

FIRST REGULAR SESSION

HOUSE BILL NO. 469

103RD GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE DOLL.

1608H.011

DANA RADEMAN MILLER, Chief Clerk

AN ACT

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

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

Section A. Section 208.152, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 208.152, to read as follows:

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

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

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section

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

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

22 (3) Laboratory and X-ray services;

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

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

44 (6) Physicians' services, whether furnished in the office, home, hospital, nursing
45 home, or elsewhere, 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 abortion
47 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 ~~[304]~~ **1396 et seq.**, as amended, shall
114 include the following mental health services when such services are provided by community
115 mental health facilities operated by the department of mental health or designated by the
116 department of mental health as a community mental health facility or as an alcohol and drug
117 abuse facility or as a child-serving agency within the comprehensive children's mental health
118 service system established in section 630.097. The department of mental health shall
119 establish by administrative rule the definition and criteria for designation as a community
120 mental health facility and for designation as an alcohol and drug abuse facility. Such mental
121 health services 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) **Medically necessary cochlear implants and hearing instruments, as defined**
213 **in section 345.015, that are:**

214 (a) **Prescribed by an audiologist, as defined in section 345.015; or**

215 (b) **Dispensed by a hearing instrument specialist, as defined in section 346.010;**

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

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

230 (1) Dental services;

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

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

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

235 (5) Hospice care. As used in this subdivision, the term "hospice care" means a
236 coordinated program of active professional medical attention within a home, outpatient and
237 inpatient care which treats the terminally ill patient and family as a unit, employing a
238 medically directed interdisciplinary team. The program provides relief of severe pain or other

239 physical symptoms and supportive care to meet the special needs arising out of physical,
240 psychological, spiritual, social, and economic stresses which are experienced during the final
241 stages of illness, and during dying and bereavement and meets the Medicare requirements for
242 participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement
243 paid by the MO HealthNet division to the hospice provider for room and board furnished by a
244 nursing home to an eligible hospice patient shall not be less than ninety-five percent of the
245 rate of reimbursement which would have been paid for facility services in that nursing home
246 facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239
247 (Omnibus Budget Reconciliation Act of 1989);

248 (6) Comprehensive day rehabilitation services beginning early posttrauma as part of a
249 coordinated system of care for individuals with disabling impairments. Rehabilitation
250 services must be based on an individualized, goal-oriented, comprehensive and coordinated
251 treatment plan developed, implemented, and monitored through an interdisciplinary
252 assessment designed to restore an individual to an optimal level of physical, cognitive, and
253 behavioral function. The MO HealthNet division shall establish by administrative rule the
254 definition and criteria for designation of a comprehensive day rehabilitation service facility,
255 benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is
256 defined in section 536.010, that is created under the authority delegated in this subdivision
257 shall become effective only if it complies with and is subject to all of the provisions of
258 chapter 536 and, if applicable, section 536.028. This section and chapter 536 are
259 nonseverable and if any of the powers vested with the general assembly pursuant to chapter
260 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently
261 held unconstitutional, then the grant of rulemaking authority and any rule proposed or
262 adopted after August 28, 2005, shall be invalid and void.

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

276 by participants under this section shall be in addition to and not in lieu of payments made by
277 the state for goods or services described herein except the participant portion of the pharmacy
278 professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists.
279 A provider may collect the co-payment at the time a service is provided or at a later date. A
280 provider shall not refuse to provide a service if a participant is unable to pay a required
281 payment. If it is the routine business practice of a provider to terminate future services to an
282 individual with an unclaimed debt, the provider may include uncollected co-payments under
283 this practice. Providers who elect not to undertake the provision of services based on a
284 history of bad debt shall give participants advance notice and a reasonable opportunity for
285 payment. A provider, representative, employee, independent contractor, or agent of a
286 pharmaceutical manufacturer shall not make co-payment for a participant. This subsection
287 shall not apply to other qualified children, pregnant women, or blind persons. If the Centers
288 for Medicare and Medicaid Services does not approve the MO HealthNet state plan
289 amendment submitted by the department of social services that would allow a provider to
290 deny future services to an individual with uncollected co-payments, the denial of services
291 shall not be allowed. The department of social services shall inform providers regarding the
292 acceptability of denying services as the result of unpaid co-payments.

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

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

301 6. Beginning July 1, 1990, reimbursement for services rendered in federally funded
302 health centers shall be in accordance with the provisions of subsection 6402(c) and Section
303 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations
304 promulgated thereunder.

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

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

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

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

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

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

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

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

345 15. There shall be no payments made under this section for gender transition
346 surgeries, cross-sex hormones, or puberty-blocking drugs, as such terms are defined in section
347 191.1720, for the purpose of a gender transition.

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