

FIRST REGULAR SESSION

HOUSE BILL NO. 842

103RD GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE PETERS.

1868H.011

JOSEPH ENGLER, Chief Clerk

AN ACT

To repeal section 208.152, RSMo, and to enact in lieu thereof two new sections relating to payments for home blood pressure monitoring.

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

Section A. Section 208.152, RSMo, is repealed and two new sections enacted in lieu thereof, to be known as sections 208.152 and 376.1960, to read as follows: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 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 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 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) **For pregnant and postpartum women, a home blood pressure monitoring**
232 **device and home blood pressure monitoring device services. As used in this subdivision,**
233 **the term "home blood pressure monitoring device" means a mobile device that can be**
234 **used to measure blood pressure and that is validated for clinical accuracy and device**
235 **calibration. As used in this subdivision, the term "home blood pressure monitoring**
236 **device services" means patient education and training services on the setup and use of a**
237 **home blood pressure monitoring device, separate self-measurement blood pressure**
238 **readings, daily collection and transmission of data reports by the patient or caregiver to**

239 **the health care provider in order to communicate blood pressure readings, review of the**
240 **reports by the health care provider, and creation or modification of treatment plans**
241 **based on the reports;**

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

255 ~~[(6)]~~ (7) Comprehensive day rehabilitation services beginning early posttrauma as
256 part of a coordinated system of care for individuals with disabling impairments.
257 Rehabilitation services must be based on an individualized, goal-oriented, comprehensive
258 and coordinated treatment plan developed, implemented, and monitored through an
259 interdisciplinary assessment designed to restore an individual to an optimal level of
260 physical, cognitive, and behavioral function. The MO HealthNet division shall establish by
261 administrative rule the definition and criteria for designation of a comprehensive day
262 rehabilitation service facility, benefit limitations and payment mechanism. Any rule or
263 portion of a rule, as that term is defined in section 536.010, that is created under the authority
264 delegated in this subdivision shall become effective only if it complies with and is subject to
265 all of the provisions of chapter 536 and, if applicable, section 536.028. This section and
266 chapter 536 are nonseverable and if any of the powers vested with the general assembly
267 pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a
268 rule are subsequently held unconstitutional, then the grant of rulemaking authority and any
269 rule proposed or adopted after August 28, 2005, shall be invalid and void.

270 3. The MO HealthNet division may require any participant receiving MO HealthNet
271 benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after
272 July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all
273 covered services except for those services covered under subdivisions (15) and (16) of
274 subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner
275 authorized by Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.)

276 and regulations thereunder. When substitution of a generic drug is permitted by the prescriber
277 according to section 338.056, and a generic drug is substituted for a name-brand drug, the
278 MO HealthNet division may not lower or delete the requirement to make a co-payment
279 pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods
280 or services described under this section must collect from all participants the additional
281 payment that may be required by the MO HealthNet division under authority granted herein,
282 if the division exercises that authority, to remain eligible as a provider. Any payments made
283 by participants under this section shall be in addition to and not in lieu of payments made by
284 the state for goods or services described herein except the participant portion of the pharmacy
285 professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists.
286 A provider may collect the co-payment at the time a service is provided or at a later date. A
287 provider shall not refuse to provide a service if a participant is unable to pay a required
288 payment. If it is the routine business practice of a provider to terminate future services to an
289 individual with an unclaimed debt, the provider may include uncollected co-payments under
290 this practice. Providers who elect not to undertake the provision of services based on a
291 history of bad debt shall give participants advance notice and a reasonable opportunity for
292 payment. A provider, representative, employee, independent contractor, or agent of a
293 pharmaceutical manufacturer shall not make co-payment for a participant. This subsection
294 shall not apply to other qualified children, pregnant women, or blind persons. If the Centers
295 for Medicare and Medicaid Services does not approve the MO HealthNet state plan
296 amendment submitted by the department of social services that would allow a provider to
297 deny future services to an individual with uncollected co-payments, the denial of services
298 shall not be allowed. The department of social services shall inform providers regarding the
299 acceptability of denying services as the result of unpaid co-payments.

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

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

308 6. Beginning July 1, 1990, reimbursement for services rendered in federally funded
309 health centers shall be in accordance with the provisions of subsection 6402(c) and Section
310 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations
311 promulgated thereunder.

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

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

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

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

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

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

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

346 14. Beginning July 1, 2016, and subject to appropriations, providers of behavioral,
347 social, and psychophysiological services for the prevention, treatment, or management of
348 physical health problems shall be reimbursed utilizing the behavior assessment and

349 intervention reimbursement codes 96150 to 96154 or their successor codes under the Current
350 Procedural Terminology (CPT) coding system. Providers eligible for such reimbursement
351 shall include psychologists.

352 15. There shall be no payments made under this section for gender transition
353 surgeries, cross-sex hormones, or puberty-blocking drugs, as such terms are defined in section
354 191.1720, for the purpose of a gender transition.

376.1960. 1. As used in this section, the following terms mean:

2 (1) "Health benefit plan", the same meaning given to the term in section
3 376.1350;

4 (2) "Home blood pressure monitoring device", a mobile device that can be used
5 to measure blood pressure and that is validated for clinical accuracy and device
6 calibration;

7 (3) "Home blood pressure monitoring device services", patient education and
8 training services on the setup and use of a home blood pressure monitoring device,
9 separate self-measurement blood pressure readings, daily collection and transmission of
10 data reports by the patient or caregiver to the health care provider in order to
11 communicate blood pressure readings, review of the reports by the health care provider,
12 and creation or modification of treatment plans based on the reports.

13 2. Health benefit plans that are delivered, issued for delivery, continued, or
14 renewed in this state on or after January 1, 2026, and that provide for maternity
15 benefits shall provide coverage for a home blood pressure monitoring device and home
16 blood pressure monitoring device services for pregnant and postpartum women.

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