

SECOND REGULAR SESSION

HOUSE BILL NO. 2702

102ND GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE STINNETT.

5491H.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 anti-obesity medications.

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Section A. Section 208.152, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 208.152, to read as follows: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 **or her** plan of care. As used in
41 this subdivision, the term "temporary leave of absence" shall include all periods of time
42 during which a participant is away from the hospital or nursing home overnight because he **or**
43 **she** is visiting 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, **including medically necessary anti-obesity**
53 **medications for all participants, regardless of age**; except that no payment for drugs and
54 medicines prescribed on and after January 1, 2006, by a licensed physician, dentist, podiatrist,

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

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

59 (10) Early and periodic screening and diagnosis of individuals who are under the age
60 of twenty-one to ascertain their physical or mental defects, and health care, treatment, and
61 other measures to correct or ameliorate defects and chronic conditions discovered thereby.
62 Such services shall be provided in accordance with the provisions of Section 6403 of P.L.
63 101-239 and federal regulations promulgated thereunder;

64 (11) Home health care services;

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

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

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

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

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

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

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

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

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

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

147 (18) The services of an advanced practice registered nurse with a collaborative
148 practice agreement to the extent that such services are provided in accordance with chapters
149 334 and 335, and regulations promulgated thereunder;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

222 (1) Dental services;

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

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

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

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

238 facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239
239 (Omnibus Budget Reconciliation Act of 1989);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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