

House _____ Amendment NO. _____

Offered By _____

1 AMEND House Committee Substitute for Senate Substitute for Senate Bill No. 64, Page 42, Section
2 190.257, Line 43, by inserting after all of said section and line the following:

3
4 "190.800. 1. Each ground ambulance service, except for any ambulance service owned and
5 operated by an entity owned and operated by the state of Missouri, including but not limited to any
6 hospital owned or operated by the board of curators, as defined in chapter 172, or any department of
7 the state, shall, in addition to all other fees and taxes now required or paid, pay an ambulance
8 service reimbursement allowance tax for the privilege of engaging in the business of providing
9 ambulance services in this state.

10 2. For the purpose of this section, the following terms shall mean:

11 (1) "Ambulance", the same meaning as such term is defined in section 190.100;

12 (2) "Ambulance service", the same meaning as such term is defined in section 190.100;

13 (3) "Engaging in the business of providing ambulance services in this state", accepting
14 payment for such services;

15 (4) "Gross receipts", all amounts received by an ambulance service licensed under section
16 190.109 for its own account from the provision of all emergency services, as defined in section
17 190.100, to the public in the state of Missouri, but shall not include revenue from taxes collected
18 under law, grants, subsidies received from governmental agencies, [or] the value of charity care, or
19 revenues received from supplemental reimbursement for ground emergency medical transportation
20 under section 208.1030.

21 190.839. Sections 190.800 to 190.839 shall expire on September 30, ~~[2021]~~ 2022"; and

22
23 Further amend said bill, Page 51, Section 192.2520, Line 99, by inserting after all of said section
24 and line the following:

25
26 "196.1170. 1. This section shall be known and may be cited as the "Kratom Consumer
27 Protection Act".

28 2. As used in this section, the following terms mean:

29 (1) "Dealer", a person who sells, prepares, or maintains kratom products or advertises,
30 represents, or holds oneself out as selling, preparing, or maintaining kratom products. Such person
31 may include, but not be limited to, a manufacturer, wholesaler, store, restaurant, hotel, catering
32 facility, camp, bakery, delicatessen, supermarket, grocery store, convenience store, nursing home, or
33 food or drink company;

34 (2) "Department", the department of health and senior services;

35 (3) "Director", the director of the department or the director's designee;

36 (4) "Food", a food, food product, food ingredient, dietary ingredient, dietary supplement, or

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1 beverage for human consumption;

2 (5) "Kratom product", a food product or dietary ingredient containing any part of the leaf of
 3 the plant Mitragyna speciosa.

4 3. The general assembly hereby occupies and preempts the entire field of regulating kratom
 5 products to the complete exclusion of any order, ordinance, or regulation of any political subdivision
 6 of this state. Any political subdivision's existing or future orders, ordinances, or regulations relating
 7 to kratom products are hereby void.

8 4. (1) A dealer who prepares, distributes, sells, or exposes for sale a food that is represented
 9 to be a kratom product shall disclose on the product label the factual basis upon which that
 10 representation is made.

11 (2) A dealer shall not prepare, distribute, sell, or expose for sale a food represented to be a
 12 kratom product that does not conform to the disclosure requirement under subdivision (1) of this
 13 subsection.

14 5. A dealer shall not prepare, distribute, sell, or expose for sale any of the following:

15 (1) A kratom product that is adulterated with a dangerous non-kratom substance. A kratom
 16 product shall be considered to be adulterated with a dangerous non-kratom substance if the kratom
 17 product is mixed or packed with a non-kratom substance and that substance affects the quality or
 18 strength of the kratom product to such a degree as to render the kratom product injurious to a
 19 consumer;

20 (2) A kratom product that is contaminated with a dangerous non-kratom substance. A
 21 kratom product shall be considered to be contaminated with a dangerous non-kratom substance if
 22 the kratom product contains a poisonous or otherwise deleterious non-kratom ingredient including,
 23 but not limited to, any substance listed in section 195.017;

24 (3) A kratom product containing a level of 7-hydroxymitragynine in the alkaloid fraction
 25 that is greater than two percent of the alkaloid composition of the product;

26 (4) A kratom product containing any synthetic alkaloids, including synthetic mitragynine,
 27 synthetic 7-hydroxymitragynine, or any other synthetically derived compounds of the plant
 28 Mitragyna speciosa; or

29 (5) A kratom product that does not include on its package or label the amount of
 30 mitragynine and 7-hydroxymitragynine contained in the product.

31 6. A dealer shall not distribute, sell, or expose for sale a kratom product to an individual
 32 under eighteen years of age.

33 7. (1) If a dealer violates subdivision (1) of subsection 4 of this section, the director may,
 34 after notice and hearing, impose a fine on the dealer of no more than five hundred dollars for the
 35 first offense and no more than one thousand dollars for the second or subsequent offense.

36 (2) A dealer who violates subdivision (2) of subsection 4 of this section, subsection 5 of this
 37 section, or subsection 6 of this section is guilty of a class D misdemeanor.

38 (3) A person aggrieved by a violation of subdivision (2) of subsection 4 of this section or
 39 subsection 5 of this section may, in addition to and distinct from any other remedy at law or in
 40 equity, bring a private cause of action in a court of competent jurisdiction for damages resulting
 41 from that violation including, but not limited to, economic, noneconomic, and consequential
 42 damages.

43 (4) A dealer does not violate subdivision (2) of subsection 4 of this section or subsection 5
 44 of this section if a preponderance of the evidence shows that the dealer relied in good faith upon the
 45 representations of a manufacturer, processor, packer, or distributor of food represented to be a
 46 kratom product.

47 8. The department shall promulgate rules to implement the provisions of this section
 48 including, but not limited to, the requirements for the format, size, and placement of the disclosure
 49 label required under subdivision (1) of subsection 4 of this section and for the information to be

1 included in the disclosure label. Any rule or portion of a rule, as that term is defined in section
 2 536.010, that is created under the authority delegated in this section shall become effective only if it
 3 complies with and is subject to all of the provisions of chapter 536 and, if applicable, section
 4 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the
 5 general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and
 6 annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any
 7 rule proposed or adopted after August 28, 2021, shall be invalid and void."; and

8
 9 Further amend said bill and page, Section 197.135, Line 7, by deleting all of said line and inserting
 10 in lieu there of the following:

11
 12 "age shall be referred, and victims fourteen years of age or older but less than eighteen years
 13 of age may be"; and

14
 15 Further amend said bill and section , Page 52, Line 47, by inserting after all of said section the
 16 following:

17 "198.439. Sections 198.401 to 198.436 shall expire on September 30, [2021] 2022.

18 208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy
 19 persons as described in section 208.151 who are unable to provide for it in whole or in part, with
 20 any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the
 21 services as defined and determined by the MO HealthNet division, unless otherwise hereinafter
 22 provided, for the following:

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

31 (2) All outpatient hospital services, payments therefor to be in amounts which represent no
 32 more than eighty percent of the lesser of reasonable costs or customary charges for such services,
 33 determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97,
 34 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.), but the MO
 35 HealthNet division may evaluate outpatient hospital services rendered under this section and deny
 36 payment for services which are determined by the MO HealthNet division not to be medically
 37 necessary, in accordance with federal law and regulations;

38 (3) Laboratory and X-ray services;

39 (4) Nursing home services for participants, except to persons with more than five hundred
 40 thousand dollars equity in their home or except for persons in an institution for mental diseases who
 41 are under the age of sixty-five years, when residing in a hospital licensed by the department of
 42 health and senior services or a nursing home licensed by the department of health and senior
 43 services or appropriate licensing authority of other states or government-owned and -operated
 44 institutions which are determined to conform to standards equivalent to licensing requirements in
 45 Title XIX of the federal Social Security Act (42 U.S.C. Section 301, et seq.), as amended, for
 46 nursing facilities. The MO HealthNet division may recognize through its payment methodology for
 47 nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The
 48 MO HealthNet division when determining the amount of the benefit payments to be made on behalf
 49 of persons under the age of twenty-one in a nursing facility may consider nursing facilities

1 furnishing care to persons under the age of twenty-one as a classification separate from other
2 nursing facilities;

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

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

12 (7) Subject to appropriation, up to twenty visits per year for services limited to
13 examinations, diagnoses, adjustments, and manipulations and treatments of malpositioned
14 articulations and structures of the body provided by licensed chiropractic physicians practicing
15 within their scope of practice. Nothing in this subdivision shall be interpreted to otherwise expand
16 MO HealthNet services;

17 (8) Drugs and medicines when prescribed by a licensed physician, dentist, podiatrist, or an
18 advanced practice registered nurse; except that no payment for drugs and medicines prescribed on
19 and after January 1, 2006, by a licensed physician, dentist, podiatrist, or an advanced practice
20 registered nurse may be made on behalf of any person who qualifies for prescription drug coverage
21 under the provisions of P.L. 108-173;

22 (9) Emergency ambulance services and, effective January 1, 1990, medically necessary
23 transportation to scheduled, physician-prescribed nonelective treatments;

24 (10) Early and periodic screening and diagnosis of individuals who are under the age of
25 twenty-one to ascertain their physical or mental defects, and health care, treatment, and other
26 measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services
27 shall be provided in accordance with the provisions of Section 6403 of P.L. 101-239 and federal
28 regulations promulgated thereunder;

29 (11) Home health care services;

30 (12) Family planning as defined by federal rules and regulations; provided, however, that
31 such family planning services shall not include;

32 (a) Abortions unless such abortions are certified in writing by a physician to the MO
33 HealthNet agency that, in the physician's professional judgment, the life of the mother would be
34 endangered if the fetus were carried to term; and

35 (b) Subject to the receipt of any necessary federal waivers, any drug or device approved by
36 the federal Food and Drug Administration intended to cause the destruction of an unborn child, as
37 defined in section 188.015;

38 (13) Inpatient psychiatric hospital services for individuals under age twenty-one as defined
39 in Title XIX of the federal Social Security Act (42 U.S.C. Section 1396d, et seq.);

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

46 (15) Personal care services which are medically oriented tasks having to do with a person's
47 physical requirements, as opposed to housekeeping requirements, which enable a person to be
48 treated by his or her physician on an outpatient rather than on an inpatient or residential basis in a
49 hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be

rendered by an individual not a member of the participant'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 participant one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such services, when delivered in a residential care facility or assisted living facility licensed under chapter 198 shall be authorized on a tier level based on the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal physician. Such authorized units of personal care services or tier level shall be transferred with such resident if he or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as to whether the relevant waivers are approved or a determination of noncompliance is made;

(16) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. Section 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 or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097. 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 home and community-based 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.

1 With respect to services established by this subdivision, the department of social services, MO
 2 HealthNet division, shall enter into an agreement with the department of mental health. Matching
 3 funds for outpatient mental health services, clinic mental health services, and rehabilitation services
 4 for mental health and alcohol and drug abuse shall be certified by the department of mental health to
 5 the MO HealthNet division. The agreement shall establish a mechanism for the joint
 6 implementation of the provisions of this subdivision. In addition, the agreement shall establish a
 7 mechanism by which rates for services may be jointly developed;

8 (17) Such additional services as defined by the MO HealthNet division to be furnished
 9 under waivers of federal statutory requirements as provided for and authorized by the federal Social
 10 Security Act (42 U.S.C. Section 301, et seq.) subject to appropriation by the general assembly;

11 (18) The services of an advanced practice registered nurse with a collaborative practice
 12 agreement to the extent that such services are provided in accordance with chapters 334 and 335,
 13 and regulations promulgated thereunder;

14 (19) Nursing home costs for participants receiving benefit payments under subdivision (4)
 15 of this subsection to reserve a bed for the participant in the nursing home during the time that the
 16 participant is absent due to admission to a hospital for services which cannot be performed on an
 17 outpatient basis, subject to the provisions of this subdivision:

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

19 a. The occupancy rate of the nursing home is at or above ninety-seven percent of MO
 20 HealthNet certified licensed beds, according to the most recent quarterly census provided to the
 21 department of health and senior services which was taken prior to when the participant is admitted
 22 to the hospital; and

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

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

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

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

36 (20) Prescribed medically necessary durable medical equipment. An electronic web-based
 37 prior authorization system using best medical evidence and care and treatment guidelines consistent
 38 with national standards shall be used to verify medical need;

39 (21) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated
 40 program of active professional medical attention within a home, outpatient and inpatient care which
 41 treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary
 42 team. The program provides relief of severe pain or other physical symptoms and supportive care to
 43 meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses
 44 which are experienced during the final stages of illness, and during dying and bereavement and
 45 meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418.
 46 The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and
 47 board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five
 48 percent of the rate of reimbursement which would have been paid for facility services in that nursing
 49 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) Prescribed medically necessary dental services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(23) Prescribed medically necessary optometric services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(24) Blood clotting products-related services. For persons diagnosed with a bleeding disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section 338.400, such services include:

(a) Home delivery of blood clotting products and ancillary infusion equipment and supplies, including the emergency deliveries of the product when medically necessary;

(b) Medically necessary ancillary infusion equipment and supplies required to administer the blood clotting products; and

(c) Assessments conducted in the participant's home by a pharmacist, nurse, or local home health care agency trained in bleeding disorders when deemed necessary by the participant's treating physician;

(25) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and for third-party payor average dental reimbursement rates. Such plan shall be subject to appropriation and the division shall include in its annual budget request to the governor the necessary funding needed to complete the four-year plan developed under this subdivision.

2. Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons 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 MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Dental services;

(2) Services of podiatrists as defined in section 330.010;

(3) Optometric services as described in section 336.010;

(4) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs;

(5) Hospice care. As used in this subdivision, 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. The rate of reimbursement paid by the MO HealthNet division 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);

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a

1 coordinated system of care for individuals with disabling impairments. Rehabilitation services must
 2 be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan
 3 developed, implemented, and monitored through an interdisciplinary assessment designed to restore
 4 an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet
 5 division shall establish by administrative rule the definition and criteria for designation of a
 6 comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. Any
 7 rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority
 8 delegated in this subdivision shall become effective only if it complies with and is subject to all of
 9 the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are
 10 nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to
 11 review, to delay the effective date, or to disapprove and annul a rule are subsequently held
 12 unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after
 13 August 28, 2005, shall be invalid and void.

14 3. The MO HealthNet division may require any participant receiving MO HealthNet
 15 benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1,
 16 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services
 17 except for those services covered under subdivisions (15) and (16) of subsection 1 of this section
 18 and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the
 19 federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations thereunder. When
 20 substitution of a generic drug is permitted by the prescriber according to section 338.056, and a
 21 generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or
 22 delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal
 23 Social Security Act. A provider of goods or services described under this section must collect from
 24 all participants the additional payment that may be required by the MO HealthNet division under
 25 authority granted herein, if the division exercises that authority, to remain eligible as a provider.
 26 Any payments made by participants under this section shall be in addition to and not in lieu of
 27 payments made by the state for goods or services described herein except the participant portion of
 28 the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to
 29 pharmacists. A provider may collect the co-payment at the time a service is provided or at a later
 30 date. A provider shall not refuse to provide a service if a participant is unable to pay a required
 31 payment. If it is the routine business practice of a provider to terminate future services to an
 32 individual with an unclaimed debt, the provider may include uncollected co-payments under this
 33 practice. Providers who elect not to undertake the provision of services based on a history of bad
 34 debt shall give participants advance notice and a reasonable opportunity for payment. A provider,
 35 representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall
 36 not make co-payment for a participant. This subsection shall not apply to other qualified children,
 37 pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not
 38 approve the MO HealthNet state plan amendment submitted by the department of social services
 39 that would allow a provider to deny future services to an individual with uncollected co-payments,
 40 the denial of services shall not be allowed. The department of social services shall inform providers
 41 regarding the acceptability of denying services as the result of unpaid co-payments.

42 4. The MO HealthNet division shall have the right to collect medication samples from
 43 participants in order to maintain program integrity.

44 5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection
 45 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and
 46 services are available under the state plan for MO HealthNet benefits at least to the extent that such
 47 care and services are available to the general population in the geographic area, as required under
 48 subparagraph (a)(30)(A) of 42 U.S.C. Section 1396a and federal regulations promulgated
 49 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 MO HealthNet benefits 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. Section 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 MO HealthNet 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. Section 1396a (a)(13)(C).

10. The MO HealthNet division may enroll qualified residential care facilities and assisted living facilities, as defined in chapter 198, as MO HealthNet personal care providers.

11. Any income earned by individuals eligible for certified extended employment at a sheltered workshop under chapter 178 shall not be considered as income for purposes of determining eligibility under this section.

12. If the Missouri Medicaid audit and compliance unit changes any interpretation or application of the requirements for reimbursement for MO HealthNet services from the interpretation or application that has been applied previously by the state in any audit of a MO HealthNet provider, the Missouri Medicaid audit and compliance unit shall notify all affected MO HealthNet providers five business days before such change shall take effect. Failure of the Missouri Medicaid audit and compliance unit to notify a provider of such change shall entitle the provider to continue to receive and retain reimbursement until such notification is provided and shall waive any liability of such provider for recoupment or other loss of any payments previously made prior to the five business days after such notice has been sent. Each provider shall provide the Missouri Medicaid audit and compliance unit a valid email address and shall agree to receive communications electronically. The notification required under this section shall be delivered in writing by the United States Postal Service or electronic mail to each provider.

13. Nothing in this section shall be construed to abrogate or limit the department's statutory requirement to promulgate rules under chapter 536.

14. Beginning July 1, 2016, and subject to appropriations, providers of behavioral, social, and psychophysiological services for the prevention, treatment, or management of physical health problems shall be reimbursed utilizing the behavior assessment and intervention reimbursement codes 96150 to 96154 or their successor codes under the Current Procedural Terminology (CPT) coding system. Providers eligible for such reimbursement shall include psychologists."; and

Further amend said bill, Page 56, Section 208.227, Line 100, by inserting after all of said section the following:

"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 commerce and insurance. The director of the department of commerce and insurance 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, ~~[2021]~~ 2022.

208.480. Notwithstanding the provisions of section 208.471 to the contrary, sections 208.453 to 208.480 shall expire on September 30, ~~[2021]~~ 2022."; and

Further amend said bill, Pages 61-63, Section 334.036, Lines 1-75, by deleting all of said section and lines from the bill; and

Further amend said bill, Page 63, Section 338.010, Line 13, by inserting after the word "vaccines" the words "by physician protocol"; and

Further amend said bill and section, Page 66, Line 110, by inserting after all of said section the following:

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

(1) The aggregate dispensing fee as appropriated by the general assembly 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 as appropriated by the general assembly for products dispensed by pharmacies is changed resulting in lower reimbursement to the pharmacist in the aggregate than provided in fiscal year 2003; or

(3) September 30, ~~[2021]~~ 2022.

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.

2. Sections 338.500 to 338.550 shall expire on September 30, [2021] 2022."; and

Further amend said bill, Page 69, Section 574.203, Line 2, by inserting after the word "disability" the words ", mental disorder, or mental illness"; and

Further amend said bill, Page 72, Section 579.076, Line 12, by inserting after all of said section the following:

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

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

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

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

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

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

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

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

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

6. In the alternative, a provider may direct that the director of the department of social services offset, from the amount of any payment to be made by the state to the provider, the amount

1 of the assessment payment owed for any month.

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

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

17 9. Every provider of services of intermediate care facilities for the intellectually disabled
18 shall submit a certified annual report of net operating revenues from the furnishing of services of
19 intermediate care facilities for the intellectually disabled. The reports shall be in such form as may
20 be prescribed by rule by the director of the department of mental health. Final payments of the
21 assessment for each year shall be due for all providers of services of intermediate care facilities for
22 the intellectually disabled upon the due date for submission of the certified annual report.

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

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

30 12. In the event a provider objects to the estimate described in subsection 11 of this section,
31 or any other decision of the department of mental health related to this section, the provider of
32 services may request a hearing. If a hearing is requested, the director of the department of mental
33 health shall provide the provider of services an opportunity to be heard and to present evidence
34 bearing on the amount due for an assessment or other issue related to this section within thirty days
35 after collection of an amount due or receipt of a request for a hearing, whichever is later. The
36 director shall issue a final decision within forty-five days of the completion of the hearing. After
37 reconsideration of the assessment determination and a final decision by the director of the
38 department of mental health, an intermediate care facility for the intellectually disabled provider's
39 appeal of the director's final decision shall be to the administrative hearing commission in
40 accordance with sections 208.156 and 621.055.

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

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

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

1 section and chapter 536 are nonseverable and if any of the powers vested with the general assembly
2 pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are
3 subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or
4 adopted after August 28, 2008, shall be invalid and void.

5 16. The provisions of this section shall expire on September 30, [~~2024~~] 2022."; and

6
7 Further amend said bill by amending the title, enacting clause, and intersectional references
8 accordingly.