FIRST REGULAR SESSION

# HOUSE BILL NO. 55

## 91ST GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES WARD AND SELBY (Co-sponsors).

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ANNE C. WALKER, Chief Clerk

0173L.01I

## AN ACT

To repeal section 208.152, RSMo 2000, relating to Medicaid coverage, and to enact in lieu thereof one new section relating to the same subject.

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

Section A. Section 208.152, RSMo 2000, is repealed and one new section enacted in lieu
2 thereof, to be known as section 208.152, to read as follows:

208.152. 1. Benefit payments for medical assistance shall be made on behalf of those
2 eligible needy persons who are unable to provide for it in whole or in part, with any payments
3 to be made on the basis of the reasonable cost of the care or reasonable charge for the services
4 as defined and determined by the division of medical services, unless otherwise hereinafter
5 provided, for the following:
6 (1) Inpatient hospital services, except to persons in an institution for mental diseases who
7 are under the age of sixty-five years and over the age of twenty-one years; provided that the
8 division of medical services shall provide through rule and regulation an exception process for
9 coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile
10 professional activities study (PAS) or the medicaid children's diagnosis length-of-stay schedule;
11 and provided further that the division of medical services shall take into account through its
12 payment system for hospital services the situation of hospitals which serve a disproportionate
13 number of low-income patients;
14 (2) All outpatient hospital services, payments therefor to be in amounts which represent
15 no more than eighty percent of the lesser of reasonable costs or customary charges for such
16 services, determined in accordance with the principles set forth in Title XVIII A and B, Public
17 Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et seq.), but the
18 division of medical services may evaluate outpatient hospital services rendered under this section

19 and deny payment for services which are determined by the division of medical services not to
20 be medically necessary, in accordance with federal law and regulations;
21 (3) Laboratory and X-ray services;
22 (4) Nursing home services for recipients, except to persons in an institution for mental
23 diseases who are under the age of sixty-five years, when residing in a hospital licensed by the
24 department of health or a nursing home licensed by the division of aging or appropriate licensing
25 authority of other states or government-owned and -operated institutions which are determined
26 to conform to standards equivalent to licensing requirements in Title XIX, of the federal Social
27 Security Act (42 U.S.C. 301, et seq.), as amended, for nursing facilities. The division of medical
28 services may recognize through its payment methodology for nursing facilities those nursing
29 facilities which serve a high volume of medicaid patients. The division of medical services when
30 determining the amount of the benefit payments to be made on behalf of persons under the age
31 of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons
32 under the age of twenty-one as a classification separate from other nursing facilities;
33 (5) Nursing home costs for recipients of benefit payments under subdivision (4) of this
34 section for those days, which shall not exceed twelve per any period of six consecutive months,
35 during which the recipient is on a temporary leave of absence from the hospital or nursing home,
36 provided that no such recipient shall be allowed a temporary leave of absence unless it is
37 specifically provided for in his plan of care. As used in this subdivision, the term "temporary
38 leave of absence" shall include all periods of time during which a recipient is away from the
39 hospital or nursing home overnight because he is visiting a friend or relative;
40 (6) Physicians' services, whether furnished in the office, home, hospital, nursing home,
41 or elsewhere;
42 (7) Dental services;
43 (8) Services of podiatrists as defined in section 330.010, RSMo**, and chiropractors**
44 **licensed pursuant to chapter 331, RSMo**;
45 (9) Drugs and medicines when prescribed by a licensed physician, dentist, or podiatrist;
46 (10) Emergency ambulance services and, effective January 1, 1990, medically necessary
47 transportation to scheduled, physician-prescribed nonelective treatments. The department of
48 social services may conduct demonstration projects related to the provision of medically
49 necessary transportation to recipients of medical assistance under this chapter. Such
50 demonstration projects shall be funded only by appropriations made for the purpose of such
51 demonstration projects. If funds are appropriated for such demonstration projects, the
52 department shall submit to the general assembly a report on the significant aspects and results
53 of such demonstration projects;
54 (11) Early and periodic screening and diagnosis of individuals who are under the age of

55 twenty-one to ascertain their physical or mental defects, and health care, treatment, and other
56 measures to correct or ameliorate defects and chronic conditions discovered thereby. Such
57 services shall be provided in accordance with the provisions of section 6403 of P.L.53 101-239
58 and federal regulations promulgated thereunder;
59 (12) Home health care services;
60 (13) Optometric services as defined in section 336.010, RSMo;
61 (14) Family planning as defined by federal rules and regulations; provided, however, that
62 such family planning services shall not include abortions unless such abortions are certified in
63 writing by a physician to the medicaid agency that, in his professional judgment, the life of the
64 mother would be endangered if the fetus were carried to term;
65 (15) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing
66 aids, and wheelchairs;
67 (16) Inpatient psychiatric hospital services for individuals under age twenty-one as
68 defined in Title XIX of the federal Social Security Act (42 U.S.C. 1396d, et seq.);
69 (17) Outpatient surgical procedures, including presurgical diagnostic services performed
70 in ambulatory surgical facilities which are licensed by the department of health of the state of
71 Missouri; except, that such outpatient surgical services shall not include persons who are eligible
72 for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal
73 Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX,
74 Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;
75 (18) Personal care services which are medically oriented tasks having to do with a
76 person's physical requirements, as opposed to housekeeping requirements, which enable a person
77 to be treated by his physician on an outpatient, rather than on an inpatient or residential basis in
78 a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be
79 rendered by an individual not a member of the recipient's family who is qualified to provide such
80 services where the services are prescribed by a physician in accordance with a plan of treatment
81 and are supervised by a licensed nurse. Persons eligible to receive personal care services shall
82 be those persons who would otherwise require placement in a hospital, intermediate care facility,
83 or skilled nursing facility. Benefits payable for personal care services shall not exceed for any
84 one recipient one hundred percent of the average statewide charge for care and treatment in an
85 intermediate care facility for a comparable period of time;
86 (19) Mental health services. The state plan for providing medical assistance under Title
87 XIX of the Social Security Act, 42 U.S.C. 301, as amended, shall include the following mental
88 health services when such services are provided by community mental health facilities operated
89 by the department of mental health or designated by the department of mental health as a
90 community mental health facility or as an alcohol and drug abuse facility. The department of

91 mental health shall establish by administrative rule the definition and criteria for designation as
92 a community mental health facility and for designation as an alcohol and drug abuse facility.
93 Such mental health services shall include:
94 (a) Outpatient mental health services including preventive, diagnostic, therapeutic,
95 rehabilitative, and palliative interventions rendered to individuals in an individual or group
96 setting by a mental health professional in accordance with a plan of treatment appropriately
97 established, implemented, monitored, and revised under the auspices of a therapeutic team as a
98 part of client services management;
99 (b) Clinic mental health services including preventive, diagnostic, therapeutic,
100 rehabilitative, and palliative interventions rendered to individuals in an individual or group
101 setting by a mental health professional in accordance with a plan of treatment appropriately
102 established, implemented, monitored, and revised under the auspices of a therapeutic team as a
103 part of client services management;
104 (c) Rehabilitative mental health and alcohol and drug abuse services including
105 preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to
106 individuals in an individual or group setting by a mental health or alcohol and drug abuse
107 professional in accordance with a plan of treatment appropriately established, implemented,
108 monitored, and revised under the auspices of a therapeutic team as a part of client services
109 management. As used in this section, "mental health professional" and "alcohol and drug abuse
110 professional" shall be defined by the department of mental health pursuant to duly promulgated
111 rules. With respect to services established by this subdivision, the department of social services,
112 division of medical services, shall enter into an agreement with the department of mental health.
113 Matching funds for outpatient mental health services, clinic mental health services, and
114 rehabilitation services for mental health and alcohol and drug abuse shall be certified by the
115 department of mental health to the division of medical services. The agreement shall establish
116 a mechanism for the joint implementation of the provisions of this subdivision. In addition, the
117 agreement shall establish a mechanism by which rates for services may be jointly developed;
118 (20) Comprehensive day rehabilitation services beginning early posttrauma as part of a
119 coordinated system of care for individuals with disabling impairments. Rehabilitation services
120 must be based on an individualized, goal-oriented, comprehensive and coordinated treatment
121 plan developed, implemented, and monitored through an interdisciplinary assessment designed
122 to restore an individual to optimal level of physical, cognitive and behavioral function. The
123 division of medical services shall establish by administrative rule the definition and criteria for
124 designation of a comprehensive day rehabilitation service facility, benefit limitations and
125 payment mechanism;
126 (21) Hospice care. As used in this subsection, the term "hospice care" means a

127 coordinated program of active professional medical attention within a home, outpatient and
128 inpatient care which treats the terminally ill patient and family as a unit, employing a medically
129 directed interdisciplinary team. The program provides relief of severe pain or other physical
130 symptoms and supportive care to meet the special needs arising out of physical, psychological,
131 spiritual, social and economic stresses which are experienced during the final stages of illness,
132 and during dying and bereavement and meets the medicare requirements for participation as a
133 hospice as are provided in 42 CFR Part 418. Beginning July 1, 1990, the rate of reimbursement
134 paid by the division of medical services to the hospice provider for room and board furnished
135 by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the
136 rate of reimbursement which would have been paid for facility services in that nursing home
137 facility for that patient, in accordance with subsection (c) of section 6408 of P.L. 101-239
138 (Omnibus Budget Reconciliation Act of 1989);

139 (22) Such additional services as defined by the division of medical services to be
140 furnished under waivers of federal statutory requirements as provided for and authorized by the
141 federal Social Security Act (42 U.S.C. 301, et seq.) subject to appropriation by the general
142 assembly;

143 (23) Beginning July 1, 1990, the services of a certified pediatric or family nursing
144 practitioner to the extent that such services are provided in accordance with chapter 335, RSMo,
145 and regulations promulgated thereunder, regardless of whether the nurse practitioner is
146 supervised by or in association with a physician or other health care provider;

147 (24) Subject to appropriations, the department of social services shall conduct
148 demonstration projects for nonemergency, physician-prescribed transportation for pregnant
149 women who are recipients of medical assistance under this chapter in counties selected by the
150 director of the division of medical services. The funds appropriated pursuant to this subdivision
151 shall be used for the purposes of this subdivision and for no other purpose. The department shall
152 not fund such demonstration projects with revenues received for any other purpose. This
153 subdivision shall not authorize transportation of a pregnant woman in active labor. The division
154 of medical services shall notify recipients of nonemergency transportation services under this
155 subdivision of such other transportation services which may be appropriate during active labor
156 or other medical emergency;

157 (25) Nursing home costs for recipients of benefit payments under subdivision (4) of this
158 subsection to reserve a bed for the recipient in the nursing home during the time that the recipient
159 is absent due to admission to a hospital for services which cannot be performed on an outpatient
160 basis, subject to the provisions of this subdivision:

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

162 a. The occupancy rate of the nursing home is at or above ninety-seven percent of

163 medicaid certified licensed beds, according to the most recent quarterly census provided to the
164 division of aging which was taken prior to when the recipient is admitted to the hospital; and
165 b. The patient is admitted to a hospital for a medical condition with an anticipated stay
166 of three days or less;
167 (b) The payment to be made under this subdivision shall be provided for a maximum of
168 three days per hospital stay;
169 (c) For each day that nursing home costs are paid on behalf of a recipient pursuant to this
170 subdivision during any period of six consecutive months such recipient shall, during the same
171 period of six consecutive months, be ineligible for payment of nursing home costs of two
172 otherwise available temporary leave of absence days provided under subdivision (5) of this
173 subsection; and
174 (d) The provisions of this subdivision shall not apply unless the nursing home receives
175 notice from the recipient or the recipient's responsible party that the recipient intends to return
176 to the nursing home following the hospital stay. If the nursing home receives such notification
177 and all other provisions of this subsection have been satisfied, the nursing home shall provide
178 notice to the recipient or the recipient's responsible party prior to release of the reserved bed.
179 2. Benefit payments for medical assistance for surgery as defined by rule duly
180 promulgated by the division of medical services, and any costs related directly thereto, shall be
181 made only when a second medical opinion by a licensed physician as to the need for the surgery
182 is obtained prior to the surgery being performed.
183 3. The division of medical services may require any recipient of medical assistance to
184 pay part of the charge or cost, as defined by rule duly promulgated by the division of medical
185 services, for dental services, drugs and medicines, optometric services, eye glasses, dentures,
186 hearing aids, and other services, to the extent and in the manner authorized by Title XIX of the
187 federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder. When
188 substitution of a generic drug is permitted by the prescriber according to section 338.056, RSMo,
189 and a generic drug is substituted for a name brand drug, the division of medical services may not
190 lower or delete the requirement to make a copayment pursuant to regulations of Title XIX of the
191 federal Social Security Act. A provider of goods or services described under this section must
192 collect from all recipients the partial payment that may be required by the division of medical
193 services under authority granted herein, if the division exercises that authority, to remain eligible
194 as a provider. Any payments made by recipients under this section shall be in addition to, and
195 not in lieu of, any payments made by the state for goods or services described herein.
196 4. The division of medical services shall have the right to collect medication samples
197 from recipients in order to maintain program integrity.
198 5. Reimbursement for obstetrical and pediatric services under subdivision (6) of

199 subsection 1 of this section shall be timely and sufficient to enlist enough health care providers
200 so that care and services are available under the state plan for medical assistance at least to the
201 extent that such care and services are available to the general population in the geographic area,
202 as required under subparagraph (a)(30)(A) of 42 U.S.C. 1396a and federal regulations
203 promulgated thereunder.

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

208 7. Beginning July 1, 1990, the department of social services shall provide notification
209 and referral of children below age five, and pregnant, breast-feeding, or postpartum women who
210 are determined to be eligible for medical assistance under section 208.151 to the special
211 supplemental food programs for women, infants and children administered by the department
212 of health. Such notification and referral shall conform to the requirements of section 6406 of
213 P.L. 101-239 and regulations promulgated thereunder.

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

217 9. Reimbursement rates to long-term care providers with respect to a total change in
218 ownership, at arm's length, for any facility previously licensed and certified for participation in
219 the medicaid program shall not increase payments in excess of the increase that would result
220 from the application of section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. 1396a
221 (a)(13)(C).

222 10. The department of social services, division of medical services, may enroll qualified
223 residential care facilities, as defined in chapter 198, RSMo, as medicaid personal care providers.