FIRST REGULAR SESSION

HOUSE BILL NO. 1114

94TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES BAKER (25) (Sponsor), BROWN (50), NASHEED, DARROUGH, LAMPE, KUESSNER, AULL, PAGE, WILDBERGER, SCHAAF, SKAGGS, LOW (39), McCLANAHAN AND HOLSMAN (Co-sponsors).

Read 1st time March 13, 2007 and copies ordered printed.

D. ADAM CRUMBLISS, Chief Clerk

2463L.02I

AN ACT

To repeal sections 167.606, 208.152, and 217.230, RSMo, and to enact in lieu thereof four new sections relating to telehealth.

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

Section A. Sections 167.606, 208.152, and 217.230, RSMo, are repeated and four new sections enacted in lieu thereof, to be known as sections 167.606, 191.425, 208.152, and 217.230, to read as follows:

167.606. 1. The departments of social services and elementary and secondary education shall develop a plan to encourage public schools and school districts to be Medicaid providers and to provide the most accessible care to school age children. A public school district, or a public school within any district, may elect to function as and be compensated for acting as a provider of Medicaid services. Pursuant to state and federal laws and regulations, a public school or school district shall, upon such election, provide such Medicaid services to all Medicaid-eligible school age children located in the service area of the school or district electing to be a Medicaid provider. The public school or school district may elect to provide services under subdivision (1) or (2) of this subsection or to provide services under both subdivisions (1) and (2). Based upon its election, the public school or school district shall provide the following Medicaid services:

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.

(1) Early periodic screening, diagnosis, and treatment (EPSDT) services of the Medicaid program as provided in subdivision (11) of subsection 1 of section 208.152, RSMo, subject to the provisions of section 167.611;

(2) Primary and preventive health care services to school age children who are eligible for Medicaid services under section 208.151, RSMo, subject to the provisions of section 167.611.

2. The department of social services and the public school or school district shall, by written agreement, determine the scope of EPSDT or primary and preventive health services to be provided by the public school or school district. The scope of services offered shall be designed to encourage the public school or school district to participate as a Medicaid provider.

3. EPSDT services in subdivision (1) of subsection 1 of this section may be provided by school district personnel.

4. Primary health care services may be provided by:

(1) Federally qualified health centers;

(2) City, county or city and county health departments;

(3) Federally certified rural health clinics; or

(4) Physicians, hospitals, or other licensed providers in the community in which the school is located.

Such services shall be by contract with a participating school district. A school district shall include provisions for the maintenance of medical records and other administrative tasks as are required by the department of social services in contracts executed under the provisions of this subsection.

5. If a school district is unable to contract for primary health care services pursuant to subdivisions (1) to (4) of subsection 4 of this section, then it may employ the appropriate employees and medical professionals as required by the Medicaid program to provide Medicaid services. Screening, diagnosis, and treatments performed by school district employees pursuant to the provisions of this act shall be performed under standing orders and protocols of a physician whose service area encompasses all of or part of the city or county in which the school is located.

6. School districts electing to be providers in the state Medicaid program under this section are strongly encouraged to use telehealth, where appropriate, in accordance with section 191.425, RSMo.

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

(1) "Health care provider", a person licensed in this state to provide health care to patients, including physicians, chiropractic physicians, optometrists, dentists, podiatrists, osteopathic physicians, physician assistants, certified nurse practitioners, physical

therapists, occupational therapists, psychologists, registered nurses, licensed practical nurses, dental hygienists, and pharmacists;

(2) "Original site", a place where a patient may receive health care via telehealth. An originating site may include:

(a) An ambulatory surgical center;

(b) A long-term care facility;

(c) A home health agency;

(d) A school-based program;

(e) A mental health clinic;

(f) The patient's residence;

(3) "Telehealth", the use of electronic information, imaging, and communication technologies, including interactive audio, video, data communications, and store-and-forward technologies, to provide and support health care delivery, diagnosis, consultation, treatment, transfer of medical data and education when distance separates the patient and the health care provider.

2. The delivery of health care via telehealth is recognized and encouraged as a safe, practical, and necessary practice in Missouri. No health care provider or operator of an originating site shall be disciplined for or discouraged from participating in telehealth under this section. In using telehealth procedures, health care providers and operators of originating sites shall comply with all applicable federal and state guidelines and shall follow established federal and state rules regarding security, confidentiality, and privacy protections for health care information.

3. (1) This section does not alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting or in a manner not otherwise authorized by law.

(2) Notwithstanding the strong encouragement to use telehealth, nothing in this section shall require a health carrier, health maintenance organization, managed care organization, or other provider service organization to include telehealth within the scope of the plan or policy offered by such entity.

(3) The state medical assistance program, schools providing Medicaid services in accordance with section 167.606, RSMo, and prisons providing health care services under section 217.230, RSMo, are strongly encouraged to use telehealth where appropriate.

4. The departments of health and senior services, mental health, and social services shall promulgate rules regarding the utilization of telehealth. 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 section 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, 2007, shall be invalid and void.

208.152. 1. Benefit payments for medical assistance 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 division of medical services, 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 division of medical services shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the Medicaid children's diagnosis length-of-stay schedule; and provided further that the division of medical services 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 division of medical services may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the division of medical services not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for recipients, except to persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. 301, et seq.), as amended, for nursing facilities. The division of medical services may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of Medicaid patients. The division of medical services when determining the amount of the

benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

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

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

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

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

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

(10) Home health care services;

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

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

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

permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

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

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

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

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

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established,

implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, "mental health professional" and "alcohol and drug abuse professional" shall be defined by the department of mental health pursuant to duly promulgated rules.

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

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

(17) Beginning July 1, 1990, the services of a certified pediatric or family nursing practitioner to the extent that such services are provided in accordance with chapter 335, RSMo, and regulations promulgated thereunder, regardless of whether the nurse practitioner is supervised by or in association with a physician or other health care provider;

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

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

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

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

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

(c) For each day that nursing home costs are paid on behalf of a recipient pursuant to this subdivision during any period of six consecutive months such recipient shall, during the same period of six consecutive months, be ineligible for payment of nursing home costs of two

otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

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

2. Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons 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 division of medical services, unless otherwise hereinafter provided, for the following:

(1) Dental services;

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

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

(4) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, 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.

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

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

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

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

12. The department is strongly encouraged to use telehealth where appropriate and reimburse for the provision of such services under the state medical assistance programs in accordance with section 191.425, RSMo. The department shall promulgate rules

regarding the utilization of telehealth. 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 section 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, 2007, shall be invalid and void.

217.230. The director shall arrange for necessary health care services for offenders confined in correctional centers. **The director is strongly encouraged to use telehealth where appropriate in the provisions of such health care services in accordance with section 191.425, RSMo.**

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