

SECOND REGULAR SESSION

HOUSE BILL NO. 1563

102ND GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE KELLEY (127).

3761H.011

DANA RADEMAN MILLER, Chief Clerk

AN ACT

To repeal sections 188.220, 208.152, 208.153, 208.164, and 208.659, RSMo, and to enact in lieu thereof seven new sections relating to public funding of health care.

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

Section A. Sections 188.220, 208.152, 208.153, 208.164, and 208.659, RSMo, are
2 repealed and seven new sections enacted in lieu thereof, to be known as sections 188.202,
3 188.207, 188.220, 208.152, 208.153, 208.164, and 208.659, to read as follows:

**188.202. 1. No federal act, law, executive order, administrative order, rule, or
2 regulation shall infringe on the right of the people of Missouri to:**

3 **(1) Protect state sovereignty and state taxpayers by restricting public funds,
4 public facilities, and public employees from being used to perform, induce, or assist in
5 an abortion, except as provided for in state statutes;**

6 **(2) Encourage childbirth over abortion in the use of the state's public funds,
7 public facilities, and public employees;**

8 **(3) Defend the religious beliefs or moral convictions of any person who, or entity
9 that, does not want to be forced to directly or indirectly fund or participate in abortion;**

10 **(4) Prevent the state or its political subdivisions from being coerced, compelled,
11 or commandeered by the federal government to enact, administer, or enforce a federal
12 regulatory program that directly or indirectly funds abortion; or**

13 **(5) Prohibit the federal government from commanding or conscripting public
14 officials of the state or its political subdivisions to enforce a federal regulatory program
15 that directly or indirectly funds abortion.**

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.

16 **2. In any action to enforce the provisions of sections 188.200 to 188.215 by a**
17 **taxpayer under the provisions of section 188.220, a court of competent jurisdiction may**
18 **order injunctive or other equitable relief, recovery of damages or other legal remedies,**
19 **or both, as well as payment of reasonable attorney's fees, costs, and expenses of the**
20 **taxpayer. The relief and remedies set forth shall not be deemed exclusive and shall be in**
21 **addition to any other relief or remedies permitted by law.**

22 **3. In addition to a cause of action brought by a taxpayer under section 188.220,**
23 **the attorney general is authorized to bring a cause of action to enforce the provisions of**
24 **sections 188.200 to 188.215.**

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

 188.220. Any taxpayer of this state or its political subdivisions shall have standing to
2 bring ~~[suit in a circuit court of proper venue]~~ **a cause of action in any court or**
3 **administrative agency of competent jurisdiction** to enforce the provisions of sections
4 188.200 to 188.215.

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

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

14 (2) All outpatient hospital services, payments therefor to be in amounts which
15 represent no more than eighty percent of the lesser of reasonable costs or customary charges
16 for such services, determined in accordance with the principles set forth in Title XVIII A and
17 B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section
18 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services
19 rendered under this section and deny payment for services which are determined by the MO
20 HealthNet division not to be medically necessary, in accordance with federal law and
21 regulations;

22 (3) Laboratory and X-ray services;

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

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

44 (6) Physicians' services, whether furnished in the office, home, hospital, nursing
45 home, or elsewhere; **provided, however, that no funds shall be expended to any abortion**
46 **facility, as defined in section 188.015, or to any affiliate or associate 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, however,**
67 **that no funds shall be expended to any abortion facility, as defined in section 188.015, or**
68 **to any affiliate or associate of such abortion facility; and further** provided, however, that
69 such family planning services shall not include abortions or any abortifacient drug or device
70 that is used for the purpose of inducing an abortion unless such abortions are certified in
71 writing by a physician to the MO HealthNet agency that, in the physician's professional
72 judgment, the life of the mother would be endangered if the fetus were carried to term;

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

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

82 (15) Personal care services which are medically oriented tasks having to do with a
83 person's physical requirements, as opposed to housekeeping requirements, which enable a
84 person to be treated by his or her physician on an outpatient rather than on an inpatient or
85 residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal
86 care services shall be rendered by an individual not a member of the participant's family who
87 is qualified to provide such services where the services are prescribed by a physician in
88 accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible
89 to receive personal care services shall be those persons who would otherwise require
90 placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable
91 for personal care services shall not exceed for any one participant one hundred percent of the
92 average statewide charge for care and treatment in an intermediate care facility for a
93 comparable period of time. Such services, when delivered in a residential care facility or
94 assisted living facility licensed under chapter 198 shall be authorized on a tier level based on
95 the services the resident requires and the frequency of the services. A resident of such facility
96 who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a

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

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

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

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

131 (c) Rehabilitative mental health and alcohol and drug abuse services including home
132 and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative
133 interventions rendered to individuals in an individual or group setting by a mental health

134 or alcohol and drug abuse professional in accordance with a plan of treatment appropriately
135 established, implemented, monitored, and revised under the auspices of a therapeutic team as
136 a part of client services management. As used in this section, mental health professional and
137 alcohol and drug abuse professional shall be defined by the department of mental health
138 pursuant to duly promulgated rules. With respect to services established by this subdivision,
139 the department of social services, MO HealthNet division, shall enter into an agreement with
140 the department of mental health. Matching funds for outpatient mental health services, clinic
141 mental health services, and rehabilitation services for mental health and alcohol and drug
142 abuse shall be certified by the department of mental health to the MO HealthNet division.
143 The agreement shall establish a mechanism for the joint implementation of the provisions of
144 this subdivision. In addition, the agreement shall establish a mechanism by which rates for
145 services may be jointly developed;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

225 (1) Dental services;

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

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

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

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

243 (6) Comprehensive day rehabilitation services beginning early posttrauma as part of a
244 coordinated system of care for individuals with disabling impairments. Rehabilitation

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

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

282 shall not apply to other qualified children, pregnant women, or blind persons. If the Centers
283 for Medicare and Medicaid Services does not approve the MO HealthNet state plan
284 amendment submitted by the department of social services that would allow a provider to
285 deny future services to an individual with uncollected co-payments, the denial of services
286 shall not be allowed. The department of social services shall inform providers regarding the
287 acceptability of denying services as the result of unpaid co-payments.

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

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

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

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

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

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

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

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

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

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

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

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

208.153. 1. Pursuant to and not inconsistent with the provisions of sections 208.151
2 and 208.152, the MO HealthNet division shall by rule and regulation define the reasonable
3 costs, manner, extent, quantity, quality, charges and fees of MO HealthNet benefits herein
4 provided. The benefits available under these sections shall not replace those provided under
5 other federal or state law or under other contractual or legal entitlements of the persons
6 receiving them, and all persons shall be required to apply for and utilize all benefits available
7 to them and to pursue all causes of action to which they are entitled. Any person entitled to
8 MO HealthNet benefits may obtain it from any provider of services **that is not excluded or**
9 **disqualified as a provider under any provision of law including, but not limited to,**
10 **section 208.164,** with which an agreement is in effect under this section and which
11 undertakes to provide the services, as authorized by the MO HealthNet division. At the
12 discretion of the director of the MO HealthNet division and with the approval of the governor,
13 the MO HealthNet division is authorized to provide medical benefits for participants

14 receiving public assistance by expending funds for the payment of federal medical insurance
15 premiums, coinsurance and deductibles pursuant to the provisions of Title XVIII B and XIX,
16 Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et
17 seq.), as amended.

18 2. MO HealthNet shall include benefit payments on behalf of qualified Medicare
19 beneficiaries as defined in 42 U.S.C. Section 1396d(p). The family support division shall by
20 rule and regulation establish which qualified Medicare beneficiaries are eligible. The MO
21 HealthNet division shall define the premiums, deductible and coinsurance provided for in 42
22 U.S.C. Section 1396d(p) to be provided on behalf of the qualified Medicare beneficiaries.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

113 **(6) Is an abortion facility, as defined in section 188.015, or an affiliate or**
114 **associate of such abortion facility.**

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

✓