

SECOND REGULAR SESSION
HOUSE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 2634
102ND GENERAL ASSEMBLY

5500H.02C

DANA RADEMAN MILLER, Chief Clerk

AN ACT

To repeal sections 188.015, 188.220, 208.152, 208.153, 208.164, and 208.659, RSMo, and to enact in lieu thereof seven new sections relating to health care, with an emergency clause.

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

Section A. Sections 188.015, 188.220, 208.152, 208.153, 208.164, and 208.659, RSMo, are repealed and seven new sections enacted in lieu thereof, to be known as sections 188.015, 188.207, 188.220, 208.152, 208.153, 208.164, and 208.659, to read as follows:

188.015. As used in this chapter, the following terms mean:

(1) "Abortion":

(a) The act of using or prescribing any instrument, device, medicine, drug, or any other means or substance with the intent to destroy the life of an embryo or fetus in his or her mother's womb; or

(b) The intentional termination of the pregnancy of a mother by using or prescribing any instrument, device, medicine, drug, or other means or substance with an intention other than to increase the probability of a live birth or to remove a dead unborn child;

(2) "Abortion facility", a clinic, physician's office, or any other place or facility in which abortions are performed or induced other than a hospital;

(3) "Affiliate", **a person or entity who enters into, with an abortion facility, a legal relationship created or governed by at least one written instrument, including a certificate of formation, a franchise agreement, standards of affiliation, bylaws, or a license, that demonstrates:**

(a) Common ownership, management, or control between the parties to the relationship;

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 **(b) A franchise granted by the person or entity to the affiliate; or**
 18 **(c) The granting or extension of a license or other agreement authorizing the**
 19 **affiliate to use the other person's or entity's brand name, trademark, service mark, or**
 20 **other registered identification mark;**
- 21 **(4) "Conception", the fertilization of the ovum of a female by a sperm of a male;**
 22 ~~[(4)]~~ **(5) "Department", the department of health and senior services;**
 23 ~~[(5)]~~ **(6) "Down Syndrome", the same meaning as defined in section 191.923;**
 24 ~~[(6)]~~ **(7) "Gestational age", length of pregnancy as measured from the first day of the**
 25 **woman's last menstrual period;**
- 26 ~~[(7)]~~ **(8) "Medical emergency", a condition which, based on reasonable medical**
 27 **judgment, so complicates the medical condition of a pregnant woman as to necessitate the**
 28 **immediate abortion of her pregnancy to avert the death of the pregnant woman or for which a**
 29 **delay will create a serious risk of substantial and irreversible physical impairment of a major**
 30 **bodily function of the pregnant woman;**
- 31 ~~[(8)]~~ **(9) "Physician", any person licensed to practice medicine in this state by the**
 32 **state board of registration for the healing arts;**
- 33 ~~[(9)]~~ **(10) "Reasonable medical judgment", a medical judgment that would be made**
 34 **by a reasonably prudent physician, knowledgeable about the case and the treatment**
 35 **possibilities with respect to the medical conditions involved;**
- 36 ~~[(10)]~~ **(11) "Unborn child", the offspring of human beings from the moment of**
 37 **conception until birth and at every stage of its biological development, including the human**
 38 **conceptus, zygote, morula, blastocyst, embryo, and fetus;**
- 39 ~~[(11)]~~ **(12) "Viability" or "viable", that stage of fetal development when the life of the**
 40 **unborn child may be continued indefinitely outside the womb by natural or artificial life-**
 41 **supportive systems;**
- 42 ~~[(12)]~~ **(13) "Viable pregnancy" or "viable intrauterine pregnancy", in the first**
 43 **trimester of pregnancy, an intrauterine pregnancy that can potentially result in a liveborn**
 44 **baby.**

188.207. It shall be unlawful for any public funds to be expended to any abortion facility, or to any affiliate or associate of such abortion facility.

188.220. 1. Any taxpayer of this state or its political subdivisions shall have standing to bring ~~[suit in a circuit court of proper venue]~~ **a cause of action in any court or administrative agency of competent jurisdiction** to enforce the provisions of sections 188.200 to 188.215.

2. **The attorney general is authorized to bring a cause of action in any court or administrative agency of competent jurisdiction to enforce the provisions of sections 188.200 to 188.215.**

8 **3. In any action to enforce the provisions of sections 188.200 to 188.215 by a**
9 **taxpayer or the attorney general, a court of competent jurisdiction may order injunctive**
10 **or other equitable relief, recovery of damages or other legal remedies, or both, as well as**
11 **payment of reasonable attorney's fees, costs, and expenses of the taxpayer or the state.**
12 **The relief and remedies set forth shall not be deemed exclusive and shall be in addition**
13 **to any other relief or remedies permitted by law.**

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

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

14 (2) All outpatient hospital services, payments therefor to be in amounts which
15 represent no more than eighty percent of the lesser of reasonable costs or customary charges
16 for such services, determined in accordance with the principles set forth in Title XVIII A and
17 B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section
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 301,
30 et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize
31 through its payment methodology for nursing facilities those nursing facilities which serve a

32 high volume of MO HealthNet patients. The MO HealthNet division when determining the
33 amount of the benefit payments to be made on behalf of persons under the age of twenty-one
34 in a nursing facility may consider nursing facilities furnishing care to persons under the age of
35 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, **provided, that no funds shall be expended to any abortion facility, as**
46 **defined in section 188.015, or to any affiliate, as defined in section 188.015, of such**
47 **abortion facility;**

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

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

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

60 (10) Early and periodic screening and diagnosis of individuals who are under the age
61 of twenty-one to ascertain their physical or mental defects, and health care, treatment, and
62 other measures to correct or ameliorate defects and chronic conditions discovered thereby.
63 Such services shall be provided in accordance with the provisions of Section 6403 of P.L.
64 101-239 and federal regulations promulgated thereunder;

65 (11) Home health care services;

66 (12) Family planning as defined by federal rules and regulations; **provided, that no**
67 **funds shall be expended to any abortion facility, as defined in section 188.015, or to any**
68 **affiliate, as defined in section 188.015, of such abortion facility; and further provided,**

69 however, that such family planning services shall not include abortions or any abortifacient
70 drug or device that is used for the purpose of inducing an abortion unless such abortions are
71 certified in writing by a physician to the MO HealthNet agency that, in the physician's
72 professional judgment, the life of the mother would be endangered if the fetus were carried to
73 term;

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

76 (14) Outpatient surgical procedures, including presurgical diagnostic services
77 performed in ambulatory surgical facilities which are licensed by the department of health
78 and senior services of the state of Missouri; except, that such outpatient surgical services shall
79 not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-
80 97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such
81 persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal
82 Social Security Act, as amended;

83 (15) Personal care services which are medically oriented tasks having to do with a
84 person's physical requirements, as opposed to housekeeping requirements, which enable a
85 person to be treated by his or her physician on an outpatient rather than on an inpatient or
86 residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal
87 care services shall be rendered by an individual not a member of the participant's family who
88 is qualified to provide such services where the services are prescribed by a physician in
89 accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible
90 to receive personal care services shall be those persons who would otherwise require
91 placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable
92 for personal care services shall not exceed for any one participant one hundred percent of the
93 average statewide charge for care and treatment in an intermediate care facility for a
94 comparable period of time. Such services, when delivered in a residential care facility or
95 assisted living facility licensed under chapter 198 shall be authorized on a tier level based on
96 the services the resident requires and the frequency of the services. A resident of such facility
97 who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a
98 physician, qualify for the tier level with the fewest services. The rate paid to providers for
99 each tier of service shall be set subject to appropriations. Subject to appropriations, each
100 resident of such facility who qualifies for assistance under section 208.030 and meets the
101 level of care required in this section shall, at a minimum, if prescribed by a physician, be
102 authorized up to one hour of personal care services per day. Authorized units of personal care
103 services shall not be reduced or tier level lowered unless an order approving such reduction or
104 lowering is obtained from the resident's personal physician. Such authorized units of personal
105 care services or tier level shall be transferred with such resident if he or she transfers to

106 another such facility. Such provision shall terminate upon receipt of relevant waivers from
107 the federal Department of Health and Human Services. If the Centers for Medicare and
108 Medicaid Services determines that such provision does not comply with the state plan, this
109 provision shall be null and void. The MO HealthNet division shall notify the revisor of
110 statutes as to whether the relevant waivers are approved or a determination of noncompliance
111 is made;

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

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

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

143 abuse shall be certified by the department of mental health to the MO HealthNet division.
144 The agreement shall establish a mechanism for the joint implementation of the provisions of
145 this subdivision. In addition, the agreement shall establish a mechanism by which rates for
146 services may be jointly developed;

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

151 (18) The services of an advanced practice registered nurse with a collaborative
152 practice agreement to the extent that such services are provided in accordance with chapters
153 334 and 335, and regulations promulgated thereunder;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

212 (25) The MO HealthNet division shall, by January 1, 2008, and annually thereafter,
213 report the status of MO HealthNet provider reimbursement rates as compared to one hundred
214 percent of the Medicare reimbursement rates and compared to the average dental

215 reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet
216 division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve
217 parity with Medicare reimbursement rates and for third-party payor average dental
218 reimbursement rates. Such plan shall be subject to appropriation and the division shall
219 include in its annual budget request to the governor the necessary funding needed to complete
220 the four-year plan developed under this subdivision.

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

226 (1) Dental services;

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

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

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

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

244 (6) Comprehensive day rehabilitation services beginning early posttrauma as part of a
245 coordinated system of care for individuals with disabling impairments. Rehabilitation
246 services must be based on an individualized, goal-oriented, comprehensive and coordinated
247 treatment plan developed, implemented, and monitored through an interdisciplinary
248 assessment designed to restore an individual to optimal level of physical, cognitive, and
249 behavioral function. The MO HealthNet division shall establish by administrative rule the
250 definition and criteria for designation of a comprehensive day rehabilitation service facility,
251 benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is

252 defined in section 536.010, that is created under the authority delegated in this subdivision
253 shall become effective only if it complies with and is subject to all of the provisions of
254 chapter 536 and, if applicable, section 536.028. This section and chapter 536 are
255 nonseverable and if any of the powers vested with the general assembly pursuant to chapter
256 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently
257 held unconstitutional, then the grant of rulemaking authority and any rule proposed or
258 adopted after August 28, 2005, shall be invalid and void.

259 3. The MO HealthNet division may require any participant receiving MO HealthNet
260 benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after
261 July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all
262 covered services except for those services covered under subdivisions (15) and (16) of
263 subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner
264 authorized by Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.)
265 and regulations thereunder. When substitution of a generic drug is permitted by the prescriber
266 according to section 338.056, and a generic drug is substituted for a name-brand drug, the
267 MO HealthNet division may not lower or delete the requirement to make a co-payment
268 pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods
269 or services described under this section must collect from all participants the additional
270 payment that may be required by the MO HealthNet division under authority granted herein,
271 if the division exercises that authority, to remain eligible as a provider. Any payments made
272 by participants under this section shall be in addition to and not in lieu of payments made by
273 the state for goods or services described herein except the participant portion of the pharmacy
274 professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists.
275 A provider may collect the co-payment at the time a service is provided or at a later date. A
276 provider shall not refuse to provide a service if a participant is unable to pay a required
277 payment. If it is the routine business practice of a provider to terminate future services to an
278 individual with an unclaimed debt, the provider may include uncollected co-payments under
279 this practice. Providers who elect not to undertake the provision of services based on a
280 history of bad debt shall give participants advance notice and a reasonable opportunity for
281 payment. A provider, representative, employee, independent contractor, or agent of a
282 pharmaceutical manufacturer shall not make co-payment for a participant. This subsection
283 shall not apply to other qualified children, pregnant women, or blind persons. If the Centers
284 for Medicare and Medicaid Services does not approve the MO HealthNet state plan
285 amendment submitted by the department of social services that would allow a provider to
286 deny future services to an individual with uncollected co-payments, the denial of services
287 shall not be allowed. The department of social services shall inform providers regarding the
288 acceptability of denying services as the result of unpaid co-payments.

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

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

297 6. Beginning July 1, 1990, reimbursement for services rendered in federally funded
298 health centers shall be in accordance with the provisions of subsection 6402(c) and Section
299 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations
300 promulgated thereunder.

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

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

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

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

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

320 12. If the Missouri Medicaid audit and compliance unit changes any interpretation or
321 application of the requirements for reimbursement for MO HealthNet services from the
322 interpretation or application that has been applied previously by the state in any audit of a MO
323 HealthNet provider, the Missouri Medicaid audit and compliance unit shall notify all affected
324 MO HealthNet providers five business days before such change shall take effect. Failure of
325 the Missouri Medicaid audit and compliance unit to notify a provider of such change shall

326 entitle the provider to continue to receive and retain reimbursement until such notification is
327 provided and shall waive any liability of such provider for recoupment or other loss of any
328 payments previously made prior to the five business days after such notice has been sent.
329 Each provider shall provide the Missouri Medicaid audit and compliance unit a valid email
330 address and shall agree to receive communications electronically. The notification required
331 under this section shall be delivered in writing by the United States Postal Service or
332 electronic mail to each provider.

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

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

341 15. There shall be no payments made under this section for gender transition
342 surgeries, cross-sex hormones, or puberty-blocking drugs, as such terms are defined in section
343 191.1720, for the purpose of a gender transition.

208.153. 1. Pursuant to and not inconsistent with the provisions of sections 208.151
2 and 208.152, the MO HealthNet division shall by rule and regulation define the reasonable
3 costs, manner, extent, quantity, quality, charges and fees of MO HealthNet benefits herein
4 provided. The benefits available under these sections shall not replace those provided under
5 other federal or state law or under other contractual or legal entitlements of the persons
6 receiving them, and all persons shall be required to apply for and utilize all benefits available
7 to them and to pursue all causes of action to which they are entitled. Any person entitled to
8 MO HealthNet benefits may obtain it from any provider of services **that is not excluded or**
9 **disqualified as a provider under any provision of law including, but not limited to,**
10 **section 208.164,** with which an agreement is in effect under this section and which
11 undertakes to provide the services, as authorized by the MO HealthNet division. At the
12 discretion of the director of the MO HealthNet division and with the approval of the governor,
13 the MO HealthNet division is authorized to provide medical benefits for participants
14 receiving public assistance by expending funds for the payment of federal medical insurance
15 premiums, coinsurance and deductibles pursuant to the provisions of Title XVIII B and XIX,
16 Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et
17 seq.), as amended.

18 2. MO HealthNet shall include benefit payments on behalf of qualified Medicare
19 beneficiaries as defined in 42 U.S.C. Section 1396d(p). The family support division shall by

20 rule and regulation establish which qualified Medicare beneficiaries are eligible. The MO
21 HealthNet division shall define the premiums, deductible and coinsurance provided for in 42
22 U.S.C. Section 1396d(p) to be provided on behalf of the qualified Medicare beneficiaries.

23 3. MO HealthNet shall include benefit payments for Medicare Part A cost sharing as
24 defined in clause (p)(3)(A)(i) of 42 U.S.C. 1396d on behalf of qualified disabled and working
25 individuals as defined in subsection (s) of Section 42 U.S.C. 1396d as required by subsection
26 (d) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989). The MO
27 HealthNet division may impose a premium for such benefit payments as authorized by
28 paragraph (d)(3) of Section 6408 of P.L. 101-239.

29 4. MO HealthNet shall include benefit payments for Medicare Part B cost sharing
30 described in 42 U.S.C. Section 1396(d)(p)(3)(A)(ii) for individuals described in subsection 2
31 of this section, but for the fact that their income exceeds the income level established by the
32 state under 42 U.S.C. Section 1396(d)(p)(2) but is less than one hundred and ten percent
33 beginning January 1, 1993, and less than one hundred and twenty percent beginning January
34 1, 1995, of the official poverty line for a family of the size involved.

35 5. For an individual eligible for MO HealthNet under Title XIX of the Social Security
36 Act, MO HealthNet shall include payment of enrollee premiums in a group health plan and all
37 deductibles, coinsurance and other cost-sharing for items and services otherwise covered
38 under the state Title XIX plan under Section 1906 of the federal Social Security Act and
39 regulations established under the authority of Section 1906, as may be amended. Enrollment
40 in a group health plan must be cost effective, as established by the Secretary of Health and
41 Human Services, before enrollment in the group health plan is required. If all members of a
42 family are not eligible for MO HealthNet and enrollment of the Title XIX eligible members in
43 a group health plan is not possible unless all family members are enrolled, all premiums for
44 noneligible members shall be treated as payment for MO HealthNet of eligible family
45 members. Payment for noneligible family members must be cost effective, taking into
46 account payment of all such premiums. Non-Title XIX eligible family members shall pay all
47 deductible, coinsurance and other cost-sharing obligations. Each individual as a condition of
48 eligibility for MO HealthNet benefits shall apply for enrollment in the group health plan.

49 6. Any Social Security cost-of-living increase at the beginning of any year shall be
50 disregarded until the federal poverty level for such year is implemented.

51 7. If a MO HealthNet participant has paid the requested spenddown in cash for any
52 month and subsequently pays an out-of-pocket valid medical expense for such month, such
53 expense shall be allowed as a deduction to future required spenddown for up to three months
54 from the date of such expense.

208.164. 1. As used in this section, unless the context clearly requires otherwise, the
2 following terms mean:

3 (1) "Abuse", a documented pattern of inducing, furnishing, or otherwise causing a
4 recipient to receive services or merchandise not otherwise required or requested by the
5 recipient, attending physician or appropriate utilization review team; a documented pattern of
6 performing and billing tests, examinations, patient visits, surgeries, drugs or merchandise that
7 exceed limits or frequencies determined by the department for like practitioners for which
8 there is no demonstrable need, or for which the provider has created the need through
9 ineffective services or merchandise previously rendered. The decision to impose any of the
10 sanctions authorized in this section shall be made by the director of the department, following
11 a determination of demonstrable need or accepted medical practice made in consultation with
12 medical or other health care professionals, or qualified peer review teams;

13 (2) "Department", the department of social services;

14 (3) "Excessive use", the act, by a person eligible for services under a contract or
15 provider agreement between the department of social services or its divisions and a provider,
16 of seeking and/or obtaining medical assistance benefits from a number of like providers and
17 in quantities which exceed the levels that are considered medically necessary by current
18 medical practices and standards for the eligible person's needs;

19 (4) "Fraud", a known false representation, including the concealment of a material
20 fact that **the** provider knew or should have known through the usual conduct of his profession
21 or occupation, upon which the provider claims reimbursement under the terms and conditions
22 of a contract or provider agreement and the policies pertaining to such contract or provider
23 agreement of the department or its divisions in carrying out the providing of services, or
24 under any approved state plan authorized by the federal Social Security Act;

25 (5) "Health plan", a group of services provided to recipients of medical assistance
26 benefits by providers under a contract with the department;

27 (6) "Medical assistance benefits", those benefits authorized to be provided by sections
28 208.152 and 208.162;

29 (7) "Prior authorization", approval to a provider to perform a service or services for
30 an eligible person required by the department or its divisions in advance of the actual service
31 being provided or approved for a recipient to receive a service or services from a provider,
32 required by the department or its designated division in advance of the actual service or
33 services being received;

34 (8) "Provider", any person, partnership, corporation, not-for-profit corporation,
35 professional corporation, or other business entity that enters into a contract or provider
36 agreement with the department or its divisions for the purpose of providing services to
37 eligible persons, and obtaining from the department or its divisions reimbursement therefor;

38 (9) "Recipient", a person who is eligible to receive medical assistance benefits
39 allocated through the department;

40 (10) "Service", the specific function, act, successive acts, benefits, continuing
41 benefits, requested by an eligible person or provided by the provider under contract with the
42 department or its divisions.

43 2. The department or its divisions shall have the authority to suspend, revoke, or
44 cancel any contract or provider agreement or refuse to enter into a new contract or provider
45 agreement with any provider where it is determined the provider has committed or allowed its
46 agents, servants, or employees to commit acts defined as abuse or fraud in this section.

47 3. The department or its divisions shall have the authority to impose prior
48 authorization as defined in this section:

49 (1) When it has reasonable cause to believe a provider or recipient has knowingly
50 followed a course of conduct which is defined as abuse or fraud or excessive use by this
51 section; or

52 (2) When it determines by rule that prior authorization is reasonable for a specified
53 service or procedure.

54 4. If a provider or recipient reports to the department or its divisions the name or
55 names of providers or recipients who, based upon their personal knowledge has reasonable
56 cause to believe an act or acts are being committed which are defined as abuse, fraud or
57 excessive use by this section, such report shall be confidential and the reporter's name shall
58 not be divulged to anyone by the department or any of its divisions, except at a judicial
59 proceeding upon a proper protective order being entered by the court.

60 5. Payments for services under any contract or provider agreement between the
61 department or its divisions and a provider may be withheld by the department or its divisions
62 from the provider for acts or omissions defined as abuse or fraud by this section, until such
63 time as an agreement between the parties is reached or the dispute is adjudicated under the
64 laws of this state.

65 6. The department or its designated division shall have the authority to review all
66 cases and claim records for any recipient of public assistance benefits and to determine from
67 these records if the recipient has, as defined in this section, committed excessive use of such
68 services by seeking or obtaining services from a number of like providers of services and in
69 quantities which exceed the levels considered necessary by current medical or health care
70 professional practice standards and policies of the program.

71 7. The department or its designated division shall have the authority with respect to
72 recipients of medical assistance benefits who have committed excessive use to limit or restrict
73 the use of the recipient's Medicaid identification card to designated providers and for
74 designated services; the actual method by which such restrictions are imposed shall be at the
75 discretion of the department of social services or its designated division.

76 8. The department or its designated division shall have the authority with respect to
77 any recipient of medical assistance benefits whose use has been restricted under subsection 7
78 of this section and who obtains or seeks to obtain medical assistance benefits from a provider
79 other than one of the providers for designated services to terminate medical assistance
80 benefits as defined by this chapter, where allowed by the provisions of the federal Social
81 Security Act.

82 9. The department or its designated division shall have the authority with respect to
83 any provider who knowingly allows a recipient to violate subsection 7 of this section or who
84 fails to report a known violation of subsection 7 of this section to the department of social
85 services or its designated division to terminate or otherwise sanction such provider's status as
86 a participant in the medical assistance program. Any person making such a report shall not be
87 civilly liable when the report is made in good faith.

88 **10. In order to comply with the provisions of 42 U.S.C. Section 1320a-7(a)**
89 **relating to mandatory exclusion of certain individuals and entities from participation in**
90 **any federal health care program, and in furtherance of the state's authority under**
91 **federal law, as implemented by 42 CFR 1002.3(b), to exclude an individual or entity**
92 **from MO HealthNet for any reason or period authorized by state law, the department or**
93 **its divisions shall suspend, revoke, or cancel any contract or provider agreement or**
94 **refuse to enter into a new contract or provider agreement with any provider where it is**
95 **determined that such provider is not qualified to perform the service or services**
96 **required, as described in 42 U.S.C. Section 1396a(a)(23), because such provider, or such**
97 **provider's agent, servant, or employee acting under such provider's authority:**

98 **(1) Has a conviction related to the delivery of any item or service under**
99 **Medicare or under any state health care program, as described in 42 U.S.C. Section**
100 **1320a-7(a)(1);**

101 **(2) Has a conviction related to the neglect or abuse of a patient in connection**
102 **with the delivery of any health care item or service, as described in 42 U.S.C. Section**
103 **1320a-7(a)(2);**

104 **(3) Has a felony conviction related to health care fraud, theft, embezzlement,**
105 **breach of fiduciary responsibility, or other financial misconduct, as described in 42**
106 **U.S.C. Section 1320a-7(a)(3);**

107 **(4) Has a felony conviction related to the unlawful manufacture, distribution,**
108 **prescription, or dispensation of a controlled substance, as described in 42 U.S.C. Section**
109 **1320a-7(a)(4);**

110 **(5) Has been found guilty of, or civilly liable for, a pattern of intentional**
111 **discrimination in the delivery or nondelivery of any health care item or service based on**
112 **the race, color, or national origin of recipients, as described in 42 U.S.C. Section 2000d;**

- 113 **(6) Has discriminated or had historically discriminated against persons of**
114 **certain races, colors, or national origin by promoting eugenics as a means of limiting the**
115 **procreation of such persons of such races, colors, or national origin, including, but not**
116 **limited to, sterilization or the use of targeted abortions; or**
- 117 **(7) Is an abortion facility, as defined in section 188.015, or an affiliate, as defined**
118 **in section 188.015, of such abortion facility.**

208.659. The MO HealthNet division shall revise the eligibility requirements for the
2 uninsured women's health program, as established in 13 CSR Section 70- 4.090, to include
3 women who are at least eighteen years of age and with a net family income of at or below one
4 hundred eighty-five percent of the federal poverty level. In order to be eligible for such
5 program, the applicant shall not have assets in excess of two hundred and fifty thousand
6 dollars, nor shall the applicant have access to employer-sponsored health insurance. Such
7 change in eligibility requirements shall not result in any change in services provided under the
8 program. **No funds shall be expended to any abortion facility, as defined in section**
9 **188.015, or to any affiliate, as defined in section 188.015, of such abortion facility.**

Section B. Because of the need to protect all life in Missouri, born and unborn,
2 section A of this act is deemed necessary for the immediate preservation of the public health,
3 welfare, peace, and safety, and is hereby declared to be an emergency act within the meaning
4 of the constitution, and section A of this act shall be in full force and effect upon its passage
5 and approval.

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