

SENATE BILL NO. 667

101ST GENERAL ASSEMBLY

INTRODUCED BY SENATOR BURLISON.

4237S.02I

ADRIANE D. CROUSE, Secretary

AN ACT

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

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

Section A. Sections 208.152, 208.153, 208.164, and
2 208.659, RSMo, are repealed and six new sections enacted in
3 lieu thereof, to be known as sections 188.202, 188.207, 208.152,
4 208.153, 208.164, and 208.659, to read as follows:

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

4 (1) Protect state sovereignty and state taxpayers by
5 restricting public funds, public facilities, and public
6 employees from being used to perform, induce, or assist in
7 an abortion, except as provided for in state statutes;

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

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

15 (4) Prevent the state or its political subdivisions
16 from being coerced, compelled, or commandeered by the
17 federal government to enact, administer, or enforce a

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

18 federal regulatory program that directly or indirectly funds
19 abortion; and

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

24 2. In any action to enforce the provisions of sections
25 188.200 to 188.215 by a taxpayer under the provisions of
26 section 188.220, a court of competent jurisdiction may order
27 injunctive or other equitable relief, recovery of damages or
28 other legal remedies, or both, as well as payment of
29 reasonable attorney's fees, costs, and expenses of the
30 taxpayer. The relief and remedies set forth shall not be
31 deemed exclusive and shall be in addition to any other
32 relief or remedies permitted by law.

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

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

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

9 (1) Inpatient hospital services, except to persons in
10 an institution for mental diseases who are under the age of

11 sixty-five years and over the age of twenty-one years;
12 provided that the MO HealthNet division shall provide
13 through rule and regulation an exception process for
14 coverage of inpatient costs in those cases requiring
15 treatment beyond the seventy-fifth percentile professional
16 activities study (PAS) or the MO HealthNet children's
17 diagnosis length-of-stay schedule; and provided further that
18 the MO HealthNet division shall take into account through
19 its payment system for hospital services the situation of
20 hospitals which serve a disproportionate number of low-
21 income patients;

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

34 (3) Laboratory and X-ray services;

35 (4) Nursing home services for participants, except to
36 persons with more than five hundred thousand dollars equity
37 in their home or except for persons in an institution for
38 mental diseases who are under the age of sixty-five years,
39 when residing in a hospital licensed by the department of
40 health and senior services or a nursing home licensed by the
41 department of health and senior services or appropriate
42 licensing authority of other states or government-owned and -

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

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

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

(7) Subject to appropriation, up to twenty visits per year for services limited to examinations, diagnoses,

adjustments, and manipulations and treatments of malpositioned articulations and structures of the body provided by licensed chiropractic physicians practicing within their scope of practice. Nothing in this subdivision shall be interpreted to otherwise expand MO HealthNet services;

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

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

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

(11) Home health care services;

(12) Family planning as defined by federal rules and regulations; **provided, that no funds shall be expended to any abortion facility, as defined in section 188.015, or to any affiliate or associate of such abortion facility; and further** provided, however, that such family planning services shall not include abortions or any abortifacient

107 drug or device that is used for the purpose of inducing an
108 abortion unless such abortions are certified in writing by a
109 physician to the MO HealthNet agency that, in the
110 physician's professional judgment, the life of the mother
111 would be endangered if the fetus were carried to term;

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

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

126 (15) Personal care services which are medically
127 oriented tasks having to do with a person's physical
128 requirements, as opposed to housekeeping requirements, which
129 enable a person to be treated by his or her physician on an
130 outpatient rather than on an inpatient or residential basis
131 in a hospital, intermediate care facility, or skilled
132 nursing facility. Personal care services shall be rendered
133 by an individual not a member of the participant's family
134 who is qualified to provide such services where the services
135 are prescribed by a physician in accordance with a plan of
136 treatment and are supervised by a licensed nurse. Persons
137 eligible to receive personal care services shall be those
138 persons who would otherwise require placement in a hospital,

139 intermediate care facility, or skilled nursing facility.
140 Benefits payable for personal care services shall not exceed
141 for any one participant one hundred percent of the average
142 statewide charge for care and treatment in an intermediate
143 care facility for a comparable period of time. Such
144 services, when delivered in a residential care facility or
145 assisted living facility licensed under chapter 198 shall be
146 authorized on a tier level based on the services the
147 resident requires and the frequency of the services. A
148 resident of such facility who qualifies for assistance under
149 section 208.030 shall, at a minimum, if prescribed by a
150 physician, qualify for the tier level with the fewest
151 services. The rate paid to providers for each tier of
152 service shall be set subject to appropriations. Subject to
153 appropriations, each resident of such facility who qualifies
154 for assistance under section 208.030 and meets the level of
155 care required in this section shall, at a minimum, if
156 prescribed by a physician, be authorized up to one hour of
157 personal care services per day. Authorized units of
158 personal care services shall not be reduced or tier level
159 lowered unless an order approving such reduction or lowering
160 is obtained from the resident's personal physician. Such
161 authorized units of personal care services or tier level
162 shall be transferred with such resident if he or she
163 transfers to another such facility. Such provision shall
164 terminate upon receipt of relevant waivers from the federal
165 Department of Health and Human Services. If the Centers for
166 Medicare and Medicaid Services determines that such
167 provision does not comply with the state plan, this
168 provision shall be null and void. The MO HealthNet division
169 shall notify the revisor of statutes as to whether the

170 relevant waivers are approved or a determination of
171 noncompliance is made;

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

187 (a) Outpatient mental health services including
188 preventive, diagnostic, therapeutic, rehabilitative, and
189 palliative interventions rendered to individuals in an
190 individual or group setting by a mental health professional
191 in accordance with a plan of treatment appropriately
192 established, implemented, monitored, and revised under the
193 auspices of a therapeutic team as a part of client services
194 management;

195 (b) Clinic mental health services including
196 preventive, diagnostic, therapeutic, rehabilitative, and
197 palliative interventions rendered to individuals in an
198 individual or group setting by a mental health professional
199 in accordance with a plan of treatment appropriately
200 established, implemented, monitored, and revised under the

201 auspices of a therapeutic team as a part of client services
202 management;

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

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

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

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

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

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

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

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

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

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

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

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

295 patient, in accordance with subsection (c) of Section 6408
296 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

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

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

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

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

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

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

323 (25) The MO HealthNet division shall, by January 1,
324 2008, and annually thereafter, report the status of MO
325 HealthNet provider reimbursement rates as compared to one
326 hundred percent of the Medicare reimbursement rates and

327 compared to the average dental reimbursement rates paid by
328 third-party payors licensed by the state. The MO HealthNet
329 division shall, by July 1, 2008, provide to the general
330 assembly a four-year plan to achieve parity with Medicare
331 reimbursement rates and for third-party payor average dental
332 reimbursement rates. Such plan shall be subject to
333 appropriation and the division shall include in its annual
334 budget request to the governor the necessary funding needed
335 to complete the four-year plan developed under this
336 subdivision.

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

- 344 (1) Dental services;
- 345 (2) Services of podiatrists as defined in section
346 330.010;
- 347 (3) Optometric services as described in section
348 336.010;
- 349 (4) Orthopedic devices or other prosthetics, including
350 eye glasses, dentures, hearing aids, and wheelchairs;
- 351 (5) Hospice care. As used in this subdivision, the
352 term "hospice care" means a coordinated program of active
353 professional medical attention within a home, outpatient and
354 inpatient care which treats the terminally ill patient and
355 family as a unit, employing a medically directed
356 interdisciplinary team. The program provides relief of
357 severe pain or other physical symptoms and supportive care
358 to meet the special needs arising out of physical,

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

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this subdivision shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective

391 date, or to disapprove and annul a rule are subsequently
392 held unconstitutional, then the grant of rulemaking
393 authority and any rule proposed or adopted after August 28,
394 2005, shall be invalid and void.

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

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

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

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

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

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

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

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

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

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

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

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

513 14. Beginning July 1, 2016, and subject to
514 appropriations, providers of behavioral, social, and
515 psychophysiological services for the prevention, treatment,
516 or management of physical health problems shall be
517 reimbursed utilizing the behavior assessment and

518 intervention reimbursement codes 96150 to 96154 or their
519 successor codes under the Current Procedural Terminology
520 (CPT) coding system. Providers eligible for such
521 reimbursement shall include psychologists.

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

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

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

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

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

5. For an individual eligible for MO HealthNet under Title XIX of the Social Security Act, MO HealthNet shall include payment of enrollee premiums in a group health plan and all deductibles, coinsurance and other cost-sharing for items and services otherwise covered under the state Title XIX plan under Section 1906 of the federal Social Security Act and regulations established under the authority of Section 1906, as may be amended. Enrollment in a group health plan must be cost effective, as established by the Secretary of Health and Human Services, before enrollment in

the group health plan is required. If all members of a family are not eligible for MO HealthNet and enrollment of the Title XIX eligible members in a group health plan is not possible unless all family members are enrolled, all premiums for noneligible members shall be treated as payment for MO HealthNet of eligible family members. Payment for noneligible family members must be cost effective, taking into account payment of all such premiums. Non-Title XIX eligible family members shall pay all deductible, coinsurance and other cost-sharing obligations. Each individual as a condition of eligibility for MO HealthNet benefits shall apply for enrollment in the group health plan.

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

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

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

(1) "Abuse", a documented pattern of inducing, furnishing, or otherwise causing a recipient to receive services or merchandise not otherwise required or requested by the recipient, attending physician or appropriate utilization review team; a documented pattern of performing and billing tests, examinations, patient visits, surgeries, drugs or merchandise that exceed limits or frequencies determined by the department for like practitioners for which there is no demonstrable need, or for which the

12 provider has created the need through ineffective services
13 or merchandise previously rendered. The decision to impose
14 any of the sanctions authorized in this section shall be
15 made by the director of the department, following a
16 determination of demonstrable need or accepted medical
17 practice made in consultation with medical or other health
18 care professionals, or qualified peer review teams;

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

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

28 (4) "Fraud", a known false representation, including
29 the concealment of a material fact that **the** provider knew or
30 should have known through the usual conduct of his **or her**
31 profession or occupation, upon which the provider claims
32 reimbursement under the terms and conditions of a contract
33 or provider agreement and the policies pertaining to such
34 contract or provider agreement of the department or its
35 divisions in carrying out the providing of services, or
36 under any approved state plan authorized by the federal
37 Social Security Act;

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

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

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

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

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

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

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

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

(1) When it has reasonable cause to believe a provider or recipient has knowingly followed a course of conduct

75 which is defined as abuse or fraud or excessive use by this
76 section; or

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

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

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

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

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

114 8. The department or its designated division shall
115 have the authority with respect to any recipient of medical
116 assistance benefits whose use has been restricted under
117 subsection 7 of this section and who obtains or seeks to
118 obtain medical assistance benefits from a provider other
119 than one of the providers for designated services to
120 terminate medical assistance benefits as defined by this
121 chapter, where allowed by the provisions of the federal
122 Social Security Act.

123 9. The department or its designated division shall
124 have the authority with respect to any provider who
125 knowingly allows a recipient to violate subsection 7 of this
126 section or who fails to report a known violation of
127 subsection 7 of this section to the department of social
128 services or its designated division to terminate or
129 otherwise sanction such provider's status as a participant
130 in the medical assistance program. Any person making such a
131 report shall not be civilly liable when the report is made
132 in good faith.

133 **10. The department or its designated division shall**
134 **have the authority to suspend, revoke, or cancel any**
135 **contract or provider agreement or refuse to enter into a new**
136 **contract or provider agreement with any provider where it is**
137 **determined that the provider, or any affiliate or associate**

thereof, has committed fraud, abuse, or unethical behavior and has been removed or prohibited from being a Medicaid provider in another state's Medicaid program.

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

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

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

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

(4) Has a felony conviction related to the unlawful manufacture, distribution, prescription, or dispensation of

170 a controlled substance, as described in 42 U.S.C. Section
171 1320a-7 (a) (4) ;

172 (5) Has been found guilty of a pattern of intentional
173 discrimination in the delivery or nondelivery of any health
174 care item or service based on the race, color, or national
175 origin of recipients, as described in 42 U.S.C. Section
176 2000d, or was founded by a person who supported eugenics as
177 the solution for racial, political, and social problems and
178 who advocated for the use of birth control for "the
179 elimination of the unfit" and stopping "the reproduction of
180 the unfit"; or

181 (6) Is an abortion facility, as defined in section
182 188.015, or an affiliate or associate of such abortion
183 facility.

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

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