

SENATE SUBSTITUTE

FOR

SENATE BILL NO. 1

AN ACT

To repeal sections 190.839, 198.439, 208.152, 208.153, 208.437, 208.480, 208.659, 338.550, and 633.401, RSMo, and to enact in lieu thereof nine new sections relating to health care, with an emergency clause.

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

Section A. Sections 190.839, 198.439, 208.152, 208.153, 208.437, 208.480, 208.659, 338.550, and 633.401, RSMo, are repealed and nine new sections enacted in lieu thereof, to be known as sections 190.839, 198.439, 208.152, 208.153, 208.437, 208.480, 208.659, 338.550, and 633.401, to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

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

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

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

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

(b) At the time of either approval by the Centers for Medicare and Medicaid Services (CMS) or an administrative or judicial action requiring CMS approval, no funds shall be expended to any abortion facility, as defined in section 188.015, or any affiliate or associate thereof. The state shall exhaust all administrative and judicial remedies available to compel CMS approval related to the provisions of this paragraph;

(7) Subject to appropriation, up to twenty visits per year for services limited to examinations, diagnoses, adjustments, and manipulations and treatments of

malpositioned articulations and structures of the body provided by licensed chiropractic physicians practicing within their scope of practice. Nothing in this subdivision shall be interpreted to otherwise expand MO HealthNet services;

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

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

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

(11) Home health care services;

(12) Family planning as defined by federal rules and regulations; provided, however, that such family planning services shall not include abortions or any abortifacient drug or device unless such abortions are certified in writing by a physician to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term. As used in this subdivision, "abortifacient drug or

device" includes the following when prescribed and intended for family planning: mifepristone in a regimen with or without misoprostol when used to induce an abortion; misoprostol alone when used to induce an abortion; levonorgestrel (Plan B) when used to induce an abortion; ulipristal acetate (ella) or other progesterone antagonists when used to induce an abortion; an intrauterine device (IUD) or a manual vacuum aspirator (MVA) when used to induce an abortion; or any other drug or device approved by the federal Food and Drug Administration that is intended to cause the destruction of an unborn child, as defined in section 188.015;

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

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

(15) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his or her physician on an outpatient rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be rendered

by an individual not a member of the participant's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one participant one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such 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:

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

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

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

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

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

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the participant

or the participant's responsible party that the participant intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the participant or the participant's responsible party prior to release of the reserved bed;

(20) Prescribed medically necessary durable medical equipment. 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;

(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);

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

317 (23) Prescribed medically necessary optometric
318 services. Such services shall be subject to
319 appropriations. An electronic web-based prior authorization
320 system using best medical evidence and care and treatment
321 guidelines consistent with national standards shall be used
322 to verify medical need;

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

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

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

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

337 (25) The MO HealthNet division shall, by January 1,
338 2008, and annually thereafter, report the status of MO
339 HealthNet provider reimbursement rates as compared to one
340 hundred percent of the Medicare reimbursement rates and
341 compared to the average dental reimbursement rates paid by
342 third-party payors licensed by the state. The MO HealthNet
343 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.

409 3. The MO HealthNet division may require any
410 participant receiving MO HealthNet benefits to pay part of
411 the charge or cost until July 1, 2008, and an additional
412 payment after July 1, 2008, as defined by rule duly
413 promulgated by the MO HealthNet division, for all covered
414 services except for those services covered under
415 subdivisions (15) and (16) of subsection 1 of this section
416 and sections 208.631 to 208.657 to the extent and in the
417 manner authorized by Title XIX of the federal Social
418 Security Act (42 U.S.C. Section 1396, et seq.) and
419 regulations thereunder. When substitution of a generic drug
420 is permitted by the prescriber according to section 338.056,
421 and a generic drug is substituted for a name-brand drug, the
422 MO HealthNet division may not lower or delete the
423 requirement to make a co-payment pursuant to regulations of
424 Title XIX of the federal Social Security Act. A provider of
425 goods or services described under this section must collect
426 from all participants the additional payment that may be
427 required by the MO HealthNet division under authority
428 granted herein, if the division exercises that authority, to
429 remain eligible as a provider. Any payments made by
430 participants under this section shall be in addition to and
431 not in lieu of payments made by the state for goods or
432 services described herein except the participant portion of
433 the pharmacy professional dispensing fee shall be in
434 addition to and not in lieu of payments to pharmacists. A
435 provider may collect the co-payment at the time a service is
436 provided or at a later date. A provider shall not refuse to
437 provide a service if a participant is unable to pay a
438 required payment. If it is the routine business practice of
439 a provider to terminate future services to an individual
440 with an unclaimed debt, the provider may include uncollected
441 co-payments under this practice. Providers who elect not to

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

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

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

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

474 7. Beginning July 1, 1990, the department of social
475 services shall provide notification and referral of children
476 below age five, and pregnant, breast-feeding, or postpartum
477 women who are determined to be eligible for MO HealthNet
478 benefits under section 208.151 to the special supplemental
479 food programs for women, infants and children administered
480 by the department of health and senior services. Such
481 notification and referral shall conform to the requirements
482 of Section 6406 of P.L. 101-239 and regulations promulgated
483 thereunder.

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

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

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

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

504 12. If the Missouri Medicaid audit and compliance unit
505 changes any interpretation or application of the
506 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.

208.153. 1. Pursuant to and not inconsistent with the provisions of sections 208.151 and 208.152, the MO HealthNet division shall by rule and regulation define the reasonable costs, manner, extent, quantity, quality, charges and fees

5 of MO HealthNet benefits herein provided. The benefits
6 available under these sections shall not replace those
7 provided under other federal or state law or under other
8 contractual or legal entitlements of the persons receiving
9 them, and all persons shall be required to apply for and
10 utilize all benefits available to them and to pursue all
11 causes of action to which they are entitled. Any person
12 entitled to MO HealthNet benefits may obtain it from any
13 provider of services with which an agreement is in effect
14 under this section and which undertakes to provide the
15 services, as authorized by the MO HealthNet division;
16 provided, said provider shall not include any abortion
17 facility, as defined in section 188.015, or any affiliate or
18 associate thereof, consistent with the provisions of
19 paragraph (b) of subdivision (6) of subsection 1 of section
20 208.152. At the discretion of the director of the MO
21 HealthNet division and with the approval of the governor,
22 the MO HealthNet division is authorized to provide medical
23 benefits for participants receiving public assistance by
24 expending funds for the payment of federal medical insurance
25 premiums, coinsurance and deductibles pursuant to the
26 provisions of Title XVIII B and XIX, Public Law 89-97, 1965
27 amendments to the federal Social Security Act (42 U.S.C.
28 301, et seq.), as amended.

29 2. MO HealthNet shall include benefit payments on
30 behalf of qualified Medicare beneficiaries as defined in 42
31 U.S.C. Section 1396d(p). The family support division shall
32 by rule and regulation establish which qualified Medicare
33 beneficiaries are eligible. The MO HealthNet division shall
34 define the premiums, deductible and coinsurance provided for
35 in 42 U.S.C. Section 1396d(p) to be provided on behalf of
36 the qualified Medicare beneficiaries.

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

46 4. MO HealthNet shall include benefit payments for
47 Medicare Part B cost sharing described in 42 U.S.C. Section
48 1396(d) (p) (3) (A) (ii) for individuals described in subsection
49 2 of this section, but for the fact that their income
50 exceeds the income level established by the state under 42
51 U.S.C. Section 1396(d) (p) (2) but is less than one hundred
52 and ten percent beginning January 1, 1993, and less than one
53 hundred and twenty percent beginning January 1, 1995, of the
54 official poverty line for a family of the size involved.

55 5. For an individual eligible for MO HealthNet under
56 Title XIX of the Social Security Act, MO HealthNet shall
57 include payment of enrollee premiums in a group health plan
58 and all deductibles, coinsurance and other cost-sharing for
59 items and services otherwise covered under the state Title
60 XIX plan under Section 1906 of the federal Social Security
61 Act and regulations established under the authority of
62 Section 1906, as may be amended. Enrollment in a group
63 health plan must be cost effective, as established by the
64 Secretary of Health and Human Services, before enrollment in
65 the group health plan is required. If all members of a
66 family are not eligible for MO HealthNet and enrollment of
67 the Title XIX eligible members in a group health plan is not
68 possible unless all family members are enrolled, all
69 premiums for noneligible members shall be treated as payment

for MO HealthNet of eligible family members. Payment for noneligible family members must be cost effective, taking into account payment of all such premiums. Non-Title XIX eligible family members shall pay all deductible, coinsurance and other cost-sharing obligations. Each individual as a condition of eligibility for MO HealthNet benefits shall apply for enrollment in the group health plan.

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

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

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

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]~~ 2026.

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]~~ 2026.

208.659. 1. The MO HealthNet division shall revise
2 the eligibility requirements for the uninsured women's
3 health program, as established in 13 CSR Section 70- 4.090,
4 to include women who are at least eighteen years of age and
5 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
following terms mean:

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

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

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

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

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
application of such provisions to others or other
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.