

SECOND REGULAR SESSION  
HOUSE COMMITTEE SUBSTITUTE FOR  
**HOUSE BILL NO. 1410**  
**99TH GENERAL ASSEMBLY**

4388H.03C

D. ADAM CRUMBLISS, Chief Clerk

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**AN ACT**

To repeal sections 190.839, 198.439, 208.437, 208.471, 208.480, 338.550, and 633.401, RSMo, and to enact in lieu thereof seven new sections relating to reimbursement allowance taxes.

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

Section A. Sections 190.839, 198.439, 208.437, 208.471, 208.480, 338.550, and  
2 633.401, RSMo, are repealed and seven new sections enacted in lieu thereof, to be known as  
3 sections 190.839, 198.439, 208.437, 208.471, 208.480, 338.550, and 633.401, to read as follows:

190.839. Sections 190.800 to 190.839 shall expire on September 30, ~~2018~~ **2019**.

198.439. Sections 198.401 to 198.436 shall expire on September 30, ~~2018~~ **2019**.

208.437. 1. A Medicaid managed care organization reimbursement allowance period  
2 as provided in sections 208.431 to 208.437 shall be from the first day of July to the thirtieth day  
3 of June. The department shall notify each Medicaid managed care organization with a balance  
4 due on the thirtieth day of June of each year the amount of such balance due. If any managed  
5 care organization fails to pay its managed care organization reimbursement allowance within  
6 thirty days of such notice, the reimbursement allowance shall be delinquent. The reimbursement  
7 allowance may remain unpaid during an appeal.

8 2. Except as otherwise provided in this section, if any reimbursement allowance imposed  
9 under the provisions of sections 208.431 to 208.437 is unpaid and delinquent, the department of  
10 social services may compel the payment of such reimbursement allowance in the circuit court  
11 having jurisdiction in the county where the main offices of the Medicaid managed care  
12 organization are located. In addition, the director of the department of social services or the  
13 director's designee may cancel or refuse to issue, extend or reinstate a Medicaid contract

EXPLANATION — Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

14 agreement to any Medicaid managed care organization which fails to pay such delinquent  
15 reimbursement allowance required by sections 208.431 to 208.437 unless under appeal.

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

23 4. Nothing in sections 208.431 to 208.437 shall be deemed to effect or in any way limit  
24 the tax-exempt or nonprofit status of any Medicaid managed care organization with a contract  
25 under 42 U.S.C. Section 1396b(m) granted by state law.

26 5. Sections 208.431 to 208.437 shall expire on September 30, ~~[2018]~~ **2019**.

208.471. 1. The department of social services shall make payments to those hospitals  
2 which have a Medicaid provider agreement with the department. ~~[Prior to June 30, 2002, the  
3 payment shall be in an annual, aggregate statewide amount which is at least the same as that paid  
4 in fiscal year 1991-1992 pursuant to rules in effect on August 30, 1991, under the federally  
5 approved state plan amendments.]~~

6 2. ~~[Beginning July 1, 2002, sections 208.453 to 208.480 shall expire one hundred eighty  
7 days after the end of any state fiscal year in which the aggregate federal reimbursement  
8 allowance (FRA) assessment on hospitals is more than eighty-five percent of the sum of  
9 aggregate direct Medicaid payments, uninsured add-on payments and enhanced graduate medical  
10 education payments, unless during such one hundred eighty-day period, such payments or  
11 assessments are adjusted prospectively by the director of the department of social services to  
12 comply with the eighty-five percent test imposed by this subsection. Enhanced graduate medical  
13 education payments shall not be included in the calculation required by this subsection if the  
14 general assembly appropriates the state's share of such payments from a source other than the  
15 federal reimbursement allowance. For purposes of this section, direct Medicaid payments,  
16 uninsured add-on payments and enhanced graduate medical education payments shall:~~

17 ~~—— (1) Include direct Medicaid payments, uninsured add-on payments and enhanced  
18 graduate medical education payments as defined in state regulations as of July 1, 2000;~~

19 ~~—— (2) Include payments that substantially replace or supplant the payments described in  
20 subdivision (1) of this subsection;~~

21 ~~—— (3) Include new payments that supplement the payments described in subdivision (1) of  
22 this subsection; and~~

23 ~~———— (4) Exclude payments and assessments of acute care hospitals with an unsponsored care~~  
24 ~~ratio of at least sixty-five percent that are licensed to operate less than fifty inpatient beds in~~  
25 ~~which the state's share of such payments are made by certification.~~

26 ~~———— 3. The MO HealthNet division may provide an alternative reimbursement for outpatient~~  
27 ~~services. Other provisions of law to the contrary notwithstanding, the payment limits imposed~~  
28 ~~by subdivision (2) of subsection 1 of section 208.152 shall not apply to such alternative~~  
29 ~~reimbursement for outpatient services. Such alternative reimbursement may include enhanced~~  
30 ~~payments or grants to hospital-sponsored clinics serving low income uninsured patients.] In each~~  
31 ~~state fiscal year, the amount of federal reimbursement allowance levied under sections~~  
32 ~~208.450 to 208.482 shall not exceed forty-one percent of the total payments to hospitals~~  
33 ~~from the federal reimbursement allowance fund and associated federal match, including~~  
34 ~~payments made to hospitals from state-contracted managed care organizations that are~~  
35 ~~attributed to the federal reimbursement allowance fund and associated federal match. By~~  
36 ~~October first of each subsequent state fiscal year, the department shall report this~~  
37 ~~calculation and the underlying data supporting the calculation to the budget committee of~~  
38 ~~the house of representatives and the appropriations committee of the senate. The~~  
39 ~~underlying data shall include the amount of federal reimbursement allowance assessment~~  
40 ~~levied on the hospitals and the total amount of Medicaid payments to hospitals funded by~~  
41 ~~the federal reimbursement allowance, including payments made to hospitals from all state-~~  
42 ~~contracted managed care organizations in aggregate. Payments made by the department~~  
43 ~~to hospitals and payments made, in aggregate, by all state-contracted managed care~~  
44 ~~organizations to hospitals shall be reported separately. Expenditures reported by the~~  
45 ~~department and all state-contracted managed care organizations in aggregate shall be~~  
46 ~~broken down by fund source, inpatient or outpatient category of service, and individual~~  
47 ~~hospital. In addition, the department shall separately and concurrently disclose the~~  
48 ~~amount of hospital payments made by the department and the amount of hospital~~  
49 ~~payments made by each of the managed care plans, with the payment data broken down~~  
50 ~~by plan, fund source, inpatient or outpatient category of service, and individual hospital,~~  
51 ~~to the hospitals receiving such payments specific to that hospital or to an organization~~  
52 ~~designated by such hospitals to receive such data and as otherwise authorized or required~~  
53 ~~by law. Such payment data shall otherwise be regarded as proprietary and confidential~~  
54 ~~under subdivision (15) of section 610.021.~~

208.480. Notwithstanding the provisions of section 208.471 to the contrary, sections  
2 208.453 to 208.480 shall expire on September 30, [2018] 2019.

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

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

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

9 (3) September 30, ~~[2018]~~ **2019**.

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

16 2. Sections 338.500 to 338.550 shall expire on September 30, ~~[2018]~~ **2019**.

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

2 (1) “Engaging in the business of providing health benefit services”, accepting payment  
3 for health benefit services;

4 (2) “Intermediate care facility for the intellectually disabled”, a private or department of  
5 mental health facility which admits persons who are intellectually disabled or developmentally  
6 disabled for residential habilitation and other services pursuant to chapter 630. Such term shall  
7 include habilitation centers and private or public intermediate care facilities for the intellectually  
8 disabled that have been certified to meet the conditions of participation under 42 CFR, Section  
9 483, Subpart ~~[H]~~ **I**;

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

16 (4) “Services of intermediate care facilities for the intellectually disabled” has the same  
17 meaning as the term services of intermediate care facilities for the mentally retarded, as used in  
18 Title 42 United States Code, Section 1396b(w)(7)(A)(iv), as amended, and as such qualifies as  
19 a class of health care services recognized in federal Public Law 102-234, the Medicaid Voluntary  
20 Contribution and Provider-Specific Tax ~~[Amendment]~~ **Amendments** of 1991.

21 2. Beginning July 1, 2008, each provider of services of intermediate care facilities for  
22 the intellectually disabled shall, in addition to all other fees and taxes now required or paid, pay

23 assessments on their net operating revenues for the privilege of engaging in the business of  
24 providing services of the intermediate care facilities for the intellectually disabled or  
25 developmentally disabled in this state.

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

28         4. For purposes of determining rates of payment under the medical assistance program  
29 for providers of services of intermediate care facilities for the intellectually disabled, the  
30 assessment imposed pursuant to this section on net operating revenues shall be a reimbursable  
31 cost to be reflected as timely as practicable in rates of payment applicable within the assessment  
32 period, contingent, for payments by governmental agencies, on all federal approvals necessary  
33 by federal law and regulation for federal financial participation in payments made for  
34 beneficiaries eligible for medical assistance under Title XIX of the federal Social Security Act,  
35 **42 U.S.C. Section 1396 et seq., as amended.**

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

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

43         7. Assessment payments shall be deposited in the state treasury to the credit of the  
44 “Intermediate Care Facility Intellectually Disabled Reimbursement Allowance Fund”, which is  
45 hereby created in the state treasury. All investment earnings of this fund shall be credited to the  
46 fund. Notwithstanding the provisions of section 33.080 to the contrary, any unexpended balance  
47 in the intermediate care facility intellectually disabled reimbursement allowance fund at the end  
48 of the biennium shall not revert to the general revenue fund but shall accumulate from year to  
49 year. The state treasurer shall maintain records that show the amount of money in the fund at  
50 any time and the amount of any investment earnings on that amount.

51         8. Each provider of services of intermediate care facilities for the intellectually disabled  
52 shall keep such records as may be necessary to determine the amount of the assessment for which  
53 it is liable under this section. On or before the forty-fifth day after the end of each month  
54 commencing July 1, 2008, each provider of services of intermediate care facilities for the  
55 intellectually disabled shall submit to the department of social services a report on a cash basis  
56 that reflects such information as is necessary to determine the amount of the assessment payable  
57 for that month.

58           9. Every provider of services of intermediate care facilities for the intellectually disabled  
59 shall submit a certified annual report of net operating revenues from the furnishing of services  
60 of intermediate care facilities for the intellectually disabled. The reports shall be in such form  
61 as may be prescribed by rule by the director of the department of mental health. Final payments  
62 of the assessment for each year shall be due for all providers of services of intermediate care  
63 facilities for the intellectually disabled upon the due date for submission of the certified annual  
64 report.

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

67           11. Upon receipt of notification from the director of the department of mental health of  
68 a provider's delinquency in paying assessments required under this section, the director of the  
69 department of social services shall withhold, and shall remit to the director of the department of  
70 revenue, an assessment amount estimated by the director of the department of mental health from  
71 any payment to be made by the state to the provider.

72           12. In the event a provider objects to the estimate described in subsection 11 of this  
73 section, or any other decision of the department of mental health related to this section, the  
74 provider of services may request a hearing. If a hearing is requested, the director of the  
75 department of mental health shall provide the provider of services an opportunity to be heard and  
76 to present evidence bearing on the amount due for an assessment or other issue related to this  
77 section within thirty days after collection of an amount due or receipt of a request for a hearing,  
78 whichever is later. The director shall issue a final decision within forty-five days of the  
79 completion of the hearing. After reconsideration of the assessment determination and a final  
80 decision by the director of the department of mental health, an intermediate care facility for the  
81 intellectually disabled provider's appeal of the director's final decision shall be to the  
82 administrative hearing commission in accordance with sections 208.156 and 621.055.

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

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

89           15. The director of the department of mental health shall promulgate rules and  
90 regulations to implement this section. Any rule or portion of a rule, as that term is defined in  
91 section 536.010, that is created under the authority delegated in this section shall become  
92 effective only if it complies with and is subject to all of the provisions of chapter 536 and, if  
93 applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the

94 powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective  
95 date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of  
96 rulemaking authority and any rule proposed or adopted after August 28, 2008, shall be invalid  
97 and void.

98 16. The provisions of this section shall expire on September 30, ~~2018~~ **2019**.

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