

SECOND REGULAR SESSION

HOUSE BILL NO. 1713

96TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE GRISAMORE.

4742L.011

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal section 208.152, RSMo, and to enact in lieu thereof one new section relating to MO HealthNet benefits.

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

Section A. Section 208.152, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 208.152, to read as follows:

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 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

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.

18 MO HealthNet division may evaluate outpatient hospital services rendered under this section and
19 deny payment for services which are determined by the MO HealthNet division not to be
20 medically necessary, in accordance with federal law and regulations;

21 (3) Laboratory and X-ray services;

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

35 (5) Nursing home costs for participants receiving benefit payments under subdivision
36 (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 subdivision, the term "hospice care" means a
165 coordinated program of active professional medical attention within a home, outpatient and
166 inpatient care which treats the terminally ill patient and family as a unit, employing a medically
167 directed interdisciplinary team. The program provides relief of severe pain or other physical
168 symptoms and supportive care to meet the special needs arising out of physical, psychological,
169 spiritual, social, and economic stresses which are experienced during the final stages of illness,
170 and during dying and bereavement and meets the Medicare requirements for participation as a
171 hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO
172 HealthNet division to the hospice provider for room and board furnished by a nursing home to
173 an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement
174 which would have been paid for facility services in that nursing home facility for that patient,
175 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) **Prescribed medically necessary hearing aids. Such services shall be subject to**
186 **appropriations. An electronic web-based prior authorization system using best medical**
187 **evidence and care and treatment guidelines consistent with national standards shall be**
188 **used to verify medical need;**

189 (24) Blood clotting products-related services. For persons diagnosed with a bleeding
190 disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section
191 338.400, such services include:

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

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

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

199 [(24)] **(25)** The MO HealthNet division shall, by January 1, 2008, and annually
200 thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one
201 hundred percent of the Medicare reimbursement rates and compared to the average dental
202 reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division
203 shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with
204 Medicare reimbursement rates and for third-party payor average dental reimbursement rates.
205 Such plan shall be subject to appropriation and the division shall include in its annual budget
206 request to the governor the necessary funding needed to complete the four-year plan developed
207 under this subdivision.

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

213 (1) Dental services;

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

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

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

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

231 (6) Comprehensive day rehabilitation services beginning early posttrauma as part of a
232 coordinated system of care for individuals with disabling impairments. Rehabilitation services
233 must be based on an individualized, goal-oriented, comprehensive and coordinated treatment
234 plan developed, implemented, and monitored through an interdisciplinary assessment designed
235 to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO
236 HealthNet division shall establish by administrative rule the definition and criteria for
237 designation of a comprehensive day rehabilitation service facility, benefit limitations and
238 payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010,
239 that is created under the authority delegated in this subdivision shall become effective only if it
240 complies with and is subject to all of the provisions of chapter 536 and, if applicable, section
241 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the
242 general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove
243 and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority
244 and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

245 3. The MO HealthNet division may require any participant receiving MO HealthNet
246 benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July
247 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered
248 services except for those services covered under subdivisions (14) and (15) of subsection 1 of
249 this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title
250 XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder.
251 When substitution of a generic drug is permitted by the prescriber according to section 338.056,
252 and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not
253 lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of
254 the federal Social Security Act. A provider of goods or services described under this section
255 must collect from all participants the additional payment that may be required by the MO
256 HealthNet division under authority granted herein, if the division exercises that authority, to
257 remain eligible as a provider. Any payments made by participants under this section shall be in
258 addition to and not in lieu of payments made by the state for goods or services described herein
259 except the participant portion of the pharmacy professional dispensing fee shall be in addition
260 to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time
261 a service is provided or at a later date. A provider shall not refuse to provide a service if a
262 participant is unable to pay a required payment. If it is the routine business practice of a provider
263 to terminate future services to an individual with an unclaimed debt, the provider may include
264 uncollected co-payments under this practice. Providers who elect not to undertake the provision
265 of services based on a history of bad debt shall give participants advance notice and a reasonable
266 opportunity for payment. A provider, representative, employee, independent contractor, or agent

267 of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection
268 shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for
269 Medicare and Medicaid Services does not approve the Missouri MO HealthNet state plan
270 amendment submitted by the department of social services that would allow a provider to deny
271 future services to an individual with uncollected co-payments, the denial of services shall not be
272 allowed. The department of social services shall inform providers regarding the acceptability
273 of denying services as the result of unpaid co-payments.

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

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

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

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

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

295 9. Reimbursement rates to long-term care providers with respect to a total change in
296 ownership, at arm's length, for any facility previously licensed and certified for participation in
297 the MO HealthNet program shall not increase payments in excess of the increase that would
298 result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C.
299 1396a (a)(13)(C).

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

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

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