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SENATE SUBSTITUTE

FOR

SENATE BILL NO. 39

AN ACT

To repeal section 208.152, RSMo, and to enact in lieu thereof three new sections relating to child protection, with a severability clause.

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

Section A. Section 208.152, RSMo, is repealed and three
2 new sections enacted in lieu thereof, to be known as sections
3 163.048, 191.1720, and 208.152, to read as follows:

163.048. 1. As used in this section, the following
2 terms mean:
3 (1) "Athletics", any interscholastic athletic games,
4 contests, programs, activities, exhibitions, or other
5 similar competitions organized and provided for students;
6 (2) "Sex", the two main categories of male and female
7 into which individuals are divided based on an individual's
8 reproductive biology at birth and the individual's genome.
9 2. (1) The general assembly hereby finds the
10 following:
11 (a) A noticeable disparity continues between the
12 athletics participation rates of students who are male and
13 students who are female; and
14 (b) Courts have recognized that classification by sex
15 is the only feasible classification to promote the
16 governmental interest of providing opportunities for
17 athletics for females.
18 (2) The general assembly hereby declares that it is
19 the public policy of this state to further the governmental
20 interest of ensuring that sufficient opportunities for

21 athletics remain available for females to remedy past
22 discrimination on the basis of sex.
23 3. (1) Except as provided under subdivision (2) of
24 this subsection, no private school, public school district,
25 or public charter school shall allow any student to compete
26 in an athletics competition that is designated for the
27 biological sex opposite to the student's biological sex as
28 correctly stated on the student's official birth certificate
29 as described in subsection 4 of this section or, if the
30 student's official birth certificate is unobtainable,
31 another government record.
32 (2) A private school, public school, or public charter
33 school may allow a female student to compete in an athletics
34 competition that is designated for male students if no
35 corresponding athletics competition designated for female
36 students is offered or available.
37 4. For purposes of this section, a statement of a
38 student's biological sex on the student's official birth
39 certificate or another government record shall be deemed to
40 have correctly stated the student's biological sex only if
41 the statement was:
42 (1) Entered at or near the time of the student's
43 birth; or
44 (2) Modified to correct any scrivener's error in the
45 student's biological sex.
46 5. No private school, public school district, or
47 public charter school that violates subdivision (1) of
48 subsection 3 of this section shall receive any state aid
49 under this chapter or any other revenues from the state.
50 6. The parent or guardian of any student, or any
51 student who is over eighteen years of age, who is deprived
52 of an athletic opportunity as a result of a violation of
53 this section shall have a cause of action for injunctive or

54 other equitable relief, as well as payment of reasonable
55 attorney's fees, costs, and expenses of the parent,
56 guardian, or student. The relief and remedies set forth
57 shall not be deemed exclusive and shall be in addition to
58 any other relief or remedies permitted by law.
59 7. The department of elementary and secondary
60 education shall promulgate all necessary rules and
61 regulations for the implementation and administration of
62 this section. Such rules and regulations shall ensure
63 compliance with state and federal law regarding the
64 confidentiality of student medical information. Any rule or
65 portion of a rule, as that term is defined in section
66 536.010, that is created under the authority delegated in
67 this section shall become effective only if it complies with
68 and is subject to all of the provisions of chapter 536 and,
69 if applicable, section 536.028. This section and chapter
70 536 are nonseverable and if any of the powers vested with
71 the general assembly pursuant to chapter 536 to review, to
72 delay the effective date, or to disapprove and annul a rule
73 are subsequently held unconstitutional, then the grant of
74 rulemaking authority and any rule proposed or adopted after
75 August 28, 2023, shall be invalid and void.
191.1720. 1. This section shall be known and may be
2 cited as the "Missouri Save Adolescents from Experimentation
3 (SAFE) Act".
4 2. For purposes of this section, the following terms
5 mean:
6 (1) "Biological sex", the biological indication of
7 male or female in the context of reproductive potential or
8 capacity, such as sex chromosomes, naturally occurring sex
9 hormones, gonads, and nonambiguous internal and external
10 genitalia present at birth, without regard to an

11 individual's psychological, chosen, or subjective experience
12 of gender;
13 (2) "Cross-sex hormones", testosterone, estrogen, or
14 other androgens given to an individual in amounts that are
15 greater or more potent than would normally occur naturally
16 in a healthy individual of the same age and sex;
17 (3) "Gender", the psychological, behavioral, social,
18 and cultural aspects of being male or female;
19 (4) "Gender transition", the process in which an
20 individual transitions from identifying with and living as a
21 gender that corresponds to his or her biological sex to
22 identifying and living as a gender different from his or her
23 biological sex, and may involve social, legal, or physical
24 changes;
25 (5) "Gender transition procedures":
26 (a) Any medical or surgical service, including, but
27 not limited to, physician's services, inpatient and
28 outpatient hospital services, or prescribed drugs, related
29 to gender transition that seeks to:
30 a. Alter or remove physical or anatomical
31 characteristics or features that are typical for the
32 individual's biological sex; or
33 b. Instill or create physiological or anatomical
34 characteristics that resemble a sex different from the
35 individual's biological sex, including, but not limited to:
36 (i) Medical services that provide puberty-blocking
37 drugs, cross-sex hormones, or other mechanisms to promote
38 the development of feminizing or masculinizing features in
39 the opposite biological sex; or
40 (ii) Genital or nongenital gender reassignment surgery
41 performed for the purpose of assisting an individual with a
42 gender transition;

43 (b) The term "gender transition procedures" shall not
44 include:
45 a. Services to individuals born with a medically-
46 verifiable disorder of sex development, including, but not
47 limited to, an individual with external biological sex
48 characteristics that are irresolvably ambiguous, such as
49 those born with 46,XX chromosomes with virilization, 46,XY
50 chromosomes with undervirilization, or having both ovarian
51 and testicular tissue;
52 b. Services provided when a physician has otherwise
53 diagnosed an individual with a disorder of sex development
54 and determined through genetic or biochemical testing that
55 the individual does not have normal sex chromosome
56 structure, sex steroid hormone production, or sex steroid
57 hormone action;
58 c. The treatment of any infection, injury, disease, or
59 disorder that has been caused by or exacerbated by the
60 performance of gender transition procedures regardless of
61 whether the gender transition procedure was performed in
62 accordance with state and federal law; or
63 d. Any procedure undertaken because the individual
64 suffers from a physical disorder, physical injury, or
65 physical illness that would, as certified by a physician,
66 place the individual in imminent danger of death or
67 impairment of a major bodily function unless surgery is
68 performed;
69 (6) "Genital gender reassignment surgery", a genital
70 surgical procedure performed for the purpose of assisting an
71 individual with a gender transition, including, but not
72 limited to:
73 (a) Surgical procedures that sterilize, including, but
74 not limited to, castration, vasectomy, hysterectomy,
75 oophorectomy, orchiectomy, or penectomy; or

76 (b) Surgical procedures that artificially construct
77 tissue with the appearance of genitalia that differs from
78 the individual's biological sex, including, but not limited
79 to, metoidioplasty, phalloplasty, and vaginoplasty;
80 (7) "Health care provider", an individual who is
81 licensed, certified, or otherwise authorized by the laws of
82 this state to administer health care in the ordinary course
83 of the practice of his or her profession;
84 (8) "Nongenital gender reassignment surgery", a
85 nongenital surgical procedure performed for the purpose of
86 assisting an individual with a gender transition, including,
87 but not limited to, augmentation mammoplasty, subcutaneous
88 mastectomy, facial surgery, liposuction, lipofilling, voice
89 surgery, thyroid cartilage reduction, pectoral implants,
90 gluteal augmentation, hair reconstruction, or various
91 aesthetic procedures;
92 (9) "Physician", an individual who is licensed under
93 chapter 334;
94 (10) "Puberty-blocking drugs", gonadotropin-releasing
95 hormone analogues or other synthetic drugs used to stop
96 luteinizing hormone secretion and follicle stimulating
97 hormone secretion, synthetic antiandrogen drugs to block the
98 androgen receptor, or any other drug used to delay or
99 suppress pubertal development in children for the purpose of
100 assisting an individual with a gender transition.
101 3. A physician or other health care provider shall not
102 knowingly provide gender transition procedures to any
103 individual under eighteen years of age and shall not
104 knowingly refer any individual under eighteen years of age
105 to any health care provider for gender transition procedures.
106 4. Any referral for or provision of gender transition
107 procedures to an individual under eighteen years of age
108 shall be considered unprofessional conduct and any health

109 care provider doing so shall be subject to discipline by the
110 appropriate licensing entity or disciplinary review board
111 with competent jurisdiction in this state.
112 5. (1) The provision of a gender transition procedure
113 to an individual under eighteen years of age in this section
114 shall be considered grounds for a cause of action against
115 the physician or health care provider. The provisions of
116 chapter 538 shall not apply to any action brought under this
117 subsection.
118 (2) An individual under eighteen years of age may
119 bring an action under this subsection throughout the
120 individual's minority through a parent or next friend and
121 may bring an action under this subsection in the
122 individual's own name upon reaching the age of majority at
123 any time from that point until thirty years after reaching
124 the age of majority or four years from the time of discovery
125 by the injured party of both the injury and the causal
126 relationship between the treatment and the injury, whichever
127 date is later. If, at the time the individual described in
128 subdivision (1) of this subsection attains eighteen years of
129 age, he or she is under a legal disability, the limitation
130 period shall not begin to run until the removal of the
131 disability. The limitation period shall not run during a
132 time period when the individual is subject to threats,
133 intimidation, manipulation, fraudulent concealment, or fraud
134 perpetrated by the physician or other health care provider
135 who provided gender transition procedures or by any person
136 acting in the interest of the physician or other health care
137 provider.
138 (3) An individual bringing an action under this
139 subsection shall be entitled to a rebuttable presumption
140 that the individual was harmed, and that the harm was a
141 direct result of any treatment defined by this section.

142 Such presumption may be rebutted only by clear and
143 convincing evidence.
144 (4) An individual may assert an actual or threatened
145 violation of this section as a claim or defense in a
146 judicial proceeding.
147 (5) The following damages may be awarded to a claimant
148 described in subdivision (1) of this subsection:
149 (a) Compensatory damages including, but not limited to:
150 a. Pain and suffering;
151 b. Loss of reputation;
152 c. Loss of income; and
153 d. Loss of consortium, including, but not limited to,
154 the loss of expectation of sharing parenthood;
155 (b) Injunctive relief;
156 (c) Declaratory judgment;
157 (d) Punitive damages; and
158 (e) Any other appropriate relief.
159 (6) A prevailing party who establishes a violation of
160 this section shall recover reasonable attorney's fees.
161 (7) Notwithstanding any other provision of law to the
162 contrary, an action under this subsection may be commenced,
163 and relief may be granted, in a judicial proceeding without
164 regard to whether the individual commencing the action has
165 sought or exhausted available administrative remedies.
166 6. The provisions of this section shall not apply to
167 any speech protected by the First Amendment of the United
168 State Constitution.
169 7. The provisions of this section shall become
170 effective on March 1, 2024.
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 -
43 operated institutions which are determined to conform to
44 standards equivalent to licensing requirements in Title XIX
45 of the federal Social Security Act (42 U.S.C. Section 301,
46 et seq.), as amended, for nursing facilities. The MO
47 HealthNet division may recognize through its payment
48 methodology for nursing facilities those nursing facilities
49 which serve a high volume of MO HealthNet patients. The MO
50 HealthNet division when determining the amount of the
51 benefit payments to be made on behalf of persons under the
52 age of twenty-one in a nursing facility may consider nursing
53 facilities furnishing care to persons under the age of
54 twenty-one as a classification separate from other nursing
55 facilities;
56 (5) Nursing home costs for participants receiving
57 benefit payments under subdivision (4) of this subsection
58 for those days, which shall not exceed twelve per any period
59 of six consecutive months, during which the participant is
60 on a temporary leave of absence from the hospital or nursing
61 home, provided that no such participant shall be allowed a
62 temporary leave of absence unless it is specifically
63 provided for in his plan of care. As used in this
64 subdivision, the term "temporary leave of absence" shall
65 include all periods of time during which a participant is
66 away from the hospital or nursing home overnight because he
67 is visiting a friend or relative;
68 (6) Physicians' services, whether furnished in the
69 office, home, hospital, nursing home, or elsewhere;

70 (7) Subject to appropriation, up to twenty visits per
71 year for services limited to examinations, diagnoses,
72 adjustments, and manipulations and treatments of
73 malpositioned articulations and structures of the body
74 provided by licensed chiropractic physicians practicing
75 within their scope of practice. Nothing in this subdivision
76 shall be interpreted to otherwise expand MO HealthNet
77 services;
78 (8) Drugs and medicines when prescribed by a licensed
79 physician, dentist, podiatrist, or an advanced practice
80 registered nurse; except that no payment for drugs and
81 medicines prescribed on and after January 1, 2006, by a
82 licensed physician, dentist, podiatrist, or an advanced
83 practice registered nurse may be made on behalf of any
84 person who qualifies for prescription drug coverage under
85 the provisions of P.L. 108-173;
86 (9) Emergency ambulance services and, effective
87 January 1, 1990, medically necessary transportation to
88 scheduled, physician-prescribed nonelective treatments;
89 (10) Early and periodic screening and diagnosis of
90 individuals who are under the age of twenty-one to ascertain
91 their physical or mental defects, and health care,
92 treatment, and other measures to correct or ameliorate
93 defects and chronic conditions discovered thereby. Such
94 services shall be provided in accordance with the provisions
95 of Section 6403 of P.L. 101-239 and federal regulations
96 promulgated thereunder;
97 (11) Home health care services;
98 (12) Family planning as defined by federal rules and
99 regulations; provided, however, that such family planning
100 services shall not include abortions or any abortifacient
101 drug or device that is used for the purpose of inducing an
102 abortion unless such abortions are certified in writing by a

103 physician to the MO HealthNet agency that, in the
104 physician's professional judgment, the life of the mother
105 would be endangered if the fetus were carried to term;
106 (13) Inpatient psychiatric hospital services for
107 individuals under age twenty-one as defined in Title XIX of
108 the federal Social Security Act (42 U.S.C. Section 1396d, et
109 seq.);
110 (14) Outpatient surgical procedures, including
111 presurgical diagnostic services performed in ambulatory
112 surgical facilities which are licensed by the department of
113 health and senior services of the state of Missouri; except,
114 that such outpatient surgical services shall not include
115 persons who are eligible for coverage under Part B of Title
116 XVIII, Public Law 89-97, 1965 amendments to the federal
117 Social Security Act, as amended, if exclusion of such
118 persons is permitted under Title XIX, Public Law 89-97, 1965
119 amendments to the federal Social Security Act, as amended;
120 (15) Personal care services which are medically
121 oriented tasks having to do with a person's physical
122 requirements, as opposed to housekeeping requirements, which
123 enable a person to be treated by his or her physician on an
124 outpatient rather than on an inpatient or residential basis
125 in a hospital, intermediate care facility, or skilled
126 nursing facility. Personal care services shall be rendered
127 by an individual not a member of the participant's family
128 who is qualified to provide such services where the services
129 are prescribed by a physician in accordance with a plan of
130 treatment and are supervised by a licensed nurse. Persons
131 eligible to receive personal care services shall be those
132 persons who would otherwise require placement in a hospital,
133 intermediate care facility, or skilled nursing facility.
134 Benefits payable for personal care services shall not exceed
135 for any one participant one hundred percent of the average

136 statewide charge for care and treatment in an intermediate
137 care facility for a comparable period of time. Such
138 services, when delivered in a residential care facility or
139 assisted living facility licensed under chapter 198 shall be
140 authorized on a tier level based on the services the
141 resident requires and the frequency of the services. A
142 resident of such facility who qualifies for assistance under
143 section 208.030 shall, at a minimum, if prescribed by a
144 physician, qualify for the tier level with the fewest
145 services. The rate paid to providers for each tier of
146 service shall be set subject to appropriations. Subject to
147 appropriations, each resident of such facility who qualifies
148 for assistance under section 208.030 and meets the level of
149 care required in this section shall, at a minimum, if
150 prescribed by a physician, be authorized up to one hour of
151 personal care services per day. Authorized units of
152 personal care services shall not be reduced or tier level
153 lowered unless an order approving such reduction or lowering
154 is obtained from the resident's personal physician. Such
155 authorized units of personal care services or tier level
156 shall be transferred with such resident if he or she
157 transfers to another such facility. Such provision shall
158 terminate upon receipt of relevant waivers from the federal
159 Department of Health and Human Services. If the Centers for
160 Medicare and Medicaid Services determines that such
161 provision does not comply with the state plan, this
162 provision shall be null and void. The MO HealthNet division
163 shall notify the revisor of statutes as to whether the
164 relevant waivers are approved or a determination of
165 noncompliance is made;
166 (16) Mental health services. The state plan for
167 providing medical assistance under Title XIX of the Social
168 Security Act, 42 U.S.C. Section 301, as amended, shall

169 include the following mental health services when such
170 services are provided by community mental health facilities
171 operated by the department of mental health or designated by
172 the department of mental health as a community mental health
173 facility or as an alcohol and drug abuse facility or as a
174 child-serving agency within the comprehensive children's
175 mental health service system established in section
176 630.097. The department of mental health shall establish by
177 administrative rule the definition and criteria for
178 designation as a community mental health facility and for
179 designation as an alcohol and drug abuse facility. Such
180 mental health services shall include:

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

189 (b) Clinic 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 (c) Rehabilitative mental health and alcohol and drug
198 abuse services including home and community-based
199 preventive, diagnostic, therapeutic, rehabilitative, and
200 palliative interventions rendered to individuals in an
201 individual or group setting by a mental health or alcohol

202 and drug abuse professional in accordance with a plan of
203 treatment appropriately established, implemented, monitored,
204 and revised under the auspices of a therapeutic team as a
205 part of client services management. As used in this
206 section, mental health professional and alcohol and drug
207 abuse professional shall be defined by the department of
208 mental health pursuant to duly promulgated rules. With
209 respect to services established by this subdivision, the
210 department of social services, MO HealthNet division, shall
211 enter into an agreement with the department of mental
212 health. Matching funds for outpatient mental health
213 services, clinic mental health services, and rehabilitation
214 services for mental health and alcohol and drug abuse shall
215 be certified by the department of mental health to the MO
216 HealthNet division. The agreement shall establish a
217 mechanism for the joint implementation of the provisions of
218 this subdivision. In addition, the agreement shall
219 establish a mechanism by which rates for services may be
220 jointly developed;
221 (17) Such additional services as defined by the MO
222 HealthNet division to be furnished under waivers of federal
223 statutory requirements as provided for and authorized by the
224 federal Social Security Act (42 U.S.C. Section 301, et seq.)
225 subject to appropriation by the general assembly;
226 (18) The services of an advanced practice registered
227 nurse with a collaborative practice agreement to the extent
228 that such services are provided in accordance with chapters
229 334 and 335, and regulations promulgated thereunder;
230 (19) Nursing home costs for participants receiving
231 benefit payments under subdivision (4) of this subsection to
232 reserve a bed for the participant in the nursing home during
233 the time that the participant is absent due to admission to
234 a hospital for services which cannot be performed on an

235 outpatient basis, subject to the provisions of this
236 subdivision:
237 (a) The provisions of this subdivision shall apply
238 only if:
239 a. The occupancy rate of the nursing home is at or
240 above ninety-seven percent of MO HealthNet certified
241 licensed beds, according to the most recent quarterly census
242 provided to the department of health and senior services
243 which was taken prior to when the participant is admitted to
244 the hospital; and
245 b. The patient is admitted to a hospital for a medical
246 condition with an anticipated stay of three days or less;
247 (b) The payment to be made under this subdivision
248 shall be provided for a maximum of three days per hospital
249 stay;
250 (c) For each day that nursing home costs are paid on
251 behalf of a participant under this subdivision during any
252 period of six consecutive months such participant shall,
253 during the same period of six consecutive months, be
254 ineligible for payment of nursing home costs of two
255 otherwise available temporary leave of absence days provided
256 under subdivision (5) of this subsection; and
257 (d) The provisions of this subdivision shall not apply
258 unless the nursing home receives notice from the participant
259 or the participant's responsible party that the participant
260 intends to return to the nursing home following the hospital
261 stay. If the nursing home receives such notification and
262 all other provisions of this subsection have been satisfied,
263 the nursing home shall provide notice to the participant or
264 the participant's responsible party prior to release of the
265 reserved bed;
266 (20) Prescribed medically necessary durable medical
267 equipment. An electronic web-based prior authorization

268 system using best medical evidence and care and treatment
269 guidelines consistent with national standards shall be used
270 to verify medical need;
271 (21) Hospice care. As used in this subdivision, the
272 term "hospice care" means a coordinated program of active
273 professional medical attention within a home, outpatient and
274 inpatient care which treats the terminally ill patient and
275 family as a unit, employing a medically directed
276 interdisciplinary team. The program provides relief of
277 severe pain or other physical symptoms and supportive care
278 to meet the special needs arising out of physical,
279 psychological, spiritual, social, and economic stresses
280 which are experienced during the final stages of illness,
281 and during dying and bereavement and meets the Medicare
282 requirements for participation as a hospice as are provided
283 in 42 CFR Part 418. The rate of reimbursement paid by the
284 MO HealthNet division to the hospice provider for room and
285 board furnished by a nursing home to an eligible hospice
286 patient shall not be less than ninety-five percent of the
287 rate of reimbursement which would have been paid for
288 facility services in that nursing home facility for that
289 patient, in accordance with subsection (c) of Section 6408
290 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);
291 (22) Prescribed medically necessary dental services.
292 Such services shall be subject to appropriations. An
293 electronic web-based prior authorization system using best
294 medical evidence and care and treatment guidelines
295 consistent with national standards shall be used to verify
296 medical need;
297 (23) Prescribed medically necessary optometric
298 services. Such services shall be subject to
299 appropriations. An electronic web-based prior authorization
300 system using best medical evidence and care and treatment

301 guidelines consistent with national standards shall be used
302 to verify medical need;
303 (24) Blood clotting products-related services. For
304 persons diagnosed with a bleeding disorder, as defined in
305 section 338.400, reliant on blood clotting products, as
306 defined in section 338.400, such services include:
307 (a) Home delivery of blood clotting products and
308 ancillary infusion equipment and supplies, including the
309 emergency deliveries of the product when medically necessary;
310 (b) Medically necessary ancillary infusion equipment
311 and supplies required to administer the blood clotting
312 products; and
313 (c) Assessments conducted in the participant's home by
314 a pharmacist, nurse, or local home health care agency
315 trained in bleeding disorders when deemed necessary by the
316 participant's treating physician;
317 (25) The MO HealthNet division shall, by January 1,
318 2008, and annually thereafter, report the status of MO
319 HealthNet provider reimbursement rates as compared to one
320 hundred percent of the Medicare reimbursement rates and
321 compared to the average dental reimbursement rates paid by
322 third-party payors licensed by the state. The MO HealthNet
323 division shall, by July 1, 2008, provide to the general
324 assembly a four-year plan to achieve parity with Medicare
325 reimbursement rates and for third-party payor average dental
326 reimbursement rates. Such plan shall be subject to
327 appropriation and the division shall include in its annual
328 budget request to the governor the necessary funding needed
329 to complete the four-year plan developed under this
330 subdivision.
331 2. Additional benefit payments for medical assistance
332 shall be made on behalf of those eligible needy children,
333 pregnant women and blind persons with any payments to be

334 made on the basis of the reasonable cost of the care or
335 reasonable charge for the services as defined and determined
336 by the MO HealthNet division, unless otherwise hereinafter
337 provided, for the following:
338 (1) Dental services;
339 (2) Services of podiatrists as defined in section
340 330.010;
341 (3) Optometric services as described in section
342 336.010;
343 (4) Orthopedic devices or other prosthetics, including
344 eye glasses, dentures, hearing aids, and wheelchairs;
345 (5) Hospice care. As used in this subdivision, the
346 term "hospice care" means a coordinated program of active
347 professional medical attention within a home, outpatient and
348 inpatient care which treats the terminally ill patient and
349 family as a unit, employing a medically directed
350 interdisciplinary team. The program provides relief of
351 severe pain or other physical symptoms and supportive care
352 to meet the special needs arising out of physical,
353 psychological, spiritual, social, and economic stresses
354 which are experienced during the final stages of illness,
355 and during dying and bereavement and meets the Medicare
356 requirements for participation as a hospice as are provided
357 in 42 CFR Part 418. The rate of reimbursement paid by the
358 MO HealthNet division to the hospice provider for room and
359 board furnished by a nursing home to an eligible hospice
360 patient shall not be less than ninety-five percent of the
361 rate of reimbursement which would have been paid for
362 facility services in that nursing home facility for that
363 patient, in accordance with subsection (c) of Section 6408
364 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);
365 (6) Comprehensive day rehabilitation services
366 beginning early posttrauma as part of a coordinated system

367 of care for individuals with disabling impairments.
368 Rehabilitation services must be based on an individualized,
369 goal-oriented, comprehensive and coordinated treatment plan
370 developed, implemented, and monitored through an
371 interdisciplinary assessment designed to restore an
372 individual to optimal level of physical, cognitive, and
373 behavioral function. The MO HealthNet division shall
374 establish by administrative rule the definition and criteria
375 for designation of a comprehensive day rehabilitation
376 service facility, benefit limitations and payment
377 mechanism. Any rule or portion of a rule, as that term is
378 defined in section 536.010, that is created under the
379 authority delegated in this subdivision shall become
380 effective only if it complies with and is subject to all of
381 the provisions of chapter 536 and, if applicable, section
382 536.028. This section and chapter 536 are nonseverable and
383 if any of the powers vested with the general assembly
384 pursuant to chapter 536 to review, to delay the effective
385 date, or to disapprove and annul a rule are subsequently
386 held unconstitutional, then the grant of rulemaking
387 authority and any rule proposed or adopted after August 28,
388 2005, shall be invalid and void.
389 3. The MO HealthNet division may require any
390 participant receiving MO HealthNet benefits to pay part of
391 the charge or cost until July 1, 2008, and an additional
392 payment after July 1, 2008, as defined by rule duly
393 promulgated by the MO HealthNet division, for all covered
394 services except for those services covered under
395 subdivisions (15) and (16) of subsection 1 of this section
396 and sections 208.631 to 208.657 to the extent and in the
397 manner authorized by Title XIX of the federal Social
398 Security Act (42 U.S.C. Section 1396, et seq.) and
399 regulations thereunder. When substitution of a generic drug

400 is permitted by the prescriber according to section 338.056,
401 and a generic drug is substituted for a name-brand drug, the
402 MO HealthNet division may not lower or delete the
403 requirement to make a co-payment pursuant to regulations of
404 Title XIX of the federal Social Security Act. A provider of
405 goods or services described under this section must collect
406 from all participants the additional payment that may be
407 required by the MO HealthNet division under authority
408 granted herein, if the division exercises that authority, to
409 remain eligible as a provider. Any payments made by
410 participants under this section shall be in addition to and
411 not in lieu of payments made by the state for goods or
412 services described herein except the participant portion of
413 the pharmacy professional dispensing fee shall be in
414 addition to and not in lieu of payments to pharmacists. A
415 provider may collect the co-payment at the time a service is
416 provided or at a later date. A provider shall not refuse to
417 provide a service if a participant is unable to pay a
418 required payment. If it is the routine business practice of
419 a provider to terminate future services to an individual
420 with an unclaimed debt, the provider may include uncollected
421 co-payments under this practice. Providers who elect not to
422 undertake the provision of services based on a history of
423 bad debt shall give participants advance notice and a
424 reasonable opportunity for payment. A provider,
425 representative, employee, independent contractor, or agent
426 of a pharmaceutical manufacturer shall not make co-payment
427 for a participant. This subsection shall not apply to other
428 qualified children, pregnant women, or blind persons. If
429 the Centers for Medicare and Medicaid Services does not
430 approve the MO HealthNet state plan amendment submitted by
431 the department of social services that would allow a
432 provider to deny future services to an individual with

433 uncollected co-payments, the denial of services shall not be
434 allowed. The department of social services shall inform
435 providers regarding the acceptability of denying services as
436 the result of unpaid co-payments.

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

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

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

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

464 8. Providers of long-term care services shall be
465 reimbursed for their costs in accordance with the provisions

466 of Section 1902 (a)(13)(A) of the Social Security Act, 42
467 U.S.C. Section 1396a, as amended, and regulations
468 promulgated thereunder.
469 9. Reimbursement rates to long-term care providers
470 with respect to a total change in ownership, at arm's
471 length, for any facility previously licensed and certified
472 for participation in the MO HealthNet program shall not
473 increase payments in excess of the increase that would
474 result from the application of Section 1902 (a)(13)(C) of
475 the Social Security Act, 42 U.S.C. Section 1396a (a)(13)(C).
476 10. The MO HealthNet division may enroll qualified
477 residential care facilities and assisted living facilities,
478 as defined in chapter 198, as MO HealthNet personal care
479 providers.
480 11. Any income earned by individuals eligible for
481 certified extended employment at a sheltered workshop under
482 chapter 178 shall not be considered as income for purposes
483 of determining eligibility under this section.
484 12. If the Missouri Medicaid audit and compliance unit
485 changes any interpretation or application of the
486 requirements for reimbursement for MO HealthNet services
487 from the interpretation or application that has been applied
488 previously by the state in any audit of a MO HealthNet
489 provider, the Missouri Medicaid audit and compliance unit
490 shall notify all affected MO HealthNet providers five
491 business days before such change shall take effect. Failure
492 of the Missouri Medicaid audit and compliance unit to notify
493 a provider of such change shall entitle the provider to
494 continue to receive and retain reimbursement until such
495 notification is provided and shall waive any liability of
496 such provider for recoupment or other loss of any payments
497 previously made prior to the five business days after such
498 notice has been sent. Each provider shall provide the

499 Missouri Medicaid audit and compliance unit a valid email
500 address and shall agree to receive communications
501 electronically. The notification required under this
502 section shall be delivered in writing by the United States
503 Postal Service or electronic mail to each provider.
504 13. Nothing in this section shall be construed to
505 abrogate or limit the department's statutory requirement to
506 promulgate rules under chapter 536.
507 14. Beginning July 1, 2016, and subject to
508 appropriations, providers of behavioral, social, and
509 psychophysiological services for the prevention, treatment,
510 or management of physical health problems shall be
511 reimbursed utilizing the behavior assessment and
512 intervention reimbursement codes 96150 to 96154 or their
513 successor codes under the Current Procedural Terminology
514 (CPT) coding system. Providers eligible for such
515 reimbursement shall include psychologists.
516 15. There shall be no payments made under this section
517 for gender transition procedures as prohibited under section
518 191.1720.
Section B. If any provision of section A of this act
2 or the application thereof to anyone or to any circumstance
3 is held invalid, the remainder of those sections and the
4 application of such provisions to others or other
5 circumstances shall not be affected thereby.