section 330.010;

(3) Optometric services as **[**defined**]** **described** in section 336.010;

(4) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs;

(5) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. 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 subdivision 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, 2005, shall be invalid and void.

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions (14) and (15) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by participants under this section shall be in addition to and not in lieu of payments made by the state for goods or services described herein except the participant portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a participant is unable to pay a required payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the MO HealthNet state plan amendment

submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

4. The MO HealthNet division shall have the right to collect medication samples from participants in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for MO HealthNet benefits at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. Section 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for MO HealthNet benefits under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. Section 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the MO HealthNet program shall not increase payments in excess of the increase that would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. Section 1396a (a)(13)(C).

10. The MO HealthNet division**[**,**]** may enroll qualified residential care facilities and assisted living facilities, as defined in chapter 198, as MO

HealthNet personal care providers.

11. Any income earned by individuals eligible for certified extended employment at a sheltered workshop under chapter 178 shall not be considered as income for purposes of determining eligibility under this section.

12. If the Missouri Medicaid audit and compliance unit changes any interpretation or application of the requirements for reimbursement for MO HealthNet services from the interpretation or application that has been applied previously by the state in any audit of a MO HealthNet provider, the Missouri Medicaid audit and compliance unit shall notify all affected MO HealthNet providers five business days before such change shall take effect. Failure of the Missouri Medicaid audit and compliance unit to notify a provider of such change shall entitle the provider to continue to receive and retain reimbursement until such notification is provided and shall waive any liability of such provider for recoupment or other loss of any payments previously made prior to the five business days after such notice has been sent. Each provider shall provide the Missouri Medicaid audit and compliance unit a valid email address and shall agree to receive communications electronically. The notification required under this section shall be delivered in writing by the United States Postal Service or electronic mail to each provider.

13. Nothing in this section shall be construed to abrogate or limit the department's statutory requirement to promulgate rules under chapter 536.

14. Beginning July 1, 2016, and subject to appropriations, providers of behavioral, social, and psychophysiological services for the prevention, treatment, or management of physical health problems shall be reimbursed utilizing the behavior assessment and intervention reimbursement codes 96150 to 96154 or their successor codes under the Current Procedural Terminology (CPT) coding system. Providers eligible for such reimbursement shall include psychologists.

208.952. 1. There is hereby established **[**the**]** **a permanent** "Joint Committee on **[**MO HealthNet**]** **Public Assistance**". The committee shall have **[**as its purpose the study of**]** the **following purposes:**

(1) Studying, monitoring, and reviewing the efficacy of the public assistance programs within the state;

(2) Determining the level and adequacy of resources needed **[**to continue and improve the MO HealthNet program over time**]** **for the public assistance programs within the state; and**

(3) Developing recommendations to the general assembly on the

public assistance programs within the state and on promoting independence from safety net programs among participants as may be appropriate.

The committee shall receive and obtain information from the departments of social services, mental health, health and senior services, and elementary and secondary education, and any other department as applicable, regarding the public assistance programs within the state including, but not limited to, MO HealthNet, the supplemental nutrition assistance program (SNAP), and temporary assistance for needy families (TANF). Such information shall include projected enrollment growth, budgetary matters, trends in childhood poverty and hunger, and any other information deemed to be relevant to the committee's purpose.

2. The directors of the department of social services, mental health, and health and senior services shall each submit an annual written report to the committee providing data and statistical information regarding the caseloads of the department's employees involved in the administration of public assistance programs.

3. The committee shall consist of ten members:

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

(2) The chair and the ranking minority member of the senate committee on appropriations **[**committee**]**;

(3) The chair and the ranking minority member of the **standing** house **of representatives** committee **[**on appropriations for health, mental health, and social services**] designated to consider public assistance legislation and matters**;

(4) The chair and the ranking minority member of the **standing** senate committee **[**on health and mental health**] designated to consider public assistance legislation and matters**;

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

(6) A senator chosen by the president pro **[**tem**] tempore** of the senate.

No more than **[**three**] four** members from each **[**house**] chamber** shall be of the same political party.

[2.**] 4.** A chair of the committee shall be selected by the members of the committee.

[3.**]** **5.** The committee shall meet **[**as necessary**]** **at least twice a year. A portion of the meeting shall be set aside for the purpose of receiving public testimony. The committee shall seek recommendations from social, economic, and public assistance experts on ways to improve the effectiveness of public assistance programs, to improve program efficiency and reduce costs, and to promote self-sufficiency among public assistance recipients as may be appropriate**.

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

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

6. **The committee is authorized to hire staff and enter into employment contracts including, but not limited to, an executive director to conduct special reviews or investigations of the public assistance programs within the state in order to assist the committee with its duties. Staff appointments shall be approved by the president pro tempore of the senate and the speaker of the house of representatives. The compensation of committee staff and the expenses of the committee shall be paid from the joint contingent fund or jointly from the senate and house of representatives contingent funds until an appropriation is made therefor.**

7. The committee shall **annually conduct a rolling five-year forecast of the public assistance programs within the state and** make recommendations in a report to the general assembly by January first each year, beginning in **[**2008**]** **2018**, on anticipated growth **[**in the MO HealthNet program**]** **of the public assistance programs within the state**, needed improvements, anticipated needed appropriations, and suggested strategies on ways to structure the state budget in order to satisfy the future needs of **[**the program**]** **such programs**.

208.1030. 1. An eligible provider, as described in subsection 2 of this section, may, in addition to the rate of payment that the provider would otherwise receive for Medicaid ground emergency medical transportation services, receive MO HealthNet supplemental reimbursement to the extent provided by law.

2. A provider shall be eligible for Medicaid supplemental reimbursement if the provider meets the following characteristics during the state reporting period:

(1) Provides ground emergency medical transportation services to MO HealthNet participants;

(2) Is enrolled as a MO HealthNet provider for the period being claimed; and

(3) Is owned, operated, or contracted by the state or a political subdivision.

3. An eligible provider's Medicaid supplemental reimbursement under this section shall be calculated and paid as follows:

(1) The supplemental reimbursement to an eligible provider, as described in subsection 2 of this section, shall be equal to the amount of federal financial participation received as a result of the claims submitted under subdivision (2) of subsection 6 of this section;

(2) In no instance shall the amount certified under subdivision (1) of subsection 5 of this section, when combined with the amount received from all other sources of reimbursement from the MO HealthNet program, exceed one hundred percent of actual costs, as determined under the Medicaid state plan for ground emergency medical transportation services; and

(3) The supplemental Medicaid reimbursement provided by this section shall be distributed exclusively to eligible providers under a payment methodology based on ground emergency medical transportation services provided to MO HealthNet participants by eligible providers on a per-transport basis or other federally permissible basis. The department of social services shall obtain approval from the Centers for Medicare and Medicaid Services for the payment methodology to be utilized and shall not make any payment under this section prior to obtaining that approval.

4. An eligible provider, as a condition of receiving supplemental reimbursement under this section, shall enter into and maintain an agreement with the department's designee for the purposes of implementing this section and reimbursing the department of social services for the costs of administering this section. The non-federal share of the supplemental reimbursement submitted to the Centers for Medicare and Medicaid Services for purposes of claiming federal financial participation shall be paid with funds from the governmental entities described in subdivision (3) of subsection 2 of this section and certified to the state as provided in subsection 5 of this section.

5. Participation in the program by an eligible provider described in this section is voluntary. If an applicable governmental entity elects to seek supplemental reimbursement under this section on behalf of an eligible provider owned or operated by the entity, as described in subdivision (3) of subsection 2 of this section, the governmental entity shall do the following:

(1) Certify in conformity with the requirements of 42 CFR 433.51 that the claimed expenditures for the ground emergency medical transportation services are eligible for federal financial participation;

(2) Provide evidence supporting the certification as specified by the department of social services;

(3) Submit data as specified by the department of social services to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation; and

(4) Keep, maintain, and have readily retrievable any records specified by the department of social services to fully disclose reimbursement amounts to which the eligible provider is entitled and any other records required by the Centers for Medicare and Medicaid Services.

6. The department of social services shall be authorized to seek any necessary federal approvals for the implementation of this section. The department may limit the program to those costs that are allowable expenditures under Title XIX of the Social Security Act, 42 U.S.C. Section 1396, et seq.

(1) The department of social services shall submit claims for federal financial participation for the expenditures for the services described in subsection 5 of this section that are allowable expenditures under federal law.

(2) The department of social services shall, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for federal financial participation shall include only those expenditures that are allowable under federal law.

208.1032. 1. The department of social services shall be authorized to design and implement in consultation and coordination with eligible providers as described in subsection 2 of this section an intergovernmental transfer program relating to ground emergency medical transport services, including those services provided at the

emergency medical responder, emergency medical technician (EMT), advanced EMT, EMT intermediate, or paramedic levels in the pre-stabilization and preparation for transport, in order to increase capitation payments for the purpose of increasing reimbursement to eligible providers.

2. A provider shall be eligible for increased reimbursement under this section only if the provider meets the following conditions in an applicable state fiscal year:

(1) Provides ground emergency medical transportation services to MO HealthNet participants;

(2) Is enrolled as a MO HealthNet provider for the period being claimed; and

(3) Is owned, operated, or contracted by the state or a political subdivision.

3. To the extent intergovernmental transfers are voluntarily made by and accepted from an eligible provider described in subsection 2 of this section or a governmental entity affiliated with an eligible provider, the department of social services shall make increased capitation payments to applicable MO HealthNet eligible providers for covered ground emergency medical transportation services.

(1) The increased capitation payments made under this section shall be in amounts at least actuarially equivalent to the supplemental fee-for-service payments and up to equivalent of commercial reimbursement rates available for eligible providers to the extent permissible under federal law.

(2) Except as provided in subsection 6 of this section, all funds associated with intergovernmental transfers made and accepted under this section shall be used to fund additional payments to eligible providers.

(3) MO HealthNet managed care plans and coordinated care organizations shall pay one hundred percent of any amount of increased capitation payments made under this section to eligible providers for providing and making available ground emergency medical transportation and pre-stabilization services pursuant to a contract or other arrangement with a MO HealthNet managed care plan or coordinated care organization.

4. The intergovernmental transfer program developed under this

section shall be implemented on the date federal approval is obtained, and only to the extent intergovernmental transfers from the eligible provider, or the governmental entity with which it is affiliated, are provided for this purpose. The department of social services shall implement the intergovernmental transfer program and increased capitation payments under this section on a retroactive basis as permitted by federal law.

5. Participation in the intergovernmental transfers under this section is voluntary on the part of the transferring entities for purposes of all applicable federal laws.

6. As a condition of participation under this section, each eligible provider as described in subsection 2 of this section or the governmental entity affiliated with an eligible provider shall agree to reimburse the department of social services for any costs associated with implementing this section. Intergovernmental transfers described in this section are subject to an administration fee of up to twenty percent of the nonfederal share paid to the department of social services and shall be allowed to count as a cost of providing the services not to exceed one hundred twenty percent of the total amount.

7. As a condition of participation under this section, MO HealthNet managed care plans, coordinated care organizations, eligible providers as described in subsection 2 of this section, and governmental entities affiliated with eligible providers shall agree to comply with any requests for information or similar data requirements imposed by the department of social services for purposes of obtaining supporting documentation necessary to claim federal funds or to obtain federal approvals.

8. This section shall be implemented only if and to the extent federal financial participation is available and is not otherwise jeopardized, and any necessary federal approvals have been obtained.

9. To the extent that the director of the department of social services determines that the payments made under this section do not comply with federal Medicaid requirements, the director retains the discretion to return or not accept an intergovernmental transfer, and may adjust payments under this section as necessary to comply with federal Medicaid requirements.

[208.985. 1. Pursuant to section 33.803, by January 1,

2008, and each January first thereafter, the legislative budget office shall annually conduct a rolling five-year MO HealthNet forecast. The forecast shall be issued to the general assembly, the governor, the joint committee on MO HealthNet, and the oversight committee established in section 208.955. The forecast shall include, but not be limited to, the following, with additional items as determined by the legislative budget office:

(1) The projected budget of the entire MO HealthNet program;

(2) The projected budgets of selected programs within MO HealthNet;

(3) Projected MO HealthNet enrollment growth, categorized by population and geographic area;

(4) Projected required reimbursement rates for MO HealthNet providers; and

(5) Projected financial need going forward.

2. In preparing the forecast required in subsection 1 of this section, where the MO HealthNet program overlaps more than one department or agency, the legislative budget office may provide for review and investigation of the program or service level on an interagency or interdepartmental basis in an effort to review all aspects of the program.**]**