First Look: SB 301
Medicaid Transformation

SB 301, sponsored by Sen. Silvey (R-Clay County), changes the Medicaid delivery system by expanding Medicaid managed care statewide for adults, children, and pregnant women. It also expands Missouri’s successful health home demonstration for those who are aged, have a disability, or are medically frail.

The bill also makes some changes to Medicaid eligibility and covered benefits, but it does not expand Medicaid to cover 300,000 adult Missourians ages 19-64 with incomes up to 133% of poverty.

Other provisions of SB 301 not discussed in this brief include TANF and SNAP rule changes, provisions for medical bill transparency, and changes to the state’s Certificate of Need process for new and expanding health care facilities and services.

DELIVERY SYSTEM CHANGES

Managed Care

• **Expands Medicaid Managed Care statewide for children, pregnant women, and low-income parents.** §208.998.1. Currently, most children, parents, and pregnant women in 54 counties in St. Louis, Kansas City and along the I-70 corridor are enrolled in managed care. The bill expands managed care statewide for these groups no earlier than January 1, 2016 and no later than July 1, 2016.

  • Does not expand Medicaid managed care to include those who are elderly, have a disability, or are blind.

  • Leaves in place §208.950.4 that provides that “No provisions of any state law shall be construed as to require any aged, blind, or disabled person to enroll in a risk-bearing coordination plan.”

• Allows the department to accept bids for regional as well as statewide managed care options including provider sponsored initiatives, pediatric care networks, pediatric centers for excellence, and medical homes for children. §208.998.2

• Does not address whether Department of Social Services (DSS) can exempt services (also called "carve outs"), like mental health and pharmacy, from managed care contracts when cost effective do so. This provision was in Sen. Silvey’s bill last year and creates important statutory protection for what has been DSS practice.

• Requires the department to establish uniform utilization review protocols for all managed care plans to use when determining if care is medically necessary and appropriate. §208.998.3

• Requires managed care plans to contract with “any willing” doctor or licensed mental health professional who meets national credentialing criteria and who is willing to accept Medicaid fee-for-service rates. §208.998.11
• **Creates important and significant new transparency and accountability requirements for Medicaid managed care plans.** §208.999
  - Requires reporting of medical loss ratios, provider networks, provider reimbursement rates, access to services, and quality of care.
  - Provides for an annual “secret shopper” survey to test whether plans are in compliance with network adequacy standards and can provide timely appointments. §208.999.3

**Private Plans**
- Continues existing authority to provide *subsidies for employer sponsored plans or other private plans* for low-income parents, children, and pregnant women when it is cost effective. §208.991.4

**Health Care Homes Program**
- Creates a “Health Care Homes Program” for those who are medically frail and using fee-for-service Medicaid and those who are “otherwise identified by the department.” §208.991.5 and §208.997.1
  - **Defines the medically frail as** children with serious emotional disturbances and others with disabling mental conditions; chronic substance use disorders; serious and complex medical conditions; physical, intellectual, or developmental disability that significantly impairs their ability to engage in one or more activities of daily living; or a disability determination based on Social Security criteria children eligible for SSI, or in foster care or other out-of-home placement. §208.991.1(7)
  - Allows individuals to opt out of the Health Care Homes Program. §208.991.5

**PERSONAL RESPONSIBILITY**

**Wellness Incentives and Promoting Healthy Behavior**
- Directs DSS to develop an *incentive program for those who are medically frail to promote health personal habits*, including limiting tobacco use and obesity prevention. §208.991.6

**ELIGIBILITY**

- **Increases the resource limit** from $1,000 to $2,000 per person and $2,000 to $4,000 for a couple for those who qualify based on age or disability, primarily. There is no resource limit for CHIP and most other Medicaid groups, including children, parents and pregnant women. §208.010.2(4)
- **Eliminates coverage for pregnant women with income between 133-185% poverty**, effective Jan. 2015. §208.991.2(b) and §208.991.2(d)
  - These pregnant women will be eligible for CHIP coverage through the new “Show-Me Healthy Babies Program” if funding for that program is available.
• If CHIP coverage is not available, these women will have to rely on employer-sponsored coverage and Marketplace plans which have limited open enrollment periods. This means that uninsured women who become pregnant after open enrollment will have no source of insurance to cover their prenatal care and delivery until the next enrollment period because pregnancy is not a “qualifying life event” that triggers a special enrollment period

• **Eliminates entirely the uninsured women’s health program** that provides family planning services for women at least 18 years of age with incomes below 185% of poverty who do not have access to employer-sponsored health insurance, effective July 2016. §208.659.2

**COVERED SERVICES**

• Adds coverage for **chiropractic services**. §208.960

• Allows licensed **clinical social workers and professional counselors** providing services to those enrolled managed care to be reimbursed in any setting, not just in a clinic setting. §208.998.11(2)
  • No similar provision for those enrolled in fee-for-service.

• Provides that those enrolled in managed care are to receive a package of benefits similar to the ten “essential health benefits” now required for private plans, including, **preventive services, mental health and substance abuse treatment, and outpatient rehabilitation**. §208.998.5
  • This means that the aged, blind, and disabled enrolled in fee-for-service Medicaid may get fewer benefits than parents, children, and pregnant women who must enroll in managed care because **fee-for-service Medicaid presently does not cover outpatient rehabilitation services** like physical therapy, occupational therapy, or speech therapy. There is no statutory requirement and although the legislature appropriated funding last year, the Governor withheld funding.

  • A coverage differential in which there are more services available in managed care may pressure those who are aged, blind, and disabled to “voluntarily” enroll in managed care in order to access services like outpatient rehabilitation that are not available in fee-for-service Medicaid.

**OVERSIGHT**

**MO HealthNet Oversight Committee and Joint Committee on Mo HealthNet**
Repeals the statutory authorization for the Oversight Committee. Makes permanent the