SECOND REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 563

99TH GENERAL ASSEMBLY

4371H.03C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 208.431, 208.432, 208.433, 208.434, 208.435, 208.436, 208.437, 208.471, 208.480, and 208.790, RSMo, and to enact in lieu thereof ten new sections relating to the MO HealthNet program, with a delayed effective date for a certain section.

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

Section A. Sections 208.431, 208.432, 208.433, 208.434, 208.435, 208.436, 208.437, 208.471, 208.480, and 208.790, RSMo, are repealed and ten new sections enacted in lieu thereof, to be known as sections 208.431, 208.432, 208.433, 208.434, 208.435, 208.436, 208.437, 208.471, 208.480, and 208.790, to read as follows:

208.431. 1. For purposes of sections 208.431 to 208.437, the following terms mean:

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

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

2. Beginning July 1, **[**~~2005~~**] 2019**, each **[**~~Medicaid~~**]** managed care organization in this state shall, in addition to all other fees and taxes now required or paid, pay a **[**~~Medicaid~~**]** managed care organization reimbursement allowance for the privilege of engaging in the business of providing health benefit services in this state. **The managed care organization reimbursement allowance may be imposed on the basis of revenue or enrollment and may impose differential rates on Medicaid and commercial business. The managed care organization**

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.

reimbursement allowance shall not apply to an organization that is exempt from assessment under federal law under 42 CFR 422.404 or 5 U.S.C. Section 8909(f)(1).

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

208.432. Each **[**~~Medicaid~~**]** managed care organization shall keep such records as may be necessary to determine the amount of its reimbursement allowance. Every **[**~~Medicaid~~**]** managed care organization shall submit to the department of social services a statement that accurately reflects such information as is necessary to determine that **[**~~Medicaid~~**]** managed care organization's reimbursement allowance.

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

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

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

208.434. 1. Each **[**~~Medicaid~~**]** managed care organization reimbursement allowance determination shall be final after receipt of written notice from the department of social services, unless the **[**~~Medicaid~~**]** managed care organization files a protest with the director of the department of social services setting forth the grounds on which the protest is based, within thirty

days from the date of receipt of written notice from the department of social services to the managed care organization.

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

208.435. 1. The department of social services shall promulgate rules, including emergency rules if necessary, to implement the provisions of sections 208.431 to 208.437, including but not limited to:

(1) The form and content of any documents required to be filed under sections 208.431 to 208.437;

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

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

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

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

(2) The amount remitted shall be deposited in the state treasury to the credit of the "**[**~~Medicaid~~**]** Managed Care Organization Reimbursement Allowance Fund", which is hereby created for the sole purposes of providing payment to **[**~~Medicaid~~**]** managed care organizations.

All investment earnings of the managed care organization reimbursement allowance fund shall be credited to the **[**~~Medicaid~~**]** managed care organization reimbursement allowance fund.

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

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

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

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

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

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

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

5. Sections 208.431 to 208.437 shall expire on September 30, **[**~~2018~~**] 2020**.

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

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

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

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

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

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

~~3. The MO HealthNet division may provide an alternative reimbursement for outpatient services. Other provisions of law to the contrary notwithstanding, the payment limits imposed by subdivision (2) of subsection 1 of section 208.152 shall not apply to such alternative reimbursement for outpatient services. Such alternative reimbursement may include enhanced payments or grants to hospital-sponsored clinics serving low income uninsured patients.~~**] In each state fiscal year, the amount of federal reimbursement allowance levied under sections 208.450 to 208.482 shall not exceed forty-one percent of the total payments to hospitals**

from the federal reimbursement allowance fund and associated federal match, including payments made to hospitals from state-contracted managed care organizations that are attributed to the federal reimbursement allowance fund and associated federal match. By October first of each subsequent state fiscal year, the department shall report this calculation and the underlying data supporting the calculation to the budget committee of the house of representatives and the appropriations committee of the senate. The underlying data shall include the amount of federal reimbursement allowance assessment levied on the hospitals and the total amount of Medicaid payments to hospitals funded by the federal reimbursement allowance, including payments made to hospitals from all state-contracted managed care organizations in aggregate. Payments made by the department to hospitals and payments made, in aggregate, by all state-contracted managed care organizations to hospitals shall be reported separately. Expenditures reported by the department and all state-contracted managed care organizations in aggregate shall be broken down by fund source, inpatient or outpatient category of service, and individual hospital. In addition, the department shall separately and concurrently disclose the amount of hospital payments made by the department and the amount of hospital payments made by each of the managed care plans, with the payment data broken down by plan, fund source, inpatient or outpatient category of service, and individual hospital, to the hospitals receiving such payments specific to that hospital or to an organization designated by such hospitals to receive such data and as otherwise authorized or required by law. Such payment data shall otherwise be regarded as proprietary and confidential under subdivision (15) of section 610.021.

208.480. Notwithstanding the provisions of section 208.471 to the contrary, sections 208.453 to 208.480 shall expire on September 30, **[**~~2018~~**] 2020**.

208.790. 1. The applicant shall have or intend to have a fixed place of residence in Missouri, with the present intent of maintaining a permanent home in Missouri for the indefinite future. The burden of establishing proof of residence within this state is on the applicant. The requirement also applies to persons residing in long-term care facilities located in the state of Missouri.

2. The department shall promulgate rules outlining standards for documenting proof of residence in Missouri. Documents used to show proof of residence shall include the applicant's name and address in the state of Missouri.

3. Applicant household income limits for eligibility shall be subject to appropriations, but in no event shall applicants have household income that is greater than one hundred eighty-five percent of the federal poverty level for the applicable family size for the applicable

year as converted to the MAGI equivalent net income standard. **[**~~The provisions of this subsection shall only apply to Medicaid dual eligible individuals.~~**]**

4. The department shall promulgate rules outlining standards for documenting proof of household income.

Section B. The repeal and reenactment of section 208.790 of this bill shall be effective beginning July 1, 2019.

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