

SENATE SUBSTITUTE

FOR

SENATE COMMITTEE SUBSTITUTE

FOR

SENATE BILLS NOS. 49, 236 & 164

AN ACT

To repeal sections 208.152, 217.230, and 221.120, RSMo, and to enact in lieu thereof four new sections relating to gender transition procedures.

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

Section A. Sections 208.152, 217.230, and 221.120, RSMo, are repealed and four new sections enacted in lieu thereof, to be known as sections 191.1720, 208.152, 217.230, and 221.120, to read as follows:

191.1720. 1. This section shall be known and may be cited as the "Missouri Save Adolescents from Experimentation (SAFE) Act".

2. For purposes of this section, the following terms mean:

(1) "Biological sex", the biological indication of male or female in the context of reproductive potential or capacity, such as sex chromosomes, naturally occurring sex hormones, gonads, and nonambiguous internal and external genitalia present at birth, without regard to an individual's psychological, chosen, or subjective experience of gender;

(2) "Cross-sex hormones", testosterone, estrogen, or other androgens given to an individual in amounts that are greater or more potent than would normally occur naturally in a healthy individual of the same age and sex;

(3) "Gender", the psychological, behavioral, social, 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 with and living as a gender different from his
23 or her biological sex, and may involve social, legal, or
24 physical changes;

25 (5) "Gender transition surgery", a surgical procedure
26 performed for the purpose of assisting an individual with a
27 gender transition, including, but not limited to:

28 (a) Surgical procedures that sterilize, including, but
29 not limited to, castration, vasectomy, hysterectomy,
30 oophorectomy, orchiectomy, or penectomy;

31 (b) Surgical procedures that artificially construct
32 tissue with the appearance of genitalia that differs from
33 the individual's biological sex, including, but not limited
34 to, metoidioplasty, phalloplasty, or vaginoplasty; or

35 (c) Augmentation mammoplasty or subcutaneous
36 mastectomy;

37 (6) "Health care provider", an individual who is
38 licensed, certified, or otherwise authorized by the laws of
39 this state to administer health care in the ordinary course
40 of the practice of his or her profession;

41 (7) "Puberty-blocking drugs", gonadotropin-releasing
42 hormone analogues or other synthetic drugs used to stop
43 luteinizing hormone secretion and follicle stimulating
44 hormone secretion, synthetic antiandrogen drugs to block the
45 androgen receptor, or any other drug used to delay or
46 suppress pubertal development in children for the purpose of
47 assisting an individual with a gender transition.

48 3. A health care provider shall not knowingly perform
49 a gender transition surgery on any individual under eighteen
50 years of age.

51 4. (1) A health care provider shall not knowingly
52 prescribe or administer cross-sex hormones or puberty-
53 blocking drugs for the purpose of a gender transition for
54 any individual under eighteen years of age.

55 (2) The provisions of this subsection shall not apply
56 to the prescription or administration of cross-sex hormones
57 or puberty-blocking drugs for any individual under eighteen
58 years of age who was prescribed or administered such
59 hormones or drugs prior to August 28, 2023, for the purpose
60 of assisting the individual with a gender transition.

61 (3) The provisions of this subsection shall expire on
62 August 28, 2027.

63 5. The performance of a gender transition surgery or
64 the prescription or administration of cross-sex hormones or
65 puberty-blocking drugs to an individual under eighteen years
66 of age in violation of this section shall be considered
67 unprofessional conduct and any health care provider doing so
68 shall have his or her license to practice revoked by the
69 appropriate licensing entity or disciplinary review board
70 with competent jurisdiction in this state.

71 6. (1) The prescription or administration of cross-
72 sex hormones or puberty-blocking drugs to an individual
73 under eighteen years of age for the purpose of a gender
74 transition shall be considered grounds for a cause of action
75 against the health care provider. The provisions of chapter
76 538 shall not apply to any action brought under this
77 subsection.

78 (2) An action brought pursuant to this subsection
79 shall be brought within fifteen years of the individual
80 injured attaining the age of twenty-one or of the date the
81 treatment of the injury at issue in the action by the
82 defendant has ceased, whichever is later.

83 (3) An individual bringing an action under this
84 subsection shall be entitled to a rebuttable presumption
85 that the individual was harmed if the individual is
86 infertile following the prescription or administration of
87 cross-sex hormones or puberty-blocking drugs and that the
88 harm was a direct result of the hormones or drugs prescribed
89 or administered by the health care provider. Such
90 presumption may be rebutted only by clear and convincing
91 evidence.

92 (4) In any action brought pursuant to this subsection,
93 a plaintiff may recover economic and noneconomic damages and
94 punitive damages, without limitation to the amount and no
95 less than five hundred thousand dollars in the aggregate.
96 The judgment against a defendant in an action brought
97 pursuant to this subsection shall be in an amount of three
98 times the amount of any economic and noneconomic damages or
99 punitive damages assessed. Any award of damages in an
100 action brought pursuant to this subsection to a prevailing
101 plaintiff shall include attorney's fees and court costs.

102 (5) An action brought pursuant to this subsection may
103 be brought in any circuit court of this state.

104 (6) No health care provider shall require a waiver of
105 the right to bring an action pursuant to this subsection as
106 a condition of services. The right to bring an action by or
107 through an individual under the age of eighteen shall not be
108 waived by a parent or legal guardian.

109 (7) A plaintiff to an action brought under this
110 subsection may enter into a voluntary agreement of
111 settlement or compromise of the action, but no agreement
112 shall be valid until approved by the court. No agreement
113 allowed by the court shall include a provision regarding the
114 nondisclosure or confidentiality of the terms of such

115 agreement unless such provision was specifically requested
116 and agreed to by the plaintiff.

117 (8) If requested by the plaintiff, any pleadings,
118 attachments, or exhibits filed with the court in any action
119 brought pursuant to this subsection, as well as any
120 judgments issued by the court in such actions, shall not
121 include the personal identifying information of the
122 plaintiff. Such information shall be provided in a
123 confidential information filing sheet contemporaneously
124 filed with the court or entered by the court, which shall
125 not be subject to public inspection or availability.

126 7. The provisions of this section shall not apply to
127 any speech protected by the First Amendment of the United
128 States Constitution.

129 8. The provisions of this section shall not apply to
130 the following:

131 (1) Services to individuals born with a medically-
132 verifiable disorder of sex development, including, but not
133 limited to, an individual with external biological sex
134 characteristics that are irresolvably ambiguous, such as
135 those born with 46,XX chromosomes with virilization, 46,XY
136 chromosomes with undervirilization, or having both ovarian
137 and testicular tissue;

138 (2) Services provided when a physician has otherwise
139 diagnosed an individual with a disorder of sex development
140 and determined through genetic or biochemical testing that
141 the individual does not have normal sex chromosome
142 structure, sex steroid hormone production, or sex steroid
143 hormone action;

144 (3) The treatment of any infection, injury, disease,
145 or disorder that has been caused by or exacerbated by the
146 performance of gender transition surgery or the prescription
147 or administration of cross-sex hormones or puberty-blocking

148 drugs regardless of whether the surgery was performed or the
149 hormones or drugs were prescribed or administered in
150 accordance with state and federal law; or

151 (4) Any procedure undertaken because the individual
152 suffers from a physical disorder, physical injury, or
153 physical illness that would, as certified by a physician,
154 place the individual in imminent danger of death or
155 impairment of a major bodily function unless surgery is
156 performed.

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 surgeries, cross-sex hormones, or
518 puberty-blocking drugs, as such terms are defined in section
519 191.1720, for the purpose of a gender transition.

 217.230. The director shall arrange for necessary
2 health care services for offenders confined in correctional
3 centers, which shall not include any gender transition
4 surgery, as defined in section 191.1720.

 221.120. 1. If any prisoner confined in the county
2 jail is sick and in the judgment of the jailer, requires the
3 attention of a physician, dental care, or medicine, the
4 jailer shall procure the necessary medicine, dental care or
5 medical attention necessary or proper to maintain the health
6 of the prisoner; provided, that this shall not include any
7 gender transition surgery, as defined in section 191.1720.
8 The costs of such medicine, dental care, or medical
9 attention shall be paid by the prisoner through any health
10 insurance policy as defined in subsection 3 of this section,
11 from which the prisoner is eligible to receive benefits. If
12 the prisoner is not eligible for such health insurance
13 benefits then the prisoner shall be liable for the payment
14 of such medical attention, dental care, or medicine, and the
15 assets of such prisoner may be subject to levy and execution
16 under court order to satisfy such expenses in accordance
17 with the provisions of section 221.070, and any other
18 applicable law. The county commission of the county may at
19 times authorize payment of certain medical costs that the
20 county commission determines to be necessary and
21 reasonable. As used in this section, the term "medical
22 costs" includes the actual costs of medicine, dental care or
23 other medical attention and necessary costs associated with
24 such medical care such as transportation, guards and
25 inpatient care.

26 2. The county commission may, in their discretion,
27 employ a physician by the year, to attend such prisoners,
28 and make such reasonable charge for his service and
29 medicine, when required, to be taxed and collected as
30 provided by law.

31 3. As used in this section, the following terms mean:

32 (1) "Assets", property, tangible or intangible, real
33 or personal, belonging to or due a prisoner or a former
34 prisoner, including income or payments to such prisoner from
35 Social Security, workers' compensation, veterans'
36 compensation, pension benefits, previously earned salary or
37 wages, bonuses, annuities, retirement benefits, compensation
38 paid to the prisoner per work or services performed while a
39 prisoner or from any other source whatsoever, including any
40 of the following:

41 (a) Money or other tangible assets received by the
42 prisoner as a result of a settlement of a claim against the
43 state, any agency thereof, or any claim against an employee
44 or independent contractor arising from and in the scope of
45 the employee's or contractor's official duties on behalf of
46 the state or any agency thereof;

47 (b) A money judgment received by the prisoner from the
48 state as a result of a civil action in which the state, an
49 agency thereof or any state employee or independent
50 contractor where such judgment arose from a claim arising
51 from the conduct of official duties on behalf of the state
52 by the employee or subcontractor or for any agency of the
53 state;

54 (c) A current stream of income from any source
55 whatsoever, including a salary, wages, disability benefits,
56 retirement benefits, pension benefits, insurance or annuity
57 benefits, or similar payments; and

58 (2) "Health insurance policy", any group insurance
59 policy providing coverage on an expense-incurred basis, any
60 group service or indemnity contract issued by a not-for-
61 profit health services corporation or any self-insured group
62 health benefit plan of any type or description.