

SECOND REGULAR SESSION

SENATE BILL NO. 972

94TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR STOUFFER.

Read 1st time January 17, 2008, and ordered printed.

TERRY L. SPIELER, Secretary.

4527S.02I

AN ACT

To repeal section 208.152, RSMo, and to enact in lieu thereof one new section relating to comprehensive day rehabilitation services under the MO HealthNet program.

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

Section A. Section 208.152, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 208.152, to read as follows:

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

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

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

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

19 set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the
20 federal Social Security Act (42 U.S.C. 301, et seq.), but the MO HealthNet
21 division may evaluate outpatient hospital services rendered under this section
22 and deny payment for services which are determined by the MO HealthNet
23 division not to be medically necessary, in accordance with federal law and
24 regulations;

25 (3) Laboratory and X-ray services;

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

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

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

52 (7) Drugs and medicines when prescribed by a licensed physician, dentist,
53 or podiatrist; except that no payment for drugs and medicines prescribed on and
54 after January 1, 2006, by a licensed physician, dentist, or podiatrist may be made

55 on behalf of any person who qualifies for prescription drug coverage under the
56 provisions of P.L. 108-173;

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

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

66 (10) Home health care services;

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

72 (12) Inpatient psychiatric hospital services for individuals under age
73 twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C.
74 1396d, et seq.);

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

83 (14) Personal care services which are medically oriented tasks having to
84 do with a person's physical requirements, as opposed to housekeeping
85 requirements, which enable a person to be treated by his physician on an
86 outpatient rather than on an inpatient or residential basis in a hospital,
87 intermediate care facility, or skilled nursing facility. Personal care services shall
88 be rendered by an individual not a member of the participant's family who is
89 qualified to provide such services where the services are prescribed by a physician
90 in accordance with a plan of treatment and are supervised by a licensed

91 nurse. Persons eligible to receive personal care services shall be those persons
92 who would otherwise require placement in a hospital, intermediate care facility,
93 or skilled nursing facility. Benefits payable for personal care services shall not
94 exceed for any one participant one hundred percent of the average statewide
95 charge for care and treatment in an intermediate care facility for a comparable
96 period of time. Such services, when delivered in a residential care facility or
97 assisted living facility licensed under chapter 198, RSMo, shall be authorized on
98 a tier level based on the services the resident requires and the frequency of the
99 services. A resident of such facility who qualifies for assistance under section
100 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier
101 level with the fewest services. The rate paid to providers for each tier of service
102 shall be set subject to appropriations. Subject to appropriations, each resident
103 of such facility who qualifies for assistance under section 208.030 and meets the
104 level of care required in this section shall, at a minimum, if prescribed by a
105 physician, be authorized up to one hour of personal care services per
106 day. Authorized units of personal care services shall not be reduced or tier level
107 lowered unless an order approving such reduction or lowering is obtained from
108 the resident's personal physician. Such authorized units of personal care services
109 or tier level shall be transferred with such resident if her or she transfers to
110 another such facility. Such provision shall terminate upon receipt of relevant
111 waivers from the federal Department of Health and Human Services. If the
112 Centers for Medicare and Medicaid Services determines that such provision does
113 not comply with the state plan, this provision shall be null and void. The MO
114 HealthNet division shall notify the revisor of statutes as to whether the relevant
115 waivers are approved or a determination of noncompliance is made;

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

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

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

139 (c) Rehabilitative mental health and alcohol and drug abuse services
140 including home and community-based preventive, diagnostic, therapeutic,
141 rehabilitative, and palliative interventions rendered to individuals in an
142 individual or group setting by a mental health or alcohol and drug abuse
143 professional in accordance with a plan of treatment appropriately established,
144 implemented, monitored, and revised under the auspices of a therapeutic team
145 as a part of client services management. As used in this section, mental health
146 professional and alcohol and drug abuse professional shall be defined by the
147 department of mental health pursuant to duly promulgated rules.

148 With respect to services established by this subdivision, the department of social
149 services, MO HealthNet division, shall enter into an agreement with the
150 department of mental health. Matching funds for outpatient mental health
151 services, clinic mental health services, and rehabilitation services for mental
152 health and alcohol and drug abuse shall be certified by the department of mental
153 health to the MO HealthNet division. The agreement shall establish a
154 mechanism for the joint implementation of the provisions of this subdivision. In
155 addition, the agreement shall establish a mechanism by which rates for services
156 may be jointly developed;

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

161 (17) Beginning July 1, 1990, the services of a certified pediatric or family
162 nursing practitioner with a collaborative practice agreement to the extent that

163 such services are provided in accordance with chapters 334 and 335, RSMo, and
164 regulations promulgated thereunder;

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

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

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

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

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

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

184 (d) The provisions of this subdivision shall not apply unless the nursing
185 home receives notice from the participant or the participant's responsible party
186 that the participant intends to return to the nursing home following the hospital
187 stay. If the nursing home receives such notification and all other provisions of
188 this subsection have been satisfied, the nursing home shall provide notice to the
189 participant or the participant's responsible party prior to release of the reserved
190 bed;

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

195 (20) **Comprehensive day rehabilitation services beginning early**
196 **posttrauma as part of a coordinated system of care for individuals with**
197 **disabling impairments. Rehabilitation services must be based on an**
198 **individualized, goal-oriented, comprehensive, and coordinated**

199 treatment plan developed, implemented, and monitored through an
200 interdisciplinary assessment designed to restore an individual to
201 optimal level of physical, cognitive, and behavioral function. The MO
202 HealthNet division shall establish by administrative rule the definition
203 and criteria for designation of a comprehensive day rehabilitation
204 service facility, benefit limitations, and payment mechanism utilizing
205 the expertise of brain injury rehabilitation service providers and the
206 Missouri head injury advisory council created under section 192.745,
207 RSMo. Such services shall be provided in a community-based facility
208 and be authorized on tier levels based on the services the patient
209 requires and the frequency of the services as guided by a qualified
210 rehabilitation professional associated with a health care home. Any
211 rule or portion of a rule, as that term is defined in section 536.010,
212 RSMo, that is created under the authority delegated in this subdivision
213 shall become effective only if it complies with and is subject to all of
214 the provisions of chapter 536, RSMo, and, if applicable, section 536.028,
215 RSMo. This section and chapter 536, RSMo, are nonseverable and if any
216 of the powers vested with the general assembly pursuant to chapter
217 536, RSMo, to review, to delay the effective date, or to disapprove and
218 annul a rule are subsequently held unconstitutional, then the grant of
219 rulemaking authority and any rule proposed or adopted after August
220 28, 2008, shall be invalid and void;

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

235 Budget Reconciliation Act of 1989);

236 [(21)] **(22)** Prescribed medically necessary dental services. Such services
237 shall be subject to appropriations. An electronic web-based prior authorization
238 system using best medical evidence and care and treatment guidelines consistent
239 with national standards shall be used to verify medical need;

240 [(22)] **(23)** Prescribed medically necessary optometric services. Such
241 services shall be subject to appropriations. An electronic web-based prior
242 authorization system using best medical evidence and care and treatment
243 guidelines consistent with national standards shall be used to verify medical
244 need;

245 [(23)] **(24)** The MO HealthNet division shall, by January 1, 2008, and
246 annually thereafter, report the status of MO HealthNet provider reimbursement
247 rates as compared to one hundred percent of the Medicare reimbursement rates
248 and compared to the average dental reimbursement rates paid by third-party
249 payors licensed by the state. The MO HealthNet division shall, by July 1, 2008,
250 provide to the general assembly a four-year plan to achieve parity with Medicare
251 reimbursement rates and for third-party payor average dental reimbursement
252 rates. Such plan shall be subject to appropriation and the division shall include
253 in its annual budget request to the governor the necessary funding needed to
254 complete the four-year plan developed under this subdivision.

255 2. Additional benefit payments for medical assistance shall be made on
256 behalf of those eligible needy children, pregnant women and blind persons with
257 any payments to be made on the basis of the reasonable cost of the care or
258 reasonable charge for the services as defined and determined by the division of
259 medical services, unless otherwise hereinafter provided, for the following:

- 260 (1) Dental services;
- 261 (2) Services of podiatrists as defined in section 330.010, RSMo;
- 262 (3) Optometric services as defined in section 336.010, RSMo;
- 263 (4) Orthopedic devices or other prosthetics, including eye glasses,
264 dentures, hearing aids, and wheelchairs;
- 265 (5) Hospice care. As used in this subsection, the term "hospice care"
266 means a coordinated program of active professional medical attention within a
267 home, outpatient and inpatient care which treats the terminally ill patient and
268 family as a unit, employing a medically directed interdisciplinary team. The
269 program provides relief of severe pain or other physical symptoms and supportive
270 care to meet the special needs arising out of physical, psychological, spiritual,

271 social, and economic stresses which are experienced during the final stages of
272 illness, and during dying and bereavement and meets the Medicare requirements
273 for participation as a hospice as are provided in 42 CFR Part 418. The rate of
274 reimbursement paid by the MO HealthNet division to the hospice provider for
275 room and board furnished by a nursing home to an eligible hospice patient shall
276 not be less than ninety-five percent of the rate of reimbursement which would
277 have been paid for facility services in that nursing home facility for that patient,
278 in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus
279 Budget Reconciliation Act of 1989);

280 (6) Comprehensive day rehabilitation services beginning early posttrauma
281 as part of a coordinated system of care for individuals with disabling
282 impairments. Rehabilitation services must be based on an individualized,
283 goal-oriented, comprehensive and coordinated treatment plan developed,
284 implemented, and monitored through an interdisciplinary assessment designed
285 to restore an individual to optimal level of physical, cognitive, and behavioral
286 function. The MO HealthNet division shall establish by administrative rule the
287 definition and criteria for designation of a comprehensive day rehabilitation
288 service facility, benefit limitations and payment mechanism. Any rule or portion
289 of a rule, as that term is defined in section 536.010, RSMo, that is created under
290 the authority delegated in this subdivision shall become effective only if it
291 complies with and is subject to all of the provisions of chapter 536, RSMo, and,
292 if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are
293 nonseverable and if any of the powers vested with the general assembly pursuant
294 to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and
295 annul a rule are subsequently held unconstitutional, then the grant of
296 rulemaking authority and any rule proposed or adopted after August 28, 2005,
297 shall be invalid and void.

298 3. The MO HealthNet division may require any participant receiving MO
299 HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an
300 additional payment after July 1, 2008, as defined by rule duly promulgated by the
301 MO HealthNet division, for all covered services except for those services covered
302 under subdivisions (14) and (15) of subsection 1 of this section and sections
303 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the
304 federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations
305 thereunder. When substitution of a generic drug is permitted by the prescriber
306 according to section 338.056, RSMo, and a generic drug is substituted for a

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

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

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

342 6. Beginning July 1, 1990, reimbursement for services rendered in

343 federally funded health centers shall be in accordance with the provisions of
344 subsection 6402(c) and Section 6404 of P.L. 101-239 (Omnibus Budget
345 Reconciliation Act of 1989) and federal regulations promulgated thereunder.

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

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

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

361 10. The MO HealthNet division, may enroll qualified residential care
362 facilities and assisted living facilities, as defined in chapter 198, RSMo, as MO
363 HealthNet personal care providers.

364 11. Any income earned by individuals eligible for certified extended
365 employment at a sheltered workshop under chapter 178, RSMo, shall not be
366 considered as income for purposes of determining eligibility under this section.

Copy ✓