FIRST REGULAR SESSION

HOUSE BILL NO. 741

92ND GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES BEARDEN, JETTON, WRIGHT, REINHART, PORTWOOD (Co-sponsors) AND PURGASON.

Read 1st time April 10, 2003, and copies ordered printed.

STEPHEN S. DAVIS, Chief Clerk

2083L.02I

AN ACT

To repeal sections 208.152, 208.153, 208.154, 208.156, 208.162, 338.501, 338.515, 338.520, 338.525, 338.545, and 338.550, RSMo, and to enact in lieu thereof nine new sections relating to medical assistance benefits.

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

Section A. Sections 208.152, 208.153, 208.154, 208.156, 208.162, 338.501, 338.515, 338.520, 338.525, 338.545, and 338.550, RSMo, are repealed and nine new sections enacted in lieu thereof, to be known as sections 208.149, 208.152, 208.153, 208.154, 208.156, 208.162, 338.515, 338.520, and 338.550, to read as follows:

208.149. Notwithstanding any provision of law to the contrary, any benefit payments for medical assistance not mandated by federal law, including those medical benefits available for federal financial participation to states participating in the Medicaid program and those benefits funded solely by the state shall be subject to appropriation and contingent upon available moneys. Resources available shall be documented by the moneys appropriated in the appropriations bill and signed by the governor and any withholdings imposed by the governor. If the department is bound by federally mandated requirements, the department or its divisions shall not be required to file a notice of proposed rulemaking as referenced in chapter 536, RSMo.

2. Notwithstanding any statutory provision to the contrary, providers of medical assistance benefits shall be administered within appropriations provided; except that nothing in this subsection shall be construed as permitting a reduction in provider fees.

3. The department of social services and its divisions may reduce expenditures in

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

response to withholdings announced by the governor to conform with available moneys; except that nothing in this subsection shall be construed as permitting a reduction in provider fees.

4. If services or payments must be reduced to modify expenditures to conform to available moneys, the department of social services or its divisions may establish prior authorization of services by emergency rule based on the need of the agency to conform with available moneys.

5. If services or payments are reduced to modify expenditures to conform to available moneys, the agency is not required to grant a hearing if the sole issue is a program change pursuant to law that adversely affects some or all recipients.

208.152. 1. Benefit payments for medical assistance shall be made on behalf of those eligible needy persons who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the division of medical services, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the division of medical services shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the Medicaid children's diagnosis length-of-stay schedule; and provided further that the division of medical services shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et seq.), but the division of medical services may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the division of medical services not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for recipients, except to persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the division of aging or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX,

of the federal Social Security Act (42 U.S.C. 301, et seq.), as amended, for nursing facilities. The division of medical services may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of Medicaid patients. The division of medical services when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

(5) Nursing home costs for recipients of benefit payments under subdivision (4) of this section for those days, which shall not exceed twelve per any period of six consecutive months, during which the recipient is on a temporary leave of absence from the hospital or nursing home, provided that no such recipient shall be allowed a temporary leave of absence unless it is specifically provided for in his plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a recipient is away from the hospital or nursing home overnight because he is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere;

(7) **[**Dental services;

(8)**]** Services of podiatrists as defined in section 330.010, RSMo;

[(9) Drugs and medicines when prescribed by a licensed physician, dentist, or podiatrist**]** **(8) Prescription and nonprescription drugs and items directly related to their administration if prescribed by a health care professional authorized in their state of residence to issue a prescription and if such drugs are cost effective. Such drugs and items shall be approved for safety and effectiveness under Section 505 or 507 of the Federal Food, Drug and Cosmetic Act**;

[(10)**]** **(9)** Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments. The department of social services may conduct demonstration projects related to the provision of medically necessary transportation to recipients of medical assistance under this chapter. Such demonstration projects shall be funded only by appropriations made for the purpose of such demonstration projects. If funds are appropriated for such demonstration projects, the department shall submit to the general assembly a report on the significant aspects and results of such demonstration projects;

[(11)**]** **(10)** Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of section 6403 of P.L.53 101-239

and federal regulations promulgated thereunder;

[(12)**] (11)** Home health care services;

[(13)**] (12)** Optometric services as defined in section 336.010, RSMo;

[(14)**] (13)** Family planning as defined by federal rules and regulations; provided, however, that such family planning services shall not include abortions unless such abortions are certified in writing by a physician to the Medicaid agency that, in his professional judgment, the life of the mother would be endangered if the fetus were carried to term;

[(15)**] (14)** Orthopedic devices or other prosthetics, including **one pair of** eye glasses **following cataract surgery**, **[**dentures,**]** hearing aids, and wheelchairs;

[(16)**] (15)** Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C. 1396d, et seq.);

[(17)**] (16)** Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

[(18)**] (17)** Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his **or her** physician on an outpatient, rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the recipient's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one recipient one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time;

[(19)**] (18)** Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. 301, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility.

Such mental health services shall include:

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(b) Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(c) Rehabilitative mental health and alcohol and drug abuse services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, "mental health professional" and "alcohol and drug abuse professional" shall be defined by the department of mental health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, division of medical services, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the division of medical services. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

[(20)**]** **(19)** Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive and behavioral function. The division of medical services shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism;

[(21)**]** **(20)** Hospice care. As used in this subsection, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically

directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. Beginning July 1, 1990, the rate of reimbursement paid by the division of medical services to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

[(22)**] (21)** Such additional services as defined by the division of medical services to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. 301, et seq.) subject to appropriation by the general assembly;

[(23)**] (22)** Beginning July 1, 1990, the services of a certified pediatric or family nursing practitioner to the extent that such services are provided in accordance with chapter 335, RSMo, and regulations promulgated thereunder, regardless of whether the nurse practitioner is supervised by or in association with a physician or other health care provider;

[(24)**] (23)** Subject to appropriations, the department of social services shall conduct demonstration projects for nonemergency, physician-prescribed transportation for pregnant women who are recipients of medical assistance under this chapter in counties selected by the director of the division of medical services. The funds appropriated pursuant to this subdivision shall be used for the purposes of this subdivision and for no other purpose. The department shall not fund such demonstration projects with revenues received for any other purpose. This subdivision shall not authorize transportation of a pregnant woman in active labor. The division of medical services shall notify recipients of nonemergency transportation services under this subdivision of such other transportation services which may be appropriate during active labor or other medical emergency;

[(25)**] (24)** Nursing home costs for recipients of benefit payments under subdivision (4) of this subsection to reserve a bed for the recipient in the nursing home during the time that the recipient is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of Medicaid certified licensed beds, according to the most recent quarterly census provided to the **[**division of aging**] department of health and senior services** which was taken prior to when

the recipient is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a recipient pursuant to this subdivision during any period of six consecutive months such recipient shall, during the same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the recipient or the recipient's responsible party that the recipient intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the recipient or the recipient's responsible party prior to release of the reserved bed.

2. Benefit payments for medical assistance for surgery as defined by rule duly promulgated by the division of medical services, and any costs related directly thereto, shall be made only when a second medical opinion by a licensed physician as to the need for the surgery is obtained prior to the surgery being performed.

3. The division of medical services may require any recipient of medical assistance to pay part of the charge or cost, as defined by rule duly promulgated by the division of medical services, for **[**dental services, drugs and medicines, optometric services, eye glasses, dentures, hearing aids, and other**] all covered** services, to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, RSMo, and a generic drug is substituted for a name brand drug, the division of medical services may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all recipients the partial payment that may be required by the division of medical services under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by recipients under this section shall be in addition to, and not in lieu of, any payments made by the state for goods or services described herein.

4. The division of medical services shall have the right to collect medication samples from recipients in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of

subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for medical assistance at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for medical assistance under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the Medicaid program shall not increase payments in excess of the increase that would result from the application of section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. 1396a (a)(13)(C).

10. The department of social services, division of medical services, may enroll qualified residential care facilities, as defined in chapter 198, RSMo, as Medicaid personal care providers.

208.153. 1. Pursuant to and not inconsistent with the provisions of sections 208.151 and 208.152, the division of medical services shall by rule and regulation define the reasonable costs, manner, extent, quantity, quality, charges and fees of medical assistance herein provided **on a basis ensuring the greatest amount of medical care consonant with the moneys available**. The benefits available under these sections shall not replace those provided under other federal or state law or under other contractual or legal entitlements of the persons receiving them, and all persons shall be required to apply for and utilize all benefits available to them and to pursue all causes of action to which they are entitled. Any person entitled to medical assistance may obtain it from any provider of services with which an agreement is in effect under this section and which undertakes to provide the services, as authorized by the division of medical services. At the discretion of the director of medical services and with the approval of the governor, the

division of medical services is authorized to provide medical benefits for recipients of public assistance by expending funds for the payment of federal medical insurance premiums, coinsurance and deductibles pursuant to the provisions of Title XVIII B and XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301 et seq.), as amended.

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

3. Beginning July 1, 1990, medical assistance shall include benefit payments for Medicare Part A cost sharing as defined in clause (p)(3)(A)(i) of 42 U.S.C. 1396d on behalf of qualified disabled and working individuals as defined in subsection (s) of section 42 U.S.C. 1396d as required by subsection (d) of section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989). The division of medical services may impose a premium for such benefit payments as authorized by paragraph (d)(3) of section 6408 of P.L. 101-239.

4. Medical assistance shall include benefit payments for Medicare Part B cost-sharing described in 42 U.S.C. section 1396(d)(p)(3)(A)(ii) for individuals described in subsection 2 of this section, but for the fact that their income exceeds the income level established by the state under 42 U.S.C. section 1396(d)(p)(2) but is less than one hundred and ten percent beginning January 1, 1993, and less than one hundred and twenty percent beginning January 1, 1995, of the official poverty line for a family of the size involved.

5. Beginning July 1, 1991, for an individual eligible for medical assistance under Title XIX of the Social Security Act, medical assistance shall include payment of enrollee premiums in a group health plan and all deductibles, coinsurance and other cost-sharing for items and services otherwise covered under the state Title XIX plan under section 1906 of the federal Social Security Act and regulations established under the authority of section 1906, as may be amended. Enrollment in a group health plan must be cost effective, as established by the Secretary of Health and Human Services, before enrollment in the group health plan is required. If all members of a family are not eligible for medical assistance under Title XIX and enrollment of the Title XIX eligible members in a group health plan is not possible unless all family members are enrolled, all premiums for noneligible members shall be treated as payment for medical assistance of eligible family members.

Payment for noneligible family members must be cost effective, taking into account payment of all such premiums. Non-Title XIX eligible family members shall pay all deductible, coinsurance and other cost-sharing obligations. Each individual as a condition of eligibility for medical

assistance shall apply for enrollment in the group health plan.

208.154. If the funds at the disposal or which may be obtained by the **[**division of family services**]** **department of social services or its divisions** for the payment of public assistance money payment benefits or to or on behalf of any person for medical assistance benefits shall at any time become insufficient to pay the full amount thereof, the amount of any type of payment to or on behalf of each of such persons shall be reduced pro rata **during the final six months of the fiscal year** in proportion to such deficiency **as based on the consensus budget estimates and first quarter actual receipts** in the total amount available or to become available for such purpose.

208.156. 1. The **[**division of family services**]** **department of social services or its divisions** shall provide for granting an opportunity for a fair hearing under section 208.080 to any applicant or recipient whose claim for medical assistance is denied or is not acted upon with reasonable promptness.

2. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 whose claim for reimbursement for such services is denied or is not acted upon with reasonable promptness shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.

3. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 who is denied participation in any program or programs established under the provisions of chapter 208 shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.

4. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 who is aggrieved by any rule or regulation promulgated by the department of social services or any division therein shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.

5. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 who is aggrieved by any rule or regulation, contractual agreement, or decision, as provided for in section 208.166, by the department of social services or any division therein shall be entitled to a hearing before the administrative hearing commission pursuant to the provisions of chapter 621, RSMo.

6. No provider of service may file a petition for a hearing before the administrative hearing commission unless the amount for which he **or she** seeks reimbursement exceeds five hundred dollars.

7. One or more providers of service as will fairly insure adequate representation of others having similar claims against the department of social services or any division therein may

institute the hearing on behalf of all in the class if there is a common question of law or fact affecting the several rights and a common relief is sought.

8. Any person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152 and who is entitled to a hearing as provided for in the preceding sections shall have thirty days from the date of mailing or delivery of a decision of the department of social services or its designated division in which to file his **or her** petition for review with the administrative hearing commission except that claims of less than five hundred dollars may be accumulated until they total that sum and at which time the provider shall have ninety days to file his **or her** petition.

9. When a person entitled to a hearing as provided for in this section applies to the administrative hearing commission for a stay order staying the actions of the department of social services or its divisions, the administrative hearing commission shall not grant such stay order until after a full hearing on such application. The application shall be advanced on the docket for immediate hearing and determination. The person applying for such stay order shall not be granted such stay order unless that person shall show that immediate and irreparable injury, loss, or damage will result if such stay order is denied, or that such person has a reasonable likelihood of success upon the merits of his **or her** claim; and provided further that no stay order shall be issued without the person seeking such order posting a bond in such sum as the administrative hearing commission finds sufficient to protect and preserve the interest of the department of social services or its divisions. In no event may the administrative hearing commission grant such stay order where the claim arises under a program or programs funded by federal funds or by any combination of state and federal funds, unless it is specified in writing by the financial section of the appropriate federal agency that federal financial participation will be continued under the stay order.

10. The other provisions of this section notwithstanding, a person receiving or providing benefits shall have the right to bring an action in appealing from the administrative hearing commission in the circuit court of Cole County, Missouri, or the county of his **or her** residence pursuant to section 536.050, RSMo.

11. If services or payments are reduced to modify expenditures to conform to available moneys, the department of social services and its divisions shall not be required to grant a hearing if the sole issue is a program change pursuant to law which adversely affects some or all recipients.

208.162. 1. Benefit payments for medical assistance shall be made on behalf of those individuals who **[**are receiving general relief benefits under section 208.015**]** **would have been eligible for general relief benefits as defined on June 30, 2003**, with any payments to be made on the basis of reasonable cost of the care or reasonable charge for the services as defined and

determined by the division of family services, for the following, provided that the division of family services may negotiate a rate of payment for hospital services different than the Medicare rate for such services:

(1) Inpatient hospital services, including the first three pints of whole blood unless available to the patient from other sources; provided, that in the case of eligible persons who are provided benefits under Title XVIII A, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C.A. section 301 et seq.), as amended, payment for the first ninety days during any spell of illness shall not exceed the cost of any deductibles imposed by such title, plus coinsurance after the first sixty days;

(2) All outpatient hospital services, including diagnostic services; provided, however, that the division of family services shall evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the division of family services not to be medically necessary;

(3) Laboratory and X-ray services;

(4) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere;

(5) Drugs and medicines when prescribed by a licensed physician;

(6) Emergency ambulance services;

(7) Any other services provided under section 208.152, to the extent and in the manner as defined and determined by the division of family services.

2. The division of family services shall have the right to collect medication samples from recipients in order to maintain program integrity.

3. Payments shall be prorated within the limits of the appropriation.

4. No rule or portion of a rule promulgated under the authority of this section shall become effective unless it has been promulgated pursuant to the provisions of **[**section 536.024**]** **chapter 536**, RSMo.

338.515. The tax imposed by sections 338.500 to 338.550 shall become effective July 1, **[**2002**]** **2003**, or the effective date of sections 338.500 to 338.550, whichever is later.

338.520. 1. The determination of the amount of tax due shall be the monthly gross retail prescription receipts reported to the department of revenue multiplied by the tax rate established by rule by the department of social services. Such tax rate may be a graduated rate based on gross retail prescription receipts and shall not exceed a rate of six percent per annum of gross retail prescription receipts; provided, that such rate shall not exceed one-tenth of one percent per annum in the case of licensed pharmacies of which eighty percent or more of such gross receipts are attributable to prescription drugs that are delivered directly to the patient via common carrier, by mail, or a courier service.

2. The department of social services shall notify each licensed retail pharmacy of the amount of tax due. Such amount may be paid in increments over the balance of the assessment period.

3. The department of social services may adjust the tax rate quarterly on a prospective basis. The department of social services may adjust more frequently for individual providers if there is a substantial and statistically significant change in their pharmacy sales characteristics. The department of social services may define such adjustment criteria by rule.

338.550. 1. The pharmacy tax required by sections 338.500 to 338.550 shall **[**be the subject of an annual health care cost impact study commissioned by the department of insurance to be completed prior to or on January 1, 2003, and each year the tax is in effect. The report shall be submitted to the speaker of the house, president pro tem of the senate, and the governor. This study shall employ an independent economist and an independent actuary paid for by the state's department of social services. The department shall seek the advice and input from the department of social services, business health care purchasers, as well as health care insurers in the selection of the economist and actuary. This study shall assess the degree of health care costs shifted to individual Missourians and individual and group health plans resulting from this tax.

2.**]** **expire ninety days after any one or more of the following conditions are met:**

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

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

(3) July 1, 2005.

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

[3.**]** **2.** Sections 338.500 to 338.550 shall expire on June 30, **[**2003**]** **2005**.

[338.501. In fiscal year 2003, the amount generated by the tax imposed pursuant to section 338.500, less any amount paid pursuant to section 338.545, shall be used in the formula necessary to qualify for the calculations included in house bill 1102, section 2.325 through section 2.333 as passed by the ninety-first general assembly, second regular session.**]**

[338.525. If a pharmacy's gross retail prescription receipts are included in the

revenue assessed by the federal reimbursement allowance or the nursing facility reimbursement allowance, the proportion of those taxes paid or the entire tax due shall be allowed as a credit for the pharmacy tax due pursuant to section 338.500.**]**

[338.545. 1. The Medicaid pharmacy dispensing fee shall be adjusted to include a supplemental payment amount equal to the tax assessment due plus ten percent.

2. The amount of the supplemental payment shall be adjusted once annually beginning July first or once annually after the initial start date of the pharmacy tax, whichever is later.

3. If the pharmacy tax required by sections 338.500 to 338.550 is declared invalid, the pharmacy dispensing fee for the Medicaid program shall be the same as the amount required on July 1, 2001.**]**