

SENATE SUBSTITUTE

FOR

SENATE BILL NO. 1

AN ACT

To repeal sections 190.800, 190.839, 198.439, 208.152, 208.437, 208.480, 338.550, and 633.401, RSMo, and to enact in lieu thereof eight new sections relating to MO HealthNet.

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

Section A. Sections 190.800, 190.839, 198.439, 208.152, 208.437, 208.480, 338.550, and 633.401, RSMo, are repealed and eight new sections enacted in lieu thereof, to be known as sections 190.800, 190.839, 198.439, 208.152, 208.437, 208.480, 338.550, and 633.401, to read as follows:

190.800. 1. Each ground ambulance service, except for any ambulance service owned and operated by an entity owned and operated by the state of Missouri, including but not limited to any hospital owned or operated by the board of curators, as defined in chapter 172, or any department of the state, shall, in addition to all other fees and taxes now required or paid, pay an ambulance service reimbursement allowance tax for the privilege of engaging in the business of providing ambulance services in this state.

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

(1) "Ambulance", the same meaning as such term is defined in section 190.100;

(2) "Ambulance service", the same meaning as such term is defined in section 190.100;

(3) "Engaging in the business of providing ambulance services in this state", accepting payment for such services;

(4) "Gross receipts", all amounts received by an ambulance service licensed under section 190.109 for its own

20 account from the provision of all emergency services, as
21 defined in section 190.100, to the public in the state of
22 Missouri, but shall not include revenue from taxes collected
23 under law, grants, subsidies received from governmental
24 agencies, [or] the value of charity care, or revenues
25 received from supplemental reimbursement for ground
26 emergency medical transportation under section 208.1030.

190.839. Sections 190.800 to 190.839 shall expire on
2 September 30, [2021] 2023.

198.439. Sections 198.401 to 198.436 shall expire on
2 September 30, [2021] 2023.

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

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

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

34 (3) Laboratory and X-ray services;

35 (4) Nursing home services for participants, except to
36 persons with more than five hundred thousand dollars equity
37 in their home or except for persons in an institution for
38 mental diseases who are under the age of sixty-five years,
39 when residing in a hospital licensed by the department of
40 health and senior services or a nursing home licensed by the
41 department of health and senior services or appropriate
42 licensing authority of other states or government-owned and -
43 operated institutions which are determined to conform to
44 standards equivalent to licensing requirements in Title XIX
45 of the federal Social Security Act (42 U.S.C. Section 301,
46 et seq.), as amended, for nursing facilities. The MO
47 HealthNet division may recognize through its payment
48 methodology for nursing facilities those nursing facilities
49 which serve a high volume of MO HealthNet patients. The MO
50 HealthNet division when determining the amount of the
51 benefit payments to be made on behalf of persons under the
52 age of twenty-one in a nursing facility may consider nursing
53 facilities furnishing care to persons under the age of

54 twenty-one as a classification separate from other nursing
55 facilities;

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

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

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

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

- 86 (9) Emergency ambulance services and, effective
87 January 1, 1990, medically necessary transportation to
88 scheduled, physician-prescribed nonelective treatments;
- 89 (10) Early and periodic screening and diagnosis of
90 individuals who are under the age of twenty-one to ascertain
91 their physical or mental defects, and health care,
92 treatment, and other measures to correct or ameliorate
93 defects and chronic conditions discovered thereby. Such
94 services shall be provided in accordance with the provisions
95 of Section 6403 of P.L. 101-239 and federal regulations
96 promulgated thereunder;
- 97 (11) Home health care services;
- 98 (12) Family planning as defined by federal rules and
99 regulations; provided, however, that such family planning
100 services shall not include:
- 101 (a) Abortions 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; and
- 106 (b) Any drug or device approved by the federal Food
107 and Drug Administration that may cause the destruction of,
108 or prevent the implantation of, an unborn child, as defined
109 in section 188.015;
- 110 (13) Inpatient psychiatric hospital services for
111 individuals under age twenty-one as defined in Title XIX of
112 the federal Social Security Act (42 U.S.C. Section 1396d, et
113 seq.);
- 114 (14) Outpatient surgical procedures, including
115 presurgical diagnostic services performed in ambulatory
116 surgical facilities which are licensed by the department of
117 health and senior services of the state of Missouri; except,
118 that such outpatient surgical services shall not include

119 persons who are eligible for coverage under Part B of Title
120 XVIII, Public Law 89-97, 1965 amendments to the federal
121 Social Security Act, as amended, if exclusion of such
122 persons is permitted under Title XIX, Public Law 89-97, 1965
123 amendments to the federal Social Security Act, as amended;

124 (15) Personal care services which are medically
125 oriented tasks having to do with a person's physical
126 requirements, as opposed to housekeeping requirements, which
127 enable a person to be treated by his or her physician on an
128 outpatient rather than on an inpatient or residential basis
129 in a hospital, intermediate care facility, or skilled
130 nursing facility. Personal care services shall be rendered
131 by an individual not a member of the participant's family
132 who is qualified to provide such services where the services
133 are prescribed by a physician in accordance with a plan of
134 treatment and are supervised by a licensed nurse. Persons
135 eligible to receive personal care services shall be those
136 persons who would otherwise require placement in a hospital,
137 intermediate care facility, or skilled nursing facility.
138 Benefits payable for personal care services shall not exceed
139 for any one participant one hundred percent of the average
140 statewide charge for care and treatment in an intermediate
141 care facility for a comparable period of time. Such
142 services, when delivered in a residential care facility or
143 assisted living facility licensed under chapter 198 shall be
144 authorized on a tier level based on the services the
145 resident requires and the frequency of the services. A
146 resident of such facility who qualifies for assistance under
147 section 208.030 shall, at a minimum, if prescribed by a
148 physician, qualify for the tier level with the fewest
149 services. The rate paid to providers for each tier of
150 service shall be set subject to appropriations. Subject to
151 appropriations, each resident of such facility who qualifies

152 for assistance under section 208.030 and meets the level of
153 care required in this section shall, at a minimum, if
154 prescribed by a physician, be authorized up to one hour of
155 personal care services per day. Authorized units of
156 personal care services shall not be reduced or tier level
157 lowered unless an order approving such reduction or lowering
158 is obtained from the resident's personal physician. Such
159 authorized units of personal care services or tier level
160 shall be transferred with such resident if he or she
161 transfers to another such facility. Such provision shall
162 terminate upon receipt of relevant waivers from the federal
163 Department of Health and Human Services. If the Centers for
164 Medicare and Medicaid Services determines that such
165 provision does not comply with the state plan, this
166 provision shall be null and void. The MO HealthNet division
167 shall notify the revisor of statutes as to whether the
168 relevant waivers are approved or a determination of
169 noncompliance is made;

170 (16) Mental health services. The state plan for
171 providing medical assistance under Title XIX of the Social
172 Security Act, 42 U.S.C. Section 301, as amended, shall
173 include the following mental health services when such
174 services are provided by community mental health facilities
175 operated by the department of mental health or designated by
176 the department of mental health as a community mental health
177 facility or as an alcohol and drug abuse facility or as a
178 child-serving agency within the comprehensive children's
179 mental health service system established in section
180 630.097. The department of mental health shall establish by
181 administrative rule the definition and criteria for
182 designation as a community mental health facility and for
183 designation as an alcohol and drug abuse facility. Such
184 mental health services shall include:

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

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

201 (c) Rehabilitative mental health and alcohol and drug
202 abuse services including home and community-based
203 preventive, diagnostic, therapeutic, rehabilitative, and
204 palliative interventions rendered to individuals in an
205 individual or group setting by a mental health or alcohol
206 and drug abuse professional in accordance with a plan of
207 treatment appropriately established, implemented, monitored,
208 and revised under the auspices of a therapeutic team as a
209 part of client services management. As used in this
210 section, mental health professional and alcohol and drug
211 abuse professional shall be defined by the department of
212 mental health pursuant to duly promulgated rules. With
213 respect to services established by this subdivision, the
214 department of social services, MO HealthNet division, shall
215 enter into an agreement with the department of mental
216 health. Matching funds for outpatient mental health
217 services, clinic mental health services, and rehabilitation

218 services for mental health and alcohol and drug abuse shall
219 be certified by the department of mental health to the MO
220 HealthNet division. The agreement shall establish a
221 mechanism for the joint implementation of the provisions of
222 this subdivision. In addition, the agreement shall
223 establish a mechanism by which rates for services may be
224 jointly developed;

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

230 (18) The services of an advanced practice registered
231 nurse with a collaborative practice agreement to the extent
232 that such services are provided in accordance with chapters
233 334 and 335, and regulations promulgated thereunder;

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

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

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

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

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

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

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

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

275 (21) Hospice care. As used in this subdivision, the
276 term "hospice care" means a coordinated program of active
277 professional medical attention within a home, outpatient and
278 inpatient care which treats the terminally ill patient and
279 family as a unit, employing a medically directed
280 interdisciplinary team. The program provides relief of
281 severe pain or other physical symptoms and supportive care
282 to meet the special needs arising out of physical,
283 psychological, spiritual, social, and economic stresses

284 which are experienced during the final stages of illness,
285 and during dying and bereavement and meets the Medicare
286 requirements for participation as a hospice as are provided
287 in 42 CFR Part 418. The rate of reimbursement paid by the
288 MO HealthNet division to the hospice provider for room and
289 board furnished by a nursing home to an eligible hospice
290 patient shall not be less than ninety-five percent of the
291 rate of reimbursement which would have been paid for
292 facility services in that nursing home facility for that
293 patient, in accordance with subsection (c) of Section 6408
294 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

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

301 (23) Prescribed medically necessary optometric
302 services. Such services shall be subject to
303 appropriations. An electronic web-based prior authorization
304 system using best medical evidence and care and treatment
305 guidelines consistent with national standards shall be used
306 to verify medical need;

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

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

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

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

321 (25) The MO HealthNet division shall, by January 1,
322 2008, and annually thereafter, report the status of MO
323 HealthNet provider reimbursement rates as compared to one
324 hundred percent of the Medicare reimbursement rates and
325 compared to the average dental reimbursement rates paid by
326 third-party payors licensed by the state. The MO HealthNet
327 division shall, by July 1, 2008, provide to the general
328 assembly a four-year plan to achieve parity with Medicare
329 reimbursement rates and for third-party payor average dental
330 reimbursement rates. Such plan shall be subject to
331 appropriation and the division shall include in its annual
332 budget request to the governor the necessary funding needed
333 to complete the four-year plan developed under this
334 subdivision.

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

342 (1) Dental services;

343 (2) Services of podiatrists as defined in section
344 330.010;

345 (3) Optometric services as described in section
346 336.010;

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

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

369 (6) Comprehensive day rehabilitation services
370 beginning early posttrauma as part of a coordinated system
371 of care for individuals with disabling impairments.
372 Rehabilitation services must be based on an individualized,
373 goal-oriented, comprehensive and coordinated treatment plan
374 developed, implemented, and monitored through an
375 interdisciplinary assessment designed to restore an
376 individual to optimal level of physical, cognitive, and
377 behavioral function. The MO HealthNet division shall
378 establish by administrative rule the definition and criteria
379 for designation of a comprehensive day rehabilitation
380 service facility, benefit limitations and payment
381 mechanism. Any rule or portion of a rule, as that term is

382 defined in section 536.010, that is created under the
383 authority delegated in this subdivision shall become
384 effective only if it complies with and is subject to all of
385 the provisions of chapter 536 and, if applicable, section
386 536.028. This section and chapter 536 are nonseverable and
387 if any of the powers vested with the general assembly
388 pursuant to chapter 536 to review, to delay the effective
389 date, or to disapprove and annul a rule are subsequently
390 held unconstitutional, then the grant of rulemaking
391 authority and any rule proposed or adopted after August 28,
392 2005, shall be invalid and void.

393 3. The MO HealthNet division may require any
394 participant receiving MO HealthNet benefits to pay part of
395 the charge or cost until July 1, 2008, and an additional
396 payment after July 1, 2008, as defined by rule duly
397 promulgated by the MO HealthNet division, for all covered
398 services except for those services covered under
399 subdivisions (15) and (16) of subsection 1 of this section
400 and sections 208.631 to 208.657 to the extent and in the
401 manner authorized by Title XIX of the federal Social
402 Security Act (42 U.S.C. Section 1396, et seq.) and
403 regulations thereunder. When substitution of a generic drug
404 is permitted by the prescriber according to section 338.056,
405 and a generic drug is substituted for a name-brand drug, the
406 MO HealthNet division may not lower or delete the
407 requirement to make a co-payment pursuant to regulations of
408 Title XIX of the federal Social Security Act. A provider of
409 goods or services described under this section must collect
410 from all participants the additional payment that may be
411 required by the MO HealthNet division under authority
412 granted herein, if the division exercises that authority, to
413 remain eligible as a provider. Any payments made by
414 participants under this section shall be in addition to and

415 not in lieu of payments made by the state for goods or
416 services described herein except the participant portion of
417 the pharmacy professional dispensing fee shall be in
418 addition to and not in lieu of payments to pharmacists. A
419 provider may collect the co-payment at the time a service is
420 provided or at a later date. A provider shall not refuse to
421 provide a service if a participant is unable to pay a
422 required payment. If it is the routine business practice of
423 a provider to terminate future services to an individual
424 with an unclaimed debt, the provider may include uncollected
425 co-payments under this practice. Providers who elect not to
426 undertake the provision of services based on a history of
427 bad debt shall give participants advance notice and a
428 reasonable opportunity for payment. A provider,
429 representative, employee, independent contractor, or agent
430 of a pharmaceutical manufacturer shall not make co-payment
431 for a participant. This subsection shall not apply to other
432 qualified children, pregnant women, or blind persons. If
433 the Centers for Medicare and Medicaid Services does not
434 approve the MO HealthNet state plan amendment submitted by
435 the department of social services that would allow a
436 provider to deny future services to an individual with
437 uncollected co-payments, the denial of services shall not be
438 allowed. The department of social services shall inform
439 providers regarding the acceptability of denying services as
440 the result of unpaid co-payments.

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

444 5. Reimbursement for obstetrical and pediatric
445 services under subdivision (6) of subsection 1 of this
446 section shall be timely and sufficient to enlist enough
447 health care providers so that care and services are

448 available under the state plan for MO HealthNet benefits at
449 least to the extent that such care and services are
450 available to the general population in the geographic area,
451 as required under subparagraph (a)(30)(A) of 42 U.S.C.
452 Section 1396a and federal regulations promulgated thereunder.

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

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

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

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

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

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

488 12. If the Missouri Medicaid audit and compliance unit
489 changes any interpretation or application of the
490 requirements for reimbursement for MO HealthNet services
491 from the interpretation or application that has been applied
492 previously by the state in any audit of a MO HealthNet
493 provider, the Missouri Medicaid audit and compliance unit
494 shall notify all affected MO HealthNet providers five
495 business days before such change shall take effect. Failure
496 of the Missouri Medicaid audit and compliance unit to notify
497 a provider of such change shall entitle the provider to
498 continue to receive and retain reimbursement until such
499 notification is provided and shall waive any liability of
500 such provider for recoupment or other loss of any payments
501 previously made prior to the five business days after such
502 notice has been sent. Each provider shall provide the
503 Missouri Medicaid audit and compliance unit a valid email
504 address and shall agree to receive communications
505 electronically. The notification required under this
506 section shall be delivered in writing by the United States
507 Postal Service or electronic mail to each provider.

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

511 14. Beginning July 1, 2016, and subject to
512 appropriations, providers of behavioral, social, and

513 psychophysiological services for the prevention, treatment,
514 or management of physical health problems shall be
515 reimbursed utilizing the behavior assessment and
516 intervention reimbursement codes 96150 to 96154 or their
517 successor codes under the Current Procedural Terminology
518 (CPT) coding system. Providers eligible for such
519 reimbursement shall include psychologists.

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

12 2. Except as otherwise provided in this section, if
13 any reimbursement allowance imposed under the provisions of
14 sections 208.431 to 208.437 is unpaid and delinquent, the
15 department of social services may compel the payment of such
16 reimbursement allowance in the circuit court having
17 jurisdiction in the county where the main offices of the
18 Medicaid managed care organization are located. In
19 addition, the director of the department of social services
20 or the director's designee may cancel or refuse to issue,
21 extend or reinstate a Medicaid contract agreement to any
22 Medicaid managed care organization which fails to pay such
23 delinquent reimbursement allowance required by sections
24 208.431 to 208.437 unless under appeal.

25 3. Except as otherwise provided in this section,
26 failure to pay a delinquent reimbursement allowance imposed

27 under sections 208.431 to 208.437 shall be grounds for
28 denial, suspension or revocation of a license granted by the
29 department of commerce and insurance. The director of the
30 department of commerce and insurance may deny, suspend or
31 revoke the license of a Medicaid managed care organization
32 with a contract under 42 U.S.C. Section 1396b(m) which fails
33 to pay a managed care organization's delinquent
34 reimbursement allowance unless under appeal.

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

40 5. Sections 208.431 to 208.437 shall expire on
41 September 30, ~~[2021]~~ 2023.

208.480. Notwithstanding the provisions of section
2 208.471 to the contrary, sections 208.453 to 208.480 shall
3 expire on September 30, ~~[2021]~~ 2023.

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]~~ 2023.

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~~] 2023.

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

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

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

115 12. In the event a provider objects to the estimate
116 described in subsection 11 of this section, or any other
117 decision of the department of mental health related to this
118 section, the provider of services may request a hearing. If
119 a hearing is requested, the director of the department of
120 mental health shall provide the provider of services an
121 opportunity to be heard and to present evidence bearing on
122 the amount due for an assessment or other issue related to

123 this section within thirty days after collection of an
124 amount due or receipt of a request for a hearing, whichever
125 is later. The director shall issue a final decision within
126 forty-five days of the completion of the hearing. After
127 reconsideration of the assessment determination and a final
128 decision by the director of the department of mental health,
129 an intermediate care facility for the intellectually
130 disabled provider's appeal of the director's final decision
131 shall be to the administrative hearing commission in
132 accordance with sections 208.156 and 621.055.

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

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

142 15. The director of the department of mental health
143 shall promulgate rules and regulations to implement this
144 section. Any rule or portion of a rule, as that term is
145 defined in section 536.010, that is created under the
146 authority delegated in this section shall become effective
147 only if it complies with and is subject to all of the
148 provisions of chapter 536 and, if applicable, section
149 536.028. This section and chapter 536 are nonseverable and
150 if any of the powers vested with the general assembly
151 pursuant to chapter 536 to review, to delay the effective
152 date, or to disapprove and annul a rule are subsequently
153 held unconstitutional, then the grant of rulemaking
154 authority and any rule proposed or adopted after August 28,
155 2008, shall be invalid and void.

156 16. The provisions of this section shall expire on
157 September 30, [2021] 2023.

 Section B. If any provision of section A of this act
2 or the application thereof to anyone or to any circumstance
3 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.