

SECOND REGULAR SESSION

HOUSE BILL NO. 2626

102ND GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE PARKER.

5464H.011

DANA RADEMAN MILLER, Chief Clerk

AN ACT

To repeal section 208.152, RSMo, and to enact in lieu thereof one new section relating to MO HealthNet coverage of hearing-related devices.

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Section A. Section 208.152, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 208.152, to read as follows: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 described 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 Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section

EXPLANATION — Matter enclosed in bold-faced brackets **[thus]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

18 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services
19 rendered under this section and deny payment for services which are determined by the MO
20 HealthNet division not to be medically necessary, in accordance with federal law and
21 regulations;

22 (3) Laboratory and X-ray services;

23 (4) Nursing home services for participants, except to persons with more than five
24 hundred thousand dollars equity in their home or except for persons in an institution for
25 mental diseases who are under the age of sixty-five years, when residing in a hospital licensed
26 by the department of health and senior services or a nursing home licensed by the department
27 of health and senior services or appropriate licensing authority of other states or government-
28 owned and -operated institutions which are determined to conform to standards equivalent to
29 licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. Section
30 ~~301,~~ **1396** et seq.), as amended, for nursing facilities. The MO HealthNet division may
31 recognize through its payment methodology for nursing facilities those nursing facilities
32 which serve a high volume of MO HealthNet patients. The MO HealthNet division when
33 determining the amount of the benefit payments to be made on behalf of persons under the
34 age of twenty-one in a nursing facility may consider nursing facilities furnishing care to
35 persons under the age of twenty-one as a classification separate from other nursing facilities;

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

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

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

51 (8) Drugs and medicines when prescribed by a licensed physician, dentist, podiatrist,
52 or an advanced practice registered nurse; except that no payment for drugs and medicines
53 prescribed on and after January 1, 2006, by a licensed physician, dentist, podiatrist, or an

54 advanced practice registered nurse may be made on behalf of any person who qualifies for
55 prescription drug coverage under the provisions of P.L. 108-173;

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

58 (10) Early and periodic screening and diagnosis of individuals who are under the age
59 of twenty-one to ascertain their physical or mental defects, and health care, treatment, and
60 other measures to correct or ameliorate defects and chronic conditions discovered thereby.
61 Such services shall be provided in accordance with the provisions of Section 6403 of P.L.
62 101-239 and federal regulations promulgated thereunder;

63 (11) Home health care services;

64 (12) Family planning as defined by federal rules and regulations; provided, however,
65 that such family planning services shall not include abortions or any abortifacient drug or
66 device that is used for the purpose of inducing an abortion unless such abortions are certified
67 in writing by a physician to the MO HealthNet agency that, in the physician's professional
68 judgment, the life of the mother would be endangered if the fetus were carried to term;

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

71 (14) Outpatient surgical procedures, including presurgical diagnostic services
72 performed in ambulatory surgical facilities which are licensed by the department of health
73 and senior services of the state of Missouri; except, that such outpatient surgical services shall
74 not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-
75 97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such
76 persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal
77 Social Security Act, as amended;

78 (15) Personal care services which are medically oriented tasks having to do with a
79 person's physical requirements, as opposed to housekeeping requirements, which enable a
80 person to be treated by his or her physician on an outpatient rather than on an inpatient or
81 residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal
82 care services shall be rendered by an individual not a member of the participant's family who
83 is qualified to provide such services where the services are prescribed by a physician in
84 accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible
85 to receive personal care services shall be those persons who would otherwise require
86 placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable
87 for personal care services shall not exceed for any one participant one hundred percent of the
88 average statewide charge for care and treatment in an intermediate care facility for a
89 comparable period of time. Such services, when delivered in a residential care facility or
90 assisted living facility licensed under chapter 198 shall be authorized on a tier level based on

91 the services the resident requires and the frequency of the services. A resident of such facility
92 who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a
93 physician, qualify for the tier level with the fewest services. The rate paid to providers for
94 each tier of service shall be set subject to appropriations. Subject to appropriations, each
95 resident of such facility who qualifies for assistance under section 208.030 and meets the
96 level of care required in this section shall, at a minimum, if prescribed by a physician, be
97 authorized up to one hour of personal care services per day. Authorized units of personal care
98 services shall not be reduced or tier level lowered unless an order approving such reduction or
99 lowering is obtained from the resident's personal physician. Such authorized units of personal
100 care services or tier level shall be transferred with such resident if he or she transfers to
101 another such facility. Such provision shall terminate upon receipt of relevant waivers from
102 the federal Department of Health and Human Services. If the Centers for Medicare and
103 Medicaid Services determines that such provision does not comply with the state plan, this
104 provision shall be null and void. The MO HealthNet division shall notify the revisor of
105 statutes as to whether the relevant waivers are approved or a determination of noncompliance
106 is made;

107 (16) Mental health services. The state plan for providing medical assistance under
108 Title XIX of the Social Security Act, 42 U.S.C. Section ~~[304]~~ **1396 et seq.**, as amended, shall
109 include the following mental health services when such services are provided by community
110 mental health facilities operated by the department of mental health or designated by the
111 department of mental health as a community mental health facility or as an alcohol and drug
112 abuse facility or as a child-serving agency within the comprehensive children's mental health
113 service system established in section 630.097. The department of mental health shall
114 establish by administrative rule the definition and criteria for designation as a community
115 mental health facility and for designation as an alcohol and drug abuse facility. Such mental
116 health services shall include:

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

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

127 (c) Rehabilitative mental health and alcohol and drug abuse services including home
128 and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative
129 interventions rendered to individuals in an individual or group setting by a mental health
130 or alcohol and drug abuse professional in accordance with a plan of treatment appropriately
131 established, implemented, monitored, and revised under the auspices of a therapeutic team as
132 a part of client services management. As used in this section, mental health professional and
133 alcohol and drug abuse professional shall be defined by the department of mental health
134 pursuant to duly promulgated rules. With respect to services established by this subdivision,
135 the department of social services, MO HealthNet division, shall enter into an agreement with
136 the department of mental health. Matching funds for outpatient mental health services, clinic
137 mental health services, and rehabilitation services for mental health and alcohol and drug
138 abuse shall be certified by the department of mental health to the MO HealthNet division.
139 The agreement shall establish a mechanism for the joint implementation of the provisions of
140 this subdivision. In addition, the agreement shall establish a mechanism by which rates for
141 services may be jointly developed;

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

146 (18) The services of an advanced practice registered nurse with a collaborative
147 practice agreement to the extent that such services are provided in accordance with chapters
148 334 and 335, and regulations promulgated thereunder;

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

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

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

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

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

162 (c) For each day that nursing home costs are paid on behalf of a participant under this
163 subdivision during any period of six consecutive months such participant shall, during the

164 same period of six consecutive months, be ineligible for payment of nursing home costs of
165 two otherwise available temporary leave of absence days provided under subdivision (5) of
166 this subsection; and

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

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

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

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

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

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

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

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

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

207 (25) **Medically necessary cochlear implants and hearing instruments, as defined**
208 **in section 345.015;**

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

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

223 (1) Dental services;

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

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

226 (4) Orthopedic devices or other prosthetics, including eye glasses, dentures, [~~hearing~~
227 ~~aids;~~] and wheelchairs;

228 (5) Hospice care. As used in this subdivision, the term "hospice care" means a
229 coordinated program of active professional medical attention within a home, outpatient and
230 inpatient care which treats the terminally ill patient and family as a unit, employing a
231 medically directed interdisciplinary team. The program provides relief of severe pain or other
232 physical symptoms and supportive care to meet the special needs arising out of physical,
233 psychological, spiritual, social, and economic stresses which are experienced during the final
234 stages of illness, and during dying and bereavement and meets the Medicare requirements for
235 participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement
236 paid by the MO HealthNet division to the hospice provider for room and board furnished by a

237 nursing home to an eligible hospice patient shall not be less than ninety-five percent of the
238 rate of reimbursement which would have been paid for facility services in that nursing home
239 facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239
240 (Omnibus Budget Reconciliation Act of 1989);

241 (6) Comprehensive day rehabilitation services beginning early posttrauma as part of a
242 coordinated system of care for individuals with disabling impairments. Rehabilitation
243 services must be based on an individualized, goal-oriented, comprehensive and coordinated
244 treatment plan developed, implemented, and monitored through an interdisciplinary
245 assessment designed to restore an individual to optimal level of physical, cognitive, and
246 behavioral function. The MO HealthNet division shall establish by administrative rule the
247 definition and criteria for designation of a comprehensive day rehabilitation service facility,
248 benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is
249 defined in section 536.010, that is created under the authority delegated in this subdivision
250 shall become effective only if it complies with and is subject to all of the provisions of
251 chapter 536 and, if applicable, section 536.028. This section and chapter 536 are
252 nonseverable and if any of the powers vested with the general assembly pursuant to chapter
253 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently
254 held unconstitutional, then the grant of rulemaking authority and any rule proposed or
255 adopted after August 28, 2005, shall be invalid and void.

256 3. The MO HealthNet division may require any participant receiving MO HealthNet
257 benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after
258 July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all
259 covered services except for those services covered under subdivisions (15) and (16) of
260 subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner
261 authorized by Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.)
262 and regulations thereunder. When substitution of a generic drug is permitted by the prescriber
263 according to section 338.056, and a generic drug is substituted for a name-brand drug, the
264 MO HealthNet division may not lower or delete the requirement to make a co-payment
265 pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods
266 or services described under this section must collect from all participants the additional
267 payment that may be required by the MO HealthNet division under authority granted herein,
268 if the division exercises that authority, to remain eligible as a provider. Any payments made
269 by participants under this section shall be in addition to and not in lieu of payments made by
270 the state for goods or services described herein except the participant portion of the pharmacy
271 professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists.
272 A provider may collect the co-payment at the time a service is provided or at a later date. A
273 provider shall not refuse to provide a service if a participant is unable to pay a required

274 payment. If it is the routine business practice of a provider to terminate future services to an
275 individual with an unclaimed debt, the provider may include uncollected co-payments under
276 this practice. Providers who elect not to undertake the provision of services based on a
277 history of bad debt shall give participants advance notice and a reasonable opportunity for
278 payment. A provider, representative, employee, independent contractor, or agent of a
279 pharmaceutical manufacturer shall not make co-payment for a participant. This subsection
280 shall not apply to other qualified children, pregnant women, or blind persons. If the Centers
281 for Medicare and Medicaid Services does not approve the MO HealthNet state plan
282 amendment submitted by the department of social services that would allow a provider to
283 deny future services to an individual with uncollected co-payments, the denial of services
284 shall not be allowed. The department of social services shall inform providers regarding the
285 acceptability of denying services as the result of unpaid co-payments.

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

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

294 6. Beginning July 1, 1990, reimbursement for services rendered in federally funded
295 health centers shall be in accordance with the provisions of subsection 6402(c) and Section
296 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations
297 promulgated thereunder.

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

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

307 9. Reimbursement rates to long-term care providers with respect to a total change in
308 ownership, at arm's length, for any facility previously licensed and certified for participation
309 in the MO HealthNet program shall not increase payments in excess of the increase that

310 would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42
311 U.S.C. Section 1396a (a)(13)(C).

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

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

317 12. If the Missouri Medicaid audit and compliance unit changes any interpretation or
318 application of the requirements for reimbursement for MO HealthNet services from the
319 interpretation or application that has been applied previously by the state in any audit of a MO
320 HealthNet provider, the Missouri Medicaid audit and compliance unit shall notify all affected
321 MO HealthNet providers five business days before such change shall take effect. Failure of
322 the Missouri Medicaid audit and compliance unit to notify a provider of such change shall
323 entitle the provider to continue to receive and retain reimbursement until such notification is
324 provided and shall waive any liability of such provider for recoupment or other loss of any
325 payments previously made prior to the five business days after such notice has been sent.
326 Each provider shall provide the Missouri Medicaid audit and compliance unit a valid email
327 address and shall agree to receive communications electronically. The notification required
328 under this section shall be delivered in writing by the United States Postal Service or
329 electronic mail to each provider.

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

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

338 15. There shall be no payments made under this section for gender transition
339 surgeries, cross-sex hormones, or puberty-blocking drugs, as such terms are defined in section
340 191.1720, for the purpose of a gender transition.

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