House ____ Amendment NO.____

Offered By

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AMEND House Committee Substitute for House Bill No. 2012, Page 1, Section A, Line 3, by inserting after all of said section and line the following:

"188.035. [~~Whoever, with intent to do so, shall take the life of a child aborted alive, shall be guilty of murder of the second degree.~~] 1. This section shall be known and may be cited as the "Born-Alive Abortion Survivors Protection Act".

2. A child born alive during or after an abortion or an attempted abortion shall have all the rights, privileges, and immunities available to other persons, citizens, and residents of this state, including any other liveborn child.

3. Any health care provider licensed, registered, or certified in this state who is present at the time a child is born alive during or after an abortion or attempted abortion shall:

(1) Exercise the same degree of professional skill, care, and diligence to preserve the life and health of the child as a reasonably diligent and conscientious health care provider would render to any other child born alive at the same gestational age; and

(2) Ensure that the child born alive is immediately transported and admitted to a hospital following the exercise of skill, care, and diligence required under subdivision (1) of this subsection.

4. In addition to any criminal or administrative liability which may be incurred, a person shall be civilly liable when he or she:

(1) Knowingly, recklessly, or negligently causes the death of a child who is born alive during or after an abortion or an attempted abortion;

(2) Knowingly fails to comply with any of the provisions of subsection 3 of this section if the person is a health care provider subject to such provisions;

(3) Knowingly performs or induces, or attempts to perform or induce, an unlawful abortion upon another person;

(4) Knowingly aids or abets another person to undergo a self-induced abortion or attempted self-induced abortion or to procure an unlawful abortion or attempted unlawful abortion;

(5) Knowingly, recklessly, or negligently supplies or makes available any instrument, device, medicine, drug, or any other means or substance for another person to undergo a self-induced abortion or attempted self-induced abortion or to procure an unlawful abortion or attempted unlawful abortion; or

Action Taken______________________________ Date ______________

1 (6) Knowingly incites, solicits, or otherwise uses speech or writing as an integral part of
2 conduct in violation of a valid criminal statute to influence another person to undergo a self-induced
3 abortion or attempted self-induced abortion or to procure an unlawful abortion or attempted
4 unlawful abortion.
5 5. If injury or death arises out of or results from any circumstance under subsection 4 of this
6 section to any of the following persons, including:
7 (1) A person upon whom the unlawful abortion or attempted unlawful abortion was
8 performed or induced;
9 (2) A person who underwent a self-induced abortion or attempted self-induced abortion or
10 who procured an unlawful abortion or attempted unlawful abortion;
11 (3) A child who was born alive during or after an abortion or attempted abortion; or
12 (4) An unborn child,

13 then a cause of action for personal injury, bodily injury, or wrongful death may be brought. In a
14 cause of action for wrongful death, the spouse, partner, parents, siblings, and children of the
15 deceased person, child, or unborn child shall be entitled to bring the action. Damages for injury or
16 death may be recovered for, including, but not limited to, any damages described in chapters 537
17 and 538 that are applicable; loss of future fertility; loss of love and companionship of the spouse,
18 partner, parent, child, unborn child, or sibling; and for injury to or destruction of the spouse, partner,
19 parent, child, unborn child, or sibling relationship in such amount as, under all the circumstances of
20 the case, may be just. The court shall also award a prevailing plaintiff reasonable attorney's fees and
21 litigation costs, including, but not limited to, expert witness fees and expenses as part of the costs.
22 A defendant shall not be permitted to plead or prove as a defense that the plaintiff or deceased
23 person assumed the risk of undergoing, or consented to undergo, a self-induced abortion or
24 attempted self-induced abortion or that the plaintiff or deceased person assumed the risk of
25 procuring, or consented to procure, an unlawful abortion or attempted unlawful abortion. The fact
26 that a plaintiff or deceased person consented to undergo a self-induced abortion or attempted self-
27 induced abortion or to procure an unlawful abortion or attempted unlawful abortion shall not, in and
28 of itself, be considered evidence of contributory or comparative negligence. Any exculpatory
29 agreement between or among parties that is related to undergoing a self-induced abortion or
30 attempted self-induced abortion or to procuring an unlawful abortion or attempted unlawful abortion
31 shall be against public policy and shall be void."; and
32
33 Further amend said bill, Page 3, Section 188.165, Line 10, by inserting after all of said section and
34 line the following:
35
36 "188.202. 1. No federal act, law, executive order, administrative order, rule, or regulation
37 shall infringe on the right of the people of Missouri to:
38 (1) Protect state sovereignty and state taxpayers by restricting public funds, public facilities,
39 and public employees from being used to perform, induce, or assist in an abortion, except as

provided for in state statutes;

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

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

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

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

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

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

188.207. It shall be unlawful for any public funds to be expended to any abortion 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 bring **[**~~suit in a circuit court of proper venue~~**]** a cause of action in any court or administrative agency of competent jurisdiction to enforce the provisions of sections 188.200 to 188.215.

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

1 more than eighty percent of the lesser of reasonable costs or customary charges for such services,
2 determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97,
3 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.), but the MO
4 HealthNet division may evaluate outpatient hospital services rendered under this section and deny
5 payment for services which are determined by the MO HealthNet division not to be medically
6 necessary, in accordance with federal law and regulations;
7 (3) Laboratory and X-ray services;
8 (4) Nursing home services for participants, except to persons with more than five hundred
9 thousand dollars equity in their home or except for persons in an institution for mental diseases who
10 are under the age of sixty-five years, when residing in a hospital licensed by the department of
11 health and senior services or a nursing home licensed by the department of health and senior
12 services or appropriate licensing authority of other states or government-owned and -operated
13 institutions which are determined to conform to standards equivalent to licensing requirements in
14 Title XIX of the federal Social Security Act (42 U.S.C. Section 301, et seq.), as amended, for
15 nursing facilities. The MO HealthNet division may recognize through its payment methodology for
16 nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The
17 MO HealthNet division when determining the amount of the benefit payments to be made on behalf
18 of persons under the age of twenty-one in a nursing facility may consider nursing facilities
19 furnishing care to persons under the age of twenty-one as a classification separate from other
20 nursing facilities;
21 (5) Nursing home costs for participants receiving benefit payments under subdivision (4) of
22 this subsection for those days, which shall not exceed twelve per any period of six consecutive
23 months, during which the participant is on a temporary leave of absence from the hospital or nursing
24 home, provided that no such participant shall be allowed a temporary leave of absence unless it is
25 specifically provided for in his plan of care. As used in this subdivision, the term "temporary leave
26 of absence" shall include all periods of time during which a participant is away from the hospital or
27 nursing home overnight because he is visiting a friend or relative;
28 (6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or
29 elsewhere; provided that, no funds shall be expended to any abortion facility, as defined in section
30 188.015, or to any affiliate or associate of such abortion facility;
31 (7) Subject to appropriation, up to twenty visits per year for services limited to
32 examinations, diagnoses, adjustments, and manipulations and treatments of malpositioned
33 articulations and structures of the body provided by licensed chiropractic physicians practicing
34 within their scope of practice. Nothing in this subdivision shall be interpreted to otherwise expand
35 MO HealthNet services;
36 (8) Drugs and medicines when prescribed by a licensed physician, dentist, podiatrist, or an
37 advanced practice registered nurse; except that no payment for drugs and medicines prescribed on
38 and after January 1, 2006, by a licensed physician, dentist, podiatrist, or an advanced practice
39 registered nurse may be made on behalf of any person who qualifies for prescription drug coverage

under the provisions of P.L. 108-173;

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

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

(11) Home health care services;

(12) Family planning as defined by federal rules and regulations; provided that, no funds shall be expended to any abortion facility, as defined in section 188.015, or to any affiliate or associate of such abortion facility; and further provided, however, that such family planning services shall not include abortions or any abortifacient drug or device that is used for the purpose of inducing an abortion unless such abortions are certified in writing by a physician to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term;

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

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

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

1 shall be set subject to appropriations. Subject to appropriations, each resident of such facility who
2 qualifies for assistance under section 208.030 and meets the level of care required in this section
3 shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care
4 services per day. Authorized units of personal care services shall not be reduced or tier level
5 lowered unless an order approving such reduction or lowering is obtained from the resident's
6 personal physician. Such authorized units of personal care services or tier level shall be transferred
7 with such resident if he or she transfers to another such facility. Such provision shall terminate upon
8 receipt of relevant waivers from the federal Department of Health and Human Services. If the
9 Centers for Medicare and Medicaid Services determines that such provision does not comply with
10 the state plan, this provision shall be null and void. The MO HealthNet division shall notify the
11 revisor of statutes as to whether the relevant waivers are approved or a determination of
12 noncompliance is made;
13 (16) Mental health services. The state plan for providing medical assistance under Title
14 XIX of the Social Security Act, 42 U.S.C. Section 301, as amended, shall include the following
15 mental health services when such services are provided by community mental health facilities
16 operated by the department of mental health or designated by the department of mental health as a
17 community mental health facility or as an alcohol and drug abuse facility or as a child-serving
18 agency within the comprehensive children's mental health service system established in section
19 630.097. The department of mental health shall establish by administrative rule the definition and
20 criteria for designation as a community mental health facility and for designation as an alcohol and
21 drug abuse facility. Such mental health services shall include:
22 (a) Outpatient mental health services including preventive, diagnostic, therapeutic,
23 rehabilitative, and palliative interventions rendered to individuals in an individual or group setting
24 by a mental health professional in accordance with a plan of treatment appropriately established,
25 implemented, monitored, and revised under the auspices of a therapeutic team as a part of client
26 services management;
27 (b) Clinic mental health services including preventive, diagnostic, therapeutic,
28 rehabilitative, and palliative interventions rendered to individuals in an individual or group setting
29 by a mental health professional in accordance with a plan of treatment appropriately established,
30 implemented, monitored, and revised under the auspices of a therapeutic team as a part of client
31 services management;
32 (c) Rehabilitative mental health and alcohol and drug abuse services including home and
33 community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions
34 rendered to individuals in an individual or group setting by a mental health or alcohol and drug
35 abuse professional in accordance with a plan of treatment appropriately established, implemented,
36 monitored, and revised under the auspices of a therapeutic team as a part of client services
37 management. As used in this section, mental health professional and alcohol and drug abuse
38 professional shall be defined by the department of mental health pursuant to duly promulgated rules.
39 With respect to services established by this subdivision, the department of social services, MO

1 HealthNet division, shall enter into an agreement with the department of mental health. Matching
2 funds for outpatient mental health services, clinic mental health services, and rehabilitation services
3 for mental health and alcohol and drug abuse shall be certified by the department of mental health to
4 the MO HealthNet division. The agreement shall establish a mechanism for the joint
5 implementation of the provisions of this subdivision. In addition, the agreement shall establish a
6 mechanism by which rates for services may be jointly developed;
7 (17) Such additional services as defined by the MO HealthNet division to be furnished
8 under waivers of federal statutory requirements as provided for and authorized by the federal Social
9 Security Act (42 U.S.C. Section 301, et seq.) subject to appropriation by the general assembly;
10 (18) The services of an advanced practice registered nurse with a collaborative practice
11 agreement to the extent that such services are provided in accordance with chapters 334 and 335,
12 and regulations promulgated thereunder;
13 (19) Nursing home costs for participants receiving benefit payments under subdivision (4)
14 of this subsection to reserve a bed for the participant in the nursing home during the time that the
15 participant is absent due to admission to a hospital for services which cannot be performed on an
16 outpatient basis, subject to the provisions of this subdivision:
17 (a) The provisions of this subdivision shall apply only if:
18 a. The occupancy rate of the nursing home is at or above ninety-seven percent of MO
19 HealthNet certified licensed beds, according to the most recent quarterly census provided to the
20 department of health and senior services which was taken prior to when the participant is admitted
21 to the hospital; and
22 b. The patient is admitted to a hospital for a medical condition with an anticipated stay of
23 three days or less;
24 (b) The payment to be made under this subdivision shall be provided for a maximum of
25 three days per hospital stay;
26 (c) For each day that nursing home costs are paid on behalf of a participant under this
27 subdivision during any period of six consecutive months such participant shall, during the same
28 period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise
29 available temporary leave of absence days provided under subdivision (5) of this subsection; and
30 (d) The provisions of this subdivision shall not apply unless the nursing home receives
31 notice from the participant or the participant's responsible party that the participant intends to return
32 to the nursing home following the hospital stay. If the nursing home receives such notification and
33 all other provisions of this subsection have been satisfied, the nursing home shall provide notice to
34 the participant or the participant's responsible party prior to release of the reserved bed;
35 (20) Prescribed medically necessary durable medical equipment. An electronic web-based
36 prior authorization system using best medical evidence and care and treatment guidelines consistent
37 with national standards shall be used to verify medical need;
38 (21) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated
39 program of active professional medical attention within a home, outpatient and inpatient care which

1 treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary
2 team. The program provides relief of severe pain or other physical symptoms and supportive care to
3 meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses
4 which are experienced during the final stages of illness, and during dying and bereavement and
5 meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418.
6 The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and
7 board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five
8 percent of the rate of reimbursement which would have been paid for facility services in that nursing
9 home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239
10 (Omnibus Budget Reconciliation Act of 1989);
11 (22) Prescribed medically necessary dental services. Such services shall be subject to
12 appropriations. An electronic web-based prior authorization system using best medical evidence
13 and care and treatment guidelines consistent with national standards shall be used to verify medical
14 need;
15 (23) Prescribed medically necessary optometric services. Such services shall be subject to
16 appropriations. An electronic web-based prior authorization system using best medical evidence
17 and care and treatment guidelines consistent with national standards shall be used to verify medical
18 need;
19 (24) Blood clotting products-related services. For persons diagnosed with a bleeding
20 disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section
21 338.400, such services include:
22 (a) Home delivery of blood clotting products and ancillary infusion equipment and supplies,
23 including the emergency deliveries of the product when medically necessary;
24 (b) Medically necessary ancillary infusion equipment and supplies required to administer
25 the blood clotting products; and
26 (c) Assessments conducted in the participant's home by a pharmacist, nurse, or local home
27 health care agency trained in bleeding disorders when deemed necessary by the participant's treating
28 physician;
29 (25) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report
30 the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of
31 the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by
32 third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide
33 to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and
34 for third-party payor average dental reimbursement rates. Such plan shall be subject to
35 appropriation and the division shall include in its annual budget request to the governor the
36 necessary funding needed to complete the four-year plan developed under this subdivision.
37 2. Additional benefit payments for medical assistance shall be made on behalf of those
38 eligible needy children, pregnant women and blind persons with any payments to be made on the
39 basis of the reasonable cost of the care or reasonable charge for the services as defined and

1 determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:
2 (1) Dental services;
3 (2) Services of podiatrists as defined in section 330.010;
4 (3) Optometric services as described in section 336.010;
5 (4) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids,
6 and wheelchairs;
7 (5) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated
8 program of active professional medical attention within a home, outpatient and inpatient care which
9 treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary
10 team. The program provides relief of severe pain or other physical symptoms and supportive care to
11 meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses
12 which are experienced during the final stages of illness, and during dying and bereavement and
13 meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418.
14 The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and
15 board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five
16 percent of the rate of reimbursement which would have been paid for facility services in that nursing
17 home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239
18 (Omnibus Budget Reconciliation Act of 1989);
19 (6) Comprehensive day rehabilitation services beginning early posttrauma as part of a
20 coordinated system of care for individuals with disabling impairments. Rehabilitation services must
21 be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan
22 developed, implemented, and monitored through an interdisciplinary assessment designed to restore
23 an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet
24 division shall establish by administrative rule the definition and criteria for designation of a
25 comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. Any
26 rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority
27 delegated in this subdivision shall become effective only if it complies with and is subject to all of
28 the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are
29 nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to
30 review, to delay the effective date, or to disapprove and annul a rule are subsequently held
31 unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after
32 August 28, 2005, shall be invalid and void.
33 3. The MO HealthNet division may require any participant receiving MO HealthNet
34 benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1,
35 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services
36 except for those services covered under subdivisions (15) and (16) of subsection 1 of this section
37 and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the
38 federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations thereunder. When
39 substitution of a generic drug is permitted by the prescriber according to section 338.056, and a

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

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

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

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

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

1 8. Providers of long-term care services shall be reimbursed for their costs in accordance
2 with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. Section 1396a,
3 as amended, and regulations promulgated thereunder.
4 9. Reimbursement rates to long-term care providers with respect to a total change in
5 ownership, at arm's length, for any facility previously licensed and certified for participation in the
6 MO HealthNet program shall not increase payments in excess of the increase that would result from
7 the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. Section 1396a
8 (a)(13)(C).
9 10. The MO HealthNet division may enroll qualified residential care facilities and assisted
10 living facilities, as defined in chapter 198, as MO HealthNet personal care providers.
11 11. Any income earned by individuals eligible for certified extended employment at a
12 sheltered workshop under chapter 178 shall not be considered as income for purposes of
13 determining eligibility under this section.
14 12. If the Missouri Medicaid audit and compliance unit changes any interpretation or
15 application of the requirements for reimbursement for MO HealthNet services from the
16 interpretation or application that has been applied previously by the state in any audit of a MO
17 HealthNet provider, the Missouri Medicaid audit and compliance unit shall notify all affected MO
18 HealthNet providers five business days before such change shall take effect. Failure of the Missouri
19 Medicaid audit and compliance unit to notify a provider of such change shall entitle the provider to
20 continue to receive and retain reimbursement until such notification is provided and shall waive any
21 liability of such provider for recoupment or other loss of any payments previously made prior to the
22 five business days after such notice has been sent. Each provider shall provide the Missouri
23 Medicaid audit and compliance unit a valid email address and shall agree to receive
24 communications electronically. The notification required under this section shall be delivered in
25 writing by the United States Postal Service or electronic mail to each provider.
26 13. Nothing in this section shall be construed to abrogate or limit the department's statutory
27 requirement to promulgate rules under chapter 536.
28 14. Beginning July 1, 2016, and subject to appropriations, providers of behavioral, social,
29 and psychophysiological services for the prevention, treatment, or management of physical health
30 problems shall be reimbursed utilizing the behavior assessment and intervention reimbursement
31 codes 96150 to 96154 or their successor codes under the Current Procedural Terminology (CPT)
32 coding system. Providers eligible for such reimbursement shall include psychologists.
33 208.153. 1. Pursuant to and not inconsistent with the provisions of sections 208.151 and
34 208.152, the MO HealthNet division shall by rule and regulation define the reasonable costs,
35 manner, extent, quantity, quality, charges and fees of MO HealthNet benefits herein provided. The
36 benefits available under these sections shall not replace those provided under other federal or state
37 law or under other contractual or legal entitlements of the persons receiving them, and all persons
38 shall be required to apply for and utilize all benefits available to them and to pursue all causes of
39 action to which they are entitled. Any person entitled to MO HealthNet benefits may obtain it from

1 any provider of services which is not excluded or disqualified as a provider under any provision of
2 law including, but not limited to, section 208.164, with which an agreement is in effect under this
3 section and which undertakes to provide the services, as authorized by the MO HealthNet division.
4 At the discretion of the director of the MO HealthNet division and with the approval of the
5 governor, the MO HealthNet division is authorized to provide medical benefits for participants
6 receiving public assistance by expending funds for the payment of federal medical insurance
7 premiums, coinsurance and deductibles pursuant to the provisions of Title XVIII B and XIX, Public
8 Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et seq.), as
9 amended.
10 2. MO HealthNet shall include benefit payments on behalf of qualified Medicare
11 beneficiaries as defined in 42 U.S.C. Section 1396d(p). The family support division shall by rule
12 and regulation establish which qualified Medicare beneficiaries are eligible. The MO HealthNet
13 division shall define the premiums, deductible and coinsurance provided for in 42 U.S.C. Section
14 1396d(p) to be provided on behalf of the qualified Medicare beneficiaries.
15 3. MO HealthNet shall include benefit payments for Medicare Part A cost sharing as defined
16 in clause (p)(3)(A)(i) of 42 U.S.C. 1396d on behalf of qualified disabled and working individuals as
17 defined in subsection (s) of Section 42 U.S.C. 1396d as required by subsection (d) of Section 6408
18 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989). The MO HealthNet division may
19 impose a premium for such benefit payments as authorized by paragraph (d)(3) of Section 6408 of
20 P.L. 101-239.
21 4. MO HealthNet shall include benefit payments for Medicare Part B cost sharing described
22 in 42 U.S.C. Section 1396(d)(p)(3)(A)(ii) for individuals described in subsection 2 of this section,
23 but for the fact that their income exceeds the income level established by the state under 42 U.S.C.
24 Section 1396(d)(p)(2) but is less than one hundred and ten percent beginning January 1, 1993, and
25 less than one hundred and twenty percent beginning January 1, 1995, of the official poverty line for
26 a family of the size involved.
27 5. For an individual eligible for MO HealthNet under Title XIX of the Social Security Act,
28 MO HealthNet shall include payment of enrollee premiums in a group health plan and all
29 deductibles, coinsurance and other cost-sharing for items and services otherwise covered under the
30 state Title XIX plan under Section 1906 of the federal Social Security Act and regulations
31 established under the authority of Section 1906, as may be amended. Enrollment in a group health
32 plan must be cost effective, as established by the Secretary of Health and Human Services, before
33 enrollment in the group health plan is required. If all members of a family are not eligible for MO
34 HealthNet and enrollment of the Title XIX eligible members in a group health plan is not possible
35 unless all family members are enrolled, all premiums for noneligible members shall be treated as
36 payment for MO HealthNet of eligible family members. Payment for noneligible family members
37 must be cost effective, taking into account payment of all such premiums. Non-Title XIX eligible
38 family members shall pay all deductible, coinsurance and other cost-sharing obligations. Each
39 individual as a condition of eligibility for MO HealthNet benefits shall apply for enrollment in the

1 group health plan.
2 6. Any Social Security cost-of-living increase at the beginning of any year shall be
3 disregarded until the federal poverty level for such year is implemented.
4 7. If a MO HealthNet participant has paid the requested spenddown in cash for any month
5 and subsequently pays an out-of-pocket valid medical expense for such month, such expense shall
6 be allowed as a deduction to future required spenddown for up to three months from the date of such
7 expense.
8 208.164. 1. As used in this section, unless the context clearly requires otherwise, the
9 following terms mean:
10 (1) "Abuse", a documented pattern of inducing, furnishing, or otherwise causing a recipient
11 to receive services or merchandise not otherwise required or requested by the recipient, attending
12 physician or appropriate utilization review team; a documented pattern of performing and billing
13 tests, examinations, patient visits, surgeries, drugs or merchandise that exceed limits or frequencies
14 determined by the department for like practitioners for which there is no demonstrable need, or for
15 which the provider has created the need through ineffective services or merchandise previously
16 rendered. The decision to impose any of the sanctions authorized in this section shall be made by
17 the director of the department, following a determination of demonstrable need or accepted medical
18 practice made in consultation with medical or other health care professionals, or qualified peer
19 review teams;
20 (2) "Department", the department of social services;
21 (3) "Excessive use", the act, by a person eligible for services under a contract or provider
22 agreement between the department of social services or its divisions and a provider, of seeking
23 and/or obtaining medical assistance benefits from a number of like providers and in quantities which
24 exceed the levels that are considered medically necessary by current medical practices and standards
25 for the eligible person's needs;
26 (4) "Fraud", a known false representation, including the concealment of a material fact that
27 the provider knew or should have known through the usual conduct of his or her profession or
28 occupation, upon which the provider claims reimbursement under the terms and conditions of a
29 contract or provider agreement and the policies pertaining to such contract or provider agreement of
30 the department or its divisions in carrying out the providing of services, or under any approved state
31 plan authorized by the federal Social Security Act;
32 (5) "Health plan", a group of services provided to recipients of medical assistance benefits
33 by providers under a contract with the department;
34 (6) "Medical assistance benefits", those benefits authorized to be provided by sections
35 208.152 and 208.162;
36 (7) "Prior authorization", approval to a provider to perform a service or services for an
37 eligible person required by the department or its divisions in advance of the actual service being
38 provided or approved for a recipient to receive a service or services from a provider, required by the
39 department or its designated division in advance of the actual service or services being received;

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

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

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

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

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

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

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

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

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

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

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

1 department of social services or its designated division.
2 8. The department or its designated division shall have the authority with respect to any
3 recipient of medical assistance benefits whose use has been restricted under subsection 7 of this
4 section and who obtains or seeks to obtain medical assistance benefits from a provider other than
5 one of the providers for designated services to terminate medical assistance benefits as defined by
6 this chapter, where allowed by the provisions of the federal Social Security Act.
7 9. The department or its designated division shall have the authority with respect to any
8 provider who knowingly allows a recipient to violate subsection 7 of this section or who fails to
9 report a known violation of subsection 7 of this section to the department of social services or its
10 designated division to terminate or otherwise sanction such provider's status as a participant in the
11 medical assistance program. Any person making such a report shall not be civilly liable when the
12 report is made in good faith.
13 10. In order to comply with the provisions of 42 U.S.C. Section 1320a-7(a) relating to
14 mandatory exclusion of certain individuals and entities from participation in any federal health care
15 program, and in furtherance of the state's authority under federal law, as implemented by 42 CFR
16 1002.3(b), to exclude an individual or entity from MO HealthNet for any reason or period
17 authorized by state law, the department or its divisions shall suspend, revoke, or cancel any contract
18 or provider agreement or refuse to enter into a new contract or provider agreement with any
19 provider where it is determined that such provider is not qualified to perform the service or services
20 required, as described in 42 U.S.C. Section 1396a(a)(23), because such provider, or such provider's
21 agent, servant, or employee acting under such provider's authority:
22 (1) Has a conviction related to the delivery of any item or service under Medicare or under
23 any state health care program, as described in 42 U.S.C. Section 1320a-7(a)(1);
24 (2) Has a conviction related to the neglect or abuse of a patient in connection with the
25 delivery of any health care item or service, as described in 42 U.S.C. Section 1320a-7(a)(2);
26 (3) Has a felony conviction related to health care fraud, theft, embezzlement, breach of
27 fiduciary responsibility, or other financial misconduct, as described in 42 U.S.C. Section 1320a-
28 7(a)(3);
29 (4) Has a felony conviction related to the unlawful manufacture, distribution, prescription,
30 or dispensation of a controlled substance, as described in 42 U.S.C. Section 1320a-7(a)(4);
31 (5) Has been found guilty of a pattern of intentional discrimination in the delivery or
32 nondelivery of any health care item or service based on the race, color, or national origin of
33 recipients, as described in 42 U.S.C. Section 175 2000d; or is an organization whose original
34 "principles and aims" were to limit the "reckless procreation" of "[t]hose least fit to carry on the
35 race", "[t]o create a race of well born children", and for the "sterilization of the insane and
36 feebleminded", and whose founder and first president supported eugenics as the solution for racial,
37 political, and social problems and advocated for the use of birth control for "the elimination of the
38 unfit" and stopping "the reproduction of the unfit"; or
39 (6) Is an abortion facility, as defined in section 188.015, or an affiliate or associate of such

1 abortion facility.

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

11

12 Further amend said bill by amending the title, enacting clause, and intersectional references
13 accordingly.