

FIRST REGULAR SESSION

HOUSE BILL NO. 447

94TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES SCHAAF (Sponsor), DENISON, DOUGHERTY, ONDER,
KINGERY AND PAGE (Co-sponsors).

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D. ADAM CRUMBLISS, Chief Clerk

1085L.01I

AN ACT

To repeal section 208.152, RSMo, and to enact in lieu thereof one new section relating to
Medicaid services.

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Section A. Section 208.152, RSMo, is repealed and one new section enacted in lieu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

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

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

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.

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

21 (3) Laboratory and X-ray services;

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

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

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

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

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

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

54 (10) Home health care services;

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

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

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

68 (14) Personal care services which are medically oriented tasks having to do with a
69 person's physical requirements, as opposed to housekeeping requirements, which enable a person
70 to be treated by his physician on an outpatient, rather than on an inpatient or residential basis in
71 a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be
72 rendered by an individual not a member of the recipient's family who is qualified to provide such
73 services where the services are prescribed by a physician in accordance with a plan of treatment
74 and are supervised by a licensed nurse. Persons eligible to receive personal care services shall
75 be those persons who would otherwise require placement in a hospital, intermediate care facility,
76 or skilled nursing facility. Benefits payable for personal care services shall not exceed for any
77 one recipient one hundred percent of the average statewide charge for care and treatment in an
78 intermediate care facility for a comparable period of time;

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

85 630.097, RSMo. The department of mental health shall establish by administrative rule the
86 definition and criteria for designation as a community mental health facility and for designation
87 as an alcohol and drug abuse facility. Such mental health services shall include:

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

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

98 (c) Rehabilitative mental health and alcohol and drug abuse services including home and
99 community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions
100 rendered to individuals in an individual or group setting by a mental health or alcohol and drug
101 abuse professional in accordance with a plan of treatment appropriately established,
102 implemented, monitored, and revised under the auspices of a therapeutic team as a part of client
103 services management. As used in this section, "mental health professional" and "alcohol and
104 drug abuse professional" shall be defined by the department of mental health pursuant to duly
105 promulgated rules.

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107 With respect to services established by this subdivision, the department of social services,
108 division of medical services, shall enter into an agreement with the department of mental health.
109 Matching funds for outpatient mental health services, clinic mental health services, and
110 rehabilitation services for mental health and alcohol and drug abuse shall be certified by the
111 department of mental health to the division of medical services. The agreement shall establish
112 a mechanism for the joint implementation of the provisions of this subdivision. In addition, the
113 agreement shall establish a mechanism by which rates for services may be jointly developed;

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

118 (17) Beginning July 1, 1990, the services of a certified pediatric or family nursing
119 practitioner to the extent that such services are provided in accordance with chapter 335, RSMo,

120 and regulations promulgated thereunder, regardless of whether the nurse practitioner is
121 supervised by or in association with a physician or other health care provider;

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

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

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

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

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

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

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

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

150 (1) Dental services;

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

152 (3) Optometric services as defined in section 336.010, RSMo;

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

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

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

3. Benefit payments for medical assistance for surgery as defined by rule duly promulgated by the division of medical services, and any costs related directly thereto, shall be made only when a second medical opinion by a licensed physician as to the need for the surgery is obtained prior to the surgery being performed.

4. The division of medical services may require any recipient of medical assistance to pay part of the charge or cost, as defined by rule duly promulgated by the division of medical services, for all covered services except for those services covered under subdivisions (14) and (15) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the

manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, RSMo, and a generic drug is substituted for a name brand drug, the division of medical services may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all recipients the partial payment that may be required by the division of medical services under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by recipients under this section shall be reduced from any payments made by the state for goods or services described herein except the recipient portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a recipient is unable to pay a required cost sharing. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give recipients advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a recipient. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the Missouri Medicaid state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

5. The division of medical services shall have the right to collect medication samples from recipients in order to maintain program integrity.

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

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

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

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

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

241 11. The department of social services, division of medical services, may enroll qualified
242 residential care facilities, as defined in chapter 198, RSMo, as Medicaid personal care providers.

243 **12. The benefit payments required by this section shall be in an amount sufficient**
244 **to cover the reasonable costs incurred by each provider of the care or services provided.**

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