

SECOND REGULAR SESSION

[REPERFECTED]

HOUSE BILL NO. 1516

99TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE WIEMANN.

4120H.02R

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

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

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

Section A. Section 208.152, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 208.152, to read as follows:

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

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

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such

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 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. Section 301, et seq.),
18 but the MO HealthNet division may evaluate outpatient hospital services rendered under this
19 section and deny payment for services which are determined by the MO HealthNet division not
20 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) **Subject to appropriation, up to twenty visits per year for services limited to**
45 **examinations, diagnoses, adjustments, and manipulations and treatments of malpositioned**
46 **articulations and structures of the body provided by licensed chiropractic physicians**
47 **practicing within their scope of practice. Nothing in this subdivision shall be interpreted**
48 **to otherwise expand MO HealthNet services;**

49 (8) Drugs and medicines when prescribed by a licensed physician, dentist, podiatrist, or
50 an advanced practice registered nurse; except that no payment for drugs and medicines
51 prescribed on and after January 1, 2006, by a licensed physician, dentist, podiatrist, or an

52 advanced practice registered nurse may be made on behalf of any person who qualifies for
53 prescription drug coverage under the provisions of P.L. 108-173;

54 ~~[(8)]~~ **(9)** Emergency ambulance services and, effective January 1, 1990, medically
55 necessary transportation to scheduled, physician-prescribed nonelective treatments;

56 ~~[(9)]~~ **(10)** Early and periodic screening and diagnosis of individuals who are under the
57 age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and
58 other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such
59 services shall be provided in accordance with the provisions of Section 6403 of P.L. 101-239 and
60 federal regulations promulgated thereunder;

61 ~~[(10)]~~ **(11)** Home health care services;

62 ~~[(11)]~~ **(12)** Family planning as defined by federal rules and regulations; provided,
63 however, that such family planning services shall not include abortions unless such abortions are
64 certified in writing by a physician to the MO HealthNet agency that, in the physician's
65 professional judgment, the life of the mother would be endangered if the fetus were carried to
66 term;

67 ~~[(12)]~~ **(13)** Inpatient psychiatric hospital services for individuals under age twenty-one
68 as defined in Title XIX of the federal Social Security Act (42 U.S.C. Section 1396d, et seq.);

69 ~~[(13)]~~ **(14)** Outpatient surgical procedures, including presurgical diagnostic services
70 performed in ambulatory surgical facilities which are licensed by the department of health and
71 senior services of the state of Missouri; except, that such outpatient surgical services shall not
72 include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97,
73 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons
74 is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security
75 Act, as amended;

76 ~~[(14)]~~ **(15)** Personal care services which are medically oriented tasks having to do with
77 a person's physical requirements, as opposed to housekeeping requirements, which enable a
78 person to be treated by his or her physician on an outpatient rather than on an inpatient or
79 residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care
80 services shall be rendered by an individual not a member of the participant's family who is
81 qualified to provide such services where the services are prescribed by a physician in accordance
82 with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive
83 personal care services shall be those persons who would otherwise require placement in a
84 hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care
85 services shall not exceed for any one participant one hundred percent of the average statewide
86 charge for care and treatment in an intermediate care facility for a comparable period of time.
87 Such services, when delivered in a residential care facility or assisted living facility licensed

88 under chapter 198 shall be authorized on a tier level based on the services the resident requires
89 and the frequency of the services. A resident of such facility who qualifies for assistance under
90 section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with
91 the fewest services. The rate paid to providers for each tier of service shall be set subject to
92 appropriations. Subject to appropriations, each resident of such facility who qualifies for
93 assistance under section 208.030 and meets the level of care required in this section shall, at a
94 minimum, if prescribed by a physician, be authorized up to one hour of personal care services
95 per day. Authorized units of personal care services shall not be reduced or tier level lowered
96 unless an order approving such reduction or lowering is obtained from the resident's personal
97 physician. Such authorized units of personal care services or tier level shall be transferred with
98 such resident if he or she transfers to another such facility. Such provision shall terminate upon
99 receipt of relevant waivers from the federal Department of Health and Human Services. If the
100 Centers for Medicare and Medicaid Services determines that such provision does not comply
101 with the state plan, this provision shall be null and void. The MO HealthNet division shall notify
102 the revisor of statutes as to whether the relevant waivers are approved or a determination of
103 noncompliance is made;

104 ~~[(15)]~~ **(16)** Mental health services. The state plan for providing medical assistance
105 under Title XIX of the Social Security Act, 42 U.S.C. Section 301, as amended, shall include the
106 following mental health services when such services are provided by community mental health
107 facilities operated by the department of mental health or designated by the department of mental
108 health as a community mental health facility or as an alcohol and drug abuse facility or as a
109 child-serving agency within the comprehensive children's mental health service system
110 established in section 630.097. The department of mental health shall establish by administrative
111 rule the definition and criteria for designation as a community mental health facility and for
112 designation as an alcohol and drug abuse facility. Such mental health services shall include:

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

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

123 (c) Rehabilitative mental health and alcohol and drug abuse services including home and
124 community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions
125 rendered to individuals in an individual or group setting by a mental health or alcohol and drug
126 abuse professional in accordance with a plan of treatment appropriately established,
127 implemented, monitored, and revised under the auspices of a therapeutic team as a part of client
128 services management. As used in this section, mental health professional and alcohol and drug
129 abuse professional shall be defined by the department of mental health pursuant to duly
130 promulgated rules. With respect to services established by this subdivision, the department of
131 social services, MO HealthNet division, shall enter into an agreement with the department of
132 mental health. Matching funds for outpatient mental health services, clinic mental health
133 services, and rehabilitation services for mental health and alcohol and drug abuse shall be
134 certified by the department of mental health to the MO HealthNet division. The agreement shall
135 establish a mechanism for the joint implementation of the provisions of this subdivision. In
136 addition, the agreement shall establish a mechanism by which rates for services may be jointly
137 developed;

138 ~~[(16)]~~ **(17)** Such additional services as defined by the MO HealthNet division to be
139 furnished under waivers of federal statutory requirements as provided for and authorized by the
140 federal Social Security Act (42 U.S.C. Section 301, et seq.) subject to appropriation by the
141 general assembly;

142 ~~[(17)]~~ **(18)** The services of an advanced practice registered nurse with a collaborative
143 practice agreement to the extent that such services are provided in accordance with chapters 334
144 and 335, and regulations promulgated thereunder;

145 ~~[(18)]~~ **(19)** Nursing home costs for participants receiving benefit payments under
146 subdivision (4) of this subsection to reserve a bed for the participant in the nursing home during
147 the time that the participant is absent due to admission to a hospital for services which cannot
148 be performed on an outpatient basis, subject to the provisions of this subdivision:

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

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

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

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

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

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

169 ~~[(19)]~~ (20) Prescribed medically necessary durable medical equipment. An electronic
170 web-based prior authorization system using best medical evidence and care and treatment
171 guidelines consistent with national standards shall be used to verify medical need;

172 ~~[(20)]~~ (21) Hospice care. As used in this subdivision, the term "hospice care" means
173 a coordinated program of active professional medical attention within a home, outpatient and
174 inpatient care which treats the terminally ill patient and family as a unit, employing a medically
175 directed interdisciplinary team. The program provides relief of severe pain or other physical
176 symptoms and supportive care to meet the special needs arising out of physical, psychological,
177 spiritual, social, and economic stresses which are experienced during the final stages of illness,
178 and during dying and bereavement and meets the Medicare requirements for participation as a
179 hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO
180 HealthNet division to the hospice provider for room and board furnished by a nursing home to
181 an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement
182 which would have been paid for facility services in that nursing home facility for that patient,
183 in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget
184 Reconciliation Act of 1989);

185 ~~[(21)]~~ (22) Prescribed medically necessary dental services. Such services shall be
186 subject to appropriations. An electronic web-based prior authorization system using best medical
187 evidence and care and treatment guidelines consistent with national standards shall be used to
188 verify medical need;

189 ~~[(22)]~~ (23) Prescribed medically necessary optometric services. Such services shall be
190 subject to appropriations. An electronic web-based prior authorization system using best medical
191 evidence and care and treatment guidelines consistent with national standards shall be used to
192 verify medical need;

193 ~~[(23)]~~ **(24)** Blood clotting products-related services. For persons diagnosed with a
194 bleeding disorder, as defined in section 338.400, reliant on blood clotting products, as defined
195 in section 338.400, such services include:

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

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

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

203 ~~[(24)]~~ **(25)** The MO HealthNet division shall, by January 1, 2008, and annually
204 thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one
205 hundred percent of the Medicare reimbursement rates and compared to the average dental
206 reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division
207 shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with
208 Medicare reimbursement rates and for third-party payor average dental reimbursement rates.
209 Such plan shall be subject to appropriation and the division shall include in its annual budget
210 request to the governor the necessary funding needed to complete the four-year plan developed
211 under this subdivision.

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

217 (1) Dental services;

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

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

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

222 (5) Hospice care. As used in this subdivision, the term "hospice care" means a
223 coordinated program of active professional medical attention within a home, outpatient and
224 inpatient care which treats the terminally ill patient and family as a unit, employing a medically
225 directed interdisciplinary team. The program provides relief of severe pain or other physical
226 symptoms and supportive care to meet the special needs arising out of physical, psychological,
227 spiritual, social, and economic stresses which are experienced during the final stages of illness,
228 and during dying and bereavement and meets the Medicare requirements for participation as a

229 hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO
230 HealthNet division to the hospice provider for room and board furnished by a nursing home to
231 an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement
232 which would have been paid for facility services in that nursing home facility for that patient,
233 in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget
234 Reconciliation Act of 1989);

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

249 3. The MO HealthNet division may require any participant receiving MO HealthNet
250 benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July
251 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered
252 services except for those services covered under subdivisions ~~[(14)]~~ (15) and ~~[(15)]~~ (16) of
253 subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner
254 authorized by Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and
255 regulations thereunder. When substitution of a generic drug is permitted by the prescriber
256 according to section 338.056, and a generic drug is substituted for a name-brand drug, the MO
257 HealthNet division may not lower or delete the requirement to make a co-payment pursuant to
258 regulations of Title XIX of the federal Social Security Act. A provider of goods or services
259 described under this section must collect from all participants the additional payment that may
260 be required by the MO HealthNet division under authority granted herein, if the division
261 exercises that authority, to remain eligible as a provider. Any payments made by participants
262 under this section shall be in addition to and not in lieu of payments made by the state for goods
263 or services described herein except the participant portion of the pharmacy professional
264 dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may

265 collect the co-payment at the time a service is provided or at a later date. A provider shall not
266 refuse to provide a service if a participant is unable to pay a required payment. If it is the routine
267 business practice of a provider to terminate future services to an individual with an unclaimed
268 debt, the provider may include uncollected co-payments under this practice. Providers who elect
269 not to undertake the provision of services based on a history of bad debt shall give participants
270 advance notice and a reasonable opportunity for payment. A provider, representative, employee,
271 independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment
272 for a participant. This subsection shall not apply to other qualified children, pregnant women,
273 or blind persons. If the Centers for Medicare and Medicaid Services does not approve the MO
274 HealthNet state plan amendment submitted by the department of social services that would allow
275 a provider to deny future services to an individual with uncollected co-payments, the denial of
276 services shall not be allowed. The department of social services shall inform providers regarding
277 the acceptability of denying services as the result of unpaid co-payments.

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

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

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

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

296 8. Providers of long-term care services shall be reimbursed for their costs in accordance
297 with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. Section
298 1396a, as amended, and regulations promulgated thereunder.

299 9. Reimbursement rates to long-term care providers with respect to a total change in
300 ownership, at arm's length, for any facility previously licensed and certified for participation in

301 the MO HealthNet program shall not increase payments in excess of the increase that would
302 result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C.
303 Section 1396a (a)(13)(C).

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

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

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

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

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

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