FIRST REGULAR SESSION

[P E R F E C T E D**]**

SENATE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 577

94TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR SHIELDS.

Offered April 2, 2007.

Senate Substitute adopted, April 4, 2007.

Taken up for Perfection April 4, 2007. Bill declared Perfected and Ordered Printed, as amended.

TERRY L. SPIELER, Secretary.

2227S.06P

AN ACT

To repeal sections 191.411, 191.900, 191.905, 191.910, 208.014, 208.151, 208.152, 208.153, 208.201, 208.212, 208.215, 208.217, 208.631, 208.930, 473.398, 660.546, 660.547, 660.549, 660.551, 660.553, 660.555, and 660.557, RSMo, and to enact in lieu thereof thirty-six 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 191.411, 191.900, 191.905, 191.910, 208.014, 208.151, 208.152, 208.153, 208.201, 208.212, 208.215, 208.217, 208.631, 208.930, 473.398, 660.546, 660.547, 660.549, 660.551, 660.553, 660.555, and 660.557, RSMo, are repealed and thirty-six new sections enacted in lieu thereof, to be known as sections 191.411, 191.900, 191.905, 191.907, 191.908, 191.909, 191.910, 191.914, 208.001, 208.151, 208.152, 208.153, 208.197, 208.201, 208.202, 208.212, 208.215, 208.217, 208.230, 208.631, 208.659, 208.670, 208.690, 208.692, 208.694, 208.696, 208.698, 208.930, 208.950, 208.955, 208.975, 473.398, 1, 2, 3, and 4, to read as follows:

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

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

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". 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, psychologists, or other mental health providers licensed under chapter 337, RSMo,** 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 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, and, upon conviction, forever shall be excluded from participation as a provider for the medical assistance program.

[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. 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.

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 recipient 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) Number of MO HealthNet long-term care facility reviews;

(3) Number of MO HealthNet provider and recipient 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 knowingly with the intent to defraud the medical assistance program shall 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 person who previously has been convicted of making a false report or claim under this section and who is subsequently convicted of making a false report or claim under this section is guilty of 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.

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 Health Improvement Act of 2007".

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". Where the title Medicaid appears it shall be replaced with MO HealthNet throughout Missouri Revised Statutes. Where the title division of medical services appears it shall be replaced with "MO HealthNet Division".

3. The department of social services, MO HealthNet division is authorized to promulgate rules, including emergency rules if necessary, to implement the provisions of the "Missouri Health Improvement Act of 2007" including but not limited to the form and content of any documents required to be filed under the "Missouri Health Improvement Act of 2007";

4. When construing the provisions of the "Missouri Health Improvement Act of 2007" and any rules promulgated thereunder, the department shall ensure that any rules are promulgated consistent with the principles of transparency, personal responsibility, prevention and

wellness, performance-based assessments, and achievement of improved health outcomes and cost-effective delivery through the use of technology and coordination of care.

5. 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 Health Improvement Act of 2007, 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 Health Improvement Act of 2007, shall be invalid and void.

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 state supplemental payments for the aged, blind and disabled;

(2) All recipients of aid to families with dependent children benefits, including all persons under nineteen years of age who would be classified as dependent children except for the requirements of subdivision (1) of subsection 1 of section 208.040**. Participants 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 the dependent child or children are removed from the custody of the participant**;

(3) All recipients of blind pension benefits;

(4) All persons who would be determined to be eligible for old age assistance benefits, permanent and total disability benefits, or aid to the blind benefits under the eligibility standards in effect December 31, 1973, or less restrictive standards as established by rule of the family support division, who

are sixty-five years of age or over and are patients in state institutions for mental diseases or tuberculosis;

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

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

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

(8) All recipients of family foster home or nonprofit private child-care institution care, subsidized adoption benefits and parental school care wherein state funds are used as partial or full payment for such care;

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

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

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

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

(13) Children who have attained one year of age but have not attained six years of age who are eligible for medical assistance under 6401 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989). The family support division 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. The division may consider training such current or former welfare recipients as **[**case workers**]** **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;

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

(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. 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. 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**, but in no event shall such waiver applications or amendments seek to waive the services of a rural health clinic or a federally qualified health center as defined in 42 U.S.C. 1396d(l)(1) and (2) or the payment requirements for such clinics and centers as provided in 42 U.S.C. 1396a(a)(15) and 1396a(bb)**. 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**]** **Medical assistance on behalf of needy persons shall be known as MO HealthNet. 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, **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 benefit payments under subdivision (4) of this subsection for those days, which shall not exceed twelve per any period of six consecutive months, during which the recipient is on a temporary leave of absence from the hospital or nursing home, provided that no such recipient shall be allowed a temporary leave of absence unless it is

specifically provided for in his plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a recipient is away from the hospital or nursing home overnight because he is visiting a friend or relative;

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

(7) 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 family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one recipient one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time;

(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 to the extent that such services are provided in accordance with chapter 335, RSMo, and regulations promulgated thereunder, regardless of whether the nurse practitioner is supervised by or in association with a physician or other health care provider;

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

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

a. The occupancy rate of the nursing home is at or above ninety-seven percent of **[**Medicaid**]** **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 is admitted to the hospital; and

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

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

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

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

(19) Prescribed, medically necessary durable medical equipment. An electronic prior authorization system using best medical evidence and accepted care and treatment guidelines 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**]** **MO HealthNet division**, unless otherwise hereinafter provided, for the following:

(1) Dental services;

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

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

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

(5) Hospice care. As used in this subsection, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the **[**division of medical services**]** **MO HealthNet division** to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed,

implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The **[**division of medical services**]** **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.

3. Benefit payments for medical assistance for surgery as defined by rule duly promulgated by the **[**division of medical services**]** **MO HealthNet division**, 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**]** **MO HealthNet division** may require any recipient of **[**medical assistance**]** **MO HealthNet benefits** to pay part of the charge or cost, 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 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 under this section shall be reduced from any payments made

by the state for goods or services described herein except the recipient portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. **If the provider is unable to collect the co-payment from the recipient, the division shall make full payment to the provider for services rendered and shall not reduce the payment as though the co-payment had been collected, provided however, that the provider demonstrates to the division that reasonable efforts were made to collect the co-payment.** A provider shall not refuse to provide a service if a recipient is unable to pay a required cost sharing. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected 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 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. 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. The **[**division of medical services**]** **MO HealthNet division** shall have the right to collect medication samples from recipients in order to maintain program integrity.

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

7. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of

subsection 6402(c) and Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

8. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for **[**medical assistance**]** **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. 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. 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. The **[**department of social services, division of medical services**]** **MO HealthNet division**, may enroll qualified residential care facilities, as defined in chapter 198, RSMo, as **[**Medicaid**]** **MO HealthNet** personal care providers.

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 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, pursuant to and not inconsistent with the provisions of sections 208.151, 208.152, and 208.153, the MO HealthNet division shall by rule and regulation develop pay-for-performance payment program guidelines. The pay-for-performance payment program guidelines shall be developed and maintained by the professional services payment committee, as established in section 208.197. Providers operating under a risk-bearing care coordination plan and an administrative services organization plan, as defined in section 208.950, shall be required to participate in a pay-for-performance payment program, and providers operating under the state care management point of service plan, as defined in section 208.950, shall participate in the pay-for-performance payment program.**

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.

208.197. 1. The "Professional Services Payment Committee" is hereby established within the MO HealthNet division to develop and oversee the pay-for-performance payment program guidelines under 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 nine physicians licensed to practice in this state, two patient advocates and the attorney general, or his or her designee. The remaining members shall be persons actively engaged in hospital administration, nursing home administration, dentistry, and pharmaceuticals. 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 accurate data and evidence-based measures, 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 Missouri 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.

208.202. 1. The director of the MO HealthNet Division, in collaboration with other appropriate agencies, is authorized to implement, subject to appropriation, a premium offset program for making standardized private health insurance coverage available to qualified individuals. Under the program:

(1) An individual is qualified for the premium offset if the individual has been uninsured for one year;

(2) The premium offset shall only be payable for an employee if the employer or employee or both pay their respective shares of the required premium. Absent employer participation, a qualified employee, or qualified employee and qualified spouse, may directly enroll in the MO HealthNet premium offset program;

(3) The qualified uninsured individual shall not be entitled to MO HealthNet wraparound services.

2. Individuals qualified for the premium offset program established under this section who apply after appropriation authority is depleted to pay for the premium offset shall be placed on a waiting list for that state fiscal year. If additional money is appropriated the MO HealthNet division shall process applications for MO HealthNet premium offset services based on the order in which applicants were placed on the waiting list.

3. The department of social services is authorized to pursue either a federal waiver or a state plan amendment, or both, to obtain federal funds necessary to implement a premium offset program to assist uninsured lower-income Missourians in obtaining health care coverage.

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.

208.215. 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 public assistance on account of personal injury to or disability or disease or benefits arising from a health insurance plan to which the recipient may be entitled, payments made by the department of social services **or MO HealthNet division** shall be a debt due the state and recoverable from the

liable party or recipient for all payments made in behalf of the recipient and the debt due the state shall not exceed the payments made from **[**medical assistance**]** **MO HealthNet benefits** provided under sections 208.151 to 208.158 and section 208.162 and section 208.204 on behalf of the recipient, minor or estate for payments on account of the injury, disease, or disability or benefits arising from a health insurance program to which the recipient may be entitled. **Any health benefit plan as defined in section 376.1350, 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 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, or its contractor** may maintain an appropriate action to recover funds **paid by the department of social services or MO HealthNet division or its contractor 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, minor or estate.

3. Any recipient, minor, guardian, conservator, personal representative, estate, including persons entitled under section 537.080, RSMo, to bring an action for wrongful death who pursues legal rights against a person, corporation, institution, public agency, or private agency liable to that recipient or minor for injuries, disease or disability or benefits arising from a health insurance plan to which the recipient may be entitled as outlined in subsection 1 of this section shall upon actual knowledge that the department of social services **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 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, 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 shall cooperate with the agency in obtaining third-party resources due to the applicant, recipient, or child for whom assistance is claimed. Failure to cooperate without good cause as determined by the department of social services**,** **MO HealthNet division** in accordance with federally prescribed standards shall render the applicant or recipient ineligible for **[**medical assistance**]** **MO HealthNet benefits** under sections 208.151 to 208.159 and sections 208.162 and 208.204. **A recipient who has notice or who has actual knowledge of the department's rights to third-party benefits who receives any third-party benefit or proceeds for a covered illness or injury is either required to pay the division within sixty days after receipt of settlement proceeds, the full amount of the third-party benefits up to the total MO HealthNet benefits provided or to place the full amount of the third-party benefits in a trust account for the benefit of the division pending judicial or administrative determination of the division's right to third-party benefits.**

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 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 to recover damages for such injuries, disease, or disability, or benefits arising from a health insurance program to which the recipient may be entitled.

6. Every recipient, minor, guardian, conservator, personal representative, estate, including persons entitled under section 537.080, RSMo, to bring an action for wrongful death, or his attorney or legal representative shall promptly notify the **[**department**]** **MO HealthNet division** of any recovery from a third party

and shall immediately reimburse the department **of social services, MO HealthNet division, or its contractor** from the proceeds of any settlement, judgment, or other recovery in any action or claim initiated against any such third party. **A judgment, award, or settlement in an action by a recipient to recover damages for injuries or other third-party benefits in which the division has an interest may not be satisfied without first giving the division notice and a reasonable opportunity to file and satisfy the claim or proceed with any action as otherwise permitted by law.**

7. The department **[**director**] of social services, MO HealthNet division or its contractor** shall have a right to recover the amount of payments made to a provider under this chapter because of an injury, disease, or disability, or benefits arising from a health insurance plan to which the recipient may be entitled for which a third party is or may be liable in contract, tort or otherwise under law or equity. **Upon request by the MO HealthNet division, all third-party payers shall provide the MO HealthNet division with information contained in a 270/271 Health Care Eligibility Benefits Inquiry and Response standard transaction mandated under the federal Health Insurance Portability and Accountability Act, except that third party payers shall not include accident-only, specified disease, disability income, hospital indemnity, or other fixed indemnity insurance policies.**

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

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

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

(3) The total hospital, doctor and other medical expenses incurred for care and treatment of the injury to the date of recovery therefor, the portion of such expenses theretofore paid by the recipient, by insurance provided by the recipient, and by the department, and the amount of such previously incurred expenses

which remain unpaid at the time of recovery and by whom such incurred, unpaid expenses are to be paid;

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

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

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

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

11. The court may reduce and apportion the department's **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 because of its advancement of any assistance,

such charge shall not be satisfied out of any recovery until the attorney's claim for fees is satisfied, irrespective of whether or not an action based on recipient's claim has been filed in court. Nothing herein shall prohibit the director from entering into a compromise agreement with any recipient, after consideration of the factors in subsections 9 to 13 of this section.

13. This section shall be inapplicable to any claim, demand or cause of action arising under the workers' compensation act, chapter 287, RSMo. From funds recovered pursuant to this section the federal government shall be paid a portion thereof equal to the proportionate part originally provided by the federal government to pay for **[**medical assistance**]** **MO HealthNet benefits** to the recipient 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 has sole legal interest or a legal interest based upon co-ownership of the property which is the result of a transfer of property for less than the fair market value within thirty months prior to the recipient's entering the nursing facility. The following provisions shall apply to such liens:

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

(2) The **[**director of the department or the director's designee**]** **MO HealthNet division** shall file for record, with the recorder of deeds of the county in which any real property of the recipient is situated, a written notice of the lien. The notice of lien shall contain the name of the recipient and a description of the real estate. The recorder shall note the time of receiving such notice, and shall record and index the notice of lien in the same manner as deeds of real estate are required to be recorded and indexed. The director or the director's designee may release or discharge all or part of the lien and notice of the release shall also be filed with the recorder**. The department of social services, 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 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 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 department of social services, 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

recipient 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 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 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**]** **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.

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

2. Any applicant for health care benefits under public assistance programs, including, but not limited to, state Medicaid assistance under this chapter, or any person requesting uncompensated care in a hospital, shall identify the employer or employers of the proposed beneficiary of the health care benefits. If the proposed beneficiary is not employed, the applicant must identify the employer or employers of any adult who is responsible for providing all or some of the proposed beneficiary's support.

3. (1) The department of social services shall annually prepare a public assistance program beneficiary employer report to be submitted to the governor and general assembly. For the purposes of this section, a "public assistance program beneficiary" means a person who receives medical assistance under the state Medicaid system, Title XIX, P.L. 89-97, 1965, amendments to the federal Social Security Act, 42 U.S.C. Section 30, et. seq., as amended. The report shall provide the following information for each employer who has more than fifty employees and twenty-five or more public assistance program beneficiaries:

(a) The name and address of the qualified employer;

(b) The number of public assistance program beneficiaries;

(c) The number of public assistance program beneficiaries who are spouses or dependents of employees of the employer;

(d) Information on whether the employer offers health insurance benefits to employees and their dependents;

(e) Information on whether the employer receives health insurance benefits through the company;

(f) Whether an employer offers health insurance benefits, and, if so, information on the level of premium subsidies for such health insurance;

(g) The cost to the state of Missouri of providing public

assistance program benefits for the employer's employees and enrolled dependents.

(2) The report shall not include the names of any individual public assistance program beneficiary and shall be subject to privacy standards both in the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, and in Title XIX of the federal Social Security Act.

(3) The report shall be issued within thirty days of the end of each calendar year, starting with calendar year 2008. The department of social services shall make the report available to the public through the department's Internet website. Any member of the public shall have the right to request and receive a copy of the report published under this subsection. The department shall have the discretion to determine the appropriate cost and number of copies given.

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**]** **208.657** is subject to appropriation. The provisions of sections 208.631 to 208.657**, "Health Care for Uninsured Children"** shall be void and of no **[**effect after June 30, 2008**] affect 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 pursuant to the Federal Social Security Act**.

2. For the purposes of sections 208.631 to 208.657, "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. The division of medical services 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, these terms shall have the following meaning:

(1) "Provider", any provider of medical services and 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. Reimbursement for such services shall be made in the same way as reimbursement for in-person contacts.

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 and professional regulation 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. 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 and professional regulation. 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 and professional regulation 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 and professional regulation shall:

(1) Develop requirements to ensure 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;

(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;

(a) This subsection shall not apply to inflation protection as required under Section 6021(a)(1)(iii)(iv) of the Federal Deficit Reduction Act of 2005;

(b) The inflation protection required for partnership policies, as stated under Section 6021(a)(1)(iii)(iv) of the Federal Deficit Reduction Act of 2005, shall be no less favorable than the inflation protection offered for all long-term care policies under the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Regulation as specified in 42 U.S.C. 1917(b);

(3) 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; and

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

2. The director of the department of insurance, financial and professional regulation 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 and professional regulation as provided in Section 6021 of the Federal Deficit Reduction Act of 2005.

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**]** **non-MO 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**]** **2009**.

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

(1) "Administrative services organization", a system of health care delivery providing care management and health plan administration services on a noncapitated basis;

(2) "Health care advocate", a health care professional that

provides comprehensive coordinated physical and behavioral health in partnership with the patient, their family, and their caregivers to assure optimal consideration of medical, behavioral or psychosocial needs. The services of the health care advocate shall provide a health care home for the participant, where the primary goal is to assist patients and their support system with accessing more choices in obtaining primary care services, coordinating referrals, and obtaining specialty care. The health care advocate encourages health-based educational-interventions with related services, both in-home and out-of-home care, family support assistance from both private and public-sector providers. A health care advocate shall be trained and certified by the department of social services to provide those services prescribed under this section;

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

(4) "Health improvement plan", a health care delivery mechanism which is either risk-bearing care coordination, an administrative services organization, or a state care management point of service plan;

(5) "Risk-bearing care coordination", a system of health care delivery providing payment to providers on a prepaid capitated basis, as defined in section 208.166;

(6) "State care management point of service plan", a system of health care delivery administered by the department of social services.

2. Beginning no later than July 1, 2008, the MO Healthnet Division shall function as a third party administrator, providing all participants of the MO HealthNet benefits 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., a choice of which health improvement plans to enroll in. The three access choices for a health improvement plan shall include a risk-bearing care coordination plan, an administrative services organization plan, and a state care management point of service plan. The state shall provide to applicants information on all three health improvement plans prior to the applicant choosing a plan. The participant shall also choose between available vendors in the health improvement plan.

3. The department of social services shall, if required, request

the appropriate waiver or state plan amendment from the Secretary of the federal Department of Health and Human Services to permit the establishment of administrative services organizations.

4. By July 1, 2013, all participants of 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 enrolled in the health improvement plan of their choice. The department shall implement a plan for enrolling all such participants in accordance with the time line specified in subsections 11, 12, and 13 of this section.

5. No provision of any statute shall be construed as to require any aged, blind or disabled person to enroll in a risk-bearing care coordination plan unless there is no other health improvement plan available in the area.

6. The department shall implement a risk-bearing care coordination plan, an administrative services organization plan, and a state care management point of service plan. The office of administration shall commission an independent evaluation and comparison of all models on the basis of cost, quality, health improvement, health outcomes, social and behavioral outcomes, health status, customer satisfaction, use of evidence-based medicine, and use of best practices. The annual evaluation by the department shall be submitted to the oversight committee established under section 208.955. Each contractor or state agency evaluated shall bear the cost of their portion of the evaluation. Nothing in this subsection shall be construed to require the department to limit the implementation of these plans as a pilot project.

7. The department shall promulgate rules outlining an exemption process for participants whose current treating physicians are not participating in either a risk-bearing care coordination or administrative services organization network in order to prevent interruption in the continuity of medical care. However, the department shall formulate a plan so that by July 1, 2013, all participants are enrolled in one of the plans mentioned in subsection 1 of this section.

8. The department shall require participants in the risk-bearing care coordination plan to choose a primary care provider from the

approved risk-bearing care coordination plan within thirty days of enrollment in the plan. If the participant does not choose a primary care provider, a provider will be selected for the participant.

9. The department shall engage in a public process for the design, development, and implementation of the health improvement plans, health advocates, and health improvement points, and other provisions of MO HealthNet; such public process shall include but not be limited to processes to allow for input from consumers, health advocates, disability advocates, and other key stakeholders parties.

10. (1) The department shall promulgate rules for the implementation of the risk-bearing care coordination plan. Under the plan there shall be the establishment of risk-based coordinated care with a guaranteed savings level that is actuarially sound. The risk-bearing care coordination plan shall operate generally under a traditional managed care model, and as outlined in section 208.166, including offering care coordination ensuring the coverage of services as prescribed under section 208.152, RSMo, utilization management, claims adjudication, participant education, primary care case management, and pharmacy management. However, the state shall retain coverage of services and provider reimbursement of services as prescribed under paragraph (c) of subdivision (15) of section 208.152. The plan vendor may subcontract pharmacy management to the state.

(2) All risk-bearing care coordination plans shall spend at least one-half percent of the per member per month capitated rate reimbursed by the state on healthy behavior promotion and wellness programs. The plans shall spend at least a majority of the one-half percent amount directly on programs for its members. The one-half percent of the per member per month capitated rate reimbursed by the state shall not be included by the state's actuaries when developing the capitated rates. Upon subsequent request for proposals or contract amendments, the risk-bearing care coordination plans shall specify both the plans and goals for promoting healthy behaviors and wellness activities and how the one-half percent of the per member per month rate shall be spent to promote healthy behavior and wellness on its members. The risk-bearing care coordination plans shall submit a report every six months to the oversight committee established under

section 208.955, on health and wellness outcomes, and on any adjustments to the plan as a result of outcomes measured.

11. The department shall promulgate rules for the implementation of the administrative service organization plan. For the administrative service organization plan, the financial terms shall require that the vendor fees be reduced if savings and quality targets specified by the department are not met. For a risk-bearing coordination of care plan, the contract shall require that the contracted per diem be reduced or other financial penalty occur if the quality targets specified by the department are not met. For purposes of this subsection, "quality targets specified by the department for administrative services organization plans and risk-bearing coordination of care plans" shall include, but not be limited to, rates at which participants whose care is being managed by such plans seek to use hospital emergency department services for nonemergency medical conditions. The administrative services organization plan shall provide care coordination, utilization management, participant education, and primary care case management. The state shall continue to retain provider reimbursement, pharmacy management, eligibility determination, and provider network management ensuring the coverage of services as prescribed under section 208.152.

12. For the risk-bearing care coordination and administrative service organization plans, there shall be competitive requests for proposals as is consistent with state procurement policies of chapter 34, RSMo, or through other existing state procurement processes. The department shall establish criteria for award selection to include preference for Missouri-based vendors and prior experience as required by chapter 34, RSMo. The risk-bearing care coordination and administrative service organization plans shall include the elements outlined in this subsection. The state care management point of service plan as defined in subsection 1 of this section may include any or all of the elements outlined in this subsection.

(1) For all plans, there shall be an option for participants to choose a health care advocate. The vendor shall assist the participant in choosing the health care advocate. The health care advocate, serving on behalf of a health care home, shall coordinate and facilitate, either directly or indirectly through care managers, an individual's

health care needs by making referrals, conducting health risk assessments, providing care management, and helping the participant navigate the health care system. The health care advocate, in conjunction with a multi-disciplinary team of health care professionals, if applicable to a participant's health care needs, and using the information from the health risk assessment, shall create a complete physical and behavioral plan of care for the participant based on that participant's unique health care needs and goals. The vendor shall take all steps to ensure that the services of the health care advocate are accessible, continuous, comprehensive, coordinated and family-centered, providing a health care home for participants;

(2) For all plans, the vendors shall issue electronic access cards to participants. Such cards may be used to satisfy cost-sharing at the hospital, physician's office, pharmacy, or any other health care professional and also allow participants to earn enhanced health improvement points by signing a health improvement participant agreement, participating in healthy practices that include following the plan of care, and making responsible lifestyle choices consistent with the participant's unique health care needs and goals. These health improvement points will provide participants the ability to use the card to pay for approved health care expenditures. The health care advocate shall advise the participant regarding the appropriate health care expenditures for each participant consistent with the participant's plan of care. Participants who engage in a discussion with their health care advocate on the participant's recommended plan of care may access physical therapy, speech therapy, or occupational therapy, or comprehensive day rehabilitation services, or a combination of therapy if the general assembly has passed an appropriation and the governor has signed the appropriation for the therapy and the therapy is part of the participant's plan of care that includes evidence-based performance measures. The MO HealthNet division shall promulgate regulations designating the format of the plan of care and outcome measures, with preference given to electronic documents. The MO HealthNet division may by state regulation promulgate a range of approved activities or behaviors that can earn credit amounts. The division shall also promulgate a list of approved health care expenditures, including but not limited to: Medicaid eligible services, co-pays, spenddown, over-

the-counter drugs, and vitamins. Nothing in this subdivision shall be construed to deny a currently covered eligible service if such participant fails or is unable to follow their health improvement participation agreement;

(3) For all plans, there will be three-year contract terms subject to annual savings and quality targets determined by the department and which shall include consumer and provider satisfaction levels;

(4) For all plans, there shall be mechanisms in place to promote and determine the appropriate use of in-home care for participants prior to admissions in custodial skilled nursing facilities. Such in-home care providers shall meet, at a minimum, quality standards currently required through MO HealthNet contracts;

(5) For all plans, there shall be at least quarterly reporting of participant and provider quality and satisfaction indicators including, but not limited to, complaints, prompt payment of providers, call center statistics, and denials of care, to be determined by the department, to ensure the highest levels of care;

(6) For all plans, the vendors shall establish participant call centers based in Missouri to receive questions from participants regarding the program and to refer the participants to appropriate state offices, when necessary;

(7) For all plans, the state shall establish a level of copayments to be paid by participants for state-designated services that are not federally mandated, including but not limited to prescription drugs;

(8) For all plans, the state shall establish a sliding scale fee level of co-pays for emergency department visits to a hospital. The co-pay shall be waived if the participant is subsequently admitted on an in-patient basis into the hospital;

(9) For all plans, if the plans are established within a sixty-mile radius of a federally qualified health center, rural health clinic, community mental health center, local public health agency, or a program designated by the department of mental health, the vendors shall establish partnerships with such health centers, clinics, and designated programs, as well as seek arrangements with telehealth providers as described under section 208.670, to ensure availability of care. Payment to such federally qualified health centers or rural health clinics shall be as provided in 42 U.S.C. 1396a(a)(15); and

(10) For all plans, the vendors shall also establish a twenty-four-hour, confidential, toll-free nurse health line to be staffed by licensed registered nurses. Participants shall be encouraged to call when symptomatic, before making appointments or visiting an urgent care room. The nurse shall assess symptoms and provide care recommendation to seek services at the appropriate time and level of intervention. The nurses shall not diagnose nor provide treatment.

13. By July 1, 2008, the department shall begin enrollment of parents and children not already enrolled in MO HealthNet managed care in a health improvement plan, with complete enrollment by July 1, 2009.

14. By July 1, 2009, the department shall begin enrollment in a health improvement plan for one-half of the participants of MO HealthNet benefits who receive such assistance on the basis of being aged, blind, or disabled, as specified in subdivision (24) of section 208.151, on an opt-out basis, with complete enrollment for participants under this subsection completed by July 1, 2010.

15. By July 1, 2013, enrollment in a health improvement plan shall be completed for the remainder of the recipients of MO HealthNet benefits who receive such assistance on the basis of being aged, blind, or disabled, as specified in subdivision (24) of section 208.151.

16. 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.

208.955. 1. There is hereby established in the department of social services an "Oversight Committee on Health Improvement Plans". The oversight committee shall be appointed by January 1, 2008, and shall consist of fourteen members:

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

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

(3) Two consumer representatives, not from the same geographic area or health improvement plan, appointed by the governor;

(4) Two health care providers, not from the same geographic area, appointed by the governor;

(5) Two advocates of health care, appointed by the governor;

(6) The directors of the department of social services, the department of mental health, and the department of health and senior services, or the directors' designee; and

(7) The attorney general, or his or her designee.

2. The members of the 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 committee shall be selected by the members of the committee. Of the members first appointed to the committee by the governor, three members shall serve a term of two years, three 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 committee shall be filled in the same manner as the original appointment. Members shall serve on the 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 and administrative support services as required by the committee. The oversight committee shall:

(1) Meet on at least four occasions the first year and then on at least two occasions each year thereafter;

(2) Review the participant and provider satisfaction reports required of the plan vendors under subdivision (5) of subsection 10 of section 208.950;

(3) Review the call center statistics required to be maintained by the plan vendors under subdivision (5) of subsection 10 of section 208.950;

(4) Determine how the data collected from subdivisions (2) and (3) of this subsection shall be analyzed to determine the health or other outcomes and financial impact from the plans as defined by the state,

and how such findings may be communicated to consumers, health care providers, and public officials;

(5) Report significant findings indicating satisfaction or dissatisfaction of the plans to the general assembly;

(6) Perform other tasks as necessary, including making recommendations to the department of social services concerning the promulgation of emergency rules to ensure quality of care, availability, participant satisfaction and status information on the plans.

3. By July 1, 2013, the oversight committee shall issue findings to the general assembly on the success and failure of the health improvement plans and recommend whether to discontinue any of the plans.

4. The oversight committee shall designate a subcommittee devoted to 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;

(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; and

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

5. The subcommittee shall include the following members:

(1) The lieutenant governor or his 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 industry, designated by the governor;

(4) One member representing long-term care facilities, designated by the governor;

(5) One gerontologist, designated by the governor;

(6) One member representing the state hospital industry, 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) Two consumer representatives with expertise in services for seniors or the disabled, designated by the governor;

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

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

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

(13) 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:

(1) A complete state-wide information and assistance system accessible by phone, in-person, or 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) A uniform intake or screening and assessment mechanism for establishing consumers' needs for services;

(3) A mechanism for developing a plan of service or care to authorize appropriate services;

(4) A pre-admission screening mechanism 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.

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.

208.975. 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 fund shall be administered by the department of social services.

2. 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. Any moneys remaining in the fund at the end of the biennium shall revert to the credit of the general revenue fund. The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

3. Upon appropriation, moneys in the fund shall be used to promote technological advances to improve patient care, decrease administrative burdens, 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; and

(6) Telemonitoring.

4. The department of social services 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 preference for not-for-profit 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.

473.398. 1. Upon the death of a person, who has been a recipient 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 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; 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.

Section 1. Notwithstanding any other provision of this act to the contrary, no request for proposal for an administrative services organization plan, as established in section 208.950, RSMo, shall be permitted or no contract for an administrative services organization plan shall be awarded prior to August 28, 2007. Any request for proposal or contract for an administrative services organization plan shall be limited to the portions of the state which are not covered by a Medicaid managed care program. For purposes of a request for proposal for health improvement plans, as defined in section 208.950, RSMo, there shall be a request for proposal for at least six regions in the state, however in no case shall there be a single provider for the state. Counties with a risk bearing care coordination plan as of July

1, 2007, shall continue as risk bearing care coordination plans for the categories of aid in such program as of July 1, 2007.

Section 2. 1. Beginning September 1, 2007, an advisory working group is hereby created for the purpose of conducting 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 working group 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. The advisory working group shall consist of the following:

(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 advisory working group.

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

3. A chair of the advisory working group shall be selected by the members of the advisory working group.

4. The advisory working group shall meet as necessary.

Section 3. Any funds remaining after the appropriation of funds to the attorney general or the prosecuting or circuit attorney pursuant to 191.905.11, which have been appropriated to the state agency responsible for administering the medical assistance program, shall be used to increase MO HealthNet provider reimbursement until the average MO HealthNet provider reimbursement equals the average Medicare provider reimbursement for comparable services.

Section 4. Centers for independent living, as defined in section 178.651, RSMo, that assist eligible MO HealthNet participants in the refurbishing of prescribed, medically necessary durable medical

equipment, in place of purchasing new durable medical equipment shall receive twenty percent of the savings generated by such actions.

[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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