

FIRST REGULAR SESSION  
HOUSE COMMITTEE SUBSTITUTE FOR  
**HOUSE BILL NO. 669**  
**96TH GENERAL ASSEMBLY**

1664L.04C

D. ADAM CRUMBLISS, Chief Clerk

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**AN ACT**

To repeal sections 103.089, 191.227, and 208.152, RSMo, and to enact in lieu thereof twelve new sections relating to public health care policies.

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

Section A. Sections 103.089, 191.227, and 208.152, RSMo, are repealed and twelve new  
2 sections enacted in lieu thereof, to be known as sections 103.082, 103.089, 191.227, 191.774,  
3 208.152, 208.960, 338.400, 376.394, 376.1226, 376.1227, 376.1231, and 376.1235, to read as  
4 follows:

**103.082. 1. Beginning on a date specified by the board but not later than January  
2 1, 2013, the board shall develop a cost-neutral or cost-positive plan for providing bariatric  
3 coverage for persons insured under the Missouri consolidated health care plan.**

**4 2. The board may adopt rules necessary to implement the provisions of this  
5 subsection. Any rule or portion of a rule, as that term is defined in section 536.010, that  
6 is created under the authority delegated in this section shall become effective only if it  
7 complies with and is subject to all of the provisions of chapter 536 and, if applicable,  
8 section 536.028. This section and chapter 536 are nonseverable and if any of the powers  
9 vested with the general assembly pursuant to chapter 536 to review, to delay the effective  
10 date, or to disapprove and annul a rule are subsequently held unconstitutional, then the  
11 grant of rulemaking authority and any rule proposed or adopted after August 28, 2011,  
12 shall be invalid and void.**

103.089. Participants in the program of medical benefits coverage provided by sections  
2 103.003 to 103.175 who are eligible for Medicare benefits and who are not eligible for the  
3 program of medical benefits coverage provided under sections 103.083 to 103.098 to be their  
4 primary plan of coverage benefits shall be provided [the same] **substantially similar** benefits

EXPLANATION — Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

5 provided participants who are not eligible for Medicare benefits. Medical benefits coverage  
6 provided under sections 103.003 to 103.175 shall be coordinated with Medicare benefits for  
7 participants covered by part A or part B, or both, of Medicare benefits, or **for participants**  
8 **eligible for but not covered by part A or part B, or both, of Medicare benefits**, reduced by  
9 an amount determined by the claims administrator to provide a benefit equivalent to the amount  
10 which would be provided on a coordination of benefit basis for **such** participants [not] **if such**  
11 **participants were** covered by part A or part B, or both, of Medicare benefits. As used in  
12 sections 103.083 to 103.098, the term "Medicare benefits" shall include those medical benefits  
13 provided by Title XVIII, A and B, Public Law 89-97, 1965 amendments to the federal Social  
14 Security Act (42 U.S.C. section 301, et seq.) and amendments thereto. Any participating  
15 member agency having employees or eligible retirees not covered by Medicare shall authorize  
16 the plan at its option to enroll those individuals for medical benefits as provided by Title XVIII,  
17 A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act whenever they  
18 become eligible for such benefits and the plan shall pay the premium for such enrollment on  
19 behalf of that person. The Medicare premium amounts shall be included in the rate established  
20 by the actuary for providing medical benefits coverage to such a participating member agency.  
21 Anyone not authorizing this Medicare enrollment shall be denied coverage.

191.227. 1. All physicians, chiropractors, hospitals, dentists, and other duly licensed  
2 practitioners in this state, herein called "providers", shall, upon written request of a patient, or  
3 guardian or legally authorized representative of a patient, furnish a copy of his or her record of  
4 that patient's health history and treatment rendered to the person submitting a written request,  
5 except that such right shall be limited to access consistent with the patient's condition and sound  
6 therapeutic treatment as determined by the provider. Beginning August 28, [1994] **2011**, such  
7 record shall be furnished within [a reasonable time] **fifteen business days** of the receipt of the  
8 request therefor and upon payment of a fee as provided in this section. **If a provider is unable**  
9 **to provide such record within fifteen business days for good cause, the provider shall notify**  
10 **the person requesting the record of the delay in providing the medical record and the**  
11 **reason for such delay, and shall provide the record within a reasonable time based on the**  
12 **circumstances; except that, in no event shall a reasonable time exceed ninety calendar days.**

13 2. Health care providers may condition the furnishing of the patient's health care records  
14 to the patient, the patient's authorized representative or any other person or entity authorized by  
15 law to obtain or reproduce such records upon payment of a fee for:

- 16 (1) Copying, in an amount not more than seventeen dollars and five cents plus forty cents  
17 per page for the cost of supplies and labor;  
18 (2) Postage, to include packaging and delivery cost; and  
19 (3) Notary fee, not to exceed two dollars, if requested.

20           3. Notwithstanding provisions of this section to the contrary, providers may charge for  
21 the reasonable cost of all duplications of health care record material or information which cannot  
22 routinely be copied or duplicated on a standard commercial photocopy machine.

23           4. The transfer of the patient's record done in good faith shall not render the provider  
24 liable to the patient or any other person for any consequences which resulted or may result from  
25 disclosure of the patient's record as required by this section.

26           5. Effective February first of each year, the fees listed in subsection 2 of this section shall  
27 be increased or decreased annually based on the annual percentage change in the unadjusted,  
28 U.S. city average, annual average inflation rate of the medical care component of the Consumer  
29 Price Index for All Urban Consumers (CPI-U). The current reference base of the index, as  
30 published by the Bureau of Labor Statistics of the United States Department of Labor, shall be  
31 used as the reference base. For purposes of this subsection, the annual average inflation rate  
32 shall be based on a twelve-month calendar year beginning in January and ending in December  
33 of each preceding calendar year. The department of health and senior services shall report the  
34 annual adjustment and the adjusted fees authorized in this section on the department's Internet  
35 website by February first of each year.

36           **6. Any provider who fails to provide a medical record within the time period**  
37 **required under subsection 1 of this section or fails to notify a person of a delay in the**  
38 **provision of such records as required under subsection 1 of this section shall forfeit the**  
39 **collection of any medical record fees authorized under subsection 2 of this section. Any**  
40 **provider who is more than thirty calendar days delinquent in providing a medical record**  
41 **requested within the time periods established under this section shall be liable to the**  
42 **requester in the amount of three times the allowable fee for copying such medical records**  
43 **under subsection 2 of this section.**

44           **7. (1) A provider shall, upon written request of a patient, or guardian or legal**  
45 **representative of a patient, furnish a copy of any statement of medical expenses incurred**  
46 **for services rendered by the provider. Such statement shall be furnished within fifteen**  
47 **business days of the receipt of the request.**

48           **(2) Any provider who fails to provide a statement of expenses incurred for services**  
49 **rendered by the provider within fifteen business days shall be liable to the requester in the**  
50 **amount of three times the allowable fee for copying medical records under subsection 2 of**  
51 **this section.**

**191.774. 1. No person shall smoke or otherwise use tobacco products in any area**  
2 **of a state correctional center or the grounds thereof. Any person who violates the**  
3 **provisions of this section is guilty of an infraction.**

4           **2. The provisions of this section shall become effective July 1, 2012.**

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy persons as defined 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. 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. 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

37 consecutive months, during which the participant is on a temporary leave of absence from the  
38 hospital or nursing home, provided that no such participant shall be allowed a temporary leave  
39 of absence unless it is specifically provided for in his plan of care. As used in this subdivision,  
40 the term "temporary leave of absence" shall include all periods of time during which a participant  
41 is away from the hospital or nursing home overnight because he is visiting a friend or relative;

42 (6) Physicians' services, whether furnished in the office, home, hospital, nursing home,  
43 or elsewhere;

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

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

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

55 (10) Home health care services;

56 (11) Family planning as defined by federal rules and regulations; provided, however, that  
57 such family planning services shall not include abortions unless such abortions are certified in  
58 writing by a physician to the MO HealthNet agency that, in his professional judgment, the life  
59 of the mother would be endangered if the fetus were carried to term;

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

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

69 (14) Personal care services which are medically oriented tasks having to do with a  
70 person's physical requirements, as opposed to housekeeping requirements, which enable a person  
71 to be treated by his physician on an outpatient rather than on an inpatient or residential basis in  
72 a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be

73 rendered by an individual not a member of the participant's family who is qualified to provide  
74 such services where the services are prescribed by a physician in accordance with a plan of  
75 treatment and are supervised by a licensed nurse. Persons eligible to receive personal care  
76 services shall be those persons who would otherwise require placement in a hospital,  
77 intermediate care facility, or skilled nursing facility. Benefits payable for personal care services  
78 shall not exceed for any one participant one hundred percent of the average statewide charge for  
79 care and treatment in an intermediate care facility for a comparable period of time. Such  
80 services, when delivered in a residential care facility or assisted living facility licensed under  
81 chapter 198 shall be authorized on a tier level based on the services the resident requires and the  
82 frequency of the services. A resident of such facility who qualifies for assistance under section  
83 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the  
84 fewest services. The rate paid to providers for each tier of service shall be set subject to  
85 appropriations. Subject to appropriations, each resident of such facility who qualifies for  
86 assistance under section 208.030 and meets the level of care required in this section shall, at a  
87 minimum, if prescribed by a physician, be authorized up to one hour of personal care services  
88 per day. Authorized units of personal care services shall not be reduced or tier level lowered  
89 unless an order approving such reduction or lowering is obtained from the resident's personal  
90 physician. Such authorized units of personal care services or tier level shall be transferred with  
91 such resident if her or she transfers to another such facility. Such provision shall terminate upon  
92 receipt of relevant waivers from the federal Department of Health and Human Services. If the  
93 Centers for Medicare and Medicaid Services determines that such provision does not comply  
94 with the state plan, this provision shall be null and void. The MO HealthNet division shall notify  
95 the revisor of statutes as to whether the relevant waivers are approved or a determination of  
96 noncompliance is made;

97 (15) Mental health services. The state plan for providing medical assistance under Title  
98 XIX of the Social Security Act, 42 U.S.C. 301, as amended, shall include the following mental  
99 health services when such services are provided by community mental health facilities operated  
100 by the department of mental health or designated by the department of mental health as a  
101 community mental health facility or as an alcohol and drug abuse facility or as a child-serving  
102 agency within the comprehensive children's mental health service system established in section  
103 630.097. The department of mental health shall establish by administrative rule the definition  
104 and criteria for designation as a community mental health facility and for designation as an  
105 alcohol and drug abuse facility. Such mental health services shall include:

106 (a) Outpatient mental health services including preventive, diagnostic, therapeutic,  
107 rehabilitative, and palliative interventions rendered to individuals in an individual or group  
108 setting by a mental health professional in accordance with a plan of treatment appropriately

109 established, implemented, monitored, and revised under the auspices of a therapeutic team as a  
110 part of client services management;

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

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

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

134 (17) Beginning July 1, 1990, the services of a certified pediatric or family nursing  
135 practitioner with a collaborative practice agreement to the extent that such services are provided  
136 in accordance with chapters 334 and 335, and regulations promulgated thereunder;

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

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

142 a. The occupancy rate of the nursing home is at or above ninety-seven percent of MO  
143 HealthNet certified licensed beds, according to the most recent quarterly census provided to the

144 department of health and senior services which was taken prior to when the participant is  
145 admitted to the hospital; and

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

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

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

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

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

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

177           (21) Prescribed medically necessary dental services. Such services shall be subject to  
178 appropriations. An electronic web-based prior authorization system using best medical evidence

179 and care and treatment guidelines consistent with national standards shall be used to verify  
180 medical need;

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

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

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

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

192 (c) **In-home assessments conducted by a pharmacist, nurse, or local home health**  
193 **care agency trained in bleeding disorders when deemed necessary by the participant's**  
194 **treating physician;**

195 (24) The MO HealthNet division shall, by January 1, 2008, and annually thereafter,  
196 report the status of MO HealthNet provider reimbursement rates as compared to one hundred  
197 percent of the Medicare reimbursement rates and compared to the average dental reimbursement  
198 rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July  
199 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare  
200 reimbursement rates and for third-party payor average dental reimbursement rates. Such plan  
201 shall be subject to appropriation and the division shall include in its annual budget request to the  
202 governor the necessary funding needed to complete the four-year plan developed under this  
203 subdivision.

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

209 (1) Dental services;

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

211 (3) Optometric services as defined in section 336.010;

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

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

227 (6) Comprehensive day rehabilitation services beginning early posttrauma as part of a  
228 coordinated system of care for individuals with disabling impairments. Rehabilitation services  
229 must be based on an individualized, goal-oriented, comprehensive and coordinated treatment  
230 plan developed, implemented, and monitored through an interdisciplinary assessment designed  
231 to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO  
232 HealthNet division shall establish by administrative rule the definition and criteria for  
233 designation of a comprehensive day rehabilitation service facility, benefit limitations and  
234 payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010,  
235 that is created under the authority delegated in this subdivision shall become effective only if it  
236 complies with and is subject to all of the provisions of chapter 536 and, if applicable, section  
237 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the  
238 general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove  
239 and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority  
240 and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

241 3. The MO HealthNet division may require any participant receiving MO HealthNet  
242 benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July  
243 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered  
244 services except for those services covered under subdivisions (14) and (15) of subsection 1 of  
245 this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title  
246 XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder.  
247 When substitution of a generic drug is permitted by the prescriber according to section 338.056,  
248 and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not  
249 lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of

250 the federal Social Security Act. A provider of goods or services described under this section  
251 must collect from all participants the additional payment that may be required by the MO  
252 HealthNet division under authority granted herein, if the division exercises that authority, to  
253 remain eligible as a provider. Any payments made by participants under this section shall be in  
254 addition to and not in lieu of payments made by the state for goods or services described herein  
255 except the participant portion of the pharmacy professional dispensing fee shall be in addition  
256 to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time  
257 a service is provided or at a later date. A provider shall not refuse to provide a service if a  
258 participant is unable to pay a required payment. If it is the routine business practice of a provider  
259 to terminate future services to an individual with an unclaimed debt, the provider may include  
260 uncollected co-payments under this practice. Providers who elect not to undertake the provision  
261 of services based on a history of bad debt shall give participants advance notice and a reasonable  
262 opportunity for payment. A provider, representative, employee, independent contractor, or agent  
263 of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection  
264 shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for  
265 Medicare and Medicaid Services does not approve the Missouri MO HealthNet state plan  
266 amendment submitted by the department of social services that would allow a provider to deny  
267 future services to an individual with uncollected co-payments, the denial of services shall not be  
268 allowed. The department of social services shall inform providers regarding the acceptability  
269 of denying services as the result of unpaid co-payments.

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

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

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

282 7. Beginning July 1, 1990, the department of social services shall provide notification  
283 and referral of children below age five, and pregnant, breast-feeding, or postpartum women who  
284 are determined to be eligible for MO HealthNet benefits under section 208.151 to the special  
285 supplemental food programs for women, infants and children administered by the department

286 of health and senior services. Such notification and referral shall conform to the requirements  
287 of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.

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

291 9. Reimbursement rates to long-term care providers with respect to a total change in  
292 ownership, at arm's length, for any facility previously licensed and certified for participation in  
293 the MO HealthNet program shall not increase payments in excess of the increase that would  
294 result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C.  
295 1396a (a)(13)(C).

296 10. The MO HealthNet division, may enroll qualified residential care facilities and  
297 assisted living facilities, as defined in chapter 198, as MO HealthNet personal care providers.

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

**208.960. Health care professionals licensed under chapter 331 shall be reimbursed  
2 under the MO HealthNet program for providing services currently covered under section  
3 208.152 and within the scope of practice under section 331.010.**

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

2 (1) "Ancillary infusion equipment and supplies", the equipment and supplies  
3 required to infuse a blood clotting therapy product into a human vein, including syringes,  
4 needles, sterile gauze, field pads, gloves, alcohol swabs, numbing creams, tourniquets,  
5 medical tape, sharps or equivalent biohazard waste containers, and cold compression  
6 packs;

7 (2) "Assay", the amount of a particular constituent of a mixture or of the biological  
8 or pharmacological potency of a drug;

9 (3) "Bleeding disorder", a medical condition characterized by a deficiency or  
10 absence of one or more essential blood-clotting components in the human blood, including  
11 all forms of hemophilia, von Willebrand's disease, and other bleeding disorders that result  
12 in uncontrollable bleeding or abnormal blood clotting;

13 (4) "Blood clotting product", a medicine approved for distribution by the federal  
14 Food and Drug Administration that is used for the treatment and prevention of symptoms  
15 associated with bleeding disorders, including but not limited to recombinant Factor VII,  
16 recombinant-activated Factor VIIa, recombinant Factor VIII, plasma-derived Factor VIII,  
17 recombinant Factor IX, plasma-derived Factor IX, von Willebrand factor products, bypass

18 **products for patients with inhibitors, prothrombin complex concentrates; and activated**  
19 **prothrombin complex concentrates;**

20 **(5) "Home nursing services", specialized nursing care provided in the home setting**  
21 **to assist a patient in the reconstitution and administration of blood clotting products;**

22 **(6) "Home use", infusion or other use of a blood clotting product in a place other**  
23 **than a hemophilia treatment center, hospital, emergency room, physician's office,**  
24 **outpatient facility, or clinic;**

25 **(7) "Pharmacy", an entity engaged in practice of pharmacy as defined in section**  
26 **338.010 that provides patients with blood clotting products and ancillary infusion**  
27 **equipment and supplies.**

28 **2. The Missouri state board of pharmacy shall promulgate rules governing the**  
29 **standard of care for pharmacies dispensing blood clotting therapies. Such rules shall**  
30 **include, when feasible, the standards established by the medical advisory committees of the**  
31 **patient groups representing the hemophilia and von Willebrand diseases, including but not**  
32 **limited to Recommendation 188 of the National Hemophilia Foundation's Medical and**  
33 **Scientific Advisory Council. Such rules shall include safeguards to ensure the pharmacy:**

34 **(1) Has the ability to obtain and fill a physician prescription as written of all brands**  
35 **of blood clotting products approved by the federal Food and Drug Administration in**  
36 **multiple assay ranges of low, medium, and high, as applicable, and vial sizes, including**  
37 **products manufactured from human plasma and those manufactured from recombinant**  
38 **technology techniques, provided manufacturer supply exists and payer authorization is**  
39 **obtained;**

40 **(2) Provides for the shipment of prescribed blood clotting products to the patient**  
41 **within two business days or less for established patients and three business days or less for**  
42 **new patients in nonemergency situations;**

43 **(3) Provides established patients with access to blood clotting products within**  
44 **twelve hours of notification by the physician of the patient's emergent need for blood**  
45 **clotting products;**

46 **(4) Provides all ancillary infusion equipment and supplies necessary for established**  
47 **patients for administration of blood clotting products;**

48 **(5) Has a pharmacist available twenty-four hours a day, seven days a week, every**  
49 **day of the year, either onsite or on call, to fill prescriptions for blood clotting products;**

50 **(6) Provides patients who have received blood clotting products with a designated**  
51 **contact telephone number for reporting problems with a delivery or product;**

52           (7) Provides patients with notification of recalls and withdrawals of blood clotting  
53 products and ancillary infusion equipment within twenty-four hours of receipt of the  
54 notification; and

55           (8) Provides containers for the disposal of hazardous waste, and provide patients  
56 with instructions on the proper collection, removal, and disposal of hazardous waste under  
57 state and federal law.

**376.394.** No health carrier or health benefit plan, as defined in section 376.1350,  
2 shall deny reimbursement for providing or interpreting diagnostic imaging services based  
3 solely on the specialty or professional board certification of a physician licensed under  
4 chapter 334.

**376.1226.** 1. No contract between a health carrier or health benefit plan and a  
2 dentist for the provision of dental services under a dental plan shall require that the dentist  
3 provide dental services to insureds in the dental plan at a fee established by the health  
4 carrier or health benefit plan if such dental services are not covered services under the  
5 dental plan.

6           2. For purposes of this section, the following terms shall mean:

7           (1) "Covered services", services reimbursable by a health carrier or health benefit  
8 plan under an applicable dental plan, subject to such contractual limitations on benefits  
9 as may apply, including but not limited to deductibles, waiting periods, or frequency  
10 limitations;

11           (2) "Dental plan", any policy or contract of insurance which provides for coverage  
12 of dental services;

13           (3) "Health benefit plan", the same meaning as such term is defined in section  
14 376.1350;

15           (4) "Health carrier", the same meaning as such term is defined in section 376.1350.

**376.1227.** 1. No contract between a health carrier or health benefit plan and an  
2 optometrist for the provision of optometric services under a vision plan shall require that  
3 the optometrist provide optometric services to insureds in the vision plan at a fee  
4 established by the health carrier or health benefit plan if such optometric services are not  
5 covered services under the vision plan.

6           2. For purposes of this section, the following terms shall mean:

7           (1) "Covered services", services reimbursable by a health carrier or health benefit  
8 plan under an applicable vision plan, subject to such contractual limitations on benefits as  
9 may apply, including but not limited to deductibles, waiting periods, or frequency  
10 limitations;

11           (2) "Health benefit plan", the same meaning as such term is defined in section  
12 376.1350;

13           (3) "Health carrier", the same meaning as such term is defined in section 376.1350;

14           (4) "Vision plan", any policy or contract of insurance which provides for coverage  
15 of vision care services.

**376.1231. Reimbursement amounts and copays paid by health carriers for any**  
2 **particular health care service or procedure rendered by a physical therapist within the**  
3 **scope of practice, as defined in chapter 334, shall be in the same amounts as**  
4 **reimbursements paid by health carriers to any other licensed physical therapist performing**  
5 **the same or similar procedures. Such uniform reimbursement requirement shall apply**  
6 **regardless of the setting or venue in which the applicable health care services or**  
7 **procedures are rendered.**

**376.1235. 1. Each health carrier or health benefit plan that offers or issues health**  
2 **benefit plans which are delivered, issued for delivery, continued, or renewed in this state**  
3 **on or after January 1, 2012, shall not deny coverage for a renewal of prescription**  
4 **maintenance eye drops when:**

5           (1) The renewal is requested by the insured less than thirty days from the later of:

6           (a) The original prescription was distributed to the insured; or

7           (b) The date the last renewal of such prescription was distributed to the insured;

8 and

9           (2) The prescribing health care professional indicates on the original prescription  
10 that additional quantities are needed and the renewal requested by the insured does not  
11 exceed the number of additional quantities needed.

12           2. For the purposes of this section, "health carrier" and "health benefit plan" shall  
13 have the same meaning as defined in section 376.1350. For purposes of this section,  
14 "prescription maintenance eye drops" means eye drops prescribed as a type of  
15 maintenance medication that is used on a regular basis.

16           3. The coverage required by this section shall not be subject to any greater  
17 deductible or co-payment than other similar health care services provided by the health  
18 benefit plan.

19           4. The provisions of this section shall not apply to a supplemental insurance policy,  
20 including a life care contract, accident-only policy, specified disease policy, hospital policy  
21 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy,  
22 short-term major medical policies of six months' or less duration, or any other  
23 supplemental policy as determined by the director of the department of insurance,  
24 financial institutions and professional registration.