FIRST EXTRAORDINARY SESSION

SENATE BILL NO. 6

101ST GENERAL ASSEMBLY

INTRODUCED BY SENATOR ONDER.

2838S.01I ADRIANE D. CROUSE, Secretary

AN ACT

To repeal sections 190.839, 198.439, 208.152, 208.153, 208.437, 208.480, 338.550, and 633.401, RSMo, and to enact in lieu thereof eight new sections relating to MO HealthNet.

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

Section A. Sections 190.839, 198.439, 208.152, 208.153,
2 208.437, 208.480, 338.550, and 633.401, RSMo, are repealed and
3 eight new sections enacted in lieu thereof, to be known as
4 sections 190.839, 198.439, 208.152, 208.153, 208.437, 208.480,
5 338.550, and 633.401, to read as follows:

190.839. Sections 190.800 to 190.839 shall expire on
2 September 30, **[**2021**]** **2022.**

198.439. Sections 198.401 to 198.436 shall expire on
2 September 30, **[**2021**]** **2022.**

208.152. 1. MO HealthNet payments shall be made on
2 behalf of those eligible needy persons as described in
3 section 208.151 who are unable to provide for it in whole or
4 in part, with any payments to be made on the basis of the
5 reasonable cost of the care or reasonable charge for the
6 services as defined and determined by the MO HealthNet
7 division, unless otherwise hereinafter provided, for the
8 following:
9 (1) Inpatient hospital services, except to persons in
10 an institution for mental diseases who are under the age of
11 sixty-five years and over the age of twenty-one years;
12 provided that the MO HealthNet division shall provide

EXPLANATION-Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

13 through rule and regulation an exception process for
14 coverage of inpatient costs in those cases requiring
15 treatment beyond the seventy-fifth percentile professional
16 activities study (PAS) or the MO HealthNet children's
17 diagnosis length-of-stay schedule; and provided further that
18 the MO HealthNet division shall take into account through
19 its payment system for hospital services the situation of
20 hospitals which serve a disproportionate number of low-
21 income patients;
22 (2) All outpatient hospital services, payments
23 therefor to be in amounts which represent no more than
24 eighty percent of the lesser of reasonable costs or
25 customary charges for such services, determined in
26 accordance with the principles set forth in Title XVIII A
27 and B, Public Law 89-97, 1965 amendments to the federal
28 Social Security Act (42 U.S.C. Section 301, et seq.), but
29 the MO HealthNet division may evaluate outpatient hospital
30 services rendered under this section and deny payment for
31 services which are determined by the MO HealthNet division
32 not to be medically necessary, in accordance with federal
33 law and regulations;
34 (3) Laboratory and X-ray services;
35 (4) Nursing home services for participants, except to
36 persons with more than five hundred thousand dollars equity
37 in their home or except for persons in an institution for
38 mental diseases who are under the age of sixty-five years,
39 when residing in a hospital licensed by the department of
40 health and senior services or a nursing home licensed by the
41 department of health and senior services or appropriate
42 licensing authority of other states or government-owned and -
43 operated institutions which are determined to conform to
44 standards equivalent to licensing requirements in Title XIX

45 of the federal Social Security Act (42 U.S.C. Section 301,
46 et seq.), as amended, for nursing facilities. The MO
47 HealthNet division may recognize through its payment
48 methodology for nursing facilities those nursing facilities
49 which serve a high volume of MO HealthNet patients. The MO
50 HealthNet division when determining the amount of the
51 benefit payments to be made on behalf of persons under the
52 age of twenty-one in a nursing facility may consider nursing
53 facilities furnishing care to persons under the age of
54 twenty-one as a classification separate from other nursing
55 facilities;

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

68 (6) Physicians' services, whether furnished in the
69 office, home, hospital, nursing home, or elsewhere,
70 **provided, no funds shall be expended to any abortion**
71 **facility, as defined in section 188.015, or any affiliate or**
72 **associate thereof**;

73 (7) Subject to appropriation, up to twenty visits per
74 year for services limited to examinations, diagnoses,
75 adjustments, and manipulations and treatments of
76 malpositioned articulations and structures of the body

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

108 (13) Inpatient psychiatric hospital services for
109 individuals under age twenty-one as defined in Title XIX of
110 the federal Social Security Act (42 U.S.C. Section 1396d, et
111 seq.);
112 (14) Outpatient surgical procedures, including
113 presurgical diagnostic services performed in ambulatory
114 surgical facilities which are licensed by the department of
115 health and senior services of the state of Missouri; except,
116 that such outpatient surgical services shall not include
117 persons who are eligible for coverage under Part B of Title
118 XVIII, Public Law 89-97, 1965 amendments to the federal
119 Social Security Act, as amended, if exclusion of such
120 persons is permitted under Title XIX, Public Law 89-97, 1965
121 amendments to the federal Social Security Act, as amended;
122 (15) Personal care services which are medically
123 oriented tasks having to do with a person's physical
124 requirements, as opposed to housekeeping requirements, which
125 enable a person to be treated by his or her physician on an
126 outpatient rather than on an inpatient or residential basis
127 in a hospital, intermediate care facility, or skilled
128 nursing facility. Personal care services shall be rendered
129 by an individual not a member of the participant's family
130 who is qualified to provide such services where the services
131 are prescribed by a physician in accordance with a plan of
132 treatment and are supervised by a licensed nurse. Persons
133 eligible to receive personal care services shall be those
134 persons who would otherwise require placement in a hospital,
135 intermediate care facility, or skilled nursing facility.
136 Benefits payable for personal care services shall not exceed
137 for any one participant one hundred percent of the average
138 statewide charge for care and treatment in an intermediate
139 care facility for a comparable period of time. Such

140 services, when delivered in a residential care facility or
141 assisted living facility licensed under chapter 198 shall be
142 authorized on a tier level based on the services the
143 resident requires and the frequency of the services. A
144 resident of such facility who qualifies for assistance under
145 section 208.030 shall, at a minimum, if prescribed by a
146 physician, qualify for the tier level with the fewest
147 services. The rate paid to providers for each tier of
148 service shall be set subject to appropriations. Subject to
149 appropriations, each resident of such facility who qualifies
150 for assistance under section 208.030 and meets the level of
151 care required in this section shall, at a minimum, if
152 prescribed by a physician, be authorized up to one hour of
153 personal care services per day. Authorized units of
154 personal care services shall not be reduced or tier level
155 lowered unless an order approving such reduction or lowering
156 is obtained from the resident's personal physician. Such
157 authorized units of personal care services or tier level
158 shall be transferred with such resident if he or she
159 transfers to another such facility. Such provision shall
160 terminate upon receipt of relevant waivers from the federal
161 Department of Health and Human Services. If the Centers for
162 Medicare and Medicaid Services determines that such
163 provision does not comply with the state plan, this
164 provision shall be null and void. The MO HealthNet division
165 shall notify the revisor of statutes as to whether the
166 relevant waivers are approved or a determination of
167 noncompliance is made;
168 (16) Mental health services. The state plan for
169 providing medical assistance under Title XIX of the Social
170 Security Act, 42 U.S.C. Section 301, as amended, shall
171 include the following mental health services when such

172 services are provided by community mental health facilities
173 operated by the department of mental health or designated by
174 the department of mental health as a community mental health
175 facility or as an alcohol and drug abuse facility or as a
176 child-serving agency within the comprehensive children's
177 mental health service system established in section
178 630.097. The department of mental health shall establish by
179 administrative rule the definition and criteria for
180 designation as a community mental health facility and for
181 designation as an alcohol and drug abuse facility. Such
182 mental health services shall include:
183 (a) Outpatient mental health services including
184 preventive, diagnostic, therapeutic, rehabilitative, and
185 palliative interventions rendered to individuals in an
186 individual or group setting by a mental health professional
187 in accordance with a plan of treatment appropriately
188 established, implemented, monitored, and revised under the
189 auspices of a therapeutic team as a part of client services
190 management;
191 (b) Clinic mental health services including
192 preventive, diagnostic, therapeutic, rehabilitative, and
193 palliative interventions rendered to individuals in an
194 individual or group setting by a mental health professional
195 in accordance with a plan of treatment appropriately
196 established, implemented, monitored, and revised under the
197 auspices of a therapeutic team as a part of client services
198 management;
199 (c) Rehabilitative mental health and alcohol and drug
200 abuse services including home and community-based
201 preventive, diagnostic, therapeutic, rehabilitative, and
202 palliative interventions rendered to individuals in an
203 individual or group setting by a mental health or alcohol

204 and drug abuse professional in accordance with a plan of
205 treatment appropriately established, implemented, monitored,
206 and revised under the auspices of a therapeutic team as a
207 part of client services management. As used in this
208 section, mental health professional and alcohol and drug
209 abuse professional shall be defined by the department of
210 mental health pursuant to duly promulgated rules. With
211 respect to services established by this subdivision, the
212 department of social services, MO HealthNet division, shall
213 enter into an agreement with the department of mental
214 health. Matching funds for outpatient mental health
215 services, clinic mental health services, and rehabilitation
216 services for mental health and alcohol and drug abuse shall
217 be certified by the department of mental health to the MO
218 HealthNet division. The agreement shall establish a
219 mechanism for the joint implementation of the provisions of
220 this subdivision. In addition, the agreement shall
221 establish a mechanism by which rates for services may be
222 jointly developed;
223 (17) Such additional services as defined by the MO
224 HealthNet division to be furnished under waivers of federal
225 statutory requirements as provided for and authorized by the
226 federal Social Security Act (42 U.S.C. Section 301, et seq.)
227 subject to appropriation by the general assembly;
228 (18) The services of an advanced practice registered
229 nurse with a collaborative practice agreement to the extent
230 that such services are provided in accordance with chapters
231 334 and 335, and regulations promulgated thereunder;
232 (19) Nursing home costs for participants receiving
233 benefit payments under subdivision (4) of this subsection to
234 reserve a bed for the participant in the nursing home during
235 the time that the participant is absent due to admission to

236 a hospital for services which cannot be performed on an
237 outpatient basis, subject to the provisions of this
238 subdivision:
239 (a) The provisions of this subdivision shall apply
240 only if:
241 a. The occupancy rate of the nursing home is at or
242 above ninety-seven percent of MO HealthNet certified
243 licensed beds, according to the most recent quarterly census
244 provided to the department of health and senior services
245 which was taken prior to when the participant is admitted to
246 the hospital; and
247 b. The patient is admitted to a hospital for a medical
248 condition with an anticipated stay of three days or less;
249 (b) The payment to be made under this subdivision
250 shall be provided for a maximum of three days per hospital
251 stay;
252 (c) For each day that nursing home costs are paid on
253 behalf of a participant under this subdivision during any
254 period of six consecutive months such participant shall,
255 during the same period of six consecutive months, be
256 ineligible for payment of nursing home costs of two
257 otherwise available temporary leave of absence days provided
258 under subdivision (5) of this subsection; and
259 (d) The provisions of this subdivision shall not apply
260 unless the nursing home receives notice from the participant
261 or the participant's responsible party that the participant
262 intends to return to the nursing home following the hospital
263 stay. If the nursing home receives such notification and
264 all other provisions of this subsection have been satisfied,
265 the nursing home shall provide notice to the participant or
266 the participant's responsible party prior to release of the
267 reserved bed;

268 (20) Prescribed medically necessary durable medical
269 equipment. An electronic web-based prior authorization
270 system using best medical evidence and care and treatment
271 guidelines consistent with national standards shall be used
272 to verify medical need;
273 (21) Hospice care. As used in this subdivision, the
274 term "hospice care" means a coordinated program of active
275 professional medical attention within a home, outpatient and
276 inpatient care which treats the terminally ill patient and
277 family as a unit, employing a medically directed
278 interdisciplinary team. The program provides relief of
279 severe pain or other physical symptoms and supportive care
280 to meet the special needs arising out of physical,
281 psychological, spiritual, social, and economic stresses
282 which are experienced during the final stages of illness,
283 and during dying and bereavement and meets the Medicare
284 requirements for participation as a hospice as are provided
285 in 42 CFR Part 418. The rate of reimbursement paid by the
286 MO HealthNet division to the hospice provider for room and
287 board furnished by a nursing home to an eligible hospice
288 patient shall not be less than ninety-five percent of the
289 rate of reimbursement which would have been paid for
290 facility services in that nursing home facility for that
291 patient, in accordance with subsection (c) of Section 6408
292 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);
293 (22) Prescribed medically necessary dental services.
294 Such services shall be subject to appropriations. An
295 electronic web-based prior authorization system using best
296 medical evidence and care and treatment guidelines
297 consistent with national standards shall be used to verify
298 medical need;

299 (23) Prescribed medically necessary optometric
300 services. Such services shall be subject to
301 appropriations. An electronic web-based prior authorization
302 system using best medical evidence and care and treatment
303 guidelines consistent with national standards shall be used
304 to verify medical need;
305 (24) Blood clotting products-related services. For
306 persons diagnosed with a bleeding disorder, as defined in
307 section 338.400, reliant on blood clotting products, as
308 defined in section 338.400, such services include:
309 (a) Home delivery of blood clotting products and
310 ancillary infusion equipment and supplies, including the
311 emergency deliveries of the product when medically necessary;
312 (b) Medically necessary ancillary infusion equipment
313 and supplies required to administer the blood clotting
314 products; and
315 (c) Assessments conducted in the participant's home by
316 a pharmacist, nurse, or local home health care agency
317 trained in bleeding disorders when deemed necessary by the
318 participant's treating physician;
319 (25) The MO HealthNet division shall, by January 1,
320 2008, and annually thereafter, report the status of MO
321 HealthNet provider reimbursement rates as compared to one
322 hundred percent of the Medicare reimbursement rates and
323 compared to the average dental reimbursement rates paid by
324 third-party payors licensed by the state. The MO HealthNet
325 division shall, by July 1, 2008, provide to the general
326 assembly a four-year plan to achieve parity with Medicare
327 reimbursement rates and for third-party payor average dental
328 reimbursement rates. Such plan shall be subject to
329 appropriation and the division shall include in its annual
330 budget request to the governor the necessary funding needed

331 to complete the four-year plan developed under this
332 subdivision.
333 2. Additional benefit payments for medical assistance
334 shall be made on behalf of those eligible needy children,
335 pregnant women and blind persons with any payments to be
336 made on the basis of the reasonable cost of the care or
337 reasonable charge for the services as defined and determined
338 by the MO HealthNet division, unless otherwise hereinafter
339 provided, for the following:
340 (1) Dental services;
341 (2) Services of podiatrists as defined in section
342 330.010;
343 (3) Optometric services as described in section
344 336.010;
345 (4) Orthopedic devices or other prosthetics, including
346 eye glasses, dentures, hearing aids, and wheelchairs;
347 (5) Hospice care. As used in this subdivision, the
348 term "hospice care" means a coordinated program of active
349 professional medical attention within a home, outpatient and
350 inpatient care which treats the terminally ill patient and
351 family as a unit, employing a medically directed
352 interdisciplinary team. The program provides relief of
353 severe pain or other physical symptoms and supportive care
354 to meet the special needs arising out of physical,
355 psychological, spiritual, social, and economic stresses
356 which are experienced during the final stages of illness,
357 and during dying and bereavement and meets the Medicare
358 requirements for participation as a hospice as are provided
359 in 42 CFR Part 418. The rate of reimbursement paid by the
360 MO HealthNet division to the hospice provider for room and
361 board furnished by a nursing home to an eligible hospice
362 patient shall not be less than ninety-five percent of the

363 rate of reimbursement which would have been paid for
364 facility services in that nursing home facility for that
365 patient, in accordance with subsection (c) of Section 6408
366 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);
367 (6) Comprehensive day rehabilitation services
368 beginning early posttrauma as part of a coordinated system
369 of care for individuals with disabling impairments.
370 Rehabilitation services must be based on an individualized,
371 goal-oriented, comprehensive and coordinated treatment plan
372 developed, implemented, and monitored through an
373 interdisciplinary assessment designed to restore an
374 individual to optimal level of physical, cognitive, and
375 behavioral function. The MO HealthNet division shall
376 establish by administrative rule the definition and criteria
377 for designation of a comprehensive day rehabilitation
378 service facility, benefit limitations and payment
379 mechanism. Any rule or portion of a rule, as that term is
380 defined in section 536.010, that is created under the
381 authority delegated in this subdivision shall become
382 effective only if it complies with and is subject to all of
383 the provisions of chapter 536 and, if applicable, section
384 536.028. This section and chapter 536 are nonseverable and
385 if any of the powers vested with the general assembly
386 pursuant to chapter 536 to review, to delay the effective
387 date, or to disapprove and annul a rule are subsequently
388 held unconstitutional, then the grant of rulemaking
389 authority and any rule proposed or adopted after August 28,
390 2005, shall be invalid and void.
391 3. The MO HealthNet division may require any
392 participant receiving MO HealthNet benefits to pay part of
393 the charge or cost until July 1, 2008, and an additional
394 payment after July 1, 2008, as defined by rule duly

395 promulgated by the MO HealthNet division, for all covered
396 services except for those services covered under
397 subdivisions (15) and (16) of subsection 1 of this section
398 and sections 208.631 to 208.657 to the extent and in the
399 manner authorized by Title XIX of the federal Social
400 Security Act (42 U.S.C. Section 1396, et seq.) and
401 regulations thereunder. When substitution of a generic drug
402 is permitted by the prescriber according to section 338.056,
403 and a generic drug is substituted for a name-brand drug, the
404 MO HealthNet division may not lower or delete the
405 requirement to make a co-payment pursuant to regulations of
406 Title XIX of the federal Social Security Act. A provider of
407 goods or services described under this section must collect
408 from all participants the additional payment that may be
409 required by the MO HealthNet division under authority
410 granted herein, if the division exercises that authority, to
411 remain eligible as a provider. Any payments made by
412 participants under this section shall be in addition to and
413 not in lieu of payments made by the state for goods or
414 services described herein except the participant portion of
415 the pharmacy professional dispensing fee shall be in
416 addition to and not in lieu of payments to pharmacists. A
417 provider may collect the co-payment at the time a service is
418 provided or at a later date. A provider shall not refuse to
419 provide a service if a participant is unable to pay a
420 required payment. If it is the routine business practice of
421 a provider to terminate future services to an individual
422 with an unclaimed debt, the provider may include uncollected
423 co-payments under this practice. Providers who elect not to
424 undertake the provision of services based on a history of
425 bad debt shall give participants advance notice and a
426 reasonable opportunity for payment. A provider,

427 representative, employee, independent contractor, or agent
428 of a pharmaceutical manufacturer shall not make co-payment
429 for a participant. This subsection shall not apply to other
430 qualified children, pregnant women, or blind persons. If
431 the Centers for Medicare and Medicaid Services does not
432 approve the MO HealthNet state plan amendment submitted by
433 the department of social services that would allow a
434 provider to deny future services to an individual with
435 uncollected co-payments, the denial of services shall not be
436 allowed. The department of social services shall inform
437 providers regarding the acceptability of denying services as
438 the result of unpaid co-payments.
439 4. The MO HealthNet division shall have the right to
440 collect medication samples from participants in order to
441 maintain program integrity.
442 5. Reimbursement for obstetrical and pediatric
443 services under subdivision (6) of subsection 1 of this
444 section shall be timely and sufficient to enlist enough
445 health care providers so that care and services are
446 available under the state plan for MO HealthNet benefits at
447 least to the extent that such care and services are
448 available to the general population in the geographic area,
449 as required under subparagraph (a)(30)(A) of 42 U.S.C.
450 Section 1396a and federal regulations promulgated thereunder.
451 6. Beginning July 1, 1990, reimbursement for services
452 rendered in federally funded health centers shall be in
453 accordance with the provisions of subsection 6402(c) and
454 Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation
455 Act of 1989) and federal regulations promulgated thereunder.
456 7. Beginning July 1, 1990, the department of social
457 services shall provide notification and referral of children
458 below age five, and pregnant, breast-feeding, or postpartum

459 women who are determined to be eligible for MO HealthNet
460 benefits under section 208.151 to the special supplemental
461 food programs for women, infants and children administered
462 by the department of health and senior services. Such
463 notification and referral shall conform to the requirements
464 of Section 6406 of P.L. 101-239 and regulations promulgated
465 thereunder.
466 8. Providers of long-term care services shall be
467 reimbursed for their costs in accordance with the provisions
468 of Section 1902 (a)(13)(A) of the Social Security Act, 42
469 U.S.C. Section 1396a, as amended, and regulations
470 promulgated thereunder.
471 9. Reimbursement rates to long-term care providers
472 with respect to a total change in ownership, at arm's
473 length, for any facility previously licensed and certified
474 for participation in the MO HealthNet program shall not
475 increase payments in excess of the increase that would
476 result from the application of Section 1902 (a)(13)(C) of
477 the Social Security Act, 42 U.S.C. Section 1396a (a)(13)(C).
478 10. The MO HealthNet division may enroll qualified
479 residential care facilities and assisted living facilities,
480 as defined in chapter 198, as MO HealthNet personal care
481 providers.
482 11. Any income earned by individuals eligible for
483 certified extended employment at a sheltered workshop under
484 chapter 178 shall not be considered as income for purposes
485 of determining eligibility under this section.
486 12. If the Missouri Medicaid audit and compliance unit
487 changes any interpretation or application of the
488 requirements for reimbursement for MO HealthNet services
489 from the interpretation or application that has been applied
490 previously by the state in any audit of a MO HealthNet

491 provider, the Missouri Medicaid audit and compliance unit
492 shall notify all affected MO HealthNet providers five
493 business days before such change shall take effect. Failure
494 of the Missouri Medicaid audit and compliance unit to notify
495 a provider of such change shall entitle the provider to
496 continue to receive and retain reimbursement until such
497 notification is provided and shall waive any liability of
498 such provider for recoupment or other loss of any payments
499 previously made prior to the five business days after such
500 notice has been sent. Each provider shall provide the
501 Missouri Medicaid audit and compliance unit a valid email
502 address and shall agree to receive communications
503 electronically. The notification required under this
504 section shall be delivered in writing by the United States
505 Postal Service or electronic mail to each provider.
506 13. Nothing in this section shall be construed to
507 abrogate or limit the department's statutory requirement to
508 promulgate rules under chapter 536.
509 14. Beginning July 1, 2016, and subject to
510 appropriations, providers of behavioral, social, and
511 psychophysiological services for the prevention, treatment,
512 or management of physical health problems shall be
513 reimbursed utilizing the behavior assessment and
514 intervention reimbursement codes 96150 to 96154 or their
515 successor codes under the Current Procedural Terminology
516 (CPT) coding system. Providers eligible for such
517 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
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.** At the discretion of the director of the
19 MO HealthNet division and with the approval of the governor,
20 the MO HealthNet division is authorized to provide medical
21 benefits for participants receiving public assistance by
22 expending funds for the payment of federal medical insurance
23 premiums, coinsurance and deductibles pursuant to the
24 provisions of Title XVIII B and XIX, Public Law 89-97, 1965
25 amendments to the federal Social Security Act (42 U.S.C.
26 301, et seq.), as amended.

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

35 3. MO HealthNet shall include benefit payments for
36 Medicare Part A cost sharing as defined in clause
37 (p)(3)(A)(i) of 42 U.S.C. 1396d on behalf of qualified

38 disabled and working individuals as defined in subsection
39 (s) of Section 42 U.S.C. 1396d as required by subsection (d)
40 of Section 6408 of P.L. 101-239 (Omnibus Budget
41 Reconciliation Act of 1989). The MO HealthNet division may
42 impose a premium for such benefit payments as authorized by
43 paragraph (d)(3) of Section 6408 of P.L. 101-239.
44 4. MO HealthNet shall include benefit payments for
45 Medicare Part B cost sharing described in 42 U.S.C. Section
46 1396(d)(p)(3)(A)(ii) for individuals described in subsection
47 2 of this section, but for the fact that their income
48 exceeds the income level established by the state under 42
49 U.S.C. Section 1396(d)(p)(2) but is less than one hundred
50 and ten percent beginning January 1, 1993, and less than one
51 hundred and twenty percent beginning January 1, 1995, of the
52 official poverty line for a family of the size involved.
53 5. For an individual eligible for MO HealthNet under
54 Title XIX of the Social Security Act, MO HealthNet shall
55 include payment of enrollee premiums in a group health plan
56 and all deductibles, coinsurance and other cost-sharing for
57 items and services otherwise covered under the state Title
58 XIX plan under Section 1906 of the federal Social Security
59 Act and regulations established under the authority of
60 Section 1906, as may be amended. Enrollment in a group
61 health plan must be cost effective, as established by the
62 Secretary of Health and Human Services, before enrollment in
63 the group health plan is required. If all members of a
64 family are not eligible for MO HealthNet and enrollment of
65 the Title XIX eligible members in a group health plan is not
66 possible unless all family members are enrolled, all
67 premiums for noneligible members shall be treated as payment
68 for MO HealthNet of eligible family members. Payment for
69 noneligible family members must be cost effective, taking

70 into account payment of all such premiums. Non-Title XIX
71 eligible family members shall pay all deductible,
72 coinsurance and other cost-sharing obligations. Each
73 individual as a condition of eligibility for MO HealthNet
74 benefits shall apply for enrollment in the group health plan.
75 6. Any Social Security cost-of-living increase at the
76 beginning of any year shall be disregarded until the federal
77 poverty level for such year is implemented.
78 7. If a MO HealthNet participant has paid the
79 requested spenddown in cash for any month and subsequently
80 pays an out-of-pocket valid medical expense for such month,
81 such expense shall be allowed as a deduction to future
82 required spenddown for up to three months from the date of
83 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**] 2022**.

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**] 2022**.

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**]** **2022**.

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**]** **2022**.

633.401. 1. For purposes of this section, the
2 following terms mean:
3 (1) "Engaging in the business of providing health
4 benefit services", accepting payment for health benefit
5 services;
6 (2) "Intermediate care facility for the intellectually
7 disabled", a private or department of mental health facility
8 which admits persons who are intellectually disabled or
9 developmentally disabled for residential habilitation and
10 other services pursuant to chapter 630. Such term shall
11 include habilitation centers and private or public
12 intermediate care facilities for the intellectually disabled

13 that have been certified to meet the conditions of
14 participation under 42 CFR, Section 483, Subpart I;
15 (3) "Net operating revenues from providing services of
16 intermediate care facilities for the intellectually
17 disabled" shall include, without limitation, all moneys
18 received on account of such services pursuant to rates of
19 reimbursement established and paid by the department of
20 social services, but shall not include charitable
21 contributions, grants, donations, bequests and income from
22 nonservice related fund-raising activities and government
23 deficit financing, contractual allowance, discounts or bad
24 debt;
25 (4) "Services of intermediate care facilities for the
26 intellectually disabled" has the same meaning as the term
27 services of intermediate care facilities for the mentally
28 retarded, as used in Title 42 United States Code, Section
29 1396b(w)(7)(A)(iv), as amended, and as such qualifies as a
30 class of health care services recognized in federal Public
31 Law 102-234, the Medicaid Voluntary Contribution and
32 Provider-Specific Tax Amendments of 1991.
33 2. Beginning July 1, 2008, each provider of services
34 of intermediate care facilities for the intellectually
35 disabled shall, in addition to all other fees and taxes now
36 required or paid, pay assessments on their net operating
37 revenues for the privilege of engaging in the business of
38 providing services of the intermediate care facilities for
39 the intellectually disabled or developmentally disabled in
40 this state.
41 3. Each facility's assessment shall be based on a
42 formula set forth in rules and regulations promulgated by
43 the department of mental health.

44 4. For purposes of determining rates of payment under
45 the medical assistance program for providers of services of
46 intermediate care facilities for the intellectually
47 disabled, the assessment imposed pursuant to this section on
48 net operating revenues shall be a reimbursable cost to be
49 reflected as timely as practicable in rates of payment
50 applicable within the assessment period, contingent, for
51 payments by governmental agencies, on all federal approvals
52 necessary by federal law and regulation for federal
53 financial participation in payments made for beneficiaries
54 eligible for medical assistance under Title XIX of the
55 federal Social Security Act, 42 U.S.C. Section 1396, et
56 seq., as amended.
57 5. Assessments shall be submitted by or on behalf of
58 each provider of services of intermediate care facilities
59 for the intellectually disabled on a monthly basis to the
60 director of the department of mental health or his or her
61 designee and shall be made payable to the director of the
62 department of revenue.
63 6. In the alternative, a provider may direct that the
64 director of the department of social services offset, from
65 the amount of any payment to be made by the state to the
66 provider, the amount of the assessment payment owed for any
67 month.
68 7. Assessment payments shall be deposited in the state
69 treasury to the credit of the "Intermediate Care Facility
70 Intellectually Disabled Reimbursement Allowance Fund", which
71 is hereby created in the state treasury. All investment
72 earnings of this fund shall be credited to the fund.
73 Notwithstanding the provisions of section 33.080 to the
74 contrary, any unexpended balance in the intermediate care
75 facility intellectually disabled reimbursement allowance

76 fund at the end of the biennium shall not revert to the
77 general revenue fund but shall accumulate from year to
78 year. The state treasurer shall maintain records that show
79 the amount of money in the fund at any time and the amount
80 of any investment earnings on that amount.
81 8. Each provider of services of intermediate care
82 facilities for the intellectually disabled shall keep such
83 records as may be necessary to determine the amount of the
84 assessment for which it is liable under this section. On or
85 before the forty-fifth day after the end of each month
86 commencing July 1, 2008, each provider of services of
87 intermediate care facilities for the intellectually disabled
88 shall submit to the department of social services a report
89 on a cash basis that reflects such information as is
90 necessary to determine the amount of the assessment payable
91 for that month.
92 9. Every provider of services of intermediate care
93 facilities for the intellectually disabled shall submit a
94 certified annual report of net operating revenues from the
95 furnishing of services of intermediate care facilities for
96 the intellectually disabled. The reports shall be in such
97 form as may be prescribed by rule by the director of the
98 department of mental health. Final payments of the
99 assessment for each year shall be due for all providers of
100 services of intermediate care facilities for the
101 intellectually disabled upon the due date for submission of
102 the certified annual report.
103 10. The director of the department of mental health
104 shall prescribe by rule the form and content of any document
105 required to be filed pursuant to the provisions of this
106 section.

107 11. Upon receipt of notification from the director of
108 the department of mental health of a provider's delinquency
109 in paying assessments required under this section, the
110 director of the department of social services shall
111 withhold, and shall remit to the director of the department
112 of revenue, an assessment amount estimated by the director
113 of the department of mental health from any payment to be
114 made by the state to the provider.
115 12. In the event a provider objects to the estimate
116 described in subsection 11 of this section, or any other
117 decision of the department of mental health related to this
118 section, the provider of services may request a hearing. If
119 a hearing is requested, the director of the department of
120 mental health shall provide the provider of services an
121 opportunity to be heard and to present evidence bearing on
122 the amount due for an assessment or other issue related to
123 this section within thirty days after collection of an
124 amount due or receipt of a request for a hearing, whichever
125 is later. The director shall issue a final decision within
126 forty-five days of the completion of the hearing. After
127 reconsideration of the assessment determination and a final
128 decision by the director of the department of mental health,
129 an intermediate care facility for the intellectually
130 disabled provider's appeal of the director's final decision
131 shall be to the administrative hearing commission in
132 accordance with sections 208.156 and 621.055.
133 13. Notwithstanding any other provision of law to the
134 contrary, appeals regarding this assessment shall be to the
135 circuit court of Cole County or the circuit court in the
136 county in which the facility is located. The circuit court
137 shall hear the matter as the court of original jurisdiction.

138 14. Nothing in this section shall be deemed to affect
139 or in any way limit the tax-exempt or nonprofit status of
140 any intermediate care facility for the intellectually
141 disabled granted by state law.
142 15. The director of the department of mental health
143 shall promulgate rules and regulations to implement this
144 section. Any rule or portion of a rule, as that term is
145 defined in section 536.010, that is created under the
146 authority delegated in this section shall become effective
147 only if it complies with and is subject to all of the
148 provisions of chapter 536 and, if applicable, section
149 536.028. This section and chapter 536 are nonseverable and
150 if any of the powers vested with the general assembly
151 pursuant to chapter 536 to review, to delay the effective
152 date, or to disapprove and annul a rule are subsequently
153 held unconstitutional, then the grant of rulemaking
154 authority and any rule proposed or adopted after August 28,
155 2008, shall be invalid and void.
156 16. The provisions of this section shall expire on
157 September 30, **[**2021**] 2022**.

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