

## SENATE SUBSTITUTE

FOR

SENATE BILL NO. 1

## AN ACT

To repeal sections 190.839, 198.439, 208.152, 208.437, 208.480, 208.659, 338.550, and 633.401, RSMo, and to enact in lieu thereof eight new sections relating to health care, with an emergency clause.

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Section A. Sections 190.839, 198.439, 208.152, 208.437, 208.480, 208.659, 338.550, and 633.401, RSMo, are repealed and eight new sections enacted in lieu thereof, to be known as sections 190.839, 198.439, 208.152, 208.437, 208.480, 208.659, 338.550, and 633.401, to read as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

190.839. Sections 190.800 to 190.839 shall expire on September 30, ~~[2021]~~ 2026.

198.439. Sections 198.401 to 198.436 shall expire on September 30, ~~[2021]~~ 2026.

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

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the MO HealthNet division shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional

activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the MO HealthNet division shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the MO HealthNet division not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for participants, except to persons with more than five hundred thousand dollars equity in their home or except for persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. Section 301, et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities

49 which serve a high volume of MO HealthNet patients. The MO  
50 HealthNet division when determining the amount of the  
51 benefit payments to be made on behalf of persons under the  
52 age of twenty-one in a nursing facility may consider nursing  
53 facilities furnishing care to persons under the age of  
54 twenty-one as a classification separate from other nursing  
55 facilities;

56 (5) Nursing home costs for participants receiving  
57 benefit payments under subdivision (4) of this subsection  
58 for those days, which shall not exceed twelve per any period  
59 of six consecutive months, during which the participant is  
60 on a temporary leave of absence from the hospital or nursing  
61 home, provided that no such participant shall be allowed a  
62 temporary leave of absence unless it is specifically  
63 provided for in his plan of care. As used in this  
64 subdivision, the term "temporary leave of absence" shall  
65 include all periods of time during which a participant is  
66 away from the hospital or nursing home overnight because he  
67 is visiting a friend or relative;

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

70 (7) Subject to appropriation, up to twenty visits per  
71 year for services limited to examinations, diagnoses,  
72 adjustments, and manipulations and treatments of  
73 malpositioned articulations and structures of the body  
74 provided by licensed chiropractic physicians practicing  
75 within their scope of practice. Nothing in this subdivision  
76 shall be interpreted to otherwise expand MO HealthNet  
77 services;

78 (8) Drugs and medicines when prescribed by a licensed  
79 physician, dentist, podiatrist, or an advanced practice  
80 registered nurse; except that no payment for drugs and  
81 medicines prescribed on and after January 1, 2006, by a

82 licensed physician, dentist, podiatrist, or an advanced  
83 practice registered nurse may be made on behalf of any  
84 person who qualifies for prescription drug coverage under  
85 the provisions of P.L. 108-173;

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

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

97 (11) Home health care services;

98 (12) Family planning as defined by federal rules and  
99 regulations; provided, however, that such family planning  
100 services shall not include abortions or any abortifacient  
101 drug or device unless such abortions are certified in  
102 writing by a physician to the MO HealthNet agency that, in  
103 the physician's professional judgment, the life of the  
104 mother would be endangered if the fetus were carried to  
105 term. As used in this subdivision, "abortifacient drug or  
106 device" includes: mifepristone in a regimen with or without  
107 misoprostol; misoprostol alone when used to induce an  
108 abortion; levonorgestrel (Plan B); ulipristal acetate  
109 (ella); an intrauterine device (IUD) or a manual vacuum  
110 aspirator (MVA) when used to induce an abortion; or any  
111 other drug or device approved by the federal Food and Drug  
112 Administration that is intended to cause the destruction of  
113 an unborn child, as defined in section 188.015;

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

118 (14) Outpatient surgical procedures, including  
119 presurgical diagnostic services performed in ambulatory  
120 surgical facilities which are licensed by the department of  
121 health and senior services of the state of Missouri; except,  
122 that such outpatient surgical services shall not include  
123 persons who are eligible for coverage under Part B of Title  
124 XVIII, Public Law 89-97, 1965 amendments to the federal  
125 Social Security Act, as amended, if exclusion of such  
126 persons is permitted under Title XIX, Public Law 89-97, 1965  
127 amendments to the federal Social Security Act, as amended;

128 (15) Personal care services which are medically  
129 oriented tasks having to do with a person's physical  
130 requirements, as opposed to housekeeping requirements, which  
131 enable a person to be treated by his or her physician on an  
132 outpatient rather than on an inpatient or residential basis  
133 in a hospital, intermediate care facility, or skilled  
134 nursing facility. Personal care services shall be rendered  
135 by an individual not a member of the participant's family  
136 who is qualified to provide such services where the services  
137 are prescribed by a physician in accordance with a plan of  
138 treatment and are supervised by a licensed nurse. Persons  
139 eligible to receive personal care services shall be those  
140 persons who would otherwise require placement in a hospital,  
141 intermediate care facility, or skilled nursing facility.  
142 Benefits payable for personal care services shall not exceed  
143 for any one participant one hundred percent of the average  
144 statewide charge for care and treatment in an intermediate  
145 care facility for a comparable period of time. Such  
146 services, when delivered in a residential care facility or

assisted living facility licensed under chapter 198 shall be authorized on a tier level based on the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal physician. Such authorized units of personal care services or tier level shall be transferred with such resident if he or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as to whether the relevant waivers are approved or a determination of noncompliance is made;

(16) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. Section 301, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by

the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

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

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

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a

part of client services management. As used in this section, mental health professional and alcohol and drug abuse professional shall be defined by the department of mental health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, MO HealthNet division, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the MO HealthNet division. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

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

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

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

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

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

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

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

258           (c) For each day that nursing home costs are paid on  
259 behalf of a participant under this subdivision during any  
260 period of six consecutive months such participant shall,  
261 during the same period of six consecutive months, be  
262 ineligible for payment of nursing home costs of two  
263 otherwise available temporary leave of absence days provided  
264 under subdivision (5) of this subsection; and

265           (d) The provisions of this subdivision shall not apply  
266 unless the nursing home receives notice from the participant  
267 or the participant's responsible party that the participant  
268 intends to return to the nursing home following the hospital  
269 stay. If the nursing home receives such notification and  
270 all other provisions of this subsection have been satisfied,  
271 the nursing home shall provide notice to the participant or  
272 the participant's responsible party prior to release of the  
273 reserved bed;

274           (20) Prescribed medically necessary durable medical  
275 equipment. An electronic web-based prior authorization  
276 system using best medical evidence and care and treatment

guidelines consistent with national standards shall be used to verify medical need;

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

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

(23) Prescribed medically necessary optometric services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment

guidelines consistent with national standards shall be used to verify medical need;

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

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

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

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

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

2. Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons with any payments to be

made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

- (1) Dental services;
- (2) Services of podiatrists as defined in section 330.010;
- (3) Optometric services as described in section 336.010;
- (4) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs;
- (5) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);
- (6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system

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

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions (15) and (16) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations thereunder. When substitution of a generic drug

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

441 uncollected co-payments, the denial of services shall not be  
442 allowed. The department of social services shall inform  
443 providers regarding the acceptability of denying services as  
444 the result of unpaid co-payments.

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

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

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

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

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

of Section 1902 (a) (13) (A) of the Social Security Act, 42 U.S.C. Section 1396a, as amended, and regulations promulgated thereunder.

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

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

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

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

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

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

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

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

2. Except as otherwise provided in this section, if any reimbursement allowance imposed under the provisions of sections 208.431 to 208.437 is unpaid and delinquent, the department of social services may compel the payment of such reimbursement allowance in the circuit court having

jurisdiction in the county where the main offices of the Medicaid managed care organization are located. In addition, the director of the department of social services or the director's designee may cancel or refuse to issue, extend or reinstate a Medicaid contract agreement to any Medicaid managed care organization which fails to pay such delinquent reimbursement allowance required by sections 208.431 to 208.437 unless under appeal.

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

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

5. Sections 208.431 to 208.437 shall expire on September 30, ~~[2021]~~ 2026.

208.480. Notwithstanding the provisions of section 208.471 to the contrary, sections 208.453 to 208.480 shall expire on September 30, ~~[2021]~~ 2026.

208.659. 1. The MO HealthNet division shall revise the eligibility requirements for the uninsured women's health program, as established in 13 CSR Section 70- 4.090, to include women who are at least eighteen years of age and with a net family income of at or below one hundred eighty-

6 five percent of the federal poverty level. In order to be  
7 eligible for such program, the applicant shall not have  
8 assets in excess of two hundred and fifty thousand dollars,  
9 nor shall the applicant have access to employer-sponsored  
10 health insurance. Such change in eligibility requirements  
11 shall not result in any change in services provided under  
12 the program.

13 2. A provider shall not be eligible for reimbursement  
14 under the uninsured women's health program if such provider  
15 is an abortion facility, as defined in section 188.015, or  
16 any affiliate or associate thereof.

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

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

8 (2) The formula used to calculate the reimbursement as  
9 appropriated by the general assembly for products dispensed  
10 by pharmacies is changed resulting in lower reimbursement to  
11 the pharmacist in the aggregate than provided in fiscal year  
12 2003; or

13 (3) September 30, [2021] 2026.

14 The director of the department of social services shall  
15 notify the revisor of statutes of the expiration date as  
16 provided in this subsection. The provisions of sections  
17 338.500 to 338.550 shall not apply to pharmacies domiciled  
18 or headquartered outside this state which are engaged in  
19 prescription drug sales that are delivered directly to  
20 patients within this state via common carrier, mail or a  
21 carrier service.

22           2. Sections 338.500 to 338.550 shall expire on  
23 September 30, [2021] 2026.

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

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

6           (2) "Intermediate care facility for the intellectually  
7 disabled", a private or department of mental health facility  
8 which admits persons who are intellectually disabled or  
9 developmentally disabled for residential habilitation and  
10 other services pursuant to chapter 630. Such term shall  
11 include habilitation centers and private or public  
12 intermediate care facilities for the intellectually disabled  
13 that have been certified to meet the conditions of  
14 participation under 42 CFR, Section 483, Subpart I;

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

25           (4) "Services of intermediate care facilities for the  
26 intellectually disabled" has the same meaning as the term  
27 services of intermediate care facilities for the mentally  
28 retarded, as used in Title 42 United States Code, Section  
29 1396b(w) (7) (A) (iv), as amended, and as such qualifies as a  
30 class of health care services recognized in federal Public

31 Law 102-234, the Medicaid Voluntary Contribution and  
32 Provider-Specific Tax Amendments of 1991.

33 2. Beginning July 1, 2008, each provider of services  
34 of intermediate care facilities for the intellectually  
35 disabled shall, in addition to all other fees and taxes now  
36 required or paid, pay assessments on their net operating  
37 revenues for the privilege of engaging in the business of  
38 providing services of the intermediate care facilities for  
39 the intellectually disabled or developmentally disabled in  
40 this state.

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

44 4. For purposes of determining rates of payment under  
45 the medical assistance program for providers of services of  
46 intermediate care facilities for the intellectually  
47 disabled, the assessment imposed pursuant to this section on  
48 net operating revenues shall be a reimbursable cost to be  
49 reflected as timely as practicable in rates of payment  
50 applicable within the assessment period, contingent, for  
51 payments by governmental agencies, on all federal approvals  
52 necessary by federal law and regulation for federal  
53 financial participation in payments made for beneficiaries  
54 eligible for medical assistance under Title XIX of the  
55 federal Social Security Act, 42 U.S.C. Section 1396, et  
56 seq., as amended.

57 5. Assessments shall be submitted by or on behalf of  
58 each provider of services of intermediate care facilities  
59 for the intellectually disabled on a monthly basis to the  
60 director of the department of mental health or his or her  
61 designee and shall be made payable to the director of the  
62 department of revenue.

63           6. In the alternative, a provider may direct that the  
64 director of the department of social services offset, from  
65 the amount of any payment to be made by the state to the  
66 provider, the amount of the assessment payment owed for any  
67 month.

68           7. Assessment payments shall be deposited in the state  
69 treasury to the credit of the "Intermediate Care Facility  
70 Intellectually Disabled Reimbursement Allowance Fund", which  
71 is hereby created in the state treasury. All investment  
72 earnings of this fund shall be credited to the fund.  
73 Notwithstanding the provisions of section 33.080 to the  
74 contrary, any unexpended balance in the intermediate care  
75 facility intellectually disabled reimbursement allowance  
76 fund at the end of the biennium shall not revert to the  
77 general revenue fund but shall accumulate from year to  
78 year. The state treasurer shall maintain records that show  
79 the amount of money in the fund at any time and the amount  
80 of any investment earnings on that amount.

81           8. Each provider of services of intermediate care  
82 facilities for the intellectually disabled shall keep such  
83 records as may be necessary to determine the amount of the  
84 assessment for which it is liable under this section. On or  
85 before the forty-fifth day after the end of each month  
86 commencing July 1, 2008, each provider of services of  
87 intermediate care facilities for the intellectually disabled  
88 shall submit to the department of social services a report  
89 on a cash basis that reflects such information as is  
90 necessary to determine the amount of the assessment payable  
91 for that month.

92           9. Every provider of services of intermediate care  
93 facilities for the intellectually disabled shall submit a  
94 certified annual report of net operating revenues from the  
95 furnishing of services of intermediate care facilities for

the intellectually disabled. The reports shall be in such form as may be prescribed by rule by the director of the department of mental health. Final payments of the assessment for each year shall be due for all providers of services of intermediate care facilities for the intellectually disabled upon the due date for submission of the certified annual report.

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

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

12. In the event a provider objects to the estimate described in subsection 11 of this section, or any other decision of the department of mental health related to this section, the provider of services may request a hearing. If a hearing is requested, the director of the department of mental health shall provide the provider of services an opportunity to be heard and to present evidence bearing on the amount due for an assessment or other issue related to this section within thirty days after collection of an amount due or receipt of a request for a hearing, whichever is later. The director shall issue a final decision within forty-five days of the completion of the hearing. After reconsideration of the assessment determination and a final decision by the director of the department of mental health,

an intermediate care facility for the intellectually disabled provider's appeal of the director's final decision shall be to the administrative hearing commission in accordance with sections 208.156 and 621.055.

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

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

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

16. The provisions of this section shall expire on September 30, ~~2021~~ 2026.

Section B. If any provision of section A of this act or the application thereof to anyone or to any circumstance is held invalid, the remainder of those sections and the

4 application of such provisions to others or other  
5 circumstances shall not be affected thereby.

Section C. Because of the importance and immediate  
2 need to preserve access to health care services for Missouri  
3 residents, section A of this act is deemed necessary for the  
4 immediate preservation of the public health, welfare, peace,  
5 and safety, and is hereby declared to be an emergency act  
6 within the meaning of the constitution, and section A of  
7 this act shall be in full force and effect upon its passage  
8 and approval.