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Section A. Sections 190.839, 198.439, 208.152, 208.153, 208.437, 208.480, 208.659, 338.550, and 633.401, RSMo, are repealed and nine new sections enacted in lieu thereof, to be known as sections 190.839, 198.439, 208.152, 208.153, 208.437, 208.480, 208.659, 338.550, and 633.401, to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

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) (a) Physicians' services, whether furnished in
69 the office, home, hospital, nursing home, or elsewhere;
70 (b) At the time of either approval by the Centers for
71 Medicare and Medicaid Services (CMS) or an administrative or
72 judicial action requiring CMS approval, no funds shall be
73 expended to any abortion facility, as defined in section
74 188.015, or any affiliate or associate thereof. The state
75 shall exhaust all administrative and judicial remedies
76 available to compel CMS approval related to the provisions
77 of this paragraph;
78 (7) Subject to appropriation, up to twenty visits per
79 year for services limited to examinations, diagnoses,
80 adjustments, and manipulations and treatments of

81 malpositioned articulations and structures of the body
82 provided by licensed chiropractic physicians practicing
83 within their scope of practice. Nothing in this subdivision
84 shall be interpreted to otherwise expand MO HealthNet
85 services;
86 (8) Drugs and medicines when prescribed by a licensed
87 physician, dentist, podiatrist, or an advanced practice
88 registered nurse; except that no payment for drugs and
89 medicines prescribed on and after January 1, 2006, by a
90 licensed physician, dentist, podiatrist, or an advanced
91 practice registered nurse may be made on behalf of any
92 person who qualifies for prescription drug coverage under
93 the provisions of P.L. 108-173;
94 (9) Emergency ambulance services and, effective
95 January 1, 1990, medically necessary transportation to
96 scheduled, physician-prescribed nonelective treatments;
97 (10) Early and periodic screening and diagnosis of
98 individuals who are under the age of twenty-one to ascertain
99 their physical or mental defects, and health care,
100 treatment, and other measures to correct or ameliorate
101 defects and chronic conditions discovered thereby. Such
102 services shall be provided in accordance with the provisions
103 of Section 6403 of P.L. 101-239 and federal regulations
104 promulgated thereunder;
105 (11) Home health care services;
106 (12) Family planning as defined by federal rules and
107 regulations; provided, however, that such family planning
108 services shall not include abortions <u>or any abortifacient</u>
109 <u>drug or device</u> unless such abortions are certified in
110 writing by a physician to the MO HealthNet agency that, in
111 the physician's professional judgment, the life of the
112 mother would be endangered if the fetus were carried to
113 term<u>. As used in this subdivision, "abortifacient drug or</u>

114 device" includes the following when prescribed and intended
115 for family planning: mifepristone in a regimen with or
116 without misoprostol when used to induce an abortion;
117 misoprostol alone when used to induce an abortion;
118 levonorgestrel (Plan B) when used to induce an abortion;
119 ulipristal acetate (ella) or other progesterone antagonists
120 when used to induce an abortion; an intrauterine device
121 (IUD) or a manual vacuum aspirator (MVA) when used to induce
122 an abortion; or any other drug or device approved by the
123 federal Food and Drug Administration that is intended to
124 cause the destruction of an unborn child, as defined in
125 section 188.015;
126 (13) Inpatient psychiatric hospital services for
127 individuals under age twenty-one as defined in Title XIX of
128 the federal Social Security Act (42 U.S.C. Section 1396d, et
129 seq.);
130 (14) Outpatient surgical procedures, including
131 presurgical diagnostic services performed in ambulatory
132 surgical facilities which are licensed by the department of
133 health and senior services of the state of Missouri; except,
134 that such outpatient surgical services shall not include
135 persons who are eligible for coverage under Part B of Title
136 XVIII, Public Law 89-97, 1965 amendments to the federal
137 Social Security Act, as amended, if exclusion of such
138 persons is permitted under Title XIX, Public Law 89-97, 1965
139 amendments to the federal Social Security Act, as amended;
140 (15) Personal care services which are medically
141 oriented tasks having to do with a person's physical
142 requirements, as opposed to housekeeping requirements, which
143 enable a person to be treated by his or her physician on an
144 outpatient rather than on an inpatient or residential basis
145 in a hospital, intermediate care facility, or skilled
146 nursing facility. Personal care services shall be rendered

147 by an individual not a member of the participant's family
148 who is qualified to provide such services where the services
149 are prescribed by a physician in accordance with a plan of
150 treatment and are supervised by a licensed nurse. Persons
151 eligible to receive personal care services shall be those
152 persons who would otherwise require placement in a hospital,
153 intermediate care facility, or skilled nursing facility.
154 Benefits payable for personal care services shall not exceed
155 for any one participant one hundred percent of the average
156 statewide charge for care and treatment in an intermediate
157 care facility for a comparable period of time. Such
158 services, when delivered in a residential care facility or
159 assisted living facility licensed under chapter 198 shall be
160 authorized on a tier level based on the services the
161 resident requires and the frequency of the services. A
162 resident of such facility who qualifies for assistance under
163 section 208.030 shall, at a minimum, if prescribed by a
164 physician, qualify for the tier level with the fewest
165 services. The rate paid to providers for each tier of
166 service shall be set subject to appropriations. Subject to
167 appropriations, each resident of such facility who qualifies
168 for assistance under section 208.030 and meets the level of
169 care required in this section shall, at a minimum, if
170 prescribed by a physician, be authorized up to one hour of
171 personal care services per day. Authorized units of
172 personal care services shall not be reduced or tier level
173 lowered unless an order approving such reduction or lowering
174 is obtained from the resident's personal physician. Such
175 authorized units of personal care services or tier level
176 shall be transferred with such resident if he or she
177 transfers to another such facility. Such provision shall
178 terminate upon receipt of relevant waivers from the federal
179 Department of Health and Human Services. If the Centers for

180 Medicare and Medicaid Services determines that such
181 provision does not comply with the state plan, this
182 provision shall be null and void. The MO HealthNet division
183 shall notify the revisor of statutes as to whether the
184 relevant waivers are approved or a determination of
185 noncompliance is made;
186 (16) Mental health services. The state plan for
187 providing medical assistance under Title XIX of the Social
188 Security Act, 42 U.S.C. Section 301, as amended, shall
189 include the following mental health services when such
190 services are provided by community mental health facilities
191 operated by the department of mental health or designated by
192 the department of mental health as a community mental health
193 facility or as an alcohol and drug abuse facility or as a
194 child-serving agency within the comprehensive children's
195 mental health service system established in section
196 630.097. The department of mental health shall establish by
197 administrative rule the definition and criteria for
198 designation as a community mental health facility and for
199 designation as an alcohol and drug abuse facility. Such
200 mental health services shall include:
201 (a) Outpatient mental health services including
202 preventive, diagnostic, therapeutic, rehabilitative, and
203 palliative interventions rendered to individuals in an
204 individual or group setting by a mental health professional
205 in accordance with a plan of treatment appropriately
206 established, implemented, monitored, and revised under the
207 auspices of a therapeutic team as a part of client services
208 management;
209 (b) Clinic mental health services including
210 preventive, diagnostic, therapeutic, rehabilitative, and
211 palliative interventions rendered to individuals in an
212 individual or group setting by a mental health professional

213 in accordance with a plan of treatment appropriately
214 established, implemented, monitored, and revised under the
215 auspices of a therapeutic team as a part of client services
216 management;
217 (c) Rehabilitative mental health and alcohol and drug
218 abuse services including home and community-based
219 preventive, diagnostic, therapeutic, rehabilitative, and
220 palliative interventions rendered to individuals in an
221 individual or group setting by a mental health or alcohol
222 and drug abuse professional in accordance with a plan of
223 treatment appropriately established, implemented, monitored,
224 and revised under the auspices of a therapeutic team as a
225 part of client services management. As used in this
226 section, mental health professional and alcohol and drug
227 abuse professional shall be defined by the department of
228 mental health pursuant to duly promulgated rules. With
229 respect to services established by this subdivision, the
230 department of social services, MO HealthNet division, shall
231 enter into an agreement with the department of mental
232 health. Matching funds for outpatient mental health
233 services, clinic mental health services, and rehabilitation
234 services for mental health and alcohol and drug abuse shall
235 be certified by the department of mental health to the MO
236 HealthNet division. The agreement shall establish a
237 mechanism for the joint implementation of the provisions of
238 this subdivision. In addition, the agreement shall
239 establish a mechanism by which rates for services may be
240 jointly developed;
241 (17) Such additional services as defined by the MO
242 HealthNet division to be furnished under waivers of federal
243 statutory requirements as provided for and authorized by the
244 federal Social Security Act (42 U.S.C. Section 301, et seq.)
245 subject to appropriation by the general assembly;

246 (18) The services of an advanced practice registered
247 nurse with a collaborative practice agreement to the extent
248 that such services are provided in accordance with chapters
249 334 and 335, and regulations promulgated thereunder;
250 (19) Nursing home costs for participants receiving
251 benefit payments under subdivision (4) of this subsection to
252 reserve a bed for the participant in the nursing home during
253 the time that the participant is absent due to admission to
254 a hospital for services which cannot be performed on an
255 outpatient basis, subject to the provisions of this
256 subdivision:
257 (a) The provisions of this subdivision shall apply
258 only if:
259 a. The occupancy rate of the nursing home is at or
260 above ninety-seven percent of MO HealthNet certified
261 licensed beds, according to the most recent quarterly census
262 provided to the department of health and senior services
263 which was taken prior to when the participant is admitted to
264 the hospital; and
265 b. The patient is admitted to a hospital for a medical
266 condition with an anticipated stay of three days or less;
267 (b) The payment to be made under this subdivision
268 shall be provided for a maximum of three days per hospital
269 stay;
270 (c) For each day that nursing home costs are paid on
271 behalf of a participant under this subdivision during any
272 period of six consecutive months such participant shall,
273 during the same period of six consecutive months, be
274 ineligible for payment of nursing home costs of two
275 otherwise available temporary leave of absence days provided
276 under subdivision (5) of this subsection; and
277 (d) The provisions of this subdivision shall not apply
278 unless the nursing home receives notice from the participant

279 or the participant's responsible party that the participant
280 intends to return to the nursing home following the hospital
281 stay. If the nursing home receives such notification and
282 all other provisions of this subsection have been satisfied,
283 the nursing home shall provide notice to the participant or
284 the participant's responsible party prior to release of the
285 reserved bed;
286 (20) Prescribed medically necessary durable medical
287 equipment. An electronic web-based prior authorization
288 system using best medical evidence and care and treatment
289 guidelines consistent with national standards shall be used
290 to verify medical need;
291 (21) Hospice care. As used in this subdivision, the
292 term "hospice care" means a coordinated program of active
293 professional medical attention within a home, outpatient and
294 inpatient care which treats the terminally ill patient and
295 family as a unit, employing a medically directed
296 interdisciplinary team. The program provides relief of
297 severe pain or other physical symptoms and supportive care
298 to meet the special needs arising out of physical,
299 psychological, spiritual, social, and economic stresses
300 which are experienced during the final stages of illness,
301 and during dying and bereavement and meets the Medicare
302 requirements for participation as a hospice as are provided
303 in 42 CFR Part 418. The rate of reimbursement paid by the
304 MO HealthNet division to the hospice provider for room and
305 board furnished by a nursing home to an eligible hospice
306 patient shall not be less than ninety-five percent of the
307 rate of reimbursement which would have been paid for
308 facility services in that nursing home facility for that
309 patient, in accordance with subsection (c) of Section 6408
310 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

344 assembly a four-year plan to achieve parity with Medicare
345 reimbursement rates and for third-party payor average dental
346 reimbursement rates. Such plan shall be subject to
347 appropriation and the division shall include in its annual
348 budget request to the governor the necessary funding needed
349 to complete the four-year plan developed under this
350 subdivision.
351 2. Additional benefit payments for medical assistance
352 shall be made on behalf of those eligible needy children,
353 pregnant women and blind persons with any payments to be
354 made on the basis of the reasonable cost of the care or
355 reasonable charge for the services as defined and determined
356 by the MO HealthNet division, unless otherwise hereinafter
357 provided, for the following:
358 (1) Dental services;
359 (2) Services of podiatrists as defined in section
360 330.010;
361 (3) Optometric services as described in section
362 336.010;
363 (4) Orthopedic devices or other prosthetics, including
364 eye glasses, dentures, hearing aids, and wheelchairs;
365 (5) Hospice care. As used in this subdivision, the
366 term "hospice care" means a coordinated program of active
367 professional medical attention within a home, outpatient and
368 inpatient care which treats the terminally ill patient and
369 family as a unit, employing a medically directed
370 interdisciplinary team. The program provides relief of
371 severe pain or other physical symptoms and supportive care
372 to meet the special needs arising out of physical,
373 psychological, spiritual, social, and economic stresses
374 which are experienced during the final stages of illness,
375 and during dying and bereavement and meets the Medicare
376 requirements for participation as a hospice as are provided

377 in 42 CFR Part 418. The rate of reimbursement paid by the
378 MO HealthNet division to the hospice provider for room and
379 board furnished by a nursing home to an eligible hospice
380 patient shall not be less than ninety-five percent of the
381 rate of reimbursement which would have been paid for
382 facility services in that nursing home facility for that
383 patient, in accordance with subsection (c) of Section 6408
384 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);
385 (6) Comprehensive day rehabilitation services
386 beginning early posttrauma as part of a coordinated system
387 of care for individuals with disabling impairments.
388 Rehabilitation services must be based on an individualized,
389 goal-oriented, comprehensive and coordinated treatment plan
390 developed, implemented, and monitored through an
391 interdisciplinary assessment designed to restore an
392 individual to optimal level of physical, cognitive, and
393 behavioral function. The MO HealthNet division shall
394 establish by administrative rule the definition and criteria
395 for designation of a comprehensive day rehabilitation
396 service facility, benefit limitations and payment
397 mechanism. Any rule or portion of a rule, as that term is
398 defined in section 536.010, that is created under the
399 authority delegated in this subdivision shall become
400 effective only if it complies with and is subject to all of
401 the provisions of chapter 536 and, if applicable, section
402 536.028. This section and chapter 536 are nonseverable and
403 if any of the powers vested with the general assembly
404 pursuant to chapter 536 to review, to delay the effective
405 date, or to disapprove and annul a rule are subsequently
406 held unconstitutional, then the grant of rulemaking
407 authority and any rule proposed or adopted after August 28,
408 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

442 undertake the provision of services based on a history of
443 bad debt shall give participants advance notice and a
444 reasonable opportunity for payment. A provider,
445 representative, employee, independent contractor, or agent
446 of a pharmaceutical manufacturer shall not make co-payment
447 for a participant. This subsection shall not apply to other
448 qualified children, pregnant women, or blind persons. If
449 the Centers for Medicare and Medicaid Services does not
450 approve the MO HealthNet state plan amendment submitted by
451 the department of social services that would allow a
452 provider to deny future services to an individual with
453 uncollected co-payments, the denial of services shall not be
454 allowed. The department of social services shall inform
455 providers regarding the acceptability of denying services as
456 the result of unpaid co-payments.
457 4. The MO HealthNet division shall have the right to
458 collect medication samples from participants in order to
459 maintain program integrity.
460 5. Reimbursement for obstetrical and pediatric
461 services under subdivision (6) of subsection 1 of this
462 section shall be timely and sufficient to enlist enough
463 health care providers so that care and services are
464 available under the state plan for MO HealthNet benefits at
465 least to the extent that such care and services are
466 available to the general population in the geographic area,
467 as required under subparagraph (a)(30)(A) of 42 U.S.C.
468 Section 1396a and federal regulations promulgated thereunder.
469 6. Beginning July 1, 1990, reimbursement for services
470 rendered in federally funded health centers shall be in
471 accordance with the provisions of subsection 6402(c) and
472 Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation
473 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

507 from the interpretation or application that has been applied
508 previously by the state in any audit of a MO HealthNet
509 provider, the Missouri Medicaid audit and compliance unit
510 shall notify all affected MO HealthNet providers five
511 business days before such change shall take effect. Failure
512 of the Missouri Medicaid audit and compliance unit to notify
513 a provider of such change shall entitle the provider to
514 continue to receive and retain reimbursement until such
515 notification is provided and shall waive any liability of
516 such provider for recoupment or other loss of any payments
517 previously made prior to the five business days after such
518 notice has been sent. Each provider shall provide the
519 Missouri Medicaid audit and compliance unit a valid email
520 address and shall agree to receive communications
521 electronically. The notification required under this
522 section shall be delivered in writing by the United States
523 Postal Service or electronic mail to each provider.
524 13. Nothing in this section shall be construed to
525 abrogate or limit the department's statutory requirement to
526 promulgate rules under chapter 536.
527 14. Beginning July 1, 2016, and subject to
528 appropriations, providers of behavioral, social, and
529 psychophysiological services for the prevention, treatment,
530 or management of physical health problems shall be
531 reimbursed utilizing the behavior assessment and
532 intervention reimbursement codes 96150 to 96154 or their
533 successor codes under the Current Procedural Terminology
534 (CPT) coding system. Providers eligible for such
535 reimbursement shall include psychologists.
208.153. 1. Pursuant to and not inconsistent with the
2 provisions of sections 208.151 and 208.152, the MO HealthNet
3 division shall by rule and regulation define the reasonable
4 costs, manner, extent, quantity, quality, charges and fees

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

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

70 for MO HealthNet of eligible family members. Payment for
71 noneligible family members must be cost effective, taking
72 into account payment of all such premiums. Non-Title XIX
73 eligible family members shall pay all deductible,
74 coinsurance and other cost-sharing obligations. Each
75 individual as a condition of eligibility for MO HealthNet
76 benefits shall apply for enrollment in the group health plan.
77 6. Any Social Security cost-of-living increase at the
78 beginning of any year shall be disregarded until the federal
79 poverty level for such year is implemented.
80 7. If a MO HealthNet participant has paid the
81 requested spenddown in cash for any month and subsequently
82 pays an out-of-pocket valid medical expense for such month,
83 such expense shall be allowed as a deduction to future
84 required spenddown for up to three months from the date of
85 such expense.

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**]** 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

eligible for such program, the applicant shall not have assets in excess of two hundred and fifty thousand dollars, nor shall the applicant have access to employer-sponsored health insurance. Such change in eligibility requirements shall not result in any change in services provided under the program.

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

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

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

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

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

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

2. Sections 338.500 to 338.550 shall expire on 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

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**]** 2026.

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.

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.