FIRST REGULAR SESSION

SENATE BILL NO. 695

92ND GENERAL ASSEMBLY

INTRODUCED BY SENATORS GOODE AND RUSSELL.

Read 1st time February 27, 2003, and 1,000 copies ordered printed.

TERRY L. SPIELER, Secretary.

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AN ACT

To repeal sections 167.600, 167.603, 167.606, 167.609, 167.611, 167.614, 167.617, 167.619, 167.621, 191.831, 198.401, 208.030, 208.043, 208.151, 208.152, 208.153, 208.162, 208.166, 208.168, 208.201, 208.204, 208.215, 208.453, 208.631, 208.633, 208.636, 208.640, 208.643, 208.646, 208.650, 208.655, 208.657, 630.005, 660.026, and 660.075, RSMo, and to enact in lieu thereof thirty-five new sections relating to medical services and eligibility.

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

Section A. Sections 167.600, 167.603, 167.606, 167.609, 167.611, 167.614, 167.617, 167.619, 167.621, 191.831, 198.401, 208.030, 208.043, 208.151, 208.152, 208.153, 208.162, 208.166, 208.168, 208.201, 208.204, 208.215, 208.453, 208.631, 208.633, 208.636, 208.640, 208.643, 208.646, 208.650, 208.655, 208.657, 630.005, 660.026, and 660.075, RSMo, are repealed and thirty-five new sections enacted in lieu thereof, to be known as sections 167.600, 167.603, 167.606, 167.609, 167.611, 167.614, 167.617, 167.619, 167.621, 191.831, 198.401, 208.030, 208.043, 208.151, 208.152, 208.153, 208.162, 208.166, 208.168, 208.201, 208.204, 208.215, 208.453, 208.631, 208.633, 208.636, 208.640, 208.643, 208.646, 208.650, 208.655, 208.657, 630.005, 660.026, and 660.075, to read as follows:

167.600. 1. As used in sections 167.600 to 167.621, the following terms mean:

(1) "Family practitioner", a primary care provider, including a licensed physician, nurse practitioner or primary care physician sponsor as defined in subdivision (4) of subsection 1 of section 208.166, RSMo, or a primary care contracted health provider plan, approved by the parent, guardian or legal custodian of a school age child pursuant to section 167.611;

(2) "Most accessible care", that care or services which reach the most children where they

normally are during school hours or where children are most likely to participate with the least obstacles to participation and may include, but shall not be limited to, private, public or parochial schools, learning centers, preschools, child care facilities, common community gathering places, licensed health care facilities, physicians' offices and community centers and may also include the use of traveling medical professionals;

(3) "School age children", all children under the age of nineteen without regard to whether they are currently enrolled in any school and without regard to what public, private, parochial or home school they may attend;

(4) "School children health services", services, including immunization, screening for physical or mental disease, disability or injury, treatment of pathological disease or injury, emergency medical treatment or first aid, or administration of drugs or treatment as ordered by the child's family practitioner, provided that the term shall only include the enumerated services and services directly related to the services enumerated herein;

(5) "Service area", the public school district, if the school district elects to be a Medicaid provider, or an area determined by the department of social services at the time a public school within a school district elects to be a Medicaid provider.

2. Sections 167.600 to 167.621 shall not be severable from each other.

3. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

167.603. **1.** Subject to appropriation, the directors of the departments of health and senior services and social services, in consultation with the commissioner of education of the department of elementary and secondary education, may provide grants from the health initiatives fund to assist public schools, public school districts, or local public health departments in expanding school children health services for all school age children. Preference in grants shall be given based on the greater need for school children health services and the least ability to fund such services. The directors shall jointly promulgate rules and regulations governing the grants pursuant to section 192.013, RSMo, and section 660.017, RSMo. The director of social services may also provide Medicaid payment incentives.

2. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

167.606. 1. The departments of social services and elementary and secondary education shall develop a plan to encourage public schools and school districts to be Medicaid providers and to provide the most accessible care to school age children. A public school district, or a public school within any district, may elect to function as and be compensated for acting as a provider of Medicaid services. Pursuant to state and federal laws and regulations, a public school or school district shall, upon such election, provide such Medicaid services to all Medicaid-eligible school age children located in the service area of the school or district electing to be a Medicaid

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provider. The public school or school district may elect to provide services under subdivision (1) or (2) of this subsection or to provide services under both subdivisions (1) and (2). Based upon its election, the public school or school district shall provide the following Medicaid services:

(1) Early periodic screening, diagnosis, and treatment (EPSDT) services of the Medicaid program as provided in subdivision (11) of subsection 1 of section 208.152, RSMo, subject to the provisions of section 167.611;

(2) Primary and preventive health care services to school age children who are eligible for Medicaid services under section 208.151, RSMo, subject to the provisions of section 167.611.

2. The department of social services and the public school or school district shall, by written agreement, determine the scope of EPSDT or primary and preventive health services to be provided by the public school or school district. The scope of services offered shall be designed to encourage the public school or school district to participate as a Medicaid provider.

3. EPSDT services in subdivision (1) of subsection 1 of this section may be provided by school district personnel.

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4. Primary health care services may be provided by:

(1) Federally qualified health centers;

(2) City, county or city and county health departments;

(3) Federally certified rural health clinics; or

(4) Physicians, hospitals, or other licensed providers in the community in which the school is located.

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Such services shall be by contract with a participating school district. A school district shall include provisions for the maintenance of medical records and other administrative tasks as are required by the department of social services in contracts executed under the provisions of this subsection.

5. If a school district is unable to contract for primary health care services pursuant to subdivisions (1) to (4) of subsection 4 of this section, then it may employ the appropriate employees and medical professionals as required by the Medicaid program to provide Medicaid services. Screening, diagnosis, and treatments performed by school district employees pursuant to the provisions of this act shall be performed under standing orders and protocols of a physician whose service area encompasses all of or part of the city or county in which the school is located.

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6. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

167.609. 1. The director of the department of social services shall at least annually determine the amount of money each public school district which elects to participate as a Medicaid provider shall contribute to underwrite the costs associated with the services provided for in section 167.606. Each public school district shall be provided the assessment for each school year by the director of the department of social services. Notice of each district's

assessment shall also be provided to the commissioner of the office of administration.

2. (1) The office of administration, the department of social services and the department of elementary and secondary education shall develop procedures whereby public schools or school districts may arrange to have a portion of the disbursement which they are to receive pursuant to section 163.031, RSMo, transferred to the health initiatives fund established in section 191.831, RSMo, for the purpose of earning federal funds pursuant to the intergovernmental transfer provisions of the federal Medicaid law, 42 U.S.C. 1396, et seq. The office of administration, the department of social services and the department of elementary and secondary education shall promulgate such rules as may be necessary to implement the provisions of this subsection.

(2) Public schools or school districts participating in this transfer arrangement shall receive the original transferred amount plus federal funds. The original transferred amount plus federal funds shall not be less than two hundred percent of the original transferred amount. The department of social services shall determine such percentage by a formula established by rule and regulation.

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(3) The original amount transferred on behalf of the school or school district to the health initiatives fund shall be disbursed pursuant to section 163.031, RSMo, to the participating school or school district and shall be deposited by such school or district in the same manner as are all other moneys disbursed pursuant to section 163.031, RSMo. The federal funds shall be disbursed to the school or school district directly, shall not be subject to section 163.031, RSMo, and shall be used for school health purposes or programs used to generate Medicaid funds.

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(4) The procedures developed pursuant to this section shall assure that:

(a) Public schools or school districts shall not receive less money than they would have otherwise received; and

(b) Nonparticipating public schools or school districts shall not receive their money at a later time than they would have otherwise received their money; and

(c) Participating public schools or school districts shall not receive their money at a later time than they would have otherwise received their money, except with their express written consent.

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3. If a public school or school district which elects to be a Medicaid provider and to contribute to the costs associated with providing EPSDT services and enhanced primary and preventive care to Medicaid eligible children in the service area has a disproportionate number of eligible resident children not included in the calculation of state funding under section 163.081, RSMo, then the department of social services shall work with that public school or school district to ensure the most accessible care for school age children and the department of social services shall commit general revenue funds necessary to ensure access to EPSDT services and primary and preventive health services for all eligible resident children. The department may

also make arrangements with health care service providers listed in subsection 4 of section 167.606 to assist in providing such services in the service area.

4. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

167.611. 1. A public school or school district may establish an advisory committee to review and advise on the services to be offered. Advisory committees shall be composed of an appropriate mix of parents, teachers, health professionals, administrators and students. The advisory committee shall monitor the delivery of services under sections 167.600 to 167.621 and may advise the public school or school district regarding any changes or improvements in the delivery of services which they believe should be adopted. Any public school or school district which has existing committees of similar composition may use those committees for the purposes established herein in lieu of establishing another advisory committee.

2. Before providing any services under sections 167.600 to 167.621, the school, school district, or contractor shall provide each parent or guardian with a consent form and checklist of services to be provided and shall request each parent and guardian to specify those services which may not be provided to his or her child. No services shall be provided which the parent or guardian has specifically indicated may not be provided. If the public school or school district elects to include referral for contraceptive devices and contraceptive drugs in the services to be provided to children, then the check list shall include a specific item stating that health services may include referral to the family practitioner for contraceptive devices and contraceptive drugs. No referral for contraceptive devices or contraceptive drugs shall be made unless the parent, guardian or legal custodian affirmatively selects such services. No service shall be provided nor referral made for services which are not included in either section 208.152, RSMo, or subdivision (4) of subsection 1 of section 167.600.

3. School personnel shall make a reasonable effort to identify the family practitioner for each school age child six years or older by asking the parent, guardian or legal custodian of the child. The school may also at this time ask the parent, guardian or legal custodian to identify the family practitioner for children under age six. The fact that a family practitioner has a contractual relationship with the public school or school district shall not prohibit the family practitioner from being selected by the parent, guardian, or legal custodian to be the designated family practitioner for his child. If the family does not identify a family practitioner, the school may not recommend a specific practitioner or practitioners and shall provide the parent, guardian or legal custodian a randomly selected list of no fewer than twenty-five or a list of all family practitioners who practice in the service area. The parent, guardian or legal custodian may change the selection of the family practitioner at any time by notice to the school. The school shall also provide the parent, guardian or legal custodian the opportunity to provide relevant medical history on the child. At the beginning of each school year, the school shall make a

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reasonable effort to update the information on the family practitioner.

4. Contraceptive devices or contraceptive drugs shall not be provided by school personnel or their agents. When a child seeks contraceptive devices or contraceptive drugs, the child shall be referred to the previously designated family practitioner.

5. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

167.614. **1.** Participating schools and school districts may discontinue their participation as Medicaid providers at the direction of the local school district board of education.

2. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

167.617. **1.** Nothing in sections 167.600 to 167.621 shall prohibit schools or school districts from continuing health or medical services which were provided by such schools or school districts prior to August 28, 1993.

2. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

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167.619. **1.** When a school or school district enrolls as a Medicaid provider pursuant to section 167.606 or receives a grant under section 167.603, the department of social services shall assure that the grants or funds are used to provide the most accessible care to school age children. No resident child shall be denied or discriminated against in school children health services or Medicaid services offered by a school district or a local health department under sections 167.600 to 167.621 on the grounds that the child regularly attends or does not attend a public, private, parochial, parish or home school.

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2. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

167.621. 1. Persons providing health services under sections 167.600 to 167.621 shall obtain authorization from a parent or guardian of the child before providing services as provided by section 431.061, RSMo.

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2. No employee of any school district may be required to administer medication or medical services for which the employee is not qualified according to standard medical practices. No employee who refuses to violate this provision shall be subject to any disciplinary action for such refusal. Nothing herein shall be construed to prevent any employee from providing routine first aid, provided that any employee shall be held harmless from any liability if such employee is following a proper procedure adopted by the local school board.

3. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

191.831. 1. There is hereby established in the state treasury a "Health Initiatives Fund", to which shall be deposited all revenues designated for the fund under subsection 8 of sections

149.015, RSMo, and subsection 3 of section 149.160, RSMo, and section 167.609, RSMo, and all other funds donated to the fund or otherwise deposited pursuant to law. The state treasurer shall administer the fund. Money in the fund shall be appropriated to provide funding for implementing the new programs and initiatives established by sections 105.711 and 105.721, RSMo. The moneys in the fund may further be used to fund those programs established by sections 191.411, 191.520 and 191.600, sections 208.151 and 208.152, RSMo, and sections 103.178, RSMo, 143.999, RSMo, 167.600 to 167.621, RSMo, 188.230, RSMo, 191.211, 191.231, 191.825 to 191.839, RSMo, 192.013, RSMo, 208.177, 208.178, 208.179 and 208.181, RSMo, 211.490, RSMo, 285.240, RSMo, 337.093, RSMo, 374.126, RSMo, 376.891 to 376.894, RSMo, 431.064, RSMo, 660.016, 660.017 and 660.018, RSMo; in addition, not less than fifteen percent of the proceeds deposited to the health initiative fund pursuant to sections 149.015 and 149.160, RSMo, shall be appropriated annually to provide funding for the C-STAR substance abuse rehabilitation program of the department of mental health, or its successor program, and a C-STAR pilot project developed by the director of the division of alcohol and drug abuse and the director of the department of corrections as an alternative to incarceration, as provided in subsections 2, 3, and 4 of this section. Such pilot project shall be known as the "Alt-care" program. In addition, five percent of the proceeds deposited to the health initiatives fund pursuant to sections 149.015 and 149.160, RSMo, shall be appropriated annually to the division of alcohol and drug abuse of the department of mental health to be used for a pilot project to provide access to treatment and rehabilitation services by persons referred to such programs by an alcohol or drug related traffic offender education or rehabilitation program pursuant to sections 302.540, RSMo, 577.049 and 577.520, RSMo. The provisions of section 33.080, RSMo, to the contrary notwithstanding, money in the health initiatives fund shall not be transferred at the close of the biennium to the general revenue fund.

2. The director of the division of alcohol and drug abuse and the director of the department of corrections shall develop and administer a pilot project to provide a comprehensive substance abuse treatment and rehabilitation program as an alternative to incarceration, hereinafter referred to as "Alt-care". Alt-care shall be funded using money provided under subsection 1 of this section through the Missouri Medicaid program, the C-STAR program of the department of mental health, and the division of alcohol and drug abuse's purchase-of-service system. Alt-care shall offer a flexible combination of clinical services and living arrangements individually adapted to each client and her children. Alt-care shall consist of the following components:

(1) Assessment and treatment planning;

(2) Community support to provide continuity, monitoring of progress and access to services and resources;

(3) Counseling from individual to family therapy;

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(4) Day treatment services which include accessibility seven days per week, transportation to and from the Alt-care program, weekly drug testing, leisure activities, weekly events for families and companions, job and education preparedness training, peer support and self-help and daily living skills; and

(5) Living arrangement options which are permanent, substance-free and conducive to treatment and recovery.

3. Any female who is pregnant or is the custodial parent of a child or children under the age of twelve years, and who has pleaded guilty to or found guilty of violating the provisions of chapter 195, RSMo, and whose controlled substance abuse was a precipitating or contributing factor in the commission of the offense, and who is placed on probation may be required, as a condition of probation, to participate in Alt-care, if space is available in the pilot project area. Determinations of eligibility for the program, placement, and continued participation shall be made by the division of alcohol and drug abuse, in consultation with the department of corrections.

4. The availability of space in Alt-care shall be determined by the director of the division of alcohol and drug abuse in conjunction with the director of the department of corrections. If the sentencing court is advised that there is no space available, the court shall consider other authorized dispositions.

5. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

198.401. 1. Each nursing facility, except for state-owned and -operated facilities, shall, in addition to all other fees and taxes now required or paid, pay a nursing facility reimbursement allowance for the privilege of engaging in the business of providing nursing facility services, other than services in an institution for mental diseases, in this state.

2. For the purpose of this section, the phrase "engaging in the business of providing nursing facility services, other than services in an institution for mental diseases, in this state" means accepting payment for such services.

3. For the purpose of this section, the term "nursing facility" shall be defined using the definition in section 1396r, Title 42 United States Code, as amended, and as such qualifies as a class of health care providers recognized in federal Public Law 102-234 Medicaid Voluntary Contribution and Provider Specific Tax Amendment of 1991.

4. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.030. 1. The division of family services shall make monthly payments to each person who was a recipient of old age assistance, aid to the permanently and totally disabled, and aid to the blind and who:

(1) Received such assistance payments from the state of Missouri for the month of

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December, 1973, to which they were legally entitled; and

(2) Is a resident of Missouri.

2. The amount of supplemental payment made to persons who meet the eligibility requirements for and receive federal supplemental security income payments shall be in an amount, as established by rule and regulation of the division of family services, sufficient to, when added to all other income, equal the amount of cash income received in December, 1973; except, in establishing the amount of the supplemental payments, there shall be disregarded cost-of-living increases provided for in Titles II and XVI of the federal Social Security Act and any benefits or income required to be disregarded by an act of Congress of the United States or any regulation duly promulgated thereunder. As long as the recipient continues to receive a supplemental security income payment, the supplemental payment shall not be reduced. The minimum supplemental payment for those persons who continue to meet the December, 1973, eligibility standards for aid to the blind shall be in an amount which, when added to the federal supplemental security income payment, equals the amount of the blind pension grant as provided for in chapter 209, RSMo.

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3. The amount of supplemental payment made to persons who do not meet the eligibility requirements for federal supplemental security income benefits, but who do meet the December, 1973, eligibility standards for old age assistance, permanent and total disability and aid to the blind or less restrictive requirements as established by rule or regulation of the division of family services, shall be in an amount established by rule and regulation of the division of family services sufficient to, when added to all other income, equal the amount of cash income received in December, 1973; except, in establishing the amount of the supplemental payment, there shall be disregarded cost-of-living increases provided for in Titles II and XVI of the federal Social Security Act and any other benefits or income required to be disregarded by an act of Congress of the United States or any regulation duly promulgated thereunder. The minimum supplemental payments for those persons who continue to meet the December, 1973, eligibility standards for aid to the blind shall be a blind pension payment as prescribed in chapter 209, RSMo.

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4. The division of family services shall make monthly payments to persons meeting the eligibility standards for the aid to the blind program in effect December 31, 1973, who are bona fide residents of the state of Missouri. The payment shall be in the amount prescribed in subsection 1 of section 209.040, RSMo, less any federal supplemental security income payment.

5. The division of family services shall make monthly payments to persons age twenty-one or over who meet the eligibility requirements in effect on December 31, 1973, or less restrictive requirements as established by rule or regulation of the division of family services, who were receiving old age assistance, permanent and total disability assistance, general relief assistance, or aid to the blind assistance lawfully, who are not eligible for nursing home care

under the Title XIX program, and who reside in a licensed residential care facility I, a licensed residential care facility II, a licensed intermediate care facility or a licensed skilled nursing facility in Missouri and whose total cash income is not sufficient to pay the amount charged by the facility; and to all applicants age twenty-one or over who are not eligible for nursing home care under the Title XIX program who are residing in a licensed residential care facility I, a licensed residential care facility II, a licensed intermediate care facility or a licensed skilled nursing facility in Missouri, who make application after December 31, 1973, provided they meet the eligibility standards for old age assistance, permanent and total disability assistance, general relief assistance, or aid to the blind assistance in effect on December 31, 1973, or less restrictive requirements as established by rule or regulation of the division of family services, who are bona fide residents of the state of Missouri, and whose total cash income is not sufficient to pay the amount charged by the facility. Until July 1, 1983, the amount of the total state payment for home care in licensed residential care facilities I shall not exceed one hundred twenty dollars monthly, for care in licensed intermediate care facilities or licensed skilled nursing facilities shall not exceed three hundred dollars monthly, and for care in licensed residential care facilities II shall not exceed two hundred twenty-five dollars monthly. Beginning July 1, 1983, for fiscal year 1983-1984 and each year thereafter, the amount of the total state payment for home care in licensed residential care facilities I shall not exceed one hundred fifty-six dollars monthly, for care in licensed intermediate care facilities or licensed skilled nursing facilities shall not exceed three hundred ninety dollars monthly, and for care in licensed residential care facilities II shall not exceed two hundred ninety-two dollars and fifty cents monthly. No intermediate care or skilled nursing payment shall be made to a person residing in a licensed intermediate care facility or in a licensed skilled nursing facility unless such person has been determined, by his own physician or doctor, to medically need such services subject to review and approval by the department. Residential care payments may be made to persons residing in licensed intermediate care facilities or licensed skilled nursing facilities. Any person eligible to receive a monthly payment pursuant to this subsection shall receive an additional monthly payment of not more than twenty-five dollars. The exact amount of the additional payment shall be determined by rule of the department. This additional payment shall not be used to pay for any supplies or services, or for any other items that would have been paid for by the division of family services if that person would have been receiving medical assistance benefits under Title XIX of the federal Social Security Act for nursing home services pursuant to the provisions of section 208.159. Notwithstanding the previous part of this subsection, the person eligible shall not receive this additional payment if such eligible person is receiving funds for personal expenses from some other state or federal program.

6. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

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208.043. 1. Notwithstanding the provisions of section 208.040, aid to dependent children benefits shall be granted on behalf of a needy child and may be granted to a needy eligible legal guardian caring for a needy dependent child who:

(1) Has been deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent;

(2) Is living with a legal guardian;

(3) Is under the age of eighteen; and

(4) Is not eligible for aid to dependent children benefits under section 208.040 because the child is not living with a specified relative.

2. The amount of the monthly public assistance benefit payable hereunder shall be determined by the standards set forth in section 208.150.

3. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.151. 1. For the purpose of paying medical assistance on behalf of needy persons and to comply with Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301 et seq.) as amended, the following needy persons shall be eligible to receive medical assistance to the extent and in the manner hereinafter provided:

(1) All recipients of state supplemental payments for the aged, blind and disabled;

(2) All recipients of aid to families with dependent children benefits, including all persons under nineteen years of age who would be classified as dependent children except for the requirements of subdivision (1) of subsection 1 of section 208.040;

(3) All recipients of blind pension benefits;

(4) All persons who would be determined to be eligible for old age assistance benefits, permanent and total disability benefits, or aid to the blind benefits under the eligibility standards in effect December 31, 1973, or less restrictive standards as established by rule of the division of family services, who are sixty-five years of age or over and are patients in state institutions for mental diseases or tuberculosis;

(5) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children except for the requirements of subdivision (2) of subsection 1 of section 208.040, and who are residing in an intermediate care facility, or receiving active treatment as inpatients in psychiatric facilities or programs, as defined in 42 U.S.C. 1396d, as amended;

(6) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children benefits except for the requirement of deprivation of parental support as provided for in subdivision (2) of subsection 1 of section 208.040;

(7) All persons eligible to receive nursing care benefits;

(8) All recipients of family foster home or nonprofit private child-care institution care,

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subsidized adoption benefits and parental school care wherein state funds are used as partial or full payment for such care;

(9) All persons who were recipients of old age assistance benefits, aid to the permanently and totally disabled, or aid to the blind benefits on December 31, 1973, and who continue to meet the eligibility requirements, except income, for these assistance categories, but who are no longer receiving such benefits because of the implementation of Title XVI of the federal Social Security Act, as amended;

(10) Pregnant women who meet the requirements for aid to families with dependent children, except for the existence of a dependent child in the home;

(11) Pregnant women who meet the requirements for aid to families with dependent children, except for the existence of a dependent child who is deprived of parental support as provided for in subdivision (2) of subsection 1 of section 208.040;

(12) Pregnant women or infants under one year of age, or both, whose family income does not exceed an income eligibility standard equal to one hundred eighty-five percent of the federal poverty level as established and amended by the federal Department of Health and Human Services, or its successor agency;

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(13) Children who have attained one year of age but have not attained six years of age who are eligible for medical assistance under 6401 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989). The division of family services shall use an income eligibility standard equal to one hundred thirty-three percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency;

(14) Children who have attained six years of age but have not attained nineteen years of age. For children who have attained six years of age but have not attained nineteen years of age, the division of family services shall use an income assessment methodology which provides for eligibility when family income is equal to or less than equal to one hundred percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency. As necessary to provide Medicaid coverage under this subdivision, the department of social services may revise the state Medicaid plan to extend coverage under 42 U.S.C. 1396a (a)(10)(A)(i)(III) to children who have attained six years of age but have not attained nineteen years of age as permitted by paragraph (2) of subsection (n) of 42 U.S.C. 1396d using a more liberal income assessment methodology as authorized by paragraph (2) of subsection (r) of 42 U.S.C. 1396a;

(15) The following children with family income which does not exceed two hundred percent of the federal poverty guideline for the applicable family size:

(a) Infants who have not attained one year of age with family income greater than one hundred eighty-five percent of the federal poverty guideline for the applicable family size;

(b) Children who have attained one year of age but have not attained six years of age

with family income greater than one hundred thirty-three percent of the federal poverty guideline for the applicable family size; and

(c) Children who have attained six years of age but have not attained nineteen years of age with family income greater than one hundred percent of the federal poverty guideline for the applicable family size.

Coverage under this subdivision shall be subject to the receipt of notification by the director of the department of social services and the revisor of statutes of approval from the secretary of the U.S. Department of Health and Human Services of applications for waivers of federal requirements necessary to promulgate regulations to implement this subdivision. The director of the department of social services shall apply for such waivers. The regulations may provide for a basic primary and preventive health care services package, not to include all medical services covered by section 208.152, and may also establish co-payment, coinsurance, deductible, or premium requirements for medical assistance under this subdivision. Eligibility for medical assistance under this subdivision shall be available only to those infants and children who do not have or have not been eligible for employer-subsidized health care insurance coverage for the six months prior to application for medical assistance. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The division of family services may establish a resource eligibility standard in assessing eligibility for persons under this subdivision. The division of medical services shall define the amount and scope of benefits which are available to individuals under this subdivision in accordance with the requirement of federal law and regulations. Coverage under this subdivision shall be subject to appropriation to provide services approved under the provisions of this subdivision;

(16) The division of family services shall not establish a resource eligibility standard in assessing eligibility for persons under subdivision (12), (13) or (14) of this subsection. The division of medical services shall define the amount and scope of benefits which are available to individuals eligible under each of the subdivisions (12), (13), and (14) of this subsection, in accordance with the requirements of federal law and regulations promulgated thereunder except that the scope of benefits shall include case management services;

(17) Notwithstanding any other provisions of law to the contrary, ambulatory prenatal care shall be made available to pregnant women during a period of presumptive eligibility pursuant to 42 U.S.C. Section 1396r-1, as amended;

(18) A child born to a woman eligible for and receiving medical assistance under this section on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of time determined in accordance with applicable federal and state law and regulations so long as the child is a member of the woman's household and either the woman remains eligible for such assistance or for children born on or

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after January 1, 1991, the woman would remain eligible for such assistance if she were still pregnant. Upon notification of such child's birth, the division of family services shall assign a medical assistance eligibility identification number to the child so that claims may be submitted and paid under such child's identification number;

(19) Pregnant women and children eligible for medical assistance pursuant to subdivision (12), (13) or (14) of this subsection shall not as a condition of eligibility for medical assistance benefits be required to apply for aid to families with dependent children. The division of family services shall utilize an application for eligibility for such persons which eliminates information requirements other than those necessary to apply for medical assistance. The division shall provide such application forms to applicants whose preliminary income information indicates that they are ineligible for aid to families with dependent children. Applicants for medical assistance benefits under subdivision (12), (13) or (14) shall be informed of the aid to families with dependent children program and that they are entitled to apply for such benefits. Any forms utilized by the division of family services for assessing eligibility under this chapter shall be as simple as practicable;

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(20) Subject to appropriations necessary to recruit and train such staff, the division of family services shall provide one or more full-time, permanent case workers to process applications for medical assistance at the site of a health care provider, if the health care provider requests the placement of such case workers and reimburses the division for the expenses including but not limited to salaries, benefits, travel, training, telephone, supplies, and equipment, of such case workers. The division may provide a health care provider with a part-time or temporary case worker at the site of a health care provider if the health care provider requests the placement of such a case worker and reimburses the division for the expenses, including but not limited to the salary, benefits, travel, training, telephone, supplies, and equipment, of such a case worker. The division may seek to employ such case workers who are otherwise qualified for such positions and who are current or former welfare recipients. The division may consider training such current or former welfare recipients as case workers for this program;

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(21) Pregnant women who are eligible for, have applied for and have received medical assistance under subdivision (2), (10), (11) or (12) of this subsection shall continue to be considered eligible for all pregnancy-related and postpartum medical assistance provided under section 208.152 until the end of the sixty-day period beginning on the last day of their pregnancy;

(22) Case management services for pregnant women and young children at risk shall be a covered service. To the greatest extent possible, and in compliance with federal law and regulations, the department of health and senior services shall provide case management services to pregnant women by contract or agreement with the department of social services through local health departments organized under the provisions of chapter 192, RSMo, or chapter 205, RSMo,

or a city health department operated under a city charter or a combined city-county health department or other department of health and senior services designees. To the greatest extent possible the department of social services and the department of health and senior services shall mutually coordinate all services for pregnant women and children with the crippled children's program, the prevention of mental retardation program and the prenatal care program administered by the department of health and senior services. The department of social services shall by regulation establish the methodology for reimbursement for case management services provided by the department of health and senior services. For purposes of this section, the term "case management" shall mean those activities of local public health personnel to identify prospective Medicaid-eligible high-risk mothers and enroll them in the state's Medicaid program, refer them to local physicians or local health departments who provide prenatal care under physician protocol and who participate in the Medicaid program for prenatal care and to ensure that said high-risk mothers receive support from all private and public programs for which they are eligible and shall not include involvement in any Medicaid prepaid, case-managed programs;

(23) By January 1, 1988, the department of social services and the department of health and senior services shall study all significant aspects of presumptive eligibility for pregnant women and submit a joint report on the subject, including projected costs and the time needed for implementation, to the general assembly. The department of social services, at the direction of the general assembly, may implement presumptive eligibility by regulation promulgated pursuant to chapter 207, RSMo;

(24) All recipients who would be eligible for aid to families with dependent children benefits except for the requirements of paragraph (d) of subdivision (1) of section 208.150;

(25) All persons who would be determined to be eligible for old age assistance benefits, permanent and total disability benefits, or aid to the blind benefits, under the eligibility standards in effect December 31, 1973; except that, on or after July 1, 2002, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to eighty percent of the federal poverty level and, as of July 1, 2003, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to ninety percent of the federal poverty level and, as of July 1, 2004, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to one hundred percent of the federal poverty level. If federal law or regulation authorizes the division of family services to, by rule, exclude the income or resources of a parent or parents of a person under the age of eighteen and such exclusion of income or resources can be limited to such parent or parents, then notwithstanding the provisions of section 208.010:

(a) The division may by rule exclude such income or resources in determining such person's eligibility for permanent and total disability benefits; and

(b) Eligibility standards for permanent and total disability benefits shall not be limited

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by age;

(26) Within thirty days of the effective date of an initial appropriation authorizing medical assistance on behalf of "medically needy" individuals for whom federal reimbursement is available under 42 U.S.C. 1396a (a)(10)(c), the department of social services shall submit an amendment to the Medicaid state plan to provide medical assistance on behalf of, at a minimum, an individual described in subclause (I) or (II) of clause 42 U.S.C. 1396a (a)(10)(C)(ii);

(27) Persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage pursuant to 42 U.S.C. 1396a (a)(10)(A)(ii)(XVIII). Such persons shall be eligible during a period of presumptive eligibility in accordance with 42 U.S.C. 1396r-1.

2. Rules and regulations to implement this section shall be promulgated in accordance with section 431.064, RSMo, and chapter 536, RSMo. 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, 2002, shall be invalid and void.

3. After December 31, 1973, and before April 1, 1990, any family eligible for assistance pursuant to 42 U.S.C. 601 et seq., as amended, in at least three of the last six months immediately preceding the month in which such family became ineligible for such assistance because of increased income from employment shall, while a member of such family is employed, remain eligible for medical assistance for four calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of income and resource limitation. After April 1, 1990, any family receiving aid pursuant to 42 U.S.C. 601 et seq., as amended, in at least three of the six months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of employment or income from employment of the caretaker relative, shall remain eligible for medical assistance for six calendar months following the month of such ineligibility as long as such family includes a child as provided in 42 U.S.C. 1396r-6. Each family which has received such medical assistance during the entire six-month period described in this section and which meets reporting requirements and income tests established by the division and continues to include a child as provided in 42 U.S.C. 1396r-6 shall receive medical assistance without fee for an additional six months. The division of medical services may provide by rule the scope of medical assistance coverage to be granted to such families.

4. For purposes of Section 1902(1), (10) of Title XIX of the federal Social Security Act, as amended, any individual who, for the month of August, 1972, was eligible for or was receiving

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aid or assistance pursuant to the provisions of Titles I, X, XIV, or Part A of Title IV of such act and who, for such month, was entitled to monthly insurance benefits under Title II of such act, shall be deemed to be eligible for such aid or assistance for such month thereafter prior to October, 1974, if such individual would have been eligible for such aid or assistance for such month had the increase in monthly insurance benefits under Title II of such act resulting from enactment of Public Law 92-336 amendments to the federal Social Security Act (42 U.S.C. 301 et seq.), as amended, not been applicable to such individual.

5. When any individual has been determined to be eligible for medical assistance, such medical assistance will be made available to him for care and services furnished in or after the third month before the month in which he made application for such assistance if such individual was, or upon application would have been, eligible for such assistance at the time such care and services were furnished; provided, further, that such medical expenses remain unpaid.

6. The department of social services may apply to the federal Department of Health and Human Services for a Medicaid waiver amendment to the Section 1115 demonstration waiver or for any additional Medicaid waivers necessary and desirable to implement the increased income limit, as authorized in subdivision (25) of subsection 1 of this section.

7. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

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

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

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

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be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for recipients, except to persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the division of aging or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX, of the federal Social Security Act (42 U.S.C. 301, et seq.), as amended, for nursing facilities. The division of medical services may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of Medicaid patients. The division of medical services when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

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

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

(7) Dental services;

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

(9) Drugs and medicines when prescribed by a licensed physician, dentist, or podiatrist;

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

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

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(12) Home health care services;

(13) Optometric services as defined in section 336.010, RSMo;

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

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

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

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

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

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

(a) Outpatient mental health services including preventive, diagnostic, therapeutic,

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

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

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

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

(21) Hospice care. As used in this subsection, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness,

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and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. Beginning July 1, 1990, the rate of reimbursement paid by the division of medical services to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

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

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

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

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

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

a. The occupancy rate of the nursing home is at or above ninety-seven percent of Medicaid certified licensed beds, according to the most recent quarterly census provided to the division of aging which was taken prior to when the recipient is admitted to the hospital; and

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

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

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

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

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

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

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

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

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded

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health centers shall be in accordance with the provisions of subsection 6402(c) and section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

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

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

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

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

11. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.153. 1. Pursuant to and not inconsistent with the provisions of sections 208.151 and 208.152, the division of medical services shall by rule and regulation define the reasonable costs, manner, extent, quantity, quality, charges and fees of medical assistance herein provided. The benefits available under these sections shall not replace those provided under other federal or state law or under other contractual or legal entitlements of the persons receiving them, and all persons shall be required to apply for and utilize all benefits available to them and to pursue all causes of action to which they are entitled. Any person entitled to medical assistance may obtain it from any provider of services with which an agreement is in effect under this section and which undertakes to provide the services, as authorized by the division of medical services. At the discretion of the director of medical services and with the approval of the governor, the division of medical services is authorized to provide medical benefits for recipients of public assistance by expending funds for the payment of federal medical insurance premiums, coinsurance and deductibles pursuant to the provisions of Title XVIII B and XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301 et seq.), as amended.

2. Medical assistance shall include benefit payments on behalf of qualified Medicare beneficiaries as defined in 42 U.S.C. section 1396d(p). The division of family services shall by

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

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

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

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

6. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.162. 1. Benefit payments for medical assistance shall be made on behalf of those individuals who are receiving general relief benefits under section 208.015, with any payments to be made on the basis of reasonable cost of the care or reasonable charge for the services as defined and determined by the division of family services, for the following, provided that the division of family services may negotiate a rate of payment for hospital services different than

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the Medicare rate for such services:

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

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

(3) Laboratory and X-ray services;

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

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

(6) Emergency ambulance services;

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

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

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

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

5. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.166. 1. As used in this section, the following terms mean:

(1) "Department", the Missouri department of social services;

(2) "Prepaid capitated", a mode of payment by which the department periodically reimburse a contracted health provider plan or primary care physician sponsor for delivering health care services for the duration of a contract to a maximum specified number of members based on a fixed rate per member, notwithstanding:

(a) The actual number of members who receive care from the provider; or

(b) The amount of health care services provided to any members;

(3) "Primary care case-management", a mode of payment by which the department reimburses a contracted primary care physician sponsor on a fee-for-service schedule plus a monthly fee to manage each recipient's case;

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(4) "Primary care physician sponsor", a physician licensed pursuant to chapter 334, RSMo, who is a family practitioner, general practitioner, pediatrician, general internist or an obstetrician or gynecologist;

(5) "Specialty physician services arrangement", an arrangement where the department may restrict recipients of specialty services to designated providers of such services, even in the absence of a primary care case-management system.

2. The department or its designated division shall maximize the use of prepaid health plans, where appropriate, and other alternative service delivery and reimbursement methodologies, including, but not limited to, individual primary care physician sponsors or specialty physician services arrangements, designed to facilitate the cost-effective purchase of comprehensive health care.

3. In order to provide comprehensive health care, the department or its designated division shall have authority to:

(1) Purchase medical services for recipients of public assistance from prepaid health plans, health maintenance organizations, health insuring organizations, preferred provider organizations, individual practice associations, local health units, community health centers, or primary care physician sponsors;

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(2) Reimburse those health care plans or primary care physicians' sponsors who enter into direct contract with the department on a prepaid capitated or primary care case-management basis on the following conditions:

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(a) That the department or its designated division shall ensure, whenever possible and consistent with quality of care and cost factors, that publicly supported neighborhood and community-supported health clinics shall be utilized as providers;

(b) That the department or its designated division shall ensure reasonable access to medical services in geographic areas where managed or coordinated care programs are initiated; and

(c) That the department shall ensure full freedom of choice for prescription drugs at any Medicaid participating pharmacy;

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(3) Limit providers of medical assistance benefits to those who demonstrate efficient and economic service delivery for the level of service they deliver, and provided that such limitation shall not limit recipients from reasonable access to such levels of service;

(4) Provide recipients of public assistance with alternative services as provided for in state law, subject to appropriation by the general assembly;

(5) Designate providers of medical assistance benefits to assure specifically defined medical assistance benefits at a reduced cost to the state, to assure reasonable access to all levels of health services and to assure maximization of federal financial participation in the delivery of health related services to Missouri citizens; provided, all qualified providers that deliver such

specifically defined services shall be afforded an opportunity to compete to meet reasonable state criteria and to be so designated;

(6) Upon mutual agreement with any entity of local government, to elect to use local government funds as the matching share for Title XIX payments, as allowed by federal law or regulation;

(7) To elect not to offset local government contributions from the allowable costs under the Title XIX program, unless prohibited by federal law and regulation.

4. Nothing in this section shall be construed to authorize the department or its designated division to limit the recipient's freedom of selection among health care plans or primary care physician sponsors, as authorized in this section, who have entered into contract with the department or its designated division to provide a comprehensive range of health care services on a prepaid capitated or primary care case-management basis, except in those instances of overutilization of Medicaid services by the recipient.

5. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.168. 1. Beginning July 1, 1983, in addition to those benefit payments for medical assistance for eligible needy persons authorized under the provisions of section 208.152, benefit payments for medical assistance may be made on behalf of those eligible needy persons who are unable to provide for it in whole or in part for adult day care and treatment to those persons who would require placement in an intermediate care facility or skilled nursing home as the latter two terms are defined by section 198.006, RSMo.

2. Payments under this section shall be made on the basis of the reasonable cost of the care as reasonable cost of the services is defined and determined by the division of family services.

3. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.201. 1. The "Division of Medical Services" is hereby established within the department of social services. The director of the division shall be appointed by the director of the department.

2. The division of medical services is an integral part of the department of social services and shall have and exercise all the powers and duties necessary to carry out fully and effectively the purposes assigned to it by law and shall be the state agency to administer payments to providers under the medical assistance program and to carry out such other functions, duties, and responsibilities as the division of medical services may be transferred by law, or by a departmental reorganizational plan pursuant to law.

3. All powers, duties and functions of the division of family services relative to the development, administration and enforcement of the medical assistance programs of this state are

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transferred by type I transfer as defined in the Omnibus State Reorganization Act of 1974 to the division of medical services. The division of family services shall retain the authority to determine and regulate the eligibility of needy persons for participation in the medical assistance program.

4. The director of the division of medical services shall exercise the powers and duties of an appointing authority under chapter 36, RSMo, to employ such administrative, technical, and other personnel as may be necessary, and may designate subdivisions as needed for the performance of the duties and responsibilities of the division.

5. In addition to the powers, duties and functions vested in the division of medical services by other provisions of this chapter or by other laws of this state, the division of medical services shall have the power:

(1) To sue and be sued;

(2) To adopt, amend and rescind such rules and regulations necessary or desirable to perform its duties under state law and not inconsistent with the constitution or laws of this state;

(3) To make and enter into contracts and carry out the duties imposed upon it by this or any other law;

(4) To administer, disburse, accept, dispose of and account for funds, equipment, supplies or services, and any kind of property given, granted, loaned, advanced to or appropriated by the state of Missouri or the federal government for any lawful purpose;

(5) To cooperate with the United States government in matters of mutual concern pertaining to any duties of the division of medical services or the department of social services, including the adoption of such methods of administration as are found by the United States government to be necessary for the efficient operation of state medical assistance plans required by federal law, and the modification or amendment of a state medical assistance plan where required by federal law;

(6) To make reports in such form and containing such information as the United States government may, from time to time, require and comply with such provisions as the United States government may, from time to time, find necessary to assure the correctness and verification of such reports;

(7) To create and appoint, when and if it may deem necessary, advisory committees not otherwise provided in any other provision of the law to provide professional or technical consultation with respect to medical assistance program administration. Each advisory committee shall consult with and advise the division of medical services with respect to policies incident to the administration of the particular function germane to their respective field of competence;

(8) To define, establish and implement the policies and procedures necessary to administer payments to providers under the medical assistance program;

(9) To conduct utilization reviews to determine the appropriateness of services and

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reimbursement amounts to providers participating in the medical assistance program;

(10) To establish or cooperate in research or demonstration projects relative to the medical assistance programs, including those projects which will aid in effective coordination or planning between private and public medical assistance programs and providers, or which will help improve the administration and effectiveness of medical assistance programs.

6. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.204. **1.** The division of medical services may administer the funds appropriated to the department of social services or any division of the department for payment of medical care provided to children in the legal custody of the department of social services or any division of the department.

2. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.215. 1. Medicaid is payer of last resort unless otherwise specified by law. When any person, corporation, institution, public agency or private agency is liable, either pursuant to contract or otherwise, to a recipient of public assistance on account of personal injury to or disability or disease or benefits arising from a health insurance plan to which the recipient may be entitled, payments made by the department of social services shall be a debt due the state and recoverable from the liable party or recipient for all payments made in behalf of the recipient and the debt due the state shall not exceed the payments made from medical assistance provided under sections 208.151 to 208.158 and section 208.162 and section 208.204 on behalf of the recipient, minor or estate for payments on account of the injury, disease, or disability or benefits arising from a health insurance program to which the recipient may be entitled.

2. The department of social services may maintain an appropriate action to recover funds due under this section in the name of the state of Missouri against the person, corporation, institution, public agency, or private agency liable to the recipient, minor or estate.

3. Any recipient, minor, guardian, conservator, personal representative, estate, including persons entitled under section 537.080, RSMo, to bring an action for wrongful death who pursues legal rights against a person, corporation, institution, public agency, or private agency liable to that recipient or minor for injuries, disease or disability or benefits arising from a health insurance plan to which the recipient may be entitled as outlined in subsection 1 of this section shall upon actual knowledge that the department of social services has paid medical assistance benefits as defined by this chapter, promptly notify the department as to the pursuit of such legal rights.

4. Every applicant or recipient by application assigns his right to the department of any funds recovered or expected to be recovered to the extent provided for in this section. All applicants and recipients, including a person authorized by the probate code, shall cooperate with

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the department of social services in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services available under the state's plan for medical assistance as provided in sections 208.151 to 208.159 and sections 208.162 and 208.204. All applicants and recipients shall cooperate with the agency in obtaining third-party resources due to the applicant, recipient, or child for whom assistance is claimed. Failure to cooperate without good cause as determined by the department of social services in accordance with federally prescribed standards, shall render the applicant or recipient ineligible for medical assistance under sections 208.151 to 208.159 and sections 208.162 and 208.204.

5. Every person, corporation or partnership who acts for or on behalf of a person who is or was eligible for medical assistance under sections 208.151 to 208.159 and sections 208.162 and 208.204 for purposes of pursuing the applicant's or recipient's claim which accrued as a result of a nonoccupational or nonwork-related incident or occurrence resulting in the payment of medical assistance benefits shall notify the department upon agreeing to assist such person and further shall notify the department of any institution of a proceeding, settlement or the results of the pursuit of the claim and give thirty days' notice before any judgment, award, or settlement may be satisfied in any action or any claim by the applicant or recipient to recover damages for such injuries, disease, or disability, or benefits arising from a health insurance program to which the recipient may be entitled.

6. Every recipient, minor, guardian, conservator, personal representative, estate, including persons entitled under section 537.080, RSMo, to bring an action for wrongful death, or his attorney or legal representative shall promptly notify the department of any recovery from a third party and shall immediately reimburse the department from the proceeds of any settlement, judgment, or other recovery in any action or claim initiated against any such third party.

7. The department director shall have a right to recover the amount of payments made to a provider under this chapter because of an injury, disease, or disability, or benefits arising from a health insurance plan to which the recipient may be entitled for which a third party is or may be liable in contract, tort or otherwise under law or equity.

8. The department of social services shall have a lien upon any moneys to be paid by any insurance company or similar business enterprise, person, corporation, institution, public agency or private agency in settlement or satisfaction of a judgment on any claim for injuries or disability or disease benefits arising from a health insurance program to which the recipient may be entitled which resulted in medical expenses for which the department made payment. This lien shall also be applicable to any moneys which may come into the possession of any attorney who is handling the claim for injuries, or disability or disease or benefits arising from a health insurance plan to which the recipient may be entitled which resulted in payments made by the

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department. In each case, a lien notice shall be served by certified mail or registered mail, upon the party or parties against whom the applicant or recipient has a claim, demand or cause of action. The lien shall claim the charge and describe the interest the department has in the claim, demand or cause of action. The lien shall attach to any verdict or judgment entered and to any money or property which may be recovered on account of such claim, demand, cause of action or suit from and after the time of the service of the notice.

9. On petition filed by the department, or by the recipient, or by the defendant, the court, on written notice of all interested parties, may adjudicate the rights of the parties and enforce the charge. The court may approve the settlement of any claim, demand or cause of action either before or after a verdict, and nothing in this section shall be construed as requiring the actual trial or final adjudication of any claim, demand or cause of action upon which the department has charge. The court may determine what portion of the recovery shall be paid to the department against the recovery. In making this determination the court shall conduct an evidentiary hearing and shall consider competent evidence pertaining to the following matters:

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(1) The amount of the charge sought to be enforced against the recovery when expressed as a percentage of the gross amount of the recovery; the amount of the charge sought to be enforced against the recovery when expressed as a percentage of the amount obtained by subtracting from the gross amount of the recovery the total attorney's fees and other costs incurred by the recipient incident to the recovery; and whether the department should, as a matter of fairness and equity, bear its proportionate share of the fees and costs incurred to generate the recovery from which the charge is sought to be satisfied;

(2) The amount, if any, of the attorney's fees and other costs incurred by the recipient incident to the recovery and paid by the recipient up to the time of recovery, and the amount of such fees and costs remaining unpaid at the time of recovery;

(3) The total hospital, doctor and other medical expenses incurred for care and treatment of the injury to the date of recovery therefor, the portion of such expenses theretofore paid by the recipient, by insurance provided by the recipient, and by the department, and the amount of such previously incurred expenses which remain unpaid at the time of recovery and by whom such incurred, unpaid expenses are to be paid;

(4) Whether the recovery represents less than substantially full recompense for the injury and the hospital, doctor and other medical expenses incurred to the date of recovery for the care and treatment of the injury, so that reduction of the charge sought to be enforced against the recovery would not likely result in a double recovery or unjust enrichment to the recipient;

(5) The age of the recipient and of persons dependent for support upon the recipient, the nature and permanency of the recipient's injuries as they affect not only the future employability and education of the recipient but also the reasonably necessary and foreseeable future material, maintenance, medical rehabilitative and training needs of the recipient, the cost of such

reasonably necessary and foreseeable future needs, and the resources available to meet such needs and pay such costs;

(6) The realistic ability of the recipient to repay in whole or in part the charge sought to be enforced against the recovery when judged in light of the factors enumerated above.

10. The burden of producing evidence sufficient to support the exercise by the court of its discretion to reduce the amount of a proven charge sought to be enforced against the recovery shall rest with the party seeking such reduction.

11. The court may reduce and apportion the department's lien proportionate to the recovery of the claimant. The court may consider the nature and extent of the injury, economic and noneconomic loss, settlement offers, comparative negligence as it applies to the case at hand, hospital costs, physician costs, and all other appropriate costs. The department shall pay its pro rata share of the attorney's fees based on the department's lien as it compares to the total settlement agreed upon. This section shall not affect the priority of an attorney's lien under section 484.140, RSMo. The charges of the department described in this section, however, shall take priority over all other liens and charges existing under the laws of the state of Missouri with the exception of the attorney's lien under such statute.

12. Whenever the department of social services has a statutory charge under this section against a recovery for damages incurred by a recipient because of its advancement of any assistance, such charge shall not be satisfied out of any recovery until the attorney's claim for fees is satisfied, irrespective of whether or not an action based on recipient's claim has been filed in court. Nothing herein shall prohibit the director from entering into a compromise agreement with any recipient, after consideration of the factors in subsections 9 to 13 of this section.

13. This section shall be inapplicable to any claim, demand or cause of action arising under the workers' compensation act, chapter 287, RSMo. From funds recovered pursuant to this section the federal government shall be paid a portion thereof equal to the proportionate part originally provided by the federal government to pay for medical assistance to the recipient or minor involved. The department shall have the right to enforce TEFRA liens, 42 U.S.C. 1396p, as authorized by federal law and regulation. For the purposes of this subsection, "property" includes the homestead and all other personal and real property in which the recipient has sole legal interest or a legal interest based upon co-ownership of the property which is the result of a transfer of property for less than the fair market value within thirty months prior to the recipient's entering the nursing facility. The following provisions shall apply to such liens:

(1) The lien shall be for the debt due the state for medical assistance paid or to be paid on behalf of a recipient. The amount of the lien shall be for the full amount due the state at the time the lien is enforced;

(2) The director of the department or the director's designee shall file for record, with the recorder of deeds of the county in which any real property of the recipient is situated, a written

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notice of the lien. The notice of lien shall contain the name of the recipient and a description of the real estate. The recorder shall note the time of receiving such notice, and shall record and index the notice of lien in the same manner as deeds of real estate are required to be recorded and indexed. The director or the director's designee may release or discharge all or part of the lien and notice of the release shall also be filed with the recorder;

(3) No such lien may be imposed against the property of any individual prior to his death on account of medical assistance paid except:

(a) In the case of the real property of an individual:

a. Who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution, to spend for costs of medical care all but a minimal amount of his income required for personal needs; and

b. With respect to whom the director of the department of social services or the director's designee determines, after notice and opportunity for hearing, that he cannot reasonably be expected to be discharged from the medical institution and to return home. The hearing, if requested, shall proceed under the provisions of chapter 536, RSMo, before a hearing officer designated by the director of the department of social services; or

(b) Pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual;

(4) No lien may be imposed under paragraph (b) of subdivision (3) of this subsection on such individual's home if one or more of the following persons is lawfully residing in such home:

(a) The spouse of such individual;

(b) Such individual's child who is under twenty-one years of age, or is blind or permanently and totally disabled; or

(c) A sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution;

(5) Any lien imposed with respect to an individual pursuant to subparagraph b of paragraph (a) of subdivision (3) of this subsection shall dissolve upon that individual's discharge from the medical institution and return home.

14. The debt due the state provided by this section is subordinate to the lien provided by section 484.130, RSMo, or section 484.140, RSMo, relating to an attorney's lien and to the recipient's expenses of the claim against the third party.

15. Application for and acceptance of medical assistance under this chapter shall constitute an assignment to the department of social services of any rights to support for the purpose of medical care as determined by a court or administrative order and of any other rights to payment for medical care.

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16. All recipients of benefits as defined in this chapter shall cooperate with the state by reporting to the division of family services or the division of medical services, within thirty days, any occurrences where an injury to their persons or to a member of a household who receives medical assistance is sustained, on such form or forms as provided by the division of family services or the division of medical services.

17. If a person fails to comply with the provision of any judicial or administrative decree or temporary order requiring that person to maintain medical insurance on or be responsible for medical expenses for a dependent child, spouse, or ex-spouse, in addition to other remedies available, that person shall be liable to the state for the entire cost of the medical care provided pursuant to eligibility under any public assistance program on behalf of that dependent child, spouse, or ex-spouse during the period for which the required medical care was provided. Where a duty of support exists and no judicial or administrative decree or temporary order for support has been entered, the person owing the duty of support shall be liable to the state for the entire cost of the medical care provided on behalf of the dependent child or spouse to whom the duty of support is owed.

18. The department director or his designee may compromise, settle or waive any such claim in whole or in part in the interest of the medical assistance program.

19. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.453. **1.** Every hospital as defined by section 197.020, RSMo, except public hospitals which are operated primarily for the care and treatment of mental disorders and any hospital operated by the department of health and senior services, shall, in addition to all other fees and taxes now required or paid, pay a federal reimbursement allowance for the privilege of engaging in the business of providing inpatient health care in this state. For the purpose of this section, the phrase "engaging in the business of providing inpatient health care in this state" shall mean accepting payment for inpatient services rendered. The federal reimbursement allowance to be paid by a hospital which has an unsponsored care ratio that exceeds sixty-five percent or hospitals owned or operated by the board of curators, as defined in chapter 172, RSMo, may be eliminated by the director of the department of social services. The unsponsored care ratio shall be calculated by the department of social services.

2. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.631. 1. Notwithstanding any other provision of law to the contrary, the department of social services shall establish a program to pay for health care for uninsured children. Coverage pursuant to sections 208.631 to 208.660 is subject to appropriation. The provisions of sections 208.631 to 208.657 shall be void and of no effect after July 1, 2007.

2. For the purposes of sections 208.631 to 208.657, "children" are persons up to nineteen

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years of age. "Uninsured children" are persons up to nineteen years of age who are emancipated and do not have access to affordable employer-subsidized health care insurance or other health care coverage or persons whose parent or guardian have not had access to affordable employer-subsidized health care insurance or other health care coverage for their children for six months prior to application, are residents of the state of Missouri, and have parents or guardians who meet the requirements in section 208.636. A child who is eligible for medical assistance as authorized in section 208.151 is not uninsured for the purposes of sections 208.631 to 208.657.

3. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.633. **1.** The department of social services is authorized to pay for coverage of health care services for uninsured children whose parents or guardians have an available income between zero percent and one hundred eighty-five percent, between one hundred eighty-six percent and two hundred twenty-five percent, between two hundred twenty-six percent and two hundred fifty percent, between two hundred fifty-one percent and two hundred seventy-five percent and between two hundred seventy-six percent and three hundred percent of the federal poverty level, subject to appropriation.

2. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.636. **1.** Parents and guardians of uninsured children eligible for the program established in sections 208.631 to 208.657 shall:

(1) Furnish to the department of social services the uninsured child's Social Security number or numbers, if the uninsured child has more than one such number;

(2) Cooperate with the department of social services in identifying and providing information to assist the state in pursuing any third-party insurance carrier who may be liable to pay for health care;

(3) Cooperate with the department of social services, division of child support enforcement in establishing paternity and in obtaining support payments, including medical support;

(4) Demonstrate upon request their child's participation in wellness programs including immunizations and a periodic physical examination. This subdivision shall not apply to any child whose parent or legal guardian objects in writing to such wellness programs including immunizations and an annual physical examination because of religious beliefs or medical contraindications; and

(5) Demonstrate annually that their total net worth does not exceed two hundred fifty thousand dollars in total value.

2. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

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208.640. 1. Parents and guardians of uninsured children with available incomes between one hundred eighty-six and two hundred twenty-five percent of the federal poverty level are responsible for a five-dollar co-payment.

2. Parents and guardians of uninsured children with incomes between two hundred twenty-six and three hundred percent of the federal poverty level who do not have access to affordable employer-sponsored health care insurance or other affordable health care coverage may obtain coverage pursuant to this subsection. For the purposes of sections 208.631 to 208.657, "affordable employer-sponsored health care insurance or other affordable health care coverage" refers to health insurance requiring a monthly premium less than or equal to one hundred thirty-three percent of the monthly average premium required in the state's current Missouri consolidated health care plan. The parents and guardians of eligible uninsured children pursuant to this subsection are responsible for co-payments equal to the average co-payments required in the current Missouri consolidated health care plan rounded to the nearest dollar, and a monthly premium equal to the average premium required for the Missouri consolidated health care plan; provided that the total aggregate cost sharing for a family covered by these sections shall not exceed five percent of such family's income for the years involved. No co-payments or other cost sharing is permitted with respect to benefits for well-baby and well-child care including age-appropriate immunizations. Cost-sharing provisions pursuant to sections 208.631 to 208.657 shall not exceed the limits established by 42 U.S.C. Section 1397cc(e).

3. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.643. 1. The department of social services shall implement policies establishing a program to pay for health care for uninsured children by rules promulgated pursuant to chapter 536, RSMo, either statewide or in certain geographic areas, subject to obtaining necessary federal approval and appropriation authority. The rules may provide for a health care services package that includes all medical services covered by section 208.152, except nonemergency transportation.

2. Available income shall be determined by the department of social services by rule, which shall comply with federal laws and regulations relating to the state's eligibility to receive federal funds to implement the insurance program established in sections 208.631 to 208.657.

3. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.646. **1.** There shall be a thirty-day waiting period after enrollment for uninsured children in families with an income of more than two hundred twenty-five percent of the federal poverty level before the child becomes eligible for insurance under the provisions of sections 208.631 to 208.660. If the parent or guardian with an income of more than two hundred twenty-five percent of the federal poverty level fails to meet the co-payment or premium

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requirements, the child shall not be eligible for coverage under sections 208.631 to 208.660 for six months after the department provides notice of such failure to the parent or guardian.

2. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.650. 1. The department of social services shall commission a study on the impact of this program on providing a comprehensive array of community-based wraparound services for seriously emotionally disturbed children and children affected by substance abuse. The department shall issue a report to the general assembly within forty-five days of the twelve-month anniversary of the beginning of this program and yearly thereafter. This report shall include recommendations to the department on how to improve access to the provisions of community-based wraparound services pursuant to sections 208.631 to 208.660.

2. The department of social services shall prepare an annual report to the governor and the general assembly on the effect of this program. The report shall include, but is not limited to:

(1) The number of children participating in the program in each income category;

(2) The effect of the program on the number of children covered by private insurers;

(3) The effect of the program on medical facilities, particularly emergency rooms;

(4) The overall effect of the program on the health care of Missouri residents;

(5) The overall cost of the program to the state of Missouri; and

(6) The methodology used to determine availability for the purpose of enrollment, as established by rule.

3. The department of social services shall establish an identification program to identify children not participating in the program though eligible for extended medical coverage. The department's efforts to identify these uninsured children shall include, but not be limited to:

(1) Working closely with hospitals and other medical facilities; and

(2) Establishing a statewide education and information program.

4. The department of social services shall commission a study on any negative impact this program may have on the number of children covered by private insurance as a result of expanding health care coverage to children with a gross family income above one hundred eighty-five percent of the federal poverty level. The department shall issue a report to the general assembly within forty-five days of the twelve-month anniversary of the beginning of this program and annually thereafter. If this study demonstrates that a measurable negative impact on the number of privately insured children is occurring, the department shall take one or more of the following measures targeted at eliminating the negative impact:

(1) Implementing additional co-payments, sliding scale premiums or other cost-sharing provisions;

(2) Adding an insurability test to preclude participation;

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(3) Increasing the length of the required period of uninsured status prior to application;

(4) Limiting enrollment to an annual open enrollment period for children with gross family incomes above one hundred eighty-five percent of the federal poverty level; and

(5) Any other measures designed to efficiently respond to the measurable negative impact.

5. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

208.655. **1.** No funds used to pay for insurance or for services pursuant to sections 208.631 to 208.657 may be expended to encourage, counsel or refer for abortion unless the abortion is done to save the life of the mother or if the unborn child is the result of rape or incest. No funds may be paid pursuant to sections 208.631 to 208.657 to any person or organization that performs abortions or counsels or refers for abortion unless the abortion is done to save the life of the mother or if the unborn child is the result of rape or incest.

2. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

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208.657. **1.** Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is promulgated under the authority delegated in this chapter shall become effective only if the agency has fully complied with all of the requirements of chapter 536, RSMo, including but not limited to, section 536.028, RSMo, if applicable, after August 28, 1998. All rulemaking authority delegated prior to August 28, 1998, is of no force and effect and repealed as of August 28, 1998, however, nothing in sections 208.631 to 208.657 shall be interpreted to repeal or affect the validity of any rule adopted or promulgated prior to August 28, 1998. If the provisions of section 536.028, RSMo, apply, the provisions of sections 208.631 to 208.657 are nonseverable and if any of the powers vested with the general assembly pursuant to section 536.028, RSMo, to review, to delay the effective date, or to disapprove and annul a rule or portion of a rule are held unconstitutional or invalid, the purported grant of rulemaking authority and any rule so proposed and contained in the order of rulemaking shall be invalid and void, except that nothing in sections 208.631 to 208.660 shall affect the validity of any rule adopted and promulgated prior to August 28, 1998.

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2. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

630.005. **1.** As used in this chapter and chapters 631, 632, and 633, RSMo, unless the context clearly requires otherwise, the following terms shall mean:

(1) "Administrative entity", a provider of specialized services other than transportation to clients of the department on behalf of a division of the department;

(2) "Alcohol abuse", the use of any alcoholic beverage, which use results in intoxication or in a psychological or physiological dependency from continued use, which dependency induces

a mental, emotional or physical impairment and which causes socially dysfunctional behavior;

(3) "Chemical restraint", medication administered with the primary intent of restraining a patient who presents a likelihood of serious physical injury to himself or others, and not prescribed to treat a person's medical condition;

(4) "Client", any person who is placed by the department in a facility or program licensed and funded by the department or who is a recipient of services from a regional center, as defined in section 633.005, RSMo;

(5) "Commission", the state mental health commission;

(6) "Consumer", a person:

(a) Who qualifies to receive department services; or

(b) Who is a parent, child or sibling of a person who receives department services; or

(c) Who has a personal interest in services provided by the department. A person who provides services to persons affected by mental retardation, developmental disabilities, mental disorders, mental illness, or alcohol or drug abuse shall not be considered a consumer;

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(7) "Day program", a place conducted or maintained by any person who advertises or holds himself out as providing prevention, evaluation, treatment, habilitation or rehabilitation for persons affected by mental disorders, mental illness, mental retardation, developmental disabilities or alcohol or drug abuse for less than the full twenty-four hours comprising each daily period;

(8) "Department", the department of mental health of the state of Missouri;

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(9) "Developmental disability", a disability:

(a) Which is attributable to:

a. Mental retardation, cerebral palsy, epilepsy, head injury or autism, or a learning disability related to a brain dysfunction; or

b. Any other mental or physical impairment or combination of mental or physical impairments; and

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(b) Is manifested before the person attains age twenty-two; and

(c) Is likely to continue indefinitely; and

(d) Results in substantial functional limitations in two or more of the following areas of major life activities:

a. Self-care;

b. Receptive and expressive language development and use;

c. Learning;

d. Self-direction;

e. Capacity for independent living or economic self-sufficiency;

f. Mobility; and

(e) Reflects the person's need for a combination and sequence of special, interdisciplinary,

or generic care, habilitation or other services which may be of lifelong or extended duration and are individually planned and coordinated;

(10) "Director", the director of the department of mental health, or his designee;

(11) "Domiciled in Missouri", a permanent connection between an individual and the state of Missouri, which is more than mere residence in the state; it may be established by the individual being physically present in Missouri with the intention to abandon his previous domicile and to remain in Missouri permanently or indefinitely;

(12) "Drug abuse", the use of any drug without compelling medical reason, which use results in a temporary mental, emotional or physical impairment and causes socially dysfunctional behavior, or in psychological or physiological dependency resulting from continued use, which dependency induces a mental, emotional or physical impairment and causes socially dysfunctional behavior;

(13) "Habilitation", a process of treatment, training, care or specialized attention which seeks to enhance and maximize the mentally retarded or developmentally disabled person's abilities to cope with the environment and to live as normally as possible;

(14) "Habilitation center", a residential facility operated by the department and serving only persons who are mentally retarded, including developmentally disabled;

(15) "Head of the facility", the chief administrative officer, or his designee, of any residential facility;

(16) "Head of the program", the chief administrative officer, or his designee, of any day program;

(17) "Individualized habilitation plan", a document which sets forth habilitation goals and objectives for mentally retarded or developmentally disabled residents and clients, and which details the habilitation program as required by law, rules and funding sources;

(18) "Individualized rehabilitation plan", a document which sets forth the care, treatment and rehabilitation goals and objectives for patients and clients affected by alcohol or drug abuse, and which details the rehabilitation program as required by law, rules and funding sources;

(19) "Individualized treatment plan", a document which sets forth the care, treatment and rehabilitation goals and objectives for mentally disordered or mentally ill patients and clients, and which details the treatment program as required by law, rules and funding sources;

(20) "Investigator", an employee or contract agent of the department of mental health who is performing an investigation regarding an allegation of abuse or neglect or an investigation at the request of the director of the department of mental health or his designee;

(21) "Least restrictive environment", a reasonably available setting or mental health program where care, treatment, habilitation or rehabilitation is particularly suited to the level and quality of services necessary to implement a person's individualized treatment, habilitation or rehabilitation plan and to enable the person to maximize his functioning potential to

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participate as freely as feasible in normal living activities, giving due consideration to potentially harmful effects on the person and the safety of other facility or program clients and public safety. For some mentally disordered or mentally retarded persons, the least restrictive environment may be a facility operated by the department, a private facility, a supported community living situation, or an alternative community program designed for persons who are civilly detained for outpatient treatment or who are conditionally released pursuant to chapter 632, RSMo;

(22) "Mental disorder", any organic, mental or emotional impairment which has substantial adverse effects on a person's cognitive, volitional or emotional function and which constitutes a substantial impairment in a person's ability to participate in activities of normal living;

(23) "Mental illness", a state of impaired mental processes, which impairment results in a distortion of a person's capacity to recognize reality due to hallucinations, delusions, faulty perceptions or alterations of mood, and interferes with an individual's ability to reason, understand or exercise conscious control over his actions. The term "mental illness" does not include the following conditions unless they are accompanied by a mental illness as otherwise defined in this subdivision:

(a) Mental retardation, developmental disability or narcolepsy;

(b) Simple intoxication caused by substances such as alcohol or drugs;

(c) Dependence upon or addiction to any substances such as alcohol or drugs;

(d) Any other disorders such as senility, which are not of an actively psychotic nature;

(24) "Mental retardation", significantly subaverage general intellectual functioning which:

(a) Originates before age eighteen; and

(b) Is associated with a significant impairment in adaptive behavior;

(25) "Minor", any person under the age of eighteen years;

(26) "Patient", an individual under observation, care, treatment or rehabilitation by any hospital or other mental health facility or mental health program pursuant to the provisions of chapter 632, RSMo;

(27) "Psychosurgery",

(a) Surgery on the normal brain tissue of an individual not suffering from physical disease for the purpose of changing or controlling behavior; or

(b) Surgery on diseased brain tissue of an individual if the sole object of the surgery is to control, change or affect behavioral disturbances, except seizure disorders;

(28) "Rehabilitation", a process of restoration of a person's ability to attain or maintain normal or optimum health or constructive activity through care, treatment, training, counseling or specialized attention;

(29) "Residence", the place where the patient has last generally lodged prior to admission or, in case of a minor, where his family has so lodged; except, that admission or detention in any

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facility of the department shall not be deemed an absence from the place of residence and shall not constitute a change in residence;

(30) "Resident", a person receiving residential services from a facility, other than mental health facility, operated, funded or licensed by the department;

(31) "Residential facility", any premises where residential prevention, evaluation, care, treatment, habilitation or rehabilitation is provided for persons affected by mental disorders, mental illness, mental retardation, developmental disabilities or alcohol or drug abuse; except the person's dwelling;

(32) "Specialized service", an entity which provides prevention, evaluation, transportation, care, treatment, habilitation or rehabilitation services to persons affected by mental disorders, mental illness, mental retardation, developmental disabilities or alcohol or drug abuse;

(33) "Vendor", a person or entity under contract with the department, other than as a department employee, who provides services to patients, residents or clients.

2. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

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660.026. **1.** Subject to appropriation, the director of the department of social services, or the director's designee, may contract with and provide funding support to federally qualified health centers, as defined in 42 U.S.C. Section 1396d(1)(2)(B), in this state. Funds appropriated pursuant to this section shall be used to assist such centers in ensuring that health care, including dental care, and mental health services is available to needy persons in this state. Such funds may also be used by centers for capital expansion, infrastructure redesign or other similar uses if federal funding is not available for such purposes. No later than forty-five days following the end of each federal fiscal year, the centers shall report to the director of the department of social services the number of patients served by age, race, gender, method of payment and insurance status.

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2. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

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660.075. 1. The division of medical services shall not issue a provider agreement to an intermediate care facility for the mentally retarded provider after May 29, 1991, unless and until the department of mental health transmits a certification of authorization to provide services, provided, however, a profit or not-for-profit provider may operate a single home of six beds or less without issuance of a certificate to the division of medical services. Such certification shall be provider specific and shall contain the number of beds authorized.

2. Notwithstanding any other provision of law to the contrary, any provider intending to operate an intermediate care facility for the mentally retarded in excess of those beds in existence on May 29, 1991, shall give notice to the department of mental health of any intent to do so between July first and October first of the fiscal year preceding the fiscal year in which

they intend to operate such facility.

3. In addition to other good cause as established by administrative rules promulgated by the director of the department of mental health, such intermediate care facility for the mentally retarded operations as may be accommodated within the home and community-based waiver for the developmentally disabled shall be refused certificates of authorization by the department of mental health. The division of medical services shall refuse intermediate care facility for the mentally retarded provider agreements to providers to whom the department of mental health has refused certificates of authorization.

4. Funding for any services provided pursuant to this section are limited to the appropriations made available for such services.

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