FIRST REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 577

94TH GENERAL ASSEMBLY

Reported from the Special Committee on Health Care Facilities May 8, 2007 with recommendation that House Committee Substitute for Senate Substitute for Senate Committee Substitute for Senate Bill No. 577 Do Pass. Referred to the Committee on Rules pursuant to Rule 25(21)(f).

D. ADAM CRUMBLISS, Chief Clerk

2227L.07C

AN ACT

To repeal sections 105.711, 135.096, 191.411, 191.900, 191.905, 191.910, 198.097, 208.014, 208.151, 208.152, 208.153, 208.201, 208.212, 208.215, 208.217, 208.225, 208.612, 208.631, 208.640, 208.750, 208.930, 375.020, 473.398, 660.546, 660.547, 660.549, 660.551, 660.553, 660.555, and 660.557, RSMo, and to enact in lieu thereof sixty-one new sections relating to the creation of the MO HealthNet program in order to provide medical assistance for needy persons, with penalty provisions and an emergency clause for a certain section.

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

Section A. Sections 105.711, 135.096, 191.411, 191.900, 191.905, 191.910, 198.097, 208.014, 208.151, 208.152, 208.153, 208.201, 208.212, 208.215, 208.217, 208.225, 208.612, 208.631, 208.640, 208.750, 208.930, 375.020, 473.398, 660.546, 660.547, 660.549, 660.551, 660.553, 660.555, and 660.557, RSMo, are repealed and sixty-one new sections enacted in lieu thereof, to be known as sections 105.711, 135.096, 135.575, 167.182, 191.411, 191.900, 191.905, 191.907, 191.908, 191.909, 191.910, 191.914, 191.1050, 191.1053, 191.1056, 192.632, 198.069, 198.097, 208.001, 208.146, 208.151, 208.152, 208.153, 208.197, 208.201, 208.212, 208.213, 208.215, 208.217, 208.225, 208.230, 208.612, 208.631, 208.640, 208.659, 208.670,

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

208.690, 208.692, 208.694, 208.696, 208.698, 208.750, 208.930, 208.950, 208.952, 208.954, 208.956, 208.960, 208.962, 208.964, 208.968, 208.975, 208.978, 375.020, 375.143, 473.398, 620.510, 1, 2, 3, and 4, to read as follows:

105.711. 1. There is hereby created a "State Legal Expense Fund" which shall consist of moneys appropriated to the fund by the general assembly and moneys otherwise credited to such fund pursuant to section 105.716.

2. Moneys in the state legal expense fund shall be available for the payment of any claim or any amount required by any final judgment rendered by a court of competent jurisdiction against:

(1) The state of Missouri, or any agency of the state, pursuant to section 536.050 or 536.087, RSMo, or section 537.600, RSMo;

(2) Any officer or employee of the state of Missouri or any agency of the state, including, without limitation, elected officials, appointees, members of state boards or commissions, and members of the Missouri national guard upon conduct of such officer or employee arising out of and performed in connection with his or her official duties on behalf of the state, or any agency of the state, provided that moneys in this fund shall not be available for payment of claims made under chapter 287, RSMo; **[**or**]**

(3) (a) Any physician, psychiatrist, pharmacist, podiatrist, dentist, nurse, or other health care provider licensed to practice in Missouri under the provisions of chapter 330, 332, 334, 335, 336, 337 or 338, RSMo, who is employed by the state of Missouri or any agency of the state, under formal contract to conduct disability reviews on behalf of the department of elementary and secondary education or provide services to patients or inmates of state correctional facilities on a part-time basis, and any physician, psychiatrist, pharmacist, podiatrist, dentist, nurse, or other health care provider licensed to practice in Missouri under the provisions of chapter 330, 332, 334, 335, 336, 337, or 338, RSMo, who is under formal contract to provide services to patients or inmates at a county jail on a part-time basis;

(b) Any physician licensed to practice medicine in Missouri under the provisions of chapter 334, RSMo, and his professional corporation organized pursuant to chapter 356, RSMo, who is employed by or under contract with a city or county health department organized under chapter 192, RSMo, or chapter 205, RSMo, or a city health department operating under a city charter, or a combined city-county health department to provide services to patients for medical care caused by pregnancy, delivery, and child care, if such medical services are provided by the physician pursuant to the contract without compensation or the physician is paid from no other source than a governmental agency except for patient co-payments required by federal or state law or local ordinance;

(c) Any physician licensed to practice medicine in Missouri under the provisions of chapter 334, RSMo, who is employed by or under contract with a federally funded community health center organized under Section 315, 329, 330 or 340 of the Public Health Services Act (42 U.S.C. 216, 254c) to provide services to patients for medical care caused by pregnancy, delivery, and child care, if such medical services are provided by the physician pursuant to the contract or employment agreement without compensation or the physician is paid from no other source than a governmental agency or such a federally funded community health center except for patient co-payments required by federal or state law or local ordinance. In the case of any claim or judgment that arises under this paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of one million dollars for all claims arising out of and judgments based upon the same act or acts alleged in a single cause against any such physician, and shall not exceed one million dollars for any one claimant;

(d) Any physician licensed pursuant to chapter 334, RSMo, who is affiliated with and receives no compensation from a nonprofit entity qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, which offers a free health screening in any setting or any physician, nurse, physician assistant, dental hygienist, **[**or**]** dentist**, or other health care professional** licensed or registered **[**pursuant to chapter 332, RSMo, chapter 334, RSMo, or chapter 335**] under chapter 330, 331, 332, 334, 335, 336, 337, or 338**, RSMo, who provides **[**medical, dental, or nursing treatment**] health care services** within the scope of his **or her** license or registration at a city or county health department organized under chapter 192, RSMo, or chapter 205, RSMo, a city health department operating under a city charter, or a combined city-county health department, or a nonprofit community health center qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, if such **[**treatment is**] services are** restricted to primary care and preventive health services, provided that such **[**treatment**] services** shall not include the performance of an abortion, and if such **[**medical, dental, or nursing**] health** services are provided by the **[**physician, dentist, physician assistant, dental hygienist, or nurse**] health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo,** without compensation. Medicaid or medicare payments for primary care and preventive health services provided by a **[**physician, dentist, physician assistant, dental hygienist, or nurse**] health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo,** who volunteers at a free health clinic is not compensation for the purpose of this section if the total payment is assigned to the free health clinic. For the purposes of the section, "free health clinic" means a nonprofit community health center qualified as exempt from federal taxation under Section 501 (c)(3) of the Internal Revenue Code of 1987, as amended, that provides primary care and preventive health services to people without health insurance coverage

for the services provided without charge. In the case of any claim or judgment that arises under this paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of five hundred thousand dollars, for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed five hundred thousand dollars for any one claimant, and insurance policies purchased pursuant to the provisions of section 105.721 shall be limited to five hundred thousand dollars. Liability or malpractice insurance obtained and maintained in force by or on behalf of any **[**physician, dentist, physician assistant, dental hygienist, or nurse**] health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo,** shall not be considered available to pay that portion of a judgment or claim for which the state legal expense fund is liable under this paragraph; **[**or**]**

(e) Any physician, nurse, physician assistant, dental hygienist, or dentist licensed or registered to practice medicine, nursing, or dentistry or to act as a physician assistant or dental hygienist in Missouri under the provisions of chapter 332, RSMo, chapter 334, RSMo, or chapter 335, RSMo, who provides medical, nursing, or dental treatment within the scope of his license or registration to students of a school whether a public, private, or parochial elementary or secondary school, if such physician's treatment is restricted to primary care and preventive health services and if such medical, dental, or nursing services are provided by the physician, dentist, physician assistant, dental hygienist, or nurse without compensation. In the case of any claim or judgment that arises under this paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of five hundred thousand dollars, for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed five hundred thousand dollars for any one claimant, and insurance policies purchased pursuant to the provisions of section 105.721 shall be limited to five hundred thousand dollars; or

(f) Any physician licensed under chapter 334, RSMo, or dentist licensed under chapter 332, RSMo, providing medical care without compensation to an individual referred to his or her care by a city or county health department organized under chapter 192 or 205, RSMo, a city health department operating under a city charter, or a combined city-county health department, or nonprofit community health center qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or a federally funded community health center organized under Section 315, 329, 330, or 340 of the Public Health Services Act, 42 U.S.C. Section 216, 254c; provided that such treatment shall not include the performance of an abortion. In the case of any claim or judgment that arises under this paragraph, the aggregate of payments from the state legal expense fund shall be limited to a maximum of one million dollars, for all claims

arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed one million dollars for any one claimant, and insurance policies purchased under the provisions of section 105.721 shall be limited to one million dollars. Liability or malpractice insurance obtained and maintained in force by or on behalf of any physician licensed under chapter 334, RSMo, or any dentist licensed under chapter 332, RSMo, shall not be considered available to pay that portion of a judgment or claim for which the state legal expense fund is liable under this paragraph;

(4) Staff employed by the juvenile division of any judicial circuit; **[**or**]**

(5) Any attorney licensed to practice law in the state of Missouri who practices law at or through a nonprofit community social services center qualified as exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, or through any agency of any federal, state, or local government, if such legal practice is provided by the attorney without compensation. In the case of any claim or judgment that arises under this subdivision, the aggregate of payments from the state legal expense fund shall be limited to a maximum of five hundred thousand dollars for all claims arising out of and judgments based upon the same act or acts alleged in a single cause and shall not exceed five hundred thousand dollars for any one claimant, and insurance policies purchased pursuant to the provisions of section 105.721 shall be limited to five hundred thousand dollars**; or**

(6) Any social welfare board created under section 205.770, RSMo, and the members and officers thereof upon conduct of such officer or employee while acting in his or her capacity as a board member or officer, and any physician, nurse, physician assistant, dental hygienist, dentist, or other health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, who is referred to provide medical care without compensation by the board and who provides health care services within the scope of his or her license or registration as prescribed by the board.

3. The department of health and senior services shall promulgate rules regarding contract procedures and the documentation of care provided under paragraphs (b), (c), (d), **[**and**]** (e)**, and (f)** of subdivision (3) of subsection 2 of this section. The limitation on payments from the state legal expense fund or any policy of insurance procured pursuant to the provisions of section 105.721, provided in subsection 7 of this section, shall not apply to any claim or judgment arising under paragraph (a), (b), (c), (d), **[**or**]** (e)**, or (f)** of subdivision (3) of subsection 2 of this section. Any claim or judgment arising under paragraph (a), (b), (c), (d), **[**or**]** (e)**, or (f)** of subdivision (3) of subsection 2 of this section shall be paid by the state legal expense fund or any policy of insurance procured pursuant to section 105.721, to the extent damages are allowed under sections 538.205 to 538.235, RSMo. Liability or malpractice insurance obtained and maintained in force by any **[**physician, dentist, physician assistant, dental hygienist, or nurse**]**

health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, for coverage concerning his or her private practice and assets shall not be considered available under subsection 7 of this section to pay that portion of a judgment or claim for which the state legal expense fund is liable under paragraph (a), (b), (c), (d), **[**or**]** (e)**, or (f)** of subdivision (3) of subsection 2 of this section. However, a **[**physician, nurse, dentist, physician assistant, or dental hygienist**] health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo,** may purchase liability or malpractice insurance for coverage of liability claims or judgments based upon care rendered under paragraphs (c), (d), **[**and**]** (e)**, and (f)** of subdivision (3) of subsection 2 of this section which exceed the amount of liability coverage provided by the state legal expense fund under those paragraphs. Even if paragraph (a), (b), (c), (d), **[**or**]** (e)**, or (f)** of subdivision (3) of subsection 2 of this section is repealed or modified, the state legal expense fund shall be available for damages which occur while the pertinent paragraph (a), (b), (c), (d), **[**or**]** (e)**, or (f)** of subdivision (3) of subsection 2 of this section is in effect. **Any health care professional licensed under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo, described in paragraph (a), (b), (c), (d), (e), or (f) of subdivision (3) of subsection 2 of this section who is a defendant in a claim arising under paragraph (a), (b), (c), (d), (e), or (f) of subdivision (3) of subsection 2 of this section shall have the right to consent to the settlement of the claim and shall not be forced to settle a particular claim.**

4. The attorney general shall promulgate rules regarding contract procedures and the documentation of legal practice provided under subdivision (5) of subsection 2 of this section. The limitation on payments from the state legal expense fund or any policy of insurance procured pursuant to section 105.721 as provided in subsection 7 of this section shall not apply to any claim or judgment arising under subdivision (5) of subsection 2 of this section. Any claim or judgment arising under subdivision (5) of subsection 2 of this section shall be paid by the state legal expense fund or any policy of insurance procured pursuant to section 105.721 to the extent damages are allowed under sections 538.205 to 538.235, RSMo. Liability or malpractice insurance otherwise obtained and maintained in force shall not be considered available under subsection 7 of this section to pay that portion of a judgment or claim for which the state legal expense fund is liable under subdivision (5) of subsection 2 of this section. However, an attorney may obtain liability or malpractice insurance for coverage of liability claims or judgments based upon legal practice rendered under subdivision (5) of subsection 2 of this section that exceed the amount of liability coverage provided by the state legal expense fund under subdivision (5) of subsection 2 of this section. Even if subdivision (5) of subsection 2 of this section is repealed or amended, the state legal expense fund shall be available for damages that occur while the pertinent subdivision (5) of subsection 2 of this section is in effect.

5. All payments shall be made from the state legal expense fund by the commissioner of administration with the approval of the attorney general. Payment from the state legal expense fund of a claim or final judgment award against a **[**physician, dentist, physician assistant, dental hygienist, or nurse**] health care professional licensed or registered under chapter 330, 331, 332, 334, 335, 336, 337, or 338, RSMo,** described in paragraph (a), (b), (c), (d), **[**or**]** (e)**, or (f)** of subdivision (3) of subsection 2 of this section, or against an attorney in subdivision (5) of subsection 2 of this section, shall only be made for services rendered in accordance with the conditions of such paragraphs. In the case of any claim or judgment against an officer or employee of the state or any agency of the state based upon conduct of such officer or employee arising out of and performed in connection with his or her official duties on behalf of the state or any agency of the state that would give rise to a cause of action under section 537.600, RSMo, the state legal expense fund shall be liable, excluding punitive damages, for:

(1) Economic damages to any one claimant; and

(2) Up to three hundred fifty thousand dollars for noneconomic damages.

The state legal expense fund shall be the exclusive remedy and shall preclude any other civil actions or proceedings for money damages arising out of or relating to the same subject matter against the state officer or employee, or the officer's or employee's estate. No officer or employee of the state or any agency of the state shall be individually liable in his or her personal capacity for conduct of such officer or employee arising out of and performed in connection with his or her official duties on behalf of the state or any agency of the state. The provisions of this subsection shall not apply to any defendant who is not an officer or employee of the state or any agency of the state in any proceeding against an officer or employee of the state or any agency of the state. Nothing in this subsection shall limit the rights and remedies otherwise available to a claimant under state law or common law in proceedings where one or more defendants is not an officer or employee of the state or any agency of the state.

6. The limitation on awards for noneconomic damages provided for in this subsection shall be increased or decreased on an annual basis effective January first of each year in accordance with the Implicit Price Deflator for Personal Consumption Expenditures as published by the Bureau of Economic Analysis of the United States Department of Commerce. The current value of the limitation shall be calculated by the director of the department of insurance, who shall furnish that value to the secretary of state, who shall publish such value in the Missouri Register as soon after each January first as practicable, but it shall otherwise be exempt from the provisions of section 536.021, RSMo.

7. Except as provided in subsection 3 of this section, in the case of any claim or judgment that arises under sections 537.600 and 537.610, RSMo, against the state of Missouri,

or an agency of the state, the aggregate of payments from the state legal expense fund and from any policy of insurance procured pursuant to the provisions of section 105.721 shall not exceed the limits of liability as provided in sections 537.600 to 537.610, RSMo. No payment shall be made from the state legal expense fund or any policy of insurance procured with state funds pursuant to section 105.721 unless and until the benefits provided to pay the claim by any other policy of liability insurance have been exhausted.

8. The provisions of section 33.080, RSMo, notwithstanding, any moneys remaining to the credit of the state legal expense fund at the end of an appropriation period shall not be transferred to general revenue.

9. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is promulgated under the authority delegated in sections 105.711 to 105.726 shall become effective only if it has been promulgated pursuant to the provisions of chapter 536, RSMo. Nothing in this section shall be interpreted to repeal or affect the validity of any rule filed or adopted prior to August 28, 1999, if it fully complied with the provisions of chapter 536, 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, 1999, shall be invalid and void.

135.096. 1. In order to promote personal financial responsibility for long-term health care in this state, for all taxable years beginning after December 31, 1999, a resident individual may deduct from such individual's Missouri taxable income an amount equal to fifty percent of all nonreimbursed amounts paid by such individual for qualified long-term care insurance premiums to the extent such amounts are not included the individual's itemized deductions. **For all taxable years beginning after December 31, 2006, a resident individual may deduct from each individual's Missouri taxable income an amount equal to one hundred percent of all nonreimbursed amounts paid by such individuals for qualified long-term care insurance premiums to the extent such amounts are not included in the individual's itemized deductions.** A married individual filing a Missouri income tax return separately from his or her spouse shall be allowed to make a deduction pursuant to this section in an amount equal to the proportion of such individual's payment of all qualified long-term care insurance premiums. The director of the department of revenue shall place a line on all Missouri individual income tax returns for the deduction created by this section.

2. For purposes of this section, "qualified long-term care insurance" means any policy which meets or exceeds the provisions of sections 376.1100 to 376.1118, RSMo, and the rules and regulations promulgated pursuant to such sections for long-term care insurance.

3. Notwithstanding any other provision of law to the contrary, two or more insurers issuing a qualified long-term care insurance policy shall not act in concert with each other and with others with respect to any matters pertaining to the making of rates or rating systems.

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

(1) "Missouri healthcare access fund", the fund created in section 191.1056, RSMo;

(2) "Tax credit", a credit against the tax otherwise due under chapter 143, RSMo, excluding withholding tax imposed by sections 143.191 to 143.265, RSMo;

(3) "Taxpayer", any individual subject to the tax imposed in chapter 143, RSMo, excluding withholding tax imposed by sections 143.191 to 143.265, RSMo.

2. For all taxable years beginning on or after January 1, 2007, a taxpayer shall be allowed a tax credit for donations in excess of one hundred dollars made to the Missouri healthcare access fund. The tax credit amount shall be equal to one-half of the total donation made, but shall not exceed twenty-five thousand dollars per taxpayer claiming the credit. If the amount of the tax credit issued exceeds the amount of the taxpayer's state tax liability for the tax year for which the credit is claimed, the difference shall not be refundable but may be carried forward to any of the taxpayer's next four taxable years. No tax credit granted under this section shall be transferred, sold, or assigned. The cumulative amount of tax credits which may be issued under this section in any one fiscal year shall not exceed one million dollars.

3. The department of revenue may promulgate rules to implement 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, 2007, shall be invalid and void.

4. Pursuant to section 23.253, RSMo, of the Missouri Sunset Act:

(1) The provisions of the new program authorized under this section shall automatically sunset six years after the effective date of this section unless reauthorized by an act of the general assembly; and

(2) If such program is reauthorized, the program authorized under this section shall automatically sunset twelve years after the effective date of the reauthorization of this section; and

(3) This section shall terminate on September first of the calendar year immediately following the calendar year in which the program authorized under this section is sunset.

167.182. 1. This section shall be known as the "Cervical Cancer Prevention Public Awareness Campaign".

(1) The department of health and senior services shall create a public awareness campaign to educate parents, health care providers, and women about the causes and risk factors associated with cervical cancer, the human papillomavirus (HPV), and preventing cervical cancer. The public awareness campaign shall distribute information that includes:

(a) The risk factors for developing cervical cancer, the symptoms of the disease, how it may be diagnosed and its possible consequences if untreated;

(b) The connection between human papillomavirus and cervical cancer, how human papillomavirus is transmitted, how transmission may be prevented, including abstinence as the only completely effective way to prevent sexually transmitted diseases, and the relative risk of contracting human papillomavirus for elementary and secondary school students;

(c) The latest scientific information on the immunization against the human papillomavirus infection and the vaccine's effectiveness, including the vaccine's failure rates against causes of cervical cancer, and a complete and comprehensive description of the possible side effects of the vaccination;

(d) A statement that a pap smear is still critical for the detection of precancerous changes in the cervix to allow for treatment before cervical cancer develops; and

(e) A statement that any questions or concerns concerning immunizing the child against human papillomavirus could be answered by contacting a health care provider.

2. Beginning with the 2008–2009 school year, the department of elementary and secondary education shall establish procedures by which each school district shall provide, to the department of health and senior services, the names and addresses of all parents, conservators, and guardians of female students who are entering grade six. The department of health and senior services shall prescribe the form and content of information regarding the human papillomavirus and cervical cancer to be made available to the parents, conservators, and guardians of these students. The department shall establish procedures to ensure that the information provided:

(1) Includes the connection between human papillomavirus and cervical cancer;

(2) States that an immunization against the most common human papillomavirus infections is available;

(3) Contains age appropriate information so that a parent, conservator, or guardian may share the information with the student if he or she decides to do so;

(4) Contains the elements described in subsection 1 of this section;

(5) Is mailed directly to the attention of the parents, conservators, or guardians of each such female student by the department; and

(6) Shall not be directly distributed to any minor student by either the department of health and senior services or the department of elementary and secondary education; however, nothing in this section shall prohibit any local school board from authorizing a distribution policy.

3. Each informational mailing sent to the parents, conservators, and guardians of female students entering grade six shall include a voluntary return form for the parents, conservators, or guardians of such students to return, not later than twenty school days after the first day of school, a written statement prescribed by the department of health and senior services that:

(1) States that the parent, conservator, or guardian has received the information required under subsection 2 of this section and indicates if the student has received or is receiving the vaccination, or if the parent, conservator or guardian has chosen not to have the student immunized; and

(2) Is to be used for statistical purposes only and shall not be used to personally identify any parent, conservator or guardian, or any student.

4. Nothing in this section shall be construed to prevent a student from school attendance if such parent, conservator or guardian has opted not to have the student receive the human papillomavirus vaccination or has not returned the form prescribed in this section.

5. The human papillomavirus vaccination may be administered by any duly licensed physician or by someone under the physician's direction. If the parent, conservator or guardian is unable to pay, the child shall be immunized at public expense by a physician or nurse at or from the county, school district, city public health center or by a nurse or physician in the private office or clinic of the child's personal physician with the costs of immunization paid through the state Medicaid program, private insurance or in a manner to be determined by the department of health and senior services subject to state and federal appropriations, and after consultation with the school superintendent and the advisory committee established in section 192.630, RSMo.

6. Funds for the administration of this section and for the purchase of vaccines for children of families unable to afford them shall be appropriated to the department of health and senior services from general revenue or from federal funds if available.

7. 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 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, 2007, shall be invalid and void.

191.411. 1. The director of the department of health and senior services shall develop and implement a plan to define a system of coordinated health care services available and accessible to all persons, in accordance with the provisions of this section. The plan shall encourage the location of appropriate practitioners of health care services, including dentists, **or psychiatrists or psychologists as defined in section 632.005, RSMo,** in rural and urban areas of the state, particularly those areas designated by the director of the department of health and senior services as health resource shortage areas, in return for the consideration enumerated in subsection 2 of this section. The department of health and senior services shall have authority to contract with public and private health care providers for delivery of such services.

2. There is hereby created in the state treasury the "Health Access Incentive Fund". **With the permission of the oversight committee created under section 208.956, RSMo,** moneys in the fund shall be used to implement and encourage a program to fund loans, loan repayments, start-up grants, provide locum tenens, professional liability insurance assistance, practice subsidy, annuities when appropriate, or technical assistance in exchange for location of appropriate health providers, including dentists, who agree to serve all persons in need of health services regardless of ability to pay. The department of health and senior services shall encourage the recruitment of minorities in implementing this program.

3. In accordance with an agreement approved by both the director of the department of social services and the director of the department of health and senior services, the commissioner of the office of administration shall issue warrants to the state treasurer to transfer available funds from the health access incentive fund to the department of social services to be used to enhance **[**Medicaid**] MO HealthNet** payments to physicians **[**or**] ,** dentists**, psychiatrists, and psychologists,** in order to enhance the availability of physician **[**or**] ,** dental**, or mental health** services in shortage areas. The amount that may be transferred shall be the amount agreed upon by the directors of the departments of social services and health and senior services and shall not exceed the maximum amount specifically authorized for any such transfer by appropriation of the general assembly.

4. The general assembly shall appropriate money to the health access incentive fund from the health initiatives fund created by section 191.831. The health access incentive fund shall also contain money as otherwise provided by law, gift, bequest or devise. Notwithstanding the provisions of section 33.080, RSMo, the unexpended balance in the fund at the end of the biennium shall not be transferred to the general revenue fund of the state.

5. The director of the department of health and senior services shall have authority to promulgate reasonable rules to implement the provisions of this section pursuant to chapter 536, RSMo.

191.900. As used in sections 191.900 to 191.910, the following terms mean:

(1) "Abuse", the infliction of physical, sexual or emotional harm or injury. "Abuse" includes the taking, obtaining, using, transferring, concealing, appropriating or taking possession of property of another person without such person's consent;

(2) "Claim", any attempt to cause a health care payer to make a health care payment;

(3) "False", wholly or partially untrue. A false statement or false representation of a material fact means the failure to reveal material facts in a manner which is intended to deceive a health care payer with respect to a claim;

(4) "Health care", any service, assistance, care, product, device or thing provided pursuant to a medical assistance program, or for which payment is requested or received, in whole or part, pursuant to a medical assistance program;

(5) "Health care payer", a medical assistance program, or any person reviewing, adjusting, approving or otherwise handling claims for health care on behalf of or in connection with a medical assistance program;

(6) "Health care payment", a payment made, or the right under a medical assistance program to have a payment made, by a health care payer for a health care service;

(7) "Health care provider", any person delivering, or purporting to deliver, any health care, and including any employee, agent or other representative of such a person**[**;**] , and further including any employee, representative, or subcontractor of the state of Missouri delivering, purporting to deliver, or arranging for the delivery of any health care**;

(8) **"Knowing" and "knowingly", that a person, with respect to information:**

(a) Has actual knowledge of the information;

(b) Acts in deliberate ignorance of the truth or falsity of the information; or

(c) Acts in reckless disregard of the truth or falsity of the information.

Use of the terms "knowing" or "knowingly" shall be construed to include the term "intentionally", which means that a person, with respect to information, intended to act in violation of the law;

(9) "Medical assistance program", **MO HealthNet, or** any program to provide or finance health care to **[**recipients**] participants** which is established pursuant to title 42 of the United States Code, any successor federal health insurance program, or a waiver granted thereunder. A medical assistance program may be funded either solely by state funds or by state and federal funds jointly. The term "medical assistance program" shall include the medical assistance program provided by section 208.151, RSMo, et seq., and any state agency or agencies administering all or any part of such a program;

[(9)**] (10)** "Person", a natural person, corporation, partnership, association or any legal entity.

191.905. 1. No health care provider shall knowingly make or cause to be made a false statement or false representation of a material fact in order to receive a health care payment, including but not limited to:

(1) Knowingly presenting to a health care payer a claim for a health care payment that falsely represents that the health care for which the health care payment is claimed was medically necessary, if in fact it was not;

(2) Knowingly concealing the occurrence of any event affecting an initial or continued right under a medical assistance program to have a health care payment made by a health care payer for providing health care;

(3) Knowingly concealing or failing to disclose any information with the intent to obtain a health care payment to which the health care provider or any other health care provider is not entitled, or to obtain a health care payment in an amount greater than that which the health care provider or any other health care provider is entitled;

(4) Knowingly presenting a claim to a health care payer that falsely indicates that any particular health care was provided to a person or persons, if in fact health care of lesser value than that described in the claim was provided.

2. No person shall knowingly solicit or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind in return for:

(1) Referring another person to a health care provider for the furnishing or arranging for the furnishing of any health care; or

(2) Purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering any health care.

3. No person shall knowingly offer or pay any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, to any person to induce such person to refer another person to a health care provider for the furnishing or arranging for the furnishing of any health care.

4. Subsections 2 and 3 of this section shall not apply to a discount or other reduction in price obtained by a health care provider if the reduction in price is properly disclosed and appropriately reflected in the claim made by the health care provider to the health care payer, or any amount paid by an employer to an employee for employment in the provision of health care.

5. Exceptions to the provisions of subsections 2 and 3 of this subsection shall be provided for as authorized in 42 U.S.C. Section 1320a-7b(3)(E), as may be from time to time amended, and regulations promulgated pursuant thereto.

6. No person shall knowingly abuse a person receiving health care.

7. A person who violates subsections 1 to **[**4**] 3** of this section is guilty of a class **[**D**] C** felony upon his **or her** first conviction, and shall be guilty of a class **[**C**] B** felony upon his **or her** second and subsequent convictions**. Any person who has been convicted of such violations shall be referred to the Office of Inspector General within the United States Department of Health and Human Services**. A prior conviction shall be pleaded and proven as provided by section 558.021, RSMo. A person who violates subsection 6 of this section shall be guilty of a class C felony, unless the act involves no physical, sexual or emotional harm or injury and the value of the property involved is less than five hundred dollars, in which event a violation of subsection 6 of this section is a class A misdemeanor.

8. Any natural person who willfully prevents, obstructs, misleads, delays, or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of sections 191.900 to 191.910 is guilty of a class D felony.

[8.**] 9.** Each separate false statement or false representation of a material fact proscribed by subsection 1 of this section or act proscribed by subsection 2 or 3 of this section shall constitute a separate offense and a separate violation of this section, whether or not made at the same or different times, as part of the same or separate episodes, as part of the same scheme or course of conduct, or as part of the same claim.

[9.**] 10.** In a prosecution pursuant to subsection 1 of this section, circumstantial evidence may be presented to demonstrate that a false statement or claim was knowingly made. Such evidence of knowledge may include but shall not be limited to the following:

(1) A claim for a health care payment submitted with the health care provider's actual, facsimile, stamped, typewritten or similar signature on the claim for health care payment;

(2) A claim for a health care payment submitted by means of computer billing tapes or other electronic means;

(3) A course of conduct involving other false claims submitted to this or any other health care payer.

[10.**] 11.** Any person convicted of a violation of this section, in addition to any fines, penalties or sentences imposed by law, shall be required to make restitution to the federal and

state governments, in an amount at least equal to that unlawfully paid to or by the person, and shall be required to reimburse the reasonable costs attributable to the investigation and prosecution pursuant to sections 191.900 to 191.910. All of such restitution shall be paid and deposited to the credit of the "**[**Medicaid**] MO HealthNet** Fraud Reimbursement Fund", which is hereby established in the state treasury. Moneys in the **[**Medicaid**] MO HealthNet** fraud reimbursement fund shall be divided and appropriated to the federal government and affected state agencies in order to refund moneys falsely obtained from the federal and state governments. All of such cost reimbursements attributable to the investigation and prosecution shall be paid and deposited to the credit of the "**[**Medicaid**] MO HealthNet** Fraud Prosecution Revolving Fund", which is hereby established in the state treasury. Moneys in the **[**Medicaid**] MO HealthNet** fraud prosecution revolving fund may be appropriated to the attorney general, or to any prosecuting or circuit attorney who has successfully prosecuted an action for a violation of sections 191.900 to 191.910 and been awarded such costs of prosecution, in order to defray the costs of the attorney general and any such prosecuting or circuit attorney in connection with their duties provided by sections 191.900 to 191.910. No moneys shall be paid into the **[**Medicaid**] MO HealthNet** fraud protection revolving fund pursuant to this subsection unless the attorney general or appropriate prosecuting or circuit attorney shall have commenced a prosecution pursuant to this section, and the court finds in its discretion that payment of attorneys' fees and investigative costs is appropriate under all the circumstances, and the attorney general and prosecuting or circuit attorney shall prove to the court those expenses which were reasonable and necessary to the investigation and prosecution of such case, and the court approves such expenses as being reasonable and necessary. **Any moneys remaining in the MO HealthNet fraud reimbursement fund after division and appropriation to the federal government and affected state agencies shall be used to increase MO HealthNet provider reimbursement until it is at least one hundred percent of the Medicare provider reimbursement rate for comparable services.** The provisions of section 33.080, RSMo, notwithstanding, moneys in the **[**Medicaid**] MO HealthNet** fraud prosecution revolving fund shall not lapse at the end of the biennium.

[11.**] 12.** A person who violates subsections 1 to **[**4**] 3** of this section shall be liable for a civil penalty of not less than five thousand dollars and not more than ten thousand dollars for each separate act in violation of such subsections, plus three times the amount of damages which the state and federal government sustained because of the act of that person, except that the court may assess not more than two times the amount of damages which the state and federal government sustained because of the act of the person, if the court finds:

(1) The person committing the violation of this section furnished personnel employed by the attorney general and responsible for investigating violations of sections 191.900 to

191.910 with all information known to such person about the violation within thirty days after the date on which the defendant first obtained the information;

(2) Such person fully cooperated with any government investigation of such violation; and

(3) At the time such person furnished the personnel of the attorney general with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation.

[12.**]** **13.** Upon conviction pursuant to this section, the prosecution authority shall provide written notification of the conviction to all regulatory or disciplinary agencies with authority over the conduct of the defendant health care provider.

[13.**]** **14.** The attorney general may bring a civil action against any person who shall receive a health care payment as a result of a false statement or false representation of a material fact made or caused to be made by that person. The person shall be liable for up to double the amount of all payments received by that person based upon the false statement or false representation of a material fact, and the reasonable costs attributable to the prosecution of the civil action. All such restitution shall be paid and deposited to the credit of the **[**Medicaid**] MO HealthNet** fraud reimbursement fund, and all such cost reimbursements shall be paid and deposited to the credit of the **[**Medicaid**] MO HealthNet** fraud prosecution revolving fund. No reimbursement of such costs attributable to the prosecution of the civil action shall be made or allowed except with the approval of the court having jurisdiction of the civil action. No civil action provided by this subsection shall be brought if restitution and civil penalties provided by subsections 10 and 11 of this section have been previously ordered against the person for the same cause of action.

15. Any person who discovers a violation by himself or herself or such person's organization and who reports such information voluntarily before such information is public or known to the attorney general shall not be prosecuted for a criminal violation.

191.907. 1. Any person who is the original source of the information used by the attorney general to bring an action under subsection 14 of section 191.905 shall receive ten percent of any recovery by the attorney general. As used in this section, "original source of information" means information no part of which has been previously disclosed to or known by the government or public. If the court finds that the person who was the original source of the information used by the attorney general to bring an action under subsection 14 of section 191.905 planned, initiated, or participated in the conduct upon which the action is brought, such person shall not be entitled to any percentage of the recovery obtained in such action.

2. Any person who is the original source of information about the willful violation by any person of section 36.460, RSMo, shall receive ten percent of the amount of compensation that would have been paid the employee forfeiting his or her position under section 36.460, RSMo, if the employee was found to have acted fraudulently in connection with the state medical assistance program.

191.908. 1. An employer shall not discharge, demote, suspend, threaten, harass, or otherwise discriminate against an employee in the terms and conditions of employment because the employee initiates, assists in, or participates in a proceeding or court action under sections 191.900 to 191.910. Such prohibition shall not apply to an employment action against an employee who:

(1) The court finds brought a frivolous or clearly vexatious claim;

(2) The court finds to have planned, initiated, or participated in the conduct upon which the action is brought; or

(3) Is convicted of criminal conduct arising from a violation of sections 191.900 to 191.910.

2. An employer who violates this section is liable to the employee for all of the following:

(1) Reinstatement to the employee's position without loss of seniority;

(2) Two times the amount of lost back pay;

(3) Interest on the back pay at the rate of one percent over the prime rate.

191.909. 1. By January 1, 2008, and annually thereafter, the attorney general's office shall report to the general assembly and the governor the following:

(1) The number of provider investigations due to allegations of violations under sections 191.900 to 191.910 conducted by the attorney general's office and completed within the reporting year, including the age and type of cases;

(2) The number of referrals due to allegations of violations under sections 191.900 to 191.910 received by the attorney general's office;

(3) The total amount of overpayments identified as the result of completed investigations;

(4) The amount of fines and restitutions ordered to be reimbursed, with a delineation between amounts the provider has been ordered to repay, including whether or not such repayment will be completed in a lump sum payment or installment payments, and any adjustments or deductions ordered to future provider payments;

(5) The total amount of monetary recovery as the result of completed investigations;

(6) The total number of arrests, indictments, and convictions as the result of completed investigations.

An annual financial audit of the MO HealthNet fraud unit within the attorney general's office shall be conducted and completed by the state auditor in order to quantitatively determine the amount of money invested in the unit and the amount of money actually recovered by such office.

2. By January 1, 2008, and annually thereafter, the department of social services shall report to the general assembly and the governor the following:

(1) The number of MO HealthNet provider and participant investigations and audits relating to allegations of violations under sections 191.900 to 191.910 completed within the reporting year, including the age and type of cases;

(2) The number of MO HealthNet long-term care facility reviews;

(3) The number of MO HealthNet provider and participant utilization reviews;

(4) The number of referrals sent by the department to the attorney general's office;

(5) The total amount of overpayments identified as the result of completed investigations, reviews, or audits;

(6) The amount of fines and restitutions ordered to be reimbursed, with a delineation between amounts the provider has been ordered to repay, including whether or not such repayment will be completed in a lump sum payment or installment payments, and any adjustments or deductions ordered to future provider payments;

(7) The total amount of monetary recovery as the result of completed investigation, reviews, or audits;

(8) The number of administrative sanctions against MO HealthNet providers, including the number of providers excluded from the program.

An annual financial audit of the program integrity unit within the department of social services shall be conducted and completed by the state auditor in order to quantitatively determine the amount of money invested in the unit and the amount of money actually recovered by such office.

191.910. 1. The attorney general shall have authority to investigate alleged or suspected violations of sections 191.900 to 191.910, and shall have all powers provided by sections 407.040 to 407.090, RSMo, in connection with investigations of alleged or suspected violations of sections 191.900 to 191.910, as if the acts enumerated in subsections 1 to 3 of section 191.905 are unlawful acts proscribed by chapter 407, RSMo, provided that if the attorney general exercises such powers, the provisions of section 407.070, RSMo, shall also be applicable; and may exercise all of the powers provided by subsections 1 and 2 of section 578.387, RSMo, in connection with investigations of alleged or suspected violations of sections 191.900 to 191.910, as if the acts enumerated in subsections 1 to 3 of section 191.905 involve "public assistance" as

defined by section 578.375, RSMo. The attorney general and his **or her** authorized investigators shall be authorized to serve all subpoenas and civil process related to the enforcement of sections 191.900 to 191.910 and chapter 407, RSMo. In order for the attorney general to commence a state prosecution for violations of sections 191.900 to 191.910, the attorney general shall prepare and forward a report of the violations to the appropriate prosecuting attorney. Upon receiving a referral, the prosecuting attorney shall either commence a prosecution based on the report by the filing of a complaint, information, or indictment within sixty days of receipt of said report or shall file a written statement with the attorney general explaining why criminal charges should not be brought. This time period may be extended by the prosecuting attorney with the agreement of the attorney general for an additional sixty days. If the prosecuting attorney commences a criminal prosecution, the attorney general or his designee shall be permitted by the court to participate as a special assistant prosecuting attorney in settlement negotiations and all court proceedings, subject to the authority of the prosecuting attorney, for the purpose of providing such assistance as may be necessary. If the prosecuting attorney fails to commence a prosecution and fails to file a written statement listing the reasons why criminal charges should not be brought within the appropriate time period, or declines to prosecute on the basis of inadequate office resources, the attorney general shall have authority to commence prosecutions for violations of sections 191.900 to 191.910. In cases where a defendant pursuant to a common scheme or plan has committed acts which constitute or would constitute violations of sections 191.900 to 191.910 in more than one state, the attorney general shall have the authority to represent the state of Missouri in any plea agreement which resolves all criminal prosecutions within and without the state, and such agreement shall be binding on all state prosecutors.

2. In any investigation, hearing or other proceeding pursuant to sections 191.900 to 191.910, any record in the possession or control of a health care provider, or in the possession or control of another person on behalf of a health care provider, including but not limited to any record relating to patient care, business or accounting records, payroll records and tax records, whether written or in an electronic format, shall be made available by the health care provider to the attorney general or the court, and shall be admissible into evidence, regardless of any statutory or common law privilege which such health care provider, record custodian or patient might otherwise invoke or assert. The provisions of section 326.151, RSMo, shall not apply to actions brought pursuant to sections 191.900 to 191.910. The attorney general shall not disclose any record obtained pursuant to this section, other than in connection with a proceeding instituted or pending in any court or administrative agency. The access, provision, use, and disclosure of records or material subject to the provisions of 42 U.S.C. section 290dd-2 shall be subject to said section, as may be amended from time to time, and to regulations promulgated pursuant to said section.

3. No person shall knowingly, with the intent to defraud the medical assistance program, destroy or conceal such records as are necessary to fully disclose the nature of the health care for which a claim was submitted or payment was received under a medical assistance program, or such records as are necessary to fully disclose all income and expenditures upon which rates of payment were based under a medical assistance program. Upon submitting a claim for or upon receiving payment for health care under a medical assistance program, a person shall not destroy or conceal any records for five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if payment was not received. Any provider who knowingly destroys or conceals such records is guilty of a class A misdemeanor.

4. Sections 191.900 to 191.910 shall not be construed to prohibit or limit any other criminal or civil action against a health care provider for the violation of any other law. Any complaint, investigation or report received or completed pursuant to sections 198.070 and 198.090, RSMo, subsection 2 of section 205.967, RSMo, sections 375.991 to 375.994, RSMo, section 578.387, RSMo, or sections 660.300 and 660.305, RSMo, which indicates a violation of sections 191.900 to 191.910, shall be referred to the attorney general. A referral to the attorney general pursuant to this subsection shall not preclude the agencies charged with enforcing the foregoing sections from conducting investigations, providing protective services or taking administrative action regarding the complaint, investigation or report referred to the attorney general, as may be provided by such sections; provided that all material developed by the attorney general in the course of an investigation pursuant to sections 191.900 to 191.910 shall not be subject to subpoena, discovery, or other legal or administrative process in the course of any such administrative action. Sections 191.900 to 191.910 take precedence over the provisions of sections 198.070 and 198.090, RSMo, subsection 2 of section 205.967, RSMo, sections 375.991 to 375.994, RSMo, section 578.387, RSMo, and sections 660.300 and 660.305, RSMo, to the extent such provisions are inconsistent or overlap.

191.914. 1. Any person who intentionally files a false report or claim alleging a violation of sections 191.900 to 191.910 is guilty of a class A misdemeanor. Any second or subsequent violation of this section is a class D felony and shall be punished as provided by law.

2. Any person who receives any compensation in exchange for knowingly failing to report any violation of subsections 1 to 3 of section 191.905 is guilty of a class D felony.

191.1050. As used in sections 191.1050 to 191.1056, the following terms shall mean:

(1) "Area of defined need", a rural area or section of an urban area of this state which is located in a federally designated health professional shortage area and which is designated by the department as being in need of the services of health care professionals;

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

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

(4) "Eligible facility", a public or nonprofit private medical facility or other health care facility licensed under chapter 197, RSMo, any mental health facility defined in section 632.005, RSMo, or any group of licensed health care professionals, but excluding sole practitioners, in an area of defined need that is designated by the department as eligible to receive disbursements from the Missouri healthcare access fund under section 191.1056.

191.1053. 1. The department shall have the authority to designate an eligible facility or facilities in an area of defined need. In making such designation, the department shall consult with local health departments and consider factors, including but not limited to the health status of the population of the area, the ability of the population of the area to pay for health services, the accessibility the population of the area has to health services, and the availability of health professionals in the area.

2. The department shall reevaluate the designation of an eligible facility six years from the initial designation and every six years thereafter. Each such facility shall have the burden of proving that the facility meets the applicable requirements regarding the definition of an eligible facility.

3. The department shall not revoke the designation of an eligible facility until the department has afforded interested persons and groups in the facility's area of defined need to provide data and information in support of renewing the designation. The department may make a determination on the basis of such data and information and other data and information available to the department.

191.1056. 1. There is hereby created in the state treasury the "Missouri Healthcare Access Fund", which shall consist of gifts, grants, and devises deposited into the fund. The state treasurer shall be custodian of the fund and shall disburse moneys from the fund in accordance with sections 30.170 and 30.180, RSMo. The director shall approve disbursements from the fund to any eligible facility to attract and recruit health care professionals and other necessary personnel, to purchase or rent facilities, to pay for facility expansion or renovation, to purchase office and medical equipment, to pay personnel salaries, or to pay any other costs associated with providing primary healthcare services to the population in the facility's area of defined need.

2. The state of Missouri shall provide matching moneys from the general revenue fund equaling one-half of the amount deposited into the fund. The total annual amount available to the fund from state sources under such a match program shall be five hundred thousand dollars for fiscal year 2008, one million five hundred thousand dollars for fiscal year 2009, and one million dollars annually thereafter.

3. The maximum annual donation that any one individual or corporation may make is fifty thousand dollars. Any individual or corporation, excluding nonprofit corporations, that make a contribution to the fund totaling one hundred dollars or more shall receive a tax credit for one-half of all donations made annually under section 135.575, RSMo. In addition, any office or medical equipment donated to any eligible facility shall be an eligible donation for purposes of receipt of a tax credit under section 135.575, RSMo, but shall not be eligible for any matching funds under subsection 2 of this section.

4. If any clinic or facility has received money from the fund closes or significantly decreases its operations, as determined by the department, within one year of receiving such money, the amount of such money received and the amount of the match provided from the general revenue fund shall be refunded to each appropriate source.

5. 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.

6. 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.

192.632. 1. There is hereby created a "Chronic Kidney Disease Task Force". Unless otherwise stated, members shall be appointed by the director of the department of health and senior services and shall include, but not be limited to, the following members:

(1) Two physicians appointed from lists submitted by the Missouri state medical association;

(2) Two nephrologists;

(3) Two family physicians;

(4) Two pathologists;

(5) One member who represents owners or operators of clinical laboratories in the state;

(6) One member who represents a private renal care provider;

(7) One member who has a chronic kidney disease;

(8) One member who represents the state affiliate of the National Kidney Foundation;

(9) One member who represents the Missouri kidney program;

(10) Two members of the house of representatives appointed by the speaker of the house;

(11) Two members of the senate appointed by the president pro tem of the senate;

(12) Additional members may be chosen to represent public health clinics, community health centers, and private health insurers.

2. A chairperson and vice chairperson shall be elected by the members of the task force.

3. The chronic kidney disease task force shall:

(1) Develop a plan to educate the public and health care professionals about the advantages and methods of early screening, diagnosis, and treatment of chronic kidney disease and its complications based on kidney disease outcomes, quality initiative clinical practice guidelines for chronic kidney disease, or other medically recognized clinical practice guidelines;

(2) Make recommendations on the implementation of a cost-effective plan for early screening, diagnosis, and treatment of chronic kidney disease for the state's population;

(3) Identify barriers to adoption of best practices and potential public policy options to address such barriers;

(4) Submit a report of its findings and recommendations to the general assembly by August 30, 2008.

4. The department of health and senior services shall provide all necessary staff, research, and meeting facilities for the chronic kidney disease task force.

5. The provisions of this section shall expire August 30, 2008.

198.069. For any resident of an assisted living facility who is released from a hospital or skilled nursing facility and returns to an assisted living facility as a resident, such resident's assisted living facility shall immediately, upon return, implement physician orders in the hospital or discharge summary, and within twenty-four hours of the patient's return to the facility, review and document such review of any physician orders related to the resident's hospital discharge care plan or the skilled nursing facilities discharge care plan and modify the individual service plan for the resident accordingly. The department of health and senior services may adjust personal care units authorized as described in subsection 14 of section 208.152, RSMo, upon the effective date of the physicians orders to reflect the services required by such orders.

198.097. **1.** Any person who assumes the responsibility of managing the financial affairs of an elderly **or disabled** person who is a resident of **[**a nursing home**]** **any facility licensed under this chapter** shall be guilty of a class D felony if such person misappropriates the funds

and fails to pay for the **[**nursing home**]** **facility** care of the elderly **or disabled** person. **For purposes of this subsection, a person assumes the responsibility of managing the financial affairs of an elderly person when he or she receives, has access to, handles, or controls the elderly or disabled person's monetary funds, including but not limited to Social Security income, pension, cash, or other resident income.**

2. Evidence of misappropriating funds and failure to pay for the care of an elderly or disabled person may include but not be limited to proof that the facility has sent, by certified mail with confirmation receipt requested, notification of failure to pay facility care expenses incurred by a resident to the person who has assumed responsibility of managing the financial affairs of the resident.

3. Nothing in subsection 2 of this section shall be construed as limiting the investigations or prosecutions of violations of subsection 1 of this section or the crime of financial exploitation of an elderly or disabled person as defined by section 570.145, RSMo.

208.001. 1. Sections 191.411, 208.001, 208.151, 208.152, 208.153, 208.197, 208.201, 208.202, 208.212, 208.215, 208.217, 208.631, 208.670, 208.690, 208.692, 208.694, 208.696, 208.698, 208.930, 208.950, 208.955, 208.975, and 473.398, RSMo, may be known as and may be cited as the "Missouri Continuing Health Improvement Act".

2. In Missouri, the medical assistance program on behalf of needy persons, Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, 42 U.S.C. Section 301 et seq., shall be known as "MO HealthNet". Medicaid shall also mean "MO HealthNet" wherever it appears throughout Missouri Revised Statutes. The title "division of medical services" shall also mean "MO HealthNet division".

3. The MO HealthNet division is authorized to promulgate rules, including emergency rules if necessary, to implement the provisions of the Missouri continuing health improvement act, including but not limited to the form and content of any documents required to be filed under such act.

4. 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 the Missouri continuing health improvement act, 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 sections 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 the effective date of the Missouri continuing health improvement act, shall be invalid and void.

208.146. 1. Subject to appropriations and in accordance with 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) Except for earnings, 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) Has earned income, as defined in subsection 2 of this section;

(3) Meets the asset limits in subsection 3 of this section;

(4) Has net income, as defined in subsection 3 of this section, that does not exceed the limit for permanent and totally disabled (PTD) individuals to receive nonspenddown MO HealthNet benefits under subdivision (24) of subsection 1 of section 208.151; and

(5) Has a gross income of two hundred fifty percent or less of the federal poverty level. For purposes of this subdivision, "gross income" includes all income of the person and the person's spouse that would be considered in determining MO HealthNet eligibility for permanent and totally disabled (PTD) individuals under subdivision (24) of subsection 1 of section 208.151. Individuals with gross incomes in excess of one hundred percent of the federal poverty level shall pay a premium for participation in accordance with subsection 4 of this section.

2. For income to be considered earned income for purposes of this section, the department of social services shall document that Medicare and Social Security taxes are withheld from such income. Self-employed persons shall provide proof of payment of Medicare and Social Security taxes for income to be considered earned.

3. (1) For purposes of determining eligibility under this section, the available asset limit and the definition of available assets shall be the same as those used to determine MO HealthNet eligibility for permanent and totally disabled (PTD) individuals under subdivision (24) of subsection 1 of section 208.151 except for:

(a) Medical savings accounts limited to deposits of earned income and earnings on such income while a participant in the program created under this section with a value not to exceed two thousand five hundred dollars per year;

(b) Independent living accounts limited to deposits of earned income and earnings on such income while a participant in the program created under this section with a value not to exceed two thousand five hundred dollars per year. For purposes of this section, an "independent living 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.

(2) To determine net income, the following shall be disregarded:

(a) All earned income of the disabled worker;

(b) The first sixty-five dollars and one-half of the remaining earned income of a nondisabled spouse's earned income;

(c) A twenty-dollar standard deduction;

(d) Health insurance premiums;

(e) All Supplemental Security Income (SSI) payments;

(f) A standard deduction for impairment-related employment expenses equal to one-half of the disabled worker's earned income.

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

(1) For a person whose gross income is more than one hundred percent but less than one hundred fifty percent of the federal poverty level, seven and one-half percent of income at one hundred percent of the federal poverty level;

(2) For a person whose gross income equals or exceeds one hundred fifty percent but is less than two hundred percent of the federal poverty level, seven and one-half percent of income at one hundred fifty percent of the federal poverty level;

(3) For a person whose gross income equals or exceeds two hundred percent of the federal poverty level, seven and one-half percent of income at two hundred percent of the federal poverty level.

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

208.151. 1. **Medical assistance on behalf of needy persons shall be known as "MO HealthNet".** For the purpose of paying **[**medical assistance on behalf of needy persons**] MO HealthNet benefits** 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**] MO HealthNet benefits** to the extent and in the manner hereinafter provided:

(1) All **[**recipients of**] participants receiving** state supplemental payments for the aged, blind and disabled;

(2) All **[**recipients of**] participants receiving** 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**. Participants eligible under this subdivision who are participating in drug court, as defined in section 478.001, RSMo, shall have their eligibility automatically extended sixty days from the time their dependent child is removed from the custody of the participant, subject to approval of the Centers for Medicare and Medicaid Services**;

(3) All **[**recipients of**]** **participants receiving** 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, 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**]** **participants receiving** 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**]** **participants receiving** 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 shall use an income eligibility standard equal to one hundred thirty-three percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency;

(14) Children who have attained six years of age but have not attained nineteen years of age. For children who have attained six years of age but have not attained nineteen years of age, the family support division 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**] MO HealthNet** coverage under this subdivision, the department of social services may revise the state **[**Medicaid**] MO HealthNet** 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 family support division 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**] MO HealthNet division** 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;

(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;

(17) A child born to a woman eligible for and receiving **[**medical assistance**] MO HealthNet benefits** under this section on the date of the child's birth shall be deemed to have applied for **[**medical assistance**] MO HealthNet benefits** 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 shall assign a **[**medical assistance**] MO HealthNet**

eligibility identification number to the child so that claims may be submitted and paid under such child's identification number;

(18) Pregnant women and children eligible for **[**medical assistance**] MO HealthNet benefits** pursuant to subdivision (12), (13) or (14) of this subsection shall not as a condition of eligibility for **[**medical assistance**] MO HealthNet** benefits be required to apply for aid to families with dependent children. The family support division shall utilize an application for eligibility for such persons which eliminates information requirements other than those necessary to apply for **[**medical assistance**] MO HealthNet benefits**. 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**] MO HealthNet** 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 for assessing eligibility under this chapter shall be as simple as practicable;

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

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

(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**] MO HealthNet-eligible** high-risk mothers and enroll them in the state's **[**Medicaid**] MO HealthNet** program, refer them to local physicians or local health departments who provide prenatal care under physician protocol and who participate in the **[**Medicaid**] MO HealthNet** 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**] MO HealthNet** prepaid, case-managed programs;

(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**. By January 1, 2008, the department of social services shall study all significant aspects and report to the general assembly, the MO HealthNet oversight committee, and the joint committee on MO HealthNet on projected costs, short-term cost increases, long-term cost savings, and the time needed for implementation for:**

(a) Expanding eligibility for the aged, blind, and disabled population to one hundred percent of the federal poverty level;

(b) Raising the resource limit for participants receiving MO HealthNet for aged, blind, and disabled population who qualify for waiver services;

(c) Providing a housing disregard for participants who pay for unsubsidized housing;

(d) Expanding the protection against spousal impoverishment to couples under the age of sixty-three;

(e) Expanding the elderly and disabled waiver to participants under the age of sixty-three;

(f) Allowing participants of the elderly and disabled waiver to spend down to the waiver income limit;

(g) Expanding the Missouri Rx plan to Missouri residents sixty-five years of age or older and retired;

(h) Expanding eligibility for single adults without children;

(i) Enact the best practices from other states that appropriately place participants in an institutional care setting, including but not limited to the disparity between income eligibility for skilled nursing care versus home and community-based services; and

(j) Allowing nursing home residents who receive MO HealthNet benefits to retain not less than fifty dollars per month for discretionary spending;

(23) All **[**recipients**]** **participants** 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;

(24) (a) All persons who would be determined to be eligible for old age assistance 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**]** **MO HealthNet** state plan as 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 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**]** **MO HealthNet** 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;

(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**]** **MO HealthNet** state plan as 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 be limited by age;

(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**;**

(26) Persons who are independent foster care adolescents, as defined in 42 U.S.C. Section 1396d, or who are within reasonable categories of such adolescents who are under twenty-one years of age as specified by the state, are eligible for coverage under 42 U.S.C. Section 1396a (a)(10)(A)(ii)(XVII) without regard to income or assets.

2. Rules and regulations to implement this section shall be promulgated in accordance with section 431.064, RSMo, and chapter 536, RSMo. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2002, shall be invalid and void.

3. After December 31, 1973, and before April 1, 1990, any family eligible for assistance pursuant to 42 U.S.C. 601 et seq., as amended, in at least three of the last six months immediately preceding the month in which such family became ineligible for such assistance because of increased income from employment shall, while a member of such family is employed, remain eligible for **[**medical assistance**] MO HealthNet benefits** 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**] MO HealthNet benefits** 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**] MO HealthNet benefits** without fee for an additional six months. The **[**division of medical services**] MO HealthNet division** may provide by rule and as authorized by annual appropriation the scope of **[**medical assistance**] MO HealthNet** coverage to be granted to such families.

4. When any individual has been determined to be eligible for **[**medical assistance**] MO HealthNet benefits**, 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.

5. The department of social services may apply to the federal Department of Health and Human Services for a **[**Medicaid**] MO HealthNet** waiver amendment to the Section 1115 demonstration waiver or for any additional **[**Medicaid**] MO HealthNet** waivers necessary 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.

6. Notwithstanding any other provision of law to the contrary, in any given fiscal year, any persons made eligible for **[**medical assistance**] MO HealthNet** 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).

208.152. 1. **[**Benefit**] MO HealthNet** 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**] MO HealthNet division**, 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**] MO HealthNet division** 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**] MO HealthNet** children's diagnosis length-of-stay schedule; and provided further that the **[**division of medical services**] MO HealthNet division** 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**] MO HealthNet division** may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the **[**division of medical services**] MO HealthNet division** not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for **[**recipients,**] participants, except to persons with more than five hundred thousand dollars equity in their home or** except **[**to**] for** 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**] MO HealthNet division** may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of **[**Medicaid**] MO HealthNet** patients. The **[**division of medical services**] MO HealthNet division** 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**] participants receiving** 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**] participant** is on a temporary leave of absence from the hospital or nursing home, provided that no such **[**recipient**] participant** 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**] participant** 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) Drugs and medicines when prescribed by a licensed physician, dentist, or 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;

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

(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;

(10) Home health care services;

(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**] MO HealthNet** agency that, in his professional judgment, the life of the mother would be endangered if the fetus were carried to term;

(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.);

(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;

(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**] participant's** family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one **[**recipient**] participant** one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time**. Such services, when delivered in a residential care facility or assisted living facility licensed under chapter 198, RSMo, shall be authorized on a four-tier level based on the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations**;

(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**] MO HealthNet division**, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the **[**division of medical services**] MO HealthNet division**. 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;

(16) Such additional services as defined by the **[**division of medical services**]** **MO HealthNet division** 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;

(17) Beginning July 1, 1990, the services of a certified pediatric or family nursing practitioner **with a collaborative practice agreement** to the extent that such services are provided in accordance with **[**chapter**]** **chapters 334 and** 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**]**;

(18) Nursing home costs for **[**recipients of**]** **participants receiving** benefit payments under subdivision (4) of this subsection to reserve a bed for the **[**recipient**]** **participant** in the nursing home during the time that the **[**recipient**]** **participant** 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**]** **MO HealthNet** 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**]** **participant** 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**]** **participant under** this subdivision during any period of six consecutive months such **[**recipient**]** **participant** 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**]** **participant** or the **[**recipient's**]** **participant's** responsible party that the **[**recipient**]** **participant** 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**]** **participant** or the **[**recipient's**]** **participant's** responsible party prior to release of the reserved bed**[**.**]** **;**

(19) Prescribed medically necessary durable medical equipment and therapy services including physical, occupational, and speech therapy. Such equipment and

services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines, consistent with national standards shall be used to verify medical need;

(20) 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 MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

[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)**] (21)** Dental services**. Beginning January 1, 2008, payments made by the MO HealthNet division for dental services may be subject to precertification. Precertification shall be based on best practices, as defined in section 208.950 and shall be consistent with accepted standards of care, care and treatment guidelines, and peer-reviewed medical literature**;

[(2)**] (22)** Services of podiatrists as defined in section 330.010, RSMo**. Beginning January 1, 2008, payments made by the MO HealthNet division for podiatrists shall be subject to appropriations and may be subject to precertification. Precertification shall be based on best practices, as defined in section 208.950 and shall be consistent with accepted standards of care, care and treatment guidelines, and peer-reviewed medical literature**;

[(3)**] (23)** Optometric services as defined in section 336.010, RSMo**. Beginning January 1, 2008, payments made by the MO HealthNet division for optometric services shall be subject to appropriations and may be subject to precertification. Precertification shall be based on best practices, as defined in section 208.950 and shall be consistent with**

accepted standards of care, care and treatment guidelines, and peer-reviewed medical literature;

[(4)**] (24)** Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs**. Beginning January 1, 2008, such devices or prosthetics shall be subject to appropriations and shall be provided under the requirements in subdivision (19) of this subsection;**

(25) Services of physical therapists as defined in section 334.620, RSMo, occupational therapists as defined in section 324.050, RSMo, and speech therapists as defined in chapter 345, RSMo. Payments made by the MO HealthNet division for services outlined in this subdivision shall be subject to appropriations and may be subject to precertification. Precertification shall be based on best practices, as defined in section 208.950 and shall be consistent with accepted standards of care, care and treatment guidelines, and peer-reviewed medical literature;

[(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)**] (26)** Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services **shall be subject to appropriations and** 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**] MO HealthNet division** 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**;**

(27) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rate and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by January 1, 2008, provide to the general assembly a three-year plan to achieve parity with Medicare reimbursement rates.

Benefit payments made by the MO HealthNet division under this section shall be made on the basis of medical necessity. Medical necessity shall be based on best practices, as defined in section 208.950 and shall be consistent with accepted standards of care, care and treatment guidelines, and peer-reviewed medical literature.

[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 surgery is obtained prior to the surgery being performed.

4. The division of medical services**] 2. Beginning January 1, 2009, the MO HealthNet division** may require any **[**recipient of medical assistance**] participant receiving MO HealthNet benefits** to pay **[**part of the charge or cost**] an additional payment**, as defined by rule duly promulgated by the **[**division of medical services**] MO HealthNet division**, 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**] MO HealthNet division** 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**] participants the additional** payment that may be required by the **[**division of medical services**] MO HealthNet division** under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by **[**recipients**] participants** under this section shall be

[reduced from any**] in addition to and not in lieu of** payments made by the state for goods or services described herein except the **[**recipient**] participant** 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 co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a **[**recipient**] participant** is unable to pay a required **[**cost sharing**] payment**. 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 co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give **[**recipients**] participants** advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a **[**recipient**] participant**. 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**] MO HealthNet** state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, 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 co-payments.

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

[6.**] 4.** Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for **[**medical assistance**] MO HealthNet benefits** 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.

[7.**] 5.** 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.

[8.**] 6.** 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**] MO HealthNet benefits** under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and

referral shall conform to the requirements of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.

[9.**] 7.** 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.

[10.**] 8.** 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**] MO HealthNet** program shall not increase payments in excess of the increase that would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. 1396a (a)(13)(C).

[11.**] 9.** The **[**department of social services, division of medical services**] MO HealthNet division**, may enroll qualified residential care facilities **and assisted living facilities**, as defined in chapter 198, RSMo, as **[**Medicaid**] MO HealthNet** personal care providers.

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

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

2. **[**Medical assistance**] Subject to appropriations and, under and not inconsistent with the provisions of sections 208.151, 208.152, and 208.153, the MO HealthNet division shall by rule develop pay-for-performance payment program guidelines. The pay-for-**

performance payment program guidelines shall be developed and in consultation with the professional services payment committee, as established in section 208.197. Providers participating in a managed care plan, an ASO plan, or the state plan as each term is defined in section 208.950 may participate in a pay-for-performance payment program. The provisions of this subsection and of section 208.197 shall take effect only when:

(1) MO HealthNet payment rates to providers have reached at least one hundred percent of the Medicare payment rates to providers for the same services; and

(2) After the federal Medicare program pay-for-performance program has been placed into operation.

Any employer of a physician whose work generates any payment under this subsection shall pass the pay-for-performance payment on to the physician, without any corresponding decrease in the compensation to which that provider would otherwise be entitled.

3. MO HealthNet shall include benefit payments on behalf of qualified Medicare beneficiaries as defined in 42 U.S.C. section 1396d(p). The **[**division of family services**] family support division** shall by rule and regulation establish which qualified Medicare beneficiaries are eligible. The **[**division of medical services**] MO HealthNet division** shall define the premiums, deductible and coinsurance provided for in 42 U.S.C. section 1396d(p) to be provided on behalf of the qualified Medicare beneficiaries.

[3. Beginning July 1, 1990, medical assistance**] 4. MO HealthNet** shall include benefit payments for Medicare Part A cost sharing as defined in clause (p)(3)(A)(i) of 42 U.S.C. 1396d on behalf of qualified disabled and working individuals as defined in subsection (s) of section 42 U.S.C. 1396d as required by subsection (d) of section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989). The **[**division of medical services**] MO HealthNet division** may impose a premium for such benefit payments as authorized by paragraph (d)(3) of section 6408 of P.L. 101-239.

[4. Medical assistance**] 5. MO HealthNet** shall include benefit payments for Medicare Part B cost-sharing described in 42 U.S.C. section 1396(d)(p)(3)(A)(ii) for individuals described in subsection 2 of this section, but for the fact that their income exceeds the income level established by the state under 42 U.S.C. section 1396(d)(p)(2) but is less than one hundred and ten percent beginning January 1, 1993, and less than one hundred and twenty percent beginning January 1, 1995, of the official poverty line for a family of the size involved.

[5. Beginning July 1, 1991,**] 6.** For an individual eligible for **[**medical assistance**] MO HealthNet** under Title XIX of the Social Security Act, **[**medical assistance**] MO HealthNet** shall include payment of enrollee premiums in a group health plan and all deductibles, coinsurance and other cost-sharing for items and services otherwise covered under the state Title XIX plan

under section 1906 of the federal Social Security Act and regulations established under the authority of section 1906, as may be amended. Enrollment in a group health plan must be cost effective, as established by the Secretary of Health and Human Services, before enrollment in the group health plan is required. If all members of a family are not eligible for **[**medical assistance under Title XIX**] MO HealthNet** and enrollment of the Title XIX eligible members in a group health plan is not possible unless all family members are enrolled, all premiums for noneligible members shall be treated as payment for **[**medical assistance**] MO HealthNet** of eligible family members. Payment for noneligible family members must be cost effective, taking into account payment of all such premiums. Non-Title XIX eligible family members shall pay all deductible, coinsurance and other cost-sharing obligations. Each individual as a condition of eligibility for **[**medical assistance**] MO HealthNet benefits** shall apply for enrollment in the group health plan.

7. Any social security cost-of-living increase at the beginning of any year shall be disregarded until the federal poverty level for such year is implemented.

8. If a MO HealthNet participant has paid the requested spenddown in cash for any month and subsequently pays an out-of-pocket valid medical expense for such month, such expense shall be allowed as a deduction to future required spenddown for up to three months from the date of such expense.

208.197. 1. The "Professional Services Payment Committee" is hereby established within the MO HealthNet division to guide, develop, and provide advice about the pay-for-performance payment program guidelines required under subsection 2 of section 208.153. The members of the committee shall be appointed by the governor no later than December 31, 2007, and shall be subject to the advice and consent of the senate. The committee shall be composed of eighteen members, geographically balanced, including seven physicians licensed to practice in this state, one optometrist, one dentist, one podiatrist, one consumer advocate, one patient advocate, and two hospital administrators. The other members shall be one advance practice nurse and persons actively engaged in nursing home administration and in-home care. The members of the committee shall receive no compensation for their services other than expenses actually incurred in the performance of their official duties.

2. The MO HealthNet division shall maintain the pay-for-performance payment program in a manner that ensures quality of care, fosters the relationship between the patient and the provider, uses clinically relevant and evidence-based measures which are statistically valid, does not encourage providers from caring for patients with complex or high risk conditions, and provides fair and equitable program incentives.

208.201. 1. The **[**"Division of Medical Services"**] "MO HealthNet Division"** is hereby established within the department of social services. The director of the **MO HealthNet** division shall be appointed by the director of the department. **Where the title "division of medical services" is found in the Missouri Revised statutes it shall mean "MO HealthNet division".**

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

3. All powers, duties and functions of the **[**division of family services**] family support division** relative to the development, administration and enforcement of the medical assistance programs of this state are transferred by type I transfer as defined in the Omnibus State Reorganization Act of 1974 to the **[**division of medical services**] MO HealthNet division**. The **[**division of family services**] family support division** shall retain the authority to determine and regulate the eligibility of needy persons for participation in the **[**medical assistance**] MO HealthNet** program.

4. **All state regulations adopted under the authority of the division of medical services shall remain in effect unless withdrawn or amended by authority of the MO HealthNet division.**

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

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

(1) To sue and be sued;

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

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

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

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

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

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

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

(9) To conduct utilization reviews to determine the appropriateness of services and reimbursement amounts to providers participating in the **[**medical assistance**]** **MO HealthNet** program;

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

208.212. 1. For purposes of **[**Medicaid**]** **MO HealthNet** eligibility, **the stream of income from** investment in annuities shall be **[**limited to**]** **excluded as an available resource for** 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**]** **MO HealthNet** expenditure made by the state on the individual's behalf**; and**

(4) Name and pay the MO HealthNet claimant as the primary beneficiary.

2. The department shall establish a sixty month look-back period to review any investment in an annuity by an applicant for **[**Medicaid**]** **MO HealthNet** benefits. If an 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**]** **MO HealthNet** 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 August 28, 2005, 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.

208.213. 1. In determining if an institutionalized individual is ineligible for the periods and reasons specified in 42 U.S.C. Section 1396p, a personal care contract received in exchange for personal property, real property, or cash and securities is fair and valuable consideration only if:

(1) There is a written agreement between the individual or individuals providing services and the individual receiving care which specifies the type, frequency, and duration of the services to be provided that was signed and dated on or before the date the services began;

(2) The services do not duplicate those which another party is being paid to provide;

(3) The individual receiving the services has a documented need for the personal care services provided;

(4) The services are essential to avoid institutionalization of the individual receiving benefit of the services;

(5) Compensation for the services shall be made at the time services are performed or within two months of the provision of the services; and

(6) The fair market value of the services provided prior to the month of institutionalization is equal to the fair market value of the assets exchanged for the services.

2. The fair market value for services provided shall be based on the current rate paid to providers of such services in the county of residence.

208.215. 1. **[**Medicaid**] MO HealthNet** 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**] participant receiving** public assistance on account of personal injury to or disability or disease or benefits arising from a health insurance plan to which the **[**recipient**] participant** may be entitled, payments made by the department of social services **or MO HealthNet division** shall be a debt due the state and recoverable from the liable party or **[**recipient**] participant** for all payments made in behalf of the **[**recipient**] participant** and the debt due the state shall not exceed the payments made from **[**medical assistance**] MO HealthNet benefits** provided under sections 208.151 to 208.158 and section 208.162 and section 208.204 on behalf of the **[**recipient**] participant**, 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**] participant** may be entitled. **Any health benefit plan as defined in section 376.1350, RSMo, third-party administrator, administrative services organization, and pharmacy benefit manager shall process and pay all properly submitted medical assistance subrogation claims or MO HealthNet subrogation claims for a period of at least three years from the date the services were provided or rendered, regardless of any other timely filing requirement otherwise imposed by such entity and the entity shall not deny such claims on the basis of the type or format of the claim form, or a failure to present proper documentation of coverage at the point of sale.**

2. The **[**department of social services**] MO HealthNet division** may maintain an appropriate action to recover funds **paid by the department of social services or MO HealthNet division that are** 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**] participant**, minor or estate.

3. Any **[**recipient**] participant**, 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**] participant** or minor for injuries, disease or disability or benefits arising from a health insurance plan to which the **[**recipient**] participant** may be entitled as outlined in subsection 1 of this section shall upon actual knowledge that the department of social services **or MO HealthNet division** has paid **[**medical assistance**] MO HealthNet** benefits as defined by this chapter, promptly notify the **[**department**] MO HealthNet division** as to the pursuit of such legal rights.

4. Every applicant or **[**recipient**]** **participant** by application assigns his right to the department **of social services or MO HealthNet division** of any funds recovered or expected to be recovered to the extent provided for in this section. All applicants and **[**recipients**]** **participants**, including a person authorized by the probate code, shall cooperate with the **[**department of social services**]** **MO HealthNet division** 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**]** **MO HealthNet benefits** as provided in sections 208.151 to 208.159 and sections 208.162 and 208.204. All applicants and **[**recipients**]** **participants** shall cooperate with the agency in obtaining third-party resources due to the applicant, **[**recipient**]** **participant**, or child for whom assistance is claimed. Failure to cooperate without good cause as determined by the department of social services**, MO HealthNet division** in accordance with federally prescribed standards shall render the applicant or **[**recipient**]** **participant** ineligible for **[**medical assistance**]** **MO HealthNet benefits** under sections 208.151 to 208.159 and sections 208.162 and 208.204.

5. Every person, corporation or partnership who acts for or on behalf of a person who is or was eligible for **[**medical assistance**]** **MO HealthNet benefits** under sections 208.151 to 208.159 and sections 208.162 and 208.204 for purposes of pursuing the applicant's or **[**recipient's**]** **participant's** claim which accrued as a result of a nonoccupational or nonwork-related incident or occurrence resulting in the payment of **[**medical assistance**]** **MO HealthNet** benefits shall notify the **[**department**]** **MO HealthNet division** upon agreeing to assist such person and further shall notify the **[**department**]** **MO HealthNet division** 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**]** **participant** 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**]** **participant**, 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**]** **MO HealthNet division** of any recovery from a third party and shall immediately reimburse the department **of social services, MO HealthNet division** 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**]** **of social services, MO HealthNet division** 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**] participant** 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 **or MO HealthNet division** 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**] participant** may be entitled which resulted in medical expenses for which the department **or MO HealthNet division** 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**] participant** may be entitled which resulted in payments made by the department **or MO HealthNet division**. 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**] participant** has a claim, demand or cause of action. The lien shall claim the charge and describe the interest the department **or MO HealthNet division** 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. **If the third party and its liability insurer, if any, receives notice or knows that the individual is eligible for MO HealthNet benefits prior to release or satisfaction, no release or satisfaction of any cause of action, suit, claim, counterclaim, demand, judgment, settlement, or settlement agreement shall be valid or effectual as against a claim created under this chapter unless the division joins in the release or satisfaction or executes a release of its claim.**

9. On petition filed by the department, or by the **[**recipient**] participant**, 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**] participant** 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**] participant** incident to the recovery and paid by the **[**recipient**] participant** 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**] participant**, by insurance provided by the **[**recipient**] participant**, and by the department, and the amount of such previously incurred expenses which remain unpaid at the time of recovery and by whom such incurred, unpaid expenses are to be paid;

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

(5) The age of the **[**recipient**] participant** and of persons dependent for support upon the **[**recipient**] participant**, the nature and permanency of the **[**recipient's**] participant's** injuries as they affect not only the future employability and education of the **[**recipient**] participant** but also the reasonably necessary and foreseeable future material, maintenance, medical rehabilitative and training needs of the **[**recipient**] participant**, 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**] participant** 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 **or MO HealthNet division'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 **or MO HealthNet division** shall pay its pro rata share of the attorney's fees based on the department's **or MO HealthNet division'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 **or MO HealthNet division or contractor** 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 or MO HealthNet division has a statutory charge under this section against a recovery for damages incurred by a **[**recipient**] participant** 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**] participant's** claim has been filed in court. Nothing herein shall prohibit the director from entering into a compromise agreement with any **[**recipient**] participant**, 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**] MO HealthNet benefits** to the **[**recipient**] participant** or minor involved. The department **or MO HealthNet division** shall enforce TEFRA liens, 42 U.S.C. 1396p, as authorized by federal law and regulation on permanently institutionalized individuals. The department **or MO HealthNet division** 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, "permanently institutionalized individuals" includes those people who the department **or MO HealthNet division** 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**] participant** 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**] participant'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**] MO HealthNet benefits** paid or to be paid on behalf of a **[**recipient**] participant**. 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**] MO HealthNet division** shall file for record, with the recorder of deeds of the county in which any real property of the **[**recipient**] participant** is situated, a written notice of the lien. The notice of lien shall contain the name of the **[**recipient**] participant** 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**. The MO HealthNet division shall provide payment to the**

recorder of deeds the fees set for similar filings in connection with the filing of a lien and any other necessary documents;

(3) No such lien may be imposed against the property of any individual prior to **[**his**] the individual's** death on account of **[**medical assistance**] MO HealthNet benefits** 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 **or her** income required for personal needs; and

b. With respect to whom the director of the **[**department of social services**] MO HealthNet division** 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**] MO HealthNet division**; or

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

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

(a) The spouse of such individual;

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

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

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

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

15. Application for and acceptance of **[**medical assistance**] MO HealthNet benefits** under this chapter shall constitute an assignment to the department of social services **or MO HealthNet division** 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**] participants receiving** benefits as defined in this chapter shall cooperate with the state by reporting to the **family support** division **[**of family services or the division of medical services**] or the MO HealthNet division**, within thirty days, any occurrences where an injury to their persons or to a member of a household who receives **[**medical assistance**] MO HealthNet benefits** is sustained, on such form or forms as provided by the **family support** division **[**of family services or the division of medical services**] or MO HealthNet division**.

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**] the director's** designee may compromise, settle or waive any such claim in whole or in part in the interest of the **[**medical assistance**] MO HealthNet** program. **Notwithstanding any provision in this section to the contrary, the MO HealthNet division is not required to seek reimbursement from a liable third party on claims for which the amount it reasonably expects to recover will be less than the cost of recovery or for which recovery efforts will not be cost-effective. Cost effectiveness is determined based on the following:**

(1) Actual and legal issues of liability as may exist between the participant and the liable party;

(2) Total funds available for settlement; and

(3) An estimate of the cost to the division of pursuing its claim.

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

(1) "Data match", a method of comparing the department's information with that of another entity and identifying those records which appear in both files. This process is accomplished by a computerized comparison by which both the department and the entity utilize a computer readable electronic media format;

(2) "Department", the Missouri department of social services or any division thereof;

(3) "Entity":

(a) Any insurance company as defined in chapter 375, RSMo, or any public organization or agency transacting or doing the business of insurance; or

(b) Any health service corporation or health maintenance organization as defined in chapter 354, RSMo, or any other provider of health services as defined in chapter 354, RSMo; **[**or**]**

(c) Any self-insured organization or business providing health services as defined in chapter 354, RSMo; **or**

(d) Any third-party administrator (TPA), administrative services organization (ASO), or pharmacy benefit manager (PBM) transacting or doing business in Missouri or administering or processing claims or benefits, or both, for residents of Missouri;

(4) "Individual", any applicant or present or former **[**recipient of**] participant receiving** public assistance benefits under sections 208.151 to 208.159 and section 208.162;

(5) "Insurance", any agreement, contract, policy plan or writing entered into voluntarily or by court or administrative order providing for the payment of medical services or for the provision of medical care to or on behalf of an individual;

(6) "Request", any inquiry by the division of medical services for the purpose of determining the existence of insurance where the department may have expended **[**medical assistance**] MO HealthNet** benefits.

2. The department may enter into a contract with any entity, and the entity shall, upon request of the department of social services, inform the department of any records or information pertaining to the insurance of any individual.

3. The information which is required to be provided by the entity regarding an individual is limited to those insurance benefits that could have been claimed and paid by an insurance policy agreement or plan with respect to medical services or items which are otherwise covered under the **[**Missouri Medicaid**] MO HealthNet** program.

4. A request for a data match made by the department pursuant to this section shall include sufficient information to identify each person named in the request in a form that is compatible with the record-keeping methods of the entity. Requests for information shall pertain to any individual or the person legally responsible for such individual **and may be requested at a minimum of twice a year**.

5. The department shall reimburse the entity which is requested to supply information as provided by this section for actual direct costs, based upon industry standards, incurred in furnishing the requested information and as set out in the contract. The department shall specify the time and manner in which information is to be delivered by the entity to the department. No reimbursement will be provided for information requested by the department other than by means of a data match.

6. Any entity which has received a request from the department pursuant to this section shall provide the requested information in **[**writing**] compliance with Health Insurance**

Portability and Accountability Act (HIPPAA) required transactions within sixty days of receipt of the request. Willful failure of an entity to provide the requested information within such period shall result in liability to the state for civil penalties of up to ten dollars for each day thereafter. The attorney general shall, upon request of the department, bring an action in a circuit court of competent jurisdiction to recover the civil penalty. The court shall determine the amount of the civil penalty to be assessed. **A health insurance carrier, including instances where they act in the capacity of an administrator of an ASO account, and a TPA acting in the capacity of an administrator for a fully insured or self funded employer, is required to accept and respond to the HIPPAA ANSI standard transaction for the purpose of validating eligibility.**

7. The director of the department shall establish guidelines to assure that the information furnished to any entity or obtained from any entity does not violate the laws pertaining to the confidentiality and privacy of an applicant or **[**recipient of Medicaid**] participant receiving MO HealthNet benefits**. Any person disclosing confidential information for purposes other than set forth in this section shall be guilty of a class A misdemeanor.

8. The application for or the receipt of benefits under sections 208.151 to 208.159 and section 208.162 shall be deemed consent by the individual to allow the department to request information from any entity regarding insurance coverage of said person.

208.225. 1. To implement fully the provisions of section 208.152, the **[**division of medical services**] MO HealthNet division** shall calculate the **[**Medicaid**] MO HealthNet** per diem reimbursement rates of each nursing home participating in the **[**Medicaid**] MO HealthNet** 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**] MO HealthNet division** for its fiscal year as provided in subsection 2 of this section.

2. The recalculation of **[**Medicaid**] MO HealthNet** rates to all Missouri facilities will be performed as follows: effective July 1, 2004, the department of social services shall use the **[**Medicaid**] MO HealthNet** 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.

3. For any facility new to the MO HealthNet program that did not have a MO HealthNet cost report for the year ending in 2001, its MO HealthNet per diem reimbursement rate shall be calculated from its fiscal year cost report which covers the second twelve-month fiscal year following the facility's initial date of MO HealthNet

certification using the class ceilings of this section. Such prospective rate shall be retroactive to the beginning of the first day of the facility's second full twelve-month fiscal year.

208.230. 1. This section shall be known and may be cited as the "Public Assistance Beneficiary Employer Disclosure Act".

2. The department of social services is hereby directed to prepare a MO HealthNet beneficiary employer report to be submitted to the governor on a quarterly basis. Such report shall be known as the "Missouri Health Care Responsibility Report". For purposes of this section, a "MO HealthNet beneficiary" means a person who receives medical assistance from the state of Missouri under this chapter or Titles XIX or XXI of the federal Social Security Act, as amended. To aid in the preparation of the Missouri health care responsibility report, the department shall implement policies and procedures to acquire information required by the report. Such information sources may include, but are not limited to, the following:

(1) Information required at the time of MO HealthNet application or during the yearly reverification process;

(2) Information that is accumulated from a vendor contracting with the state of Missouri to identify available insurance;

(3) Information that is voluntarily submitted by Missouri employers.

3. The Missouri health care responsibility report shall provide the following information for each employer who has fifty or more employees that are a MO HealthNet beneficiary, the spouse of a MO HealthNet beneficiary, or a custodial parent of a MO HealthNet beneficiary:

(1) The name of the qualified employer;

(2) The number of employees who are either MO HealthNet beneficiaries or are a financially responsible spouse or custodial parent of a MO HealthNet beneficiary under Title XIX of the federal Social Security Act, listed as a percentage of the qualified employer's Missouri workforce;

(3) The number of employees who are either MO HealthNet beneficiaries or are a financially responsible spouse or custodial parent of a MO HealthNet beneficiary under Title XXI of the federal Social Security Act (SCHIP), listed as a percentage of the qualified employer's Missouri workforce;

(4) For each employer, the number of employees who are MO HealthNet beneficiaries, the number of employees who are a financially responsible spouse or custodial parent of a MO HealthNet beneficiary and the number of MO HealthNet

beneficiaries who are a spouse or a minor child less than nineteen years of age of an employee under Title XIX of the federal Social Security Act;

(5) For each employer, the number of employees who are MO HealthNet beneficiaries, the number of employees who are a financially responsible spouse or a custodial parent of a MO HealthNet beneficiary, and the number of MO HealthNet beneficiaries who are a spouse or a minor child less than nineteen years of age of an employee under Title XXI of the federal Social Security Act;

(6) Whether the reported MO HealthNet beneficiaries are full-time or part-time employees;

(7) Information on whether the employer offers health insurance benefits to full-time and part-time employees, their spouses, and their dependents;

(8) Information on whether employees receive health insurance benefits through the employer when MO HealthNet pays some or all of the premiums for such health insurance benefits;

(9) The cost to the state of Missouri of providing MO HealthNet benefits for the employer's employees and enrolled dependents listed as total cost and per capita cost;

(10) The report shall make industry-wide comparisons by sorting employers into industry categories based on available information from the department of economic development.

4. If it is determined that a MO HealthNet beneficiary has more than one employer, the department of social services shall count the beneficiary as a portion of one person for each employer for purposes of this report.

5. The Missouri health care responsibility report shall be issued one hundred twenty days after the end of each calendar quarter, starting with the first calendar quarter of 2008. The report shall be made available for public viewing on the department of social services' web site. Any member of the public shall have the right to request and receive a printed copy of the report published under this section through the department of social services.

208.612. The departments of social services, mental health, and health **and senior services** shall collaborate in addressing **[**the problems of elderly hunger**] common problems of the elderly** by entering into collaborative agreements and protocols with each other, private, public and federal agencies with the intent of creating one-stop shopping for elderly citizens to apply for all programs for which they are entitled. They shall devise one application form that will provide entry to all available elderly services and programs. Any public elderly service agency that commonly serves elderly persons shall make available and provide information relating to the one-stop shopping concept.

208.631. 1. Notwithstanding any other provision of law to the contrary, the **[**department of social services**] MO HealthNet division** shall establish a program to pay for health care for uninsured children. Coverage pursuant to sections 208.631 to **[**208.660**] 208.659** is subject to appropriation. The provisions of sections 208.631 to **[**208.657**] 208.569, health care for uninsured children,** shall be void and of no effect **[**after June 30, 2008**] if there are no funds of the United States appropriated by Congress to be provided to the state on the basis of a state plan approved by the federal government under the federal Social Security Act**. **If funds are appropriated by the United States Congress, the department of social services is authorized to manage the state children's health insurance program (SCHIP) allotment in order to ensure that the state receives maximum federal financial participation. Children in households with incomes up to one hundred fifty percent of the federal poverty level may meet all Title XIX program guidelines as required by the Centers for Medicare and Medicaid Services. Children in households with incomes of one hundred fifty percent to three hundred percent of the federal poverty level shall continue to be eligible as they were and receive services as they did on June 30, 2007, unless changed by the Missouri general assembly.**

2. For the purposes of sections 208.631 to **[**208.657**] 208.659**, "children" are persons up to nineteen years of age. "Uninsured children" are persons up to nineteen years of age who are emancipated and do not have access to affordable employer-subsidized health care insurance or other health care coverage or persons whose parent or guardian have not had access to affordable employer-subsidized health care insurance or other health care coverage for their children for six months prior to application, are residents of the state of Missouri, and have parents or guardians who meet the requirements in section 208.636. A child who is eligible for **[**medical assistance**] MO HealthNet benefits** as authorized in section 208.151 is not uninsured for the purposes of sections 208.631 to **[**208.657**] 208.659**.

208.640. **1.** Parents and guardians of uninsured children with incomes **[**between**] of more than** one hundred **[**fifty-one and**] fifty but less than** 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**] for their children under** this section. **Health insurance plans that do not cover an eligible child's preexisting condition shall not be considered affordable employer-sponsored health care insurance or other affordable health care coverage.** For the purposes of sections 208.631 to **[**208.657**] 208.659**, "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**] of:**

(1) Three percent of one hundred fifty percent of the federal poverty level for a family of three for families with a gross income of more than one hundred fifty and up to one hundred eighty-five percent of the federal poverty level for a family of three;

(2) Four percent of one hundred eighty-five percent of the federal poverty level for a family of three for a family with a gross income of more than one hundred eighty-five and up to two hundred twenty-five percent of the federal poverty level;

(3) Five percent of two hundred twenty-five percent of the federal poverty level for a family of three for a family with a gross income of more than two hundred twenty-five but less than three hundred percent of the federal poverty level.

The parents and guardians of eligible uninsured children pursuant to this section are responsible for a monthly premium **[**equal to the average premium required for the Missouri consolidated health care plan**] as required by annual state appropriation**; 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**] for their children under** sections 208.631 to **[**208.657**] 208.659** shall not exceed the limits established by 42 U.S.C. Section 1397cc(e). **If a child has exceeded the annual coverage limits for any needed health care service, the child is not considered insured and does not have access to affordable health insurance within the meaning of this section.**

2. (1) The department of social services shall promulgate rules to expand a presumptive eligibility process for children for medical assistance benefits. Such persons shall be eligible during a period of presumptive eligibility in accordance with 42 U.S.C. Section 1396r-1a; and

(2) The following organizations shall be considered qualified entities for the purpose of determining a child's temporary eligibility for medical assistance benefits under MO HealthNet and the state child health insurance program: federally qualified health centers, rural health clinics, hospitals, providers designated by the department of mental health, and other entities as determined by the department of social services.

208.659. The MO HealthNet division shall revise the eligibility requirements for the uninsured women's health program, as established in 13 C.S.R. Section 70-4.090, to include women who are at least eighteen years of age and with a net family income of at or below one hundred eighty-five percent of the federal poverty level. In order to be eligible for such program, the applicant shall not have assets in excess of two hundred and fifty thousand dollars, nor shall the applicant have access to employer-sponsored health

insurance. Such change in eligibility requirements shall not result in any change in services provided under the program.

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

(1) "Provider", any provider of medical services or mental health services, including all other medical disciplines;

(2) "Telehealth", the use of medical information exchanged from one site to another via electronic communications to improve the health status of a patient.

2. The department of social services, in consultation with the departments of mental health and health and senior services, shall promulgate rules governing the practice of telehealth in the MO HealthNet program. Such rules shall address, but not be limited to, appropriate standards for the use of telehealth, certification of agencies offering telehealth, and payment for services by providers. Telehealth providers shall be required to obtain patient consent before telehealth services are initiated and to ensure confidentiality of medical information.

3. Telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law.

208.690. 1. Sections 208.690 to 208.698 shall be known and may be cited as the "Missouri Long-term Care Partnership Program Act".

2. As used in sections 208.690 to 208.698, the following terms shall mean:

(1) "Asset disregard", the disregard of any assets or resources in an amount equal to the insurance benefit payments that are used on behalf of the individual;

(2) "Missouri qualified long-term care partnership approved policy", a long-term care insurance policy certified by the director of the department of insurance, financial institutions and professional registration as meeting the requirements of:

(a) The National Association of Insurance Commissioners' Long-term Care Insurance Model Act and Regulation as specified in 42 U.S.C. Section 1917(b); and

(b) The provisions of Section 6021 of the Federal Deficit Reduction Act of 2005.

(3) "MO HealthNet", the medical assistance program established in this state under Title XIX of the federal Social Security Act;

(4) "State plan amendment", the state MO HealthNet plan amendment to the federal Department of Health and Human Services that, in determining eligibility for state MO HealthNet benefits, provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care insurance partnership policy.

208.692. 1. In accordance with Section 6021 of the Federal Deficit Reduction Act of 2005, there is established the "Missouri Long-term Care Partnership Program", which

shall be administered by the department of social services in conjunction with the department of insurance, financial institutions and professional registration. The program shall:

(1) Provide incentives for individuals to insure against the costs of providing for their long-term care needs;

(2) Provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under MO HealthNet without first being required to substantially exhaust their resources; and

(3) Alleviate the financial burden to the MO HealthNet program by encouraging the pursuit of private initiatives.

2. Upon payment under a Missouri qualified long-term care partnership approved policy, certain assets of an individual, as provided in subsection 3 of this section, shall be disregarded when determining any of the following:

(1) MO HealthNet eligibility;

(2) The amount of any MO HealthNet payment; and

(3) Any subsequent recovery by the state of a payment for medical services.

3. The department of social services shall:

(1) Within one hundred eighty days of the effective date of sections 208.690 to 208.698, make application to the federal Department of Health and Human Services for a state plan amendment to establish a program that, in determining eligibility for state MO HealthNet benefits, provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care insurance partnership policy; and

(2) Provide information and technical assistance to the department of insurance, financial institutions and professional registration to assure that any individual who sells a qualified long-term care insurance partnership policy receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

4. The department of social services shall promulgate rules to implement the provisions of sections 208.690 to 208.698. 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, 2007, shall be invalid and void.

208.694. 1. An individual who is a beneficiary of a Missouri qualified long-term care partnership approved policy is eligible for assistance under MO HealthNet using asset disregard under sections 208.690 to 208.698.

2. If the Missouri long-term care partnership program is discontinued, an individual who purchased a qualified long-term care partnership approved policy prior to the date the program was discontinued shall be eligible to receive asset disregard, as provided by Title VI, Section 6021 of the Federal Deficit Reduction Act of 2005.

3. The department of social services may enter into reciprocal agreements with other states that have asset disregard provisions established under Title VI, Section 6021 of the Federal Deficit Reduction Act of 2005 in order to extend the asset disregard to Missouri residents who purchase long-term care policies in another state.

208.696. 1. The director of the department of insurance, financial institutions and professional registration shall:

(1) Implement the producer training requirements found in Section 9 of the 2006 National Association of Insurance Commissioners' Long-Term Care Insurance Model Act;

(2) Impose no requirements affecting the terms or benefits of qualified long-term care partnership policies unless the director imposes such a requirement on all long-term care policies sold in this state, without regard to whether the policy is covered under the partnership or is offered in connection with such partnership. This subdivision shall not apply to inflation protection as required under Section 6021(a)(1)(iii)(iv) of the Federal Deficit Reduction Act of 2005;

(3) Require that qualified long-term care partnership policies meet the inflation protection standards, as stated under Section 6021(a)(1)(iii)(iv) of the Federal Deficit Reduction Act of 2005;

(4) Develop a summary notice in clear, easily understood language for the consumer purchasing qualified long-term care insurance partnership policies on the current law pertaining to asset disregard and asset tests;

(5) Develop requirements to ensure that any individual who exchanges nonqualified long-term care insurance for a qualified long-term care insurance partnership policy receives equitable treatment for time or value gained; and

(6) Develop requirements to ensure that all long-term care policies sold in Missouri shall include home care benefits. Such benefits shall not be contingent upon the covered individual meeting Medicare home health criteria or requiring hospitalization prior to

eligibility. Such policies shall be written in a manner to encourage home care as the first long-term care option.

2. The director of the department of insurance, financial institutions and professional registration shall promulgate rules to carry out the provisions of this section, and on the process for certifying the qualified long-term care partnership policies. 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, 2007, shall be invalid and void.

208.698. The issuers of qualified long-term care partnership policies in this state shall provide regular reports to both the Secretary of the Department of Health and Human Services in accordance with federal law and regulations and to the department of social services and the department of insurance, financial institutions and professional registration as provided in Section 6021 of the Federal Deficit Reduction Act of 2005.

208.750. 1. Sections 208.750 to 208.775 shall be known and may be cited as the "Family Development Account Program".

2. For purposes of sections 208.750 to 208.775, the following terms mean:

(1) "Account holder", a person who is the owner of a family development account;

(2) "Community-based organization", any religious or charitable association formed pursuant to chapter 352, RSMo, **or any nonprofit corporation formed under chapter 355, RSMo,** that is approved by the director of the department of economic development to implement the family development account program;

(3) "Department", the department of economic development;

(4) "Director", the director of the department of economic development;

(5) "Family development account", a financial instrument established pursuant to section 208.760;

(6) "Family development account reserve fund", the fund created by an approved community-based organization for the purposes of funding the costs incurred in the administration of the program and for providing matching funds for moneys in family development accounts;

(7) "Federal poverty level", the most recent poverty income guidelines published in the calendar year by the United States Department of Health and Human Services;

(8) "Financial institution", any bank, trust company, savings bank, credit union or savings and loan association as defined in chapter 362, 369 or 370, RSMo, and with an office in Missouri which is approved by the director for participation in the program;

(9) "Program", the Missouri family development account program established in sections 208.750 to 208.775;

(10) "Program contributor", a person or entity who makes a contribution to a family development account reserve fund and is not the account holder.

208.930. 1. As used in this section, the term "department" shall mean the department of health and senior services.

2. Subject to appropriations, the department may provide financial assistance for consumer-directed personal care assistance services through eligible vendors, as provided in sections 208.900 through 208.927, to each person who was participating as a **[**non-Medicaid**]** **nonMO HealthNet** eligible client pursuant to sections 178.661 through 178.673, RSMo, on June 30, 2005, and who:

(1) Makes application to the department;

(2) Demonstrates financial need and eligibility under subsection 3 of this section;

(3) Meets all the criteria set forth in sections 208.900 through 208.927, except for subdivision (5) of subsection 1 of section 208.903;

(4) Has been found by the department of social services not to be eligible to participate under guidelines established by the **[**Medicaid state**] MO HealthNet** plan; and

(5) Does not have access to affordable employer-sponsored health care insurance or other affordable health care coverage for personal care assistance services as defined in section 208.900. For purposes of this section, "access to 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.

Payments made by the department under the provisions of this section shall be made only after all other available sources of payment have been exhausted.

3. (1) In order to be eligible for financial assistance for consumer-directed personal care assistance services under this section, a person shall demonstrate financial need, which shall be based on the adjusted gross income and the assets of the person seeking financial assistance and such person's spouse.

(2) In order to demonstrate financial need, a person seeking financial assistance under this section and such person's spouse must have an adjusted gross income, less disability-related medical expenses, as approved by the department, that is equal to or less than three hundred

percent of the federal poverty level. The adjusted gross income shall be based on the most recent income tax return.

(3) No person seeking financial assistance for personal care services under this section and such person's spouse shall have assets in excess of two hundred fifty thousand dollars.

4. The department shall require applicants and the applicant's spouse, and consumers and the consumer's spouse, to provide documentation for income, assets, and disability-related medical expenses for the purpose of determining financial need and eligibility for the program. In addition to the most recent income tax return, such documentation may include, but shall not be limited to:

(1) Current wage stubs for the applicant or consumer and the applicant's or consumer's spouse;

(2) A current W-2 form for the applicant or consumer and the applicant's or consumer's spouse;

(3) Statements from the applicant's or consumer's and the applicant's or consumer's spouse's employers;

(4) Wage matches with the division of employment security;

(5) Bank statements; and

(6) Evidence of disability-related medical expenses and proof of payment.

5. A personal care assistance services plan shall be developed by the department pursuant to section 208.906 for each person who is determined to be eligible and in financial need under the provisions of this section. The plan developed by the department shall include the maximum amount of financial assistance allowed by the department, subject to appropriation, for such services.

6. Each consumer who participates in the program is responsible for a monthly premium equal to the average premium required for the Missouri consolidated health care plan; provided that the total premium described in this section shall not exceed five percent of the consumer's and the consumer's spouse's adjusted gross income for the year involved.

7. (1) Nonpayment of the premium required in subsection 6 shall result in the denial or termination of assistance, unless the person demonstrates good cause for such nonpayment.

(2) No person denied services for nonpayment of a premium shall receive services unless such person shows good cause for nonpayment and makes payments for past-due premiums as well as current premiums.

(3) Any person who is denied services for nonpayment of a premium and who does not make any payments for past-due premiums for sixty consecutive days shall have their enrollment in the program terminated.

(4) No person whose enrollment in the program is terminated for nonpayment of a premium when such nonpayment exceeds sixty consecutive days shall be reenrolled unless such person pays any past-due premiums as well as current premiums prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument.

8. (1) Consumers determined eligible for personal care assistance services under the provisions of this section shall be reevaluated annually to verify their continued eligibility and financial need. The amount of financial assistance for consumer-directed personal care assistance services received by the consumer shall be adjusted or eliminated based on the outcome of the reevaluation. Any adjustments made shall be recorded in the consumer's personal care assistance services plan.

(2) In performing the annual reevaluation of financial need, the department shall annually send a reverification eligibility form letter to the consumer requiring the consumer to respond within ten days of receiving the letter and to provide income and disability-related medical expense verification documentation. If the department does not receive the consumer's response and documentation within the ten-day period, the department shall send a letter notifying the consumer that he or she has ten days to file an appeal or the case will be closed.

(3) The department shall require the consumer and the consumer's spouse to provide documentation for income and disability-related medical expense verification for purposes of the eligibility review. Such documentation may include but shall not be limited to the documentation listed in subsection 4 of this section.

9. (1) Applicants for personal care assistance services and consumers receiving such services pursuant to this section 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 plan concerning the provision of such services, or if services are discontinued as provided in section 208.924. Services provided under the provisions of this section shall continue during the appeal process.

(2) A request for such 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.

10. Unless otherwise provided in this section, all other provisions of sections 208.900 through 208.927 shall apply to individuals who are eligible for financial assistance for personal care assistance services under this section.

11. The department may promulgate rules and regulations, including emergency rules, to implement 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. 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 regulations, division 90, chapter 7, which are inconsistent with the provisions of this section are void and of no force and effect.

12. The provisions of this section shall expire on June 30, **[**2008**]** **2019**.

208.950. 1. As used in sections 208.950 to 208.975, the following terms shall mean:

(1) "Administrative services organization" or "ASO", a vendor contracted by the state to provide, based upon an ASO model, services determined by the division and covering defined populations of participants and required to:

(a) Operate under contractual terms that require that vendor fees be reduced if savings and quality targets specified by the division, including but not limited to target rates at which participants whose care is being managed by the ASO plan seek to use hospital emergency department services for nonemergency medical conditions are not met; and

(b) Submit semiannual reports on health and wellness outcomes and on any adjustments to the health improvement plan to the oversight committee and the MO HealthNet division;

(2) "Advisory committee", a committee of experts in a particular field, including but not limited to MO HealthNet providers whose duties shall include, but not be limited to making recommendations to the division on program improvements and cost efficiencies and who, after study of available pertinent literature, adopt the best practices guidelines used to determine medical necessity. Advisory committees include but shall not be limited to the medical and technical advisory committee and its subcommittees, established under section 208.195, the drug utilization review board, established under section 208.175, the prior authorization committee, established in 13 CSR 70-20.200, and the nonpharmaceutical mental health prior authorization advisory committee, established in 13 CSR 70-98.020, and shall be required to meet as needed to ensure the best care of MO HealthNet participants;

(3) "ASO model", a system of health care delivery designed by the division to ensure the coverage of services as prescribed under section 208.152, and any other budgeted service in which an ASO provides, not on a risk-bearing basis, to defined populations of participants, combinations of care coordination, care management, utilization management, participant education, primary care case management, health plan division, and other services, but in which the state shall retain provider reimbursement,

pharmacy management, eligibility determination, provider network, and in which, for the delivery of goods and services covered under paragraph (c) of subdivision (15) of section 208.152, the state shall retain care coordination, care management, utilization management, coverage and provider reimbursement;

(4) "ASO plan", a health improvement plan operated under the ASO model by an ASO;

(5) "Behavioral health care", a continuum of services provided for a participant suffering from mental, addictive, or other behavioral health disorders provided through contract, through provider reimbursement, or by the department of mental health, the division, or formal community supports;

(6) "Best practices", transparent evidenced-based medical and dental care and treatment guidelines used to determine medical necessity that are designed to provide good outcomes, are consistent with accepted standards of care, and have been reviewed by an advisory committee within three months of adoption and made available on the web-based patient electronic health record;

(7) "Care coordinator", a person assigned by a health improvement plan to assist in coordinating the care of a participant. Care coordinators include case managers, wellness coaches, IST coaches, and other individuals with similar duties as defined by the MO HealthNet division;

(8) "Chronic care improvement plan", or "CCIP", a component plan of the state plan in which the care of participants with certain chronic diseases is managed with a higher level of coordination and intensity;

(9) "Division", the MO HealthNet division of the department of social services;

(10) "Dual eligible" or "dually eligible", refers to a participant who is enrolled in both MO HealthNet and the federal Medicare program;

(11) "Formal community support", any combination of care, support, and services provided to a participant by a local community entity, or an entity supported by public tax dollars;

(12) "Health care home", the personalized, collaborative, multi-disciplinary team of health care professionals who work in partnership with the patient, his or her family, and his or her caregivers to create an individually-tailored physical and behavioral health plan of care for the participant. The home is led by a clinically appropriate provider, who directs a team of individuals who collectively take responsibility for the ongoing care of patients. The health care home is responsible for providing all the participant's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. A health care home includes, but is not limited to a PCP or PCP extender.

It targets a participant's predominant needs and diagnoses, and is tailored to the individual participant's needs based on the individual's health status or combination of risk factors. The health care home assists with coordinating and integrating care across all elements of the health care system and the participant's community;

(13) "Health care professional", a physician or other health care practitioner licensed, accredited, or certified by the state of Missouri to perform specified health services;

(14) "Health improvement plan", a health care delivery mechanism designed by the division to ensure the coverage of medically necessary services as prescribed under section 208.152, in which a vendor or the state provides care to defined populations of participants. Health improvement plans include managed care plans, ASO plans, the basic state plan and the component state plans, and pilot project health improvement plans in existence under subsection 10 of section 208.952;

(15) "Health risk assessment", a collection of data about a participant to be collected at each participant's health care home. The set of data required shall include history and physical examination elements as defined by rule, and may differ for specific populations of participant;

(16) "Home and community based services" or "HCBS", long-term care services that help a participant live as independent as possible and be able to live in the least restrictive care setting;

(17) "Independence screening", an assessment of both a participant's ability to live independently and perform the routine tasks and activities of daily living, and of the risks that may limit the participant's ability to continue to live independently;

(18) "Individual support team" or "IST", a team of people designed to work together to help a participant be healthy and independent and continue to live in the least restrictive care setting possible;

(19) "Individual support team coach" or "IST coach", a care coordinator who is assigned by the health improvement plan and select based on the participant's needs and who, on behalf of a participant, acts as an IST facilitator, helps arrange health-related appointment and transportation, helps to maximize formal and informal support, and helps to prevent or find solutions to problems that may cause the participant to progress to a higher level of care;

(20) "Informal support", any unpaid care, support or service provided to a participant by an individual or group;

(21) "Institutional care setting", a medical model residential setting that provides care and supervision for a participant including intermediate and skilled nursing facilities, habilitation centers and state psychiatric hospitals;

(22) "Live independently", to reside and perform routine tasks in a noninstitutional setting or in a residential setting that may provide home and community-based services;

(23) "Long-term care", "long-term care services", or "LTC", medical and nonmedical services that are expected to be needed for the rest of the participant's life, delivered by providers of services which may include, but shall not be limited to, home and community-based, supportive living, residential care or assisted living facilities, and intermediate or skilled nursing facilities;

(24) "Managed Care Organization", or "MCO", a vendor licensed by the department of insurance, financial institutions and professional registration contracted by the state to provide, with an actuarially sound rate structure and based upon a managed care model, health care related goods and services to defined populations of participants, and required to:

(a) Pay an amount equal to or more than the state plan reimbursement amounts to contracted providers for the goods and services provided to participants;

(b) Spend on wellness programs and the promotion healthy lifestyles, an amount at least one-half percent of the per member per month capitated rate paid by the state with at least half of that amount to be spent directly on programs for covered participants. The managed care organization shall not be financially penalized if participants do not take advantage of the wellness programs. Any subsequent request for proposal or contract amendment shall specify the plans and goals for both wellness programs and the promotion of healthy lifestyles and shall further specify how funds would be spent on programs for covered participants;

(c) Submit semiannual reports on health and wellness outcomes and on any adjustments to the health improvement plan to the oversight committee and the division; and

(d) Operate under contractual terms that require that contracted per diem or per month rate be reduced or other financial penalty be incurred if savings and quality targets specified by the division, including but not limited to target rates at which participants, whose care is being managed by the managed care plan, seek to use hospital emergency department services for nonemergency medical conditions, are not met;

(25) "Managed care model", a system of health care delivery designed by the division to ensure the coverage of goods and services as prescribed under section 208.152, and any other budgeted service, which, as prepaid capitated care delivery is described in

section 208.166, a managed care company provides on a risk-bearing prepaid capitated basis, goods and services to participants, care coordination, utilization management, claims adjudication, participant education, and primary care case management subject to the provisions of subsection 7 of section 208.954 and in which the managed care company shall subcontract pharmacy to the state, and in which, for the delivery of goods and services covered under paragraph (c) of subdivision (15) of section 208.152, the state shall retain care coordination, care management, utilization management, coverage and provider reimbursement. Managed care organizations with existing contracts with the state as of August 28, 2007, shall be required to begin subcontracting pharmacy management to the state beginning with the next contract renewal period. For dental management in each of the three existing managed care model regions, the division shall, in the next contract period after August 28, 2007, and for the duration of that contract period, manage one region administratively using the division's technology and internal resources, administer one region using an administrative services organization to be contracted separately from the managed care model, and in the third region, maintain management through the contracted managed care model. Three months prior to the end of at least a twenty-four-month contract period, a comparison of outcomes, access, and participant satisfaction shall be conducted by the division, and the results reported to the oversight committee, who shall then review the results, and following review, advise the division on the method of access to dental services that should be used throughout the managed care model contracting areas. The division shall monitor the study monthly and terminate the study if adverse events occur. If the results of the comparison are inconclusive, the dental management shall return to the managed care entities;

(26) "Managed care plan", or "MCP", a health improvement plan operated under the managed care model by a managed care organization. Plans operating under section 208.166 as of the effective date of this section shall be deemed managed care plans;

(27) "MO HealthNet for ABD", a program that provides services to participants through the eligibility categories for the aged, blind or disabled populations;

(28) "MO HealthNet for children and families", a program that provides MO HealthNet services to participants through any eligibility category other than aged, blind, and disabled;

(29) "Natural point of entry", an entity that has staff available to access the web-based electronic patient health record and utilize the universal information and assessment system and where a person can seek information and assistance about long-term care services including, but not limited to, hospitals, home care agencies, county developmental

disabilities boards, centers for independent living, facilities licensed under chapter 198, RSMo, area agencies on aging, health care providers, and behavioral health providers;

(30) "Nonmedical care", services provided to a participant that are not medical in nature but instead help the participant with routine tasks to allow the participant to live independently;

(31) "Oversight committee", the MO HealthNet oversight committee created in section 208.956;

(32) "Participant", a person determined to be eligible to receive MO HealthNet services under a category of coverage listed in subsection 1 of section 208.151 or section 208.631;

(33) "Primary care physician" or "PCP", a physician licensed under chapter 334, RSMo, who is a family practitioner, general practitioner, pediatrician, general internist, obstetrician, gynecologist or psychiatrist. A PCP shall be responsible for any care delivered to a participant by a PCP extender pursuant to a collaborative or supervisory agreement;

(34) "Primary care physician extender", or "PCP extender", a licensed physician assistant or nurse practitioner who has a collaborative or supervisory agreement with a participant's chosen or assigned PCP, or by the entity which employs such PCP;

(35) "Prior authorization system", or "PA system", a method used to determine whether or not services or equipment requested by a provider for delivery to a participant are medically necessary. The single state agency, when utilizing PA systems, shall ensure that they be transparent and subject to best practices, and as soon as possible, shall automate them into an electronic web-based format to increase timeliness and efficiency;

(36) "Risk prediction", a procedure that uses risk factors or other statistical or scientific methods to predict, based upon a participant's health risk assessment and other known data, a participant's likelihood of developing certain illnesses, diseases outcomes or complications;

(37) "State plan", "state point of service plan", "component state plan", or "basic state plan", a system of health care delivery designed by the state to ensure the coverage of medically necessary services prescribed under section 208.152 and any other budgeted service in which care to specific populations of participants is delivered on a point-of service basis and in which the state retains financial responsibility and oversees the administrative and care management activities internally or through contracted vendors. The state plan may be subdivided, and shall include a basic state plan, which shall be available everywhere in the state, and may include component plans, each made available to a specific subset of participants based upon geographic area, diagnosis or the results of

risk prediction. The state plan shall include the basic and component state plans. The basic and component state plans may use contracted vendors to perform administrative activities including risk prediction modeling, disease management, prior authorization, retrospective service and pharmacy utilization review, and claims payments. Any component state plan managed by a contracted vendor shall submit semiannual reports on health and wellness outcomes and on any adjustments to the health improvement plan to the oversight committee and the division. The point of service plan operated outside the provisions of section 206.166, as of the effective date of this section shall be deemed the state plan. The division shall submit semiannual reports on health and wellness outcomes and on any adjustments to the health improvement plan to the oversight committee and to the joint committee on MO HealthNet;

(38) "Supervised", subject to work product quality review and termination of employment;

(39) "Transparent", or "transparency", a property applying to rules and guidelines by which decisions and determinations are made. Transparent rules and guidelines are clear, understandable, open for public inspection and when applied to a given set of facts or data yield substantially the same decision or determination no matter when or by whom the rules or guidelines are applied;

(40) "Universal information and assessment system", a system linked to the web-based electronic patient health record, that allows for web-based access to information, that includes, but not is limited to, comprehensive information about long-term care options for all Missourians, providing a variety of electronic assessments, MO HealthNet eligibility determination, and care plan design;

(41) "Unmet needs", those services, including but not limited to, activities of daily living and routine tasks, which are included in the MO HealthNet state plan and which cannot reasonably be met by the members of the participant's household or by other support systems available to the participant. Assistance with activities of daily living and routine tasks for a resident of a residential care facility or assisted living facility licensed under chapter 198, RSMo, shall be considered an unmet need if the facility is not specifically reimbursed for such assistance through other payment sources;

(42) "Web-based electronic patient health record", the computer system managed by the division through which providers can exchange patient-specific data with MO HealthNet, and implemented under subsection 20 of section 208.952;

(43) "Wellness coach", a care coordinator assigned by the health improvement plan and who is selected based upon the participant's needs to assist the participant in meeting

good health care outcome goals, and who meets defined standards for qualifications determined by the division.

208.952. 1. In order to ensure that the services delivered to participants are continuously improved and that the value received for the public funds spent on those services is continuously maximized, the division shall, in effecting the provisions of this section and in promulgating rules, be guided by the recommendations of the MO HealthNet oversight committee.

2. Each provider of services listed in section 208.152, shall be entitled to receive sufficient reimbursement from the state to ensure that each participant, subject to best practices, receives in a timely fashion the medically necessary health care services listed in section 208.152.

3. The division shall automatically enroll in the state plan all participants not enrolled in a managed care plan as of the effective date of this section. Once newly eligible participants request services and, beginning no later than July 1, 2008, once new health improvement plans are created, under subsection 9 of this section, and become available for defined populations of participants, the division shall provide to each newly enrolled participant and to each participant in the defined population information about the health improvement plans currently available to that participant and, after being given at least thirty days in which to make a choice among available health improvement plans, if that participant does not make a choice, the division shall assign that participant to a health improvement plan. In assigning participants, the division shall, when two or more plans are available to a participant, assign the participant to a health improvement plan under the provisions of section 208.962 or 208.964, whichever section applies. Each newly eligible participant shall be covered by the state plan while the participant's choice is pending. After the effective date of this section, all participants shall be continually enrolled in health improvement plans. The division shall, by rule, establish health risk assessments defined in section 208.950 after which each participant shall receive a health risk assessment subject to the provisions of subsection 2 of section 208.954.

4. The division shall use risk prediction to identify high-risk participants who, if provided a more intense level of care coordination and management, would likely have improved and more cost-effective outcomes. The participants identified shall receive more intense care coordination and management. High risk state point of service plan participants may be enrolled in the CCIP or its successor program or other component state point of service plans designed for specific populations of high risk participants. Prior to initiating a new health improvement plan, MCPs and ASOs shall be required to

submit to the division for approval planned methods for the use of risk prediction to achieve better outcomes.

5. The division may expand the CCIP component of the state point of service plan by contracting with a single ASO or multiple ASOs to provide up to state-wide coverage of that program, or may subdivide it by disease, geographic area, vendor, or other factors using multiple ASOs or other vendors.

6. The division shall maximize the use of technology to increase efficiency and reduce paperwork using real-time and web-based systems where possible. The division shall not require independent providers or groups of providers to bear the cost of purchasing any electronic medical record software.

7. The division shall request appropriate waivers or state plan amendments from the Secretary of the federal Department of Health and Human Services to permit the establishment of ASOs.

8. The division shall not operate, design, or implement any health improvement plan for any ABD participant population using a managed care model.

9. The division shall be authorized, consistent with the provisions of sections 208.962 and 208.964, using the lessons learned from the experience of other states and from any results obtained under subsections 10, 11 and 12 of this section, after consultation with the oversight committee, to design and implement new health improvement plans to cover defined populations of participants, subject to the following:

(1) When vendors are needed to implement such new health improvement plans, the division shall either utilize requests for proposals consistent with the state procurement policies of chapter 34, RSMo, or shall utilize other existing competitive state procurement processes, such as those found in chapter 630, RSMo. The division shall establish criteria for award selection to include, as required by chapter 34, RSMo, preference for Missouri-based vendors and vendors with prior experience in serving either MO HealthNet beneficiaries or Medicaid beneficiaries in other states. During the procurement process for implementation of new health improvement plans, the division shall encourage the participation of vendors through such considerations as ensuring adequate time for building provider networks and obtaining appropriate licensure, and establishing actuarially-sound capitation rate ranges; and

(2) In designing and implementing new health improvement plans, so that valid conclusions can be drawn from the experience of such plans after study, the division shall define the geographic area covered by any new ASO plan to be the same geographic area covered by an existing MCP if there is one, provided that the new ASO is serving a different population of eligibles than the existing MCP, and the division shall define the

geographic area covered by any new MCP to be the same geographic area covered by an existing ASO plan if there is one; however, the division shall waive this requirement for counties outside a vendor's authorized area of operation, as established by contract or otherwise.

10. After consultation with the oversight committee, and subject to the provisions of subsection 8 of this section the division may design and implement health improvement plans as pilot projects, with the intent of determining the best way to achieve good outcomes and cost savings in the delivery of health care services to defined populations of participants. Each such pilot health improvement plan shall be designed to match the defined population of participants covered by an existing health improvement plan both geographically and by eligibility category, and in such a way that valid conclusions can be drawn after a period of time and after analysis of outcomes and cost of both the pilot and existing health improvement plans is completed.

11. The department of social services shall biannually commission an independent study and submit the results of that study to the division, the general assembly, the governor, the joint committee on MO HealthNet, and the oversight committee. The study required by this subsection shall evaluate and compare for similar populations of participants in the same geographic areas, all health improvement plans and models on the basis of cost, health outcomes, participant satisfaction, and provider satisfaction.

12. The division shall quarterly tabulate the data collected from health risk assessments and report the results to the oversight committee. The division shall make it possible for health risk assessments to be entered and transmitted electronically, and no sooner than January 1, 2010, may by rule require that health risk assessments be entered and transmitted electronically.

13. The department of social services shall, by July 1, 2008, commission an independent survey to assess health and wellness outcomes of MO HealthNet participants by examining key health care delivery system indicators, including but not limited to disease-specific outcome measures, provider network demographic statistics including but not limited to the number of providers per unit population broken down by specialty, subspecialty, and multi-disciplinary providers by geographic areas of the state in comparison side-by-side with like indicators of providers available to the state-wide population, and participant and provider program satisfaction surveys. In counting the number of providers available, the study design shall use a definition of provider availability such that a provider that limits the number of MO HealthNet recipients seen in a unit of time is counted as a partial provider in the determination of availability. The department may contract with another organization in order to complete the survey, and

shall give preference to Missouri-based organizations. The results of the study shall be completed within six months and be submitted to the general assembly, the governor, and the oversight committee.

14. The department of social services shall engage in a public process for the design, development, and implementation of the health improvement plans and other aspects of MO HealthNet. Such public process shall allow for but not be limited to input from consumers, health advocates, disability advocates, providers, and other stakeholders.

15. Until the results of the study required by subsection 13 of this section are received and recommendations of the oversight committee required by subdivision (7) of subsection 2 of section 208.956, are received, the division shall direct the majority of any new appropriations for increased physician reimbursement to increase the reimbursement rates for evaluation and management codes as defined by the publication "Current Procedural Terminology", most current edition, until such rates reach one hundred percent of the rates reimbursed under the federal Medicare program, after which such new appropriations may be directed to increase reimbursement rates for other codes.

16. The division shall by rule require all health improvement plan vendors to enter into contracts that include rewards or penalties for meeting or failing to meet targets determined by the division, which shall include but not be limited to annual savings levels, quality targets, and participant and provider satisfaction level targets.

17. The division shall establish a sliding scale schedule of co-payments, if implemented under subsection 2 of section 208.152, to be paid by all participants for the hospital component of emergency department visits. The co-payment shall be waived if the participant is subsequently admitted to the hospital as an inpatient, or if the participant has an emergency medical condition as defined in section 354.400, RSMo. The division shall develop emergency room diversion protocols for MO HealthNet participants in collaboration with the hospital industry and with consultation from the oversight committee.

18. The division shall include in its annual budget request to the governor the necessary funding needed to complete the three-year plan developed under subdivision (27) of subsection 1 of section 208.152.

19. The division, in conjunction with the department of health and senior services and the department of mental health, shall implement and link all systems necessary to develop databases, patient and provider profiles, ad hoc reports, and intervention documents in support of clinical management including, but not limited to, pharmacy services, durable medical equipment, therapy services, long-term care services, and mental health services for MO HealthNet participants. The division shall choose a contractor or

contractors to assist in implementation of such systems under chapter 34, RSMo. Such systems shall be linked and operated by the division and shall be made available to all providers caring for participants.

20. The division shall define by rule the form of, manner of completing, and population of participants, excluding participants of the MO HealthNet for ABD program who are in an institutional care setting, on whom to complete an independence screening.

208.954. 1. The following provisions shall apply to all health improvement plans:

(1) All health improvement plans shall be required by the division to:

(a) Assist participants in remaining in the least restrictive care setting possible through the establishment and use mechanisms designed to identify participants likely to require admission to an institutional care setting and to assist in identifying the appropriate nonmedical care and behavioral health needed to prevent such admission, such mechanisms to include but not be limited to hospital discharge planning;

(b) Establish participant call centers based in Missouri to receive from participants questions about topics including, but not limited to, the health improvement plan, finding available providers, other available programs and to refer participants to appropriate state offices or to appropriate resources in their communities when necessary; however, the requirement that call centers be established in Missouri may be waived if a vendor has already established and plans to utilize such a call center based in the United States, except that this provision shall not allow a vendor to close an existing call center based in Missouri and utilize one based outside Missouri;

(c) Report at least annually on participant and provider quality and satisfaction indicators, to be determined by the division with the advice of the oversight committee, including, but not limited to, complaints, prompt payment of providers, call center statistics, emergency room usage, and denials of care;

(d) Provide information to participants education and counseling on the benefits of good nutrition and healthy lifestyles;

(e) Provide medical and dental preventive care, to MO HealthNet participants based on medical evidence and accepted prevention guidelines for the participant's age, health status and health risk factors as determined by the participant's health risk assessment. Health improvement plans shall encourage preventative care so that: health care providers can detect concerns before they become problems; participants' health can improve; outpatient health care can prevent hospital emergency care; participants can become familiar with their health care homes; and so that providers can be given the opportunity to instruct participants on good nutrition and healthy lifestyles;

(f) MCOs and ASOs and state plan vendors shall require subcontracted providers to meet, at a minimum, quality standards currently required through MO HealthNet contracts, and shall pay those providers no less than the state point of service plan fee schedule.

2. The division shall select a date no later than June 1, 2008, and after that date, the division shall allow each participant already enrolled in a health improvement plan but who has not chosen or been assigned to a PCP, and each participant enrolling after the date selected, thirty days to choose a PCP from a list of PCPs made available to the participant by the participant's health improvement plan, after which that participant shall be assigned to a PCP by the health improvement plan in which the participant is enrolled. Those participants who choose PCPs shall be assigned to them. The division shall by rule define the mechanisms by which participants can choose or change PCPs, and shall also define an exemption process for any newly enrolled participant whose treating physician does not participate in a health improvement plan available to the participant, in order to prevent interruption in the continuity of the participant's medical care. After July 1, 2008, all participants shall be assigned to PCPs, except for those whose choice is still pending and those who are dually eligible for both Medicare and MO HealthNet. Such dually eligible participants may, but shall not be required, to select a PCP, and the participant shall be allowed to have a health risk assessment completed by an alternate MO HealthNet physician, if the Medicare physician does not wish to participate in MO HealthNet or is unwilling to perform the risk assessment. After assignment to a PCP, all care delivered to a participant, unless the participant is dually-eligible, shall be done with the authorization of the participant's PCP or PCP extender, with the exception of urgent care, emergency care, or hospital care.

3. In order to improve provider access, no health improvement plan, or any of its subsidiaries, networks, contractors, or subcontractors, shall discriminate against any MO HealthNet provider who is located within its geographic coverage area and who is willing to meet the terms and conditions for provider participation established for such health improvement plan. The division shall formulate a plan to encourage the broadest possible participation of health care providers.

4. By July 1, 2008, all health improvement plans shall conduct a health risk assessment for enrolled participants and develop a plan of care for each enrolled participant with health status goals achievable through healthy lifestyles, and appropriate for the individual based on the participant's age and the results of the participant's health risk assessment.

5. In order to ensure the availability of care, all health improvement plans may include arrangements with telehealth providers as provided for in section 208.670.

6. All health improvement plans shall provide a twenty-four-hour confidential toll-free health line to be staffed by licensed registered nurses. Participants shall be encouraged by the health improvement plan to call the health line when symptomatic and before making appointments or visiting an urgent care center. The nurse shall assess the participant's symptoms and pertinent history and recommend both the level of services that would be appropriate for the participant to seek and when the participant should appropriately seek them. The nurse shall not diagnose nor provide treatment.

7. In order to ensure compliance with the provisions of 42 CFR 7, Subchapter XIX, Section 1396a, all MCP and ASO plans shall ensure that there are enough MO HealthNet providers in each provider category so that the care and services available under MO HealthNet to participants is at least the extent that such care and services are available to the general population in the geographic area of the health improvement plan, and provide proof of an adequate network to the department.

8. 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, 2007, shall be invalid and void.

208.956. 1. There is hereby established in the department of social services the "MO HealthNet Oversight Committee", which shall be appointed by January 1, 2008, and shall consist of seventeen members as follows:

(1) Two members of the house of representatives, one from each party, appointed by the speaker of the house of representatives;

(2) Two members of the Senate, one from each party, appointed by the president pro tem of the senate;

(3) One consumer representative, not from the same geographic area and not covered by the same health improvement plan, appointed by the governor;

(4) Two primary care physicians who care for participants, not from the same geographic area, appointed by the governor;

(5) Two physicians, licensed under chapter 334, RSMo, who care for participants but who are not primary care physicians and are not from the same geographic area, appointed by the governor;

(6) Two nonphysician health care professionals who care for participants, not from the same geographic area, appointed by the governor;

(7) Two patient advocates, appointed by the governor;

(8) One public member; and

(9) The directors of the department of social services, the department of mental health, the department of health and senior services, or the respective directors' designees.

2. The members of the oversight committee, other than the members from the general assembly and ex-officio members, shall be appointed by the governor with the advice and consent of the senate. A chair of the oversight committee shall be selected by the members of the oversight committee. Of the members first appointed to the oversight committee by the governor, five members shall serve a term of two years, five members shall serve a term of one year, and thereafter, members shall serve a term of two years. Members shall continue to serve until their successor is duly appointed and qualified. Any vacancy on the oversight committee shall be filled in the same manner as the original appointment. Members shall serve on the oversight committee without compensation but may be reimbursed for their actual and necessary expenses from moneys appropriated to the department of social services for that purpose. The department of social services shall provide technical, actuarial, and administrative support services as required by the oversight committee. The oversight committee shall:

(1) Meet on at least four occasions yearly, including at least four before the end of December of the first year the committee is established. Meetings can be held by telephone or video conference at the discretion of the committee;

(2) Review the participant and provider satisfaction reports required of the plan vendors under paragraph (c) of subdivision (1) of subsection 1 of section 208.954, and the reports of health and wellness outcomes and plan adjustments required under paragraph (b) of subdivision (2), paragraph (c) of subdivision (23), and subdivision (37) of section 208.950;

(3) Review the results from other states of relative success or failure of various models of health delivery attempted;

(4) Review the results of pilot projects conducted under subsection 10 of section 208.952;

(5) Review the results of studies comparing health plans conducted under subsection 11 of section 208.952;

(6) Review the data from health risk assessments collected and reported under subsection 12 of section 208.952;

(7) Review the results of the studies conducted under subsections 13 and 18 of section 208.952 and make annual recommendations to the division and to the governor on what provider fee increases are needed and what other steps should be taken so that MO HealthNet can continually be in compliance with federal law regarding provider availability;

(8) Review the results of the public process input collected under subsection 14 of section 208.952;

(9) Advise the department about proposed design and implementation plans for a new health improvement plan under subsection 9 or 10 of section 208.952, and after study, including the consideration of the reviews required by subdivisions (1) to (9) of this subsection, make recommendations and suggest modifications when necessary;

(10) Determine how best to analyze and present the data reviewed under subdivisions (2) to (8) of this subsection, so that the health outcomes, participant and provider satisfaction, results from other states, results of pilot projects, health plan comparisons, financial impact of the various health improvement plans and models of care, study of provider access, and results of public input can be used by consumers, health care providers, and public officials in meaningful ways, and to then analyze such data;

(11) Present significant findings of the analysis required in subdivision (10) of this subsection in a report to the general assembly and governor, at least annually, beginning January 1, 2009;

(12) Review the budget forecast issued by the legislative budget office, and the report required under subsection (22) of subsection 1 of section 208.151, and after study:

(a) Consider what resources would be needed and ways to obtain the resources needed to expand eligibility to all Missouri citizens that would meet such requirements for eligibility;

(b) Consider ways to expand services based upon eligibility to needy or at-risk populations;

(c) Consider ways to maximize the federal drawdown of funds;

(d) Study the demographics of the state and of the MO HealthNet population, and how those demographics are changing;

(e) Consider what steps are needed to prepare for the increasing numbers of participants as a result of the baby boom following World War II;

(13) Determine which executive branch agencies shall follow the rules promulgated by the MO HealthNet division;

(14) Ensure the division acts on directives issued;

(15) Conduct a study to determine whether an office of inspector general shall be established. Such office would be responsible for oversight, auditing, investigation, and performance review to provide increased accountability, integrity, and oversight of state medical assistance programs, to assist in improving agency and program operations, and to deter and identify fraud, abuse, and illegal acts. The committee shall review the experience of all states that have created a similar office to determine the impact of creating a similar office in this state; and

(16) Perform other tasks as necessary, including but not limited to making recommendations to the division concerning the promulgation of rules and emergency rules so that quality of care, provider availability, and participant satisfaction can be assured.

3. By July 1, 2013, the oversight committee shall issue findings to the general assembly on the success and failure of health improvement plans and shall recommend whether or not any health improvement plans should be discontinued.

4. The oversight committee shall designate a subcommittee devoted to advising the department on the development of a comprehensive entry point system for long-term care that shall:

(1) Offer Missourians an array of choices including community-based, in-home, residential and institutional services;

(2) Provide information and assistance about the array of long-term care services to Missourians;

(3) Create a delivery system that is easy to understand and access through multiple points, which shall include but shall not be limited to providers of services;

(4) Create a delivery system that is efficient, reduces duplication, and streamlines access to multiple funding sources and programs;

(5) Strengthen the long-term care quality assurance and quality improvement system;

(6) Establish a long-term care system that seeks to achieve timely access to and payment for care, foster quality and excellence in service delivery, and promote innovative and cost-effective strategies; and

(7) Study one-stop shopping for seniors as established in section 208.612.

5. The subcommittee shall include the following members:

(1) The lieutenant governor or his or her designee, who shall serve as the subcommittee chair;

(2) One member from a Missouri area agency on aging, designated by the governor;

(3) One member representing the in-home care profession, designated by the governor;

(4) One member representing residential care facilities, predominantly serving MO HealthNet participants, designated by the governor;

(5) One member representing assisted living facilities or continuing care retirement communities, predominantly serving MO HealthNet participants, designated by the governor;

(6) One member representing skilled nursing facilities, predominantly serving MO HealthNet participants, designated by the governor;

(7) One member from the office of the state ombudsman for long-term care facility residents, designated by the governor;

(8) One member representing Missouri centers for independent living, designated by the governor;

(9) One consumer representative with expertise in services for seniors or the disabled, designated by the governor;

(10) One member with expertise in Alzheimer's disease or related dementia;

(11) One member from a county developmental disability board, designated by the governor;

(12) One member representing the hospice care profession, designated by the governor;

(13) One member representing the home health care profession, designated by the governor;

(14) One member representing the adult day care profession, designated by the governor;

(15) One member gerontologist, designated by the governor;

(16) Two members representing the aged, blind, and disabled population, not of the same geographic area or demographic group designated by the governor;

(17) The directors of the departments of social services, mental health, and health and senior services, or their designees; and

(18) One member of the house of representatives and one member of the senate serving on the oversight committee, designated by the oversight committee chair.

Members shall serve on the subcommittee without compensation but may be reimbursed for their actual and necessary expenses from moneys appropriated to the department of

health and senior services for that purpose. The department of health and senior services shall provide technical and administrative support services as required by the committee.

6. By October 1, 2008, the comprehensive entry point system subcommittee shall submit its report to the governor and general assembly containing recommendations for the implementation of the comprehensive entry point system, offering suggested legislative or administrative proposals deemed necessary by the subcommittee to minimize conflict of interests for successful implementation of the system. Such report shall contain, but not be limited to, recommendations for implementation of the following consistent with the provisions of section 208.968:

(1) A complete statewide universal information and assistance system as defined in section 208.950 that is integrated into the web-based electronic patient health record that can be accessible by phone, in-person, via MO HealthNet providers and via the Internet that connects consumers to services or providers. Through the system, consumers shall be able to independently choose from a full range of home, community-based, and facility-based health and social services as well as access appropriate services to meet individual needs and preferences from the provider of the consumer's choice;

(2) The universal information and assessment system, as defined in section 208.950, to establish consumers' needs for services;

(3) A mechanism for developing a plan of service or care via the web-based electronic patient health record to authorize appropriate services;

(4) A preadmission screening mechanism for MO HealthNet participants for nursing home care;

(5) A case management or care coordination system to be available as needed; and

(6) An electronic system or database to coordinate and monitor the services provided which are integrated into the web-based electronic patient health record.

7. Starting July 1, 2009, and for three years thereafter, the subcommittee shall provide to the governor, lieutenant governor and the general assembly a yearly report that provides an update on progress made by the subcommittee toward implementing the comprehensive entry point system.

8. The provisions of section 23.253, RSMo, shall not apply to sections 208.950 to 208.955.

208.960. 1. There is hereby established the "Joint Committee on MO HealthNet". The committee shall have as its purpose the study of the resources needed to continue and improve the MO HealthNet program over time. The committee shall consist of ten members:

(1) The chair and the ranking minority member of the house committee on the budget;

(2) The chair and the ranking minority member of the senate committee on appropriations committee;

(3) The chair and the ranking minority member of the house committee on appropriations for health, mental health, and social services;

(4) The chair and the ranking minority member of the senate committee on health and mental health;

(5) A representative chosen by the speaker of the house of representatives; and

(6) A senator chosen by the president pro tem of the senate.

No more than three members from each house shall be of the same political party.

2. A chair of the committee shall be selected by the members of the committee.

3. The committee shall meet as necessary.

4. The committee is authorized to contract with a consultant. The compensation of the consultant shall be paid from the joint contingent fund or jointly from the senate and house contingent funds until an appropriation is made therefor.

5. The committee shall receive and study the five-year rolling MO HealthNet budget forecast issued annually by the legislative budget office.

6. The committee shall make recommendations in a report to the general assembly by January first each year, beginning in 2008, on anticipated growth in the MO HealthNet program, needed improvements, anticipated needed appropriations, and suggested strategies on ways to structure the state budget in order to satisfy the future needs of the program.

208.962. In addition to the provisions of section 208.954, the provisions of this section shall apply to health improvement plans offered under the MO HealthNet for children and families programs:

(1) The existing managed care plans serving MO HealthNet for children and families as of the effective date of this section shall meet the statutory requirements for managed care health improvement plans by December 31, 2007;

(2) In assigning participants who fail to choose between two or more health improvement plans as described in subsection 3 of section 208.952, the division shall:

(a) If the participant is newly eligible, the participant shall be assigned to the MCP or ASO plan that has the fewest members; and

(b) If the participant is already in a health improvement plan, the participant shall be left in that health improvement plan;

(3) The division shall establish by rule, guidelines and any needed exception process for the waiver of participation of a participant or of defined populations of participants in the available ASOs or MCPs;

(4) Each participant shall be assigned a wellness coach, whose duties and responsibilities shall be based on analysis of the participant's health risk assessment, which shall guide the level of coordination and intervention received by a participant. Such duties and responsibilities shall include, but not be limited to, coordinating health related appointment and transportation, encouraging preventive care, and coaching the participant to reach appropriate healthy lifestyle goals;

(5) In order to help high-risk participants improve their outcomes, the division may utilize any other care and case management strategies involving intensified care coordination including, but not limited to, the provision of a health care coordinator in place of a wellness coach.

(6) Care received by participants, including health care, nonmedical care and behavioral health care services, shall be coordinated in order to provide continuity of care and to reduce duplication of services and improve outcomes. A participant's care coordinator, service coordinator or case manager provided through, or by contract with, the state or formal community support, who meets the defined standards for qualifications and training, may act as a participant's wellness coach or other assigned care coordinator;

(7) Mental health services provided under MO HealthNet for children in foster care, including psychological, behavioral and counseling services, shall be provided through the basic state plan and not included as part of an ASO or MCP designed for such population. Any community based agency providing services to a child in foster care pursuant to a performance-based contract, as defined in section 210.112, RSMo, with the department of social services, shall be given the option of having any staff who meet defined standards for qualifications and training act as a wellness coach for children assigned to the agency through such contract;

(8) The department of mental health may provide services to MO HealthNet participant children or to MO HealthNet participant parents through the basic state plan or a component state plan authorized by the department of mental health, and who are also enrolled in an ASO or MCP plan designed for such population without losing their covered services in the ASO or MCP plan;

(9) The MO HealthNet division shall, request the appropriate waivers or state plan amendments from the secretary of the federal department of health and human services to implement the provisions of this section.

208.964. In addition to the provisions of section 208.954, the provisions of this section shall apply to health improvement plans offered under the MO HealthNet for ABD program:

(1) The division shall design the MO HealthNet for ABD Program to allow covered participants to:

(a) Be as healthy and live as independently as possible and be able to live in the least restrictive care setting as long as it is safe, cost-effective, and the choice of the participant; and

(b) If living in an institutional care setting, be safe and well cared for, and have the opportunity to move to a less restrictive care setting as long as it is safe, cost-effective, and the choice of the participant;

(2) In assigning participants who fail to choose between two or more health improvement plans as described in subsection 3 of section 208.952, the participants shall be left in their health improvement plans. New participants who fail to choose shall be placed in the basic state plan;

(3) Each participant shall be assigned to a PCP under subsection 2 of section 208.954, except that each dually-eligible participant whose personal primary care physician does not participate in MO HealthNet or does not want to perform the risk assessment shall be allowed to choose a participating MO HealthNet physician to complete the health risk assessment and help the participant develop healthy lifestyle goals prescribed under this section;

(4) For each participant who is not living in an institutional care setting:

(a) After completion of the health risk assessment, risk prediction shall be done to determine the level of care coordination needed by the participant. If indicated by risk prediction, an independence screening shall be completed and, if needed, a preadmission screening and resident review shall be completed. The independence screening may be completed through the universal information and assessment system. If the independence screening indicates that the participant may be eligible for long-term care services, the participant shall be referred to the department of health and senior services or a natural point of entry for eligibility determination and services;

(b) The results of risk prediction, the results of the independence screening, and the participant's care needs shall determine whether a participant is assigned a wellness coach, an IST and IST coach under subdivision (5) of this section, or other care coordinator under paragraph (c) of subdivision (3) of this section;

(c) The division may utilize any other care and case management strategies to help high risk participants improve their outcomes by the provision of intensified care

coordination including, but not limited to, providing a health care coordinator or other health care manager in place of a wellness coach;

(d) Care received by participants, including health care, nonmedical care and behavioral health care services, shall be coordinated to provide continuity of care and to reduce duplication of services and improve outcomes. A participant's care coordinator, service coordinator or case manager provided through, or by contract with, the state or formal community support, who meets the defined standards for qualifications and training, may act as a participant's wellness coach or other assigned care coordinator;

(5) Any MO HealthNet for ABD participant who is not living in an institutional care setting but who meets the qualifications for skilled or intermediate nursing home care, or who has a person managing the participant's care through the department of mental health, shall receive a higher level of care coordination which shall include, but not be limited to, the following:

(a) An individual support team made up of those members of the participant's providers and social network willing to work together to help the participant to remain healthy and independent, and for as long as possible, to live in the least restrictive care setting. The IST may include, but shall not be limited to: the participant; the participant's PCP; the primary care case manager; any physician of the participant or that physician's designee; the participant's behavioral health provider; the person managing the participant's care through the department for nonmedical care or behavioral health care; the person managing the participant's nonmedical care; any nonmedical or home-health care worker that is in the participant's home on a regular basis; any family members, friends or persons providing informal support or formal community support for the participant;

(b) An IST coach assigned to the IST and who shall act as the IST facilitator. A member of the IST may act as the IST coach if he or she meets the defined standards for qualifications and training for an IST coach. The analysis of the participant's health and independence risks shall guide the level of involvement, coordination and intervention of the IST coach, but allow for flexibility for the IST coach to help find solutions as problems arise and threaten to inappropriately place the participant in a more restrictive care setting. The IST and the IST coach may communicate electronically or by phone and shall not be required to meet in person. The duties of the IST coach may include, but shall not be limited to: coordinating health related appointment and transportation; encouraging preventive care; coaching the participant to reach healthy lifestyle goals; and maximizing informal and formal community supports;

(c) If the participant is unable or does not wish to participate in the IST, the other members and IST coach shall continue to work together to provide the coordinated care needed for the participant's benefit;

(d) If the participant moves to an institutional care setting, the IST and IST coach shall continue to work together on the participant's behalf until it is determined that the participant does not wish to, or cannot safely and cost-effectively, return to a less restrictive care setting;

(6) The division may only design ASO plans and component state plans only for those participants not living in an institutional care setting. Such plans may be designed for specific participant subsets based on the results of risk prediction, diagnosis, or care needs, and may be limited to specific geographic areas. All plans shall meet the requirements of this section and shall provide an "opt out" mechanism to allow participants, who do not want to participate in an ASO or component state plan, to participate in the basic state plan. Services provided through the department of mental health to participants eligible for MO HealthNet for ABD shall be provided through the basic state plan and not included as part of an ASO plan, managed care plan, or component state plan for such population. The division shall not design or implement any health improvement plan under MO HealthNet for ABD using a managed care model;

(7) The division shall, if required, request the appropriate waivers or state plan amendments from the secretary of the federal department of health and human services to implement the provisions of this section.

208.968. The division, in conjunction with the department of health and senior services, shall develop a universal information and assessment system as defined in section 208.950 that allows Missourians to receive information, assessments and assistance concerning long-term care services through the department of health and senior services and through natural points of entry. The division shall work with provider groups and advocates to begin development of the system design as of the effective date of this section. The division shall contract by March 1, 2008, with a vendor or vendors to provide a system that allows for web-based access and seamless access through the web-based electronic patient health record to be in operation by December 31, 2008. The universal information and assessment system shall be available to Missourians through the department of health and senior services and natural points of entry and shall assure uniform and transparent application of assessments, determinations, care plans, and service authorization. The universal information and assessment system shall include, but not be limited to:

(1) An information system accessible via the Internet, by phone or in-person that promotes access to good quality care by connecting Missourians regardless of their income to a full range of HCBS, residential, and institutional services statewide;

(2) Electronic communication between the department of health and senior services, long-term care providers, health care and behavioral health care providers, and natural points of entry;

(3) Electronic access for providers to best practice guideline for long-term care;

(4) The independence screening to determine the risk of being inappropriately moved to a more restrictive and less cost effective care setting;

(5) A screening and application process accessible via the Internet, by phone or in-person to determine the likelihood of MO HealthNet financial eligibility and the automatic connection with the family support division for the application process to begin;

(6) Guidelines for determination of level of care needs available electronically;

(7) Allowing electronic submission of level of care needs data for MO HealthNet HCBS eligibility determination;

(8) Electronic data submission for transparent, electronic care plan development based on best practices to address the patient's long-term care needs with medical and nonmedical long-term care services;

(9) Electronic authorization of long-term care services, including but not limited to, in-home care services, personal care attendant services, residential care facility and assisted living facility tiered care levels, home health care, adult day care, aged and disabled waiver services, AIDS waiver services, physical disability waiver services, independent living waiver services;

(10) An electronic request and authorization process for long-term care service modifications;

(11) Data collection and analysis functions on consumers, providers and services that allows utilization review; and

(12) An electronic bill submission and payment system for long-term care services.

208.975. 1. There is hereby created in the state treasury the "Health Care Technology Fund" which shall consist of all gifts, donations, transfers, and moneys appropriated by the general assembly, and bequests to the fund. The state treasurer shall be custodian of the fund and may approve disbursements from the fund in accordance with sections 30.170 and 30.180, RSMo. The fund shall be administered by the department of social services in accordance with the recommendations of the MO HealthNet oversight committee unless otherwise specified by the general assembly. Moneys in the fund shall be distributed in accordance with specific appropriation by the general assembly. The

director of the department of social services shall submit his or her recommendations for the disbursement of the funds to the governor and the general assembly.

2. Subject to the recommendations of the MO HealthNet oversight committee under section 208.978 and subsection 1 of this section, moneys in the fund shall be used to promote technological advances to improve patient care, decrease administrative burdens, increase access to timely services, and increase patient and health care provider satisfaction. Such programs or improvements on technology shall include encouragement and implementation of technologies intended to improve the safety, quality, and costs of health care services in the state including, but not limited to, the following:

(1) Electronic medical records;

(2) Community health records;

(3) Personal health records;

(4) E-prescribing;

(5) Telemedicine;

(6) Telemonitoring; and

(7) Electronic access for participants and providers to obtain MO HealthNet service authorizations.

3. Prior to any moneys being appropriated or expended from the healthcare technology fund for the programs or improvements listed in subsection 2 of this section, there shall be competitive requests for proposals consistent with state procurement policies of chapter 34, RSMo. After such process is completed, the provisions of subsection 1 of this section relating to the administration of fund moneys shall be effective.

4. For purposes of this section, "elected public official or any state employee" means a person who holds an elected public office in a municipality, a county government, a state government, or the federal government, or any state employee, and the spouse of either such person, and any relative within one degree of consanguinity or affinity of either such person.

5. Any amounts appropriated or expended from the healthcare technology fund in violation of this section shall be remitted by the payee to the fund with interest paid at the rate of one percent per month. The attorney general is authorized to take all necessary action to enforce the provisions of this section, including, but not limited to, obtaining an order for injunction from a court of competent jurisdiction to stop payments from being made from the fund in violation of this section.

6. Any business or corporation which receives moneys expended from the healthcare technology fund in excess of five hundred thousand dollars in exchange for products or services and, during a period of two years following receipt of such funds,

employs or contracts with any current or former elected public official or any state employee who had any direct or indirect decision-making or administrative authority over the awarding of healthcare technology fund contracts or the disbursement of moneys from the fund shall be subject to the provisions contained within subsection 5 of this section. Employment of or contracts with any current or former elected public official or any state employee which commenced prior to May 1, 2007, shall be exempt from these provisions.

7. In an effort to foster competition, innovation, and numerous pilot projects related to advanced healthcare technology, no business or corporation, or any successor entity, shall be permitted to receive funds appropriated or expended from the healthcare technology fund in excess of seven hundred fifty thousand dollars within any three-year span.

8. No funds appropriated or expended from the healthcare technology fund shall be given to businesses or corporations that produce, sell, market, utilize, or promote personal identification microchip technology intended to be implanted into human beings. For purposes of this section, "personal identification microchip technology" means surgically implanted tamper-proof microchip technology that contains a unique identification number and personal information that can be noninvasively retrieved and transmitted with an external scanning device which utilizes radio frequency energy to activate the microchip and emit a radio frequency signal containing the identification number and data.

9. Any moneys remaining in the fund at the end of the biennium shall revert to the credit of the general revenue fund, except for moneys that were gifts, donations, or bequests.

10. 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.

11. Notwithstanding any provision of this section or any other law to the contrary, no less than one-fourth of the moneys appropriated for fiscal years 2008 and 2009 in the health technology fund shall be used by the MO HealthNet division to develop a universal information and assessment system under section 208.968.

12. The MO HealthNet division shall promulgate rules setting forth the procedures and methods implementing the provisions of this section and establish criteria for the disbursement of funds under this section to include but not be limited to grants to community health networks that provide the majority of care provided to MO HealthNet and low-income uninsured individuals in the community, and preference for health care entities where the majority of the patients and clients served are either participants of MO

HealthNet or are from the medically underserved population. 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, 2007, shall be invalid and void.

208.978. 1. The MO HealthNet oversight committee shall develop and report upon recommendations to be delivered to the governor and general assembly relating to the expenditure of funds appropriated to the healthcare technology fund established under section 191.990, RSMo.

2. Recommendations from the committee shall include an analysis and review, including but not limited to the following:

(1) Reviewing the current status of healthcare information technology adoption by the healthcare delivery system in Missouri;

(2) Addressing the potential technical, scientific, economic, security, privacy, and other issues related to the adoption of interoperable healthcare information technology in Missouri;

(3) Evaluating the cost of using interoperable healthcare information technology by the healthcare delivery system in Missouri;

(4) Identifying private resources and public/private partnerships to fund efforts to adopt interoperable healthcare information technology;

(5) Exploring the use of telemedicine as a vehicle to improve healthcare access to Missourians;

(6) Identifying methods and requirements for ensuring that not less than ten percent of appropriations within a single fiscal year shall be directed toward the purpose of expanding and developing minority owned businesses that deliver technological enhancements to healthcare delivery systems and networks;

(7) Developing requirements to be recommended to the general assembly that ensure not more than twenty-five percent of appropriations from the healthcare technology fund in any fiscal year shall be contractually awarded to a single entity;

(8) Developing requirements to be recommended to the general assembly that ensure the number of contractual awards provided from the healthcare technology fund shall not be fewer than the number of congressional districts within Missouri; and

(9) Recommending best practices or policies for state government and private entities to promote the adoption of interoperable healthcare information technology by the Missouri healthcare delivery system.

3. The committee shall make and report its recommendations to the governor and general assembly on or before January 1, 2008.

4. This section shall expire on April 15, 2008.

375.020. 1. Beginning January 1, **[**1990**] 2008**, each insurance producer, unless exempt pursuant to section 375.016, licensed to sell insurance in this state shall successfully complete courses of study as required by this section. Any person licensed to act as an insurance producer shall, during each two years, attend courses or programs of instruction or attend seminars equivalent to a minimum of **[**ten**] sixteen** hours of instruction **[**for a life or accident and health license or both a life and an accident and health license and a minimum ten hours of instruction for a property or casualty license or both a property and a casualty license. Sixteen hours of training will suffice for those with a life, health, accident, property and casualty license**]**. Of the sixteen hours' training required **[**above**] in this subsection**, the hours need not be divided equally **among the lines of authority in which the product has qualified**. The courses or programs **attended by the producer during each two-year period** shall include instruction on Missouri law**, products offered in any line of authority in which the product is qualified, producers' duties and obligations to the department, and business ethics, including sales suitability**. Course credit shall be given to members of the general assembly as determined by the department.

2. Subject to approval by the director, the courses or programs of instruction which shall be deemed to meet the director's standards for continuing educational requirements shall include, but not be limited to, the following:

(1) American College Courses (CLU, ChFC);

(2) Life Underwriters Training Council (LUTC);

(3) Certified Insurance Counselor (CIC);

(4) Chartered Property and Casualty Underwriter (CPCU);

(5) Insurance Institute of America (IIA);

(6) **Any other professional financial designation approved by the director by rule;**

(7) An insurance-related course taught by an accredited college or university or qualified instructor who has taught a course of insurance law at such institution;

[(7)**] (8)** A course or program of instruction or seminar developed or sponsored by any authorized insurer, recognized producer association or insurance trade association. A local producer group may also be approved if the instructor receives no compensation for services.

3. A person teaching any approved course of instruction or lecturing at any approved seminar shall qualify for the same number of classroom hours as would be granted to a person taking and successfully completing such course, seminar or program.

4. Excess **[**classroom**]** hours accumulated during any two-year period may be carried forward to the two-year period immediately following the two-year period in which the course, program or seminar was held.

5. For good cause shown, the director may grant an extension of time during which the educational requirements imposed by this section may be completed, but such extension of time shall not exceed the period of one calendar year. The director may grant an individual waiver of the mandatory continuing education requirement upon a showing by the licensee that it is not feasible for the licensee to satisfy the requirements prior to the renewal date. Waivers may be granted for reasons including, but not limited to:

(1) Serious physical injury or illness;

(2) Active duty in the armed services for an extended period of time;

(3) Residence outside the United States; or

(4) The licensee is at least seventy years of age.

6. Every person subject to the provisions of this section shall furnish in a form satisfactory to the director, written certification as to the courses, programs or seminars of instruction taken and successfully completed by such person. Every provider of continuing education courses authorized in this state shall, within thirty working days of a licensed producer completing its approved course, provide certification to the director of the completion in a format prescribed by the director.

7. The provisions of this section shall not apply to those natural persons holding licenses for any kind or kinds of insurance for which an examination is not required by the law of this state, nor shall they apply to any limited lines insurance producer license or restricted license as the director may exempt.

8. The provisions of this section shall not apply to a life insurance producer who is limited by the terms of a written agreement with the insurer to transact only specific life insurance policies having an initial face amount of five thousand dollars or less, or annuities having an initial face amount of ten thousand dollars or less, that are designated by the purchaser for the payment of funeral or burial expenses. The director may require the insurer entering into the written agreements with the insurance producers pursuant to this subsection to certify as to the representations of the insurance producers.

9. Rules and regulations necessary to implement and administer this section shall be promulgated by the director, including, but not limited to, rules and regulations regarding the following:

(1) Course content and hour credits: The insurance advisory board established by section 375.019 shall be utilized by the director to assist him in determining acceptable content of courses, programs and seminars to include classroom equivalency;

(2) Filing fees for course approval: Every applicant seeking approval by the director of a continuing education course under this section shall pay to the director a filing fee of fifty dollars per course. Fees shall be waived for state and local insurance producer groups. Such fee shall accompany any application form required by the director. Courses shall be approved for a period of no more than one year. Applicants holding courses intended to be offered for a longer period must reapply for approval. Courses approved by the director prior to August 28, 1993, for which continuous certification is sought should be resubmitted for approval sixty days before the anniversary date of the previous approval.

10. All funds received pursuant to the provisions of this section shall be transmitted by the director to the department of revenue for deposit in the state treasury to the credit of the **[**department of**]** insurance dedicated fund. All expenditures necessitated by this section shall be paid from funds appropriated from the **[**department of**]** insurance dedicated fund by the legislature.

375.143. In order to effectuate and aid in the interpretation of section 375.141, the director may promulgate rules under section 374.045, RSMo, codifying professional standards of producer competency and trustworthiness in the handling of applications, premium funds, conflicts of interest, recordkeeping, supervision of others, and customer suitability.

473.398. 1. Upon the death of a person, who has been a **[**recipient**] participant** of aid, assistance, care, services, or who has had moneys expended on his behalf by the department of health and senior services, department of social services, or the department of mental health, or by a county commission, the total amount paid to the decedent or expended upon his behalf after January 1, 1978, shall be a debt due the state or county, as the case may be, from the estate of the decedent. The debt shall be collected as provided by the probate code of Missouri, chapters 472, 473, 474 and 475, RSMo.

2. Procedures for the allowance of such claims shall be in accordance with this chapter, and such claims shall be allowed as a claim of the seventh class under subdivision (7) of section 473.397.

3. Such claim shall not be filed or allowed if it is determined that:

(1) The cost of collection will exceed the amount of the claim;

(2) The collection of the claim will adversely affect the need of the surviving spouse or dependents of the decedent to reasonable care and support from the estate.

4. Claims consisting of moneys paid on the behalf of a **[**recipient**] participant** as defined in 42 U.S.C. 1396 shall be allowed, except as provided in subsection 3 of this section, upon the showing by the claimant of proof of moneys expended. Such proof may include but is not limited to the following items which are deemed to be competent and substantial evidence of payment:

(1) Computerized records maintained by any governmental entity as described in subsection 1 of this section of a request for payment for services rendered to the **[**recipient**] participant**; and

(2) The certified statement of the treasurer or his designee that the payment was made.

5. The provisions of this section shall not apply to any claims, adjustments or recoveries specifically prohibited by federal statutes or regulations duly promulgated thereunder. Further, the federal government shall receive from the amount recovered any portion to which it is entitled.

6. Before any probate estate may be closed under this chapter, with respect to a decedent who at the time of death was enrolled in MO HealthNet, the personal representative of the estate shall file with the clerk of the court exercising probate jurisdiction a release from the MO HealthNet division evidencing payment of all MO HealthNet benefits, premiums, or other such costs due from the estate under law, unless waived by the MO HealthNet division.

620.510. 1. There is hereby established the "Missouri Health Profession Shortage Planning Commission" within the department of economic development to develop recommendations regarding the health professions workforce in this state.

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

(1) "Economic cluster", a grouping of industries linked together through customer, supplier, or other relationships.

(2) "Health professions workforce" and "health care professionals", professionals or paraprofessionals who are qualified by special training, education, skills, and experience in providing health care, treatment, diagnostic services, and physical therapy under the supervision of or in collaboration with a licensed practitioner, and includes but is not limited to those listed in chapters 332, 334, 335, 336, and 338, RSMo, and dentists and pharmacists.

3. The commission shall consist of the following members:

(1) A member appointed by the speaker of the house of representatives;

(2) A member appointed by the president pro tem of the senate;

(3) A member appointed by the minority leader of the house of representatives;

(4) A member appointed by the minority leader of the senate;

(5) The director of the departments of health and senior services, the commissioner of elementary and secondary education, and the commissioner of the coordinating board of higher education, or their designees;

(6) The chairpersons and ranking members of the standing committees of the house of representatives and senate having cognizance of matters relating to public health, secondary education, and higher education and employment advancement, or their designees;

(7) A representative of the Missouri conference of community colleges; and

(8) A representative of the health care professions of the land grant university system training health care professionals.

Members appointed under this section shall be recognized experts in the field of health, finance, economics, or health facility management. All appointments to the board shall be made no later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority. The term of each nonlegislative member of the commission shall be three years from the date of appointment. Legislative members of the commission shall serve for the duration of their current term of office.

4. The commission shall elect a chairperson from among its members. Members of the commission shall serve without compensation, but may be reimbursed for actual and necessary expenses incurred in the performance of their duties as members of the commission. The commission shall convene its first meeting not later than sixty days after the effective date of this section.

5. The commission shall:

(1) Monitor data and trends in the health professions workforce, including but not limited to:

(a) The state's current and future supply and demand for health care professionals; and

(b) The current and future capacity of the state system area career centers and two-year and four-year institutions of higher education to educate and train students pursuing health care professions, and the capacity to utilize distance education in training and education of high school professionals;

(2) Develop recommendations for the formation and promotion of an economic cluster for health care professions;

(3) Identify recruitment and retention strategies for public and independent institutions of higher education with health care programs;

(4) Develop recommendations for promoting diversity in the health professions workforce, including but not limited to racial, ethnic, and gender diversity and for enhancing the attractiveness of health care professions;

(5) Develop recommendations regarding financial and other assistance to students enrolled in or considering enrolling in health care programs offered at area career centers public or private two-year and four-year institutions of higher education; and

(6) Identify recruitment and retention strategies for health care employers.

6. On or before January 1, 2008, and annually thereafter, the board shall submit a report on its findings and recommendations, including recommendations for legislation to address health professions workforce shortages in this state to the appropriate standing committees of the house of representatives and senate having cognizance of matters relating to public health and secondary education and higher education and employment advancement.

7. The provisions of this section shall expire August 30, 2012.

Section 1. 1. Pursuant to section 33.803, RSMo, by January 1, 2008, and each January first thereafter, the legislative budget office shall annually conduct a rolling five-year MO HealthNet forecast. The forecast shall be issued to the general assembly, the governor, the joint committee on MO HealthNet, and the oversight committee established in section 208.956, RSMo. The forecast shall include, but not be limited to, the following, with additional items as determined by the legislative budget office:

(1) The projected budget of the entire MO HealthNet program;

(2) The projected budgets of selected programs within MO HealthNet;

(3) Projected MO HealthNet enrollment growth, categorized by population and geographic area;

(4) Projected required reimbursement rates for MO HealthNet providers; and

(5) Projected financial need going forward.

2. In preparing the forecast required in subsection 1 of this section, where the MO HealthNet program overlaps more than one department or agency, the legislative budget office may provide for review and investigation of the program or service level on an interagency or interdepartmental basis in an effort to review all aspects of the program.

Section 2. Fee for service eligible policies for prescribing psychotropic medications shall not include any new limits to initial access requirements, except dose optimization or new drug combinations consisting of one or more existing drug entities or preference algorithms for SSRI antidepressants, for persons with mental illness diagnosis, or other illnesses for which treatment with psychotropic medications are indicated and the drug has been approved by the federal Food and Drug Administration for at least one indication and

is a recognized treatment in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature and deemed medically appropriate for a diagnosis. No restrictions to access shall be imposed that preclude availability of any individual atypical antipsychotic monotherapy for the treatment of schizophrenia, bipolar disorder, or psychosis associated with severe depression.

Section 3. There is hereby established in the state treasury the "Pharmacy Rebate Fund", and the "MoRx Pharmacy Rebate Fund". Any revenues received by the state, either directly or indirectly, from pharmaceutical manufacturer rebates as required by federal law or state supplemental rebates as defined in state plan amendments shall be deposited in the pharmacy rebate fund and shall be used only in the Medicaid pharmacy program or its successor programs authorized by Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, 42 U.S.C. Section 301, et seq. Any state rebates obtained in conjunction with the MoRx program shall be deposited in the MoRx pharmacy rebate fund and shall only be used for the MoRx pharmacy program.

Section 4. By August 1, 2008, the department of social services shall study and develop an acuity-based reimbursement system for the payment of care provided to nursing home residents licensed under chapter 198, RSMo. The study will consider but not be limited to the following items: the experience of other states who have implemented similar systems, the cost of such a system specific to Missouri, impact on consumers, and the long-term care system. The purpose of the study is to purpose an acuity-based system to adjust the payment to reflect the nursing home residents' changing needs for care and services. The department shall include representatives of the nursing home profession in the discussion and development of this study.

[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 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.**]**

[660.546. 1. The department of social services shall coordinate a program entitled the "Missouri Partnership for Long-term Care" whereby private insurance and Medicaid funds shall be combined to finance long-term care. Under such program, an individual may purchase a precertified long-term care insurance policy in an amount commensurate with his resources as defined pursuant to the Medicaid program. Notwithstanding any provision of law to the contrary, the resources of such an individual, to the extent such resources are equal to the amount of long-term care insurance benefit payments as provided in section 660.547, shall not be considered by the department of social services in a determination of:

(1) His eligibility for Medicaid;

(2) The amount of any Medicaid payment.

Any subsequent recovery of a payment for medical services by the state shall be as provided by federal law.

2. Notwithstanding any provision of law to the contrary, for purposes of recovering any medical assistance paid on behalf of an individual who was allowed an asset or resource disregard based on such long-term care insurance policy, the definition of estate shall be expanded to include any other real or personal property and other assets in which the individual has any legal title or interest at the time of death, to the extent of such interest, including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement.**]**

[660.547. The department of social services shall request appropriate waiver or waivers from the Secretary of the federal Department of Health and Human Services to permit the use of long-term care insurance for the preservation of resources pursuant to section 660.546. Such preservation shall be provided, to the extent approved by the federal Department of Health and Human Services, for any purchaser of a precertified long-term care insurance

policy delivered, issued for delivery or renewed within five years after receipt of the federal approval of the waiver, and shall continue for the life of the original purchaser of the policy, provided that he maintains his obligations pursuant to the precertified long-term care insurance policy. Insurance benefit payments made on behalf of a claimant, for payment of services which would be covered under section 208.152, RSMo, shall be considered to be expenditures of resources as required under chapter 208, RSMo, for eligibility for medical assistance to the extent that such payments are:

(1) For services Medicaid approves or covers for its recipients;

(2) In an amount not in excess of the charges of the health services provider;

(3) For nursing home care, or formal services delivered to insureds in the community as part of a care plan approved by a coordination, assessment and monitoring agency licensed pursuant to chapter 198, RSMo; and

(4) For services provided after the individual meets the coverage requirements for long-term care benefits established by the department of social services for this program.

The director of the department of social services shall adopt regulations in accordance with chapter 536, RSMo, to implement the provisions of sections 660.546 to 660.557, relating to determining eligibility of applicants for Medicaid and the coverage requirements for long-term care benefits.**]**

[660.549. The department of social services shall establish an outreach program to educate consumers to:

(1) The mechanisms for financing long-term; and

(2) The asset protection provided under sections 660.546 to 660.557.**]**

[660.551. 1. The department of insurance shall precertify long-term care insurance policies which are issued by insurers who, in addition to complying with other relevant laws and regulations:

(1) Alert the purchaser to the availability of consumer information and public education provided by the division of aging and the department of insurance pursuant to sections 660.546 to 660.557;

(2) Offer the option of home- and community-based services in lieu of nursing home care;

(3) Offer automatic inflation protection or optional periodic per diem upgrades until the insured begins to receive long-term care benefits; provided, however, that such inflation protection or upgrades shall not be required of life insurance policies or riders containing accelerated long-term care benefits;

(4) Provide for the keeping of records and an explanation of benefits reports to the insured and the department of insurance on insurance payments which count toward Medicaid resource exclusion; and

(5) Provide the management information and reports necessary to document the extent of Medicaid resource protection offered and to evaluate the Missouri partnership for long-term care including, but not limited to, the information listed in section 660.553.

Included among those policies precertified under this section shall be life insurance policies which offer long-term care either by rider or integrated into the life insurance policy.

2. No policy shall be precertified pursuant to sections 660.546 to 660.557, if it requires prior hospitalization or a prior stay in a nursing home as a condition of providing benefits.

3. The department of insurance may adopt regulations to carry out the provisions of sections 660.546 to 660.557.**]**

[660.553. The department of insurance shall provide public information to assist individuals in choosing appropriate insurance coverage, and shall establish an outreach program to educate consumers as to:

(1) The need for long-term; and

(2) The availability of long-term care insurance.**]**

[660.555. The director of the department of insurance each year, on January first shall report in writing to the department of social services the following information:

(1) The success in implementing the provisions of sections 660.546 to 660.557;

(2) The number of policies precertified pursuant to sections 660.546 to 660.557;

(3) The number of individuals filing consumer complaints with respect to precertified policies; and

(4) The extent and type of benefits paid, in the aggregate, under such policies that could count toward Medicaid resource protection.**]**

[660.557. The director of the department of social services shall request the federal approvals necessary to carry out the purposes of sections 660.546 to 660.557. Each year on January first, the director of the department of social services shall report in writing to the general assembly on the progress of the program. Such report will include, but not be limited to:

(1) The success in implementing the provisions of sections 660.546 to 660.557;

(2) The number of policies precertified pursuant to sections 660.546 to 660.557;

(3) The number of individuals filing consumer complaints with respect to precertified policies;

(4) The extent and type of benefits paid, in the aggregate, under such policies that could count toward Medicaid resource protection;

(5) Estimates of impact on present and future Medicaid expenditures;

(6) The cost effectiveness of the program; and

(7) A recommendation regarding the appropriateness of continuing the program.**]**

Section B. Because immediate action is necessary to ensure that the youth aging out of foster care are able to obtain services, the repeal and reenactment of section 208.151 of this act is deemed necessary for the immediate preservation of the public health, welfare, peace and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the repeal and reenactment of section 208.151 of this act shall be in full force and effect upon its passage and approval.

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