FIRST REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED]

CONFERENCE COMMITTEE SUBSTITUTE FOR

SENATE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 395

95TH GENERAL ASSEMBLY

1162S.09T 2009

AN ACT

To repeal sections 198.074, 198.075, 198.096, 198.525, 198.527, 208.437, 208.480, 208.819, 338.535, 338.550, and 633.401, RSMo, and to enact in lieu thereof fifteen new sections relating to health care services, with an emergency clause.

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

Section A. Sections 198.074, 198.075, 198.096, 198.525, 198.527, 208.437, 208.480, 208.819, 338.535, 338.550, and 633.401, RSMo, are repealed and fifteen new sections enacted in lieu thereof, to be known as sections 198.074, 198.075, 198.096, 198.187, 198.525, 198.527, 198.545, 208.016, 208.437, 208.480, 208.819, 338.535, 338.550, 633.401, and 1, to read as follows:

198.074. 1. Effective August 28, 2007, all new facilities licensed **under this chapter** on or after August 28, 2007, or any **[**facilities completing a**] section of a facility licensed under this chapter in which a** major renovation **[**to the facility**] has been completed** on or after August 28, 2007, as defined and approved by the department, **[**and which are licensed under this chapter**]** shall install and maintain an approved sprinkler system in accordance with National Fire Protection Association (NFPA) 13.

2. Facilities that were initially licensed and had an approved sprinkler system prior to August 28, 2007, shall continue to meet all laws, rules, and regulations for testing, inspection and maintenance of the sprinkler system that were in effect for such facilities on August 27, 2007.

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.

3. Multi-level assisted living facilities that accept or retain any individual with a physical, cognitive, or other impairment that prevents the individual from safely evacuating the facility with minimal assistance shall install and maintain an approved sprinkler system in accordance with NFPA 13. Single-story assisted living facilities that accept or retain any individual with a physical, cognitive, or other impairment that prevents the individual from safely evacuating the facility with minimal assistance shall install and maintain an approved sprinkler system in accordance with NFPA 13R.

4. All residential care and assisted living facilities with more than twenty residents not included in subsection 3 of this section, which are initially licensed under this chapter prior to August 28, 2007, and that do not have installed an approved sprinkler system in accordance with NFPA 13R **or 13** prior to August 28, 2007, shall install and maintain an approved sprinkler system in accordance with NFPA 13R **or 13** by December 31, 2012, unless the facility meets the safety requirements of Chapter 33 of existing residential board and care occupancies of NFPA 101 life safety code.

5. All skilled nursing and intermediate care facilities not required prior to August 28, 2007, to install and maintain an approved sprinkler system shall install and maintain an approved sprinkler system in accordance with NFPA 13 by December 31, 2012, unless the facility receives an exemption from the department and presents evidence in writing from a certified sprinkler system representative or licensed engineer that the facility is unable to install an approved National Fire Protection Association 13 system due to the unavailability of water supply requirements associated with this system **[**or the facility meets the safety requirements of Chapter 33 of existing residential board and care occupancies of NFPA 101 life safety code**]**.

6. Facilities that take a substantial step, as specified in **[**subsection 7**] subsections 4 and 5** of this section, to install an approved NFPA 13R **or 13** system prior to December 31, 2012, may apply to the **[**department**] state treasurer's office** for a loan in accordance with section 198.075 to install such system. However, such loan shall not be available if by December 31, 2009, the average total reimbursement for the care of persons eligible for Medicaid public assistance in an assisted living facility and residential care facility is equal to or exceeds fifty-two dollars per day. The average total reimbursement includes room, board, and care delivered by the facility, but shall not include payments to the facility for care or services not provided by the facility. If a facility under this subsection does not have an approved sprinkler system installed by December 31, 2012, such facility shall be required to install and maintain an approved sprinkler system in accordance with NFPA 13 by December 31, 2013. Such loans received under this subsection and in accordance with section 198.075, shall be paid in full as follows:

(1) Ten years for those facilities approved for the loan and whose average total reimbursement rate for the care of persons eligible for Medicaid public assistance is equal to forty-eight and no more than forty-nine dollars per day;

(2) Eight years for those facilities approved for the loan and whose average total reimbursement rate for the care of persons eligible for Medicaid public assistance is greater than forty-nine and no more than fifty-two dollars per day; or

(3) Five years for those facilities approved for the loan and whose average total reimbursement rate for the care of persons eligible for Medicaid public assistance is greater than fifty-two dollars per day.

(4) No payments or interest shall be due until the average total reimbursement rate for the care of persons eligible for Medicaid public assistance is equal to or greater than forty-eight dollars.

7. (1) All facilities licensed under this chapter shall be equipped with a complete fire alarm system in compliance with NFPA 101, Life Safety Code for Detection, Alarm, and Communication Systems **[**as referenced in NFPA 72**]**, or shall maintain a system that was approved by the department when such facility was constructed so long as such system is a complete fire alarm system. A complete fire alarm system shall include, but not be limited to, interconnected smoke detectors **[**throughout the facility**]**, automatic transmission to the fire department, dispatching agency, or central monitoring company, manual pull stations at each required exit and attendant's station, heat detectors, and audible and visual alarm indicators. **If a facility submits a plan of compliance for installation of a sprinkler system required by this chapter, such facility shall install a complete fire alarm system that complies with NFPA 72 upon installation of the sprinkler system. Until such time that the sprinkler system is installed in the facility which has submitted a plan of compliance, each resident room or any room designated for sleeping in the facility shall be equipped with at least one battery-powered smoke alarm installed, tested, and maintained in accordance with NFPA 72. In addition, any such facility shall be equipped with heat detectors interconnected to the fire alarm system which are installed, tested, and maintained in accordance with NFPA 72 in all areas subject to nuisance alarms, including but not limited to, kitchens, laundries, bathrooms, mechanical air handling rooms, and attic spaces.**

(2) In addition, each floor accessed by residents shall be divided into at least two smoke sections by one-hour rated smoke partitions. No smoke section shall exceed one hundred fifty feet in length. If neither the length nor the width of the floor exceeds seventy-five feet, no smoke-stop partition shall be required. Facilities with a complete fire alarm system and smoke sections meeting the requirements of this subsection prior to August 28, 2007, shall continue to

meet such requirements. Facilities initially licensed on or after August 28, 2007, shall comply with such requirements beginning August 28, 2007, or on the effective date of licensure.

(3) Except as otherwise provided in this subsection, the requirements for complete fire alarm systems and smoke sections shall be enforceable on December 31, 2008.

8. The requirements of this section shall be construed to supersede the provisions of section 198.058 relating to the exemption of facilities from construction standards.

9. Fire safety inspections of **skilled nursing and intermediate care** facilities licensed under this chapter for compliance with this section shall be conducted annually by the **[**state fire marshal if such inspections are not available to be conducted by local fire protection districts or fire departments**] department. All department inspectors who inspect facilities for compliance under this section shall complete a fire inspector course, as developed by the division of fire safety within the department of public safety, by December 31, 2012. Fire safety inspections of residential care and assisted living facilities licensed under this chapter for compliance with this section shall be conducted annually by the state fire marshal**. The provisions of this section shall be enforced by the **department or the** state fire marshal **[**or by the local fire protection district or fire department**]**, depending on which entity conducted the inspection.

10. By July 1, 2008, all facilities licensed under this chapter shall submit a plan for compliance with the provisions of this section to the state fire marshal.

198.075. 1. There is hereby created in the state treasury the "Fire Safety Standards Loan Fund", for implementing the provisions of **[**subsection 3**] subsections 4 and 5** of section 198.074. Moneys deposited in the fund shall be considered state funds under article IV, section 15 of the Missouri Constitution. The state treasurer shall be custodian of the fund and may disburse moneys from the fund in accordance with sections 30.170 and 30.180, RSMo. Any moneys remaining in the fund at the end of the biennium shall revert to the credit of the general revenue fund. The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

2. Qualifying facilities shall make an application to the **[**department of health and senior services**] state treasurer's office** upon forms provided by the **[**department**] state treasurer's office**. Upon receipt of an application for a loan, the **[**department**] state treasurer's office** shall review the application **[**and advise the governor**]** before state funds are allocated for a loan. For purposes of this section, a "qualifying facility" shall mean a facility licensed under this chapter that is in substantial compliance. "Substantial compliance" shall mean a facility that has no uncorrected deficiencies and is in compliance with department of health and senior services rules and regulations governing such facility.

3. The fund shall be a loan of which the interest rate shall not exceed two and one-half percent.

4. The fund shall be administered by the **[**department of health and senior services**] state treasurer's office**.

198.096. 1. The operator of any facility who holds in trust personal funds of residents as provided in section 198.090 shall obtain and file with the department a bond in a form approved by the department in an amount equal to one and one-half times the average monthly balance or average total of the monthly balances, rounded to the nearest one thousand dollars, in the residents' personal funds account or accounts kept pursuant to subdivision (3) of subsection 1 of section 198.090 for the preceding **[**calendar year**] twelve months**. In the case of a new facility or of an operator not previously holding in trust the personal funds of residents, the department shall determine the amount of bond to be required, taking into consideration the size and type of facility, the number of residents, and the experience of comparable facilities.

2. The required bond shall be conditioned to secure to every resident or former resident, or the estate of a former resident, the return of any moneys held in trust of which the resident has been wrongfully deprived by acts of the operator or any affiliates or employees of the operator. The liability of the surety to any and all persons shall not exceed the stated amount of the bond regardless of the period of time the bond has been in effect.

3. Whenever the director determines that the amount of any bond which is filed pursuant to this subsection is insufficient to adequately protect the money of residents which is being handled, or whenever the amount of any such bond is impaired by any recovery against the bond, the director may require the operator to file an additional bond in such amount as necessary to adequately protect the money of residents being handled.

4. In the event that any such bond includes a provision allowing the surety to cancel after notice, the bond shall provide for a minimum of sixty days' notice to the department.

5. The operator may, in lieu of a bond, place a cash deposit equal to the amount of the bond required in this section with an insured lending institution pursuant to a noncancelable escrow agreement with the lending institution if the written agreement is submitted to and approved by the department. No escrow agreement shall be approved without verification of cash deposit.

198.187. Any long-term care facility licensed under this chapter may request criminal background checks under chapter 43, RSMo, of a resident in such facility.

198.525. **1.** Except as otherwise provided pursuant to section 198.526, in order to comply with sections 198.012 and 198.022, the department of health and senior services shall inspect residential care facilities, assisted living facilities, intermediate care facilities, and skilled nursing, including those facilities attached to acute care hospitals at least twice a year.

2. The department shall not assign an individual to inspect or survey a long-term care facility licensed under this chapter, for any purpose, in which the inspector or surveyor was an employee of such facility within the preceding two years.

3. For any inspection or survey of a facility licensed under this chapter, regardless of the purpose, the department shall require every newly hired inspector or surveyor at the time of hiring or, with respect to any currently employed inspector or surveyor as of August 28, 2009, to disclose:

(1) The name of every Missouri licensed long-term care facility in which he or she has been employed; and

(2) The name of any member of his or her immediate family who has been employed or is currently employed at a Missouri licensed long-term care facility.

The disclosures under this subsection shall be disclosed to the department whenever the event giving rise to disclosure first occurs.

4. For purposes of this section, the phrase "immediate family member" shall mean husband, wife, natural or adoptive parent, child, sibling, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent or grandchild.

5. The information called for in this section shall be a public record under the provisions of subdivision (6) of section 610.010, RSMo.

6. Any person may notify the department if facts exist that would lead a reasonable person to conclude that any inspector or surveyor has any personal or business affiliation that would result in a conflict of interest in conducting an inspection or survey for a facility. Upon receiving that notice, the department, when assigning an inspector or surveyor to inspect or survey a facility, for any purpose, shall take steps to verify the information and, if the department has probable cause to believe that it is correct, shall not assign the inspector or surveyor to the facility or any facility within its organization so as to avoid an appearance of prejudice or favor to the facility or bias on the part of the inspector or surveyor.

198.527. To ensure uniformity of application of regulation standards in long-term care facilities throughout the state, the department of **[**social**]** **health and senior** services shall:

(1) Evaluate the requirements for inspectors or surveyors of facilities, including the eligibility, training and testing requirements for the position.

Based on the evaluation, the department shall develop and implement additional training and knowledge standards for inspectors and surveyors;

(2) Periodically evaluate the performance of the inspectors or surveyors regionally and statewide to identify any deviations or inconsistencies in regulation application. At a minimum, the Missouri on-site surveyor evaluation process, and the number and type of actions overturned by the informal dispute resolution process **under section 198.545** and formal appeal shall be used **[**in**] as part of** the evaluation. Based on such evaluation, the department shall develop standards and a retraining process for the region, state, or individual inspector or surveyor, as needed;

(3) In addition to the provisions of subdivisions (1) and (2) of this section, the department shall develop a single uniform comprehensive and mandatory course of instruction for inspectors/surveyors on the practical application of enforcement of statutes, rules and regulations. Such course shall also be open to attendance by administrators and staff of facilities licensed pursuant to this chapter.

198.545. 1. This section shall be known and may be cited as the "Missouri Informal Dispute Resolution Act".

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

(1) "Deficiency", a facility's failure to meet a participation requirement or standard, whether state or federal, supported by evidence gathered from observation, interview, or record review;

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

(3) "Facility", a long-term care facility licensed under this chapter;

(4) "IDR", informal dispute resolution as provided for in this section;

(5) "Independent third party", the federally designated Medicare Quality Improvement Organization in this state;

(6) "Plan of correction", a facility's response to deficiencies which explains how corrective action will be accomplished, how the facility will identify other residents who may be affected by the deficiency practice, what measures will be used or systemic changes made to ensure that the deficient practice will not reoccur, and how the facility will monitor to ensure that solutions are sustained;

(7) "QIO", the federally designated Medicare Quality Improvement Organization in this state.

3. The department of health and senior services shall contract with an independent third party to conduct informal dispute resolution (IDR) for facilities licensed under this chapter. The IDR process, including conferences, shall constitute an informal administrative process and shall not be construed to be a formal evidentiary hearing. Use of IDR under this section shall not waive the facility's right to pursue further or additional legal actions.

4. The department shall establish an IDR process to determine whether a cited deficiency as evidenced by a statement of deficiencies against a facility shall be upheld. The department shall promulgate rules to incorporate by reference the provisions of 42 CFR 488.331 regarding the IDR process and to include the following minimum requirements for the IDR process:

(1) Within ten working days of the end of the survey, the department shall by certified mail transmit to the facility a statement of deficiencies committed by the facility. Notification of the availability of an IDR and IDR process shall be included in the transmittal;

(2) Within ten calendar days of receipt of the statement of deficiencies, the facility shall return a plan of correction to the department. Within such ten-day period, the facility may request in writing an IDR conference to refute the deficiencies cited in the statement of deficiencies;

(3) Within ten working days of receipt for an IDR conference made by a facility, the QIO shall hold an IDR conference unless otherwise requested by the facility. The IDR conference shall provide the facility with an opportunity to provide additional information or clarification in support of the facility's contention that the deficiencies were erroneously cited. The facility may be accompanied by counsel during the IDR conference. The type of IDR held shall be at the discretion of the facility, but shall be limited to:

(a) A desk review of written information submitted by the facility; or

(b) A telephonic conference; or

(c) A face-to-face conference held at the headquarters of the QIO or at the facility at the request of the facility.

If the QIO determines the need for additional information, clarification, or discussion after conclusion of the IDR conference, the department and the facility shall be present.

5. Within ten days of the IDR conference described in subsection 4 of this section, the QIO shall make a determination, based upon the facts and findings presented, and shall transmit the decision and rationale for the outcome in writing to the facility and the department.

6. If the department disagrees with such determination, the department shall transmit the department's decision and rationale for the reversal of the QIO's decision to the facility within ten calendar days of receiving the QIO's decision.

7. If the QIO determines that the original statement of deficiencies should be changed as a result of the IDR conference, the department shall transmit a revised

statement of deficiencies to the facility with the notification of the determination within ten calendar days of the decision to change the statement of deficiencies.

8. Within ten calendar days of receipt of the determination made by the QIO and the revised statement of deficiencies, the facility shall submit a plan of correction to the department.

9. The department shall not post on its web site or enter into the Centers for Medicare & Medicaid Services Online Survey, Certification and Reporting System, or report to any other agency, any information about the deficiencies which are in dispute unless the dispute determination is made and the facility has responded with a revised plan of correction, if needed.

10. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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 August 28, 2009, shall be invalid and void.

208.016. In determining the amount of an institutionalized MO HealthNet individual's income that is to be applied to payment for the costs of care in the institution, there shall be deducted a personal needs allowance of no less than thirty dollars per month or the minimum amount required by 42 U.S.C. 1396a(q)(2) if more than thirty dollars. Beginning January 1, 2010, the personal needs allowance shall be increased by an amount equal to the product of the percentage of the Social Security benefit cost of living adjustment and the average amount that MO HealthNet participants are required to contribute to the cost of institutionalized care. The annual increase in the personal needs allowance shall be rounded to the nearest whole dollar and shall not exceed five dollars in any year. Once the personal needs allowance reaches fifty dollars, there shall be no further increases unless authorized by annual appropriation.

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 affect 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 **[**June**]** **September** 30, **[**2009**]** **2011**.

208.480. Notwithstanding the provisions of section 208.471 to the contrary, sections 208.453 to 208.480 shall expire on September 30, **[**2009**]** **2011**.

208.819. 1. **Subject to appropriations,** persons institutionalized in nursing homes who are **[**Medicaid**]** **MO HealthNet** eligible and who wish to move back into the community shall be eligible for a one-time **[**Missouri**]** transition **[**to independence**]** grant. The **[**Missouri**]** transition **[**to independence**]** grant shall be limited to up to **[**fifteen**]** **twenty-four** hundred dollars to offset the initial down payments **[**and**]** **,** setup costs**, and other expenditures** associated with housing a **senior or** person with disabilities **needing home and community-based services** as such person moves out of a nursing home. Such grants shall be established and administered by the division of **[**vocational rehabilitation**]** **senior and disability services** in consultation with the department of social services. The division of **[**vocational rehabilitation**]** **senior and disability services** and the department of social services shall cooperate in actively seeking federal and private grant moneys to **further** fund this program; except that, such federal and private grant moneys shall not limit the general assembly's ability to appropriate moneys for the **[**Missouri**]** transition **[**to independence**]** grants.

2. The **[**division of medical services within the department of social services, the**]** department of health and senior services and the **[**division of vocational rehabilitation within the

department of elementary and secondary education**] department of mental health** shall work together to develop information and training on community-based service options for residents transitioning into the community**[**. Representatives of disability-related community organizations shall complete such training before initiating contact with institutionalized individuals**] and shall promulgate rules as necessary. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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 August 28, 2009, shall be invalid and void**.

338.535. 1. The pharmacy tax owed or, if an offset has been made, the balance after such offset, if any, shall be remitted by the pharmacy **or the pharmacy's designee** to the department of social services. The remittance shall be made payable to the director of the department of revenue and shall be deposited in the state treasury to the credit of the "Pharmacy Reimbursement Allowance Fund" which is hereby created to provide payments for services related to the Medicaid pharmacy program. All investment earnings of the fund shall be credited to the fund.

2. An offset authorized by section 338.530 or a payment to the pharmacy reimbursement allowance fund shall be accepted as payment of the obligation set forth in section 338.500.

3. The state treasurer shall maintain records showing the amount of money in the pharmacy reimbursement allowance fund at any time and the amount of investment earnings on such amount.

4. Notwithstanding the provisions of section 33.080, RSMo, to the contrary, any unexpended balance in the pharmacy reimbursement allowance fund at the end of the biennium shall not revert to the credit of the general revenue fund.

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) **[**June**] September** 30, **[**2009**] 2011**.

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 **[**June**] September** 30, **[**2009**] 2011**.

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 mentally retarded", a private or department of mental health facility which admits persons who are mentally retarded or developmentally disabled for residential habilitation and other services pursuant to chapter 630, RSMo. Such term shall include habilitation centers and private or public intermediate care facilities for the mentally retarded that have been certified to meet the conditions of participation under 42 CFR, Section 483, Subpart 1;

(3) "Net operating revenues from providing services of intermediate care facilities for the mentally retarded" 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 mentally retarded" has the same meaning as the term 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 Amendment of 1991.

2. Beginning July 1, 2008, each provider of services of intermediate care facilities for the mentally retarded 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 mentally retarded 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 mentally retarded, 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.

5. Assessments shall be submitted by or on behalf of each provider of services of intermediate care facilities for the mentally retarded 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 of the assessment payment owed for any month.

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

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

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

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

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

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

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

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

15. The director of the department of mental health shall promulgate rules and regulations to implement this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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 August 28, 2008, shall be invalid and void.

16. The provisions of this section shall expire on **[**June**]** **September** 30, **[**2009**]** **2011**.

Section 1. Upon receipt of a properly completed referral for MO HealthNet-funded home and community-based care containing a nurse assessment or physician's order, the department of health and senior services shall:

(1) Review the recommendations regarding services and process the referral within fifteen business days;

(2) Issue a prior-authorization for home and community-based services when information contained in the referral is sufficient to establish eligibility for MO HealthNet-funded long-term care and determine the level of service need as required under state and federal regulations;

(3) Arrange for the provision of services by an in-home provider;

(4) Reimburse the in-home provider for one nurse visit to conduct an assessment and recommendation for a care plan, and where necessary based on case circumstances, a second nurse visit may be authorized to gather additional information or documentation necessary to constitute a completed referral;

(5) Notify the referring entity upon the authorization of MO HealthNet eligibility and provide MO HealthNet reimbursement for personal care benefits effective the date of the assessment or physician's order, and MO HealthNet reimbursement for waiver services effective the date the state reviews and approves the care plan;

(6) Notify the referring entity within five business days of receiving the referral if additional information is required to process the referral; and

(7) Inform the provider and contact the individual when information is insufficient or the proposed care plan requires additional evaluation by state staff that is not obtained from the referring entity to schedule an in-home assessment to be conducted by the state staff within thirty days.

Section B. Because of the need for continued imposition and collection of certain provider taxes, the repeal and reenactment of sections 208.437, 208.480, 338.535, 338.550, and 633.401 of this act is deemed necessary for the immediate preservation of the public health, welfare, peace and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the repeal and reenactment of sections 208.437, 208.480, 338.535, 338.550, and 633.401 of this act shall be in full force and effect upon its passage and approval.

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