

FIRST REGULAR SESSION
SENATE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 209
99TH GENERAL ASSEMBLY

Reported from the Committee on Professional Registration, May 4, 2017, with recommendation that the Senate Committee Substitute do pass.

0589S.02C

ADRIANE D. CROUSE, Secretary.

AN ACT

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

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

Section A. Section 208.152, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 208.152, to read as follows:

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

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

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such 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. Section 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. Section 301, et seq.), as amended, for nursing facilities. The MO
35 HealthNet division may recognize through its payment methodology for nursing
36 facilities 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) **Services provided by licensed chiropractic physicians**
53 **practicing within their scope of practice, as described in chapter 331,**
54 **for conditions currently reimbursed under MO HealthNet. Nothing in**

55 **this subdivision shall expand MO HealthNet or the conditions currently**
56 **covered under section 208.151;**

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

63 **[(8)] (9)** Emergency ambulance services and, effective January 1, 1990,
64 medically necessary transportation to scheduled, physician-prescribed nonelective
65 treatments;

66 **[(9)] (10)** Early and periodic screening and diagnosis of individuals who
67 are under the age of twenty-one to ascertain their physical or mental defects, and
68 health care, treatment, and other measures to correct or ameliorate defects and
69 chronic conditions discovered thereby. Such services shall be provided in
70 accordance with the provisions of Section 6403 of P.L. 101-239 and federal
71 regulations promulgated thereunder;

72 **[(10)] (11)** Home health care services;

73 **[(11)] (12)** Family planning as defined by federal rules and regulations;
74 provided, however, that such family planning services shall not include abortions
75 unless such abortions are certified in writing by a physician to the MO HealthNet
76 agency that, in the physician's professional judgment, the life of the mother would
77 be endangered if the fetus were carried to term;

78 **[(12)] (13)** Inpatient psychiatric hospital services for individuals under
79 age twenty-one as defined in Title XIX of the federal Social Security Act (42
80 U.S.C. Section 1396d, et seq.);

81 **[(13)] (14)** Outpatient surgical procedures, including presurgical
82 diagnostic services performed in ambulatory surgical facilities which are licensed
83 by the department of health and senior services of the state of Missouri; except,
84 that such outpatient surgical services shall not include persons who are eligible
85 for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to
86 the federal Social Security Act, as amended, if exclusion of such persons is
87 permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal
88 Social Security Act, as amended;

89 **[(14)] (15)** Personal care services which are medically oriented tasks
90 having to do with a person's physical requirements, as opposed to housekeeping

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

122 [(15)] **(16)** Mental health services. The state plan for providing medical
123 assistance under Title XIX of the Social Security Act, 42 U.S.C. Section 301, as
124 amended, shall include the following mental health services when such services
125 are provided by community mental health facilities operated by the department
126 of mental health or designated by the department of mental health as a

127 community mental health facility or as an alcohol and drug abuse facility or as
128 a child-serving agency within the comprehensive children's mental health service
129 system established in section 630.097. The department of mental health shall
130 establish by administrative rule the definition and criteria for designation as a
131 community mental health facility and for designation as an alcohol and drug
132 abuse facility. Such mental health services shall include:

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

145 (c) Rehabilitative mental health and alcohol and drug abuse services
146 including home and community-based preventive, diagnostic, therapeutic,
147 rehabilitative, and palliative interventions rendered to individuals in an
148 individual or group setting by a mental health or alcohol and drug abuse
149 professional in accordance with a plan of treatment appropriately established,
150 implemented, monitored, and revised under the auspices of a therapeutic team
151 as a part of client services management. As used in this section, mental health
152 professional and alcohol and drug abuse professional shall be defined by the
153 department of mental health pursuant to duly promulgated rules. With respect
154 to services established by this subdivision, the department of social services, MO
155 HealthNet division, shall enter into an agreement with the department of mental
156 health. Matching funds for outpatient mental health services, clinic mental
157 health services, and rehabilitation services for mental health and alcohol and
158 drug abuse shall be certified by the department of mental health to the MO
159 HealthNet division. The agreement shall establish a mechanism for the joint
160 implementation of the provisions of this subdivision. In addition, the agreement
161 shall establish a mechanism by which rates for services may be jointly developed;

162 ~~[(16)]~~ (17) Such additional services as defined by the MO HealthNet

163 division to be furnished under waivers of federal statutory requirements as
164 provided for and authorized by the federal Social Security Act (42 U.S.C. Section
165 301, et seq.) subject to appropriation by the general assembly;

166 [(17)] **(18)** The services of an advanced practice registered nurse with a
167 collaborative practice agreement to the extent that such services are provided in
168 accordance with chapters 334 and 335, and regulations promulgated thereunder;

169 [(18)] **(19)** Nursing home costs for participants receiving benefit
170 payments under subdivision (4) of this subsection to reserve a bed for the
171 participant in the nursing home during the time that the participant is absent
172 due to admission to a hospital for services which cannot be performed on an
173 outpatient basis, subject to the provisions of this subdivision:

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

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

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

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

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

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

195 [(19)] **(20)** Prescribed medically necessary durable medical equipment.
196 An electronic web-based prior authorization system using best medical evidence
197 and care and treatment guidelines consistent with national standards shall be
198 used to verify medical need;

199 [(20)] **(21)** Hospice care. As used in this subdivision, the term "hospice
200 care" means a coordinated program of active professional medical attention within
201 a home, outpatient and inpatient care which treats the terminally ill patient and
202 family as a unit, employing a medically directed interdisciplinary team. The
203 program provides relief of severe pain or other physical symptoms and supportive
204 care to meet the special needs arising out of physical, psychological, spiritual,
205 social, and economic stresses which are experienced during the final stages of
206 illness, and during dying and bereavement and meets the Medicare requirements
207 for participation as a hospice as are provided in 42 CFR Part 418. The rate of
208 reimbursement paid by the MO HealthNet division to the hospice provider for
209 room and board furnished by a nursing home to an eligible hospice patient shall
210 not be less than ninety-five percent of the rate of reimbursement which would
211 have been paid for facility services in that nursing home facility for that patient,
212 in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus
213 Budget Reconciliation Act of 1989);

214 [(21)] **(22)** Prescribed medically necessary dental services. Such services
215 shall be subject to appropriations. An electronic web-based prior authorization
216 system using best medical evidence and care and treatment guidelines consistent
217 with national standards shall be used to verify medical need;

218 [(22)] **(23)** Prescribed medically necessary optometric services. Such
219 services shall be subject to appropriations. An electronic web-based prior
220 authorization system using best medical evidence and care and treatment
221 guidelines consistent with national standards shall be used to verify medical
222 need;

223 [(23)] **(24)** Blood clotting products-related services. For persons
224 diagnosed with a bleeding disorder, as defined in section 338.400, reliant on blood
225 clotting products, as defined in section 338.400, such services include:

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

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

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

234 [(24)] **(25)** The MO HealthNet division shall, by January 1, 2008, and

235 annually thereafter, report the status of MO HealthNet provider reimbursement
236 rates as compared to one hundred percent of the Medicare reimbursement rates
237 and compared to the average dental reimbursement rates paid by third-party
238 payors licensed by the state. The MO HealthNet division shall, by July 1, 2008,
239 provide to the general assembly a four-year plan to achieve parity with Medicare
240 reimbursement rates and for third-party payor average dental reimbursement
241 rates. Such plan shall be subject to appropriation and the division shall include
242 in its annual budget request to the governor the necessary funding needed to
243 complete the four-year plan developed under this subdivision.

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

249 (1) Dental services;

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

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

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

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

269 (6) Comprehensive day rehabilitation services beginning early posttrauma
270 as part of a coordinated system of care for individuals with disabling

271 impairments. Rehabilitation services must be based on an individualized,
272 goal-oriented, comprehensive and coordinated treatment plan developed,
273 implemented, and monitored through an interdisciplinary assessment designed
274 to restore an individual to optimal level of physical, cognitive, and behavioral
275 function. The MO HealthNet division shall establish by administrative rule the
276 definition and criteria for designation of a comprehensive day rehabilitation
277 service facility, benefit limitations and payment mechanism. Any rule or portion
278 of a rule, as that term is defined in section 536.010, that is created under the
279 authority delegated in this subdivision shall become effective only if it complies
280 with and is subject to all of the provisions of chapter 536 and, if applicable,
281 section 536.028. This section and chapter 536 are nonseverable and if any of the
282 powers vested with the general assembly pursuant to chapter 536 to review, to
283 delay the effective date, or to disapprove and annul a rule are subsequently held
284 unconstitutional, then the grant of rulemaking authority and any rule proposed
285 or adopted after August 28, 2005, shall be invalid and void.

286 3. The MO HealthNet division may require any participant receiving MO
287 HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an
288 additional payment after July 1, 2008, as defined by rule duly promulgated by the
289 MO HealthNet division, for all covered services except for those services covered
290 under subdivisions [(14)] **(15)** and [(15)] **(16)** of subsection 1 of this section and
291 sections 208.631 to 208.657 to the extent and in the manner authorized by Title
292 XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and
293 regulations thereunder. When substitution of a generic drug is permitted by the
294 prescriber according to section 338.056, and a generic drug is substituted for a
295 name-brand drug, the MO HealthNet division may not lower or delete the
296 requirement to make a co-payment pursuant to regulations of Title XIX of the
297 federal Social Security Act. A provider of goods or services described under this
298 section must collect from all participants the additional payment that may be
299 required by the MO HealthNet division under authority granted herein, if the
300 division exercises that authority, to remain eligible as a provider. Any payments
301 made by participants under this section shall be in addition to and not in lieu of
302 payments made by the state for goods or services described herein except the
303 participant portion of the pharmacy professional dispensing fee shall be in
304 addition to and not in lieu of payments to pharmacists. A provider may collect
305 the co-payment at the time a service is provided or at a later date. A provider
306 shall not refuse to provide a service if a participant is unable to pay a required

307 payment. If it is the routine business practice of a provider to terminate future
308 services to an individual with an unclaimed debt, the provider may include
309 uncollected co-payments under this practice. Providers who elect not to
310 undertake the provision of services based on a history of bad debt shall give
311 participants advance notice and a reasonable opportunity for payment. A
312 provider, representative, employee, independent contractor, or agent of a
313 pharmaceutical manufacturer shall not make co-payment for a participant. This
314 subsection shall not apply to other qualified children, pregnant women, or blind
315 persons. If the Centers for Medicare and Medicaid Services does not approve the
316 MO HealthNet state plan amendment submitted by the department of social
317 services that would allow a provider to deny future services to an individual with
318 uncollected co-payments, the denial of services shall not be allowed. The
319 department of social services shall inform providers regarding the acceptability
320 of denying services as the result of unpaid co-payments.

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

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

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

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

341 8. Providers of long-term care services shall be reimbursed for their costs
342 in accordance with the provisions of Section 1902 (a)(13)(A) of the Social Security

343 Act, 42 U.S.C. Section 1396a, as amended, and regulations promulgated
344 thereunder.

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

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

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

357 12. If the Missouri Medicaid audit and compliance unit changes any
358 interpretation or application of the requirements for reimbursement for MO
359 HealthNet services from the interpretation or application that has been applied
360 previously by the state in any audit of a MO HealthNet provider, the Missouri
361 Medicaid audit and compliance unit shall notify all affected MO HealthNet
362 providers five business days before such change shall take effect. Failure of the
363 Missouri Medicaid audit and compliance unit to notify a provider of such change
364 shall entitle the provider to continue to receive and retain reimbursement until
365 such notification is provided and shall waive any liability of such provider for
366 recoupment or other loss of any payments previously made prior to the five
367 business days after such notice has been sent. Each provider shall provide the
368 Missouri Medicaid audit and compliance unit a valid email address and shall
369 agree to receive communications electronically. The notification required under
370 this section shall be delivered in writing by the United States Postal Service or
371 electronic mail to each provider.

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

374 14. Beginning July 1, 2016, and subject to appropriations, providers of
375 behavioral, social, and psychophysiological services for the prevention, treatment,
376 or management of physical health problems shall be reimbursed utilizing the
377 behavior assessment and intervention reimbursement codes 96150 to 96154 or
378 their successor codes under the Current Procedural Terminology (CPT) coding

379 system. Providers eligible for such reimbursement shall include psychologists.

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