

SECOND REGULAR SESSION

HOUSE BILL NO. 1885

95TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES GRISAMORE (Sponsor), McGHEE, STREAM, PACE, LAMPE,
SCHIEFFER AND STORCH (Co-sponsors).

3811L.01I

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal section 208.152, RSMo, and to enact in lieu thereof one new section relating to comprehensive day rehabilitation services under the MO HealthNet program.

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

Section A. Section 208.152, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 208.152, to read as follows:

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

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

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public

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.

17 Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et seq.), but the
18 MO HealthNet division may evaluate outpatient hospital services rendered under this section and
19 deny payment for services which are determined by the MO HealthNet division not to be
20 medically necessary, in accordance with federal law and regulations;

21 (3) Laboratory and X-ray services;

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

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

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

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

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

50 (9) Early and periodic screening and diagnosis of individuals who are under the age of
51 twenty-one to ascertain their physical or mental defects, and health care, treatment, and other
52 measures to correct or ameliorate defects and chronic conditions discovered thereby. Such

53 services shall be provided in accordance with the provisions of Section 6403 of P.L. 101-239 and
54 federal regulations promulgated thereunder;

55 (10) Home health care services;

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

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

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

69 (14) Personal care services which are medically oriented tasks having to do with a
70 person's physical requirements, as opposed to housekeeping requirements, which enable a person
71 to be treated by his physician on an outpatient rather than on an inpatient or residential basis in
72 a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be
73 rendered by an individual not a member of the participant's family who is qualified to provide
74 such services where the services are prescribed by a physician in accordance with a plan of
75 treatment and are supervised by a licensed nurse. Persons eligible to receive personal care
76 services shall be those persons who would otherwise require placement in a hospital,
77 intermediate care facility, or skilled nursing facility. Benefits payable for personal care services
78 shall not exceed for any one participant one hundred percent of the average statewide charge for
79 care and treatment in an intermediate care facility for a comparable period of time. Such
80 services, when delivered in a residential care facility or assisted living facility licensed under
81 chapter 198, RSMo, shall be authorized on a tier level based on the services the resident requires
82 and the frequency of the services. A resident of such facility who qualifies for assistance under
83 section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with
84 the fewest services. The rate paid to providers for each tier of service shall be set subject to
85 appropriations. Subject to appropriations, each resident of such facility who qualifies for
86 assistance under section 208.030 and meets the level of care required in this section shall, at a
87 minimum, if prescribed by a physician, be authorized up to one hour of personal care services
88 per day. Authorized units of personal care services shall not be reduced or tier level lowered

89 unless an order approving such reduction or lowering is obtained from the resident's personal
90 physician. Such authorized units of personal care services or tier level shall be transferred with
91 such resident if [her] **he** or she transfers to another such facility. Such provision shall terminate
92 upon receipt of relevant waivers from the federal Department of Health and Human Services.
93 If the Centers for Medicare and Medicaid Services determines that such provision does not
94 comply with the state plan, this provision shall be null and void. The MO HealthNet division
95 shall notify the revisor of statutes as to whether the relevant waivers are approved or a
96 determination of noncompliance is made;

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

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

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

116 (c) Rehabilitative mental health and alcohol and drug abuse services including home and
117 community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions
118 rendered to individuals in an individual or group setting by a mental health or alcohol and drug
119 abuse professional in accordance with a plan of treatment appropriately established,
120 implemented, monitored, and revised under the auspices of a therapeutic team as a part of client
121 services management. As used in this section, mental health professional and alcohol and drug
122 abuse professional shall be defined by the department of mental health pursuant to duly
123 promulgated rules.

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

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

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

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

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

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

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

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

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

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

159 provide notice to the participant or the participant's responsible party prior to release of the
160 reserved bed;

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

164 (20) **Comprehensive day rehabilitation services beginning early posttrauma as part**
165 **of a coordinated system of care for individuals with disabling impairments. Rehabilitation**
166 **services must be based on an individualized, goal-oriented, comprehensive, and**
167 **coordinated treatment plan developed, implemented, and monitored through an**
168 **interdisciplinary assessment designed to restore an individual to optimal level of physical,**
169 **cognitive, and behavioral function. The MO HealthNet division shall establish by**
170 **administrative rule the definition and criteria for designation of a comprehensive day**
171 **rehabilitation service facility, benefit limitations, and payment mechanism utilizing the**
172 **expertise of brain injury rehabilitation service providers and the Missouri head injury**
173 **advisory council created under section 192.745. Such services shall be provided in a**
174 **community-based facility and be authorized on tier levels based on the services the patient**
175 **requires and the frequency of the services as guided by a qualified rehabilitation**
176 **professional associated with a health care home. Any rule or portion of a rule, as that term**
177 **is defined in section 536.010, that is created under the authority delegated in this**
178 **subdivision shall become effective only if it complies with and is subject to all of the**
179 **provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536**
180 **are nonseverable and if any of the powers vested with the general assembly pursuant to**
181 **chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are**
182 **subsequently held unconstitutional, then the grant of rulemaking authority and any rule**
183 **proposed or adopted after August 28, 2010, shall be invalid and void;**

184 (21) Hospice care. As used in this subsection, the term "hospice care" means a
185 coordinated program of active professional medical attention within a home, outpatient and
186 inpatient care which treats the terminally ill patient and family as a unit, employing a medically
187 directed interdisciplinary team. The program provides relief of severe pain or other physical
188 symptoms and supportive care to meet the special needs arising out of physical, psychological,
189 spiritual, social, and economic stresses which are experienced during the final stages of illness,
190 and during dying and bereavement and meets the Medicare requirements for participation as a
191 hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO
192 HealthNet division to the hospice provider for room and board furnished by a nursing home to
193 an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement
194 which would have been paid for facility services in that nursing home facility for that patient,

195 in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget
196 Reconciliation Act of 1989);

197 [(21)] **(22)** Prescribed medically necessary dental services. Such services shall be
198 subject to appropriations. An electronic web-based prior authorization system using best medical
199 evidence and care and treatment guidelines consistent with national standards shall be used to
200 verify medical need;

201 [(22)] **(23)** Prescribed medically necessary optometric services. Such services shall be
202 subject to appropriations. An electronic web-based prior authorization system using best medical
203 evidence and care and treatment guidelines consistent with national standards shall be used to
204 verify medical need;

205 [(23)] **(24)** The MO HealthNet division shall, by January 1, 2008, and annually
206 thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one
207 hundred percent of the Medicare reimbursement rates and compared to the average dental
208 reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division
209 shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with
210 Medicare reimbursement rates and for third-party payor average dental reimbursement rates.
211 Such plan shall be subject to appropriation and the division shall include in its annual budget
212 request to the governor the necessary funding needed to complete the four-year plan developed
213 under this subdivision.

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

219 (1) Dental services;

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

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

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

224 (5) Hospice care. As used in this subsection, the term "hospice care" means a
225 coordinated program of active professional medical attention within a home, outpatient and
226 inpatient care which treats the terminally ill patient and family as a unit, employing a medically
227 directed interdisciplinary team. The program provides relief of severe pain or other physical
228 symptoms and supportive care to meet the special needs arising out of physical, psychological,
229 spiritual, social, and economic stresses which are experienced during the final stages of illness,
230 and during dying and bereavement and meets the Medicare requirements for participation as a

231 hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO
232 HealthNet division to the hospice provider for room and board furnished by a nursing home to
233 an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement
234 which would have been paid for facility services in that nursing home facility for that patient,
235 in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget
236 Reconciliation Act of 1989);

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

252 3. The MO HealthNet division may require any participant receiving MO HealthNet
253 benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July
254 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered
255 services except for those services covered under subdivisions (14) and (15) of subsection 1 of
256 this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title
257 XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder.
258 When substitution of a generic drug is permitted by the prescriber according to section 338.056,
259 RSMo, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may
260 not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX
261 of the federal Social Security Act. A provider of goods or services described under this section
262 must collect from all participants the additional payment that may be required by the MO
263 HealthNet division under authority granted herein, if the division exercises that authority, to
264 remain eligible as a provider. Any payments made by participants under this section shall be in
265 addition to and not in lieu of payments made by the state for goods or services described herein
266 except the participant 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 participant is unable to pay a required payment. 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 participants 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 participant. 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 MO HealthNet 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.

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

5. 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 MO HealthNet benefits 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.

6. 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.

7. 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 MO HealthNet benefits 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.

8. 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.

302 9. Reimbursement rates to long-term care providers with respect to a total change in
303 ownership, at arm's length, for any facility previously licensed and certified for participation in
304 the MO HealthNet program shall not increase payments in excess of the increase that would
305 result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C.
306 1396a (a)(13)(C).

307 10. The MO HealthNet division, may enroll qualified residential care facilities and
308 assisted living facilities, as defined in chapter 198, RSMo, as MO HealthNet personal care
309 providers.

310 11. Any income earned by individuals eligible for certified extended employment at a
311 sheltered workshop under chapter 178, RSMo, shall not be considered as income for purposes
312 of determining eligibility under this section.

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