

FIRST EXTRAORDINARY SESSION OF THE  
FIRST REGULAR SESSION

**HOUSE BILL NO. 4**

**101ST GENERAL ASSEMBLY**

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INTRODUCED BY REPRESENTATIVE COLEMAN (97).

2849H.011

DANA RADEMAN MILLER, ChiefClerk

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**AN ACT**

To repeal sections 190.839, 198.439, 208.152, 208.153, 208.164, 208.437, 208.480, 208.659, 338.550, and 633.401, RSMo, and to enact in lieu thereof twelve new sections relating to health care.

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

Section A. Sections 190.839, 198.439, 208.152, 208.153, 208.164, 208.437, 208.480, 208.659, 338.550, and 633.401, RSMo, are repealed and twelve new sections enacted in lieu thereof, to be known as sections 188.202, 188.207, 190.839, 198.439, 208.152, 208.153, 208.164, 208.437, 208.480, 208.659, 338.550, and 633.401, to read as follows:

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

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

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

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

**(4) Prevent the state or its political subdivisions from being coerced, compelled, or commandeered by the federal government to enact, administer, or enforce a federal regulatory program that directly or indirectly funds abortion; and**

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.

13           **(5) Prohibit the federal government from commanding or conscripting public**  
14 **officials of the state or its political subdivisions to enforce a federal regulatory program**  
15 **that directly or indirectly funds abortion.**

16           **2. In any action to enforce the provisions of sections 188.200 to 188.215 by a**  
17 **taxpayer under the provisions of section 188.200, a court of competent jurisdiction may**  
18 **order injunctive or other equitable relief, recovery of damages or other legal remedies, or**  
19 **both, as well as payment of reasonable attorney's fees, costs, and expenses of the taxpayer.**  
20 **The relief and remedies set forth shall not be deemed exclusive and shall be in addition to**  
21 **any other relief or remedies permitted by law.**

22           **3. In addition to a cause of action brought by a taxpayer under section 188.220, the**  
23 **attorney general is also authorized to bring a cause of action to enforce the provisions of**  
24 **sections 188.200 to 188.215.**

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

          190.839. Sections 190.800 to 190.839 shall expire on September 30, [2021] **2022.**

          198.439. Sections 198.401 to 198.436 shall expire on September 30, [2021] **2022.**

          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.),  
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 **or her** plan of care. As used in this  
40 subdivision, the term "temporary leave of absence" shall include all periods of time during which  
41 a participant is away from the hospital or nursing home overnight because he **or she** is visiting  
42 a friend or relative;

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

46 (7) Subject to appropriation, up to twenty visits per year for services limited to  
47 examinations, diagnoses, adjustments, and manipulations and treatments of malpositioned  
48 articulations and structures of the body provided by licensed chiropractic physicians practicing  
49 within their scope of practice. Nothing in this subdivision shall be interpreted to otherwise  
50 expand MO HealthNet services;

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

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

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

63 (11) Home health care services;

64 (12) Family planning as defined by federal rules and regulations; **provided that, no**  
65 **funds shall be expended to any abortion facility, as defined in section 188.015, or to any**  
66 **affiliate or associate of such abortion facility; and further** provided, however, that such  
67 family planning services shall not include abortions unless such abortions are certified in writing  
68 by a physician to the MO HealthNet agency that, in the physician's professional judgment, the  
69 life of the mother would be endangered if the fetus were carried to term;

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

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

79 (15) Personal care services which are medically oriented tasks having to do with a  
80 person's physical requirements, as opposed to housekeeping requirements, which enable a person  
81 to be treated by his or her physician on an outpatient rather than on an inpatient or residential  
82 basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services  
83 shall be rendered by an individual not a member of the participant's family who is qualified to  
84 provide such services where the services are prescribed by a physician in accordance with a plan  
85 of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care  
86 services shall be those persons who would otherwise require placement in a hospital,  
87 intermediate care facility, or skilled nursing facility. Benefits payable for personal care services  
88 shall not exceed for any one participant one hundred percent of the average statewide charge for  
89 care and treatment in an intermediate care facility for a comparable period of time. Such  
90 services, when delivered in a residential care facility or assisted living facility licensed under  
91 chapter 198 shall be authorized on a tier level based on the services the resident requires and the

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

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

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

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

126 (c) Rehabilitative mental health and alcohol and drug abuse services including home and  
127 community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions

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

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

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

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

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

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

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

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

161 (c) For each day that nursing home costs are paid on behalf of a participant under this  
162 subdivision during any period of six consecutive months such participant shall, during the same  
163 period of six consecutive months, be ineligible for payment of nursing home costs of two

164 otherwise available temporary leave of absence days provided under subdivision (5) of this  
165 subsection; and

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

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

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

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

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

196 (24) Blood clotting products-related services. For persons diagnosed with a bleeding  
197 disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section  
198 338.400, such services include:

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

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

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

206 (25) The MO HealthNet division shall, by January 1, 2008, and annually thereafter,  
207 report the status of MO HealthNet provider reimbursement rates as compared to one hundred  
208 percent of the Medicare reimbursement rates and compared to the average dental reimbursement  
209 rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July  
210 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare  
211 reimbursement rates and for third-party payor average dental reimbursement rates. Such plan  
212 shall be subject to appropriation and the division shall include in its annual budget request to the  
213 governor the necessary funding needed to complete the four-year plan developed under this  
214 subdivision.

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

220 (1) Dental services;

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

222 (3) Optometric services as described in section 336.010;

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

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



235 which would have been paid for facility services in that nursing home facility for that patient,  
236 in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget  
237 Reconciliation Act of 1989);

238 (6) Comprehensive day rehabilitation services beginning early posttrauma as part of a  
239 coordinated system of care for individuals with disabling impairments. Rehabilitation services  
240 must be based on an individualized, goal-oriented, comprehensive and coordinated treatment  
241 plan developed, implemented, and monitored through an interdisciplinary assessment designed  
242 to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO  
243 HealthNet division shall establish by administrative rule the definition and criteria for  
244 designation of a comprehensive day rehabilitation service facility, benefit limitations and  
245 payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010,  
246 that is created under the authority delegated in this subdivision shall become effective only if it  
247 complies with and is subject to all of the provisions of chapter 536 and, if applicable, section  
248 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the  
249 general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove  
250 and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority  
251 and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

252 3. The MO HealthNet division may require any participant receiving MO HealthNet  
253 benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July  
254 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered  
255 services except for those services covered under subdivisions (15) and (16) of subsection 1 of  
256 this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title  
257 XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations  
258 thereunder. When substitution of a generic drug is permitted by the prescriber according to  
259 section 338.056, and a generic drug is substituted for a name-brand drug, the MO HealthNet  
260 division may not lower or delete the requirement to make a co-payment pursuant to regulations  
261 of Title XIX of the federal Social Security Act. A provider of goods or services described under  
262 this section must collect from all participants the additional payment that may be required by the  
263 MO HealthNet division under authority granted herein, if the division exercises that authority,  
264 to remain eligible as a provider. Any payments made by participants under this section shall be  
265 in addition to and not in lieu of payments made by the state for goods or services described  
266 herein except the participant portion of the pharmacy professional dispensing fee shall be in  
267 addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment  
268 at the time a service is provided or at a later date. A provider shall not refuse to provide a service  
269 if a participant is unable to pay a required payment. If it is the routine business practice of a  
270 provider to terminate future services to an individual with an unclaimed debt, the provider may

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

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

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

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

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

299 8. Providers of long-term care services shall be reimbursed for their costs in accordance  
300 with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. Section  
301 1396a, as amended, and regulations promulgated thereunder.

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

307 10. The MO HealthNet division may enroll qualified residential care facilities and  
308 assisted living facilities, as defined in chapter 198, as MO HealthNet personal care providers.

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

312 12. If the Missouri Medicaid audit and compliance unit changes any interpretation or  
313 application of the requirements for reimbursement for MO HealthNet services from the  
314 interpretation or application that has been applied previously by the state in any audit of a MO  
315 HealthNet provider, the Missouri Medicaid audit and compliance unit shall notify all affected  
316 MO HealthNet providers five business days before such change shall take effect. Failure of the  
317 Missouri Medicaid audit and compliance unit to notify a provider of such change shall entitle the  
318 provider to continue to receive and retain reimbursement until such notification is provided and  
319 shall waive any liability of such provider for recoupment or other loss of any payments  
320 previously made prior to the five business days after such notice has been sent. Each provider  
321 shall provide the Missouri Medicaid audit and compliance unit a valid email address and shall  
322 agree to receive communications electronically. The notification required under this section  
323 shall be delivered in writing by the United States Postal Service or electronic mail to each  
324 provider.

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

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

208.153. 1. Pursuant to and not inconsistent with the provisions of sections 208.151 and  
2 208.152, the MO HealthNet division shall by rule and regulation define the reasonable costs,  
3 manner, extent, quantity, quality, charges and fees of MO HealthNet benefits herein provided.  
4 The benefits available under these sections shall not replace those provided under other federal  
5 or state law or under other contractual or legal entitlements of the persons receiving them, and  
6 all persons shall be required to apply for and utilize all benefits available to them and to pursue  
7 all causes of action to which they are entitled. ~~[Any person entitled to MO HealthNet benefits  
8 may obtain it from any provider of services with which an agreement is in effect under this  
9 section and which undertakes to provide the services, as authorized by the MO HealthNet  
10 division.]~~ At the discretion of the director of the MO HealthNet division and with the approval

11 of the governor, the MO HealthNet division is authorized to provide medical benefits for  
12 participants receiving public assistance by expending funds for the payment of federal medical  
13 insurance premiums, coinsurance and deductibles pursuant to the provisions of Title XVIII B and  
14 XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et  
15 seq.), as amended.

16 2. MO HealthNet shall include benefit payments on behalf of qualified Medicare  
17 beneficiaries as defined in 42 U.S.C. Section 1396d(p). The family support division shall by rule  
18 and regulation establish which qualified Medicare beneficiaries are eligible. The MO HealthNet  
19 division shall define the premiums, deductible and coinsurance provided for in 42 U.S.C. Section  
20 1396d(p) to be provided on behalf of the qualified Medicare beneficiaries.

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

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

33 5. For an individual eligible for MO HealthNet under Title XIX of the Social Security  
34 Act, MO HealthNet shall include payment of enrollee premiums in a group health plan and all  
35 deductibles, coinsurance and other cost-sharing for items and services otherwise covered under  
36 the state Title XIX plan under Section 1906 of the federal Social Security Act and regulations  
37 established under the authority of Section 1906, as may be amended. Enrollment in a group  
38 health plan must be cost effective, as established by the Secretary of Health and Human Services,  
39 before enrollment in the group health plan is required. If all members of a family are not eligible  
40 for MO HealthNet and enrollment of the Title XIX eligible members in a group health plan is  
41 not possible unless all family members are enrolled, all premiums for noneligible members shall  
42 be treated as payment for MO HealthNet of eligible family members. Payment for noneligible  
43 family members must be cost effective, taking into account payment of all such premiums.  
44 Non-Title XIX eligible family members shall pay all deductible, coinsurance and other  
45 cost-sharing obligations. Each individual as a condition of eligibility for MO HealthNet benefits  
46 shall apply for enrollment in the group health plan.

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

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

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

3           (1) "Abuse", a documented pattern of inducing, furnishing, or otherwise causing a  
4 recipient to receive services or merchandise not otherwise required or requested by the recipient,  
5 attending physician or appropriate utilization review team; a documented pattern of performing  
6 and billing tests, examinations, patient visits, surgeries, drugs or merchandise that exceed limits  
7 or frequencies determined by the department for like practitioners for which there is no  
8 demonstrable need, or for which the provider has created the need through ineffective services  
9 or merchandise previously rendered. The decision to impose any of the sanctions authorized in  
10 this section shall be made by the director of the department, following a determination of  
11 demonstrable need or accepted medical practice made in consultation with medical or other  
12 health care professionals, or qualified peer review teams;

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

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

19           (4) "Fraud", a known false representation, including the concealment of a material fact  
20 that **the** provider knew or should have known through the usual conduct of his **or her** profession  
21 or occupation, upon which the provider claims reimbursement under the terms and conditions  
22 of a contract or provider agreement and the policies pertaining to such contract or provider  
23 agreement of the department or its divisions in carrying out the providing of services, or under  
24 any approved state plan authorized by the federal Social Security Act;

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

27           (6) "Medical assistance benefits", those benefits authorized to be provided by sections  
28 208.152 and 208.162;

29           (7) "Prior authorization", approval to a provider to perform a service or services for an  
30 eligible person required by the department or its divisions in advance of the actual service being

31 provided or approved for a recipient to receive a service or services from a provider, required by  
32 the department or its designated division in advance of the actual service or services being  
33 received;

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

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

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

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

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

49 (1) When it has reasonable cause to believe a provider or recipient has knowingly  
50 followed a course of conduct which is defined as abuse or fraud or excessive use by this section;  
51 or

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

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

60 5. Payments for services under any contract or provider agreement between the  
61 department or its divisions and a provider may be withheld by the department or its divisions  
62 from the provider for acts or omissions defined as abuse or fraud by this section, until such time  
63 as an agreement between the parties is reached or the dispute is adjudicated under the laws of this  
64 state.

65 6. The department or its designated division shall have the authority to review all cases  
66 and claim records for any recipient of public assistance benefits and to determine from these

67 records if the recipient has, as defined in this section, committed excessive use of such services  
68 by seeking or obtaining services from a number of like providers of services and in quantities  
69 which exceed the levels considered necessary by current medical or health care professional  
70 practice standards and policies of the program.

71         7. The department or its designated division shall have the authority with respect to  
72 recipients of medical assistance benefits who have committed excessive use to limit or restrict  
73 the use of the recipient's Medicaid identification card to designated providers and for designated  
74 services; the actual method by which such restrictions are imposed shall be at the discretion of  
75 the department of social services or its designated division.

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

81         9. The department or its designated division shall have the authority with respect to any  
82 provider who knowingly allows a recipient to violate subsection 7 of this section or who fails to  
83 report a known violation of subsection 7 of this section to the department of social services or  
84 its designated division to terminate or otherwise sanction such provider's status as a participant  
85 in the medical assistance program. Any person making such a report shall not be civilly liable  
86 when the report is made in good faith.

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

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

99         **(2) Has a conviction related to the neglect or abuse of a patient in connection with**  
100 **the delivery of any health care item or service, as described in 42 U.S.C. Section 1320a-**  
101 **7(a)(2);**

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

105           **(4) Has a felony conviction related to the unlawful manufacture, distribution,**  
106 **prescription, or dispensation of a controlled substance, as described in 42 U.S.C. Section**  
107 **1320a-7(a)(4);**

108           **(5) Has a pattern of intentional discrimination in the delivery or nondelivery of any**  
109 **health care item or service based on the race, color, or national origin of recipients, as**  
110 **described in 42 U.S.C. Section 2000d, or was founded by a person who supported eugenics**  
111 **as the solution for racial, political, and social problems and who advocated for the use of**  
112 **birth control for "the elimination of the unfit" and stopping "the reproduction of the**  
113 **unfit"; or**

114           **(6) Is an abortion facility, as defined in section 188.015, or an affiliate or associate**  
115 **of such abortion facility.**

208.437. 1. A Medicaid managed care organization reimbursement allowance period  
2 as provided in sections 208.431 to 208.437 shall be from the first day of July to the thirtieth day  
3 of June. The department shall notify each Medicaid managed care organization with a balance  
4 due on the thirtieth day of June of each year the amount of such balance due. If any managed  
5 care organization fails to pay its managed care organization reimbursement allowance within  
6 thirty days of such notice, the reimbursement allowance shall be delinquent. The reimbursement  
7 allowance may remain unpaid during an appeal.

8           2. Except as otherwise provided in this section, if any reimbursement allowance imposed  
9 under the provisions of sections 208.431 to 208.437 is unpaid and delinquent, the department of  
10 social services may compel the payment of such reimbursement allowance in the circuit court  
11 having jurisdiction in the county where the main offices of the Medicaid managed care  
12 organization are located. In addition, the director of the department of social services or the  
13 director's designee may cancel or refuse to issue, extend or reinstate a Medicaid contract  
14 agreement to any Medicaid managed care organization which fails to pay such delinquent  
15 reimbursement allowance required by sections 208.431 to 208.437 unless under appeal.

16           3. Except as otherwise provided in this section, failure to pay a delinquent  
17 reimbursement allowance imposed under sections 208.431 to 208.437 shall be grounds for  
18 denial, suspension or revocation of a license granted by the department of commerce and  
19 insurance. The director of the department of commerce and insurance may deny, suspend or  
20 revoke the license of a Medicaid managed care organization with a contract under 42 U.S.C.  
21 Section 1396b(m) which fails to pay a managed care organization's delinquent reimbursement  
22 allowance unless under appeal.



23 4. Nothing in sections 208.431 to 208.437 shall be deemed to effect or in any way limit  
24 the tax-exempt or nonprofit status of any Medicaid managed care organization with a contract  
25 under 42 U.S.C. Section 1396b(m) granted by state law.

26 5. Sections 208.431 to 208.437 shall expire on September 30, ~~[2021]~~ **2022**.

208.480. Notwithstanding the provisions of section 208.471 to the contrary, sections  
2 208.453 to 208.480 shall expire on September 30, ~~[2021]~~ **2022**.

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

338.550. 1. The pharmacy tax required by sections 338.500 to 338.550 shall expire  
2 ninety days after any one or more of the following conditions are met:

3 (1) The aggregate dispensing fee as appropriated by the general assembly paid to  
4 pharmacists per prescription is less than the fiscal year 2003 dispensing fees reimbursement  
5 amount; or

6 (2) The formula used to calculate the reimbursement as appropriated by the general  
7 assembly for products dispensed by pharmacies is changed resulting in lower reimbursement to  
8 the pharmacist in the aggregate than provided in fiscal year 2003; or

9 (3) September 30, ~~[2021]~~ **2022**.

10

11 The director of the department of social services shall notify the revisor of statutes of the  
12 expiration date as provided in this subsection. The provisions of sections 338.500 to 338.550  
13 shall not apply to pharmacies domiciled or headquartered outside this state which are engaged  
14 in prescription drug sales that are delivered directly to patients within this state via common  
15 carrier, mail or a carrier service.

16 2. Sections 338.500 to 338.550 shall expire on September 30, ~~[2021]~~ **2022**.

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

2 (1) "Engaging in the business of providing health benefit services", accepting payment  
3 for health benefit services;

4 (2) "Intermediate care facility for the intellectually disabled", a private or department of  
5 mental health facility which admits persons who are intellectually disabled or developmentally

6 disabled for residential habilitation and other services pursuant to chapter 630. Such term shall  
7 include habilitation centers and private or public intermediate care facilities for the intellectually  
8 disabled that have been certified to meet the conditions of participation under 42 CFR, Section  
9 483, Subpart I;

10 (3) "Net operating revenues from providing services of intermediate care facilities for  
11 the intellectually disabled" shall include, without limitation, all moneys received on account of  
12 such services pursuant to rates of reimbursement established and paid by the department of social  
13 services, but shall not include charitable contributions, grants, donations, bequests and income  
14 from nonservice related fund-raising activities and government deficit financing, contractual  
15 allowance, discounts or bad debt;

16 (4) "Services of intermediate care facilities for the intellectually disabled" has the same  
17 meaning as the term services of intermediate care facilities for the mentally retarded, as used in  
18 Title 42 United States Code, Section 1396b(w)(7)(A)(iv), as amended, and as such qualifies as  
19 a class of health care services recognized in federal Public Law 102-234, the Medicaid Voluntary  
20 Contribution and Provider-Specific Tax Amendments of 1991.

21 2. Beginning July 1, 2008, each provider of services of intermediate care facilities for  
22 the intellectually disabled shall, in addition to all other fees and taxes now required or paid, pay  
23 assessments on their net operating revenues for the privilege of engaging in the business of  
24 providing services of the intermediate care facilities for the intellectually disabled or  
25 developmentally disabled in this state.

26 3. Each facility's assessment shall be based on a formula set forth in rules and regulations  
27 promulgated by the department of mental health.

28 4. For purposes of determining rates of payment under the medical assistance program  
29 for providers of services of intermediate care facilities for the intellectually disabled, the  
30 assessment imposed pursuant to this section on net operating revenues shall be a reimbursable  
31 cost to be reflected as timely as practicable in rates of payment applicable within the assessment  
32 period, contingent, for payments by governmental agencies, on all federal approvals necessary  
33 by federal law and regulation for federal financial participation in payments made for  
34 beneficiaries eligible for medical assistance under Title XIX of the federal Social Security Act,  
35 42 U.S.C. Section 1396, et seq., as amended.

36 5. Assessments shall be submitted by or on behalf of each provider of services of  
37 intermediate care facilities for the intellectually disabled on a monthly basis to the director of the  
38 department of mental health or his or her designee and shall be made payable to the director of  
39 the department of revenue.

40           6. In the alternative, a provider may direct that the director of the department of social  
41 services offset, from the amount of any payment to be made by the state to the provider, the  
42 amount of the assessment payment owed for any month.

43           7. Assessment payments shall be deposited in the state treasury to the credit of the  
44 "Intermediate Care Facility Intellectually Disabled Reimbursement Allowance Fund", which is  
45 hereby created in the state treasury. All investment earnings of this fund shall be credited to the  
46 fund. Notwithstanding the provisions of section 33.080 to the contrary, any unexpended balance  
47 in the intermediate care facility intellectually disabled reimbursement allowance fund at the end  
48 of the biennium shall not revert to the general revenue fund but shall accumulate from year to  
49 year. The state treasurer shall maintain records that show the amount of money in the fund at  
50 any time and the amount of any investment earnings on that amount.

51           8. Each provider of services of intermediate care facilities for the intellectually disabled  
52 shall keep such records as may be necessary to determine the amount of the assessment for which  
53 it is liable under this section. On or before the forty-fifth day after the end of each month  
54 commencing July 1, 2008, each provider of services of intermediate care facilities for the  
55 intellectually disabled shall submit to the department of social services a report on a cash basis  
56 that reflects such information as is necessary to determine the amount of the assessment payable  
57 for that month.

58           9. Every provider of services of intermediate care facilities for the intellectually disabled  
59 shall submit a certified annual report of net operating revenues from the furnishing of services  
60 of intermediate care facilities for the intellectually disabled. The reports shall be in such form  
61 as may be prescribed by rule by the director of the department of mental health. Final payments  
62 of the assessment for each year shall be due for all providers of services of intermediate care  
63 facilities for the intellectually disabled upon the due date for submission of the certified annual  
64 report.

65           10. The director of the department of mental health shall prescribe by rule the form and  
66 content of any document required to be filed pursuant to the provisions of this section.

67           11. Upon receipt of notification from the director of the department of mental health of  
68 a provider's delinquency in paying assessments required under this section, the director of the  
69 department of social services shall withhold, and shall remit to the director of the department of  
70 revenue, an assessment amount estimated by the director of the department of mental health from  
71 any payment to be made by the state to the provider.

72           12. In the event a provider objects to the estimate described in subsection 11 of this  
73 section, or any other decision of the department of mental health related to this section, the  
74 provider of services may request a hearing. If a hearing is requested, the director of the  
75 department of mental health shall provide the provider of services an opportunity to be heard and

76 to present evidence bearing on the amount due for an assessment or other issue related to this  
77 section within thirty days after collection of an amount due or receipt of a request for a hearing,  
78 whichever is later. The director shall issue a final decision within forty-five days of the  
79 completion of the hearing. After reconsideration of the assessment determination and a final  
80 decision by the director of the department of mental health, an intermediate care facility for the  
81 intellectually disabled provider's appeal of the director's final decision shall be to the  
82 administrative hearing commission in accordance with sections 208.156 and 621.055.

83 13. Notwithstanding any other provision of law to the contrary, appeals regarding this  
84 assessment shall be to the circuit court of Cole County or the circuit court in the county in which  
85 the facility is located. The circuit court shall hear the matter as the court of original jurisdiction.

86 14. Nothing in this section shall be deemed to affect or in any way limit the tax-exempt  
87 or nonprofit status of any intermediate care facility for the intellectually disabled granted by state  
88 law.

89 15. The director of the department of mental health shall promulgate rules and  
90 regulations to implement this section. Any rule or portion of a rule, as that term is defined in  
91 section 536.010, that is created under the authority delegated in this section shall become  
92 effective only if it complies with and is subject to all of the provisions of chapter 536 and, if  
93 applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the  
94 powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective  
95 date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of  
96 rulemaking authority and any rule proposed or adopted after August 28, 2008, shall be invalid  
97 and void.

98 16. The provisions of this section shall expire on September 30, [~~2021~~] **2022**.

Section B. If any provision of section A of this act or the application thereof to anyone  
2 or to any circumstance is held invalid, the remainder of those sections and the application of such  
3 provisions to others or other circumstances shall not be affected thereby.

✓