FIRST REGULAR SESSION

[P E R F E C T E D]

SENATE SUBSTITUTE FOR

SENATE BILL NO. 539

93RD GENERAL ASSEMBLY

INTRODUCED BY SENATORS PURGASON, BARTLE, SCOTT, GIBBONS,
DOLAN, RIDGEWAY AND CROWELL.

Offered March 14, 2005.

Senate Substitute adopted, March 15, 2005.

Taken up for Perfection March 15, 2005. Bill declared Perfected and Ordered Printed, as amended.

TERRY L. SPIELER, Secretary.

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AN ACT

To repeal sections 178.661, 178.662, 178.664, 178.666, 178.669, 178.671, 178.673, 208.010, 208.146, 208.151, 208.152, 208.162, 208.215, 208.225, 208.550, 208.553, 208.556, 208.559, 208.562, 208.565, 208.568, 208.571, 208.640, 453.072, and 453.073, RSMo, and to enact in lieu thereof thirty new sections relating to health care and social services, with penalty provisions and an emergency clause and a termination date for a certain section.

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

Section A. Sections 178.661, 178.662, 178.664, 178.666, 178.669, 178.671, 178.673, 208.010, 208.146, 208.151, 208.152, 208.162, 208.215, 208.225, 208.550, 208.553, 208.556, 208.559, 208.562, 208.565, 208.568, 208.571, 208.640, 453.072, and 453.073, RSMo, are repealed and thirty new sections enacted in lieu thereof, to be known as sections 208.010, 208.014, 208.147, 208.151, 208.152, 208.212, 208.215, 208.225, 208.640, 208.780, 208.782, 208.784, 208.786, 208.788, 208.790, 208.792, 208.794, 208.798, 453.072, 453.073, 660.661, 660.664, 660.667, 660.670, 660.673, 660.676, 660.679, 660.681, 660.684, and 660.687 to read as follows:

208.010. 1. In determining the eligibility of a claimant for public assistance pursuant to this law, it shall be the duty of the division of family services to consider and take into account all facts and circumstances surrounding the claimant, including his or her living conditions, earning capacity, income and resources, from whatever source received, and if

EXPLANATION–Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

from all the facts and circumstances the claimant is not found to be in need, assistance shall be denied. In determining the need of a claimant, the costs of providing medical treatment which may be furnished pursuant to sections 208.151 to 208.158 and 208.162 shall be disregarded. The amount of benefits, when added to all other income, resources, support, and maintenance shall provide such persons with reasonable subsistence compatible with decency and health in accordance with the standards developed by the division of family services; provided, when a husband and wife are living together, the combined income and resources of both shall be considered in determining the eligibility of either or both. "Living together" for the purpose of this chapter is defined as including a husband and wife separated for the purpose of obtaining medical care or nursing home care, except that the income of a husband or wife separated for such purpose shall be considered in determining the eligibility of his or her spouse, only to the extent that such income exceeds the amount necessary to meet the needs (as defined by rule or regulation of the division) of such husband or wife living separately. In determining the need of a claimant in federally aided programs there shall be disregarded such amounts per month of earned income in making such determination as shall be required for federal participation by the provisions of the federal Social Security Act (42 U.S.C.A. 301 et seq.), or any amendments thereto. When federal law or regulations require the exemption of other income or resources, the division of family services may provide by rule or regulation the amount of income or resources to be disregarded.

2. Benefits shall not be payable to any claimant who:

(1) Has or whose spouse with whom he or she is living has, prior to July 1, 1989, given away or sold a resource within the time and in the manner specified in this subdivision. In determining the resources of an individual, unless prohibited by federal statutes or regulations, there shall be included (but subject to the exclusions pursuant to subdivisions (4) and (5) of this subsection, and subsection 5 of this section) any resource or interest therein owned by such individual or spouse within the twenty-four months preceding the initial investigation, or at any time during which benefits are being drawn, if such individual or spouse gave away or sold such resource or interest within such period of time at less than fair market value of such resource or interest for the purpose of establishing eligibility for benefits, including but not limited to benefits based on December, 1973, eligibility requirements, as follows:

(a) Any transaction described in this subdivision shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance pursuant to this chapter unless such individual furnishes convincing evidence to establish that the transaction was exclusively for some other purpose;

(b) The resource shall be considered in determining eligibility from the date of the transfer for the number of months the uncompensated value of the disposed of resource is divisible by the average monthly grant paid or average Medicaid payment in the state at the

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time of the investigation to an individual or on his or her behalf under the program for which benefits are claimed, provided that:

a. When the uncompensated value is twelve thousand dollars or less, the resource shall not be used in determining eligibility for more than twenty-four months; or

b. When the uncompensated value exceeds twelve thousand dollars, the resource shall not be used in determining eligibility for more than sixty months;

(2) The provisions of subdivision (1) of subsection 2 of this section shall not apply to a transfer, other than a transfer to claimant's spouse, made prior to March 26, 1981, when the claimant furnishes convincing evidence that the uncompensated value of the disposed of resource or any part thereof is no longer possessed or owned by the person to whom the resource was transferred;

(3) Has received, or whose spouse with whom he or she is living has received, benefits to which he or she was not entitled through misrepresentation or nondisclosure of material facts or failure to report any change in status or correct information with respect to property or income as required by section 208.210. A claimant ineligible pursuant to this subsection shall be ineligible for such period of time from the date of discovery as the division of family services may deem proper; or in the case of overpayment of benefits, future benefits may be decreased, suspended or entirely withdrawn for such period of time as the division may deem proper;

(4) Owns or possesses resources in the sum of one thousand dollars or more; provided, however, that if such person is married and living with spouse, he or she, or they, individually or jointly, may own resources not to exceed two thousand dollars; and provided further, that in the case of a temporary assistance for needy families claimant, the provision of this subsection shall not apply;

(5) Prior to October 1, 1989, owns or possesses property of any kind or character, excluding amounts placed in an irrevocable prearranged funeral or burial contract pursuant to subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of section 436.053, RSMo, or has an interest in property, of which he or she is the record or beneficial owner, the value of such property, as determined by the division of family services, less encumbrances of record, exceeds twenty-nine thousand dollars, or if married and actually living together with husband or wife, if the value of his or her property, or the value of his or her interest in property, together with that of such husband and wife, exceeds such amount;

(6) In the case of temporary assistance for needy families, if the parent, stepparent, and child or children in the home owns or possesses property of any kind or character, or has an interest in property for which he or she is a record or beneficial owner, the value of such property, as determined by the division of family services and as allowed by federal law or regulation, less encumbrances of record, exceeds one thousand dollars, excluding the home

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occupied by the claimant, amounts placed in an irrevocable prearranged funeral or burial contract pursuant to subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of section 436.053, RSMo, one automobile which shall not exceed a value set forth by federal law or regulation and for a period not to exceed six months, such other real property which the family is making a good-faith effort to sell, if the family agrees in writing with the division of family services to sell such property and from the net proceeds of the sale repay the amount of assistance received during such period. If the property has not been sold within six months, or if eligibility terminates for any other reason, the entire amount of assistance paid during such period shall be a debt due the state;

(7) Is an inmate of a public institution, except as a patient in a public medical institution.

3. In determining eligibility and the amount of benefits to be granted pursuant to federally aided programs, the income and resources of a relative or other person living in the home shall be taken into account to the extent the income, resources, support and maintenance are allowed by federal law or regulation to be considered.

4. In determining eligibility and the amount of benefits to be granted pursuant to federally aided programs, the value of burial lots or any amounts placed in an irrevocable prearranged funeral or burial contract pursuant to subsection 2 of section 436.035, RSMo, and subdivision (5) of subsection 1 of section 436.053, RSMo, shall not be taken into account or considered an asset of the burial lot owner or the beneficiary of an irrevocable prearranged funeral or funeral contract. For purposes of this section, "burial lots" means any burial space as defined in section 214.270, RSMo, and any memorial, monument, marker, tombstone or letter marking a burial space. If the beneficiary, as defined in chapter 436, RSMo, of an irrevocable prearranged funeral or burial contract receives any public assistance benefits pursuant to this chapter and if the purchaser of such contract or his or her successors in interest cancel or amend the contract so that any person will be entitled to a refund, such refund shall be paid to the state of Missouri up to the amount of public assistance benefits provided pursuant to this chapter with any remainder to be paid to those persons designated in chapter 436, RSMo.

5. In determining the total property owned pursuant to subdivision (5) of subsection 2 of this section, or resources, of any person claiming or for whom public assistance is claimed, there shall be disregarded any life insurance policy, or prearranged funeral or burial contract, or any two or more policies or contracts, or any combination of policies and contracts, which provides for the payment of one thousand five hundred dollars or less upon the death of any of the following:

(1) A claimant or person for whom benefits are claimed; or

(2) The spouse of a claimant or person for whom benefits are claimed with whom he or she is living.

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If the value of such policies exceeds one thousand five hundred dollars, then the total value of such policies may be considered in determining resources; except that, in the case of temporary assistance for needy families, there shall be disregarded any prearranged funeral or burial contract, or any two or more contracts, which provides for the payment of one thousand five hundred dollars or less per family member.

6. Beginning September 30, 1989, when determining the eligibility of institutionalized spouses, as defined in 42 U.S.C. Section 1396r-5, for medical assistance benefits as provided for in section 208.151 and 42 U.S.C. Sections 1396a et seq., the division of family services shall comply with the provisions of the federal statutes and regulations. As necessary, the division shall by rule or regulation implement the federal law and regulations which shall include but not be limited to the establishment of income and resource standards and limitations. The division shall require:

(1) That at the beginning of a period of continuous institutionalization that is expected to last for thirty days or more, the institutionalized spouse, or the community spouse, may request an assessment by the division of family services of total countable resources owned by either or both spouses;

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(2) That the assessed resources of the institutionalized spouse and the community spouse may be allocated so that each receives an equal share;

(3) That upon an initial eligibility determination, if the community spouse's share does not equal at least twelve thousand dollars, the institutionalized spouse may transfer to the community spouse a resource allowance to increase the community spouse's share to twelve thousand dollars;

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(4) That in the determination of initial eligibility of the institutionalized spouse, no resources attributed to the community spouse shall be used in determining the eligibility of the institutionalized spouse, except to the extent that the resources attributed to the community spouse do exceed the community spouse's resource allowance as defined in 42 U.S.C. Section 1396r-5;

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(5) That beginning in January, 1990, the amount specified in subdivision (3) of this subsection shall be increased by the percentage increase in the consumer price index for all urban consumers between September, 1988, and the September before the calendar year involved; and

(6) That beginning the month after initial eligibility for the institutionalized spouse is determined, the resources of the community spouse shall not be considered available to the institutionalized spouse during that continuous period of institutionalization.

7. Beginning July 1, 1989, institutionalized individuals shall be ineligible for the periods required and for the reasons specified in 42 U.S.C. Section 1396p.

8. The hearings required by 42 U.S.C. Section 1396r-5 shall be conducted pursuant to the provisions of section 208.080.

9. Beginning October 1, 1989, when determining eligibility for assistance pursuant to this chapter there shall be disregarded unless otherwise provided by federal or state statutes, the home of the applicant or recipient when the home is providing shelter to the applicant or recipient, or his or her spouse or dependent child. The division of family services shall establish by rule or regulation in conformance with applicable federal statutes and regulations a definition of the home and when the home shall be considered a resource that shall be considered in determining eligibility.

10. Reimbursement for services provided by an enrolled Medicaid provider to a recipient who is duly entitled to Title XIX Medicaid and Title XVIII Medicare Part B, Supplementary Medical Insurance (SMI) shall include payment in full of deductible and coinsurance amounts as determined due pursuant to the applicable provisions of federal regulations pertaining to Title XVIII Medicare Part B, except the applicable Title XIX cost sharing.

11. A "community spouse" is defined as being the noninstitutionalized spouse.

12. An institutionalized spouse applying for Medicaid and having a spouse living in the community shall be required, to the maximum extent permitted by law, to divert income to such community spouse to raise the community spouse's income to the level of the minimum monthly needs allowance, as described in 42 U.S.C. Section 1396r-5. Such diversion of income shall occur before the community spouse is allowed to retain assets in excess of the community spouse protected amount described in 42 U.S.C. Section 1396-r.

208.014. 1. There is hereby established the "Medicaid Reform Commission". The commission shall have as its purpose the study and review of recommendations for reforms of the state Medicaid system. The commission shall consist of ten members:

(1) Five members of the house of representatives appointed by the speaker; and

(2) Five members of the senate appointed by the pro tem.

No more than three members from each house shall be of the same political party. The directors of the department of social services, the department of health and senior services, and the department of mental health or the directors' designees shall serve as ex officio members of the commission.

2. Members of the commission shall be reimbursed for the actual and necessary expenses incurred in the discharge of the member's official duties.

3. A chair of the commission shall be selected by the members of the commission.

4. The commission shall meet as necessary.

5. The commission is authorized to contract with a consultant. The

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compensation of the consultant and other personnel shall be paid from the joint contingent fund or jointly from the senate and house contingent funds until an appropriation is made therefor.

6. The commission shall make recommendations in a report to the general assembly by January 1, 2006, on reforming, redesigning, and restructuring a new, innovative state Medicaid healthcare delivery system under Title XIX, Public Law 89-97, 1965, amendments to the federal Social Security Act (42 U.S.C. Section 30 et. seq.) as amended, to replace the current state Medicaid system under Title XIX, Public Law 89-97, 1965, amendments to the federal Social Security Act (42 U.S.C. Section 30, *et seq.*), which shall sunset on June 30, 2008.

208.147. 1. The family support division shall conduct an annual income and eligibility verification review of each recipient of medical assistance. Such review shall be completed not later than twelve months after the recipient's last eligibility determination.

2. The annual eligibility review requirement may be satisfied by the completion of a periodic food stamp redetermination for the household.

3. The family support division shall annually send a re-verification eligibility form letter to the recipient requiring the recipient to respond within ten days of receiving the letter and to provide income verification documentation described in subsection 4 of this section. If the division does not receive the recipient's response and documentation within the ten days, the division shall send a letter notifying the recipient that he or she has ten days to file an appeal or the case will be closed.

4. The family support division shall require recipients to provide documentation for income verification for purposes of eligibility review described in subsection 1 of this section. Such documentation may include, but not be limited to:

(1) Current wage stubs;

(2) A current W-2 form;

(3) Statements from the recipient's employer;

(4) A wage match with the division of employment security; and

(5) Bank statements.

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;

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(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 **family support** 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, 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;

(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 **family support** division **[**of family services**]** shall use an

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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 **family support** 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

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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 **family support** 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)**]** **(16)** 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)**]** **(17)** 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 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 **family support** 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)**]** **(18)** 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 **family support** 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 **family support** division **[**of family services**]** for assessing eligibility under this chapter shall be as simple as practicable;

[(20)**]** **(19)** Subject to appropriations necessary to recruit and train such staff, the **family support** division **[**of family services**]** shall provide one or more full-time, permanent

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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;

[(21)**]** **(20)** 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;

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[(22)**]** **(21)** 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;

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[(23)**]** **(22)** 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)**]** **(23)** 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)**]** **(24) (a)** 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**, as authorized by 42 U.S.C. Section 1396a(f), or less restrictive methodologies as contained in the Medicaid state plan as of January 1, 2005**; except that, on or after July 1, **[**2002**]** **2005**, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), **[**shall**]** **may** be used to **[**raise**]** **change** 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,**]** **if authorized by annual appropriation;**

(b) All persons who would be determined to be eligible for aid to the blind benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f), or less restrictive methodologies as contained in the Medicaid state plan as of January 1, 2005, except that 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)**];**

(c) All persons who would be determined to be eligible for permanent and total disability benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. 1396a(f); or less restrictive methodologies as contained in the Medicaid state plan of January 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized by annual appropriations. Eligibility standards for permanent and total disability benefits shall not

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be limited 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)] **(25)** 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.

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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 **and as authorized by annual appropriation** 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 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 **or her** 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.

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[6.] **5.** 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] **not to exceed one million dollars in additional costs to the state. A request for such a waiver so submitted shall only become effective by executive order not sooner than ninety days after the final adjournment of the session of the general assembly to which it is submitted, unless it is disapproved within sixty days of its submission to a regular session by a senate or house resolution adopted by a majority vote of the respective elected members thereof**.

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6. Notwithstanding any other provision of law to the contrary, in any given fiscal year, any persons made eligible for medical assistance benefits under subdivisions (1) to (22) of subsection 1 of this section shall only be eligible if annual appropriations are made for such eligibility. This subsection shall not apply to classes of individuals listed in 42 U.S.C. Section 1396a(a)(10)(A)(i).

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

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the division of medical services shall provide through rule and regulation an exception

process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the Medicaid children's diagnosis length-of-stay schedule; and provided further that the division of medical services shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

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

(3) Laboratory and X-ray services;

(4) Nursing home services for recipients, except to persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services 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 subsection 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

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podiatrist; **except that no payment for drugs and medicines prescribed on and after January 1, 2006, by a licensed physician, dentist, or podiatrist may be made on behalf of any person who qualifies for prescription drug coverage under the provisions of P.L. 108-173;**

[(10)**]** **(8)** 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)**]** **(9)** 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. 101-239 and federal regulations promulgated thereunder;

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

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

(14)**]** **(11)** 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;

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

(16)**]** **(12)** 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.);

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

[(18)**]** **(14)** 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)**]** **(15)** 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 or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097, RSMo. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

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

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

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, "mental health professional" and "alcohol and drug abuse professional" shall be defined by the department of mental health pursuant to duly promulgated rules.

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

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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, 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)**]** **(16)** 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)**]** **(17)** 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

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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)] **(18)** 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 department of health and senior services which was taken prior to when the recipient is admitted to the hospital; and

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

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

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

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

2. **Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the division of medical services, unless otherwise hereinafter provided, for the following:**

(1) Dental services;

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

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

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

(5) Hospice care. As used in this subsection, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. 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);

(6) 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; 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 subdivision 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, 2005, shall be invalid and void.

3. 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

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surgery is obtained prior to the surgery being performed.

[3.] **4.** 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,] **for all covered services except for those services covered under subdivisions (14) and (15) of subsection 1 of this section and sections 208.631 to 208.657** 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,] **reduced from** any payments made by the state for goods or services described herein **except the recipient portion of the pharmacy professional dispensing fee shall be in addition to, and not in lieu of payments to pharmacists. A provider may collect the copayment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a recipient is unable to pay a required cost sharing. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected copayments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give recipients advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer, shall not make copayment for a recipient. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the Missouri Medicaid state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected copayments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid copayments**.

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

[5.] **6.** 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

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

[7.**]** **8.** 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.**]** **9.** 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.**]** **10.** 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.**]** **11.** The department of social services, division of medical services, may enroll qualified residential care facilities, as defined in chapter 198, RSMo, as Medicaid personal care providers.

208.212. 1. For purposes of Medicaid eligibility, investment in annuities shall be limited to those annuities that:

(1) Are actuarially sound as measured against the Social Security Administration Life Expectancy Tables, as amended;

(2) Provide equal or nearly equal payments for the duration of the device and which exclude "balloon" style final payments; and

(3) Provide the state of Missouri secondary or contingent beneficiary status ensuring payment if the individual predeceases the duration of the annuity, in an amount equal to the Medicaid expenditure made by the state on the individual's behalf.

2. The department shall establish a sixty month look-back period to review any investment in an annuity by an applicant for Medicaid benefits. If an

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investment in an annuity is determined by the department to have been made in anticipation of obtaining or with an intent to obtain eligibility for Medicaid benefits, the department shall have available all remedies and sanctions permitted under federal and state law regarding such investment. The fact that an investment in an annuity which occurred prior to the effective date of this section does not meet the criteria established in subsection 1 of this section shall not automatically result in a disallowance of such investment.

3. The department of social services shall promulgate rules to administer the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

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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 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.

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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 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:

(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

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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 **on permanently institutionalized individuals. The department shall have the right to enforce TEFRA liens, 42 U.S.C. 1396p, as authorized by federal law and regulation on all other institutionalized individuals**. For the purposes of this subsection,

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"permanently institutionalized individuals" includes those people who the department determines cannot reasonably be expected to be discharged and return home, and "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 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

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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.

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.

208.225. 1. To implement fully the provisions of section 208.152, the division of medical services shall **[**recalculate annually**]** **calculate** the Medicaid per diem reimbursement rates of each nursing home participating in the Medicaid program as a provider of nursing home services based on its costs reported in the Title XIX cost report filed with the division of medical services for its fiscal year **[**preceding the two facility fiscal years preceding the effective date of the recalculated rates**]** **as provided in subsection 2 of this section**.

2. The recalculation of Medicaid rates to all Missouri facilities will be performed **[**over three state fiscal years in three separate payments beginning July 1, 2004,**]** as follows:

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[(1)] Effective July 1, 2004, the department of social services shall use the Medicaid cost report containing adjusted costs for the facility fiscal year ending in 2001 and redetermine the allowable per-patient day costs for each facility. The department shall recalculate the class ceilings in the patient care, one hundred twenty percent of the median; ancillary, one hundred twenty percent of the median; and administration, one hundred ten percent of the median cost centers. Each facility shall receive as a rate increase one-third of the amount that is unpaid based on the recalculated cost determination[;

(2) Effective July 1, 2005, the department shall perform the same calculations described in subdivision (1) of this subsection, except that the calculations will be performed using the Medicaid cost report containing adjusted costs for the facility fiscal year ending in 2002. The facility shall receive as a rate increase one-third of the amount that it is underpaid;

(3) Effective July 1, 2006, the department shall perform the same calculations described in subdivision (1) of this subsection, except that the calculations will be performed using the Medicaid cost report containing adjusted costs for the facility fiscal year ending in 2003. The facility shall receive as a rate increase one-third of the amount that it is underpaid;

(4) Effective July 1, 2007, each facility shall receive a full Medicaid rate recalculation based upon its 2004 Medicaid cost report of adjusted costs].

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] **one hundred fifty-one** 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] **section**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] **section** 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

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208.631 to 208.657 shall not exceed the limits established by 42 U.S.C. Section 1397cc(e).

208.780. As used in sections 208.780 to 208.798, the following terms shall mean:

(1) "Asset test", the asset limits as defined by the Medicare Prescription Drug Improvement and Modernization Act, P.L. 108-173;

(2) "Contractor", the person, partnership, or corporate entity which has an approved contract with the department to administer the pharmaceutical assistance program established under sections 208.780 to 208.798 and this chapter;

(3) "Department", the department of social services;

(4) "Division", the department of social services, division of medical services;

(5) "Enrollee", a resident of this state who meets the conditions specified in sections 208.780 to 208.798 and in department regulations relating to eligibility for participation in the Missouri Rx plan and whose application for enrollment in the Missouri Rx plan has been approved by the department;

(6) "Federal poverty guidelines", the federal poverty guidelines updated annually in the Federal Register by the United States Department of Health and Human Services under the authority of 42 U.S.C. Section 9902(2);

(7) "Liquid assets", assets used in the eligibility determination process as defined by the Medicare Modernization Act;

(8) "Medicaid dual eligible" or "dual eligible", a person who is eligible for both Medicare and Medicaid as defined by the Medicare Modernization Act;

(9) "Medicare Modernization Act" or "MMA", the Medicare Prescription Drug, Improvement and Modernization Act of 2003, P.L. 108-173;

(10) "Medicare Part D prescription drug benefit", the prescription benefit provided under the Medicare Modernization Act, as it may vary from one prescription drug plan to another;

(11) "Missouri resident", a person who has or intends to have a fixed place of residence in Missouri, with the present intent of maintaining a permanent home in Missouri for the indefinite future;

(12) "Missouri Rx plan", the state pharmacy assistance program created in section 208.782, or the combination of state and federal programs providing services to the population described in section 208.784;

(13) "Participating pharmacy", a pharmacy that elects to participate as a pharmaceutical provider and enters into a participating network agreement with the department or contractor;

(14) "Prescription drugs", outpatient prescription drugs that have been approved as safe and effective by the United States Food and Drug

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Administration. Prescription drugs do not include experimental drugs or over-the-counter pharmaceutical products;

(15) "Prescription drug plan" or "PDP", nongovernmental drug plans under contract with the Center for Medicare and Medicaid Services to provide prescription benefits under the Medicare Modernization Act;

(16) "Program", the Missouri Rx plan created under sections 208.780 to 208.798.

208.782. 1. There is hereby established a state pharmaceutical assistance program within the meaning of federal law at 42 U.S.C. Section 1395 w-133(b), to be known as the "Missouri Rx Plan". The purpose of the Missouri Rx plan, established within the department of social services, is to provide certain pharmaceutical benefits to certain elderly and disabled residents of this state, to facilitate coordination of benefits between the Missouri Rx plan and the federal Medicare Part D drug benefit program established by the Medicare, Prescription, Drug, Improvement and Modernization Act of 2003, P.L. 108-173, and as well as to enroll such individuals in said program.

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2. The Missouri Rx plan shall assist eligible elderly and disabled individuals, including individuals qualified as dual eligibles by virtue of their eligibility for receipt of benefits under both the Medicaid and Medicare programs, in defraying the cost of medically necessary prescription drugs through coordination with the Medicare Part D drug benefit program. The Missouri Rx plan may select one or more prescription drug plans, as approved by the federal Centers for Medicare and Medicaid Services, as the preferred plan for purposes of the coordination of benefits between the Missouri Rx plan and the Medicare Part D drug. To ensure Medicare eligible seniors receive a coordinated benefit, the Missouri Rx plan may preliminarily enroll or re-enroll beneficiaries of the Missouri Rx plan into a preferred prescription drug plan or plans in the absence of any action or application of the individual beneficiary seeking such enrollment, provided that each individual so enrolled shall be promptly informed of:

(1) The procedures by which the individual may disenroll from the preferred PDP;

(2) The existence of an alternative PDP or PDPs authorized to provide Medicare Part D benefits in the region in which the individual resides;

(3) The manner by which the individual may change his or her enrollment to an alternative, non-preferred PDP or obtain assistance in doing so; and

(4) That enrollment in a non-preferred PDP will not adversely affect either the individual's eligibility for enrollment in the Missouri Rx plan or the amount of benefits the individual may be eligible to receive from the Missouri Rx

plan. The enrollment authority under this section shall also include the authority to withdraw individuals from non-preferred plans in order to maximize the benefit to the individual.

3. The department shall promulgate rules and regulations, including benefit limits, as may be necessary to implement the Missouri Rx plan. 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, 2005, shall be invalid and void.

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4. The department may delegate administrative responsibilities as necessary to implement the Missouri Rx plan. The department may designate or enter into contracts with other entities including but not limited to other states, governmental purchasing pools, or for-profit or non-profit organizations to assist in the administration of the program.

5. When requested by the department, other state agencies shall provide assistance or information necessary for the administration of the program.

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208.784. 1. The program shall coordinate prescription drug coverage with the Medicare Part D prescription drug benefit, including related supplies as determined by the department, who:

(1) Is a resident of the state of Missouri and is either:

(a) Sixty-five years of age or older; or

(b) Is disabled and receiving a Social Security benefit and is enrolled in the Medicare program;

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(2) Is enrolled in a Medicare Part D drug plan;

(3) Is not a member of a Medicare Advantage Plan that provides a prescription drug benefit;

(4) Is not a member of a retirement plan that is receiving a benefit under the Medicare Prescription Drug, Improvement and Modernization Act of 2003, P.L. 108-173.

2. The department shall give initial enrollment priority to the Medicaid dual eligible population. A second enrollment priority will be afforded to Medicare eligible applicants with annual household incomes at or below one hundred fifty percent of the federal poverty guidelines who also meet the asset test. Medicaid

dual eligible persons may be automatically enrolled into the program, as long as they may opt out of the program if they so choose. The department shall determine the procedures for automatic enrollment in, and election out of, the Missouri Rx plan. Applicants meeting the eligibility requirements set forth in this section may begin enrolling in the program as determined by the department.

3. An individual or married couple who meet the eligibility requirements in subsection 1 of this section and who are not Medicaid dual eligible persons may apply for enrollment in the program by submitting an application to the department, or the department's designee, that attests to the age, residence, household income, and liquid assets of the individual or couple.

208.786. 1. In providing program benefits, the department shall have the authority to:

(1) Adopt, amend, and rescind such rules and regulations necessary to perform its duties under this law to maximize the benefits;

(2) Enter into a contract with one or more prescription drug plans to coordinate the prescription benefits of the Missouri Rx plan and the Medicare Part D prescription benefit;

(3) Require that pharmaceutical manufacturers provide Medicaid level or greater rebates for enrollees at or below two hundred percent of the federal poverty level who also meet the asset test for Medicare Part D prescription benefit in order for the manufacturer's products to be available to the enrollees of the Missouri Rx plan. These rebates shall be no less than those provided to Medicaid under Section 1927 of Title XIX of the Social Security Act, 42 U.S.C. Section 1396r-8. If revenue is generated for the program from sources other than appropriation, the additional revenue shall be deposited in the Missouri Rx plan fund. This additional revenue shall be used to fund program benefits and make payments, as may be required, under the Medicare Prescription, Drug Improvement and Modernization Act of 2003, P.L. 108-173;

(4) Preliminarily enroll beneficiaries into a preferred Medicare Part D prescription drug plan, with an "opt out" provision for the individual. Individuals who opt out of the preferred PDP shall remain enrolled in the Missouri Rx plan unless they choose to withdraw from the program;

(5) Prescribe the application and enrollment procedures for prospective enrollees in the Missouri Rx plan;

(6) Select in accordance with applicable procurement laws, a contractor to assist in the administration of the Missouri Rx plan or negotiate the provision of administrative function for the Missouri Rx plan.

2. Program benefits shall begin January 1, 2006. For persons meeting the

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eligibility requirements in section 208.784, the program may, subject to appropriation and contingent upon available funds, pay all or some of the deductibles, coinsurance payments, premiums, and copayments required under the Medicare Part D pharmacy benefit.

208.788. 1. The program created in sections 208.780 to 208.798 is not an entitlement. The program created in or authorized under sections 208.780 to 208.798 is subject to the annual appropriation of funds by the general assembly. Benefits are limited by monies appropriated in the appropriations bill and signed by the governor less actions by the governor under article IV, sections 26 and 27 of the Missouri Constitution and section 33.290, RSMo.

2. The program is the payor of last resort, and shall only cover costs for participants that are not covered by the Medicare Part D prescription benefit.

3. Except for dual eligibles during the transition period in which they are being transferred from the Medicaid program to a prescription drug plan, applicants who are qualified for coverage of payments for prescription drugs under a public assistance program, other than MMA benefits, are ineligible for the Missouri Rx plan as long as they are so qualified.

4. Applicants who are qualified for full coverage of payments for prescription drugs under another plan of assistance or insurance are ineligible to receive benefits from the Missouri Rx plan as long as they are eligible to receive prescription drug benefits from another plan.

5. Applicants who are qualified for partial payments for prescription drugs under another insurance plan are eligible for the Missouri Rx plan, but may receive reduced assistance from the Missouri Rx plan.

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

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

208.792. 1. There is hereby established the "Missouri Rx Plan Advisory Commission" within the department of health and senior services, division of senior services and regulation to provide advice on the benefit design and operational policy of the Missouri Rx plan established in sections 208.782 to 208.798. The commission shall consist of the following fifteen members:

(1) The lieutenant governor, in his or her capacity as advocate for the

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elderly;

(2) Two members of the senate, with one member from the majority party appointed by the president pro tem of the senate and one member of the minority party appointed by the president pro tem of the senate with the concurrence of the minority floor leader of the senate;

(3) Two members of the house of representatives, with one member from the majority party appointed by the speaker of the house of representatives and one member of the minority party appointed by the speaker of the house of representatives with the concurrence of the minority floor leader of the house of representatives;

(4) The director of the division of medical services in the department of social services;

(5) The director of the division of senior services and regulation in the department of health and senior services;

(6) The chairperson of the governor's commission on special health, psychological and social needs of minority older individuals;

(7) The following four members appointed by the governor, with the advice and consent of the senate:

(a) A licensed pharmacist;

(b) A licensed physician;

(c) A representative from a senior advocacy group; and

(d) A representative from an area agency on aging;

(8) A representative from the pharmaceutical manufacturers industry as a nonvoting member appointed by the president pro tem of the senate and the speaker of the house of representatives;

(9) One public member appointed by the president pro tem of the senate; and

(10) One public member appointed by the speaker of the house of representatives.

In making the initial appointment to the committee, the governor, president pro tem, and speaker shall stagger the terms of the appointees so that four members serve initial terms of two years, four members serve initial terms of three years, four members serve initial terms of four years, and one member serves an initial term of one year. All members appointed thereafter shall serve three-year terms. All members shall be eligible for reappointment. The commission shall elect a chair and may employ an executive director and such professional, clerical, and research personnel as may be necessary to assist in the performance of the commission's duties.

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2. Recognizing the unique medical needs of the senior African American population, the president pro tem of the senate, speaker of the house of representatives, and governor will collaborate to ensure that there is adequate minority representation among legislative members and other members of the commission.

3. The commission:

(1) May provide advice on guidelines, policies, and procedures necessary to establish the Missouri Rx plan;

(2) Shall educate Missouri residents on quality prescription drug programs and cost containment strategies in medication therapy;

(3) Shall assist Missouri residents in enrolling or accessing prescription drug assistance programs for which they are eligible; and

(4) Shall hold quarterly meetings and other meetings as deemed necessary.

4. The members of the commission shall receive no compensation for their service on the commission, but shall be reimbursed for ordinary and necessary expenses incurred in the performance of their duties as a member of the commission.

208.794. 1. There is hereby created in the state treasury the "Missouri Rx Plan Fund", which shall consist of all moneys deposited in the fund under sections 208.780 to 208.798, and all moneys which may be appropriated to it by the general assembly from federal or other sources.

2. The state treasurer shall be custodian of the fund and shall approve disbursements from the fund in accordance with sections 30.170 and 30.180, RSMo. Upon appropriation, money in the fund shall be used solely for the administration of sections 208.780 to 208.798. Notwithstanding the provisions of section 33.080, RSMo, to the contrary, any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund. The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

3. All funds collected by or due and payable to the Missouri Rx plan fund shall remain in and accrue to said fund.

4. Notwithstanding the provisions of section 33.080, RSMo, to the contrary, moneys in the fund shall not revert to the credit of the general revenue fund at the end of the biennium.

208.798. 1. The provisions of sections 208.550 to 208.568 shall terminate following notice to the revisor of statutes by the Missouri RX plan advisory commission that the Medicare Prescription Drug, Improvement & Modernization

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Act of 2003 has been fully implemented.

2. Pursuant to section 23.253, RSMo, of the Missouri Sunset Act, the provisions of the new program authorized under sections 208.780 to 208.798 shall automatically sunset six years after the effective date of sections 208.780 to 208.798 unless reauthorized by an act of the general assembly.

453.072. Any subsidies available to adoptive parents pursuant to section 453.073 and section 453.074 shall also be available to a qualified relative of a child who is granted legal guardianship of the child in the same manner as such subsidies are available for adoptive parents**, including income restrictions as provided in subsection 4 of section 453.073**. As used in this section "relative" means any grandparent, aunt, uncle, adult sibling of the child or adult first cousin of the child.

453.073. 1. The **children's** division **[**of family services**]** is authorized to grant a subsidy to a child in one of the forms of allotment defined in section 453.065. Determination of the amount of monetary need is to be made by the division at the time of placement, if practicable, and in reference to the needs of the child, including consideration of the physical and mental condition, and age of the child in each case; provided, however, that the subsidy amount shall not exceed the expenses of foster care and medical care for foster children paid under the homeless, dependent and neglected foster care program.

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2. The subsidy shall be paid for children who have been in the care and custody of the **children's** division **[**of family services**]** under the homeless, dependent and neglected foster care program. In the case of a child who has been in the care and custody of a private child-caring or child-placing agency or in the care and custody of the division of youth services or the department of mental health, a subsidy shall be available from the **children's** division **[**of family services**]** subsidy program in the same manner and under the same circumstances and conditions as provided for a child who has been in the care and custody of the **children's** division **[**of family services**]**.

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3. Within thirty days after the authorization for the grant of a subsidy by the **children's** division **[**of family services**]**, a written agreement shall be entered into by the division and the parents. The agreement shall set forth the following terms and conditions:

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(1) The type of allotment;

(2) The amount of assistance payments;

(3) The services to be provided;

(4) The time period for which the subsidy is granted**[**, if that period is reasonably ascertainable**] shall not exceed one year. The agreement can be renewed for subsequent years at the discretion of the director. All existing agreements will have deemed to have expired one year after they were initially entered into**;

(5) The obligation of the parents to inform the division when they are no longer providing support to the child or when events affect the subsidy eligibility of the child;

(6) The eligibility of the child for Medicaid.

4. The subsidy shall only be granted to children who reside in a household with an income that does not exceed two hundred percent of the federal poverty level or are eligible for Title IV-E adoption assistance.

660.661. As used in sections 660.661 to 660.687, the following terms mean:

(1) "Consumer", a physically disabled person determined by the department to be eligible to receive personal care assistance services. "Consumer" does not include any individual with a legal limitation of his or her ability to make decisions, including the appointment of a guardian or conservator, or who has an effective power of attorney that authorizes another person to act as the agent or on behalf of the individual for any of the duties required by the consumer-directed program;

(2) "Consumer-directed", the hiring, training, supervising, and directing of the personal care attendant by the consumer;

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

(4) "Live independently", to reside and perform routine tasks in a noninstitutional or unsupervised residential setting;

(5) "Personal care assistance services", those routine tasks provided to meet the unmet needs required by the consumer to enable him or her to live independently;

(6) "Personal care attendant", a person, other than the consumer's spouse, who performs personal care assistance services for the consumer;

(7) "Physically disabled", loss of, or loss of use of, all or part of the neurological, muscular, or skeletal functions of the body to the extent that a person requires the assistance of another person to accomplish routine tasks;

(8) "Routine tasks":

(a) Bowel and bladder elimination;

(b) Dressing and undressing;

(c) Moving into and out of bed;

(d) Preparation and consumption of food and drink;

(e) Bathing and grooming;

(f) Use of prostheses, aids, equipment, and other similar devices; or

(g) Ambulation, housekeeping, and other functions of daily living;

(9) "Unmet needs", those routine tasks which are allowable by the Medicaid state plan but which cannot reasonably be met by the members of the consumer's household or other current support systems;

(10) "Vendor", any organization having a written agreement with the department to provide services including monitoring and oversight of the personal

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care attendant, orientation, and training of the consumer, and fiscal conduit services necessary for delivery of personal care assistance services to consumers.

660.664. 1. Subject to appropriations, the department shall provide financial assistance for consumer-directed personal care assistance services through eligible vendors to each person determined eligible to participate under guidelines established by the Medicaid state plan and who:

(1) Is capable of living independently with personal care assistance services;

(2) Is physically disabled;

(3) Is eighteen years of age or older;

(4) Is able to direct his or her own care;

(5) Is able to document proof of Medicaid eligibility under Title XIX of the Social Security Act under federal and state laws and regulations;

(6) Requires at least a nursing home level of care under regulations established by the department;

(7) Participates in an assessment or evaluation, or both, by the department; and

(8) Can have their unmet needs safely met at a cost that shall not exceed the average monthly Medicaid cost of nursing facility care as determined by the department of social services.

2. Upon certification of the employment of a personal care attendant chosen by the consumer in accordance with sections 660.661 to 660.687, the vendor shall perform the payroll and fringe benefit accounting functions for the consumer. The vendor shall be responsible for filing claims with the Missouri Medicaid program. Statutorily required fringe benefit costs shall be paid from the personal care assistant appropriation. The department shall establish the statewide rate for personal care attendant services. For purposes of this section, the personal care attendant is considered the employee of the consumer only for the period of time subsidized by personal care assistant funds. Nothing in this section shall be construed to mean that the attendant is the employee of the vendor, the department, or the state of Missouri.

660.667. 1. The department shall initiate the determination of an applicant's eligibility for personal care assistance services as follows:

(1) For all persons who had been receiving personal care assistance services on the effective date of this act, the department shall initiate re-verification of the consumer's eligibility for personal care assistance services not later than one year following the effective date of this act. For all such re-verifications in which the person is found to remain eligible, the department shall also review the person's personal care assistance authorized by the department to determine if it shall be

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maintained, adjusted, or eliminated according to the person's current situation at the re-verification;

(2) For all applicants for personal care assistance services who apply for such services on or after the effective date of this act, the department shall initiate the determination of an applicant's eligibility for personal care assistance services within thirty days of receipt of a completed application;

(3) After the assessment described in subdivisions (1) and (2) of this subsection, the department shall re-verify the applicant's eligibility for personal care assistance services at least every twelve months;

(4) All such determinations made under subdivisions (1), (2), and (3) of this subsection shall be made using the same common assessment tool used by the department for assessment of other disabled and aged adults;

(5) All such determinations made under subdivisions (1), (2), and (3) shall be made in strict compliance with the provisions of subsection 2 of section 660.670.

2. The applicant shall be notified of the initial determination of the department on his or her eligibility for personal care assistance services within ten days of determination.

3. Upon a determination of eligibility, the department shall develop a personal care assistance services plan which shall include, but is not limited to, the following:

(1) The maximum number of units of fifteen minute increments of personal care assistance services to be provided; and

(2) Dates of initiation of, and re-verification of the personal care assistance services provided.

4. Upon a determination of eligibility and completion of a personal care assistance services plan, the consumer shall choose a vendor of personal care assistance services from a list of eligible vendors maintained by the department. The vendor shall be responsible for maintaining a list of eligible personal care attendants. The personal care assistance services plan shall be signed by the consumer and a representative of the department. Copies of the plan shall be provided to the consumer, the vendor, and the department.

5. The needs of the consumer shall be re-evaluated annually by the department, and the amount of assistance authorized by the department shall be maintained, adjusted, or eliminated accordingly.

660.670. 1. Consumers receiving personal care assistance services shall be responsible for:

(1) Supervising their personal care attendant;

(2) Verifying wages to be paid to the personal care attendant;

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(3) Preparing and submitting time sheets, signed by both the consumer and personal care attendant, to the vendor on a biweekly basis;

(4) Promptly notifying the department within ten days of any changes in circumstances affecting the personal care assistance services plan or in the consumer's place of residence; and

(5) Reporting any problems resulting from the quality of services rendered by the personal care attendant to the vendor. If the consumer is unable to resolve any problems resulting from the quality of service rendered by the personal care attendant with the vendor, the consumer shall report the situation to the department.

2. Participating vendors shall be responsible for:

(1) Collecting time sheets and certifying their accuracy;

(2) The Medicaid reimbursement process, including the filing of claims and reporting data to the department as required by rule;

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(3) Transmitting the individual payment directly to the personal care attendant on behalf of the consumer;

(4) Monitoring the performance of the personal care assistance services plan.

3. No state or federal financial assistance shall be authorized or expended to pay for services provided to a consumer under sections 660.661 to 660.687, if the primary benefit of the services is to the household unit, or is a household task that the members of the consumer's household may reasonably be expected to share or do for one another when they live in the same household, unless such service is above and beyond typical activities household members may reasonably provide for another household member without a disability.

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4. No state or federal financial assistance shall be authorized or expended to pay for personal care assistance services provided by a personal care attendant who is listed on any of the background check lists in the family care safety registry under sections 210.900 to 210.937, RSMo, unless a good cause waiver is first obtained from the department in accordance with section 660.317, RSMo.

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660.673. 1. When any adult day care worker; chiropractor, Christian Science practitioner, coroner, dentist, embalmer, employee of the departments of social services, mental health, or health and senior services; employee of a local area agency on aging or an organized area agency on aging program; funeral director; home health agency or home health agency employee; hospital and clinic personnel engaged in examination, care, or treatment of persons; in-home services owner, provider, operator, or employee; law enforcement officer; long-term care facility administrator or employee; medical examiner; medical resident or intern; mental

health professional; minister; nurse; nurse practitioner; optometrist; other health practitioner; peace officer; pharmacist; physical therapist; physician; physician's assistant; podiatrist; probation or parole officer; psychologist; vendor as defined in section 660.661; personal care attendant; or social worker has reasonable cause to believe that a consumer has been abused or neglected as defined in section 660.250 as a result of the delivery of or failure to deliver personal care assistance services, he or she shall immediately report or cause a report to be made to the department. If the report is made by a physician of the consumer, the department shall maintain contact with the physician regarding the progress of the investigation.

2. When a report of deteriorating physical condition resulting in possible abuse or neglect of a consumer is received by the department, the department's case manager and the department nurse shall be notified. The case manager shall investigate and immediately report the results of the investigation to the department nurse.

3. If requested, local area agencies on aging shall provide volunteer training to those persons listed in subsection 1 of this section regarding the detection and reporting of abuse and neglect under this section.

4. Any person required in subsection 1 of this section to report or cause a report to be made to the department who fails to do so within a reasonable time after the act of abuse or neglect is guilty of a class A misdemeanor.

5. The report shall contain the names and addresses of the vendor, the personal care attendant, and the consumer, and information regarding the nature of the abuse or neglect, the name of the complainant, and any other information which might be helpful in an investigation.

6. In addition to those persons required to report under subsection 1 of this section, any other person having reasonable cause to believe that a consumer has been abused or neglected by a personal care attendant may report such information to the department.

7. If the investigation indicates possible abuse or neglect of a consumer, the investigator shall refer the complaint together with his or her report to the department director or his or her designee for appropriate action. If, during the investigation or at its completion, the department has reasonable cause to believe that immediate action is necessary to protect the consumer from abuse or neglect, the department or the local prosecuting attorney may, or the attorney general upon request of the department shall, file a petition for temporary care and protection of the consumer in a circuit court of competent jurisdiction. The circuit court in which the petition is filed shall have equitable jurisdiction to issue an ex

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parte order granting the department authority for the temporary care and protection of consumer, for a period not to exceed thirty days.

8. Reports shall be confidential, as provided under section 660.320.

9. Anyone, except any person who has abused or neglected a consumer, who makes a report pursuant to this section or who testifies in any administrative or judicial proceeding arising from the report shall be immune from any civil or criminal liability for making such a report or for testifying, except for liability for perjury, unless such person acted negligently, recklessly, in bad faith, or with malicious purpose.

10. Within five working days after a report required to be made under this section is received, the person making the report shall be notified of its receipt and of the initiation of the investigation.

11. No person who directs or exercises any authority as a vendor, and no personal care attendant, shall harass, dismiss or retaliate against a consumer because he or she or any member of his or her family has made a report of any violation or suspected violation of laws, standards or regulations applying to the vendor or personal care attendant which he or she has reasonable cause to believe has been committed or has occurred.

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12. The department shall place on the employee disqualification list established in section 660.315 the names of any persons who have been finally determined by the department, to have recklessly, knowingly or purposely abused or neglected a consumer while employed by a vendor, or employed by a consumer as a personal care attendant.

13. The department shall provide the list maintained pursuant to section 660.315 to vendors as defined in section 660.661.

14. Any person, corporation or association who received the employee disqualification list under subsection 13 of this section, or any person responsible for providing health care service, who declines to employ or terminates a person whose name is listed in this section shall be immune from suit by that person or anyone else acting for or in behalf of that person for the failure to employ or for the termination of the person whose name is listed on the employee disqualification list.

660.676. 1. Any person having reasonable cause to believe that a misappropriation of a consumer's property or funds, or the falsification of any documents verifying personal care assistance services delivery to the consumer has occurred, may report such information to the department.

2. For each report the department shall attempt to obtain the name and address of the vendor, the personal care attendant, the personal care assistance

services consumer, information regarding the nature of the misappropriation or falsification, the name of the complainant, and any other information which might be helpful in an investigation.

3. Any personal care assistance services vendor, or personal care attendant who puts to his or her own use or the use of the personal care assistance services vendor or otherwise diverts from the personal care assistance services consumer's use any personal property or funds of the consumer, or falsifies any documents for service delivery, is guilty of a class A misdemeanor.

4. Upon receipt of a report, the department shall immediately initiate an investigation and report information gained from such investigation to appropriate law enforcement authorities.

5. If the investigation indicates probable misappropriation of property or funds, or falsification of any documents for service delivery of a personal care assistance services consumer, the investigator shall refer the complaint together with the investigator's report to the department director or the director's designee for appropriate action.

6. Reports shall be confidential, as provided under section 660.320.

7. Anyone, except any person participating in or benefitting from the misappropriation of funds, who makes a report under this section or who testifies in any administrative or judicial proceeding arising from the report shall be immune from any civil or criminal liability for making such a report or for testifying except for liability for perjury, unless such person acted negligently, recklessly, in bad faith, or with malicious purpose.

8. Within five working days after a report required to be made under this section is received, the person making the report shall be notified in writing of its receipt and of the initiation of the investigation.

9. No person who directs or exercises any authority in a personal care assistance services vendor agency shall harass, dismiss or retaliate against a personal care assistance services consumer or a personal care attendant because he or she or any member of his or her family has made a report of any violation or suspected violation of laws, ordinances or regulations applying to the personal care assistance services vendor or any personal care attendant which he or she has reasonable cause to believe has been committed or has occurred.

10. The department shall maintain the employee disqualification list and place on the employee disqualification list the names of any personal care attendants who are or have been employed by a personal care assistance services consumer, and the names of any persons who are or have been employed by a vendor as defined in subdivision (10) of section 660.661, and who have been finally

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determined by the department under section 660.315 to have misappropriated any property or funds, or falsified any documents for service delivery to a personal care assistance services consumer and who came to be known to the consumer, directly, or indirectly by virtue of the consumers participation in the personal care assistance services program.

660.679. 1. In order to qualify for an agreement with the department, the vendor shall have a philosophy that promotes the consumer's ability to live independently in the most integrated setting or the maximum community inclusion of persons with physical disabilities, and shall demonstrate the ability to provide, directly or through contract, the following services:

(1) Orientation of consumers concerning the responsibilities of being an employer, supervision of personal care attendants including the preparation and verification of time sheets;

(2) Training for consumers about the recruitment and training of personal care attendants;

(3) Maintenance of a list of persons eligible to be a personal care attendant;

(4) Processing of inquiries and problems received from consumers and personal care attendants;

(5) Ensuring the personal care attendants are registered with the family care safety registry as provided in sections 210.900 to 210.937, RSMo; and

(6) The capacity to provide fiscal conduit services.

2. In order to maintain its agreement with the department, a vendor shall comply with the provisions of subsection 1 of this section and shall:

(1) Demonstrate sound fiscal management as evidenced on accurate quarterly financial reports and annual audit submitted to the department; and

(2) Demonstrate a positive impact on consumer outcomes regarding the provision of personal care assistance services as evidenced on accurate quarterly and annual service reports submitted to the department;

(3) Implement a quality assurance and supervision process that ensures program compliance and accuracy of records; and

(4) Comply with all provisions of sections 660.661 to 660.687, and the regulations promulgated thereunder.

660.681. 1. Applicants for personal care assistance services and consumers receiving such services are entitled to a hearing with the department of social services if eligibility for personal care assistance services is denied, if the type or amount of services is set at a level less than the consumer believes is necessary, if disputes arise after preparation of the personal care assistance services plan concerning the provision of such services, or if services are discontinued as

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provided in section 660.648.

2. A request for a hearing shall be made to the department of social services in writing in the form prescribed by the department of social services within ninety days after the mailing or delivery of the written decision of the department of health and senior services. The procedures for such requests and for the hearings shall be as set forth in section 208.080, RSMo.

660.684. A consumer's personal care assistance services may be discontinued under circumstances such as the following:

(1) The department learns of circumstances that require closure of a consumer's case, including one or more of the following: death, admission into a long term care facility, no longer needing service, or inability of the consumer to consumer-direct personal care assistance service;

(2) The consumer has falsified records or committed fraud;

(3) The consumer is noncompliant with the plan of care. Noncompliance requires persistent actions by the consumer which negate the services provided in the plan of care;

(4) The consumer or member of the consumer's household threatens or abuses the personal care attendant or vendor to the point where their welfare is in jeopardy and corrective action has failed;

(5) The maintenance needs of a consumer are unable to continue to be met because the plan of care hours exceed availability; and

(6) The personal care attendant is not providing services as set forth in the personal care assistance services plan and attempts to remedy the situation have been unsuccessful.

660.687. The department may promulgate rules and regulations to implement the provisions of sections 660.661 to 660.687. 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. Any provisions of the existing rules regarding the personal care assistance program promulgated by the department of elementary and secondary education in title 5, code of state regulation, division 90, chapter 7, which are inconsistent with the provisions of sections 660.661 to 660.687 are void and of no force and effect.

[178.661. As used in sections 178.661 to 178.673, the following terms mean:

(1) "After-tax income", the sum of all income from all sources to an individual including, but not limited to, salary, wages, tips, interest, dividends,

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annuities, pensions, and disability payments, less the sum of all federal, state, and local taxes on such income;

(2) "Client", a physically disabled person determined by the division to be eligible to receive personal care assistance services;

(3) "Counselor", an employee of the division responsible for determining eligibility for personal care assistance services and for developing and implementing a personal care assistance services plan;

(4) "Division", the division of vocational rehabilitation of the department of elementary and secondary education;

(5) "Employment", a minimum of sixteen hours per week for which an individual receives remuneration;

(6) "Live independently", to reside and perform routine tasks in a noninstitutional or unsupervised residential setting;

(7) "Participant-directed", hiring, training, supervising, and directing of the personal care attendant by the physically disabled person;

(8) "Personal care assistance services", those services required by a physically disabled person to enable him to perform those routine tasks necessary to enter and to maintain employment or to live independently;

(9) "Personal care attendant", a person who performs personal care assistance tasks for a physically disabled person;

(10) "Physically disabled", loss of, or loss of use of, all or part of the neurological, muscular, or skeletal functions of the body to the extent that a person requires the assistance of another person to accomplish routine tasks;

(11) "Routine tasks":

(a) Bowel and bladder elimination;

(b) Dressing and undressing;

(c) Moving into and out of bed;

(d) Preparation and consumption of food and drink;

(e) Bathing and grooming;

(f) Use of prostheses, aids, equipment, and other similar devices; or

(g) Ambulation and other functions of daily living;

(12) "Sleeping-hours attendant", a person who provides personal care assistance services to a physically disabled person during a daily eight-hour period when the physically disabled person normally sleeps;

(13) "Vendor", any person, firm or corporation certified by the division as eligible to provide evaluation and fiscal conduit services necessary for delivery of personal care assistance services to physically disabled persons.**]**

[178.662. 1. Subject to appropriations, the division shall provide

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financial assistance for participant-directed personal care assistance services through eligible vendors, except for the provisions of subsection 3 of this section, to each person selected to participate under guidelines established by the division and who:

(1) Is employed or is ready for employment, or is capable of living independently with personal care assistance;

(2) Is physically disabled;

(3) Has a documented need for a minimum of seven or a maximum of forty-two hours per week of personal care assistance or, if more than forty-two hours per week are required, substantial documentation may be used to support a request for additional time; and

(4) Is in financial need as determined by the division according to a standard means test.

2. Personal care assistance services shall be provided, at cost to the division, to the client to the extent that he is determined to be in financial need. Such need shall be determined by reducing the client's after-tax income by an amount equal to the client's necessary living expenses. Financial assistance shall be decreased as the client's ability to pay increases, in accordance with a schedule set out in the client's personal care assistance plan.

3. Upon vendor certification of the employment of a personal care attendant, the division or the vendor, at the vendor's option, shall perform the payroll and fringe benefit accounting functions for the client. The vendor shall accumulate required employee authorizing documentation and forward to the division. Although the division or the vendor shall perform the payroll and fringe benefit functions, all local monitoring and supervision of the attendant shall be the responsibility of the vendor and client. Statutorily required fringe benefit costs shall be paid from the personal care assistant appropriation. The division shall establish the statewide hourly rate for attendant services. For purposes of this section, the attendant is considered the employee of the client only for the period of time subsidized by personal care assistant funds. Nothing in this section shall be construed such that the attendant is the employee of the division or the state of Missouri.**]**

[178.664. 1. Upon application by a physically disabled person for personal care assistance services at any local division office, a counselor shall meet with the applicant and shall:

(1) Determine whether the applicant meets the criteria for eligibility set forth in section 178.662, meets the guidelines for participation; and

(2) Determine the extent of the applicant's financial need.

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2. The applicant shall be notified within thirty days of his initial application of the determination of the division on his eligibility for personal care assistance services.

3. Upon a determination of eligibility, the counselor shall refer the client to an eligible vendor of personal care assistance services for evaluation and shall develop a personal care assistance services plan which shall include, but is not limited to, the following:

(1) The maximum hours of personal care assistance services to be provided;

(2) The maximum amount of financial assistance to be provided by the division for such services;

(3) Authorization for a sleeping-hours attendant, if necessary; and

(4) Dates of evaluation for, initiation of, and reevaluations of the personal care assistance services.

4. The personal care assistance services plan shall be signed by the client, the counselor, and the vendor, and copies of the plan shall be provided to each.

5. The financial need of the client shall be reevaluated annually, and the amount of assistance received by the client shall be adjusted or eliminated accordingly.**]**

[178.666. Clients receiving personal care assistance services shall be responsible for the supervision of their personal care attendant, payment of wages to the personal care attendant, and preparation and submission of time sheets, signed by both the client and personal care attendant, to the vendor on a biweekly basis. The vendor shall accumulate time sheets, certify accuracy, and forward to the division for processing. The division shall mail the individual payment directly to the employee. In addition, the client shall promptly notify the division and his counselor of any changes in his need for personal care assistance services, in his financial status, or in his place of residence. Any problems resulting from the quality of service rendered by the personal care attendant shall be reported to the vendor.**]**

[178.669. 1. In order to be certified by the division as an eligible vendor of personal care assistance services, a vendor shall be a not-for-profit corporation organized under the provisions of chapter 355, RSMo.

2. In addition, the vendor shall demonstrate the ability to provide, directly or through contract, the following services:

(1) Evaluation of the extent of a client's need for personal care assistance services;

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(2) Orientation of clients concerning the supervision of personal care attendants including the preparation of time sheets;

(3) Training to clients in the recruitment and training of personal care attendants;

(4) Maintenance of a list of persons interested in being personal care attendants; and

(5) Processing of inquiries and problems received from clients and personal care attendants.**]**

[178.671. 1. Applicants for personal care assistance services and clients receiving such services are entitled to a hearing before the assistant commissioner of the division if eligibility for personal care assistance services is denied, if financial assistance for such services is denied or set at a level below what the client believes is necessary, or if disputes arise after preparation of the personal care assistance services plan concerning the provision of such services.

2. Requests for a hearing shall be made in writing in the form prescribed by the division to the assistant commissioner of the division within thirty days after the denial of eligibility, the denial of financial assistance, the determination of the level of financial assistance, or the signing of the personal care assistance services plan.**]**

[178.673. The division is authorized to adopt, promulgate, amend, and repeal rules, regulations, and standards to carry out the provisions of sections 178.661 to 178.673, but all rules and regulations shall be adopted and promulgated in accordance with the provisions of section 178.652 and chapter 536, RSMo.**]**

[208.146. 1. Pursuant to the federal Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) (Public Law 106-170), the medical assistance provided for in section 208.151 may be paid for a person who is employed and who:

(1) Meets the definition of disabled under the supplemental security income program or meets the definition of an employed individual with a medically improved disability under TWWIIA;

(2) Meets the asset limits in subsection 2 of this section; and

(3) Has a gross income of two hundred fifty percent or less of the federal poverty guidelines. For purposes of this subdivision, "income" does not include any income of the person's spouse up to one hundred thousand dollars or children. Individuals with incomes in excess of one hundred fifty percent of the federal poverty level shall pay a premium for participation in accordance

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with subsection 5 of this section.

2. For purposes of determining eligibility pursuant to this section, a person's assets shall not include:

(1) Any spousal assets up to one hundred thousand dollars, one-half of any marital assets and all assets excluded pursuant to section 208.010;

(2) Retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans and pension plans;

(3) Medical expense accounts set up through the person's employer;

(4) Family development accounts established pursuant to sections 208.750 to 208.775; or

(5) PASS plans.

3. A person who is otherwise eligible for medical assistance pursuant to this section shall not lose his or her eligibility if such person maintains an independent living development account. For purposes of this section, an "independent living development account" means an account established and maintained to provide savings for transportation, housing, home modification, and personal care services and assistive devices associated with such person's disability. Independent living development accounts and retirement accounts pursuant to subdivision (2) of subsection 2 of this section shall be limited to deposits of earned income and earnings on such deposits made by the eligible individual while participating in the program and shall not be considered an asset for purposes of determining and maintaining eligibility pursuant to section 208.151 until such person reaches the age of sixty-five.

4. If an eligible individual's employer offers employer-sponsored health insurance and the department of social services determines that it is more cost effective, the individual shall participate in the employer- sponsored insurance. The department shall pay such individual's portion of the premiums, co-payments and any other costs associated with participation in the employer-sponsored health insurance.

5. Any person whose income exceeds one hundred fifty percent of the federal poverty level shall pay a premium for participation in the medical assistance provided in this section. The premium shall be:

(1) For a person whose income is between one hundred fifty-one and one hundred seventy-five percent of the federal poverty level, four percent of income at one hundred sixty-three percent of the federal poverty level;

(2) For a person whose income is between one hundred seventy-six and two hundred percent of the federal poverty level, five percent of income at one hundred eighty-eight percent of the federal poverty level;

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(3) For a person whose income is between two hundred one and two hundred twenty-five percent of the federal poverty level, six percent of income at two hundred thirteen percent of the federal poverty level;

(4) For a person whose income is between two hundred twenty-six and two hundred fifty percent of the federal poverty level, seven percent of income at two hundred thirty-eight percent of the federal poverty level.

6. If the department elects to pay employer-sponsored insurance pursuant to subsection 4 of this section then the medical assistance established by this section shall be provided to an eligible person as a secondary or supplemental policy to any employer-sponsored benefits which may be available to such person.

7. The department of social services shall submit the appropriate documentation to the federal government for approval which allows the resources listed in subdivisions (1) to (5) of subsection 2 of this section and subsection 3 of this section to be exempt for purposes of determining eligibility pursuant to this section.

8. The department of social services shall apply for any and all grants which may be available to offset the costs associated with the implementation of this section.

9. The department of social services shall not contract for the collection of premiums pursuant to this chapter. To the best of their ability, the department shall collect premiums through the monthly electronic funds transfer or employer deduction.

10. Recipients of services through this chapter who pay a premium shall do so by electronic funds transfer or employer deduction unless good cause is shown to pay otherwise.**]**

[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 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

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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.**]**

[208.550. As used in sections 208.550 to 208.571, the following terms mean:

(1) "Clearinghouse", the Missouri Senior Rx clearinghouse established in section 208.571;

(2) "Commission", the commission for the Missouri Senior Rx program established in section 208.553;

(3) "Direct seller", any person, partnership, corporation, institution or entity engaged in the selling of pharmaceutical products directly to consumers in this state;

(4) "Distributor", a private entity under contract with the original labeler or holder of the national code number to manufacture, package or market the covered prescription drug;

(5) "Division", the division of aging within the department of health and senior services;

(6) "FDA", the Food and Drug Administration of the Public Health Services of the Department of Health and Human Services;

(7) "Generic drug", a chemically equivalent copy of a brand-name drug

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for which the patent has expired. Drug formulations must be of identical composition with respect to the active ingredient and must meet official standards of identity, purity, and quality of active ingredient as approved by the Food and Drug Administration;

(8) "Household income", the amount of income as defined in section 135.010, RSMo. For purposes of this section, household income shall be the household income of the applicant for the previous calendar year;

(9) "Innovator multiple-source drugs", a multiple-source drug that was originally marketed under a new drug application approved by the FDA. The term includes:

(a) Covered prescription drugs approved under Product License Approval (PLA), Establishment Licenses Approval (ELA), or Antibiotic Drug Approval (ADA); and

(b) A covered prescription drug marketed by a cross-licensed producer or distributor under the Approved New Drug Application (ANDA) when the drug product meets this definition;

(10) "Manufacturer", shall include:

(a) An entity which is engaged in any of the following:

a. The production, preparation, propagation, compounding, conversion or processing of prescription drug products:

(i) Directly or indirectly by extraction from substances of natural origin;

(ii) Independently by means of chemical synthesis; or

(iii) By a combination of extraction and chemical synthesis;

b. The packaging, repackaging, labeling or relabeling, or distribution of prescription drug products;

(b) The entity holding legal title to or possession of the national drug code number for the covered prescription drug;

(c) The term does not include a wholesale distributor of drugs, drugstore chain organization or retail pharmacy licensed by the state;

(11) "Medicaid", the program for medical assistance established pursuant to Title XIX of the federal Social Security Act and administered by the department of social services;

(12) "Missouri resident", an individual who establishes residence for a period of twelve months in a settled or permanent home or domicile within the state of Missouri with the intention of remaining in this state. An individual is a resident of this state until the individual establishes a permanent residence outside this state;

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(13) "National drug code number", the identifying drug number maintained by the FDA. The complete eleven-digit number must include the labeler code, product code and package size code;

(14) "New drug", a covered prescription drug approved as a new drug under Section 201(p) of the Federal Food, Drug, and Cosmetic Act (52 Stat. 1040, 21 U.S.C. S 321(p));

(15) "Prescription drug", a drug which may be dispensed only upon prescription by an authorized prescriber and which is approved for safety and effectiveness as a prescription drug under Section 505 or 507 of the Federal Food, Drug, and Cosmetic Act;

(16) "Program", the Missouri Senior Rx program established pursuant to section 208.556;

(17) "Single-source drugs", legend drug products for which the FDA has not approved on Abbreviated New Drug Application (ANDA);

(18) "Third-party administrator", a private party contracted to administer the Missouri Senior Rx program established in section 208.556, with duties that may include, but shall not be limited to, devising applications, enrolling members, administration of prescription drug benefits, and implementation of cost-control measures, including such programs as disease management programs, early refill edits, and fraud and abuse detection system and auditing programs;

(19) "Unit", a drug unit in the lowest identifiable amount, such as tablet or capsule for solid dosage forms, milliliter for liquid forms and gram for ointments or creams. The manufacturer shall specify the unit for each dosage form and strength of each covered prescription drug in accordance with the instructions developed by the Center for Medicare and Medicaid Services (CMS) for purposes of the Federal Medicaid Rebate Program under Section 1927 of Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. Section 301 et seq.);

(20) "Wholesaler", any person, partnership, corporation, institution or entity to which the manufacturer sells the covered prescription drug, including a pharmacy or chain of pharmacies.]

[208.553. 1. There is hereby established the "Commission for the Missouri Senior Rx Program" within the division of aging in the department of health and senior services to govern the operation of the Missouri Senior Rx program established in section 208.556. The commission shall consist of the following fifteen members:

(1) The lieutenant governor, in his or her capacity as advocate for the

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elderly;

(2) Two members of the senate, with one member from the majority party appointed by the president pro tem of the senate and one member of the minority party appointed by the president pro tem of the senate with the concurrence of the minority floor leader of the senate;

(3) Two members of the house of representatives, with one member from the majority party appointed by the speaker of the house of representatives and one member of the minority party appointed by the speaker of the house of representatives with the concurrence of the minority floor leader of the house of representatives;

(4) The director of the division of medical services in the department of social services;

(5) The director of the division of aging in the department of health and senior services;

(6) The chairperson of the commission on special health, psychological and social needs of minority older individuals;

(7) The following four members appointed by the governor with the advice and consent of the senate:

(a) A pharmacist;

(b) A physician;

(c) A representative from a senior advocacy group; and

(d) A representative from an area agency on aging;

(8) A representative from the pharmaceutical manufacturers industry as a nonvoting member appointed by the president pro tem of the senate and the speaker of the house of representatives;

(9) One public member appointed by the president pro tem of the senate; and

(10) One public member appointed by the speaker of the house of representatives.

In making the initial appointment to the committee, the governor, president pro tem, and speaker shall stagger the terms of the appointees so that four members serve initial terms of two years, four members serve initial terms of three years, four members serve initial terms of four years and one member serves an initial term of one year. All members appointed thereafter shall serve three-year terms. All members shall be eligible for reappointment. The commission shall elect a chair and may employ an executive director and such professional, clerical, and research personnel as may be necessary to assist in the performance of the commission's duties.

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2. Recognizing the unique medical needs of the senior African American population, the president pro tem of the senate, speaker of the house of representatives and governor will collaborate to ensure that there is adequate minority representation among legislative members and other members of the commission.

3. The commission:

(1) May establish guidelines, policies, and procedures necessary to establish the Missouri Senior Rx program;

(2) Shall hold quarterly meetings within fifteen days of the submission of each quarterly report required in subsection 16 of section 208.556, and other meetings as deemed necessary;

(3) May establish guidelines and collect information and data to promote and facilitate the program;

(4) May, after implementation of the program, evaluate and make recommendations to the governor and general assembly regarding the creation of a senior prescription drug benefit available to seniors who are not eligible for the program due to income that does not meet the program requirements;

(5) Shall have rulemaking authority for the implementation and administration of the program;

(6) The commission shall utilize the definition of "generic drug" as defined pursuant to section 208.550 as a general guideline and the commission may revise such definition, by rule, for the purpose of maximizing the use of generic drugs in the program.

4. The members of the commission shall receive no compensation for their service on the commission, but shall be reimbursed for ordinary and necessary expenses incurred in the performance of their duties as a member of the commission.**]**

[208.556. 1. There is hereby established the "Missouri Senior Rx Program" within the division of aging in the department of health and senior services to help defray the costs of prescription drugs for elderly Missouri residents. The division shall provide technical assistance to the commission for the administration and implementation of the program. The commission shall solicit requests for proposals from private contractors for the third-party administration of the program; except that, the commission shall either administer the rebate program established in section 208.565 or contract with the division of medical services for such rebate program. The program shall be governed by the commission for the Missouri Senior Rx program established in section 208.553.

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2. Administration of the program shall include, but not be limited to, devising program applications, enrolling participants, administration of prescription drug benefits, and implementation of cost-control measures, including such strategies as disease management programs, early refill edits, drug utilization review which includes retroactive approval systems, fraud and abuse detection system, and auditing programs. The commission shall select a responsive, cost-effective bid from the requests for proposal; however, if no responsive, cost-effective bids are received, the program shall be administered collaboratively by the department of health and senior services and the department of social services.

3. Prescription drug benefits shall not include coverage of the following drugs or classes of drugs, or their medical uses:

(1) Agents when used for anorexia or weight gain;

(2) Agents when used to promote fertility;

(3) Agents when used for cosmetic purposes or hair growth;

(4) Agents when used for the symptomatic relief of cough and colds;

(5) Agents when used to promote smoking cessation;

(6) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;

(7) Nonprescription drugs;

(8) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee;

(9) Barbiturates;

(10) Benzodiazepines.

4. Subject to appropriations, available funds and other cost-control measures authorized herein, any Missouri resident sixty-five years of age or older, who has not had access to employer-subsidized health care insurance that offers a pharmacy benefit for six months prior to application, who is not currently ineligible pursuant to subsection 8 of this section:

(1) Who has a household income at or below twelve thousand dollars for an individual or at or below seventeen thousand dollars for a married couple is eligible to participate in the program; or

(2) Who has a household income at or below seventeen thousand dollars for an individual or at or below twenty-three thousand dollars for a married couple is eligible to participate in the program.

(3) However, the commission may restrict income eligibility limits as a last resort to obtain program cost control.

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5. The commission shall have the authority to set and adjust coinsurance, deductibles and enrollment fees at different amounts pursuant to subdivisions (1) and (2) of subsection 4 of this section as a cost- containment measure.

6. Any person who has retired and received employer-sponsored health insurance while employed, but whose employer does not offer health insurance coverage to retirees shall not be subject to the six-month uninsured requirement.

7. The program established in this section is not an entitlement. Benefits shall be limited to the level supported by the moneys explicitly appropriated pursuant to this section. If in any fiscal year the commission projects that the total cost of the program will exceed the amount currently appropriated for the program, the commission may direct the third-party administrator to implement cost-control measures to reduce the projected cost. Such cost-control measures may include, but are not limited to, increasing the enrollment fees in subsection 12 of this section, the deductibles in subsection 11 of this section, and the coinsurance outlined in subsection 12 of this section. The Missouri Senior Rx program is a payer of last resort. If the federal government establishes a pharmaceutical assistance program that covers program- eligible seniors under Medicare or another program, the Missouri Senior Rx program shall cover only eligible costs not covered by the federal program.

8. Any person who is receiving Medicaid benefits shall not be eligible to participate in the program. The Missouri Senior Rx program is a payer of last resort. If a senior has coverage for pharmaceutical benefits through a health benefit plan, as defined in section 376.1350, RSMo, including a Medicare supplement or Medicare+Choice plan, or through a self-funded employee benefit plan, the Missouri Senior Rx program shall pay only for eligible costs not provided by such coverage. Individuals who have benefits with an actuarial value greater than or equal to the benefits in the program are not eligible for the program.

9. Applicants for the program shall submit an annual application to the division, or the division's designee, that attests to the age, residence, any third-party health insurance coverage, previous year prescription drug costs, annual household income for an individual or couple, if married, and any other information the commission deems necessary. The third-party administrator shall prescribe the form of the application for enrollment in the program, which shall be approved by the division. The commission shall develop and

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implement a means test by which applicants must demonstrate that they meet the income requirement of the program. Information provided by applicants and enrollees pursuant to sections 208.550 to 208.571 is confidential and shall not be disclosed by the commission, the division or any other state agency or contractor therein in any form.

10. Nothing in this section shall be construed as requiring an applicant to accept Medicaid benefits in lieu of participation in this program.

11. The following deductibles shall apply to enrollees in the program:

(1) For an individual with a household income at or below twelve thousand dollars, the deductible shall, in the initial year, not be less than two hundred fifty dollars;

(2) For a married couple with a household income at or below seventeen thousand dollars, the deductible shall, in the initial year, not be less than two hundred fifty dollars for each person;

(3) For an individual with a household income between twelve thousand one dollars and seventeen thousand dollars, the deductible shall, in the initial year, not be less than five hundred dollars; and

(4) For a married couple with a household income between seventeen thousand one dollars and twenty-three thousand dollars, the deductible shall, in the initial year, not be less than five hundred dollars for each person.

12. For prescription drugs, enrollees shall pay a forty percent coinsurance. The division may implement a higher coinsurance at the recommendation of the commission. Such coinsurance may be adjusted annually by the commission and shall be used to reduce the state's cost for the program. In addition, each enrollee with an annual household income at or below twelve thousand dollars for an individual or at or below seventeen thousand dollars for a married couple shall pay, in the initial year, not less than an annual twenty-five dollar enrollment fee and each enrollee with a household income between twelve thousand one dollars and seventeen thousand dollars for an individual or at or below between seventeen thousand one dollars and twenty-three thousand dollars for a married couple shall pay, in the initial year, not less than an annual thirty-five dollar enrollment fee to offset the administrative costs of the program.

13. The total annual expenditures for each enrollee under this program may be up to but shall not exceed five thousand dollars for each participant.

14. In providing program benefits, the department may enter into a contract with a private individual, corporation or agency to implement the program.

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15. The division shall utilize area agencies on aging, senior citizens centers, and other senior-focused entities to provide outreach, enrollment referral assistance, and education services to potentially eligible seniors for the Missouri Senior Rx program. The division and third-party administrators shall be responsible for informing eligible seniors on the availability of and providing information about pharmaceutical company benefits which may be applicable.

16. The commission shall submit quarterly reports to the governor, the senate appropriations committee, the house of representatives budget committee, the speaker of the house of representatives, the president pro tem of the senate, and the division that include:

(1) Quantified data as to the number of program applicants;

(2) An estimate of whether the current rate of expenditures will exceed the existing appropriation for the program in the current fiscal year; and

(3) Information regarding the commission's recommendations for changes to income eligibility, enrollment fees, coinsurance, deductibles, and benefit caps for enrollees in the program.

17. 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 sections 208.550 to 208.571 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. Sections 208.550 to 208.571 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.

18. Any person who knowingly makes any false statements, falsifies or permits to be falsified any records, or engages in conduct in an attempt to defraud the program is guilty of a misdemeanor and shall forfeit all rights to which he or she may be entitled hereunder.**]**

[208.559. 1. The Missouri Senior Rx program shall be operational no later than July 1, 2002. The division shall accept applications for enrollment during an initial open enrollment period from April 1, 2002, through May 30, 2002. Beginning with the enrollment period for fiscal year 2004, open enrollment periods for the program shall be held from January first through February twenty-eighth.

2. A person may apply for participation in the program outside the enrollment periods listed in subsection 1 of this section within thirty days of

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such person attaining the age and income eligibility requirements of the program established in section 208.556.]

[208.562. 1. Generic prescription drugs shall be used for the program when available. An enrollee may receive a name-brand drug when a generic drug is available only if both the physician and enrollee request that the name-brand drug be dispensed and the enrollee pays the coinsurance on the generic drug plus the difference in cost between the name-brand drug and the generic drug.

2. Pharmacists participating in the Missouri Senior Rx program shall be reimbursed for the price of prescription drugs based on the following formula:

(1) For generic prescription drugs, the average wholesale price minus twenty percent, plus a four dollar and nine cent dispensing fee; and

(2) For name-brand prescription drugs, the average wholesale price minus ten and forty-three one-hundredths percent, plus a four dollar and nine cent dispensing fee.]

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[208.565. 1. The division shall negotiate with manufacturers for participation in the program. The division shall issue a certificate of participation to pharmaceutical manufacturers participating in the Missouri Senior Rx program. A pharmaceutical manufacturer may apply for participation in the program with an application form prescribed by the commission. A certificate of participation shall remain in effect for an initial period of not less than one year and shall be automatically renewed unless terminated by either the manufacturer or the state with sixty days' notification.

2. For all transactions occurring prior to July 1, 2003, the rebate amount for each drug shall be fifteen percent of the average manufacturers' price as defined pursuant to 42 U.S.C. 1396r-8(k)(1). For all transactions occurring on or after July 1, 2003, the rebate amount for name brand prescription drugs shall be fifteen percent and the rebate amount for generic prescription drugs shall be eleven percent of the average manufacturers' price as defined pursuant to 42 U.S.C. 1396r-8(k)(1). No other discounts shall apply. In order to receive a certificate of participation a manufacturer or distributor participating in the Missouri Senior Rx program shall provide the division of aging the average manufacturers' price for their contracted products. The following shall apply to the providing of average manufacturers' price information to the division of aging:

(1) Any manufacturer or distributor with an agreement under this

section that knowingly provides false information is subject to a civil penalty in an amount not to exceed one hundred thousand dollars for each provision of false information. Such penalties shall be in addition to other penalties as prescribed by law;

(2) Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers pursuant to this subsection or under an agreement with the division pursuant to this section is confidential and shall not be disclosed by the division or any other state agency or contractor therein in any form which discloses the identity of a specific manufacturer or wholesaler or prices charged for drugs by such manufacturer or wholesaler, except to permit the state auditor to review the information provided and the division of medical services for rebate administration.

3. All rebates received through the program shall be used toward refunding the program. If a pharmaceutical manufacturer refuses to participate in the rebate program, such refusal shall not affect the manufacturer's status under the current Medicaid program. There shall be no drug formulary, prior approval system, or any similar restriction imposed on the coverage of outpatient drugs made by pharmaceutical manufacturers who have agreements to pay rebates for drugs utilized in the Missouri Senior Rx program, provided that such outpatient drugs were approved by the Food and Drug Administration.

4. Any prescription drug of a manufacturer that does not participate in the program shall not be reimbursable.**]**

[208.568. 1. There is hereby created in the state treasury the "Missouri Senior Rx Fund", which shall consist of all moneys deposited in the fund pursuant to sections 208.550 to 208.571 and all moneys which may be appropriated to it by the general assembly, from federal or other sources.

2. The state treasurer shall administer the fund and credit all interest to the fund and the moneys in the fund shall be used solely by the commission for the Missouri Senior Rx program and the division of aging for the implementation of the program for seniors established in sections 208.550 to 208.571.

3. Notwithstanding the provisions of section 33.080, RSMo, to the contrary, moneys in the fund shall not revert to the credit of the general revenue fund at the end of the biennium.**]**

[208.571. 1. Subject to appropriations, there is hereby established the "Missouri Senior Rx Clearinghouse" within the commission for the Missouri Senior Rx program established pursuant to section 208.553. The commission

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may submit requests for proposal for the third-party administration of the clearinghouse. The third-party administrator of the Missouri Senior Rx program may submit a request for proposal for administration of the clearinghouse. The purpose of the clearinghouse shall include, but not be limited to:

(1) Assist all Missouri residents in accessing prescription drug programs;

(2) Educate the public on quality drug programs and cost-containment strategies;

(3) Serve as a resource for pharmaceutical benefit issues.

2. The administration of the clearinghouse shall include, but not be limited to:

(1) Providing a one-stop-shopping clearinghouse for all information for seniors regarding prescription drug coverage programs and health insurance issues;

(2) Targeting outreach and education including print and media, social service and health care providers to promote the program;

(3) Maintaining a toll-free 800-phone number staffed by trained customer service representatives;

(4) Providing the state with measurable data to identify the progress and success of the program, including but not limited to, the number of individuals served, length and type of assistance, follow-up and program evaluation.**]**

Section B. Because of the current fiscal crisis of the state of Missouri, the enactment of section 208.014 of this act is deemed necessary for the immediate preservation of the public health, welfare, peace and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the enactment of section 208.014 of this act shall be in full force and effect upon its passage and approval.

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