

SENATE AMENDMENT NO. _____

Offered by _____ of _____

Amend Senate Bill No. 723, Page 1, Section title, Lines 2-3,

2 by striking the words "the Medicaid stabilization fund" and
3 inserting in lieu thereof the following: "MO HealthNet"; and

4 Further amend said bill and page, Section A, line 3, by
5 inserting after all of said line the following:

6 "208.152. 1. MO HealthNet payments shall be made on
7 behalf of those eligible needy persons as described in
8 section 208.151 who are unable to provide for it in whole or
9 in part, with any payments to be made on the basis of the
10 reasonable cost of the care or reasonable charge for the
11 services as defined and determined by the MO HealthNet
12 division, unless otherwise hereinafter provided, for the
13 following:

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

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

39 (3) Laboratory and X-ray services;

40 (4) Nursing home services for participants, except to
41 persons with more than five hundred thousand dollars equity
42 in their home or except for persons in an institution for
43 mental diseases who are under the age of sixty-five years,
44 when residing in a hospital licensed by the department of
45 health and senior services or a nursing home licensed by the
46 department of health and senior services or appropriate
47 licensing authority of other states or government-owned and -
48 operated institutions which are determined to conform to
49 standards equivalent to licensing requirements in Title XIX
50 of the federal Social Security Act (42 U.S.C. Section 301,
51 et seq.), as amended, for nursing facilities. The MO
52 HealthNet division may recognize through its payment
53 methodology for nursing facilities those nursing facilities
54 which serve a high volume of MO HealthNet patients. The MO
55 HealthNet division when determining the amount of the
56 benefit payments to be made on behalf of persons under the
57 age of twenty-one in a nursing facility may consider nursing
58 facilities furnishing care to persons under the age of

59 twenty-one as a classification separate from other nursing
60 facilities;

61 (5) Nursing home costs for participants receiving
62 benefit payments under subdivision (4) of this subsection
63 for those days, which shall not exceed twelve per any period
64 of six consecutive months, during which the participant is
65 on a temporary leave of absence from the hospital or nursing
66 home, provided that no such participant shall be allowed a
67 temporary leave of absence unless it is specifically
68 provided for in his plan of care. As used in this
69 subdivision, the term "temporary leave of absence" shall
70 include all periods of time during which a participant is
71 away from the hospital or nursing home overnight because he
72 is visiting a friend or relative;

73 (6) Physicians' services, whether furnished in the
74 office, home, hospital, nursing home, or elsewhere, provided, no funds shall be expended to any abortion
75 facility, as defined in section 188.015, or any affiliate or
76 associate thereof;

77
78 (7) Subject to appropriation, up to twenty visits per
79 year for services limited to examinations, diagnoses,
80 adjustments, and manipulations and treatments of
81 malpositioned articulations and structures of the body
82 provided by licensed chiropractic physicians practicing
83 within their scope of practice. Nothing in this subdivision
84 shall be interpreted to otherwise expand MO HealthNet
85 services;

86 (8) Drugs and medicines when prescribed by a licensed
87 physician, dentist, podiatrist, or an advanced practice
88 registered nurse; except that no payment for drugs and
89 medicines prescribed on and after January 1, 2006, by a
90 licensed physician, dentist, podiatrist, or an advanced
91 practice registered nurse may be made on behalf of any

92 person who qualifies for prescription drug coverage under
93 the provisions of P.L. 108-173;

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

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

105 (11) Home health care services;

106 (12) Family planning as defined by federal rules and
107 regulations; provided, however, that such family planning
108 services shall not include abortions or any abortifacient
109 drug or device that is used for the purpose of inducing an
110 abortion unless such abortions are certified in writing by a
111 physician to the MO HealthNet agency that, in the
112 physician's professional judgment, the life of the mother
113 would be endangered if the fetus were carried to term;

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

118 (14) Outpatient surgical procedures, including
119 presurgical diagnostic services performed in ambulatory
120 surgical facilities which are licensed by the department of
121 health and senior services of the state of Missouri; except,
122 that such outpatient surgical services shall not include
123 persons who are eligible for coverage under Part B of Title
124 XVIII, Public Law 89-97, 1965 amendments to the federal

125 Social Security Act, as amended, if exclusion of such
126 persons is permitted under Title XIX, Public Law 89-97, 1965
127 amendments to the federal Social Security Act, as amended;

128 (15) Personal care services which are medically
129 oriented tasks having to do with a person's physical
130 requirements, as opposed to housekeeping requirements, which
131 enable a person to be treated by his or her physician on an
132 outpatient rather than on an inpatient or residential basis
133 in a hospital, intermediate care facility, or skilled
134 nursing facility. Personal care services shall be rendered
135 by an individual not a member of the participant's family
136 who is qualified to provide such services where the services
137 are prescribed by a physician in accordance with a plan of
138 treatment and are supervised by a licensed nurse. Persons
139 eligible to receive personal care services shall be those
140 persons who would otherwise require placement in a hospital,
141 intermediate care facility, or skilled nursing facility.
142 Benefits payable for personal care services shall not exceed
143 for any one participant one hundred percent of the average
144 statewide charge for care and treatment in an intermediate
145 care facility for a comparable period of time. Such
146 services, when delivered in a residential care facility or
147 assisted living facility licensed under chapter 198 shall be
148 authorized on a tier level based on the services the
149 resident requires and the frequency of the services. A
150 resident of such facility who qualifies for assistance under
151 section 208.030 shall, at a minimum, if prescribed by a
152 physician, qualify for the tier level with the fewest
153 services. The rate paid to providers for each tier of
154 service shall be set subject to appropriations. Subject to
155 appropriations, each resident of such facility who qualifies
156 for assistance under section 208.030 and meets the level of
157 care required in this section shall, at a minimum, if

158 prescribed by a physician, be authorized up to one hour of
159 personal care services per day. Authorized units of
160 personal care services shall not be reduced or tier level
161 lowered unless an order approving such reduction or lowering
162 is obtained from the resident's personal physician. Such
163 authorized units of personal care services or tier level
164 shall be transferred with such resident if he or she
165 transfers to another such facility. Such provision shall
166 terminate upon receipt of relevant waivers from the federal
167 Department of Health and Human Services. If the Centers for
168 Medicare and Medicaid Services determines that such
169 provision does not comply with the state plan, this
170 provision shall be null and void. The MO HealthNet division
171 shall notify the revisor of statutes as to whether the
172 relevant waivers are approved or a determination of
173 noncompliance is made;

174 (16) Mental health services. The state plan for
175 providing medical assistance under Title XIX of the Social
176 Security Act, 42 U.S.C. Section 301, as amended, shall
177 include the following mental health services when such
178 services are provided by community mental health facilities
179 operated by the department of mental health or designated by
180 the department of mental health as a community mental health
181 facility or as an alcohol and drug abuse facility or as a
182 child-serving agency within the comprehensive children's
183 mental health service system established in section
184 630.097. The department of mental health shall establish by
185 administrative rule the definition and criteria for
186 designation as a community mental health facility and for
187 designation as an alcohol and drug abuse facility. Such
188 mental health services shall include:

189 (a) Outpatient mental health services including
190 preventive, diagnostic, therapeutic, rehabilitative, and

191 palliative interventions rendered to individuals in an
192 individual or group setting by a mental health professional
193 in accordance with a plan of treatment appropriately
194 established, implemented, monitored, and revised under the
195 auspices of a therapeutic team as a part of client services
196 management;

197 (b) Clinic mental health services including
198 preventive, diagnostic, therapeutic, rehabilitative, and
199 palliative interventions rendered to individuals in an
200 individual or group setting by a mental health professional
201 in accordance with a plan of treatment appropriately
202 established, implemented, monitored, and revised under the
203 auspices of a therapeutic team as a part of client services
204 management;

205 (c) Rehabilitative mental health and alcohol and drug
206 abuse services including home and community-based
207 preventive, diagnostic, therapeutic, rehabilitative, and
208 palliative interventions rendered to individuals in an
209 individual or group setting by a mental health or alcohol
210 and drug abuse professional in accordance with a plan of
211 treatment appropriately established, implemented, monitored,
212 and revised under the auspices of a therapeutic team as a
213 part of client services management. As used in this
214 section, mental health professional and alcohol and drug
215 abuse professional shall be defined by the department of
216 mental health pursuant to duly promulgated rules. With
217 respect to services established by this subdivision, the
218 department of social services, MO HealthNet division, shall
219 enter into an agreement with the department of mental
220 health. Matching funds for outpatient mental health
221 services, clinic mental health services, and rehabilitation
222 services for mental health and alcohol and drug abuse shall
223 be certified by the department of mental health to the MO

224 HealthNet division. The agreement shall establish a
225 mechanism for the joint implementation of the provisions of
226 this subdivision. In addition, the agreement shall
227 establish a mechanism by which rates for services may be
228 jointly developed;

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

234 (18) The services of an advanced practice registered
235 nurse with a collaborative practice agreement to the extent
236 that such services are provided in accordance with chapters
237 334 and 335, and regulations promulgated thereunder;

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

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

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

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

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

258 (c) For each day that nursing home costs are paid on
259 behalf of a participant under this subdivision during any
260 period of six consecutive months such participant shall,
261 during the same period of six consecutive months, be
262 ineligible for payment of nursing home costs of two
263 otherwise available temporary leave of absence days provided
264 under subdivision (5) of this subsection; and

265 (d) The provisions of this subdivision shall not apply
266 unless the nursing home receives notice from the participant
267 or the participant's responsible party that the participant
268 intends to return to the nursing home following the hospital
269 stay. If the nursing home receives such notification and
270 all other provisions of this subsection have been satisfied,
271 the nursing home shall provide notice to the participant or
272 the participant's responsible party prior to release of the
273 reserved bed;

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

279 (21) Hospice care. As used in this subdivision, the
280 term "hospice care" means a coordinated program of active
281 professional medical attention within a home, outpatient and
282 inpatient care which treats the terminally ill patient and
283 family as a unit, employing a medically directed
284 interdisciplinary team. The program provides relief of
285 severe pain or other physical symptoms and supportive care
286 to meet the special needs arising out of physical,
287 psychological, spiritual, social, and economic stresses

288 which are experienced during the final stages of illness,
289 and during dying and bereavement and meets the Medicare
290 requirements for participation as a hospice as are provided
291 in 42 CFR Part 418. The rate of reimbursement paid by the
292 MO HealthNet division to the hospice provider for room and
293 board furnished by a nursing home to an eligible hospice
294 patient shall not be less than ninety-five percent of the
295 rate of reimbursement which would have been paid for
296 facility services in that nursing home facility for that
297 patient, in accordance with subsection (c) of Section 6408
298 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

299 (22) Prescribed medically necessary dental services.
300 Such services shall be subject to appropriations. An
301 electronic web-based prior authorization system using best
302 medical evidence and care and treatment guidelines
303 consistent with national standards shall be used to verify
304 medical need;

305 (23) Prescribed medically necessary optometric
306 services. Such services shall be subject to
307 appropriations. An electronic web-based prior authorization
308 system using best medical evidence and care and treatment
309 guidelines consistent with national standards shall be used
310 to verify medical need;

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

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

318 (b) Medically necessary ancillary infusion equipment
319 and supplies required to administer the blood clotting
320 products; and

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

325 (25) The MO HealthNet division shall, by January 1,
326 2008, and annually thereafter, report the status of MO
327 HealthNet provider reimbursement rates as compared to one
328 hundred percent of the Medicare reimbursement rates and
329 compared to the average dental reimbursement rates paid by
330 third-party payors licensed by the state. The MO HealthNet
331 division shall, by July 1, 2008, provide to the general
332 assembly a four-year plan to achieve parity with Medicare
333 reimbursement rates and for third-party payor average dental
334 reimbursement rates. Such plan shall be subject to
335 appropriation and the division shall include in its annual
336 budget request to the governor the necessary funding needed
337 to complete the four-year plan developed under this
338 subdivision.

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

346 (1) Dental services;

347 (2) Services of podiatrists as defined in section
348 330.010;

349 (3) Optometric services as described in section
350 336.010;

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

353 (5) Hospice care. As used in this subdivision, the
354 term "hospice care" means a coordinated program of active
355 professional medical attention within a home, outpatient and
356 inpatient care which treats the terminally ill patient and
357 family as a unit, employing a medically directed
358 interdisciplinary team. The program provides relief of
359 severe pain or other physical symptoms and supportive care
360 to meet the special needs arising out of physical,
361 psychological, spiritual, social, and economic stresses
362 which are experienced during the final stages of illness,
363 and during dying and bereavement and meets the Medicare
364 requirements for participation as a hospice as are provided
365 in 42 CFR Part 418. The rate of reimbursement paid by the
366 MO HealthNet division to the hospice provider for room and
367 board furnished by a nursing home to an eligible hospice
368 patient shall not be less than ninety-five percent of the
369 rate of reimbursement which would have been paid for
370 facility services in that nursing home facility for that
371 patient, in accordance with subsection (c) of Section 6408
372 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

373 (6) Comprehensive day rehabilitation services
374 beginning early posttrauma as part of a coordinated system
375 of care for individuals with disabling impairments.
376 Rehabilitation services must be based on an individualized,
377 goal-oriented, comprehensive and coordinated treatment plan
378 developed, implemented, and monitored through an
379 interdisciplinary assessment designed to restore an
380 individual to optimal level of physical, cognitive, and
381 behavioral function. The MO HealthNet division shall
382 establish by administrative rule the definition and criteria
383 for designation of a comprehensive day rehabilitation
384 service facility, benefit limitations and payment
385 mechanism. Any rule or portion of a rule, as that term is

386 defined in section 536.010, that is created under the
387 authority delegated in this subdivision shall become
388 effective only if it complies with and is subject to all of
389 the provisions of chapter 536 and, if applicable, section
390 536.028. This section and chapter 536 are nonseverable and
391 if any of the powers vested with the general assembly
392 pursuant to chapter 536 to review, to delay the effective
393 date, or to disapprove and annul a rule are subsequently
394 held unconstitutional, then the grant of rulemaking
395 authority and any rule proposed or adopted after August 28,
396 2005, shall be invalid and void.

397 3. The MO HealthNet division may require any
398 participant receiving MO HealthNet benefits to pay part of
399 the charge or cost until July 1, 2008, and an additional
400 payment after July 1, 2008, as defined by rule duly
401 promulgated by the MO HealthNet division, for all covered
402 services except for those services covered under
403 subdivisions (15) and (16) of subsection 1 of this section
404 and sections 208.631 to 208.657 to the extent and in the
405 manner authorized by Title XIX of the federal Social
406 Security Act (42 U.S.C. Section 1396, et seq.) and
407 regulations thereunder. When substitution of a generic drug
408 is permitted by the prescriber according to section 338.056,
409 and a generic drug is substituted for a name-brand drug, the
410 MO HealthNet division may not lower or delete the
411 requirement to make a co-payment pursuant to regulations of
412 Title XIX of the federal Social Security Act. A provider of
413 goods or services described under this section must collect
414 from all participants the additional payment that may be
415 required by the MO HealthNet division under authority
416 granted herein, if the division exercises that authority, to
417 remain eligible as a provider. Any payments made by
418 participants under this section shall be in addition to and

419 not in lieu of payments made by the state for goods or
420 services described herein except the participant portion of
421 the pharmacy professional dispensing fee shall be in
422 addition to and not in lieu of payments to pharmacists. A
423 provider may collect the co-payment at the time a service is
424 provided or at a later date. A provider shall not refuse to
425 provide a service if a participant is unable to pay a
426 required payment. If it is the routine business practice of
427 a provider to terminate future services to an individual
428 with an unclaimed debt, the provider may include uncollected
429 co-payments under this practice. Providers who elect not to
430 undertake the provision of services based on a history of
431 bad debt shall give participants advance notice and a
432 reasonable opportunity for payment. A provider,
433 representative, employee, independent contractor, or agent
434 of a pharmaceutical manufacturer shall not make co-payment
435 for a participant. This subsection shall not apply to other
436 qualified children, pregnant women, or blind persons. If
437 the Centers for Medicare and Medicaid Services does not
438 approve the MO HealthNet state plan amendment submitted by
439 the department of social services that would allow a
440 provider to deny future services to an individual with
441 uncollected co-payments, the denial of services shall not be
442 allowed. The department of social services shall inform
443 providers regarding the acceptability of denying services as
444 the result of unpaid co-payments.

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

448 5. Reimbursement for obstetrical and pediatric
449 services under subdivision (6) of subsection 1 of this
450 section shall be timely and sufficient to enlist enough
451 health care providers so that care and services are

452 available under the state plan for MO HealthNet benefits at
453 least to the extent that such care and services are
454 available to the general population in the geographic area,
455 as required under subparagraph (a)(30)(A) of 42 U.S.C.
456 Section 1396a and federal regulations promulgated thereunder.

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

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

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

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

484 10. The MO HealthNet division may enroll qualified
485 residential care facilities and assisted living facilities,
486 as defined in chapter 198, as MO HealthNet personal care
487 providers.

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

492 12. If the Missouri Medicaid audit and compliance unit
493 changes any interpretation or application of the
494 requirements for reimbursement for MO HealthNet services
495 from the interpretation or application that has been applied
496 previously by the state in any audit of a MO HealthNet
497 provider, the Missouri Medicaid audit and compliance unit
498 shall notify all affected MO HealthNet providers five
499 business days before such change shall take effect. Failure
500 of the Missouri Medicaid audit and compliance unit to notify
501 a provider of such change shall entitle the provider to
502 continue to receive and retain reimbursement until such
503 notification is provided and shall waive any liability of
504 such provider for recoupment or other loss of any payments
505 previously made prior to the five business days after such
506 notice has been sent. Each provider shall provide the
507 Missouri Medicaid audit and compliance unit a valid email
508 address and shall agree to receive communications
509 electronically. The notification required under this
510 section shall be delivered in writing by the United States
511 Postal Service or electronic mail to each provider.

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

515 14. Beginning July 1, 2016, and subject to
516 appropriations, providers of behavioral, social, and

517 psychophysiological services for the prevention, treatment,
518 or management of physical health problems shall be
519 reimbursed utilizing the behavior assessment and
520 intervention reimbursement codes 96150 to 96154 or their
521 successor codes under the Current Procedural Terminology
522 (CPT) coding system. Providers eligible for such
523 reimbursement shall include psychologists.

524 208.153. 1. Pursuant to and not inconsistent with the
525 provisions of sections 208.151 and 208.152, the MO HealthNet
526 division shall by rule and regulation define the reasonable
527 costs, manner, extent, quantity, quality, charges and fees
528 of MO HealthNet benefits herein provided. The benefits
529 available under these sections shall not replace those
530 provided under other federal or state law or under other
531 contractual or legal entitlements of the persons receiving
532 them, and all persons shall be required to apply for and
533 utilize all benefits available to them and to pursue all
534 causes of action to which they are entitled. Any person
535 entitled to MO HealthNet benefits may obtain it from any
536 provider of services with which an agreement is in effect
537 under this section and which undertakes to provide the
538 services, as authorized by the MO HealthNet division,
539 provided, said provider shall not include any abortion
540 facility, as defined in section 188.015, or any affiliate or
541 associate thereof. At the discretion of the director of the
542 MO HealthNet division and with the approval of the governor,
543 the MO HealthNet division is authorized to provide medical
544 benefits for participants receiving public assistance by
545 expending funds for the payment of federal medical insurance
546 premiums, coinsurance and deductibles pursuant to the
547 provisions of Title XVIII B and XIX, Public Law 89-97, 1965
548 amendments to the federal Social Security Act (42 U.S.C.
549 301, et seq.), as amended.

550 2. MO HealthNet shall include benefit payments on
551 behalf of qualified Medicare beneficiaries as defined in 42
552 U.S.C. Section 1396d(p). The family support division shall
553 by rule and regulation establish which qualified Medicare
554 beneficiaries are eligible. The MO HealthNet division shall
555 define the premiums, deductible and coinsurance provided for
556 in 42 U.S.C. Section 1396d(p) to be provided on behalf of
557 the qualified Medicare beneficiaries.

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

567 4. MO HealthNet shall include benefit payments for
568 Medicare Part B cost sharing described in 42 U.S.C. Section
569 1396(d) (p) (3) (A) (ii) for individuals described in subsection
570 2 of this section, but for the fact that their income
571 exceeds the income level established by the state under 42
572 U.S.C. Section 1396(d) (p) (2) but is less than one hundred
573 and ten percent beginning January 1, 1993, and less than one
574 hundred and twenty percent beginning January 1, 1995, of the
575 official poverty line for a family of the size involved.

576 5. For an individual eligible for MO HealthNet under
577 Title XIX of the Social Security Act, MO HealthNet shall
578 include payment of enrollee premiums in a group health plan
579 and all deductibles, coinsurance and other cost-sharing for
580 items and services otherwise covered under the state Title
581 XIX plan under Section 1906 of the federal Social Security
582 Act and regulations established under the authority of

583 Section 1906, as may be amended. Enrollment in a group
584 health plan must be cost effective, as established by the
585 Secretary of Health and Human Services, before enrollment in
586 the group health plan is required. If all members of a
587 family are not eligible for MO HealthNet and enrollment of
588 the Title XIX eligible members in a group health plan is not
589 possible unless all family members are enrolled, all
590 premiums for noneligible members shall be treated as payment
591 for MO HealthNet of eligible family members. Payment for
592 noneligible family members must be cost effective, taking
593 into account payment of all such premiums. Non-Title XIX
594 eligible family members shall pay all deductible,
595 coinsurance and other cost-sharing obligations. Each
596 individual as a condition of eligibility for MO HealthNet
597 benefits shall apply for enrollment in the group health plan.

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

601 7. If a MO HealthNet participant has paid the
602 requested spenddown in cash for any month and subsequently
603 pays an out-of-pocket valid medical expense for such month,
604 such expense shall be allowed as a deduction to future
605 required spenddown for up to three months from the date of
606 such expense."; and

607 Further amend the title and enacting clause accordingly.