

SECOND REGULAR SESSION

# HOUSE BILL NO. 1939

98TH GENERAL ASSEMBLY

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INTRODUCED BY REPRESENTATIVE HICKS.

5439H.011

D. ADAM CRUMBLISS, Chief Clerk

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## AN ACT

To repeal section 208.152, RSMo, and to enact in lieu thereof one new section relating to chiropractic physician services.

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*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Section A. Section 208.152, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 208.152, to read as follows: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 **[defined]** **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 301, et

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

21 (3) Laboratory and X-ray services;

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

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

42 (6) Physicians' services, whether furnished in the office, home, hospital, nursing home,  
43 or elsewhere;

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

49 (8) Emergency ambulance services and, effective January 1, 1990, medically necessary  
50 transportation to scheduled, physician-prescribed nonelective treatments;

51 (9) Early and periodic screening and diagnosis of individuals who are under the age of  
52 twenty-one to ascertain their physical or mental defects, and health care, treatment, and other  
53 measures to correct or ameliorate defects and chronic conditions discovered thereby. Such

54 services shall be provided in accordance with the provisions of Section 6403 of P.L. 101-239 and  
55 federal regulations promulgated thereunder;

56 (10) Home health care services;

57 (11) Family planning as defined by federal rules and regulations; provided, however, that  
58 such family planning services shall not include abortions unless such abortions are certified in  
59 writing by a physician to the MO HealthNet agency that, in the physician's professional  
60 judgment, the life of the mother would be endangered if the fetus were carried to term;

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

63 (13) Outpatient surgical procedures, including presurgical diagnostic services performed  
64 in ambulatory surgical facilities which are licensed by the department of health and senior  
65 services of the state of Missouri; except, that such outpatient surgical services shall not include  
66 persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965  
67 amendments to the federal Social Security Act, as amended, if exclusion of such persons is  
68 permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security  
69 Act, as amended;

70 (14) Personal care services which are medically oriented tasks having to do with a  
71 person's physical requirements, as opposed to housekeeping requirements, which enable a person  
72 to be treated by his or her physician on an outpatient rather than on an inpatient or residential  
73 basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services  
74 shall be rendered by an individual not a member of the participant's family who is qualified to  
75 provide such services where the services are prescribed by a physician in accordance with a plan  
76 of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care  
77 services shall be those persons who would otherwise require placement in a hospital,  
78 intermediate care facility, or skilled nursing facility. Benefits payable for personal care services  
79 shall not exceed for any one participant one hundred percent of the average statewide charge for  
80 care and treatment in an intermediate care facility for a comparable period of time. Such  
81 services, when delivered in a residential care facility or assisted living facility licensed under  
82 chapter 198 shall be authorized on a tier level based on the services the resident requires and the  
83 frequency of the services. A resident of such facility who qualifies for assistance under section  
84 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the  
85 fewest services. The rate paid to providers for each tier of service shall be set subject to  
86 appropriations. Subject to appropriations, each resident of such facility who qualifies for  
87 assistance under section 208.030 and meets the level of care required in this section shall, at a  
88 minimum, if prescribed by a physician, be authorized up to one hour of personal care services  
89 per day. Authorized units of personal care services shall not be reduced or tier level lowered

90 unless an order approving such reduction or lowering is obtained from the resident's personal  
91 physician. Such authorized units of personal care services or tier level shall be transferred with  
92 such resident if he or she transfers to another such facility. Such provision shall terminate upon  
93 receipt of relevant waivers from the federal Department of Health and Human Services. If the  
94 Centers for Medicare and Medicaid Services determines that such provision does not comply  
95 with the state plan, this provision shall be null and void. The MO HealthNet division shall notify  
96 the revisor of statutes as to whether the relevant waivers are approved or a determination of  
97 noncompliance is made;

98 (15) Mental health services. The state plan for providing medical assistance under Title  
99 XIX of the Social Security Act, 42 U.S.C. Section 301, as amended, shall include the following  
100 mental health services when such services are provided by community mental health facilities  
101 operated by the department of mental health or designated by the department of mental health  
102 as a community mental health facility or as an alcohol and drug abuse facility or as a  
103 child-serving agency within the comprehensive children's mental health service system  
104 established in section 630.097. The department of mental health shall establish by administrative  
105 rule the definition and criteria for designation as a community mental health facility and for  
106 designation as an alcohol and drug abuse facility. Such mental health services shall include:

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

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

117 (c) Rehabilitative mental health and alcohol and drug abuse services including home and  
118 community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions  
119 rendered to individuals in an individual or group setting by a mental health or alcohol and drug  
120 abuse professional in accordance with a plan of treatment appropriately established,  
121 implemented, monitored, and revised under the auspices of a therapeutic team as a part of client  
122 services management. As used in this section, mental health professional and alcohol and drug  
123 abuse professional shall be defined by the department of mental health pursuant to duly  
124 promulgated rules. With respect to services established by this subdivision, the department of  
125 social services, MO HealthNet division, shall enter into an agreement with the department of

126 mental health. Matching funds for outpatient mental health services, clinic mental health  
127 services, and rehabilitation services for mental health and alcohol and drug abuse shall be  
128 certified by the department of mental health to the MO HealthNet division. The agreement shall  
129 establish a mechanism for the joint implementation of the provisions of this subdivision. In  
130 addition, the agreement shall establish a mechanism by which rates for services may be jointly  
131 developed;

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

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

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

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

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

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

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

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

157 (d) The provisions of this subdivision shall not apply unless the nursing home receives  
158 notice from the participant or the participant's responsible party that the participant intends to  
159 return to the nursing home following the hospital stay. If the nursing home receives such  
160 notification and all other provisions of this subsection have been satisfied, the nursing home shall

161 provide notice to the participant or the participant's responsible party prior to release of the  
162 reserved bed;

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

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

179 (21) Prescribed medically necessary dental services. Such services shall be subject to  
180 appropriations. An electronic web-based prior authorization system using best medical evidence  
181 and care and treatment guidelines consistent with national standards shall be used to verify  
182 medical need;

183 (22) Prescribed medically necessary optometric services. Such services shall be subject  
184 to appropriations. An electronic web-based prior authorization system using best medical  
185 evidence and care and treatment guidelines consistent with national standards shall be used to  
186 verify medical need;

187 (23) Blood clotting products-related services. For persons diagnosed with a bleeding  
188 disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section  
189 338.400, such services include:

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

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

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

197           (24) **Services provided by a chiropractic physician licensed under chapter 331**  
198 **practicing within his or her scope of practice. Such services shall not include meridian**  
199 **therapy, acupressure, or acupuncture. Services provided under this subdivision shall be**  
200 **subject to a co-payment of four dollars per visit and shall be limited to twenty-six visits in**  
201 **a calendar year;**

202           (25) The MO HealthNet division shall, by January 1, 2008, and annually thereafter,  
203 report the status of MO HealthNet provider reimbursement rates as compared to one hundred  
204 percent of the Medicare reimbursement rates and compared to the average dental reimbursement  
205 rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July  
206 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare  
207 reimbursement rates and for third-party payor average dental reimbursement rates. Such plan  
208 shall be subject to appropriation and the division shall include in its annual budget request to the  
209 governor the necessary funding needed to complete the four-year plan developed under this  
210 subdivision.

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

216           (1) Dental services;

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

218           (3) Optometric services as [defined] **described** in section 336.010;

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

221           (5) Hospice care. As used in this subdivision, the term "hospice care" means a  
222 coordinated program of active professional medical attention within a home, outpatient and  
223 inpatient care which treats the terminally ill patient and family as a unit, employing a medically  
224 directed interdisciplinary team. The program provides relief of severe pain or other physical  
225 symptoms and supportive care to meet the special needs arising out of physical, psychological,  
226 spiritual, social, and economic stresses which are experienced during the final stages of illness,  
227 and during dying and bereavement and meets the Medicare requirements for participation as a  
228 hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO  
229 HealthNet division to the hospice provider for room and board furnished by a nursing home to  
230 an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement  
231 which would have been paid for facility services in that nursing home facility for that patient,

232 in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget  
233 Reconciliation Act of 1989);

234 (6) Comprehensive day rehabilitation services beginning early posttrauma as part of a  
235 coordinated system of care for individuals with disabling impairments. Rehabilitation services  
236 must be based on an individualized, goal-oriented, comprehensive and coordinated treatment  
237 plan developed, implemented, and monitored through an interdisciplinary assessment designed  
238 to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO  
239 HealthNet division shall establish by administrative rule the definition and criteria for  
240 designation of a comprehensive day rehabilitation service facility, benefit limitations and  
241 payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010,  
242 that is created under the authority delegated in this subdivision shall become effective only if it  
243 complies with and is subject to all of the provisions of chapter 536 and, if applicable, section  
244 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the  
245 general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove  
246 and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority  
247 and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

248 3. The MO HealthNet division may require any participant receiving MO HealthNet  
249 benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July  
250 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered  
251 services except for those services covered under subdivisions (14) and (15) of subsection 1 of  
252 this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title  
253 XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations  
254 thereunder. When substitution of a generic drug is permitted by the prescriber according to  
255 section 338.056, and a generic drug is substituted for a name-brand drug, the MO HealthNet  
256 division may not lower or delete the requirement to make a co-payment pursuant to regulations  
257 of Title XIX of the federal Social Security Act. A provider of goods or services described under  
258 this section must collect from all participants the additional payment that may be required by the  
259 MO HealthNet division under authority granted herein, if the division exercises that authority,  
260 to remain eligible as a provider. Any payments made by participants under this section shall be  
261 in addition to and not in lieu of payments made by the state for goods or services described  
262 herein except the participant portion of the pharmacy professional dispensing fee shall be in  
263 addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment  
264 at the time a service is provided or at a later date. A provider shall not refuse to provide a service  
265 if a participant is unable to pay a required payment. If it is the routine business practice of a  
266 provider to terminate future services to an individual with an unclaimed debt, the provider may  
267 include uncollected co-payments under this practice. Providers who elect not to undertake the

268 provision of services based on a history of bad debt shall give participants advance notice and  
269 a reasonable opportunity for payment. A provider, representative, employee, independent  
270 contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a  
271 participant. This subsection shall not apply to other qualified children, pregnant women, or blind  
272 persons. If the Centers for Medicare and Medicaid Services does not approve the MO HealthNet  
273 state plan amendment submitted by the department of social services that would allow a provider  
274 to deny future services to an individual with uncollected co-payments, the denial of services shall  
275 not be allowed. The department of social services shall inform providers regarding the  
276 acceptability of denying services as the result of unpaid co-payments.

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

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

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

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

295 8. Providers of long-term care services shall be reimbursed for their costs in accordance  
296 with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. Section  
297 1396a, as amended, and regulations promulgated thereunder.

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

303           10. The MO HealthNet division[,] may enroll qualified residential care facilities and  
304 assisted living facilities, as defined in chapter 198, as MO HealthNet personal care providers.

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

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

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

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