

SENATE SUBSTITUTE
FOR
SENATE COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 29

AN ACT

To repeal sections 190.839, 198.439, 208.431, 208.432, 208.433, 208.434, 208.435, 208.436, 208.437, 208.480, 338.550, and 633.401, RSMo, and to enact in lieu thereof thirteen new sections relating to reimbursement allowance assessments.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

1 Section A. Sections 190.839, 198.439, 208.431, 208.432,
2 208.433, 208.434, 208.435, 208.436, 208.437, 208.480, 338.550,
3 and 633.401, RSMo, are repealed and thirteen new sections enacted
4 in lieu thereof, to be known as sections 190.839, 198.439,
5 208.431, 208.432, 208.433, 208.434, 208.435, 208.436, 208.437,
6 208.438, 208.480, 338.550, and 633.401, to read as follows:

7 190.839. Sections 190.800 to 190.839 shall expire on
8 September 30, [2019] 2021.

9 198.439. Sections 198.401 to 198.436 shall expire on
10 September 30, [2019] 2021.

11 208.431. 1. For purposes of sections 208.431 to [208.437]
12 208.438, the following terms mean:

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

15 (2) "[Medicaid] Managed care organization", a health

1 [benefit plan, as defined in section 376.1350, with] maintenance
2 organization, as defined in section 354.400, including health
3 maintenance organizations operating pursuant to a contract under
4 42 U.S.C. Section 1396b(m) to provide benefits to [Missouri MC+]
5 MO HealthNet managed care program eligibility groups.

6 2. Beginning July 1, [2005] 2020, each [Medicaid] managed
7 care organization in this state shall, in addition to all other
8 fees and taxes now required or paid, pay a [Medicaid] managed
9 care organization reimbursement allowance for the privilege of
10 engaging in the business of providing health benefit services in
11 this state. The managed care organization reimbursement
12 allowance shall not apply to an organization that is exempt from
13 assessment under federal law under 42 CFR 422.404 or 5 U.S.C.
14 Section 8909(f)(1).

15 3. Each [Medicaid] managed care organization's
16 reimbursement allowance shall be based on a formula set forth in
17 rules, including emergency rules if necessary, promulgated by the
18 department of social services. No [Medicaid] managed care
19 organization reimbursement allowance shall be collected by the
20 department of social services if the federal Center for Medicare
21 and Medicaid Services determines that such reimbursement
22 allowance is not authorized under Title XIX of the Social
23 Security Act. If such determination is made by the federal
24 Center for Medicare and Medicaid Services, any [Medicaid] managed
25 care organization reimbursement allowance collected prior to such
26 determination shall be immediately returned to the [Medicaid]
27 managed care organizations which have paid such allowance.

28 208.432. Each [Medicaid] managed care organization shall

1 keep such records as may be necessary to determine the amount of
2 its reimbursement allowance. Every [Medicaid] managed care
3 organization shall submit to the department of social services a
4 statement that accurately reflects such information as is
5 necessary to determine that [Medicaid] managed care
6 organization's reimbursement allowance.

7 208.433. 1. The director of the department of social
8 services shall make a determination as to the amount of
9 [Medicaid] managed care organization's reimbursement allowance
10 due from each [Medicaid] managed care organization.

11 2. The director of the department of social services shall
12 notify each [Medicaid] managed care organization of the annual
13 amount of its reimbursement allowance. Such amount may be paid
14 in monthly increments over the balance of the reimbursement
15 allowance period.

16 3. The department of social services shall recognize the
17 cost of the managed care organization reimbursement allowance as
18 a cost in calculating actuarially sound reimbursement rates. The
19 department of social services may offset the managed care
20 organization reimbursement allowance owed by the [Medicaid]
21 managed care organization against any payment due that managed
22 care organization only if the managed care organization requests
23 such an offset. The amounts to be offset shall result, so far as
24 practicable, in withholding from the managed care organization an
25 amount substantially equivalent to the reimbursement allowance
26 owed by the managed care organization. The office of
27 administration and state treasurer may make any fund transfers
28 necessary to execute the offset.

1 208.434. 1. Each [Medicaid] managed care organization
2 reimbursement allowance determination shall be final after
3 receipt of written notice from the department of social services,
4 unless the [Medicaid] managed care organization files a protest
5 with the director of the department of social services setting
6 forth the grounds on which the protest is based, within thirty
7 days from the date of receipt of written notice from the
8 department of social services to the managed care organization.

9 2. If a timely protest is filed, the director of the
10 department of social services shall reconsider the determination
11 and, if the [Medicaid] managed care organization has so
12 requested, the director or the director's designee shall grant
13 the managed care organization a hearing to be held within
14 forty-five days after the protest is filed, unless extended by
15 agreement between the managed care organization and the director.
16 The director shall issue a final decision within forty-five days
17 of the completion of the hearing. After reconsideration of the
18 reimbursement allowance determination and a final decision by the
19 director of the department of social services, a managed care
20 organization's appeal of the director's final decision shall be
21 to the administrative hearing commission in accordance with
22 sections 208.156 and 621.055.

23 208.435. 1. The department of social services shall
24 promulgate rules, including emergency rules if necessary, to
25 implement the provisions of sections 208.431 to [208.437]
26 208.438, including but not limited to:

27 (1) The form and content of any documents required to be
28 filed under sections 208.431 to [208.437] 208.438;

1 (2) The dates for the filing of documents by [Medicaid]
2 managed care organizations and for notification by the department
3 to each [Medicaid] managed care organization of the annual amount
4 of its reimbursement allowance; and

5 (3) The formula for determining the amount of each managed
6 care organization's reimbursement allowance.

7 2. Any rule or portion of a rule, as that term is defined
8 in section 536.010, that is created under the authority delegated
9 in sections 208.431 to [208.437] 208.438 shall become effective
10 only if it complies with and is subject to all of the provisions
11 of chapter 536 and, if applicable, section 536.028. Sections
12 208.431 to [208.437] 208.438 and chapter 536 are nonseverable and
13 if any of the powers vested with the general assembly pursuant to
14 chapter 536 to review, to delay the effective date, or to
15 disapprove and annul a rule are subsequently held
16 unconstitutional, then the grant of rulemaking authority and any
17 rule proposed or adopted after May 13, 2005, shall be invalid and
18 void.

19 208.436. 1. (1) The [Medicaid] managed care organization
20 reimbursement allowance owed or, if an offset has been requested,
21 the balance, if any, after such offset, shall be remitted by the
22 managed care organization to the department of social services.
23 The remittance shall be made payable to the director of the
24 department of revenue.

25 (2) The amount remitted shall be deposited in the state
26 treasury to the credit of the "[Medicaid] Managed Care
27 Organization Reimbursement Allowance Fund", which is hereby
28 created for the sole purposes of providing payment to [Medicaid]

1 managed care organizations. All investment earnings of the
2 managed care organization reimbursement allowance fund shall be
3 credited to the [Medicaid] managed care organization
4 reimbursement allowance fund.

5 (3) The unexpended balance in the [Medicaid] managed care
6 organization reimbursement allowance fund at the end of the
7 biennium is exempt from the provisions of section 33.080. The
8 unexpended balance shall not revert to the general revenue fund,
9 but shall accumulate in the [Medicaid] managed care organization
10 reimbursement allowance fund from year to year.

11 (4) The state treasurer shall maintain records that show
12 the amount of money in the [Medicaid] managed care organization
13 reimbursement allowance fund at any time and the amount of any
14 investment earnings on that amount. The department of social
15 services shall disclose such information to any interested party
16 upon written request.

17 2. An offset as authorized by this section or a payment to
18 the [Medicaid] managed care organization reimbursement allowance
19 fund shall be accepted as payment of the [Medicaid] managed care
20 organization's obligation imposed by section 208.431.

21 208.437. 1. A [Medicaid] managed care organization
22 reimbursement allowance period as provided in sections 208.431 to
23 ~~[208.437]~~ 208.438 shall be from the first day of July to the
24 thirtieth day of June. The department shall notify each
25 [Medicaid] managed care organization with a balance due on the
26 thirtieth day of June of each year the amount of such balance
27 due. If any managed care organization fails to pay its managed
28 care organization reimbursement allowance within thirty days of

1 such notice, the reimbursement allowance shall be delinquent.
2 The reimbursement allowance may remain unpaid during an appeal.

3 2. Except as otherwise provided in this section, if any
4 reimbursement allowance imposed under the provisions of sections
5 208.431 to [208.437] 208.438 is unpaid and delinquent, the
6 department of social services may compel the payment of such
7 reimbursement allowance in the circuit court having jurisdiction
8 in the county where the main offices of the [Medicaid] managed
9 care organization are located. In addition, the director of the
10 department of social services or the director's designee may
11 cancel or refuse to issue, extend or reinstate a [Medicaid]
12 contract agreement to any [Medicaid] managed care organization
13 which fails to pay such delinquent reimbursement allowance
14 required by sections 208.431 to [208.437] 208.438 unless under
15 appeal.

16 3. Except as otherwise provided in this section, failure to
17 pay a delinquent reimbursement allowance imposed under sections
18 208.431 to [208.437] 208.438 shall be grounds for denial,
19 suspension or revocation of a license granted by the department
20 of insurance, financial institutions and professional
21 registration. The director of the department of insurance,
22 financial institutions and professional registration may deny,
23 suspend or revoke the license of a [Medicaid] managed care
24 organization [with a contract under 42 U.S.C. Section 1396b(m)]
25 which fails to pay a managed care organization's delinquent
26 reimbursement allowance unless under appeal.

27 4. Nothing in sections 208.431 to [208.437] 208.438 shall
28 be deemed to effect or in any way limit the tax-exempt or

1 nonprofit status of any [Medicaid] managed care organization
2 [with a contract under 42 U.S.C. Section 1396b(m) granted by
3 state law].

4 5. Sections 208.431 to 208.437 shall expire on September
5 30, [2019] 2021.

6 208.438. The managed care organization reimbursement
7 allowance under sections 208.431 to 208.437 may be imposed on the
8 basis of revenue or enrollment and may impose differential rates
9 on Medicaid and commercial businesses; provided that the rate
10 applied to commercial businesses that do not provide MO HealthNet
11 services shall not exceed one dollar and eighty cents per member
12 per month.

13 208.480. Notwithstanding the provisions of section 208.471
14 to the contrary, sections 208.453 to 208.480 shall expire on
15 September 30, [2019] 2021.

16 338.550. 1. The pharmacy tax required by sections 338.500
17 to 338.550 shall expire ninety days after any one or more of the
18 following conditions are met:

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

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

27 (3) September 30, [2019] 2021.

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

8 2. Sections 338.500 to 338.550 shall expire on September
9 30, [2019] 2021.

10 633.401. 1. For purposes of this section, the following
11 terms mean:

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

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

23 (3) "Net operating revenues from providing services of
24 intermediate care facilities for the intellectually disabled"
25 shall include, without limitation, all moneys received on account
26 of such services pursuant to rates of reimbursement established
27 and paid by the department of social services, but shall not
28 include charitable contributions, grants, donations, bequests and

1 income from nonservice related fund-raising activities and
2 government deficit financing, contractual allowance, discounts or
3 bad debt;

4 (4) "Services of intermediate care facilities for the
5 intellectually disabled" has the same meaning as the term
6 services of intermediate care facilities for the mentally
7 retarded, as used in Title 42 United States Code, Section
8 1396b(w) (7) (A) (iv), as amended, and as such qualifies as a class
9 of health care services recognized in federal Public Law 102-234,
10 the Medicaid Voluntary Contribution and Provider Specific Tax
11 Amendments of 1991.

12 2. Beginning July 1, 2008, each provider of services of
13 intermediate care facilities for the intellectually disabled
14 shall, in addition to all other fees and taxes now required or
15 paid, pay assessments on their net operating revenues for the
16 privilege of engaging in the business of providing services of
17 the intermediate care facilities for the intellectually disabled
18 or developmentally disabled in this state.

19 3. Each facility's assessment shall be based on a formula
20 set forth in rules and regulations promulgated by the department
21 of mental health.

22 4. For purposes of determining rates of payment under the
23 medical assistance program for providers of services of
24 intermediate care facilities for the intellectually disabled, the
25 assessment imposed pursuant to this section on net operating
26 revenues shall be a reimbursable cost to be reflected as timely
27 as practicable in rates of payment applicable within the
28 assessment period, contingent, for payments by governmental

1 agencies, on all federal approvals necessary by federal law and
2 regulation for federal financial participation in payments made
3 for beneficiaries eligible for medical assistance under Title XIX
4 of the federal Social Security Act.

5 5. Assessments shall be submitted by or on behalf of each
6 provider of services of intermediate care facilities for the
7 intellectually disabled on a monthly basis to the director of the
8 department of mental health or his or her designee and shall be
9 made payable to the director of the department of revenue.

10 6. In the alternative, a provider may direct that the
11 director of the department of social services offset, from the
12 amount of any payment to be made by the state to the provider,
13 the amount of the assessment payment owed for any month.

14 7. Assessment payments shall be deposited in the state
15 treasury to the credit of the "Intermediate Care Facility
16 Intellectually Disabled Reimbursement Allowance Fund", which is
17 hereby created in the state treasury. All investment earnings of
18 this fund shall be credited to the fund. Notwithstanding the
19 provisions of section 33.080 to the contrary, any unexpended
20 balance in the intermediate care facility intellectually disabled
21 reimbursement allowance fund at the end of the biennium shall not
22 revert to the general revenue fund but shall accumulate from year
23 to year. The state treasurer shall maintain records that show
24 the amount of money in the fund at any time and the amount of any
25 investment earnings on that amount.

26 8. Each provider of services of intermediate care
27 facilities for the intellectually disabled shall keep such
28 records as may be necessary to determine the amount of the

1 assessment for which it is liable under this section. On or
2 before the forty-fifth day after the end of each month commencing
3 July 1, 2008, each provider of services of intermediate care
4 facilities for the intellectually disabled shall submit to the
5 department of social services a report on a cash basis that
6 reflects such information as is necessary to determine the amount
7 of the assessment payable for that month.

8 9. Every provider of services of intermediate care
9 facilities for the intellectually disabled shall submit a
10 certified annual report of net operating revenues from the
11 furnishing of services of intermediate care facilities for the
12 intellectually disabled. The reports shall be in such form as
13 may be prescribed by rule by the director of the department of
14 mental health. Final payments of the assessment for each year
15 shall be due for all providers of services of intermediate care
16 facilities for the intellectually disabled upon the due date for
17 submission of the certified annual report.

18 10. The director of the department of mental health shall
19 prescribe by rule the form and content of any document required
20 to be filed pursuant to the provisions of this section.

21 11. Upon receipt of notification from the director of the
22 department of mental health of a provider's delinquency in paying
23 assessments required under this section, the director of the
24 department of social services shall withhold, and shall remit to
25 the director of the department of revenue, an assessment amount
26 estimated by the director of the department of mental health from
27 any payment to be made by the state to the provider.

28 12. In the event a provider objects to the estimate

1 described in subsection 11 of this section, or any other decision
2 of the department of mental health related to this section, the
3 provider of services may request a hearing. If a hearing is
4 requested, the director of the department of mental health shall
5 provide the provider of services an opportunity to be heard and
6 to present evidence bearing on the amount due for an assessment
7 or other issue related to this section within thirty days after
8 collection of an amount due or receipt of a request for a
9 hearing, whichever is later. The director shall issue a final
10 decision within forty-five days of the completion of the hearing.
11 After reconsideration of the assessment determination and a final
12 decision by the director of the department of mental health, an
13 intermediate care facility for the intellectually disabled
14 provider's appeal of the director's final decision shall be to
15 the administrative hearing commission in accordance with sections
16 208.156 and 621.055.

17 13. Notwithstanding any other provision of law to the
18 contrary, appeals regarding this assessment shall be to the
19 circuit court of Cole County or the circuit court in the county
20 in which the facility is located. The circuit court shall hear
21 the matter as the court of original jurisdiction.

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

26 15. The director of the department of mental health shall
27 promulgate rules and regulations to implement this section. Any
28 rule or portion of a rule, as that term is defined in section

1 536.010, that is created under the authority delegated in this
2 section shall become effective only if it complies with and is
3 subject to all of the provisions of chapter 536 and, if
4 applicable, section 536.028. This section and chapter 536 are
5 nonseverable and if any of the powers vested with the general
6 assembly pursuant to chapter 536 to review, to delay the
7 effective date, or to disapprove and annul a rule are
8 subsequently held unconstitutional, then the grant of rulemaking
9 authority and any rule proposed or adopted after August 28, 2008,
10 shall be invalid and void.

11 16. The provisions of this section shall expire on
12 September 30, [2019] 2021.