SECOND REGULAR SESSION

HOUSE BILL NO. 2255

100TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE NEELY.

5060H.01I DANA RADEMAN MILLER, Chief Clerk

AN ACT

To repeal section 208.152, RSMo, and to enact in lieu thereof two new sections relating to insurance coverage for medically necessary dental procedures.

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

Section A. Section 208.152, RSMo, is repealed and two new sections enacted in lieu
2 thereof, to be known as sections 208.152 and 376.1067, to read as follows:

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy
2 persons as described in section 208.151 who are unable to provide for it in whole or in part, with
3 any payments to be made on the basis of the reasonable cost of the care or reasonable charge for
4 the services as defined and determined by the MO HealthNet division, unless otherwise
5 hereinafter provided, for the following:
6 (1) Inpatient hospital services, except to persons in an institution for mental diseases who
7 are under the age of sixty-five years and over the age of twenty-one years; provided that the MO
8 HealthNet division shall provide through rule and regulation an exception process for coverage
9 of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile
10 professional activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay
11 schedule; and provided further that the MO HealthNet division shall take into account through
12 its payment system for hospital services the situation of hospitals which serve a disproportionate
13 number of low-income patients;
14 (2) All outpatient hospital services, payments therefor to be in amounts which represent
15 no more than eighty percent of the lesser of reasonable costs or customary charges for such
16 services, determined in accordance with the principles set forth in Title XVIII A and B, Public
17 Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.),

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

18 but the MO HealthNet division may evaluate outpatient hospital services rendered under this
19 section and deny payment for services which are determined by the MO HealthNet division not
20 to be medically necessary, in accordance with federal law and regulations;
21 (3) Laboratory and X-ray services;
22 (4) Nursing home services for participants, except to persons with more than five
23 hundred thousand dollars equity in their home or except for persons in an institution for mental
24 diseases who are under the age of sixty-five years, when residing in a hospital licensed by the
25 department of health and senior services or a nursing home licensed by the department of health
26 and senior services or appropriate licensing authority of other states or government-owned and
27 -operated institutions which are determined to conform to standards equivalent to licensing
28 requirements in Title XIX of the federal Social Security Act (42 U.S.C. Section 301, et seq.), as
29 amended, for nursing facilities. The MO HealthNet division may recognize through its payment
30 methodology for nursing facilities those nursing facilities which serve a high volume of MO
31 HealthNet patients. The MO HealthNet division when determining the amount of the benefit
32 payments to be made on behalf of persons under the age of twenty-one in a nursing facility may
33 consider nursing facilities furnishing care to persons under the age of twenty-one as a
34 classification separate from other nursing facilities;
35 (5) Nursing home costs for participants receiving benefit payments under subdivision
36 (4) of this subsection for those days, which shall not exceed twelve per any period of six
37 consecutive months, during which the participant is on a temporary leave of absence from the
38 hospital or nursing home, provided that no such participant shall be allowed a temporary leave
39 of absence unless it is specifically provided for in his plan of care. As used in this subdivision,
40 the term "temporary leave of absence" shall include all periods of time during which a participant
41 is away from the hospital or nursing home overnight because he is visiting a friend or relative;
42 (6) Physicians' services, whether furnished in the office, home, hospital, nursing home,
43 or elsewhere;
44 (7) Subject to appropriation, up to twenty visits per year for services limited to
45 examinations, diagnoses, adjustments, and manipulations and treatments of malpositioned
46 articulations and structures of the body provided by licensed chiropractic physicians practicing
47 within their scope of practice. Nothing in this subdivision shall be interpreted to otherwise
48 expand MO HealthNet services;
49 (8) Drugs and medicines when prescribed by a licensed physician, dentist, podiatrist, or
50 an advanced practice registered nurse; except that no payment for drugs and medicines
51 prescribed on and after January 1, 2006, by a licensed physician, dentist, podiatrist, or an
52 advanced practice registered nurse may be made on behalf of any person who qualifies for
53 prescription drug coverage under the provisions of P.L. 108-173;

54 (9) Emergency ambulance services and, effective January 1, 1990, medically necessary
55 transportation to scheduled, physician-prescribed nonelective treatments;
56 (10) Early and periodic screening and diagnosis of individuals who are under the age of
57 twenty-one to ascertain their physical or mental defects, and health care, treatment, and other
58 measures to correct or ameliorate defects and chronic conditions discovered thereby. Such
59 services shall be provided in accordance with the provisions of Section 6403 of P.L. 101-239 and
60 federal regulations promulgated thereunder;
61 (11) Home health care services;
62 (12) Family planning as defined by federal rules and regulations; provided, however, that
63 such family planning services shall not include abortions unless such abortions are certified in
64 writing by a physician to the MO HealthNet agency that, in the physician's professional
65 judgment, the life of the mother would be endangered if the fetus were carried to term;
66 (13) Inpatient psychiatric hospital services for individuals under age twenty-one as
67 defined in Title XIX of the federal Social Security Act (42 U.S.C. Section 1396d, et seq.);
68 (14) Outpatient surgical procedures, including presurgical diagnostic services performed
69 in ambulatory surgical facilities which are licensed by the department of health and senior
70 services of the state of Missouri; except, that such outpatient surgical services shall not include
71 persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965
72 amendments to the federal Social Security Act, as amended, if exclusion of such persons is
73 permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security
74 Act, as amended;
75 (15) Personal care services which are medically oriented tasks having to do with a
76 person's physical requirements, as opposed to housekeeping requirements, which enable a person
77 to be treated by his or her physician on an outpatient rather than on an inpatient or residential
78 basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services
79 shall be rendered by an individual not a member of the participant's family who is qualified to
80 provide such services where the services are prescribed by a physician in accordance with a plan
81 of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care
82 services shall be those persons who would otherwise require placement in a hospital,
83 intermediate care facility, or skilled nursing facility. Benefits payable for personal care services
84 shall not exceed for any one participant one hundred percent of the average statewide charge for
85 care and treatment in an intermediate care facility for a comparable period of time. Such
86 services, when delivered in a residential care facility or assisted living facility licensed under
87 chapter 198 shall be authorized on a tier level based on the services the resident requires and the
88 frequency of the services. A resident of such facility who qualifies for assistance under section
89 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the

90 fewest services. The rate paid to providers for each tier of service shall be set subject to
91 appropriations. Subject to appropriations, each resident of such facility who qualifies for
92 assistance under section 208.030 and meets the level of care required in this section shall, at a
93 minimum, if prescribed by a physician, be authorized up to one hour of personal care services
94 per day. Authorized units of personal care services shall not be reduced or tier level lowered
95 unless an order approving such reduction or lowering is obtained from the resident's personal
96 physician. Such authorized units of personal care services or tier level shall be transferred with
97 such resident if he or she transfers to another such facility. Such provision shall terminate upon
98 receipt of relevant waivers from the federal Department of Health and Human Services. If the
99 Centers for Medicare and Medicaid Services determines that such provision does not comply
100 with the state plan, this provision shall be null and void. The MO HealthNet division shall notify
101 the revisor of statutes as to whether the relevant waivers are approved or a determination of
102 noncompliance is made;

103 (16) Mental health services. The state plan for providing medical assistance under Title
104 XIX of the Social Security Act, 42 U.S.C. Section 301, as amended, shall include the following
105 mental health services when such services are provided by community mental health facilities
106 operated by the department of mental health or designated by the department of mental health
107 as a community mental health facility or as an alcohol and drug abuse facility or as a
108 child-serving agency within the comprehensive children's mental health service system
109 established in section 630.097. The department of mental health shall establish by administrative
110 rule the definition and criteria for designation as a community mental health facility and for
111 designation as an alcohol and drug abuse facility. Such mental health services shall include:

112 (a) Outpatient mental health services including preventive, diagnostic, therapeutic,
113 rehabilitative, and palliative interventions rendered to individuals in an individual or group
114 setting by a mental health professional in accordance with a plan of treatment appropriately
115 established, implemented, monitored, and revised under the auspices of a therapeutic team as a
116 part of client services management;

117 (b) Clinic mental health services including preventive, diagnostic, therapeutic,
118 rehabilitative, and palliative interventions rendered to individuals in an individual or group
119 setting by a mental health professional in accordance with a plan of treatment appropriately
120 established, implemented, monitored, and revised under the auspices of a therapeutic team as a
121 part of client services management;

122 (c) Rehabilitative mental health and alcohol and drug abuse services including home and
123 community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions
124 rendered to individuals in an individual or group setting by a mental health or alcohol and drug
125 abuse professional in accordance with a plan of treatment appropriately established,

126 implemented, monitored, and revised under the auspices of a therapeutic team as a part of client
127 services management. As used in this section, mental health professional and alcohol and drug
128 abuse professional shall be defined by the department of mental health pursuant to duly
129 promulgated rules. With respect to services established by this subdivision, the department of
130 social services, MO HealthNet division, shall enter into an agreement with the department of
131 mental health. Matching funds for outpatient mental health services, clinic mental health
132 services, and rehabilitation services for mental health and alcohol and drug abuse shall be
133 certified by the department of mental health to the MO HealthNet division. The agreement shall
134 establish a mechanism for the joint implementation of the provisions of this subdivision. In
135 addition, the agreement shall establish a mechanism by which rates for services may be jointly
136 developed;

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

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

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

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

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

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

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

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

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

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

171 (21) Hospice care. As used in this subdivision, the term "hospice care" means a
172 coordinated program of active professional medical attention within a home, outpatient and
173 inpatient care which treats the terminally ill patient and family as a unit, employing a medically
174 directed interdisciplinary team. The program provides relief of severe pain or other physical
175 symptoms and supportive care to meet the special needs arising out of physical, psychological,
176 spiritual, social, and economic stresses which are experienced during the final stages of illness,
177 and during dying and bereavement and meets the Medicare requirements for participation as a
178 hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO
179 HealthNet division to the hospice provider for room and board furnished by a nursing home to
180 an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement
181 which would have been paid for facility services in that nursing home facility for that patient,
182 in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget
183 Reconciliation Act of 1989);

184 (22) Prescribed medically necessary dental services. **As used in this subdivision,**
185 **"prescribed medically necessary dental services" shall include dental procedures deemed**
186 **medically necessary as a result of cancer treatment.** Such services shall be subject to
187 appropriations. An electronic web-based prior authorization system using best medical evidence
188 and care and treatment guidelines consistent with national standards shall be used to verify
189 medical need;

190 (23) Prescribed medically necessary optometric services. Such services shall be subject
191 to appropriations. An electronic web-based prior authorization system using best medical
192 evidence and care and treatment guidelines consistent with national standards shall be used to
193 verify medical need;

194 (24) Blood clotting products-related services. For persons diagnosed with a bleeding
195 disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section
196 338.400, such services include:

197 (a) Home delivery of blood clotting products and ancillary infusion equipment and
198 supplies, including the emergency deliveries of the product when medically necessary;
199 (b) Medically necessary ancillary infusion equipment and supplies required to administer
200 the blood clotting products; and
201 (c) Assessments conducted in the participant's home by a pharmacist, nurse, or local
202 home health care agency trained in bleeding disorders when deemed necessary by the
203 participant's treating physician;
204 (25) The MO HealthNet division shall, by January 1, 2008, and annually thereafter,
205 report the status of MO HealthNet provider reimbursement rates as compared to one hundred
206 percent of the Medicare reimbursement rates and compared to the average dental reimbursement
207 rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July
208 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare
209 reimbursement rates and for third-party payor average dental reimbursement rates. Such plan
210 shall be subject to appropriation and the division shall include in its annual budget request to the
211 governor the necessary funding needed to complete the four-year plan developed under this
212 subdivision.
213 2. Additional benefit payments for medical assistance shall be made on behalf of those
214 eligible needy children, pregnant women and blind persons with any payments to be made on the
215 basis of the reasonable cost of the care or reasonable charge for the services as defined and
216 determined by the MO HealthNet division, unless otherwise hereinafter provided, for the
217 following:
218 (1) Dental services;
219 (2) Services of podiatrists as defined in section 330.010;
220 (3) Optometric services as described in section 336.010;
221 (4) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids,
222 and wheelchairs;
223 (5) Hospice care. As used in this subdivision, the term "hospice care" means a
224 coordinated program of active professional medical attention within a home, outpatient and
225 inpatient care which treats the terminally ill patient and family as a unit, employing a medically
226 directed interdisciplinary team. The program provides relief of severe pain or other physical
227 symptoms and supportive care to meet the special needs arising out of physical, psychological,
228 spiritual, social, and economic stresses which are experienced during the final stages of illness,
229 and during dying and bereavement and meets the Medicare requirements for participation as a
230 hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO
231 HealthNet division to the hospice provider for room and board furnished by a nursing home to
232 an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement

233 which would have been paid for facility services in that nursing home facility for that patient,
234 in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget
235 Reconciliation Act of 1989);
236 (6) Comprehensive day rehabilitation services beginning early posttrauma as part of a
237 coordinated system of care for individuals with disabling impairments. Rehabilitation services
238 must be based on an individualized, goal-oriented, comprehensive and coordinated treatment
239 plan developed, implemented, and monitored through an interdisciplinary assessment designed
240 to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO
241 HealthNet division shall establish by administrative rule the definition and criteria for
242 designation of a comprehensive day rehabilitation service facility, benefit limitations and
243 payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010,
244 that is created under the authority delegated in this subdivision shall become effective only if it
245 complies with and is subject to all of the provisions of chapter 536 and, if applicable, section
246 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the
247 general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove
248 and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority
249 and any rule proposed or adopted after August 28, 2005, shall be invalid and void.
250 3. The MO HealthNet division may require any participant receiving MO HealthNet
251 benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July
252 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered
253 services except for those services covered under subdivisions (15) and (16) of subsection 1 of
254 this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title
255 XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations
256 thereunder. When substitution of a generic drug is permitted by the prescriber according to
257 section 338.056, and a generic drug is substituted for a name-brand drug, the MO HealthNet
258 division may not lower or delete the requirement to make a co-payment pursuant to regulations
259 of Title XIX of the federal Social Security Act. A provider of goods or services described under
260 this section must collect from all participants the additional payment that may be required by the
261 MO HealthNet division under authority granted herein, if the division exercises that authority,
262 to remain eligible as a provider. Any payments made by participants under this section shall be
263 in addition to and not in lieu of payments made by the state for goods or services described
264 herein except the participant portion of the pharmacy professional dispensing fee shall be in
265 addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment
266 at the time a service is provided or at a later date. A provider shall not refuse to provide a service
267 if a participant is unable to pay a required payment. If it is the routine business practice of a
268 provider to terminate future services to an individual with an unclaimed debt, the provider may

269 include uncollected co-payments under this practice. Providers who elect not to undertake the
270 provision of services based on a history of bad debt shall give participants advance notice and
271 a reasonable opportunity for payment. A provider, representative, employee, independent
272 contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a
273 participant. This subsection shall not apply to other qualified children, pregnant women, or blind
274 persons. If the Centers for Medicare and Medicaid Services does not approve the MO HealthNet
275 state plan amendment submitted by the department of social services that would allow a provider
276 to deny future services to an individual with uncollected co-payments, the denial of services shall
277 not be allowed. The department of social services shall inform providers regarding the
278 acceptability of denying services as the result of unpaid co-payments.
279 4. The MO HealthNet division shall have the right to collect medication samples from
280 participants in order to maintain program integrity.
281 5. Reimbursement for obstetrical and pediatric services under subdivision (6) of
282 subsection 1 of this section shall be timely and sufficient to enlist enough health care providers
283 so that care and services are available under the state plan for MO HealthNet benefits at least to
284 the extent that such care and services are available to the general population in the geographic
285 area, as required under subparagraph (a)(30)(A) of 42 U.S.C. Section 1396a and federal
286 regulations promulgated thereunder.
287 6. Beginning July 1, 1990, reimbursement for services rendered in federally funded
288 health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404
289 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations
290 promulgated thereunder.
291 7. Beginning July 1, 1990, the department of social services shall provide notification
292 and referral of children below age five, and pregnant, breast-feeding, or postpartum women who
293 are determined to be eligible for MO HealthNet benefits under section 208.151 to the special
294 supplemental food programs for women, infants and children administered by the department
295 of health and senior services. Such notification and referral shall conform to the requirements
296 of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.
297 8. Providers of long-term care services shall be reimbursed for their costs in accordance
298 with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. Section
299 1396a, as amended, and regulations promulgated thereunder.
300 9. Reimbursement rates to long-term care providers with respect to a total change in
301 ownership, at arm's length, for any facility previously licensed and certified for participation in
302 the MO HealthNet program shall not increase payments in excess of the increase that would
303 result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C.
304 Section 1396a (a)(13)(C).

305 10. The MO HealthNet division may enroll qualified residential care facilities and
306 assisted living facilities, as defined in chapter 198, as MO HealthNet personal care providers.
307 11. Any income earned by individuals eligible for certified extended employment at a
308 sheltered workshop under chapter 178 shall not be considered as income for purposes of
309 determining eligibility under this section.
310 12. If the Missouri Medicaid audit and compliance unit changes any interpretation or
311 application of the requirements for reimbursement for MO HealthNet services from the
312 interpretation or application that has been applied previously by the state in any audit of a MO
313 HealthNet provider, the Missouri Medicaid audit and compliance unit shall notify all affected
314 MO HealthNet providers five business days before such change shall take effect. Failure of the
315 Missouri Medicaid audit and compliance unit to notify a provider of such change shall entitle the
316 provider to continue to receive and retain reimbursement until such notification is provided and
317 shall waive any liability of such provider for recoupment or other loss of any payments
318 previously made prior to the five business days after such notice has been sent. Each provider
319 shall provide the Missouri Medicaid audit and compliance unit a valid email address and shall
320 agree to receive communications electronically. The notification required under this section
321 shall be delivered in writing by the United States Postal Service or electronic mail to each
322 provider.
323 13. Nothing in this section shall be construed to abrogate or limit the department's
324 statutory requirement to promulgate rules under chapter 536.
325 14. Beginning July 1, 2016, and subject to appropriations, providers of behavioral,
326 social, and psychophysiological services for the prevention, treatment, or management of
327 physical health problems shall be reimbursed utilizing the behavior assessment and intervention
328 reimbursement codes 96150 to 96154 or their successor codes under the Current Procedural
329 Terminology (CPT) coding system. Providers eligible for such reimbursement shall include
330 psychologists.

376.1067. 1. An insurance policy issued, renewed, amended, or continued in this
2 **state shall provide coverage for medically necessary dental procedures that are the direct**
3 **or indirect result of cancer treatments including, but not limited to, chemotherapy,**
4 **biotherapy, or radiation therapy treatment.**
5 **2. The coverage required under this section shall include expenses for evaluations,**
6 **laboratory assessments, medications, and treatments associated with the medically**
7 **necessary dental procedures.**

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