

CONFERENCE COMMITTEE SUBSTITUTE

FOR

HOUSE COMMITTEE SUBSTITUTE

FOR

SENATE BILL NO. 607

AN ACT

To repeal sections 208.152, 208.952, and 208.985, RSMo, and to enact in lieu thereof five new sections relating to public assistance programs.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

1 Section A. Sections 208.152, 208.952, and 208.985, RSMo,
2 are repealed and five new sections enacted in lieu thereof, to be
3 known as sections 208.065, 208.152, 208.952, 208.1030, and
4 208.1032, to read as follows:

5 208.065. 1. No later than January 1, 2017, the department
6 of social services shall procure and enter into a competitively
7 bid contract with a contractor to provide verification of initial
8 and ongoing eligibility data for assistance under the
9 supplemental nutrition assistance program (SNAP); temporary
10 assistance for needy families (TANF) program; child care
11 assistance program; and MO HealthNet program. The contractor
12 shall conduct data matches using the name, date of birth,
13 address, and Social Security number of each applicant and
14 recipient, and additional data provided by the applicant or
15 recipient relevant to eligibility against public records and
16 other data sources to verify eligibility data.

1 2. The contractor shall evaluate the income, resources, and
2 assets of each applicant and recipient no less than quarterly.
3 In addition to quarterly eligibility data verification, the
4 contractor shall identify on a monthly basis any program
5 participants who have died, moved out of state, or have been
6 incarcerated longer than ninety days.

7 3. The contractor, upon completing an eligibility data
8 verification of an applicant or recipient, shall notify the
9 department of the results; except that, the contractor shall not
10 verify the eligibility data of persons residing in long-term care
11 facilities or persons receiving home- and community-based
12 services whose income and resources were at or below the
13 applicable financial eligibility standards at the time of their
14 last review. Within twenty business days of such notification,
15 the department shall make an eligibility determination. The
16 department shall retain final authority over eligibility
17 determinations. The contractor shall keep a record of all
18 eligibility data verifications communicated to the department.
19 Nothing in this subsection shall be construed to affect any
20 obligation or requirement under state or federal law or
21 regulation that the department verify the eligibility data of
22 persons residing in long-term care facilities or persons
23 receiving home- and community-based services.

24 4. Within thirty days of the end of each calendar year, the
25 department and contractor shall file a joint report to the
26 governor, the speaker of the house of representatives, and the
27 president pro tempore of the senate. The report shall include,
28 but shall not be limited to, the number of applicants and

1 recipients determined ineligible for assistance programs based on
2 the eligibility data verification by the contractor and the
3 stated reasons for the determination of ineligibility by the
4 department.

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

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

24 (2) All outpatient hospital services, payments therefor to
25 be in amounts which represent no more than eighty percent of the
26 lesser of reasonable costs or customary charges for such
27 services, determined in accordance with the principles set forth
28 in Title XVIII A and B, Public Law 89-97, 1965 amendments to the

1 federal Social Security Act (42 U.S.C. Section 301, et seq.),
2 but the MO HealthNet division may evaluate outpatient hospital
3 services rendered under this section and deny payment for
4 services which are determined by the MO HealthNet division not to
5 be medically necessary, in accordance with federal law and
6 regulations;

7 (3) Laboratory and X-ray services;

8 (4) Nursing home services for participants, except to
9 persons with more than five hundred thousand dollars equity in
10 their home or except for persons in an institution for mental
11 diseases who are under the age of sixty-five years, when residing
12 in a hospital licensed by the department of health and senior
13 services or a nursing home licensed by the department of health
14 and senior services or appropriate licensing authority of other
15 states or government-owned and -operated institutions which are
16 determined to conform to standards equivalent to licensing
17 requirements in Title XIX of the federal Social Security Act (42
18 U.S.C. Section 301, et seq.), as amended, for nursing facilities.
19 The MO HealthNet division may recognize through its payment
20 methodology for nursing facilities those nursing facilities which
21 serve a high volume of MO HealthNet patients. The MO HealthNet
22 division when determining the amount of the benefit payments to
23 be made on behalf of persons under the age of twenty-one in a
24 nursing facility may consider nursing facilities furnishing care
25 to persons under the age of twenty-one as a classification
26 separate from other nursing facilities;

27 (5) Nursing home costs for participants receiving benefit
28 payments under subdivision (4) of this subsection for those days,

1 which shall not exceed twelve per any period of six consecutive
2 months, during which the participant is on a temporary leave of
3 absence from the hospital or nursing home, provided that no such
4 participant shall be allowed a temporary leave of absence unless
5 it is specifically provided for in his plan of care. As used in
6 this subdivision, the term "temporary leave of absence" shall
7 include all periods of time during which a participant is away
8 from the hospital or nursing home overnight because he is
9 visiting a friend or relative;

10 (6) Physicians' services, whether furnished in the office,
11 home, hospital, nursing home, or elsewhere;

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

19 (8) Emergency ambulance services and, effective January 1,
20 1990, medically necessary transportation to scheduled, physician-
21 prescribed nonelective treatments;

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

1 (10) Home health care services;

2 (11) Family planning as defined by federal rules and
3 regulations; provided, however, that such family planning
4 services shall not include abortions unless such abortions are
5 certified in writing by a physician to the MO HealthNet agency
6 that, in the physician's professional judgment, the life of the
7 mother would be endangered if the fetus were carried to term;

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

11 (13) Outpatient surgical procedures, including presurgical
12 diagnostic services performed in ambulatory surgical facilities
13 which are licensed by the department of health and senior
14 services of the state of Missouri; except, that such outpatient
15 surgical services shall not include persons who are eligible for
16 coverage under Part B of Title XVIII, Public Law 89-97, 1965
17 amendments to the federal Social Security Act, as amended, if
18 exclusion of such persons is permitted under Title XIX, Public
19 Law 89-97, 1965 amendments to the federal Social Security Act, as
20 amended;

21 (14) Personal care services which are medically oriented
22 tasks having to do with a person's physical requirements, as
23 opposed to housekeeping requirements, which enable a person to be
24 treated by his or her physician on an outpatient rather than on
25 an inpatient or residential basis in a hospital, intermediate
26 care facility, or skilled nursing facility. Personal care
27 services shall be rendered by an individual not a member of the
28 participant's family who is qualified to provide such services

1 where the services are prescribed by a physician in accordance
2 with a plan of treatment and are supervised by a licensed nurse.
3 Persons eligible to receive personal care services shall be those
4 persons who would otherwise require placement in a hospital,
5 intermediate care facility, or skilled nursing facility.
6 Benefits payable for personal care services shall not exceed for
7 any one participant one hundred percent of the average statewide
8 charge for care and treatment in an intermediate care facility
9 for a comparable period of time. Such services, when delivered
10 in a residential care facility or assisted living facility
11 licensed under chapter 198 shall be authorized on a tier level
12 based on the services the resident requires and the frequency of
13 the services. A resident of such facility who qualifies for
14 assistance under section 208.030 shall, at a minimum, if
15 prescribed by a physician, qualify for the tier level with the
16 fewest services. The rate paid to providers for each tier of
17 service shall be set subject to appropriations. Subject to
18 appropriations, each resident of such facility who qualifies for
19 assistance under section 208.030 and meets the level of care
20 required in this section shall, at a minimum, if prescribed by a
21 physician, be authorized up to one hour of personal care services
22 per day. Authorized units of personal care services shall not be
23 reduced or tier level lowered unless an order approving such
24 reduction or lowering is obtained from the resident's personal
25 physician. Such authorized units of personal care services or
26 tier level shall be transferred with such resident if he or she
27 transfers to another such facility. Such provision shall
28 terminate upon receipt of relevant waivers from the federal

1 Department of Health and Human Services. If the Centers for
2 Medicare and Medicaid Services determines that such provision
3 does not comply with the state plan, this provision shall be null
4 and void. The MO HealthNet division shall notify the revisor of
5 statutes as to whether the relevant waivers are approved or a
6 determination of noncompliance is made;

7 (15) Mental health services. The state plan for providing
8 medical assistance under Title XIX of the Social Security Act, 42
9 U.S.C. Section 301, as amended, shall include the following
10 mental health services when such services are provided by
11 community mental health facilities operated by the department of
12 mental health or designated by the department of mental health as
13 a community mental health facility or as an alcohol and drug
14 abuse facility or as a child-serving agency within the
15 comprehensive children's mental health service system established
16 in section 630.097. The department of mental health shall
17 establish by administrative rule the definition and criteria for
18 designation as a community mental health facility and for
19 designation as an alcohol and drug abuse facility. Such mental
20 health services shall include:

21 (a) Outpatient mental health services including preventive,
22 diagnostic, therapeutic, rehabilitative, and palliative
23 interventions rendered to individuals in an individual or group
24 setting by a mental health professional in accordance with a plan
25 of treatment appropriately established, implemented, monitored,
26 and revised under the auspices of a therapeutic team as a part of
27 client services management;

28 (b) Clinic mental health services including preventive,

1 diagnostic, therapeutic, rehabilitative, and palliative
2 interventions rendered to individuals in an individual or group
3 setting by a mental health professional in accordance with a plan
4 of treatment appropriately established, implemented, monitored,
5 and revised under the auspices of a therapeutic team as a part of
6 client services management;

7 (c) Rehabilitative mental health and alcohol and drug abuse
8 services including home and community-based preventive,
9 diagnostic, therapeutic, rehabilitative, and palliative
10 interventions rendered to individuals in an individual or group
11 setting by a mental health or alcohol and drug abuse professional
12 in accordance with a plan of treatment appropriately established,
13 implemented, monitored, and revised under the auspices of a
14 therapeutic team as a part of client services management. As
15 used in this section, mental health professional and alcohol and
16 drug abuse professional shall be defined by the department of
17 mental health pursuant to duly promulgated rules. With respect
18 to services established by this subdivision, the department of
19 social services, MO HealthNet division, shall enter into an
20 agreement with the department of mental health. Matching funds
21 for outpatient mental health services, clinic mental health
22 services, and rehabilitation services for mental health and
23 alcohol and drug abuse shall be certified by the department of
24 mental health to the MO HealthNet division. The agreement shall
25 establish a mechanism for the joint implementation of the
26 provisions of this subdivision. In addition, the agreement shall
27 establish a mechanism by which rates for services may be jointly
28 developed;

1 (16) Such additional services as defined by the MO
2 HealthNet division to be furnished under waivers of federal
3 statutory requirements as provided for and authorized by the
4 federal Social Security Act (42 U.S.C. Section 301, et seq.)
5 subject to appropriation by the general assembly;

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

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

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

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

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

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

26 (c) For each day that nursing home costs are paid on behalf
27 of a participant under this subdivision during any period of six
28 consecutive months such participant shall, during the same period

1 of six consecutive months, be ineligible for payment of nursing
2 home costs of two otherwise available temporary leave of absence
3 days provided under subdivision (5) of this subsection; and

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

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

17 (20) Hospice care. As used in this subdivision, the term
18 "hospice care" means a coordinated program of active professional
19 medical attention within a home, outpatient and inpatient care
20 which treats the terminally ill patient and family as a unit,
21 employing a medically directed interdisciplinary team. The
22 program provides relief of severe pain or other physical symptoms
23 and supportive care to meet the special needs arising out of
24 physical, psychological, spiritual, social, and economic stresses
25 which are experienced during the final stages of illness, and
26 during dying and bereavement and meets the Medicare requirements
27 for participation as a hospice as are provided in 42 CFR Part
28 418. The rate of reimbursement paid by the MO HealthNet division

1 to the hospice provider for room and board furnished by a nursing
2 home to an eligible hospice patient shall not be less than
3 ninety-five percent of the rate of reimbursement which would have
4 been paid for facility services in that nursing home facility for
5 that patient, in accordance with subsection (c) of Section 6408
6 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

7 (21) Prescribed medically necessary dental services. Such
8 services shall be subject to appropriations. An electronic web-
9 based prior authorization system using best medical evidence and
10 care and treatment guidelines consistent with national standards
11 shall be used to verify medical need;

12 (22) Prescribed medically necessary optometric services.
13 Such services shall be subject to appropriations. An electronic
14 web-based prior authorization system using best medical evidence
15 and care and treatment guidelines consistent with national
16 standards shall be used to verify medical need;

17 (23) Blood clotting products-related services. For persons
18 diagnosed with a bleeding disorder, as defined in section
19 338.400, reliant on blood clotting products, as defined in
20 section 338.400, such services include:

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

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

26 (c) Assessments conducted in the participant's home by a
27 pharmacist, nurse, or local home health care agency trained in
28 bleeding disorders when deemed necessary by the participant's

1 treating physician;

2 (24) The MO HealthNet division shall, by January 1, 2008,
3 and annually thereafter, report the status of MO HealthNet
4 provider reimbursement rates as compared to one hundred percent
5 of the Medicare reimbursement rates and compared to the average
6 dental reimbursement rates paid by third-party payors licensed by
7 the state. The MO HealthNet division shall, by July 1, 2008,
8 provide to the general assembly a four-year plan to achieve
9 parity with Medicare reimbursement rates and for third-party
10 payor average dental reimbursement rates. Such plan shall be
11 subject to appropriation and the division shall include in its
12 annual budget request to the governor the necessary funding
13 needed to complete the four-year plan developed under this
14 subdivision.

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

21 (1) Dental services;

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

23 (3) Optometric services as **[defined]** described in section
24 336.010;

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

27 (5) Hospice care. As used in this subdivision, the term
28 "hospice care" means a coordinated program of active professional

1 medical attention within a home, outpatient and inpatient care
2 which treats the terminally ill patient and family as a unit,
3 employing a medically directed interdisciplinary team. The
4 program provides relief of severe pain or other physical symptoms
5 and supportive care to meet the special needs arising out of
6 physical, psychological, spiritual, social, and economic stresses
7 which are experienced during the final stages of illness, and
8 during dying and bereavement and meets the Medicare requirements
9 for participation as a hospice as are provided in 42 CFR Part
10 418. The rate of reimbursement paid by the MO HealthNet division
11 to the hospice provider for room and board furnished by a nursing
12 home to an eligible hospice patient shall not be less than
13 ninety-five percent of the rate of reimbursement which would have
14 been paid for facility services in that nursing home facility for
15 that patient, in accordance with subsection (c) of Section 6408
16 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

17 (6) Comprehensive day rehabilitation services beginning
18 early posttrauma as part of a coordinated system of care for
19 individuals with disabling impairments. Rehabilitation services
20 must be based on an individualized, goal-oriented, comprehensive
21 and coordinated treatment plan developed, implemented, and
22 monitored through an interdisciplinary assessment designed to
23 restore an individual to optimal level of physical, cognitive,
24 and behavioral function. The MO HealthNet division shall
25 establish by administrative rule the definition and criteria for
26 designation of a comprehensive day rehabilitation service
27 facility, benefit limitations and payment mechanism. Any rule or
28 portion of a rule, as that term is defined in section 536.010,

1 that is created under the authority delegated in this subdivision
2 shall become effective only if it complies with and is subject to
3 all of the provisions of chapter 536 and, if applicable, section
4 536.028. This section and chapter 536 are nonseverable and if
5 any of the powers vested with the general assembly pursuant to
6 chapter 536 to review, to delay the effective date, or to
7 disapprove and annul a rule are subsequently held
8 unconstitutional, then the grant of rulemaking authority and any
9 rule proposed or adopted after August 28, 2005, shall be invalid
10 and void.

11 3. The MO HealthNet division may require any participant
12 receiving MO HealthNet benefits to pay part of the charge or cost
13 until July 1, 2008, and an additional payment after July 1, 2008,
14 as defined by rule duly promulgated by the MO HealthNet division,
15 for all covered services except for those services covered under
16 subdivisions (14) and (15) of subsection 1 of this section and
17 sections 208.631 to 208.657 to the extent and in the manner
18 authorized by Title XIX of the federal Social Security Act (42
19 U.S.C. Section 1396, et seq.) and regulations thereunder. When
20 substitution of a generic drug is permitted by the prescriber
21 according to section 338.056, and a generic drug is substituted
22 for a name-brand drug, the MO HealthNet division may not lower or
23 delete the requirement to make a co-payment pursuant to
24 regulations of Title XIX of the federal Social Security Act. A
25 provider of goods or services described under this section must
26 collect from all participants the additional payment that may be
27 required by the MO HealthNet division under authority granted
28 herein, if the division exercises that authority, to remain

1 eligible as a provider. Any payments made by participants under
2 this section shall be in addition to and not in lieu of payments
3 made by the state for goods or services described herein except
4 the participant portion of the pharmacy professional dispensing
5 fee shall be in addition to and not in lieu of payments to
6 pharmacists. A provider may collect the co-payment at the time a
7 service is provided or at a later date. A provider shall not
8 refuse to provide a service if a participant is unable to pay a
9 required payment. If it is the routine business practice of a
10 provider to terminate future services to an individual with an
11 unclaimed debt, the provider may include uncollected co-payments
12 under this practice. Providers who elect not to undertake the
13 provision of services based on a history of bad debt shall give
14 participants advance notice and a reasonable opportunity for
15 payment. A provider, representative, employee, independent
16 contractor, or agent of a pharmaceutical manufacturer shall not
17 make co-payment for a participant. This subsection shall not
18 apply to other qualified children, pregnant women, or blind
19 persons. If the Centers for Medicare and Medicaid Services does
20 not approve the MO HealthNet state plan amendment submitted by
21 the department of social services that would allow a provider to
22 deny future services to an individual with uncollected co-
23 payments, the denial of services shall not be allowed. The
24 department of social services shall inform providers regarding
25 the acceptability of denying services as the result of unpaid co-
26 payments.

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

1 program integrity.

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

11 6. Beginning July 1, 1990, reimbursement for services
12 rendered in federally funded health centers shall be in
13 accordance with the provisions of subsection 6402(c) and Section
14 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989)
15 and federal regulations promulgated thereunder.

16 7. Beginning July 1, 1990, the department of social
17 services shall provide notification and referral of children
18 below age five, and pregnant, breast-feeding, or postpartum women
19 who are determined to be eligible for MO HealthNet benefits under
20 section 208.151 to the special supplemental food programs for
21 women, infants and children administered by the department of
22 health and senior services. Such notification and referral shall
23 conform to the requirements of Section 6406 of P.L. 101-239 and
24 regulations promulgated thereunder.

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

1 9. Reimbursement rates to long-term care providers with
2 respect to a total change in ownership, at arm's length, for any
3 facility previously licensed and certified for participation in
4 the MO HealthNet program shall not increase payments in excess of
5 the increase that would result from the application of Section
6 1902 (a) (13) (C) of the Social Security Act, 42 U.S.C. Section
7 1396a (a) (13) (C).

8 10. The MO HealthNet division[,] may enroll qualified
9 residential care facilities and assisted living facilities, as
10 defined in chapter 198, as MO HealthNet personal care providers.

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

15 12. If the Missouri Medicaid audit and compliance unit
16 changes any interpretation or application of the requirements for
17 reimbursement for MO HealthNet services from the interpretation
18 or application that has been applied previously by the state in
19 any audit of a MO HealthNet provider, the Missouri Medicaid audit
20 and compliance unit shall notify all affected MO HealthNet
21 providers five business days before such change shall take
22 effect. Failure of the Missouri Medicaid audit and compliance
23 unit to notify a provider of such change shall entitle the
24 provider to continue to receive and retain reimbursement until
25 such notification is provided and shall waive any liability of
26 such provider for recoupment or other loss of any payments
27 previously made prior to the five business days after such notice
28 has been sent. Each provider shall provide the Missouri Medicaid

1 audit and compliance unit a valid email address and shall agree
2 to receive communications electronically. The notification
3 required under this section shall be delivered in writing by the
4 United States Postal Service or electronic mail to each provider.

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

8 14. Beginning July 1, 2016, and subject to appropriations,
9 providers of behavioral, social, and psychophysiological services
10 for the prevention, treatment, or management of physical health
11 problems shall be reimbursed utilizing the behavior assessment
12 and intervention reimbursement codes 96150 to 96154 or their
13 successor codes under the Current Procedural Terminology (CPT)
14 coding system. Providers eligible for such reimbursement shall
15 include psychologists.

16 208.952. 1. There is hereby established [the] a permanent
17 "Joint Committee on [MO HealthNet] Public Assistance". The
18 committee shall have [as its purpose the study of] the following
19 purposes:

20 (1) Studying, monitoring, and reviewing the efficacy of the
21 public assistance programs within the state;

22 (2) Determining the level and adequacy of resources needed
23 [to continue and improve the MO HealthNet program over time] for
24 the public assistance programs within the state; and

25 (3) Developing recommendations to the general assembly on
26 the public assistance programs within the state and on promoting
27 independence from safety net programs among participants as may
28 be appropriate.

1 The committee shall receive and obtain information from the
2 departments of social services, mental health, health and senior
3 services, and elementary and secondary education, and any other
4 department as applicable, regarding the public assistance
5 programs within the state including, but not limited to, MO
6 HealthNet, the supplemental nutrition assistance program (SNAP),
7 and temporary assistance for needy families (TANF). Such
8 information shall include projected enrollment growth, budgetary
9 matters, trends in childhood poverty and hunger, and any other
10 information deemed to be relevant to the committee's purpose.

11 2. The directors of the department of social services,
12 mental health, and health and senior services shall each submit
13 an annual written report to the committee providing data and
14 statistical information regarding the caseloads of the
15 department's employees involved in the administration of public
16 assistance programs.

17 3. The committee shall consist of ten members:

18 (1) The chair and the ranking minority member of the house
19 of representatives committee on the budget;

20 (2) The chair and the ranking minority member of the senate
21 committee on appropriations [committee];

22 (3) The chair and the ranking minority member of the
23 standing house of representatives committee [on appropriations
24 for health, mental health, and social services] designated to
25 consider public assistance legislation and matters;

26 (4) The chair and the ranking minority member of the
27 standing senate committee [on health and mental health]
28 designated to consider public assistance legislation and matters;

1 (5) A representative chosen by the speaker of the house of
2 representatives; and

3 (6) A senator chosen by the president pro ~~[tem]~~ tempore of
4 the senate.

5
6 No more than ~~[three]~~ four members from each ~~[house]~~ chamber shall
7 be of the same political party.

8 [2.] 4. A chair of the committee shall be selected by the
9 members of the committee.

10 [3.] 5. The committee shall meet ~~[as necessary]~~ at least
11 twice a year. A portion of the meeting shall be set aside for
12 the purpose of receiving public testimony. The committee shall
13 seek recommendations from social, economic, and public assistance
14 experts on ways to improve the effectiveness of public assistance
15 programs, to improve program efficiency and reduce costs, and to
16 promote self-sufficiency among public assistance recipients as
17 may be appropriate.

18 [4. Nothing in this section shall be construed as
19 authorizing the committee to hire employees or enter into any
20 employment contracts.

21 5. The committee shall receive and study the five-year
22 rolling MO HealthNet budget forecast issued annually by the
23 legislative budget office.]

24 6. The committee is authorized to hire staff and enter into
25 employment contracts including, but not limited to, an executive
26 director to conduct special reviews or investigations of the
27 public assistance programs within the state in order to assist
28 the committee with its duties. Staff appointments shall be

1 approved by the president pro tempore of the senate and the
2 speaker of the house of representatives. The compensation of
3 committee staff and the expenses of the committee shall be paid
4 from the joint contingent fund or jointly from the senate and
5 house of representatives contingent funds until an appropriation
6 is made therefor.

7 7. The committee shall annually conduct a rolling five-year
8 forecast of the public assistance programs within the state and
9 make recommendations in a report to the general assembly by
10 January first each year, beginning in [2008] 2018, on anticipated
11 growth [in the MO HealthNet program] of the public assistance
12 programs within the state, needed improvements, anticipated
13 needed appropriations, and suggested strategies on ways to
14 structure the state budget in order to satisfy the future needs
15 of [the program] such programs.

16 208.1030. 1. An eligible provider, as described in
17 subsection 2 of this section, may, in addition to the rate of
18 payment that the provider would otherwise receive for Medicaid
19 ground emergency medical transportation services, receive MO
20 HealthNet supplemental reimbursement to the extent provided by
21 law.

22 2. A provider shall be eligible for Medicaid supplemental
23 reimbursement if the provider meets the following characteristics
24 during the state reporting period:

25 (1) Provides ground emergency medical transportation
26 services to MO HealthNet participants;

27 (2) Is enrolled as a MO HealthNet provider for the period
28 being claimed; and

1 (3) Is owned, operated, or contracted by the state or a
2 political subdivision.

3 3. An eligible provider's Medicaid supplemental
4 reimbursement under this section shall be calculated and paid as
5 follows:

6 (1) The supplemental reimbursement to an eligible provider,
7 as described in subsection 2 of this section, shall be equal to
8 the amount of federal financial participation received as a
9 result of the claims submitted under subdivision (2) of
10 subsection 6 of this section;

11 (2) In no instance shall the amount certified under
12 subdivision (1) of subsection 5 of this section, when combined
13 with the amount received from all other sources of reimbursement
14 from the MO HealthNet program, exceed one hundred percent of
15 actual costs, as determined under the Medicaid state plan for
16 ground emergency medical transportation services; and

17 (3) The supplemental Medicaid reimbursement provided by
18 this section shall be distributed exclusively to eligible
19 providers under a payment methodology based on ground emergency
20 medical transportation services provided to MO HealthNet
21 participants by eligible providers on a per-transport basis or
22 other federally permissible basis. The department of social
23 services shall obtain approval from the Centers for Medicare and
24 Medicaid Services for the payment methodology to be utilized and
25 shall not make any payment under this section prior to obtaining
26 that approval.

27 4. An eligible provider, as a condition of receiving
28 supplemental reimbursement under this section, shall enter into

1 and maintain an agreement with the department's designee for the
2 purposes of implementing this section and reimbursing the
3 department of social services for the costs of administering this
4 section. The non-federal share of the supplemental reimbursement
5 submitted to the Centers for Medicare and Medicaid Services for
6 purposes of claiming federal financial participation shall be
7 paid with funds from the governmental entities described in
8 subdivision (3) of subsection 2 of this section and certified to
9 the state as provided in subsection 5 of this section.

10 5. Participation in the program by an eligible provider
11 described in this section is voluntary. If an applicable
12 governmental entity elects to seek supplemental reimbursement
13 under this section on behalf of an eligible provider owned or
14 operated by the entity, as described in subdivision (3) of
15 subsection 2 of this section, the governmental entity shall do
16 the following:

17 (1) Certify in conformity with the requirements of 42 CFR
18 433.51 that the claimed expenditures for the ground emergency
19 medical transportation services are eligible for federal
20 financial participation;

21 (2) Provide evidence supporting the certification as
22 specified by the department of social services;

23 (3) Submit data as specified by the department of social
24 services to determine the appropriate amounts to claim as
25 expenditures qualifying for federal financial participation; and

26 (4) Keep, maintain, and have readily retrievable any
27 records specified by the department of social services to fully
28 disclose reimbursement amounts to which the eligible provider is

1 entitled and any other records required by the Centers for
2 Medicare and Medicaid Services.

3 6. The department of social services shall be authorized to
4 seek any necessary federal approvals for the implementation of
5 this section. The department may limit the program to those
6 costs that are allowable expenditures under Title XIX of the
7 Social Security Act, 42 U.S.C. Section 1396, et seq.

8 (1) The department of social services shall submit claims
9 for federal financial participation for the expenditures for the
10 services described in subsection 5 of this section that are
11 allowable expenditures under federal law.

12 (2) The department of social services shall, on an annual
13 basis, submit any necessary materials to the federal government
14 to provide assurances that claims for federal financial
15 participation shall include only those expenditures that are
16 allowable under federal law.

17 208.1032. 1. The department of social services shall be
18 authorized to design and implement in consultation and
19 coordination with eligible providers as described in subsection 2
20 of this section an intergovernmental transfer program relating to
21 ground emergency medical transport services, including those
22 services provided at the emergency medical responder, emergency
23 medical technician (EMT), advanced EMT, EMT intermediate, or
24 paramedic levels in the pre-stabilization and preparation for
25 transport, in order to increase capitation payments for the
26 purpose of increasing reimbursement to eligible providers.

27 2. A provider shall be eligible for increased reimbursement
28 under this section only if the provider meets the following

1 conditions in an applicable state fiscal year:

2 (1) Provides ground emergency medical transportation
3 services to MO HealthNet participants;

4 (2) Is enrolled as a MO HealthNet provider for the period
5 being claimed; and

6 (3) Is owned, operated, or contracted by the state or a
7 political subdivision.

8 3. To the extent intergovernmental transfers are
9 voluntarily made by and accepted from an eligible provider
10 described in subsection 2 of this section or a governmental
11 entity affiliated with an eligible provider, the department of
12 social services shall make increased capitation payments to
13 applicable MO HealthNet eligible providers for covered ground
14 emergency medical transportation services.

15 (1) The increased capitation payments made under this
16 section shall be in amounts at least actuarially equivalent to
17 the supplemental fee-for-service payments and up to equivalent of
18 commercial reimbursement rates available for eligible providers
19 to the extent permissible under federal law.

20 (2) Except as provided in subsection 6 of this section, all
21 funds associated with intergovernmental transfers made and
22 accepted under this section shall be used to fund additional
23 payments to eligible providers.

24 (3) MO HealthNet managed care plans and coordinated care
25 organizations shall pay one hundred percent of any amount of
26 increased capitation payments made under this section to eligible
27 providers for providing and making available ground emergency
28 medical transportation and pre-stabilization services pursuant to

1 a contract or other arrangement with a MO HealthNet managed care
2 plan or coordinated care organization.

3 4. The intergovernmental transfer program developed under
4 this section shall be implemented on the date federal approval is
5 obtained, and only to the extent intergovernmental transfers from
6 the eligible provider, or the governmental entity with which it
7 is affiliated, are provided for this purpose. The department of
8 social services shall implement the intergovernmental transfer
9 program and increased capitation payments under this section on a
10 retroactive basis as permitted by federal law.

11 5. Participation in the intergovernmental transfers under
12 this section is voluntary on the part of the transferring
13 entities for purposes of all applicable federal laws.

14 6. As a condition of participation under this section, each
15 eligible provider as described in subsection 2 of this section or
16 the governmental entity affiliated with an eligible provider
17 shall agree to reimburse the department of social services for
18 any costs associated with implementing this section.

19 Intergovernmental transfers described in this section are subject
20 to an administration fee of up to twenty percent of the
21 nonfederal share paid to the department of social services and
22 shall be allowed to count as a cost of providing the services not
23 to exceed one hundred twenty percent of the total amount.

24 7. As a condition of participation under this section, MO
25 HealthNet managed care plans, coordinated care organizations,
26 eligible providers as described in subsection 2 of this section,
27 and governmental entities affiliated with eligible providers
28 shall agree to comply with any requests for information or

1 similar data requirements imposed by the department of social
2 services for purposes of obtaining supporting documentation
3 necessary to claim federal funds or to obtain federal approvals.

4 8. This section shall be implemented only if and to the
5 extent federal financial participation is available and is not
6 otherwise jeopardized, and any necessary federal approvals have
7 been obtained.

8 9. To the extent that the director of the department of
9 social services determines that the payments made under this
10 section do not comply with federal Medicaid requirements, the
11 director retains the discretion to return or not accept an
12 intergovernmental transfer, and may adjust payments under this
13 section as necessary to comply with federal Medicaid
14 requirements.

15 [208.985. 1. Pursuant to section 33.803, by
16 January 1, 2008, and each January first thereafter, the
17 legislative budget office shall annually conduct a
18 rolling five-year MO HealthNet forecast. The forecast
19 shall be issued to the general assembly, the governor,
20 the joint committee on MO HealthNet, and the oversight
21 committee established in section 208.955. The forecast
22 shall include, but not be limited to, the following,
23 with additional items as determined by the legislative
24 budget office:

25 (1) The projected budget of the entire MO
26 HealthNet program;

27 (2) The projected budgets of selected programs
28 within MO HealthNet;

29 (3) Projected MO HealthNet enrollment growth,
30 categorized by population and geographic area;

31 (4) Projected required reimbursement rates for MO
32 HealthNet providers; and

33 (5) Projected financial need going forward.

34 2. In preparing the forecast required in
35 subsection 1 of this section, where the MO HealthNet
36 program overlaps more than one department or agency,
37 the legislative budget office may provide for review
38 and investigation of the program or service level on an
39 interagency or interdepartmental basis in an effort to
40 review all aspects of the program.]

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David Sater

Marsha Haefner