

SENATE SUBSTITUTE

FOR

SENATE BILL NO. 1

AN ACT

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

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Section A. Sections 190.839, 198.439, 208.152, 208.437, 208.480, 338.550, and 633.401, RSMo, are repealed and seven new sections enacted in lieu thereof, to be known as sections 190.839, 198.439, 208.152, 208.437, 208.480, 338.550, and 633.401, to read as follows:

190.839. Sections 190.800 to 190.839 shall expire on September 30, ~~[2021]~~ 2024.

198.439. Sections 198.401 to 198.436 shall expire on September 30, ~~[2021]~~ 2024.

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

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 abortions or any abortifacient
101 drug or device that is used for the purpose of inducing an
102 abortion unless such abortions are certified in writing by a
103 physician to the MO HealthNet agency that, in the
104 physician's professional judgment, the life of the mother
105 would be endangered if the fetus were carried to term;

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

110 (14) Outpatient surgical procedures, including
111 presurgical diagnostic services performed in ambulatory
112 surgical facilities which are licensed by the department of
113 health and senior services of the state of Missouri; except,
114 that such outpatient surgical services shall not include

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

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

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

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

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

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

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

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

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

226 (18) The services of an advanced practice registered
227 nurse with a collaborative practice agreement to the extent
228 that such services are provided in accordance with chapters
229 334 and 335, and regulations promulgated thereunder;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

317 (25) The MO HealthNet division shall, by January 1,
318 2008, and annually thereafter, report the status of MO
319 HealthNet provider reimbursement rates as compared to one
320 hundred percent of the Medicare reimbursement rates and
321 compared to the average dental reimbursement rates paid by
322 third-party payors licensed by the state. The MO HealthNet
323 division shall, by July 1, 2008, provide to the general
324 assembly a four-year plan to achieve parity with Medicare
325 reimbursement rates and for third-party payor average dental
326 reimbursement rates. Such plan shall be subject to
327 appropriation and the division shall include in its annual
328 budget request to the governor the necessary funding needed
329 to complete the four-year plan developed under this
330 subdivision.

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

- 338 (1) Dental services;
- 339 (2) Services of podiatrists as defined in section
340 330.010;
- 341 (3) Optometric services as described in section
342 336.010;
- 343 (4) Orthopedic devices or other prosthetics, including
344 eye glasses, dentures, hearing aids, and wheelchairs;

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

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

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

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

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

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

440 5. Reimbursement for obstetrical and pediatric
441 services under subdivision (6) of subsection 1 of this
442 section shall be timely and sufficient to enlist enough
443 health care providers so that care and services are

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

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

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

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

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

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

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

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

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

507 14. Beginning July 1, 2016, and subject to
508 appropriations, providers of behavioral, social, and

509 psychophysiological services for the prevention, treatment,
510 or management of physical health problems shall be
511 reimbursed utilizing the behavior assessment and
512 intervention reimbursement codes 96150 to 96154 or their
513 successor codes under the Current Procedural Terminology
514 (CPT) coding system. Providers eligible for such
515 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]~~ 2024.

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]~~ 2024.

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]~~ 2024.

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~~] 2024.

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] 2024.

 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.