SECOND REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED]

CONFERENCE COMMITTEE SUBSTITUTE FOR

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 775

99TH GENERAL ASSEMBLY

2018

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5226S.05T

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.

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,
2 and 633.401, RSMo, are repealed and seven new sections enacted in lieu thereof,
3 to be known as sections 190.839, 198.439, 208.437, 208.471, 208.480, 338.550, and
4 633.401, to read as follows:

190.839. Sections 190.800 to 190.839 shall expire on September 30, **[**2018**]**
2 **2019**.

198.439. Sections 198.401 to 198.436 shall expire on September 30, **[**2018**]**
2 **2019**.

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

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

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

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

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

32 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
2 those hospitals which have a Medicaid provider agreement with the
3 department. **[**Prior to June 30, 2002, the payment shall be in an annual,
4 aggregate statewide amount which is at least the same as that paid in fiscal year
5 1991-1992 pursuant to rules in effect on August 30, 1991, under the federally
6 approved state plan amendments.**]**

7 2. **[**Beginning July 1, 2002, sections 208.453 to 208.480 shall expire one
8 hundred eighty days after the end of any state fiscal year in which the aggregate
9 federal reimbursement allowance (FRA) assessment on hospitals is more than
10 eighty-five percent of the sum of aggregate direct Medicaid payments, uninsured
11 add-on payments and enhanced graduate medical education payments, unless
12 during such one hundred eighty-day period, such payments or assessments are

13 adjusted prospectively by the director of the department of social services to
14 comply with the eighty-five percent test imposed by this subsection. Enhanced
15 graduate medical education payments shall not be included in the calculation
16 required by this subsection if the general assembly appropriates the state's share
17 of such payments from a source other than the federal reimbursement
18 allowance. For purposes of this section, direct Medicaid payments, uninsured
19 add-on payments and enhanced graduate medical education payments shall:
20 (1) Include direct Medicaid payments, uninsured add-on payments and
21 enhanced graduate medical education payments as defined in state regulations
22 as of July 1, 2000;
23 (2) Include payments that substantially replace or supplant the payments
24 described in subdivision (1) of this subsection;
25 (3) Include new payments that supplement the payments described in
26 subdivision (1) of this subsection; and
27 (4) Exclude payments and assessments of acute care hospitals with an
28 unsponsored care ratio of at least sixty-five percent that are licensed to operate
29 less than fifty inpatient beds in which the state's share of such payments are
30 made by certification.
31 3. The MO HealthNet division may provide an alternative reimbursement
32 for outpatient services. Other provisions of law to the contrary notwithstanding,
33 the payment limits imposed by subdivision (2) of subsection 1 of section 208.152
34 shall not apply to such alternative reimbursement for outpatient services. Such
35 alternative reimbursement may include enhanced payments or grants to
36 hospital-sponsored clinics serving low income uninsured patients.**]** **In each state**
37 **fiscal year, the amount of federal reimbursement allowance levied**
38 **under sections 208.450 to 208.482 shall not exceed forty-five percent of**
39 **the total payments to hospitals from the federal reimbursement**
40 **allowance fund and associated federal match, including payments made**
41 **to hospitals from state-contracted managed care organizations that are**
42 **attributed to the federal reimbursement allowance fund and associated**
43 **federal match. By October first of each subsequent state fiscal year, the**
44 **department shall report this calculation and the underlying data**
45 **supporting the calculation to the budget committee of the house of**
46 **representatives and the appropriations committee of the senate. The**
47 **underlying data shall include the amount of federal reimbursement**
48 **allowance assessment levied on the hospitals and the total amount of**

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49 **Medicaid payments to hospitals funded by the federal reimbursement**
50 **allowance, including payments made to hospitals from all state-**
51 **contracted managed care organizations in aggregate. Payments made**
52 **by the department to hospitals and payments made, in aggregate, by all**
53 **state-contracted managed care organizations to hospitals shall be**
54 **reported separately. Expenditures reported by the department and all**
55 **state-contracted managed care organizations in aggregate shall be**
56 **broken down by fund source, inpatient or outpatient category of**
57 **service, and individual hospital. In addition, the department shall**
58 **separately and concurrently disclose the amount of hospital payments**
59 **made by the department and the amount of hospital payments made by**
60 **each of the managed care plans, with the payment data broken down**
61 **by plan, fund source, inpatient or outpatient category of service, and**
62 **individual hospital, to the hospitals receiving such payments specific**
63 **to that hospital or to an organization designated by such hospitals to**
64 **receive such data and as otherwise authorized or required by law.**
65 **Such payment data shall otherwise be regarded as proprietary and**
66 **confidential under subdivision (15) of section 610.021.**

208.480. Notwithstanding the provisions of section 208.471 to the
2 contrary, sections 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
2 shall expire 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
4 paid to pharmacists per prescription is less than the fiscal year 2003 dispensing
5 fees reimbursement amount; or
6 (2) The formula used to calculate the reimbursement as appropriated by
7 the general assembly for products dispensed by pharmacies is changed resulting
8 in lower reimbursement to the pharmacist in the aggregate than provided in
9 fiscal year 2003; or
10 (3) September 30, **[**2018**]** **2019**.
11 The director of the department of social services shall notify the revisor of
12 statutes of the expiration date as provided in this subsection. The provisions of
13 sections 338.500 to 338.550 shall not apply to pharmacies domiciled or
14 headquartered outside this state which are engaged in prescription drug sales
15 that are delivered directly to patients within this state via common carrier, mail
16 or a carrier service.

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17 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",
3 accepting payment for health benefit services;

4 (2) "Intermediate care facility for the intellectually disabled", a private or
5 department of mental health facility which admits persons who are intellectually
6 disabled or developmentally disabled for residential habilitation and other
7 services pursuant to chapter 630. Such term shall include habilitation centers
8 and private or public intermediate care facilities for the intellectually disabled
9 that have been certified to meet the conditions of participation under 42 CFR,
10 Section 483, Subpart **[**1**] I**;

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

18 (4) "Services of intermediate care facilities for the intellectually disabled"
19 has the same meaning as the term services of intermediate care facilities for the
20 mentally retarded, as used in Title 42 United States Code, Section
21 1396b(w)(7)(A)(iv), as amended, and as such qualifies as a class of health care
22 services recognized in federal Public Law 102-234, the Medicaid Voluntary
23 Contribution and Provider Specific Tax **[**Amendment**] Amendments** of 1991.

24 2. Beginning July 1, 2008, each provider of services of intermediate care
25 facilities for the intellectually disabled shall, in addition to all other fees and
26 taxes now required or paid, pay assessments on their net operating revenues for
27 the privilege of engaging in the business of providing services of the intermediate
28 care facilities for the intellectually disabled or developmentally disabled in this
29 state.

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

32 4. For purposes of determining rates of payment under the medical
33 assistance program for providers of services of intermediate care facilities for the
34 intellectually disabled, the assessment imposed pursuant to this section on net
35 operating revenues shall be a reimbursable cost to be reflected as timely as

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36 practicable in rates of payment applicable within the assessment period,
37 contingent, for payments by governmental agencies, on all federal approvals
38 necessary by federal law and regulation for federal financial participation in
39 payments made for beneficiaries eligible for medical assistance under Title XIX
40 of the federal Social Security Act.

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

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

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

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

67 9. Every provider of services of intermediate care facilities for the
68 intellectually disabled shall submit a certified annual report of net operating
69 revenues from the furnishing of services of intermediate care facilities for the
70 intellectually disabled. The reports shall be in such form as may be prescribed
71 by rule by the director of the department of mental health. Final payments of the

72 assessment for each year shall be due for all providers of services of intermediate
73 care facilities for the intellectually disabled upon the due date for submission of
74 the certified annual report.

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

78 11. Upon receipt of notification from the director of the department of
79 mental health of a provider's delinquency in paying assessments required under
80 this section, the director of the department of social services shall withhold, and
81 shall remit to the director of the department of revenue, an assessment amount
82 estimated by the director of the department of mental health from any payment
83 to be made by the state to the provider.

84 12. In the event a provider objects to the estimate described in subsection
85 11 of this section, or any other decision of the department of mental health
86 related to this section, the provider of services may request a hearing. If a
87 hearing is requested, the director of the department of mental health shall
88 provide the provider of services an opportunity to be heard and to present
89 evidence bearing on the amount due for an assessment or other issue related to
90 this section within thirty days after collection of an amount due or receipt of a
91 request for a hearing, whichever is later. The director shall issue a final decision
92 within forty-five days of the completion of the hearing. After reconsideration of
93 the assessment determination and a final decision by the director of the
94 department of mental health, an intermediate care facility for the intellectually
95 disabled provider's appeal of the director's final decision shall be to the
96 administrative hearing commission in accordance with sections 208.156 and
97 621.055.

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

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

105 15. The director of the department of mental health shall promulgate
106 rules and regulations to implement this section. Any rule or portion of a rule, as
107 that term is defined in section 536.010, that is created under the authority

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108 delegated in this section shall become effective only if it complies with and is
109 subject to all of the provisions of chapter 536 and, if applicable, section
110 536.028. This section and chapter 536 are nonseverable and if any of the powers
111 vested with the general assembly pursuant to chapter 536 to review, to delay the
112 effective date, or to disapprove and annul a rule are subsequently held
113 unconstitutional, then the grant of rulemaking authority and any rule proposed
114 or adopted after August 28, 2008, shall be invalid and void.

115 16. The provisions of this section shall expire on September 30, **[**2018**]**
116 **2019**.

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