

House _____ Amendment NO. _____

Offered By _____

1 AMEND House Committee Substitute for House Bill Nos. 1593 & 1959, Page 3, Section 188.035,
2 Line 66, by inserting after said section and line the following:

3
4 "188.202. 1. No federal act, law, executive order, administrative order, rule, or regulation
5 shall infringe on the right of the people of Missouri to:

6 (1) Protect state sovereignty and state taxpayers by restricting public funds, public facilities,
7 and public employees from being used to perform, induce, or assist in an abortion, except as
8 provided for in state statutes;

9 (2) Encourage childbirth over abortion in the use of the state's public funds, public facilities,
10 and public employees;

11 (3) Defend the religious beliefs or moral convictions of any person who, or entity which,
12 does not want to be forced to directly or indirectly fund or participate in abortion;

13 (4) Prevent the state or its political subdivisions from being coerced, compelled, or
14 commandeered by the federal government to enact, administer, or enforce a federal regulatory
15 program that directly or indirectly funds abortion; or

16 (5) Prohibit the federal government from commanding or conscripting public officials of the
17 state or its political subdivisions to enforce a federal regulatory program that directly or indirectly
18 funds abortion.

19 2. In any action to enforce the provisions of sections 188.200 to 188.215 by a taxpayer
20 under the provisions of section 188.200, a court of competent jurisdiction may order injunctive or
21 other equitable relief, recovery of damages or other legal remedies, or both, as well as payment of
22 reasonable attorney's fees, costs, and expenses of the taxpayer. The relief and remedies set forth
23 shall not be deemed exclusive and shall be in addition to any other relief or remedies permitted by
24 law.

25 3. In addition to a cause of action brought by a taxpayer under section 188.220, the attorney
26 general is also authorized to bring a cause of action to enforce the provisions of sections 188.200 to
27 188.215.

28 188.207. It shall be unlawful for any public funds to be expended to any abortion facility, or
29 to any affiliate or associate of such abortion facility.

30 188.220. Any taxpayer of this state or its political subdivisions shall have standing to bring

Action Taken _____ Date _____

1 ~~[suit in a circuit court of proper venue]~~ a cause of action in any court or administrative agency of
2 competent jurisdiction to enforce the provisions of sections 188.200 to 188.215.

3 208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy
4 persons as described in section 208.151 who are unable to provide for it in whole or in part, with
5 any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the
6 services as defined and determined by the MO HealthNet division, unless otherwise hereinafter
7 provided, for the following:

8 (1) Inpatient hospital services, except to persons in an institution for mental diseases who
9 are under the age of sixty-five years and over the age of twenty-one years; provided that the MO
10 HealthNet division shall provide through rule and regulation an exception process for coverage of
11 inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional
12 activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and
13 provided further that the MO HealthNet division shall take into account through its payment system
14 for hospital services the situation of hospitals which serve a disproportionate number of low-income
15 patients;

16 (2) All outpatient hospital services, payments therefor to be in amounts which represent no
17 more than eighty percent of the lesser of reasonable costs or customary charges for such services,
18 determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97,
19 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.), but the MO
20 HealthNet division may evaluate outpatient hospital services rendered under this section and deny
21 payment for services which are determined by the MO HealthNet division not to be medically
22 necessary, in accordance with federal law and regulations;

23 (3) Laboratory and X-ray services;

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

37 (5) Nursing home costs for participants receiving benefit payments under subdivision (4) of
38 this subsection for those days, which shall not exceed twelve per any period of six consecutive
39 months, during which the participant is on a temporary leave of absence from the hospital or nursing

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

5 (6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or
6 elsewhere; provided that, no funds shall be expended to any abortion facility, as defined in section
7 188.015, or to any affiliate or associate of such abortion facility;

8 (7) Subject to appropriation, up to twenty visits per year for services limited to
9 examinations, diagnoses, adjustments, and manipulations and treatments of malpositioned
10 articulations and structures of the body provided by licensed chiropractic physicians practicing
11 within their scope of practice. Nothing in this subdivision shall be interpreted to otherwise expand
12 MO HealthNet services;

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

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

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

25 (11) Home health care services;

26 (12) Family planning as defined by federal rules and regulations; provided that, no funds
27 shall be expended to any abortion facility, as defined in section 188.015, or to any affiliate or
28 associate of such abortion facility; and further provided, however, that such family planning services
29 shall not include abortions or any abortifacient drug or device that is used for the purpose of
30 inducing an abortion unless such abortions are certified in writing by a physician to the MO
31 HealthNet agency that, in the physician's professional judgment, the life of the mother would be
32 endangered if the fetus were carried to term;

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

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

1 Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

2 (15) Personal care services which are medically oriented tasks having to do with a person's
3 physical requirements, as opposed to housekeeping requirements, which enable a person to be
4 treated by his or her physician on an outpatient rather than on an inpatient or residential basis in a
5 hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be
6 rendered by an individual not a member of the participant's family who is qualified to provide such
7 services where the services are prescribed by a physician in accordance with a plan of treatment and
8 are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those
9 persons who would otherwise require placement in a hospital, intermediate care facility, or skilled
10 nursing facility. Benefits payable for personal care services shall not exceed for any one participant
11 one hundred percent of the average statewide charge for care and treatment in an intermediate care
12 facility for a comparable period of time. Such services, when delivered in a residential care facility
13 or assisted living facility licensed under chapter 198 shall be authorized on a tier level based on the
14 services the resident requires and the frequency of the services. A resident of such facility who
15 qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician,
16 qualify for the tier level with the fewest services. The rate paid to providers for each tier of service
17 shall be set subject to appropriations. Subject to appropriations, each resident of such facility who
18 qualifies for assistance under section 208.030 and meets the level of care required in this section
19 shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care
20 services per day. Authorized units of personal care services shall not be reduced or tier level
21 lowered unless an order approving such reduction or lowering is obtained from the resident's
22 personal physician. Such authorized units of personal care services or tier level shall be transferred
23 with such resident if he or she transfers to another such facility. Such provision shall terminate upon
24 receipt of relevant waivers from the federal Department of Health and Human Services. If the
25 Centers for Medicare and Medicaid Services determines that such provision does not comply with
26 the state plan, this provision shall be null and void. The MO HealthNet division shall notify the
27 revisor of statutes as to whether the relevant waivers are approved or a determination of
28 noncompliance is made;

29 (16) Mental health services. The state plan for providing medical assistance under Title
30 XIX of the Social Security Act, 42 U.S.C. Section 301, as amended, shall include the following
31 mental health services when such services are provided by community mental health facilities
32 operated by the department of mental health or designated by the department of mental health as a
33 community mental health facility or as an alcohol and drug abuse facility or as a child-serving
34 agency within the comprehensive children's mental health service system established in section
35 630.097. The department of mental health shall establish by administrative rule the definition and
36 criteria for designation as a community mental health facility and for designation as an alcohol and
37 drug abuse facility. Such mental health services shall include:

38 (a) Outpatient mental health services including preventive, diagnostic, therapeutic,
39 rehabilitative, and palliative interventions rendered to individuals in an individual or group setting

1 by a mental health professional in accordance with a plan of treatment appropriately established,
2 implemented, monitored, and revised under the auspices of a therapeutic team as a part of client
3 services management;

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

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

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

26 (18) The services of an advanced practice registered nurse with a collaborative practice
27 agreement to the extent that such services are provided in accordance with chapters 334 and 335,
28 and regulations promulgated thereunder;

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

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

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

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

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

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

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

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

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

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

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

35 (24) Blood clotting products-related services. For persons diagnosed with a bleeding
36 disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section
37 338.400, such services include:

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

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

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

6 (25) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report
7 the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of
8 the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by
9 third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide
10 to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and
11 for third-party payor average dental reimbursement rates. Such plan shall be subject to
12 appropriation and the division shall include in its annual budget request to the governor the
13 necessary funding needed to complete the four-year plan developed under this subdivision.

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

18 (1) Dental services;

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

20 (3) Optometric services as described in section 336.010;

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

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

35 (6) Comprehensive day rehabilitation services beginning early posttrauma as part of a
36 coordinated system of care for individuals with disabling impairments. Rehabilitation services must
37 be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan
38 developed, implemented, and monitored through an interdisciplinary assessment designed to restore
39 an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet

1 division shall establish by administrative rule the definition and criteria for designation of a
2 comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. Any
3 rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority
4 delegated in this subdivision shall become effective only if it complies with and is subject to all of
5 the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are
6 nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to
7 review, to delay the effective date, or to disapprove and annul a rule are subsequently held
8 unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after
9 August 28, 2005, shall be invalid and void.

10 3. The MO HealthNet division may require any participant receiving MO HealthNet
11 benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1,
12 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services
13 except for those services covered under subdivisions (15) and (16) of subsection 1 of this section
14 and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the
15 federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations thereunder. When
16 substitution of a generic drug is permitted by the prescriber according to section 338.056, and a
17 generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or
18 delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal
19 Social Security Act. A provider of goods or services described under this section must collect from
20 all participants the additional payment that may be required by the MO HealthNet division under
21 authority granted herein, if the division exercises that authority, to remain eligible as a provider.
22 Any payments made by participants under this section shall be in addition to and not in lieu of
23 payments made by the state for goods or services described herein except the participant portion of
24 the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to
25 pharmacists. A provider may collect the co-payment at the time a service is provided or at a later
26 date. A provider shall not refuse to provide a service if a participant is unable to pay a required
27 payment. If it is the routine business practice of a provider to terminate future services to an
28 individual with an unclaimed debt, the provider may include uncollected co-payments under this
29 practice. Providers who elect not to undertake the provision of services based on a history of bad
30 debt shall give participants advance notice and a reasonable opportunity for payment. A provider,
31 representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall
32 not make co-payment for a participant. This subsection shall not apply to other qualified children,
33 pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not
34 approve the MO HealthNet state plan amendment submitted by the department of social services
35 that would allow a provider to deny future services to an individual with uncollected co-payments,
36 the denial of services shall not be allowed. The department of social services shall inform providers
37 regarding the acceptability of denying services as the result of unpaid co-payments.

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

1 5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection
2 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and
3 services are available under the state plan for MO HealthNet benefits at least to the extent that such
4 care and services are available to the general population in the geographic area, as required under
5 subparagraph (a)(30)(A) of 42 U.S.C. Section 1396a and federal regulations promulgated
6 thereunder.

7 6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health
8 centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404 of P.L.
9 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated
10 thereunder.

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

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

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

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

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

30 12. If the Missouri Medicaid audit and compliance unit changes any interpretation or
31 application of the requirements for reimbursement for MO HealthNet services from the
32 interpretation or application that has been applied previously by the state in any audit of a MO
33 HealthNet provider, the Missouri Medicaid audit and compliance unit shall notify all affected MO
34 HealthNet providers five business days before such change shall take effect. Failure of the Missouri
35 Medicaid audit and compliance unit to notify a provider of such change shall entitle the provider to
36 continue to receive and retain reimbursement until such notification is provided and shall waive any
37 liability of such provider for recoupment or other loss of any payments previously made prior to the
38 five business days after such notice has been sent. Each provider shall provide the Missouri
39 Medicaid audit and compliance unit a valid email address and shall agree to receive

1 communications electronically. The notification required under this section shall be delivered in
2 writing by the United States Postal Service or electronic mail to each provider.

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

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

10 208.153. 1. Pursuant to and not inconsistent with the provisions of sections 208.151 and
11 208.152, the MO HealthNet division shall by rule and regulation define the reasonable costs,
12 manner, extent, quantity, quality, charges and fees of MO HealthNet benefits herein provided. The
13 benefits available under these sections shall not replace those provided under other federal or state
14 law or under other contractual or legal entitlements of the persons receiving them, and all persons
15 shall be required to apply for and utilize all benefits available to them and to pursue all causes of
16 action to which they are entitled. Any person entitled to MO HealthNet benefits may obtain it from
17 any provider of services which is not excluded or disqualified as a provider under any provision of
18 law including, but not limited to, section 208.164, with which an agreement is in effect under this
19 section and which undertakes to provide the services, as authorized by the MO HealthNet division.
20 At the discretion of the director of the MO HealthNet division and with the approval of the
21 governor, the MO HealthNet division is authorized to provide medical benefits for participants
22 receiving public assistance by expending funds for the payment of federal medical insurance
23 premiums, coinsurance and deductibles pursuant to the provisions of Title XVIII B and XIX, Public
24 Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et seq.), as
25 amended.

26 2. MO HealthNet shall include benefit payments on behalf of qualified Medicare
27 beneficiaries as defined in 42 U.S.C. Section 1396d(p). The family support division shall by rule
28 and regulation establish which qualified Medicare beneficiaries are eligible. The MO HealthNet
29 division shall define the premiums, deductible and coinsurance provided for in 42 U.S.C. Section
30 1396d(p) to be provided on behalf of the qualified Medicare beneficiaries.

31 3. MO HealthNet shall include benefit payments for Medicare Part A cost sharing as defined
32 in clause (p)(3)(A)(i) of 42 U.S.C. 1396d on behalf of qualified disabled and working individuals as
33 defined in subsection (s) of Section 42 U.S.C. 1396d as required by subsection (d) of Section 6408
34 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989). The MO HealthNet division may
35 impose a premium for such benefit payments as authorized by paragraph (d)(3) of Section 6408 of
36 P.L. 101-239.

37 4. MO HealthNet shall include benefit payments for Medicare Part B cost sharing described
38 in 42 U.S.C. Section 1396(d)(p)(3)(A)(ii) for individuals described in subsection 2 of this section,
39 but for the fact that their income exceeds the income level established by the state under 42 U.S.C.

1 Section 1396(d)(p)(2) but is less than one hundred and ten percent beginning January 1, 1993, and
 2 less than one hundred and twenty percent beginning January 1, 1995, of the official poverty line for
 3 a family of the size involved.

4 5. For an individual eligible for MO HealthNet under Title XIX of the Social Security Act,
 5 MO HealthNet shall include payment of enrollee premiums in a group health plan and all
 6 deductibles, coinsurance and other cost-sharing for items and services otherwise covered under the
 7 state Title XIX plan under Section 1906 of the federal Social Security Act and regulations
 8 established under the authority of Section 1906, as may be amended. Enrollment in a group health
 9 plan must be cost effective, as established by the Secretary of Health and Human Services, before
 10 enrollment in the group health plan is required. If all members of a family are not eligible for MO
 11 HealthNet and enrollment of the Title XIX eligible members in a group health plan is not possible
 12 unless all family members are enrolled, all premiums for noneligible members shall be treated as
 13 payment for MO HealthNet of eligible family members. Payment for noneligible family members
 14 must be cost effective, taking into account payment of all such premiums. Non-Title XIX eligible
 15 family members shall pay all deductible, coinsurance and other cost-sharing obligations. Each
 16 individual as a condition of eligibility for MO HealthNet benefits shall apply for enrollment in the
 17 group health plan.

18 6. Any Social Security cost-of-living increase at the beginning of any year shall be
 19 disregarded until the federal poverty level for such year is implemented.

20 7. If a MO HealthNet participant has paid the requested spenddown in cash for any month
 21 and subsequently pays an out-of-pocket valid medical expense for such month, such expense shall
 22 be allowed as a deduction to future required spenddown for up to three months from the date of such
 23 expense.

24 208.164. 1. As used in this section, unless the context clearly requires otherwise, the
 25 following terms mean:

26 (1) "Abuse", a documented pattern of inducing, furnishing, or otherwise causing a recipient
 27 to receive services or merchandise not otherwise required or requested by the recipient, attending
 28 physician or appropriate utilization review team; a documented pattern of performing and billing
 29 tests, examinations, patient visits, surgeries, drugs or merchandise that exceed limits or frequencies
 30 determined by the department for like practitioners for which there is no demonstrable need, or for
 31 which the provider has created the need through ineffective services or merchandise previously
 32 rendered. The decision to impose any of the sanctions authorized in this section shall be made by
 33 the director of the department, following a determination of demonstrable need or accepted medical
 34 practice made in consultation with medical or other health care professionals, or qualified peer
 35 review teams;

36 (2) "Department", the department of social services;

37 (3) "Excessive use", the act, by a person eligible for services under a contract or provider
 38 agreement between the department of social services or its divisions and a provider, of seeking
 39 and/or obtaining medical assistance benefits from a number of like providers and in quantities which

1 exceed the levels that are considered medically necessary by current medical practices and standards
2 for the eligible person's needs;

3 (4) "Fraud", a known false representation, including the concealment of a material fact that
4 the provider knew or should have known through the usual conduct of his or her profession or
5 occupation, upon which the provider claims reimbursement under the terms and conditions of a
6 contract or provider agreement and the policies pertaining to such contract or provider agreement of
7 the department or its divisions in carrying out the providing of services, or under any approved state
8 plan authorized by the federal Social Security Act;

9 (5) "Health plan", a group of services provided to recipients of medical assistance benefits
10 by providers under a contract with the department;

11 (6) "Medical assistance benefits", those benefits authorized to be provided by sections
12 208.152 and 208.162;

13 (7) "Prior authorization", approval to a provider to perform a service or services for an
14 eligible person required by the department or its divisions in advance of the actual service being
15 provided or approved for a recipient to receive a service or services from a provider, required by the
16 department or its designated division in advance of the actual service or services being received;

17 (8) "Provider", any person, partnership, corporation, not-for-profit corporation, professional
18 corporation, or other business entity that enters into a contract or provider agreement with the
19 department or its divisions for the purpose of providing services to eligible persons, and obtaining
20 from the department or its divisions reimbursement therefor;

21 (9) "Recipient", a person who is eligible to receive medical assistance benefits allocated
22 through the department;

23 (10) "Service", the specific function, act, successive acts, benefits, continuing benefits,
24 requested by an eligible person or provided by the provider under contract with the department or its
25 divisions.

26 2. The department or its divisions shall have the authority to suspend, revoke, or cancel any
27 contract or provider agreement or refuse to enter into a new contract or provider agreement with any
28 provider where it is determined the provider has committed or allowed its agents, servants, or
29 employees to commit acts defined as abuse or fraud in this section.

30 3. The department or its divisions shall have the authority to impose prior authorization as
31 defined in this section:

32 (1) When it has reasonable cause to believe a provider or recipient has knowingly followed
33 a course of conduct which is defined as abuse or fraud or excessive use by this section; or

34 (2) When it determines by rule that prior authorization is reasonable for a specified service
35 or procedure.

36 4. If a provider or recipient reports to the department or its divisions the name or names of
37 providers or recipients who, based upon their personal knowledge has reasonable cause to believe an
38 act or acts are being committed which are defined as abuse, fraud or excessive use by this section,
39 such report shall be confidential and the reporter's name shall not be divulged to anyone by the

1 department or any of its divisions, except at a judicial proceeding upon a proper protective order
2 being entered by the court.

3 5. Payments for services under any contract or provider agreement between the department
4 or its divisions and a provider may be withheld by the department or its divisions from the provider
5 for acts or omissions defined as abuse or fraud by this section, until such time as an agreement
6 between the parties is reached or the dispute is adjudicated under the laws of this state.

7 6. The department or its designated division shall have the authority to review all cases and
8 claim records for any recipient of public assistance benefits and to determine from these records if
9 the recipient has, as defined in this section, committed excessive use of such services by seeking or
10 obtaining services from a number of like providers of services and in quantities which exceed the
11 levels considered necessary by current medical or health care professional practice standards and
12 policies of the program.

13 7. The department or its designated division shall have the authority with respect to
14 recipients of medical assistance benefits who have committed excessive use to limit or restrict the
15 use of the recipient's Medicaid identification card to designated providers and for designated
16 services; the actual method by which such restrictions are imposed shall be at the discretion of the
17 department of social services or its designated division.

18 8. The department or its designated division shall have the authority with respect to any
19 recipient of medical assistance benefits whose use has been restricted under subsection 7 of this
20 section and who obtains or seeks to obtain medical assistance benefits from a provider other than
21 one of the providers for designated services to terminate medical assistance benefits as defined by
22 this chapter, where allowed by the provisions of the federal Social Security Act.

23 9. The department or its designated division shall have the authority with respect to any
24 provider who knowingly allows a recipient to violate subsection 7 of this section or who fails to
25 report a known violation of subsection 7 of this section to the department of social services or its
26 designated division to terminate or otherwise sanction such provider's status as a participant in the
27 medical assistance program. Any person making such a report shall not be civilly liable when the
28 report is made in good faith.

29 10. In order to comply with the provisions of 42 U.S.C. Section 1320a-7(a) relating to
30 mandatory exclusion of certain individuals and entities from participation in any federal health care
31 program, and in furtherance of the state's authority under federal law, as implemented by 42 CFR
32 1002.3(b), to exclude an individual or entity from MO HealthNet for any reason or period
33 authorized by state law, the department or its divisions shall suspend, revoke, or cancel any contract
34 or provider agreement or refuse to enter into a new contract or provider agreement with any
35 provider where it is determined that such provider is not qualified to perform the service or services
36 required, as described in 42 U.S.C. Section 1396a(a)(23), because such provider, or such provider's
37 agent, servant, or employee acting under such provider's authority:

38 (1) Has a conviction related to the delivery of any item or service under Medicare or under
39 any state health care program, as described in 42 U.S.C. Section 1320a-7(a)(1);

1 (2) Has a conviction related to the neglect or abuse of a patient in connection with the
 2 delivery of any health care item or service, as described in 42 U.S.C. Section 1320a-7(a)(2);

3 (3) Has a felony conviction related to health care fraud, theft, embezzlement, breach of
 4 fiduciary responsibility, or other financial misconduct, as described in 42 U.S.C. Section 1320a-
 5 7(a)(3);

6 (4) Has a felony conviction related to the unlawful manufacture, distribution, prescription,
 7 or dispensation of a controlled substance, as described in 42 U.S.C. Section 1320a-7(a)(4);

8 (5) Has been found guilty of a pattern of intentional discrimination in the delivery or
 9 nondelivery of any health care item or service based on the race, color, or national origin of
 10 recipients, as described in 42 U.S.C. Section 175 2000d; or is an organization whose original
 11 "principles and aims" were to limit the "reckless procreation" of "[t]hose least fit to carry on the
 12 race", "[t]o create a race of well born children", and for the "sterilization of the insane and
 13 feebleminded", and whose founder and first president supported eugenics as the solution for racial,
 14 political, and social problems and advocated for the use of birth control for "the elimination of the
 15 unfit" and stopping "the reproduction of the unfit"; or

16 (6) Is an abortion facility, as defined in section 188.015, or an affiliate or associate of such
 17 abortion facility.

18 208.659. The MO HealthNet division shall revise the eligibility requirements for the
 19 uninsured women's health program, as established in 13 CSR Section 70- 4.090, to include women
 20 who are at least eighteen years of age and with a net family income of at or below one hundred
 21 eighty-five percent of the federal poverty level. In order to be eligible for such program, the
 22 applicant shall not have assets in excess of two hundred and fifty thousand dollars, nor shall the
 23 applicant have access to employer-sponsored health insurance. Such change in eligibility
 24 requirements shall not result in any change in services provided under the program. No funds shall
 25 be expended to any abortion facility, as defined in section 188.015, or to any affiliate or associate of
 26 such abortion facility."; and

27
 28 Further amend said bill by amending the title, enacting clause, and intersectional references
 29 accordingly.