

SECOND REGULAR SESSION

# HOUSE BILL NO. 1854

101ST GENERAL ASSEMBLY

---

INTRODUCED BY REPRESENTATIVE SCHROER.

4259H.011

DANA RADEMAN MILLER, Chief Clerk

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## AN ACT

To repeal sections 208.152, 208.153, 208.164, and 208.659, RSMo, and to enact in lieu thereof six new sections relating to health care.

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

Section A. Sections 208.152, 208.153, 208.164, and 208.659, RSMo, are repealed and six new sections enacted in lieu thereof, to be known as sections 188.202, 188.207, 208.152, 208.153, 208.164, and 208.659, to read as follows:

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

**(1) Protect state sovereignty and state taxpayers by restricting public funds, public facilities, 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.**

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.

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

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

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

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

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

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

22           (3) Laboratory and X-ray services;

23           (4) Nursing home services for participants, except to persons with more than five  
24 hundred thousand dollars equity in their home or except for persons in an institution for  
25 mental diseases who are under the age of sixty-five years, when residing in a hospital licensed  
26 by the department of health and senior services or a nursing home licensed by the department

27 of health and senior services or appropriate licensing authority of other states or government-  
28 owned and -operated institutions which are determined to conform to standards equivalent to  
29 licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. Section 301,  
30 et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize  
31 through its payment methodology for nursing facilities those nursing facilities which serve a  
32 high volume of MO HealthNet patients. The MO HealthNet division when determining the  
33 amount of the benefit payments to be made on behalf of persons under the age of twenty-one  
34 in a nursing facility may consider nursing facilities furnishing care to persons under the age of  
35 twenty-one as a classification separate from other nursing facilities;

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

44 (6) Physicians' services, whether furnished in the office, home, hospital, nursing  
45 home, or elsewhere; **provided that, no funds shall be expended to any abortion facility, as**  
46 **defined in section 188.015, or to any affiliate or associate of such abortion facility;**

47 (7) Subject to appropriation, up to twenty visits per year for services limited to  
48 examinations, diagnoses, adjustments, and manipulations and treatments of malpositioned  
49 articulations and structures of the body provided by licensed chiropractic physicians  
50 practicing within their scope of practice. Nothing in this subdivision shall be interpreted to  
51 otherwise expand MO HealthNet services;

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

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

59 (10) Early and periodic screening and diagnosis of individuals who are under the age  
60 of twenty-one to ascertain their physical or mental defects, and health care, treatment, and  
61 other measures to correct or ameliorate defects and chronic conditions discovered thereby.  
62 Such services shall be provided in accordance with the provisions of Section 6403 of P.L.  
63 101-239 and federal regulations promulgated thereunder;

64 (11) Home health care services;

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

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

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

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

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

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

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

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

130 (c) Rehabilitative mental health and alcohol and drug abuse services including home  
131 and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative  
132 interventions rendered to individuals in an individual or group setting by a mental health  
133 or alcohol and drug abuse professional in accordance with a plan of treatment appropriately  
134 established, implemented, monitored, and revised under the auspices of a therapeutic team as  
135 a part of client services management. As used in this section, mental health professional and  
136 alcohol and drug abuse professional shall be defined by the department of mental health  
137 pursuant to duly promulgated rules. With respect to services established by this subdivision,

138 the department of social services, MO HealthNet division, shall enter into an agreement with  
139 the department of mental health. Matching funds for outpatient mental health services, clinic  
140 mental health services, and rehabilitation services for mental health and alcohol and drug  
141 abuse shall be certified by the department of mental health to the MO HealthNet division.  
142 The agreement shall establish a mechanism for the joint implementation of the provisions of  
143 this subdivision. In addition, the agreement shall establish a mechanism by which rates for  
144 services may be jointly developed;

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

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

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

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

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

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

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

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

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

174 home shall provide notice to the participant or the participant's responsible party prior to  
175 release of the reserved bed;

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

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

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

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

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

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

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

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

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

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

224 (1) Dental services;

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

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

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

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

242 (6) Comprehensive day rehabilitation services beginning early posttrauma as part of a  
243 coordinated system of care for individuals with disabling impairments. Rehabilitation  
244 services must be based on an individualized, goal-oriented, comprehensive and coordinated  
245 treatment plan developed, implemented, and monitored through an interdisciplinary  
246 assessment designed to restore an individual to optimal level of physical, cognitive, and



247 behavioral function. The MO HealthNet division shall establish by administrative rule the  
248 definition and criteria for designation of a comprehensive day rehabilitation service facility,  
249 benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is  
250 defined in section 536.010, that is created under the authority delegated in this subdivision  
251 shall become effective only if it complies with and is subject to all of the provisions of  
252 chapter 536 and, if applicable, section 536.028. This section and chapter 536 are  
253 nonseverable and if any of the powers vested with the general assembly pursuant to chapter  
254 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently  
255 held unconstitutional, then the grant of rulemaking authority and any rule proposed or  
256 adopted after August 28, 2005, shall be invalid and void.

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

284 deny future services to an individual with uncollected co-payments, the denial of services  
285 shall not be allowed. The department of social services shall inform providers regarding the  
286 acceptability of denying services as the result of unpaid co-payments.

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

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

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

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

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

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

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

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

318 12. If the Missouri Medicaid audit and compliance unit changes any interpretation or  
319 application of the requirements for reimbursement for MO HealthNet services from the  
320 interpretation or application that has been applied previously by the state in any audit of a MO

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

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

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

208.153. 1. Pursuant to and not inconsistent with the provisions of sections 208.151  
2 and 208.152, the MO HealthNet division shall by rule and regulation define the reasonable  
3 costs, manner, extent, quantity, quality, charges and fees of MO HealthNet benefits herein  
4 provided. The benefits available under these sections shall not replace those provided under  
5 other federal or state law or under other contractual or legal entitlements of the persons  
6 receiving them, and all persons shall be required to apply for and utilize all benefits available  
7 to them and to pursue all causes of action to which they are entitled. ~~[Any person entitled to~~  
8 ~~MO HealthNet benefits may obtain it from any provider of services with which an agreement~~  
9 ~~is in effect under this section and which undertakes to provide the services, as authorized by~~  
10 ~~the MO HealthNet division.]~~ At the discretion of the director of the MO HealthNet division  
11 and with the approval of the governor, the MO HealthNet division is authorized to provide  
12 medical benefits for participants receiving public assistance by expending funds for the  
13 payment of federal medical insurance premiums, coinsurance and deductibles pursuant to the  
14 provisions of Title XVIII B and XIX, Public Law 89-97, 1965 amendments to the federal  
15 Social Security Act (42 U.S.C. 301, et seq.), as amended.

16 2. MO HealthNet shall include benefit payments on behalf of qualified Medicare  
17 beneficiaries as defined in 42 U.S.C. Section 1396d(p). The family support division shall by  
18 rule and regulation establish which qualified Medicare beneficiaries are eligible. The MO

19 HealthNet division shall define the premiums, deductible and coinsurance provided for in 42  
20 U.S.C. Section 1396d(p) to be provided on behalf of the qualified Medicare beneficiaries.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

113 eugenics as the solution for racial, political, and social problems and who advocated for  
114 the use of birth control for "the elimination of the unfit" and stopping "the  
115 reproduction of the unfit"; or

116 (6) Is an abortion facility, as defined in section 188.015, or an affiliate or  
117 associate of such abortion facility.

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

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