SENATE SUBSTITUTE

FOR

HOUSE COMMITTEE SUBSTITUTE

FOR

HOUSE BILL NO. 2634

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,
2 208.164, and 208.659, RSMo, are repealed and seven new sections
3 enacted in lieu thereof, to be known as sections 188.015,
4 188.207, 188.220, 208.152, 208.153, 208.164, and 208.659, to
5 read as follows:

188.015. As used in this chapter, the following terms
2 mean:
3 (1) "Abortion":
4 (a) The act of using or prescribing any instrument,
5 device, medicine, drug, or any other means or substance with
6 the intent to destroy the life of an embryo or fetus in his
7 or her mother's womb; or
8 (b) The intentional termination of the pregnancy of a
9 mother by using or prescribing any instrument, device,
10 medicine, drug, or other means or substance with an
11 intention other than to increase the probability of a live
12 birth or to remove a dead unborn child;
13 (2) "Abortion facility", a clinic, physician's office,
14 or any other place or facility in which abortions are
15 performed or induced other than a hospital;

16 (3) "Affiliate", a person who or entity that enters
17 into, with an abortion facility, a legal relationship
18 created or governed by at least one written instrument,
19 including a certificate of formation, a franchise agreement,
20 standards of affiliation, bylaws, or a license, that
21 demonstrates:
22 (a) Common ownership, management, or control between
23 the parties to the relationship;
24 (b) A franchise granted by the person or entity to the
25 affiliate; or
26 (c) The granting or extension of a license or other
27 agreement authorizing the affiliate to use the other
28 person's or entity's brand name, trademark, service mark, or
29 other registered identification mark;
30 (4) "Conception", the fertilization of the ovum of a
31 female by a sperm of a male;
32 [(4)] (5) "Department", the department of health and
33 senior services;
34 [(5)] (6) "Down Syndrome", the same meaning as defined
35 in section 191.923;
36 [(6)] (7) "Gestational age", length of pregnancy as
37 measured from the first day of the woman's last menstrual
38 period;
39 [(7)] (8) "Medical emergency", a condition which,
40 based on reasonable medical judgment, so complicates the
41 medical condition of a pregnant woman as to necessitate the
42 immediate abortion of her pregnancy to avert the death of
43 the pregnant woman or for which a delay will create a
44 serious risk of substantial and irreversible physical
45 impairment of a major bodily function of the pregnant woman;
46 [(8)] (9) "Physician", any person licensed to practice
47 medicine in this state by the state board of registration
48 for the healing arts;

49 [(9)] (10) "Reasonable medical judgment", a medical
50 judgment that would be made by a reasonably prudent
51 physician, knowledgeable about the case and the treatment
52 possibilities with respect to the medical conditions
53 involved;
54 [(10)] (11) "Unborn child", the offspring of human
55 beings from the moment of conception until birth and at
56 every stage of its biological development, including the
57 human conceptus, zygote, morula, blastocyst, embryo, and
58 fetus;
59 [(11)] (12) "Viability" or "viable", that stage of
60 fetal development when the life of the unborn child may be
61 continued indefinitely outside the womb by natural or
62 artificial life-supportive systems;
63 [(12)] (13) "Viable pregnancy" or "viable intrauterine
64 pregnancy", in the first trimester of pregnancy, an
65 intrauterine pregnancy that can potentially result in a
66 liveborn baby.
188.207. It shall be unlawful for any public funds to
2 be expended to any abortion facility, or to any affiliate of
3 such abortion facility.
188.220. 1. Any taxpayer of this state or its
2 political subdivisions shall have standing to bring [suit in
3 a circuit court of proper venue] a cause of action in any
4 court or administrative agency of competent jurisdiction to
5 enforce the provisions of sections 188.200 to 188.215.
6 2. The attorney general is authorized to bring a cause
7 of action in any court or administrative agency of competent
8 jurisdiction to enforce the provisions of sections 188.200
9 to 188.215.
10 3. In any action to enforce the provisions of sections
11 188.200 to 188.215 by a taxpayer or the attorney general, a
12 court of competent jurisdiction may order injunctive or

13 other equitable relief, recovery of damages or other legal
14 remedies, or both, as well as payment of reasonable
15 attorney's fees, costs, and expenses of the taxpayer or the
16 state. The relief and remedies set forth shall not be
17 deemed exclusive and shall be in addition to any other
18 relief or remedies permitted by law.

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

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

22 (2) All outpatient hospital services, payments
23 therefor to be in amounts which represent no more than
24 eighty percent of the lesser of reasonable costs or
25 customary charges for such services, determined in
26 accordance with the principles set forth in Title XVIII A
27 and B, Public Law 89-97, 1965 amendments to the federal

28 Social Security Act (42 U.S.C. Section 301, et seq.), but
29 the MO HealthNet division may evaluate outpatient hospital
30 services rendered under this section and deny payment for
31 services which are determined by the MO HealthNet division
32 not to be medically necessary, in accordance with federal
33 law and regulations;
34 (3) Laboratory and X-ray services;
35 (4) Nursing home services for participants, except to
36 persons with more than five hundred thousand dollars equity
37 in their home or except for persons in an institution for
38 mental diseases who are under the age of sixty-five years,
39 when residing in a hospital licensed by the department of
40 health and senior services or a nursing home licensed by the
41 department of health and senior services or appropriate
42 licensing authority of other states or government-owned and -
43 operated institutions which are determined to conform to
44 standards equivalent to licensing requirements in Title XIX
45 of the federal Social Security Act (42 U.S.C. Section 301,
46 et seq.), as amended, for nursing facilities. The MO
47 HealthNet division may recognize through its payment
48 methodology for nursing facilities those nursing facilities
49 which serve a high volume of MO HealthNet patients. The MO
50 HealthNet division when determining the amount of the
51 benefit payments to be made on behalf of persons under the
52 age of twenty-one in a nursing facility may consider nursing
53 facilities furnishing care to persons under the age of
54 twenty-one as a classification separate from other nursing
55 facilities;
56 (5) Nursing home costs for participants receiving
57 benefit payments under subdivision (4) of this subsection
58 for those days, which shall not exceed twelve per any period
59 of six consecutive months, during which the participant is
60 on a temporary leave of absence from the hospital or nursing

61 home, provided that no such participant shall be allowed a
62 temporary leave of absence unless it is specifically
63 provided for in his plan of care. As used in this
64 subdivision, the term "temporary leave of absence" shall
65 include all periods of time during which a participant is
66 away from the hospital or nursing home overnight because he
67 is visiting a friend or relative;

68 (6) Physicians' services, whether furnished in the
69 office, home, hospital, nursing home, or elsewhere<u>,</u>
70 <u>provided, that no funds shall be expended to any abortion</u>
71 <u>facility, as defined in section 188.015, or to any</u>
72 <u>affiliate, as defined in section 188.015, of such abortion</u>
73 <u>facility</u>;

74 (7) Subject to appropriation, up to twenty visits per
75 year for services limited to examinations, diagnoses,
76 adjustments, and manipulations and treatments of
77 malpositioned articulations and structures of the body
78 provided by licensed chiropractic physicians practicing
79 within their scope of practice. Nothing in this subdivision
80 shall be interpreted to otherwise expand MO HealthNet
81 services;

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

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

93 (10) Early and periodic screening and diagnosis of
94 individuals who are under the age of twenty-one to ascertain
95 their physical or mental defects, and health care,
96 treatment, and other measures to correct or ameliorate
97 defects and chronic conditions discovered thereby. Such
98 services shall be provided in accordance with the provisions
99 of Section 6403 of P.L. 101-239 and federal regulations
100 promulgated thereunder;
101 (11) Home health care services;
102 (12) Family planning as defined by federal rules and
103 regulations; provided, that no funds shall be expended to
104 any abortion facility, as defined in section 188.015, or to
105 any affiliate, as defined in section 188.015, of such
106 abortion facility; and further provided, however, that such
107 family planning services shall not include abortions or any
108 abortifacient drug or device that is used for the purpose of
109 inducing an abortion unless such abortions are certified in
110 writing by a physician to the MO HealthNet agency that, in
111 the physician's professional judgment, the life of the
112 mother would be endangered if the fetus were carried to term;
113 (13) Inpatient psychiatric hospital services for
114 individuals under age twenty-one as defined in Title XIX of
115 the federal Social Security Act (42 U.S.C. Section 1396d, et
116 seq.);
117 (14) Outpatient surgical procedures, including
118 presurgical diagnostic services performed in ambulatory
119 surgical facilities which are licensed by the department of
120 health and senior services of the state of Missouri; except,
121 that such outpatient surgical services shall not include
122 persons who are eligible for coverage under Part B of Title
123 XVIII, Public Law 89-97, 1965 amendments to the federal
124 Social Security Act, as amended, if exclusion of such

125 persons is permitted under Title XIX, Public Law 89-97, 1965
126 amendments to the federal Social Security Act, as amended;
127 (15) Personal care services which are medically
128 oriented tasks having to do with a person's physical
129 requirements, as opposed to housekeeping requirements, which
130 enable a person to be treated by his or her physician on an
131 outpatient rather than on an inpatient or residential basis
132 in a hospital, intermediate care facility, or skilled
133 nursing facility. Personal care services shall be rendered
134 by an individual not a member of the participant's family
135 who is qualified to provide such services where the services
136 are prescribed by a physician in accordance with a plan of
137 treatment and are supervised by a licensed nurse. Persons
138 eligible to receive personal care services shall be those
139 persons who would otherwise require placement in a hospital,
140 intermediate care facility, or skilled nursing facility.
141 Benefits payable for personal care services shall not exceed
142 for any one participant one hundred percent of the average
143 statewide charge for care and treatment in an intermediate
144 care facility for a comparable period of time. Such
145 services, when delivered in a residential care facility or
146 assisted living facility licensed under chapter 198 shall be
147 authorized on a tier level based on the services the
148 resident requires and the frequency of the services. A
149 resident of such facility who qualifies for assistance under
150 section 208.030 shall, at a minimum, if prescribed by a
151 physician, qualify for the tier level with the fewest
152 services. The rate paid to providers for each tier of
153 service shall be set subject to appropriations. Subject to
154 appropriations, each resident of such facility who qualifies
155 for assistance under section 208.030 and meets the level of
156 care required in this section shall, at a minimum, if
157 prescribed by a physician, be authorized up to one hour of

158 personal care services per day. Authorized units of
159 personal care services shall not be reduced or tier level
160 lowered unless an order approving such reduction or lowering
161 is obtained from the resident's personal physician. Such
162 authorized units of personal care services or tier level
163 shall be transferred with such resident if he or she
164 transfers to another such facility. Such provision shall
165 terminate upon receipt of relevant waivers from the federal
166 Department of Health and Human Services. If the Centers for
167 Medicare and Medicaid Services determines that such
168 provision does not comply with the state plan, this
169 provision shall be null and void. The MO HealthNet division
170 shall notify the revisor of statutes as to whether the
171 relevant waivers are approved or a determination of
172 noncompliance is made;
173 (16) Mental health services. The state plan for
174 providing medical assistance under Title XIX of the Social
175 Security Act, 42 U.S.C. Section 301, as amended, shall
176 include the following mental health services when such
177 services are provided by community mental health facilities
178 operated by the department of mental health or designated by
179 the department of mental health as a community mental health
180 facility or as an alcohol and drug abuse facility or as a
181 child-serving agency within the comprehensive children's
182 mental health service system established in section
183 630.097. The department of mental health shall establish by
184 administrative rule the definition and criteria for
185 designation as a community mental health facility and for
186 designation as an alcohol and drug abuse facility. Such
187 mental health services shall include:
188 (a) Outpatient mental health services including
189 preventive, diagnostic, therapeutic, rehabilitative, and
190 palliative interventions rendered to individuals in an

191 individual or group setting by a mental health professional
192 in accordance with a plan of treatment appropriately
193 established, implemented, monitored, and revised under the
194 auspices of a therapeutic team as a part of client services
195 management;
196 (b) Clinic mental health services including
197 preventive, diagnostic, therapeutic, rehabilitative, and
198 palliative interventions rendered to individuals in an
199 individual or group setting by a mental health professional
200 in accordance with a plan of treatment appropriately
201 established, implemented, monitored, and revised under the
202 auspices of a therapeutic team as a part of client services
203 management;
204 (c) Rehabilitative mental health and alcohol and drug
205 abuse services including home and community-based
206 preventive, diagnostic, therapeutic, rehabilitative, and
207 palliative interventions rendered to individuals in an
208 individual or group setting by a mental health or alcohol
209 and drug abuse professional in accordance with a plan of
210 treatment appropriately established, implemented, monitored,
211 and revised under the auspices of a therapeutic team as a
212 part of client services management. As used in this
213 section, mental health professional and alcohol and drug
214 abuse professional shall be defined by the department of
215 mental health pursuant to duly promulgated rules. With
216 respect to services established by this subdivision, the
217 department of social services, MO HealthNet division, shall
218 enter into an agreement with the department of mental
219 health. Matching funds for outpatient mental health
220 services, clinic mental health services, and rehabilitation
221 services for mental health and alcohol and drug abuse shall
222 be certified by the department of mental health to the MO
223 HealthNet division. The agreement shall establish a

224 mechanism for the joint implementation of the provisions of
225 this subdivision. In addition, the agreement shall
226 establish a mechanism by which rates for services may be
227 jointly developed;
228 (17) Such additional services as defined by the MO
229 HealthNet division to be furnished under waivers of federal
230 statutory requirements as provided for and authorized by the
231 federal Social Security Act (42 U.S.C. Section 301, et seq.)
232 subject to appropriation by the general assembly;
233 (18) The services of an advanced practice registered
234 nurse with a collaborative practice agreement to the extent
235 that such services are provided in accordance with chapters
236 334 and 335, and regulations promulgated thereunder;
237 (19) Nursing home costs for participants receiving
238 benefit payments under subdivision (4) of this subsection to
239 reserve a bed for the participant in the nursing home during
240 the time that the participant is absent due to admission to
241 a hospital for services which cannot be performed on an
242 outpatient basis, subject to the provisions of this
243 subdivision:
244 (a) The provisions of this subdivision shall apply
245 only if:
246 a. The occupancy rate of the nursing home is at or
247 above ninety-seven percent of MO HealthNet certified
248 licensed beds, according to the most recent quarterly census
249 provided to the department of health and senior services
250 which was taken prior to when the participant is admitted to
251 the hospital; and
252 b. The patient is admitted to a hospital for a medical
253 condition with an anticipated stay of three days or less;
254 (b) The payment to be made under this subdivision
255 shall be provided for a maximum of three days per hospital
256 stay;

257 (c) For each day that nursing home costs are paid on
258 behalf of a participant under this subdivision during any
259 period of six consecutive months such participant shall,
260 during the same period of six consecutive months, be
261 ineligible for payment of nursing home costs of two
262 otherwise available temporary leave of absence days provided
263 under subdivision (5) of this subsection; and
264 (d) The provisions of this subdivision shall not apply
265 unless the nursing home receives notice from the participant
266 or the participant's responsible party that the participant
267 intends to return to the nursing home following the hospital
268 stay. If the nursing home receives such notification and
269 all other provisions of this subsection have been satisfied,
270 the nursing home shall provide notice to the participant or
271 the participant's responsible party prior to release of the
272 reserved bed;
273 (20) Prescribed medically necessary durable medical
274 equipment. An electronic web-based prior authorization
275 system using best medical evidence and care and treatment
276 guidelines consistent with national standards shall be used
277 to verify medical need;
278 (21) Hospice care. As used in this subdivision, the
279 term "hospice care" means a coordinated program of active
280 professional medical attention within a home, outpatient and
281 inpatient care which treats the terminally ill patient and
282 family as a unit, employing a medically directed
283 interdisciplinary team. The program provides relief of
284 severe pain or other physical symptoms and supportive care
285 to meet the special needs arising out of physical,
286 psychological, spiritual, social, and economic stresses
287 which are experienced during the final stages of illness,
288 and during dying and bereavement and meets the Medicare
289 requirements for participation as a hospice as are provided

290 in 42 CFR Part 418. The rate of reimbursement paid by the
291 MO HealthNet division to the hospice provider for room and
292 board furnished by a nursing home to an eligible hospice
293 patient shall not be less than ninety-five percent of the
294 rate of reimbursement which would have been paid for
295 facility services in that nursing home facility for that
296 patient, in accordance with subsection (c) of Section 6408
297 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);
298 (22) Prescribed medically necessary dental services.
299 Such services shall be subject to appropriations. An
300 electronic web-based prior authorization system using best
301 medical evidence and care and treatment guidelines
302 consistent with national standards shall be used to verify
303 medical need;
304 (23) Prescribed medically necessary optometric
305 services. Such services shall be subject to
306 appropriations. An electronic web-based prior authorization
307 system using best medical evidence and care and treatment
308 guidelines consistent with national standards shall be used
309 to verify medical need;
310 (24) Blood clotting products-related services. For
311 persons diagnosed with a bleeding disorder, as defined in
312 section 338.400, reliant on blood clotting products, as
313 defined in section 338.400, such services include:
314 (a) Home delivery of blood clotting products and
315 ancillary infusion equipment and supplies, including the
316 emergency deliveries of the product when medically necessary;
317 (b) Medically necessary ancillary infusion equipment
318 and supplies required to administer the blood clotting
319 products; and
320 (c) Assessments conducted in the participant's home by
321 a pharmacist, nurse, or local home health care agency

322 trained in bleeding disorders when deemed necessary by the
323 participant's treating physician;
324 (25) The MO HealthNet division shall, by January 1,
325 2008, and annually thereafter, report the status of MO
326 HealthNet provider reimbursement rates as compared to one
327 hundred percent of the Medicare reimbursement rates and
328 compared to the average dental reimbursement rates paid by
329 third-party payors licensed by the state. The MO HealthNet
330 division shall, by July 1, 2008, provide to the general
331 assembly a four-year plan to achieve parity with Medicare
332 reimbursement rates and for third-party payor average dental
333 reimbursement rates. Such plan shall be subject to
334 appropriation and the division shall include in its annual
335 budget request to the governor the necessary funding needed
336 to complete the four-year plan developed under this
337 subdivision.
338 2. Additional benefit payments for medical assistance
339 shall be made on behalf of those eligible needy children,
340 pregnant women and blind persons with any payments to be
341 made on the basis of the reasonable cost of the care or
342 reasonable charge for the services as defined and determined
343 by the MO HealthNet division, unless otherwise hereinafter
344 provided, for the following:
345 (1) Dental services;
346 (2) Services of podiatrists as defined in section
347 330.010;
348 (3) Optometric services as described in section
349 336.010;
350 (4) Orthopedic devices or other prosthetics, including
351 eye glasses, dentures, hearing aids, and wheelchairs;
352 (5) Hospice care. As used in this subdivision, the
353 term "hospice care" means a coordinated program of active
354 professional medical attention within a home, outpatient and

355 inpatient care which treats the terminally ill patient and
356 family as a unit, employing a medically directed
357 interdisciplinary team. The program provides relief of
358 severe pain or other physical symptoms and supportive care
359 to meet the special needs arising out of physical,
360 psychological, spiritual, social, and economic stresses
361 which are experienced during the final stages of illness,
362 and during dying and bereavement and meets the Medicare
363 requirements for participation as a hospice as are provided
364 in 42 CFR Part 418. The rate of reimbursement paid by the
365 MO HealthNet division to the hospice provider for room and
366 board furnished by a nursing home to an eligible hospice
367 patient shall not be less than ninety-five percent of the
368 rate of reimbursement which would have been paid for
369 facility services in that nursing home facility for that
370 patient, in accordance with subsection (c) of Section 6408
371 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);
372 (6) Comprehensive day rehabilitation services
373 beginning early posttrauma as part of a coordinated system
374 of care for individuals with disabling impairments.
375 Rehabilitation services must be based on an individualized,
376 goal-oriented, comprehensive and coordinated treatment plan
377 developed, implemented, and monitored through an
378 interdisciplinary assessment designed to restore an
379 individual to optimal level of physical, cognitive, and
380 behavioral function. The MO HealthNet division shall
381 establish by administrative rule the definition and criteria
382 for designation of a comprehensive day rehabilitation
383 service facility, benefit limitations and payment
384 mechanism. Any rule or portion of a rule, as that term is
385 defined in section 536.010, that is created under the
386 authority delegated in this subdivision shall become
387 effective only if it complies with and is subject to all of

388 the provisions of chapter 536 and, if applicable, section
389 536.028. This section and chapter 536 are nonseverable and
390 if any of the powers vested with the general assembly
391 pursuant to chapter 536 to review, to delay the effective
392 date, or to disapprove and annul a rule are subsequently
393 held unconstitutional, then the grant of rulemaking
394 authority and any rule proposed or adopted after August 28,
395 2005, shall be invalid and void.
396 3. The MO HealthNet division may require any
397 participant receiving MO HealthNet benefits to pay part of
398 the charge or cost until July 1, 2008, and an additional
399 payment after July 1, 2008, as defined by rule duly
400 promulgated by the MO HealthNet division, for all covered
401 services except for those services covered under
402 subdivisions (15) and (16) of subsection 1 of this section
403 and sections 208.631 to 208.657 to the extent and in the
404 manner authorized by Title XIX of the federal Social
405 Security Act (42 U.S.C. Section 1396, et seq.) and
406 regulations thereunder. When substitution of a generic drug
407 is permitted by the prescriber according to section 338.056,
408 and a generic drug is substituted for a name-brand drug, the
409 MO HealthNet division may not lower or delete the
410 requirement to make a co-payment pursuant to regulations of
411 Title XIX of the federal Social Security Act. A provider of
412 goods or services described under this section must collect
413 from all participants the additional payment that may be
414 required by the MO HealthNet division under authority
415 granted herein, if the division exercises that authority, to
416 remain eligible as a provider. Any payments made by
417 participants under this section shall be in addition to and
418 not in lieu of payments made by the state for goods or
419 services described herein except the participant portion of
420 the pharmacy professional dispensing fee shall be in

421 addition to and not in lieu of payments to pharmacists. A
422 provider may collect the co-payment at the time a service is
423 provided or at a later date. A provider shall not refuse to
424 provide a service if a participant is unable to pay a
425 required payment. If it is the routine business practice of
426 a provider to terminate future services to an individual
427 with an unclaimed debt, the provider may include uncollected
428 co-payments under this practice. Providers who elect not to
429 undertake the provision of services based on a history of
430 bad debt shall give participants advance notice and a
431 reasonable opportunity for payment. A provider,
432 representative, employee, independent contractor, or agent
433 of a pharmaceutical manufacturer shall not make co-payment
434 for a participant. This subsection shall not apply to other
435 qualified children, pregnant women, or blind persons. If
436 the Centers for Medicare and Medicaid Services does not
437 approve the MO HealthNet state plan amendment submitted by
438 the department of social services that would allow a
439 provider to deny future services to an individual with
440 uncollected co-payments, the denial of services shall not be
441 allowed. The department of social services shall inform
442 providers regarding the acceptability of denying services as
443 the result of unpaid co-payments.
444 4. The MO HealthNet division shall have the right to
445 collect medication samples from participants in order to
446 maintain program integrity.
447 5. Reimbursement for obstetrical and pediatric
448 services under subdivision (6) of subsection 1 of this
449 section shall be timely and sufficient to enlist enough
450 health care providers so that care and services are
451 available under the state plan for MO HealthNet benefits at
452 least to the extent that such care and services are
453 available to the general population in the geographic area,

454 as required under subparagraph (a)(30)(A) of 42 U.S.C.
455 Section 1396a and federal regulations promulgated thereunder.
456 6. Beginning July 1, 1990, reimbursement for services
457 rendered in federally funded health centers shall be in
458 accordance with the provisions of subsection 6402(c) and
459 Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation
460 Act of 1989) and federal regulations promulgated thereunder.
461 7. Beginning July 1, 1990, the department of social
462 services shall provide notification and referral of children
463 below age five, and pregnant, breast-feeding, or postpartum
464 women who are determined to be eligible for MO HealthNet
465 benefits under section 208.151 to the special supplemental
466 food programs for women, infants and children administered
467 by the department of health and senior services. Such
468 notification and referral shall conform to the requirements
469 of Section 6406 of P.L. 101-239 and regulations promulgated
470 thereunder.
471 8. Providers of long-term care services shall be
472 reimbursed for their costs in accordance with the provisions
473 of Section 1902 (a)(13)(A) of the Social Security Act, 42
474 U.S.C. Section 1396a, as amended, and regulations
475 promulgated thereunder.
476 9. Reimbursement rates to long-term care providers
477 with respect to a total change in ownership, at arm's
478 length, for any facility previously licensed and certified
479 for participation in the MO HealthNet program shall not
480 increase payments in excess of the increase that would
481 result from the application of Section 1902 (a)(13)(C) of
482 the Social Security Act, 42 U.S.C. Section 1396a (a)(13)(C).
483 10. The MO HealthNet division may enroll qualified
484 residential care facilities and assisted living facilities,
485 as defined in chapter 198, as MO HealthNet personal care
486 providers.

487 11. Any income earned by individuals eligible for
488 certified extended employment at a sheltered workshop under
489 chapter 178 shall not be considered as income for purposes
490 of determining eligibility under this section.
491 12. If the Missouri Medicaid audit and compliance unit
492 changes any interpretation or application of the
493 requirements for reimbursement for MO HealthNet services
494 from the interpretation or application that has been applied
495 previously by the state in any audit of a MO HealthNet
496 provider, the Missouri Medicaid audit and compliance unit
497 shall notify all affected MO HealthNet providers five
498 business days before such change shall take effect. Failure
499 of the Missouri Medicaid audit and compliance unit to notify
500 a provider of such change shall entitle the provider to
501 continue to receive and retain reimbursement until such
502 notification is provided and shall waive any liability of
503 such provider for recoupment or other loss of any payments
504 previously made prior to the five business days after such
505 notice has been sent. Each provider shall provide the
506 Missouri Medicaid audit and compliance unit a valid email
507 address and shall agree to receive communications
508 electronically. The notification required under this
509 section shall be delivered in writing by the United States
510 Postal Service or electronic mail to each provider.
511 13. Nothing in this section shall be construed to
512 abrogate or limit the department's statutory requirement to
513 promulgate rules under chapter 536.
514 14. Beginning July 1, 2016, and subject to
515 appropriations, providers of behavioral, social, and
516 psychophysiological services for the prevention, treatment,
517 or management of physical health problems shall be
518 reimbursed utilizing the behavior assessment and
519 intervention reimbursement codes 96150 to 96154 or their

520 successor codes under the Current Procedural Terminology
521 (CPT) coding system. Providers eligible for such
522 reimbursement shall include psychologists.
523 15. There shall be no payments made under this section
524 for gender transition surgeries, cross-sex hormones, or
525 puberty-blocking drugs, as such terms are defined in section
526 191.1720, for the purpose of a gender transition.

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

27 2. MO HealthNet shall include benefit payments on
28 behalf of qualified Medicare beneficiaries as defined in 42
29 U.S.C. Section 1396d(p). The family support division shall
30 by rule and regulation establish which qualified Medicare
31 beneficiaries are eligible. The MO HealthNet division shall
32 define the premiums, deductible and coinsurance provided for
33 in 42 U.S.C. Section 1396d(p) to be provided on behalf of
34 the qualified Medicare beneficiaries.
35 3. MO HealthNet shall include benefit payments for
36 Medicare Part A cost sharing as defined in clause
37 (p)(3)(A)(i) of 42 U.S.C. 1396d on behalf of qualified
38 disabled and working individuals as defined in subsection
39 (s) of Section 42 U.S.C. 1396d as required by subsection (d)
40 of Section 6408 of P.L. 101-239 (Omnibus Budget
41 Reconciliation Act of 1989). The MO HealthNet division may
42 impose a premium for such benefit payments as authorized by
43 paragraph (d)(3) of Section 6408 of P.L. 101-239.
44 4. MO HealthNet shall include benefit payments for
45 Medicare Part B cost sharing described in 42 U.S.C. Section
46 1396(d)(p)(3)(A)(ii) for individuals described in subsection
47 2 of this section, but for the fact that their income
48 exceeds the income level established by the state under 42
49 U.S.C. Section 1396(d)(p)(2) but is less than one hundred
50 and ten percent beginning January 1, 1993, and less than one
51 hundred and twenty percent beginning January 1, 1995, of the
52 official poverty line for a family of the size involved.
53 5. For an individual eligible for MO HealthNet under
54 Title XIX of the Social Security Act, MO HealthNet shall
55 include payment of enrollee premiums in a group health plan
56 and all deductibles, coinsurance and other cost-sharing for
57 items and services otherwise covered under the state Title
58 XIX plan under Section 1906 of the federal Social Security
59 Act and regulations established under the authority of

60 Section 1906, as may be amended. Enrollment in a group
61 health plan must be cost effective, as established by the
62 Secretary of Health and Human Services, before enrollment in
63 the group health plan is required. If all members of a
64 family are not eligible for MO HealthNet and enrollment of
65 the Title XIX eligible members in a group health plan is not
66 possible unless all family members are enrolled, all
67 premiums for noneligible members shall be treated as payment
68 for MO HealthNet of eligible family members. Payment for
69 noneligible family members must be cost effective, taking
70 into account payment of all such premiums. Non-Title XIX
71 eligible family members shall pay all deductible,
72 coinsurance and other cost-sharing obligations. Each
73 individual as a condition of eligibility for MO HealthNet
74 benefits shall apply for enrollment in the group health plan.
75 6. Any Social Security cost-of-living increase at the
76 beginning of any year shall be disregarded until the federal
77 poverty level for such year is implemented.
78 7. If a MO HealthNet participant has paid the
79 requested spenddown in cash for any month and subsequently
80 pays an out-of-pocket valid medical expense for such month,
81 such expense shall be allowed as a deduction to future
82 required spenddown for up to three months from the date of
83 such expense.

208.164. 1. As used in this section, unless the
2 context clearly requires otherwise, the following terms mean:
3 (1) "Abuse", a documented pattern of inducing,
4 furnishing, or otherwise causing a recipient to receive
5 services or merchandise not otherwise required or requested
6 by the recipient, attending physician or appropriate
7 utilization review team; a documented pattern of performing
8 and billing tests, examinations, patient visits, surgeries,
9 drugs or merchandise that exceed limits or frequencies

10 determined by the department for like practitioners for
11 which there is no demonstrable need, or for which the
12 provider has created the need through ineffective services
13 or merchandise previously rendered. The decision to impose
14 any of the sanctions authorized in this section shall be
15 made by the director of the department, following a
16 determination of demonstrable need or accepted medical
17 practice made in consultation with medical or other health
18 care professionals, or qualified peer review teams;
19 (2) "Department", the department of social services;
20 (3) "Excessive use", the act, by a person eligible for
21 services under a contract or provider agreement between the
22 department of social services or its divisions and a
23 provider, of seeking and/or obtaining medical assistance
24 benefits from a number of like providers and in quantities
25 which exceed the levels that are considered medically
26 necessary by current medical practices and standards for the
27 eligible person's needs;
28 (4) "Fraud", a known false representation, including
29 the concealment of a material fact that the provider knew or
30 should have known through the usual conduct of his
31 profession or occupation, upon which the provider claims
32 reimbursement under the terms and conditions of a contract
33 or provider agreement and the policies pertaining to such
34 contract or provider agreement of the department or its
35 divisions in carrying out the providing of services, or
36 under any approved state plan authorized by the federal
37 Social Security Act;
38 (5) "Health plan", a group of services provided to
39 recipients of medical assistance benefits by providers under
40 a contract with the department;
41 (6) "Medical assistance benefits", those benefits
42 authorized to be provided by sections 208.152 and 208.162;

43 (7) "Prior authorization", approval to a provider to
44 perform a service or services for an eligible person
45 required by the department or its divisions in advance of
46 the actual service being provided or approved for a
47 recipient to receive a service or services from a provider,
48 required by the department or its designated division in
49 advance of the actual service or services being received;
50 (8) "Provider", any person, partnership, corporation,
51 not-for-profit corporation, professional corporation, or
52 other business entity that enters into a contract or
53 provider agreement with the department or its divisions for
54 the purpose of providing services to eligible persons, and
55 obtaining from the department or its divisions reimbursement
56 therefor;
57 (9) "Recipient", a person who is eligible to receive
58 medical assistance benefits allocated through the department;
59 (10) "Service", the specific function, act, successive
60 acts, benefits, continuing benefits, requested by an
61 eligible person or provided by the provider under contract
62 with the department or its divisions.
63 2. The department or its divisions shall have the
64 authority to suspend, revoke, or cancel any contract or
65 provider agreement or refuse to enter into a new contract or
66 provider agreement with any provider where it is determined
67 the provider has committed or allowed its agents, servants,
68 or employees to commit acts defined as abuse or fraud in
69 this section.
70 3. The department or its divisions shall have the
71 authority to impose prior authorization as defined in this
72 section:
73 (1) When it has reasonable cause to believe a provider
74 or recipient has knowingly followed a course of conduct

75 which is defined as abuse or fraud or excessive use by this
76 section; or
77 (2) When it determines by rule that prior
78 authorization is reasonable for a specified service or
79 procedure.
80 4. If a provider or recipient reports to the
81 department or its divisions the name or names of providers
82 or recipients who, based upon their personal knowledge has
83 reasonable cause to believe an act or acts are being
84 committed which are defined as abuse, fraud or excessive use
85 by this section, such report shall be confidential and the
86 reporter's name shall not be divulged to anyone by the
87 department or any of its divisions, except at a judicial
88 proceeding upon a proper protective order being entered by
89 the court.
90 5. Payments for services under any contract or
91 provider agreement between the department or its divisions
92 and a provider may be withheld by the department or its
93 divisions from the provider for acts or omissions defined as
94 abuse or fraud by this section, until such time as an
95 agreement between the parties is reached or the dispute is
96 adjudicated under the laws of this state.
97 6. The department or its designated division shall
98 have the authority to review all cases and claim records for
99 any recipient of public assistance benefits and to determine
100 from these records if the recipient has, as defined in this
101 section, committed excessive use of such services by seeking
102 or obtaining services from a number of like providers of
103 services and in quantities which exceed the levels
104 considered necessary by current medical or health care
105 professional practice standards and policies of the program.
106 7. The department or its designated division shall
107 have the authority with respect to recipients of medical

108 assistance benefits who have committed excessive use to
109 limit or restrict the use of the recipient's Medicaid
110 identification card to designated providers and for
111 designated services; the actual method by which such
112 restrictions are imposed shall be at the discretion of the
113 department of social services or its designated division.
114 8. The department or its designated division shall
115 have the authority with respect to any recipient of medical
116 assistance benefits whose use has been restricted under
117 subsection 7 of this section and who obtains or seeks to
118 obtain medical assistance benefits from a provider other
119 than one of the providers for designated services to
120 terminate medical assistance benefits as defined by this
121 chapter, where allowed by the provisions of the federal
122 Social Security Act.
123 9. The department or its designated division shall
124 have the authority with respect to any provider who
125 knowingly allows a recipient to violate subsection 7 of this
126 section or who fails to report a known violation of
127 subsection 7 of this section to the department of social
128 services or its designated division to terminate or
129 otherwise sanction such provider's status as a participant
130 in the medical assistance program. Any person making such a
131 report shall not be civilly liable when the report is made
132 in good faith.
133 10. In order to comply with the provisions of 42
134 U.S.C. Section 1320a-7(a) relating to mandatory exclusion of
135 certain individuals and entities from participation in any
136 federal health care program, and in furtherance of the
137 state's authority under federal law, as implemented by 42
138 CFR 1002.3(b), to exclude an individual or entity from MO
139 HealthNet for any reason or period authorized by state law,
140 the department or its divisions shall suspend, revoke, or

141 cancel any contract or provider agreement or refuse to enter
142 into a new contract or provider agreement with any provider
143 where it is determined that such provider is not qualified
144 to perform the service or services required, as described in
145 42 U.S.C. Section 1396a(a)(23), because such provider, or
146 such provider's agent, servant, or employee acting under
147 such provider's authority:

148 (1) Has a conviction related to the delivery of any
149 item or service under Medicare or under any state health
150 care program, as described in 42 U.S.C. Section 1320a-
151 7(a)(1);

152 (2) Has a conviction related to the neglect or abuse
153 of a patient in connection with the delivery of any health
154 care item or service, as described in 42 U.S.C. Section
155 1320a-7(a)(2);

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

160 (4) Has a felony conviction related to the unlawful
161 manufacture, distribution, prescription, or dispensation of
162 a controlled substance, as described in 42 U.S.C. Section
163 1320a-7(a)(4);

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

169 (6) Is an abortion facility, as defined in section
170 188.015, or an affiliate, as defined in section 188.015, of
171 such abortion facility.

208.659. The MO HealthNet division shall revise the
2 eligibility requirements for the uninsured women's health

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

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